Bluestone

Child & Adolescent Psychiatric Hospital

TRANSFORMING MENTAL HEALTH

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COMMUNITY LETTER

To the Residents of Northeast Ohio:

Thank you for your interest in the 2023 Bluestone Child & Adolescent Psychiatric Hospital Community Health Needs Assessment (CHNA). As the first CHNA completed by the hospital since its opening in 2022, we are pleased to present this snapshot of the adolescent population that we serve in Northeast Ohio and beyond.

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, Speech and Language Pathologists, Occupational Therapists, Special Education Teachers, 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 status 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.

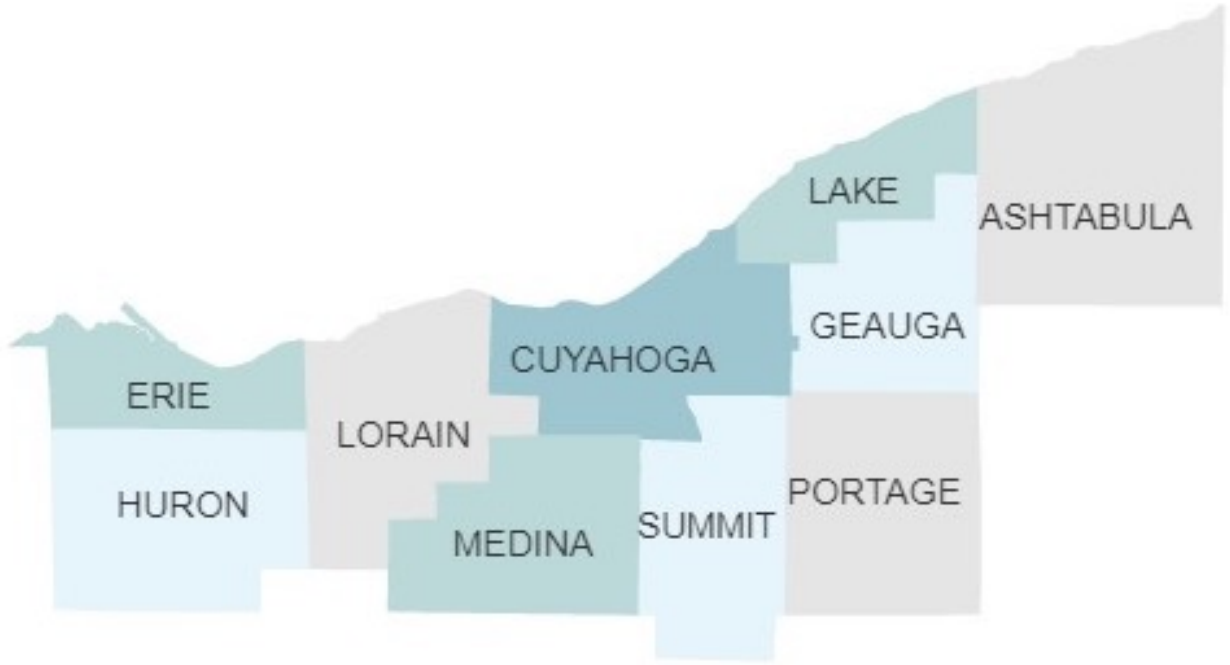
This assessment is intentionally designed to frame adolescent mental health status in the context of the whole person, to better inform the community as we seek to leverage resources and investments that will improve the mental health of the community.

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 10-county area in Northeast Ohio. This represents the geography from which 70% of the patients have been served since the hospital's opening in January 2022.

Figure 1: Bluestone Northeast Ohio Primary Service Area



COMMUNITY HEALTH NEEDS ASSESSMENT PARTNERS

Thank You.

We offer special thanks to the representatives of the CHNA Steering Committee and to the stakeholder participants of the interviews who generously gave their time and input to provide insight and guidance to the process.

Table 1 outlines the Steering Committee members.

Table 1: Steering Committee Members:

Name	Organization
Pamela Budak	Executive Director, Bluestone Child & Adolescent Psychiatric Hospital
Racheal Fuller	Director of Legal Services, Wingspan Care Group
Leigh Hall	General Counsel, Wingspan Care Group
Andrew Hertz, MD	Pediatrician/Board Member, Bluestone Child & Adolescent Psychiatric Hospital
Adam G. Jacobs, Ph.D.	Chair, Board of Directors, Bluestone Child & Adolescent Psychiatric Hospital
Lynn Milliner, MD	Pediatrician / Chair, Applewood Centers Board of Directors
Scott Moore	Chief Financial Officer, Wingspan Care Group
Beth Cohen Pollack	Director of Organizational Advancement, Wingspan Care Group
Marcy Schwartz, MD	Physician (retired) / Board Member, Bluestone Child & Adolescent Psychiatric Hospital
Stephanie Silverman	Business Owner / Chair, Bellefaire JCB Board of Directors
Sandra Wuliger	Board Member, Bluestone Child & Adolescent Psychiatric Hospital

The needs assessment was facilitated by Strategy Solutions, Inc. The project team included:

- Jacqui Catrabone, BA, MSW
- Debra Thompson, BS, MBA
- Robin Morris, BA
- Ann Camp

With qualitative research and analysis provided by Elizabeth Anthony.

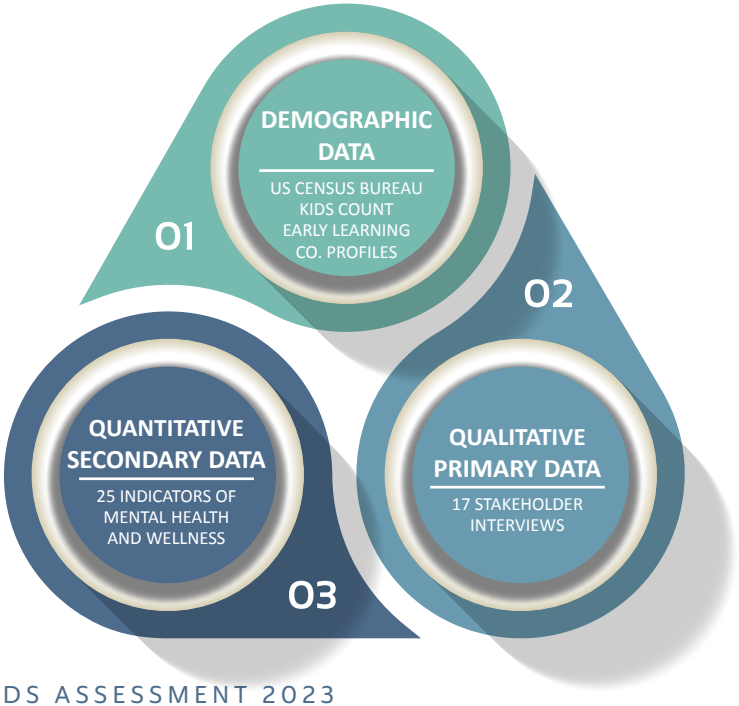
EXECUTIVE SUMMARY

Established in 2022, this is the first Community Health Needs Assessment (CHNA)conducted by Bluestone Child & Adolescent Psychiatric Hospital in partnership with the community. In 2023, the Steering Committee for the study included 11 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 17 key community stakeholders through individual interviews. As this is Bluestone's first CHNA, the report does not include an 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 the Early Learning County Profiles.
- **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.

Figure 2: Data Triangulation



Demographics

There are 636,089 children under the age of 18 in the 10-county service area that accounts for 70% of hospital admissions. This represents 24.2% of the state's youth population. The service territory has a slightly higher percentage of females 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%). Ashtabula County has the highest percentage of children with a disability (7.4%), while other counties in the service area range from 2.7% (Geauga County) to 5.7% (Cuyahoga County).

General Findings

Improving Indicators

The percentage of 7-12th grade students with anxiety issues warranting further exploration by a mental health professional has decreased in Portage County (27.5% in 2019-2020 to 26.9% in 2020-2021). The percentage of 7-12th grade students who report that they seriously considered attempting suicide that also report actually attempting suicide decreased in Cuyahoga (51.6% in 2019-2020 to 44.4% in 2020-2021) and Huron counties (54.1% to 52.7%).

The percentage of 7-12th grade students who report that they drank one or more alcoholic beverages in the past 30 days has decreased in Cuyahoga (12.5% in 2015-2016 to 7.3% in 2020-2021) and Portage (14.3% in 2019-2020 to 8.6% in 2020-2021) counties. The percentage of 7-12th grade students who report binge drinking in the past 30 days has decreased between 2019-2020 and 2020-2021 in Cuyahoga (45.6% to 34.9%) and Summit (46.6% to 45.8%) counties.

During this time the percentage of 7-12th grade students who used prescription drugs without a prescription or differently than prescribed has decreased in Huron (8.7% to 7.5%) and Portage (5.0% to 4.7%) counties. The percentage of 7-12th grade students who report using marijuana or hashish in the past 30 days has decreased in Cuyahoga (7.1% in 2015-2016 to 3.8% in 2020-2021) and Portage (5.7% to 5.2%) counties.
The child abuse and neglect rate per 1,000 is lower in Ashtabula (6.4), Geauga (1.7), Lake (3.8), Lorain (6.6), Portage (5.9) and Summit (4.4) counties in comparison to the state (6.9).

Community Needs

The percentage of 7-12th grade students with anxiety issues warranting further exploration by a mental health professional has increased in Cuyahoga (21.0% in 2015-2016 to 27.3% in 2020-2021), Huron (28.9% in 2019-2020 to 33.4% in 2020-2021) and Summit (22.1% in 2015-2016 to 36.1% in 2020-2021) counties. The percentage of 7-12th grade students with depression issues warranting further exploration by a mental health professional has increased in Cuyahoga (14.4% in 2015-2016 to 19.7% in 2020-2021), Huron (23.0% in 2019-2020 to 27.7% in 2020-2021), Portage (18.3% in 2019-2020 to 18.7% in 2020-2021) and Summit (18.0% in 2015-2016 to 31.4% in 2020-2021) counties.

The percentage of 7-12th grade students seriously considering attempting suicide has increased in Cuyahoga (10.1% in 2016-2017 to 12.5% in 2020-2021), Huron (18.9% in 2019-2020 to 19.9% in 2020-2021) and Summit (10.6% in 2019-2020 to 19.7% in 2020-2021) counties. Of those who seriously considered attempting suicide, the percentage who report they actually attempted suicide increased in Portage (40.1% in 2019-2020 to 45.2% in 2020-2021) and Summit (40.7% in 2019-2020 to 56.4%) counties.

Ohio Youth with a mental health impairment experience four or more Adverse Childhood Events (ACEs) at a higher percentage than peers without a mental health impairment.

The percentage of 7-12th grade students who report that they drank one or more alcoholic beverages in the past 30 days has increased in Huron (9.9% in 2019-2020 to 11.7% in 2020-2021) and Summit (13.1% in 2015-2016 to 16.4% in 2020-2021) counties. The percentage of 7-12th grade students who report binge drinking in the past 30 days has increased between 2019-2020 and 2020-2021 in Huron (44.4% to 50.8%) and Portage (49.1% to 53.1%) counties.

During this timeframe, the percentage of 7-12th grade students who report using marijuana or hashish in the past 30 days has increased in Huron (4.1% to 6.0%) and Summit (7.3% in 2015-2016 to 13.1% in 2020-2021) counties. Students in grades 7-12 who report lifetime use of any illicit substance, is higher in Huron County (3.2%) in comparison to Ohio (2.9%).

The child abuse and neglect rate per 1,000 is higher in Cuyahoga (9.3), Erie (7.0), Huron (7.4) and Medina (7.8) counties in comparison to the state (6.9).

Community Input

After reviewing the qualitative feedback on unmet need, more in-patient hospital beds emerged as a solution to long wait times in EDs and waitlists for in-patient settings within the realm of Bluestone Child & Adolescent Psychiatric Hospital. However, it is also important to consider how the current mismatch between in-patient bed supply and demand exists within the workforce shortage of the larger mental healthcare system.
Greater availability of prevention services and intervention at lower levels of the treatment continuum would likely reduce the need for in-patient and residential treatment according to those interviewed. Making sure transition planning for youth leaving in-patient settings is as good as it possibly could be increases the likelihood that youth will successfully reintegrate into the community and not need readmission in the near term, thus freeing up in-patient beds.

These solutions focus on effective collaboration and eliminating silos among entities serving youth, thereby improving the functioning of the system as a whole. Bluestone may also want to consider how they can focus on retaining qualified staff, addressing burnout and turnover through a variety of means such as compensation and benefits, continuing education and professional development, and workload evaluations. Or, they may want to explore opportunities for advocacy at the Federal, state or local level to change Medicaid reimbursement rates. Ultimately, any one of these changes could positively impact the larger mental healthcare system within Northeast Ohio.

Priorities

The Steering Committee met on June 6, 2023, to review primary and secondary data and discuss priorities. Upon review of both primary and secondary data, the Steering Committee identified 11 potential priorities within 4 broad categories for the hospital to possibly address through its Implementation Strategy.

Steering Committee members used a SurveyMonkey survey to rate each potential priority based on two criteria (magnitude of the problem and system resources). Based on the criteria the priorities in order of importance are:

- Youth mental health (including substance use)
- Access to mental health services
- Autism
- Workforce shortage

The Steering Committee then rated the importance of a list of possible program/implementation strategies related to each of the 4 focus areas. The following are the top identified priorities that will be addressed through the implementation strategy:

- Workforce shortage: Develop internal strategies to employee retention, recruitment, job satisfaction
- Youth mental health (including substance use): IOP groups with different specialties
- Autism services: Access to inpatient care for this population
- Access to mental health services: Address issue of medical clearance to access services at Bluestone
- Access to mental health services: Outreach to autism providers on available services at Bluestone
- Access to mental health services: Community education/outreach on available services at Bluestone

Review & Approval

This CHNA report was adopted by the Bluestone Child & Adolescent Psychiatric Hospital Board of Directors on June 20, 2023.

METHODOLOGY

Our Approach

The Public Health Accreditation board defines 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 factors 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.

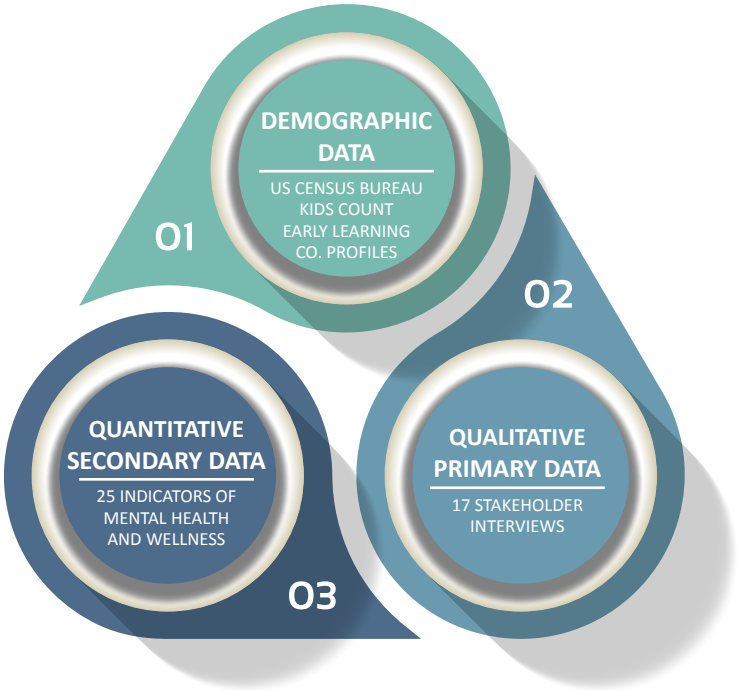
Data Methods

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 2. Three main types of data were used for this assessment:

- **Demographic Data** from the US Census Bureau, Kids Count and the Early Learning County Profiles.
- **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 10-county region in Northeast Ohio considered as the primary service area. Counties include:

- Erie
- Huron
- Lorain
- Cuyahoga
- Medina
- Summit
- Lake
- Geauga
- Portage
- Ashtabula

Demographic data was obtained from the U.S Census Bureau, Kids Count, Healthy NEO, Early Learning Advisory Council, Early Learning County Profiles.

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
- Mental Health in Ohio Report
- Healthy NEO
- 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.

Hospital staff identified individuals and organizations representing public health departments, members of medically underserved communities, low-income populations, parents of youth served, and minorities groups such that all key demographics were represented in the 10-county service region.

Next, the Director of Health and Medical Services and the hospital's Business Development Liaison (the staff member with the most contact with community partners), 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 of 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, 26 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.

Seventeen individuals, representing nine of the 10 county service region, completed interviews (69.2% response rate). Despite repeated attempts and multiple contacts, the team was unable to secure participation from individuals representing Ashtabula County. Saturation was achieved as similar responses emerged repeatedly across interviews. Additionally, a representative from the Cuyahoga County Board of Health suggested two other colleagues as having more relevant content knowledge.

Targeted demographic groups for the interviews included:

- Public Health
- Medically underserved
- Low-income populations
- Caregivers
- Minority groups/Underrepresented populations

In collaboration with hospital staff, the research team created a 7-item key informant interview protocol designed to assess the following domains: challenges within the field of youth mental healthcare, unmet youth mental healthcare needs, patient access to care, resource availability, equity and social determinants of health. All key informant interviews were completed by phone and lasted between 15-30 minutes in length. With respondent consent, interviews were audio recorded for note taking purposes. Audio files were transcribed using Fireflies.AI software. Each transcript was read multiple times for familiarity to begin the coding process. Next, one member of the research team coded transcripts by question 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:

Name	Role, Organization	County	Background	Date
Karen McHenry	Homeless and Missing Youth Program Director, Bellefaire JCB	Cuyahoga	Underserved/low-income populations	4/25/23
Jeff Lox	Executive Director, Bellefaire JCB	Cuyahoga/Lorain/ Medina/Summit	Community mental health	4/26/23
Michelle Sims	Division Director of Juvenile Justice Programming, Applewood Centers, Inc.	Cuyahoga/Lorain	Underserved, Juvenile justice involved populations	4/27/23
Carolyn Welker	Division Director Community Services, Applewood Centers, Inc.	Cuyahoga	Community/School-based mental health	4/28/23
Erin Turner	Program Manager Youth Crisis Services/Director of Training and Staff Development, Crossroads Health	Lake	Integrated primary care and behavioral health	4/28/23
Kim Hearn-Vance	ED Crisis Manager, University Hospitals Lake West Medical Center	Lake	Hospital-based, mental health crisis services	4/28/23
Karen Russell	Site Director, Firelands Counseling and Recovery Services	Erie/Huron	Hospital-based, mental health and crisis services	4/28/23
Joyce De Michele	Director of Regional Community Programs, Bellefaire JCB	Medina/Lorain	Community mental health	4/28/23
Sandee Winkelman	Parent of autistic youth and advocate	Cuyahoga	Caregiver of youth affected by Autism	4/28/23
Rebecca Jones	Children's Programming Specialist, Mental Health Board	Lorain	County-operated, state-supervised behavioral health authority	5/2/23
Sean Dawson	Director of Summit Programs, Bellefaire JCB	Summit	Community mental health	5/3/23
Stephen Poole	Parent of student, Monarch Center for Autism	Cuyahoga	Caregiver of youth affected by Autism	5/4/23
Vince Caraffi	ATI Coordinator Office of Opioid Safety, MetroHealth	Cuyahoga	Public health/Substance use disorders	5/4/23
Brad Welch	Case Coordinator, Family and Children First Council	Geauga	Capacity building, service coordination, family empowerment	5/5/23
Samantha Holmes	Office of Mental Health and Addiction Recovery, Cleveland Department of Public Health	Cuyahoga	Public health	5/5/23
Eugenia Cash-Kirkland, Rhonnetta Robinson, Alysia Yorko	Social support services (3 staff members), City of Cleveland Rec Centers	Cuyahoga	Public health/Minority populations	5/5/23
Kelly MacMullin	Social Worker, Coleman Health Services	Portage	Mental health, substance use, residential and rehabilitation services	5/8/23

Others who were outreached to and invited to participate in the study included:

Name	Role, Organization	County	Background	Date
Kathy Bean	ED social worker, Ashtabula County Medical Center	Ashtabula	Hospital-based social work	4/25/23
Dr. Michelle Clinger	Psychologist, Firelands Counseling and Recovery Services	Erie/Huron	Hospital-based, mental health and crisis services	4/26/23
Becky Karns	Cuyahoga County Board of Health	Cuyahoga	Public health	4/27/23
Anna Niciu	County Medical Center	Ashtabula	Hospital-based, mental health and crisis services	4/28/23
Laura Pritt	Social Worker, Coleman Health Services	Portage	Mental health, substance use, residential and rehabilitation services	4/28/23
Ron Seigman	Signature Health	Ashtabula, Lake, Cuyahoga	Integrated primary care and behavioral health	4/28/23
Melissa Bayer Smith	Family and Children First Council	Erie/Huron	Capacity building, service coordination, family empowerment	4/28/23
Robinlyn Vogel	Family and Children First Council	Ashtabula	Capacity building, service coordination, family empowerment	4/28/23

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 June 6, 2023, to review primary and secondary data and discuss priorities. Upon review of both primary and secondary data, the Steering Committee identified 11 potential priorities within 4 broad categories for the hospital to possibly address through its Implementation Strategy.

Steering Committee members used a SurveyMonkey survey to rate each potential priority based on two criteria (magnitude of the problem and system resources).

		Scoring		
Item	**Definition**	**Low (1)**	**Medium**	**High (10)**
Magnitude of the problem	The degree to which the problem leads to death, disability, or impaired quality of life and/or could be an epidemic based on the rate or % of population that is impacted by the issue	Low numbers of people affected; no risk for epidemic	Moderate numbers/ % of people affected and/or moderate risk	High numbers/ % of people affected and/or risk for epidemic
System Resources	The extent to which the system is already in place and functioning to address the issue/ problem	No system in place	System is in place but could be improved	System is in place and functioning well

Hospital leadership reviewed the results and identified 6 priorities within 4 focus areas to address through the Implementation Strategy. The results of the prioritization exercise and priorities being addressed appear later in this report.

Approval

The Community Health Needs Assessment Report was approved by the Bluestone Child and Adolescent Psychiatric Hospital board on June 20, 2023.

Bluestone Interior Common Area

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 10-county area in Northeast Ohio. Figure 5 illustrates the counties.

Figure 5: Primary Service Area

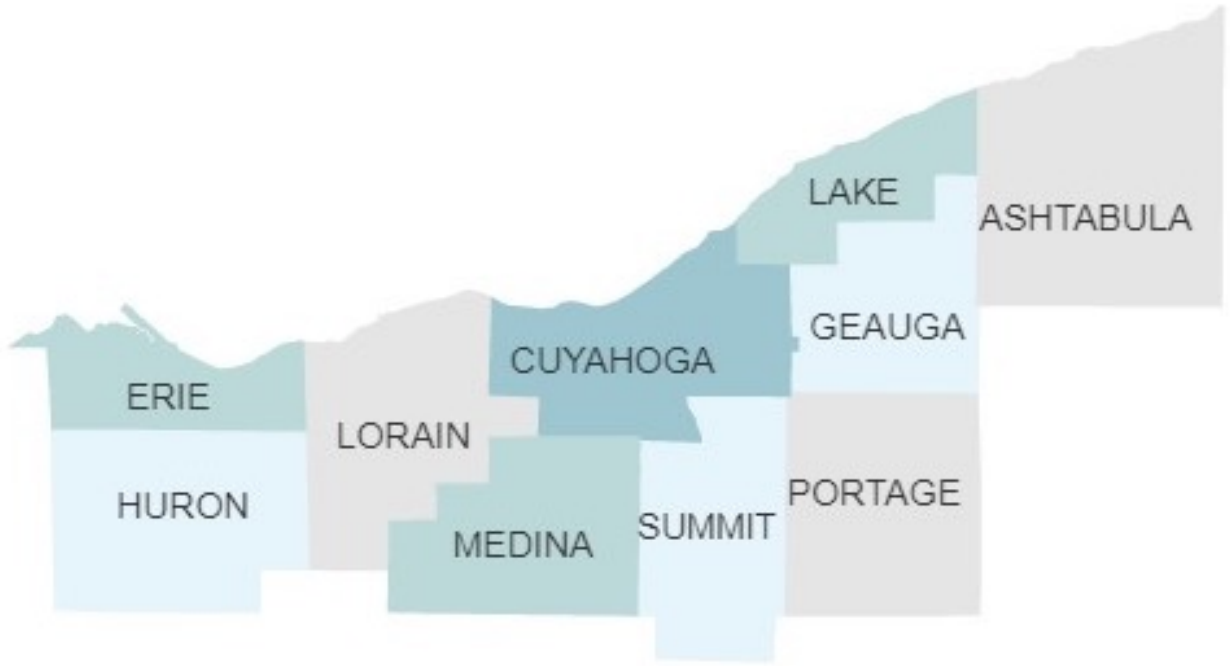


Table 2 displays the number of children under age 18 in the counties of the primary service territory and the state of Ohio overall. Ashtabula, Geauga, and Huron counties have a higher percentage of children under the age of 18 than Ohio. Portage County has the lowest percentage of children under the age of 18 in the service territory. Cuyahoga, Erie, Geauga, Lake, Lorrain, Medina and Summit also have percentages of children that are lower than the state.

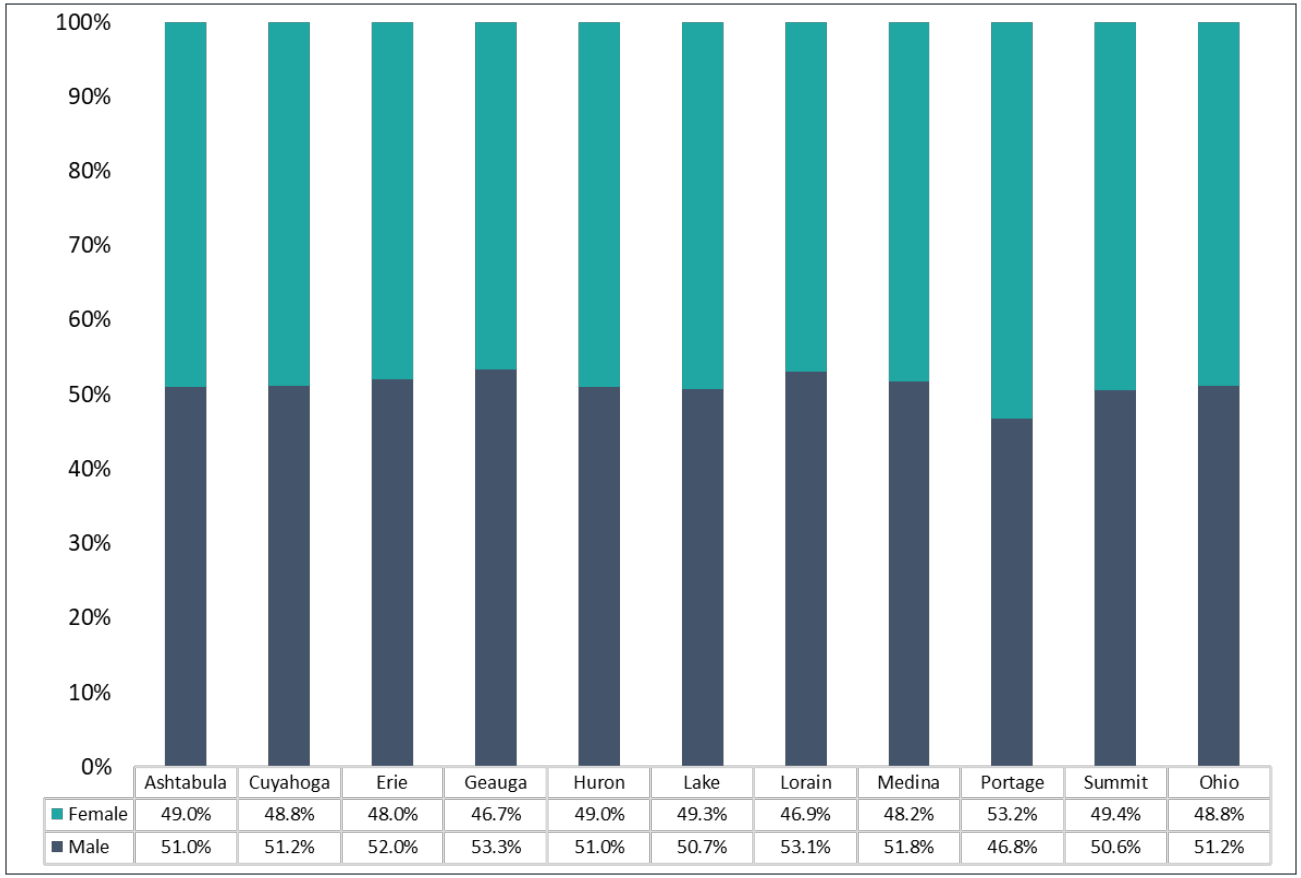
Table 2: Children Under Age 18, 2021

Geographic Area	Number	Percent of Total Population
Ashtabula County	21,748	22.9%
Cuyahoga County	262,917	21.0%
Erie County	15,461	20.7%
Geauga County	21,870	23.1%
Huron County	14,166	24.4%
Lake County	46,497	20.2%
Lorain County	68,837	22.5%
Medina County	40,419	22.4%
Portage County	30,244	18.8%
Summit County	113,930	21.3%
Ohio	2,625,951	22.6%

Source: US Census Bureau, 5 Year Estimates

Of all of the counties in the service territory, Portage County has the highest percentage of female children aged 5-19, several percentage points higher than the state percentage of 48.8%. Portage is also the only county in the territory where more than half of the children aged 5-19 are female. In all of the other counties, as well as the state overall, more than half of the children aged 5-19 are male. Geauga County has the highest percentage of males aged 5-19 at 52.3%. In addition, Erie and Geauga 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, 2021



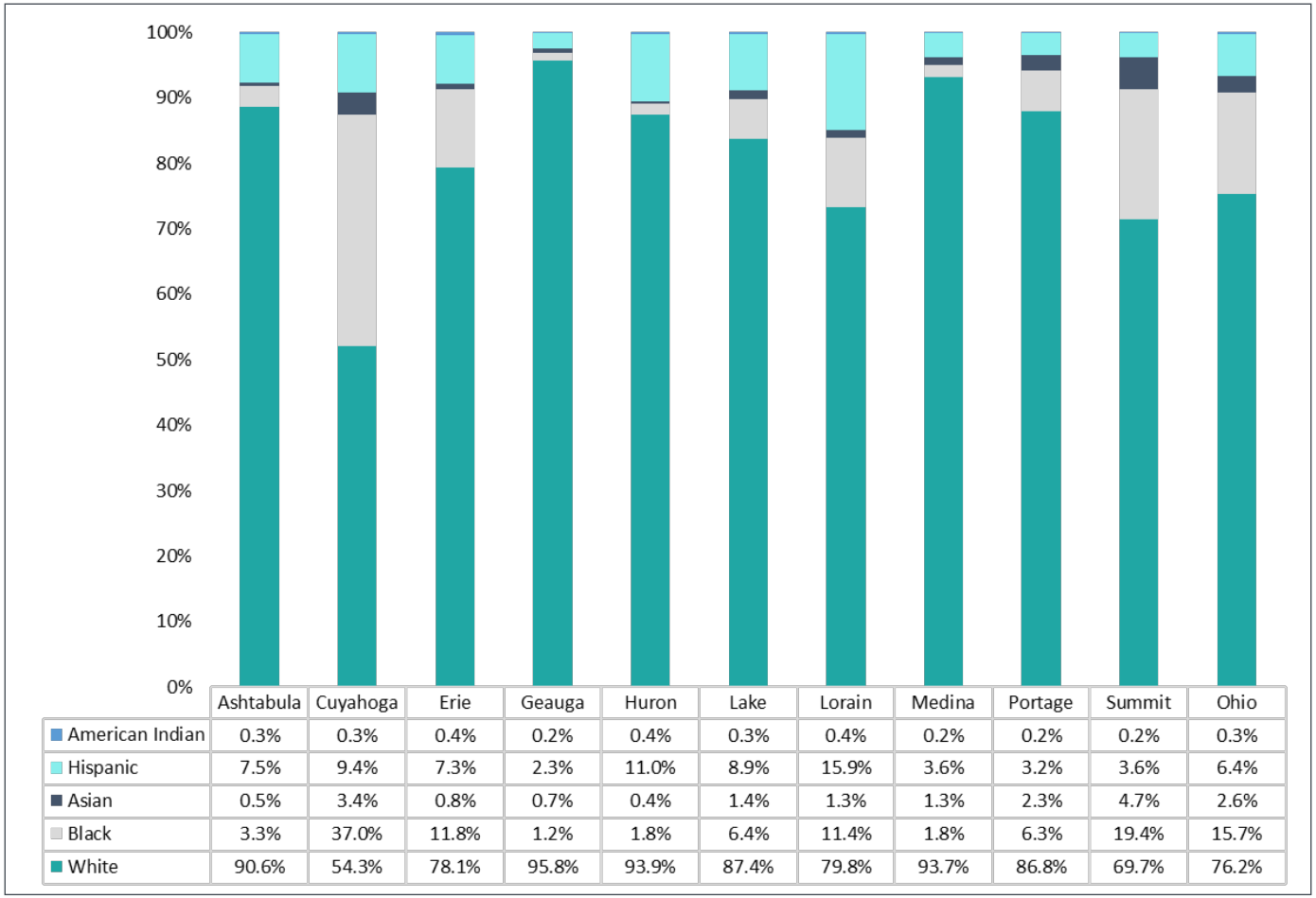
	Ashtabula	Cuyahoga	Erie	Geauga	Huron	Lake	Lorain	Medina	Portage	Summit	Ohio
Female	49.0%	48.8%	48.0%	46.7%	49.0%	49.3%	46.9%	48.2%	53.2%	49.4%	48.8%
Male	51.0%	51.2%	52.0%	53.3%	51.0%	50.7%	53.1%	51.8%	46.8%	50.6%	51.2%

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 3.5% Asian in addition to the sizable Black Population. Lorain County has the highest Hispanic population of children under the age of 18 at 15.9%. Huron, Cuyahoga, Ashtabula, Erie, and Lake Counties all have higher Hispanic populations than the state average. Summit County has the highest Asian population of the service area counties at 4.7%. Cuyahoga County is the only other county that has a higher than that state Asian population at 3.4%.

Figure 7: Race, Children Under 19, 2021

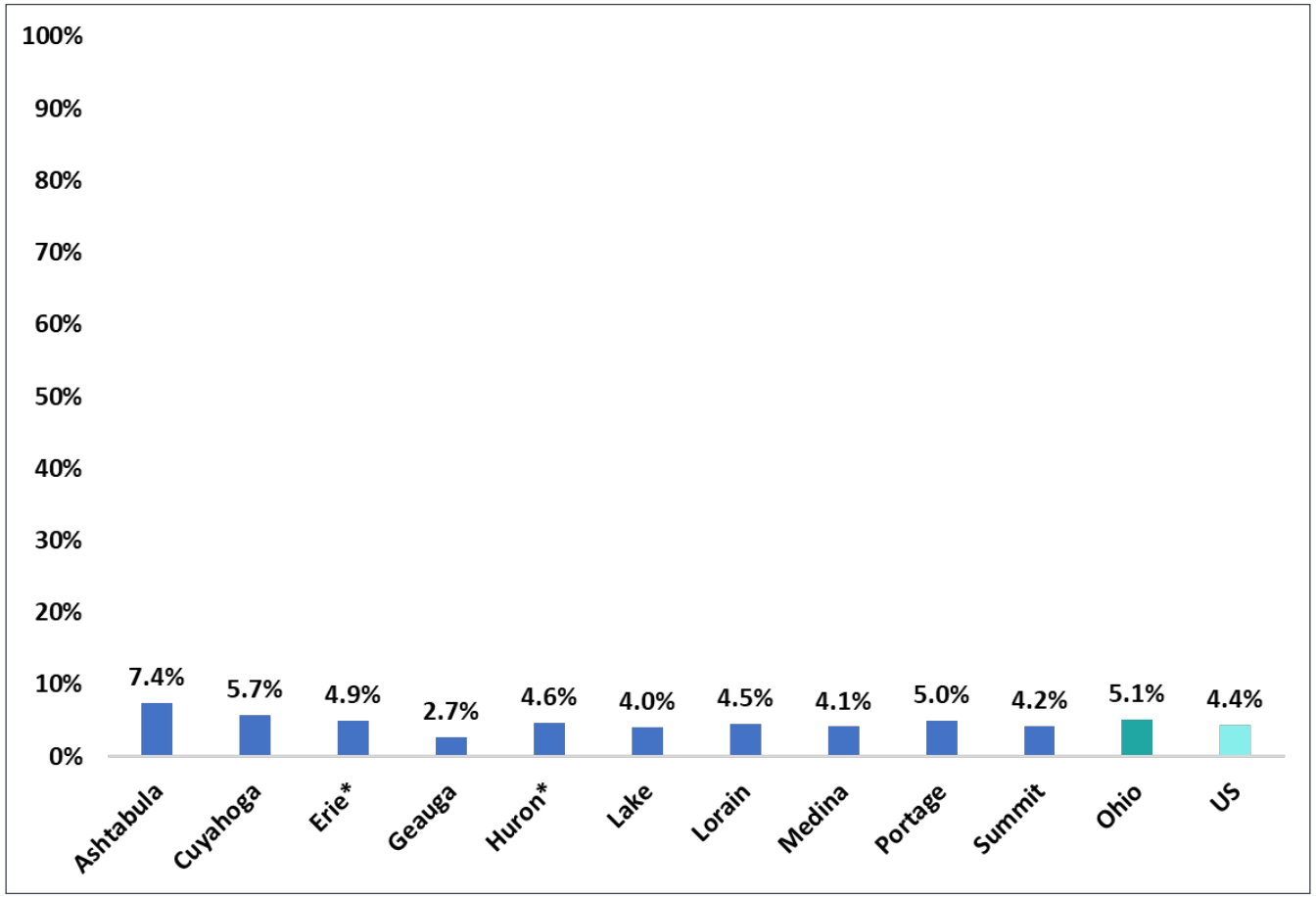


	Ashtabula	Cuyahoga	Erie	Geauga	Huron	Lake	Lorain	Medina	Portage	Summit	Ohio
American Indian	0.3%	0.3%	0.4%	0.2%	0.4%	0.3%	0.4%	0.2%	0.2%	0.2%	0.3%
Hispanic	7.5%	9.4%	7.3%	2.3%	11.0%	8.9%	15.9%	3.6%	3.2%	3.6%	6.4%
Asian	0.5%	3.4%	0.8%	0.7%	0.4%	1.4%	1.3%	1.3%	2.3%	4.7%	2.6%
Black	3.3%	37.0%	11.8%	1.2%	1.8%	6.4%	11.4%	1.8%	6.3%	19.4%	15.7%
White	90.6%	54.3%	78.1%	95.8%	93.9%	87.4%	79.8%	93.7%	86.8%	69.7%	76.2%

Source: Kids Count

As illustrated in Figure 8, the service area's rates of children with a disability range between 2.7% Geauga County to 7.4% in Ashtabula County. Ashtabula and Cuyahoga (5.7%) counties' rates are higher than Ohio overall (5.1%). Erie, Geauga, Huron, Lake, Lorain, Medina, Portage and Summit counties all have rates that are lower than the state.

Figure 8: Children With a Disability, 2017-2021



*Source: Healthy NEO, *US Census*

Table 3 displays the number of children ages 3-5 with autism enrolled in special education. In Ashtabula, Erie, Geauga, and Huron counties, the numbers are below 10 and are not displayed to preserve confidentiality. Cuyahoga County has the largest number of children with autism enrolled in special education (119), followed by Summit County (59), Lorain County (42), Portage County (17), Medina County (15) and Lake County (11). Cuyahoga County also represents 12.6% of the total number of children ages 3-5 with autism enrolled in special education in the state of Ohio. Cumulatively, the service area represents approximately 27.8% of all children with autism enrolled in special education in the state.

Outlined in Table 4 is the number of children under the age of 3 with special education needs that are enrolled in special education. Cuyahoga County has the highest number of children in all categories, followed by Summit and Lorain Counties.

Table 3: Children Ages 3-5 with Autism Enrolled in Special Education

Geographic Area	Number	Percentage of Total
Ashtabula County	1-9	NA
Cuyahoga County	119	12.6%
Erie County	1-9	NA
Geauga County	1-9	NA
Huron County	1-9	NA
Lake County	11	1.2%
Lorain County	42	4.4%
Medina County	15	1.6%
Portage County	17	1.8%
Summit County	59	6.2%
Ohio	946	100.0%

Early Childhood Advisory Council, Early Learning Development County Profiles

Table 4: Children Under 3 With Special Education Needs Enrolled in Special Education

Geographic Area	Active Individualized Family Service Plan	Active IFSP with Physical or Mental Condition	With Developmental Delay
Ashtabula County	98	48	50
Cuyahoga County	1,627	892	735
Erie County	110	77	33
Geauga County	90	49	41
Huron County	126	82	44
Lake County	191	106	85
Lorain County	400	240	160
Medina County	206	112	94
Portage County	130	76	54
Summit County	547	327	220
Ohio	13,172	7,567	5,605

Early Childhood Advisory Council, Early Learning Development County Profiles

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

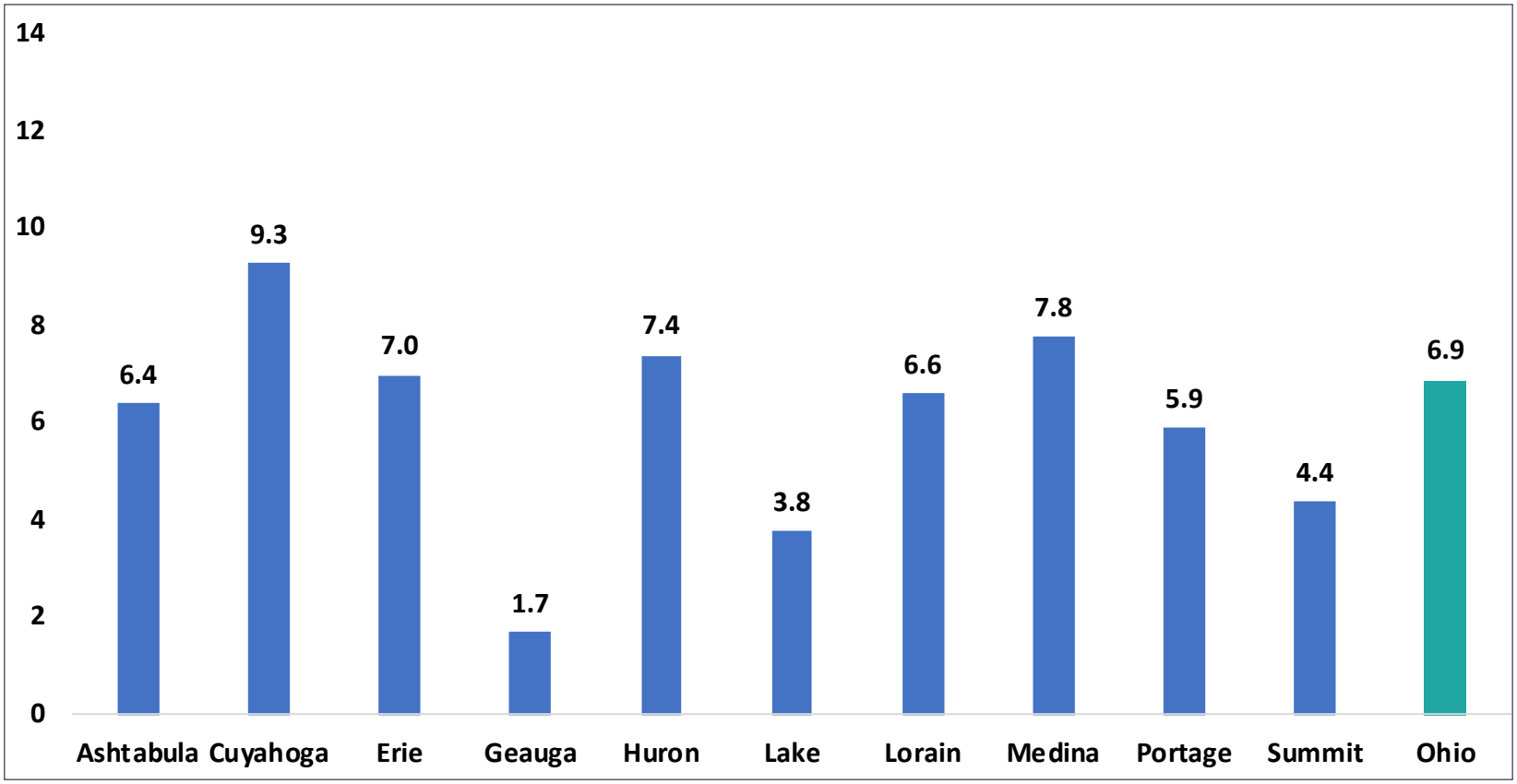
These examples are not a complete list of adverse experiences. Many other traumatic experiences could impact health and wellbeing. ACEs are linked to chronic health problems, mental illness, and substance use problems in adolescence and adulthood. ACEs can also negatively impact education, job opportunities, and earning potential.[1]

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] *https://www.cdc.gov/violenceprevention/aces/fastfact.html*

Figure 9 illustrates the Child Abuse and Neglect Rate per 1,000 children in the service area counties compared to Ohio. The rates in Cuyahoga (9.3), Erie (7.0), Huron (7.4) and Medina (7.8) Counties are higher than the state of Ohio, while Lorain (6.6), Ashtabula (6.4), Portage (5.9), Summit (4.4), Lake (3.8) and Geauga (1.7) counties are lower.

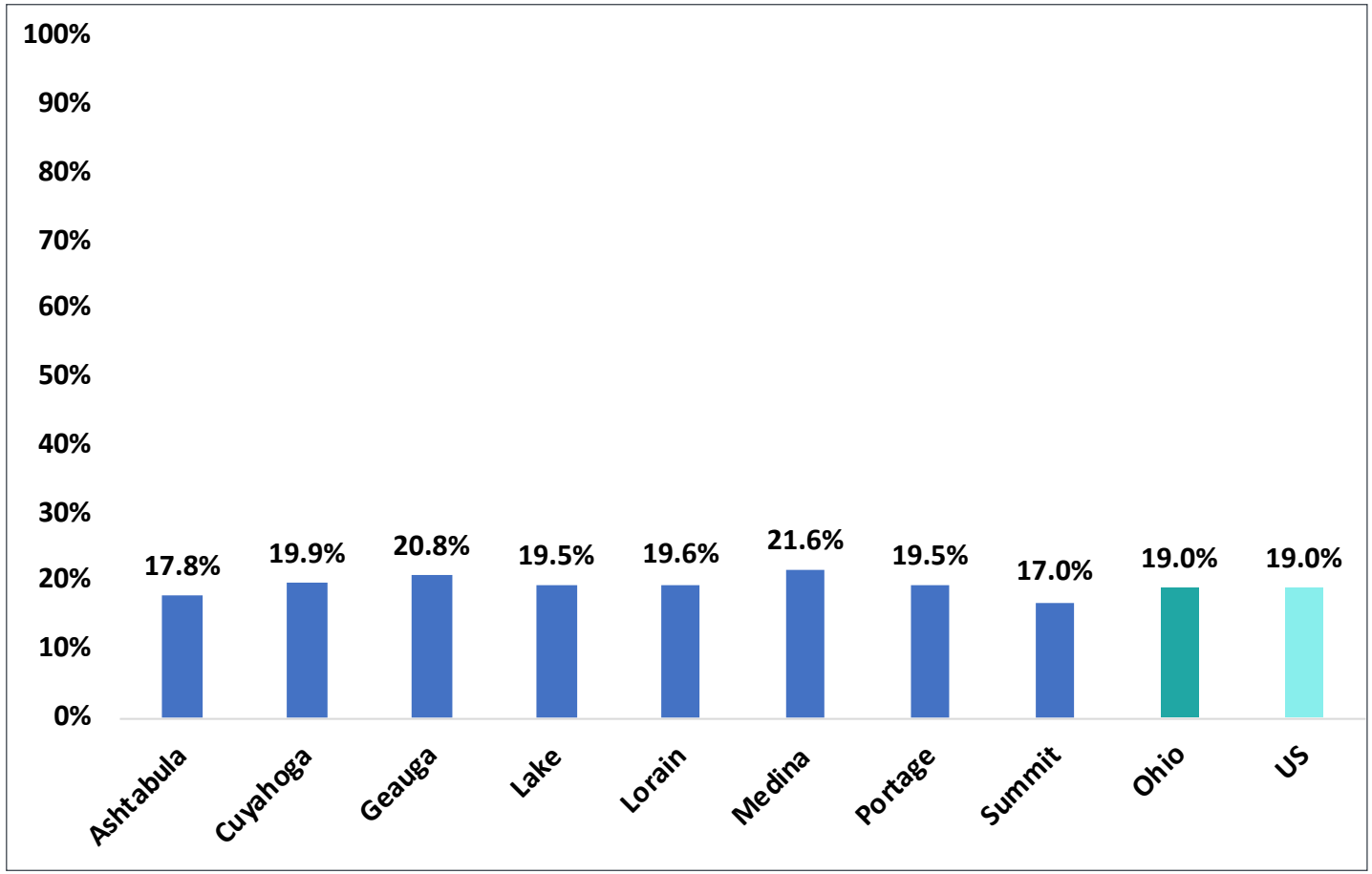
Figure 9: Child Abuse and Neglect, Rate per 1,000, 2021



Source: Kids Count

A substantial percentage of adults in the service territory for the counties where data was available reported excessive drinking in 2020, ranging from a low of 17% in Summit County to a high in Medina County of 21.6%. The rates are higher in Cuyahoga (19.9%), Geauga (20.8%), Lake (19.5%), Lorain (19.6%), Medina (21.6%) and Portage (19.5%) than Ohio (19.0%) and the US overall (19.0%). Ashtabula (17.8%) and Summit (17.0%) counties had lower rates.

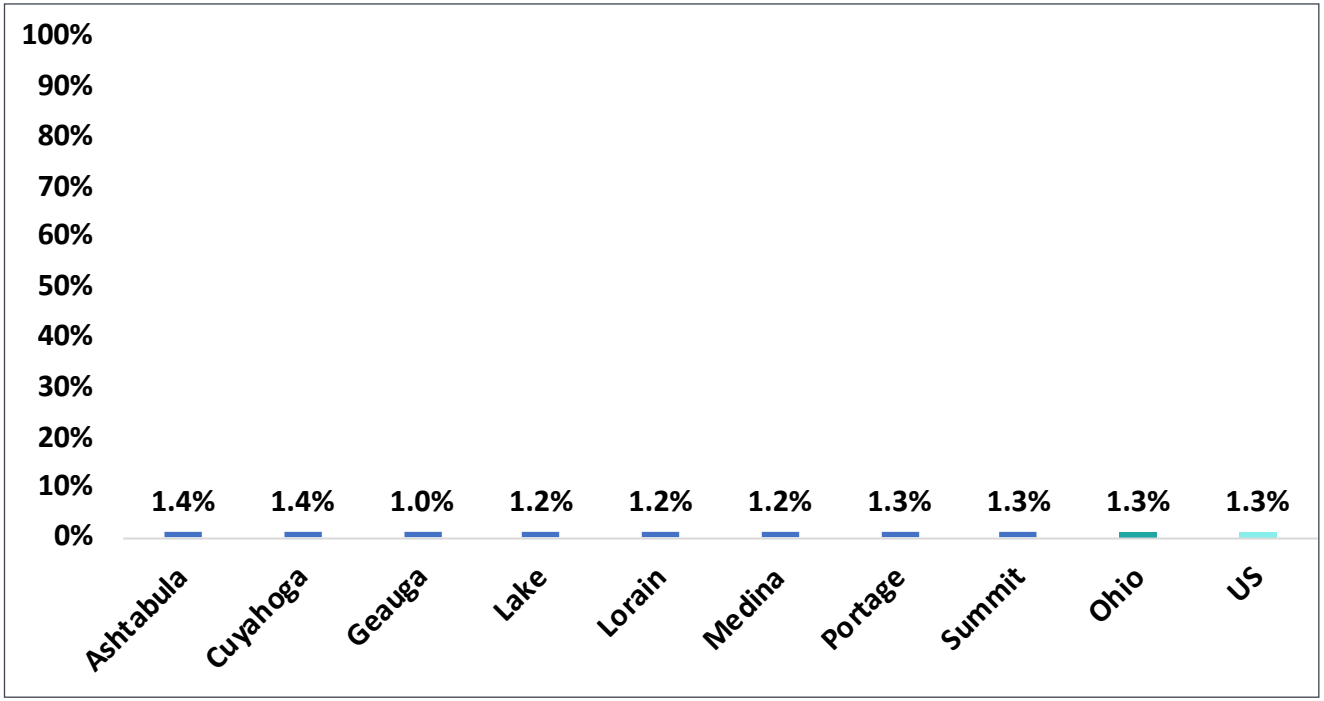
Figure 10: Adult Excessive Drinking, 2020*



Source: Healthy NEO
** 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 11, a small percentage households reported receiving substance abuse medical services during 2022 in the counties of the service territory where data was available, ranging from 1.0% in Geauga County to 1.4% Ashtabula and Cuyahoga Counties. The Ohio and US rate was 1.3%. The percentages in Portage and Summit counties was 1.3% and 1.2% in Lake, Lorain and Medina Counties.

Figure 11: Households Receiving Substance Abuse Medical Services, 2022

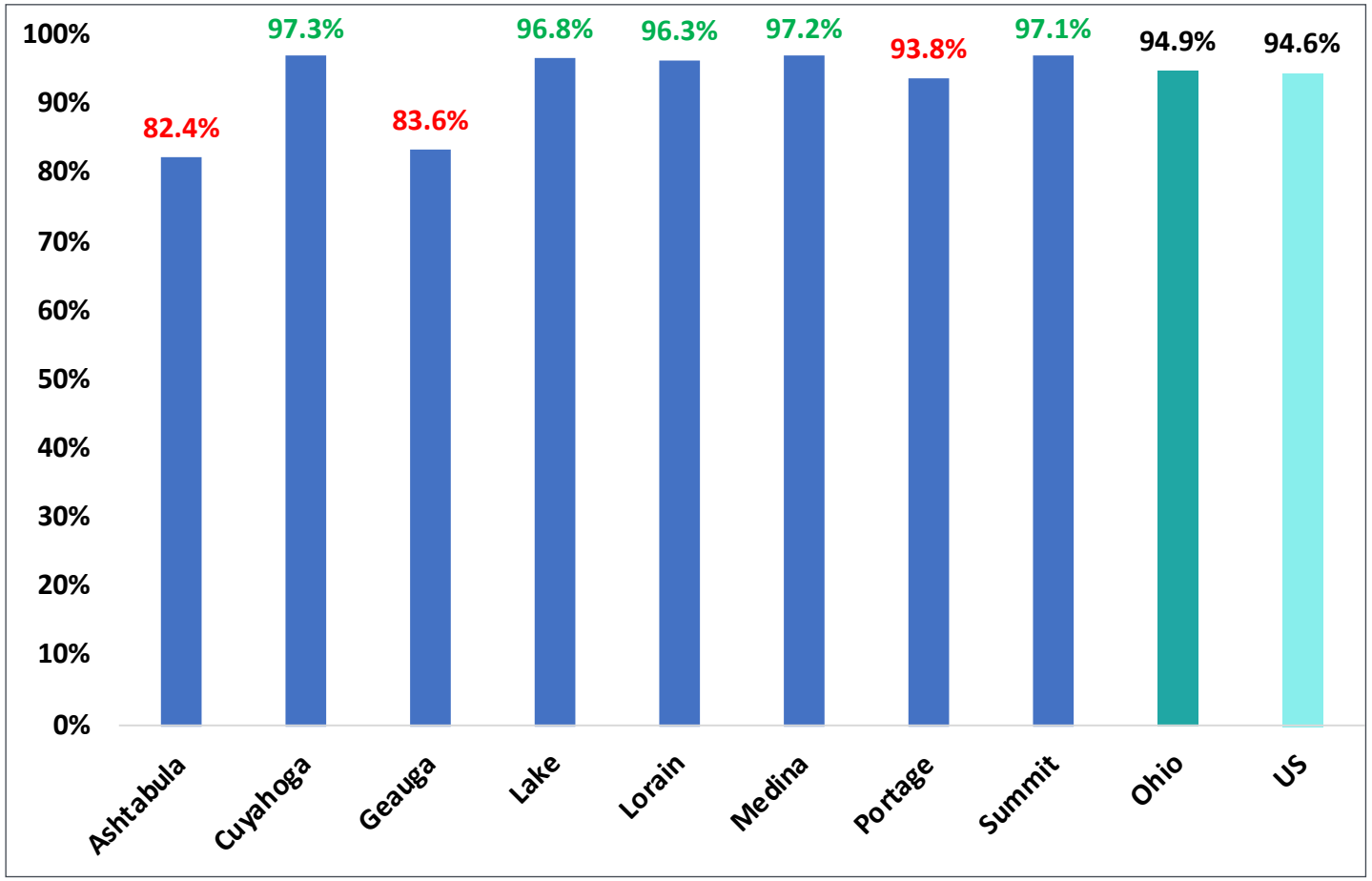


Source: Healthy NEO

Other Social Determinants of Health

Figure 12 illustrates the percentage of children with health insurance in the counties of the service area compared to Ohio (94.9%) and the US (94.6%). Ashtabul¬a (82.4%), Geauga (83.6%) and Portage (93.8%) counties were significantly lower than the state percentage, while Cuyahoga (97.3%), Lake (96.8%), Lorain (96.3%), Medina (97.2%) and Summit (97.1%) counties were significantly higher than the state.

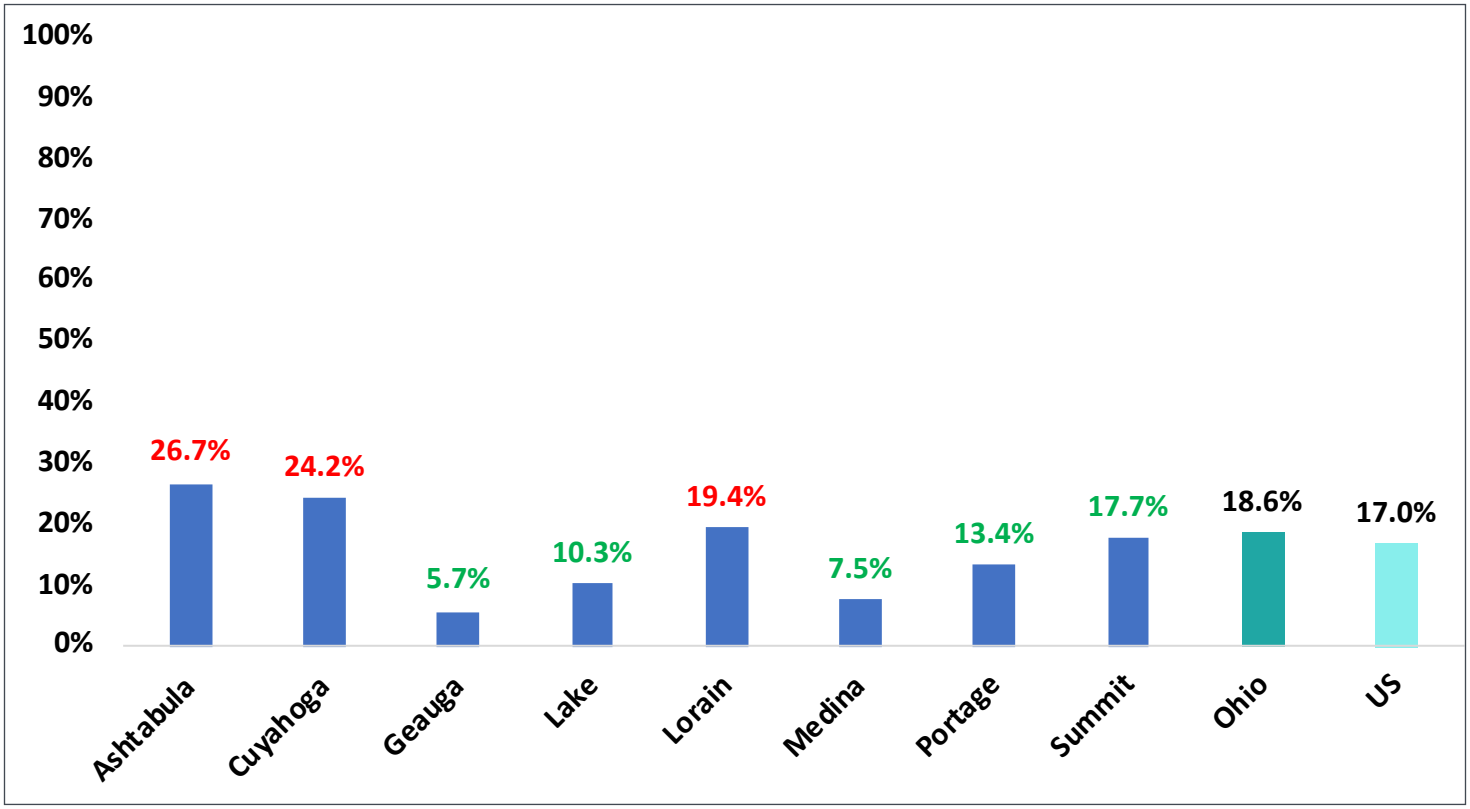
Figure 12: Children With Health Insurance, 2021



Source: Healthy NEO, American Community Survey

The percentage of children living below the federal poverty level in the service area varies by county as outlined in Figure 13. The percentage in Ohio (18.6%) is slightly higher than the US (17.0%). Ashtabula (26.7%), Cuyahoga (24.2%) and Lorain (19.4%) counties have percentages that are significantly higher than the state, while Geauga (5.7%), Lake (10.3%), Medina (7.5%), Portage (13.4%) and Summit (17.7%) have percentages that are significantly lower than the state average.

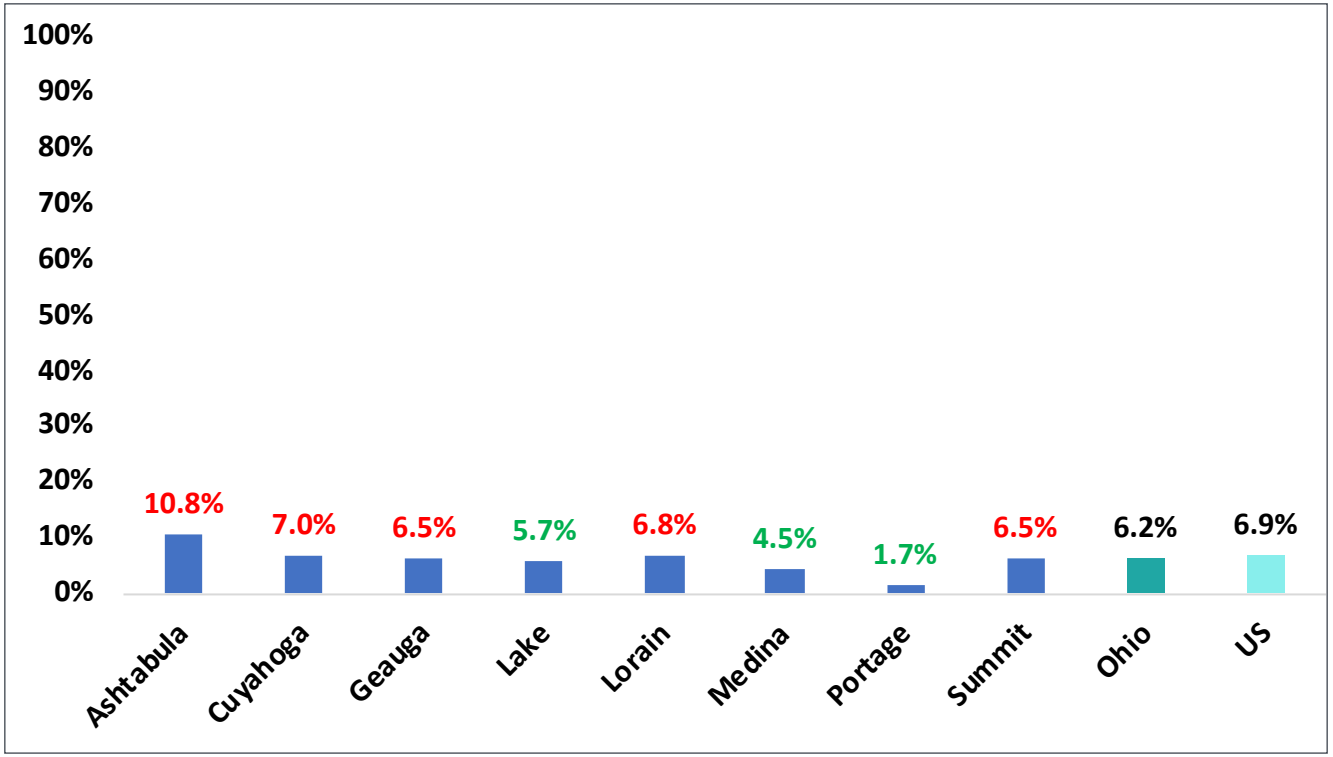
Figure 13: Children Living Below Poverty, 2017-2021



Source: US Census Bureau, American Community Survey

Figure 14 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%) and the US (6.9%). Ashtabula (10.8%), Cuyahoga (7.0%), Geauga (6.5%), Lorain (6.8%) and Summit (6.5%) counties all have percentages that are significantly higher than the state. Lake (5.7%), Medina (4.5%) and Portage (1.7%) counties have percentages that are significantly lower than the state average.

Figure 14: Youth (Ages 16-19) Not in School or Working, 2017-2021

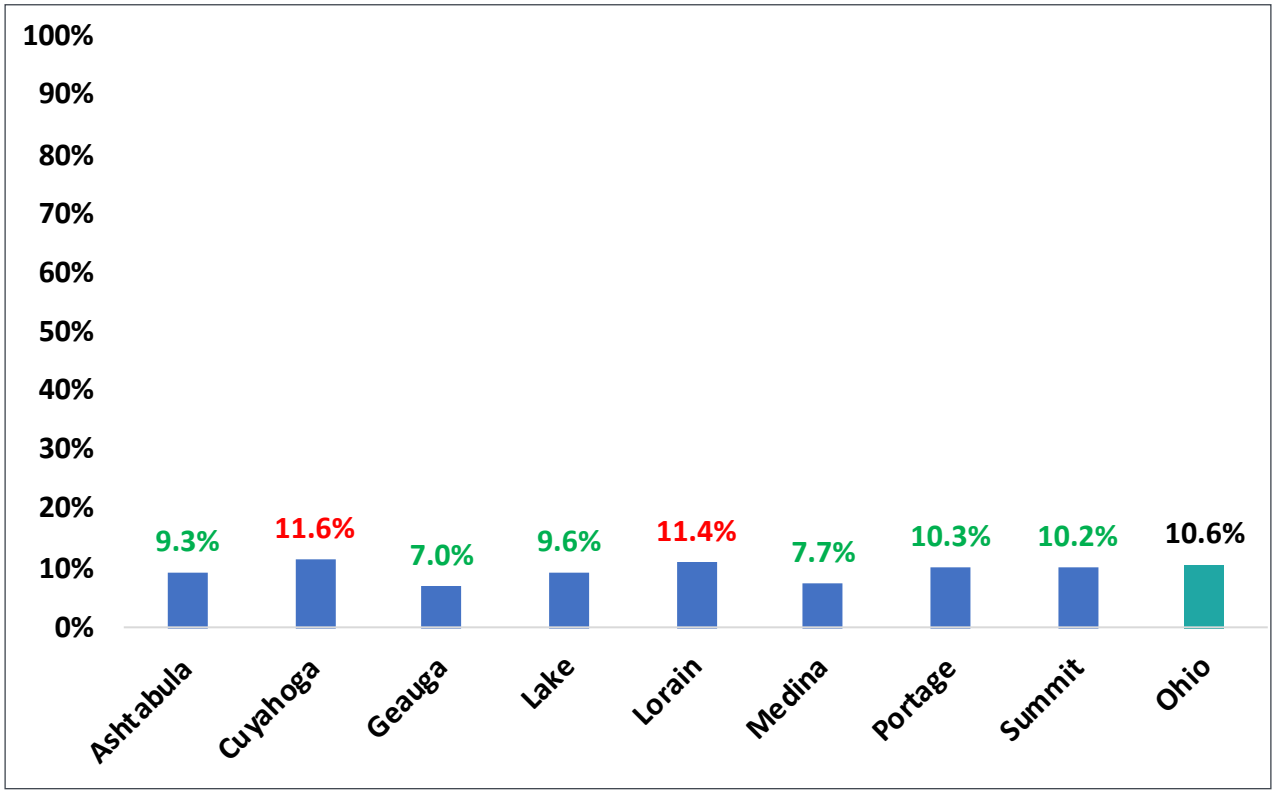


Source: Healthy NEO, American Community Survey

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 15 illustrates pre-term births for the counties of the service area compared to Ohio overall (10.6%). Cuyahoga (11.6%) and Lorain (11.4%) counties have significantly higher percentages than the state, while Ashtabula (9.3%), Geauga (7.0%), Lake (9.6%), Medina (7.7%), Portage (10.3%), and Summit (10.2%) counties had significantly lower percentages than the state.

Figure 15: Pre-Term Births, 2021

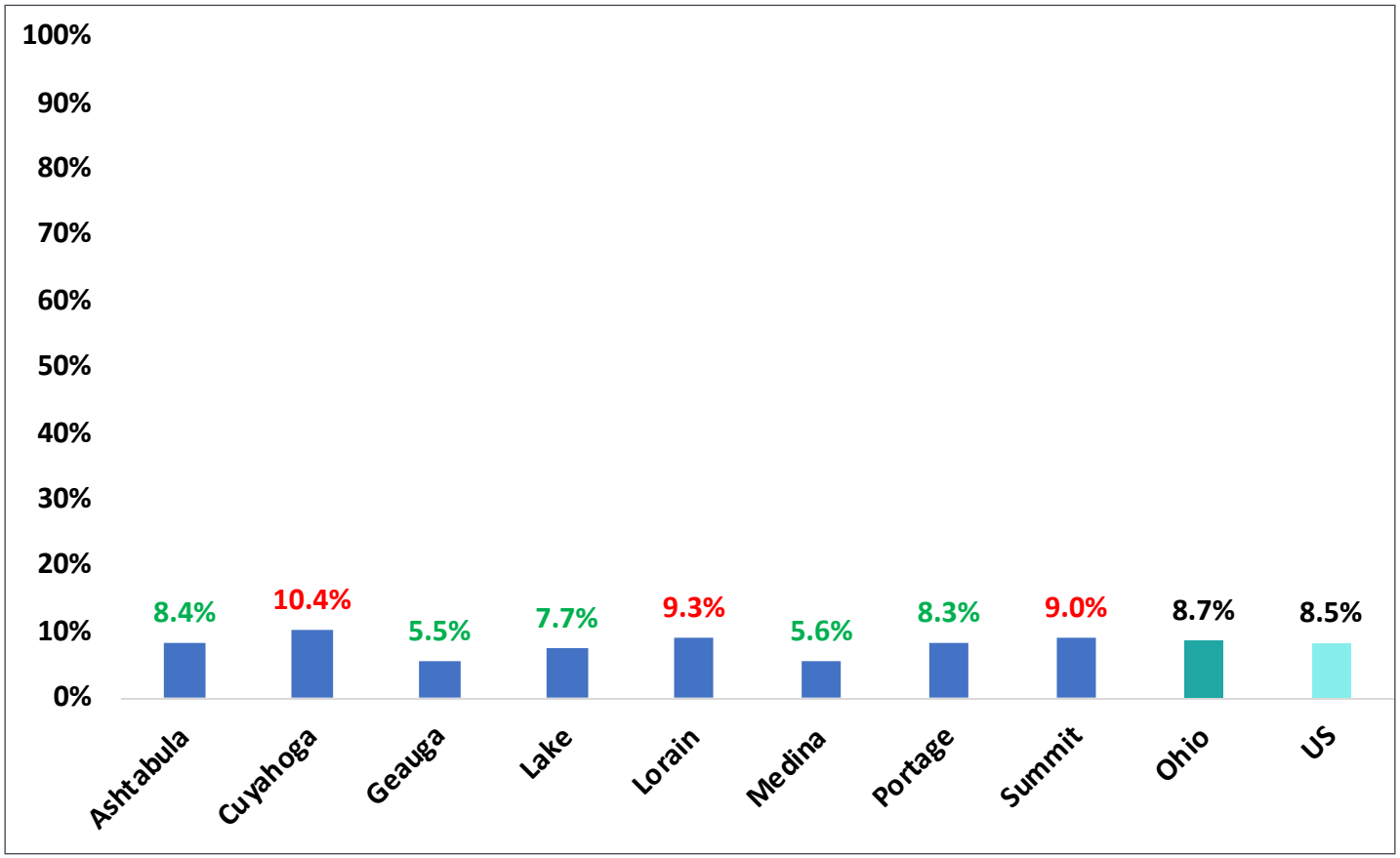


Source: Healthy NEO, Ohio Department of Health, Vital Statistics

[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*

Ohio's percentage of low birthweight babies in 2021 was 8.7%, slightly higher than the US percentage of 8.5%. This is outlined in Figure 16. Cuyahoga (10.4%), Lorain (9.3%), and Summit (9.0%) counties had percentages that were significantly higher than the state, while Ashtabula (8.4%), Geauga (5.5%), Lake (7.7%), Medina (5.6%), and Portage (8.3%) counties had percentages that were significantly lower than the state.

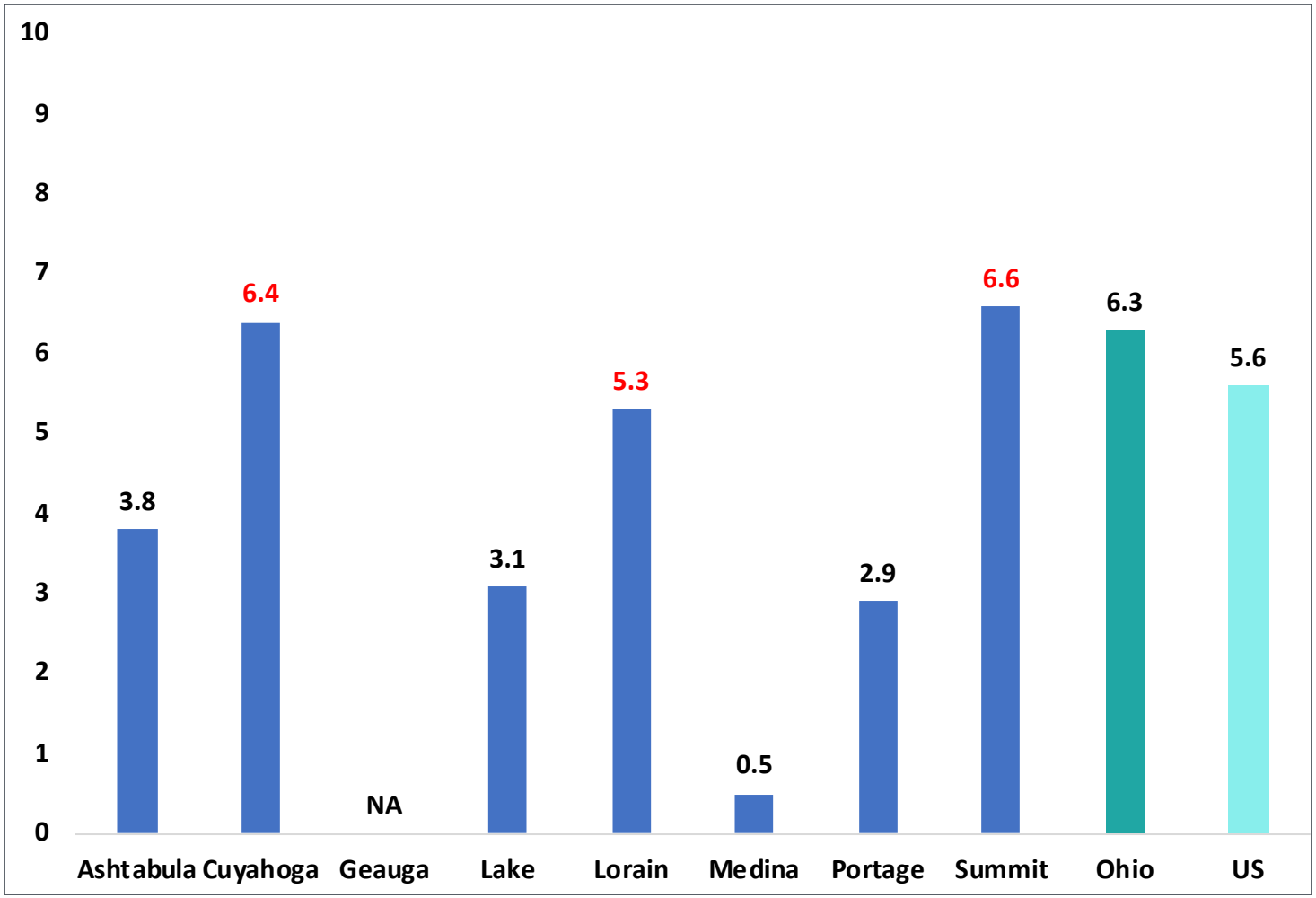
Figure 16: Babies With Low Birthweight 2021



Source: Healthy NEO, 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 (6.3) and the US (5.6) is outlined in Figure 17. Cuyahoga (6.4) and Summit (6.6) counties had significantly higher rates than the state while Ashtabula (3.8), Lake (3.1), Medina (0.5) and Portage (2.9) counties were lower. Geauga County's rate was not available.

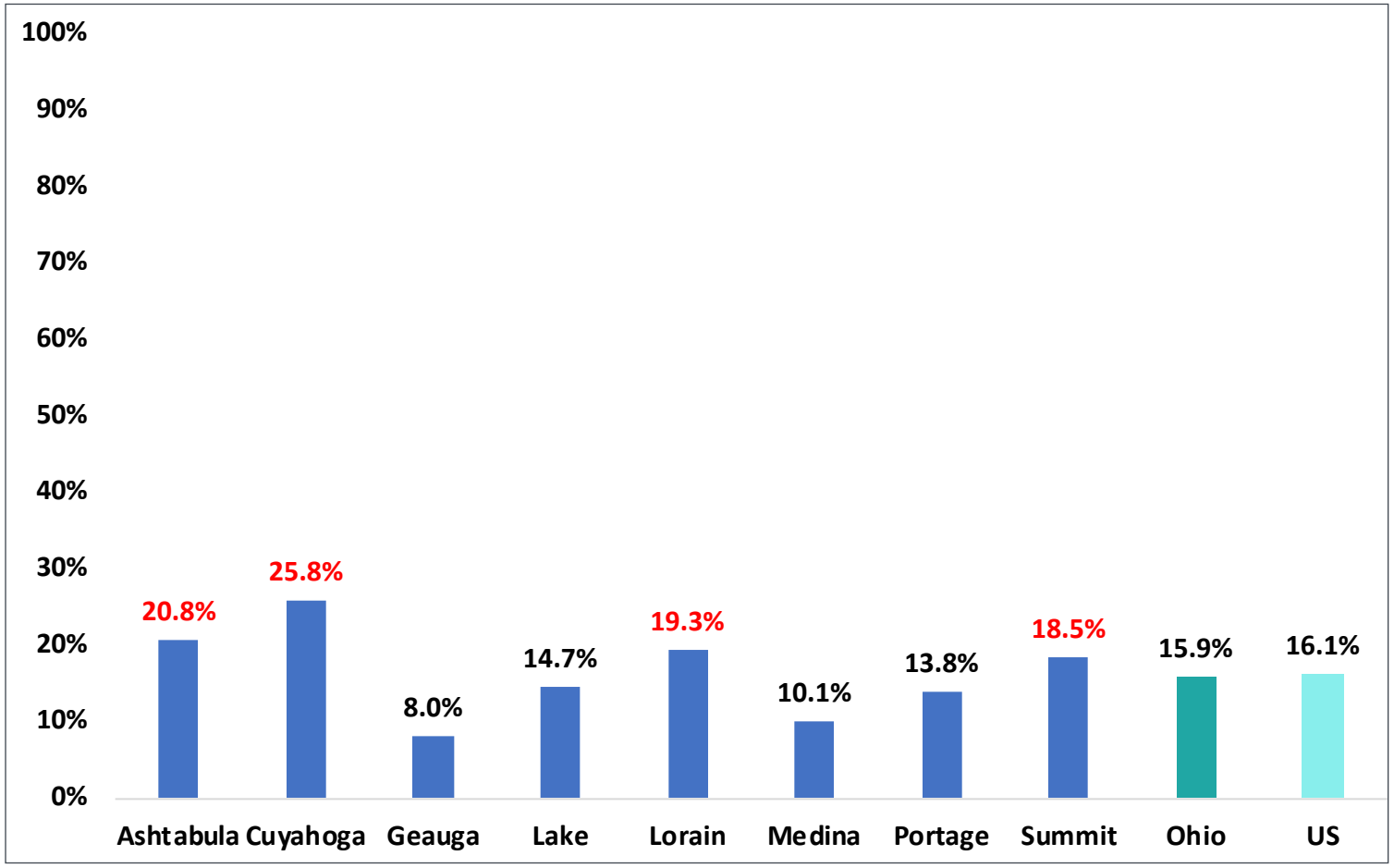
Figure 17: Teen Birth Rate, 2021*



Source: Healthy NEO, Ohio Department of Health, Vital Statistics
**live births per 1,000 females aged 15-17 years*

The percentage of children with food insecurity in the state of Ohio was 15.9% in 2020, compared to the US percentage of 16.1%. Ashtabula (20.8%), Cuyahoga (25.8%), Lorain (19.3%) and Summit (18.5%) counties had significantly higher rates of food insecurity when compared to the state. Geauga (8.0%), Lake (14.7%), Medina (10.1%), and Portage (13.8%) had lower rates.

Figure 18: Child Food Insecurity, 2020



Source: Healthy NEO

Factors Negatively Affecting Youth Mental Health

When asked, all key informant interview respondents highlighted the negative impact of the COVID pandemic on youth mental health. While not necessarily caused by the pandemic, the pandemic undoubtedly exacerbated pre-existing and underlying mental health concerns brought on by a number of factors notably poverty, violence (school shootings and the ongoing threat of school shooting) and racism.

Several interviewees shared their observations that the pandemic and subsequent migration to online and virtual platforms has significantly hindered youths' social skills and ability to manage anxiety. Respondents expressed their concerns about the increased prevalence of trauma seen among presenting youth as well as the inescapable influence of social media.

According to many interviewed, social media exposure harms youth in a number of ways including:

1. developmentally inappropriate content,
2. immediate gratification,
3. hyper fixation on self and others' perceptions of self, and
4. the inability to escape the school day's 'news cycle.'

In days past, the end of the school day provided respite from the day's happenings and gossip. Now, according to interviewees, there is no break; news travels fast, far, and wide.

Gone are the days of waiting for the news cycle to 'move on' from whatever embarrassment befell you that day. All of this is made worse by mainstream western culture's pressure to achieve, 'do more,' and 'have more.' Youth today are under a lot of pressure and are dealing with high anxiety.

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.

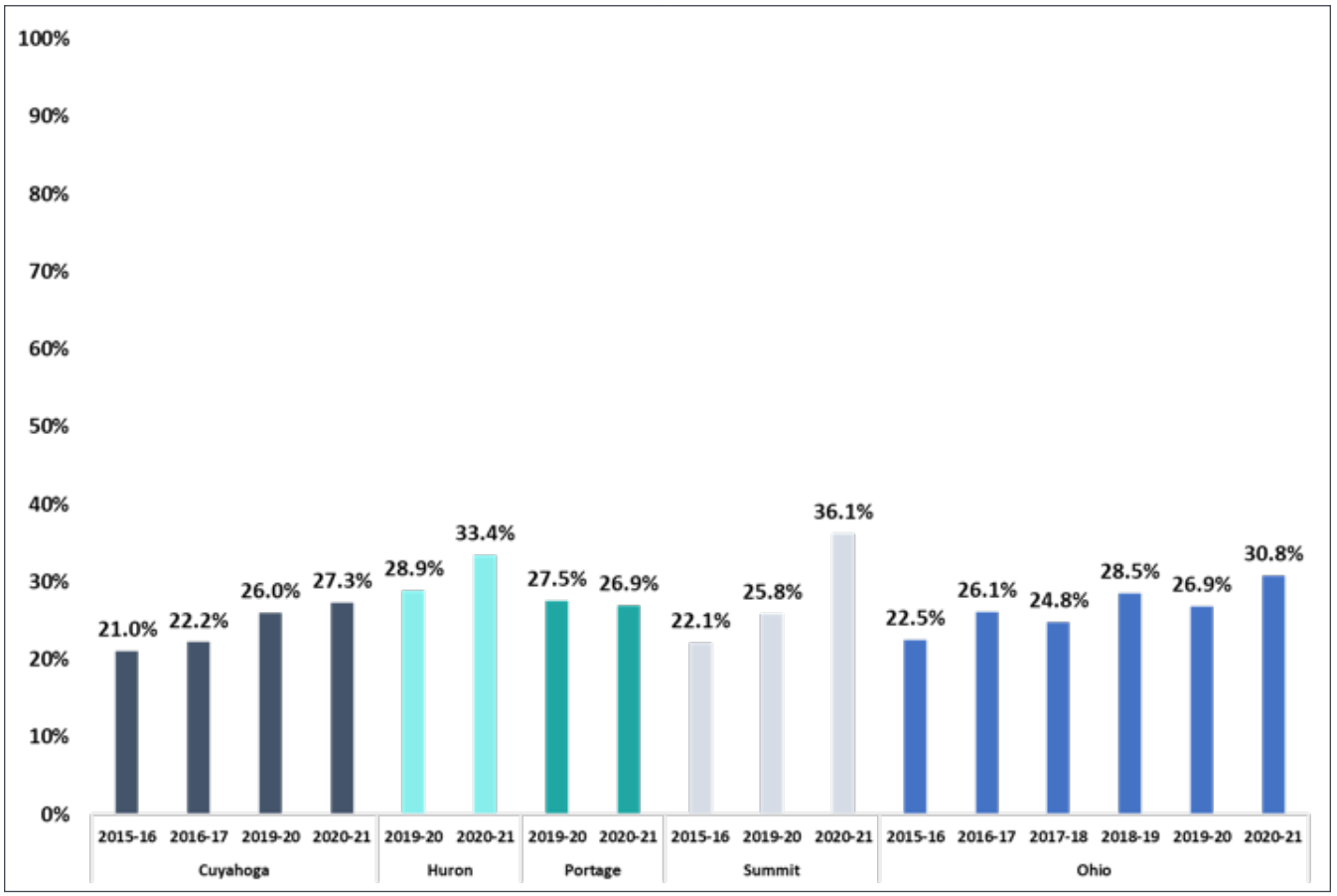
Autism Speaks also estimates that between 54-70% of people with autism also have one or more mental health conditions. In order of estimated prevalence, these include:

- **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 19 illustrates the percentages 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. Over the past five years, the percentage has increased substantially in the state of Ohio, from 22.5% in 2015-16 to 30.8% in 2020-21. The percentages are also increasing in Cuyahoga, Huron and Summit counties, with Summit increasing sharply between 2019-20 to 2020-21 from 25.8% to 36.1%. Portage County, on the other hand, had a slight decrease from 27.5% in 2019-20 to 26.9% in 2020-21. Huron and Summit counties' percentages are also higher than Ohio.

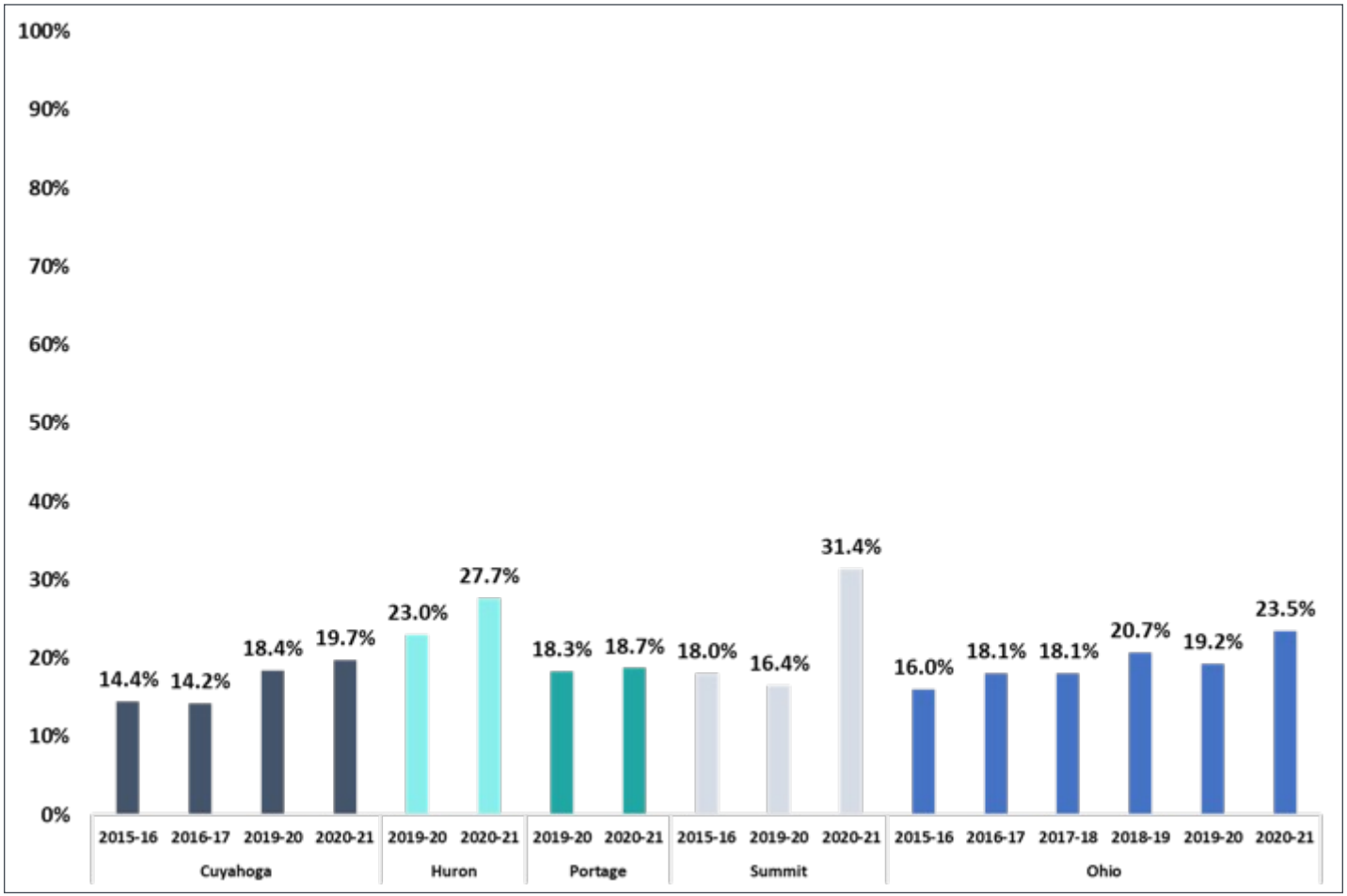
Figure 19: 7-12 Grade Students with Anxiety Issues Warranting Further Exploration by Mental Health Professional



Source: Ohio Healthy Youth Environments Survey

Ohio has also seen an overall increase in the percentages of students in grades 7-12 with depression issues warranting further exploration by a mental health professional, from 16.0% in 2015-16 to 23.5% in 2020-21, as outlined in Figure 20. The percentages are also increasing in Cuyahoga, Huron, Portage and Summit counties with Summit's percentage almost doubling from 16.4% in 2019 to 31.4% in 2020-21. Both Huron and Summit counties had percentages higher than Ohio in 2020-21 while Cuyahoga and Portage Counties were lower.

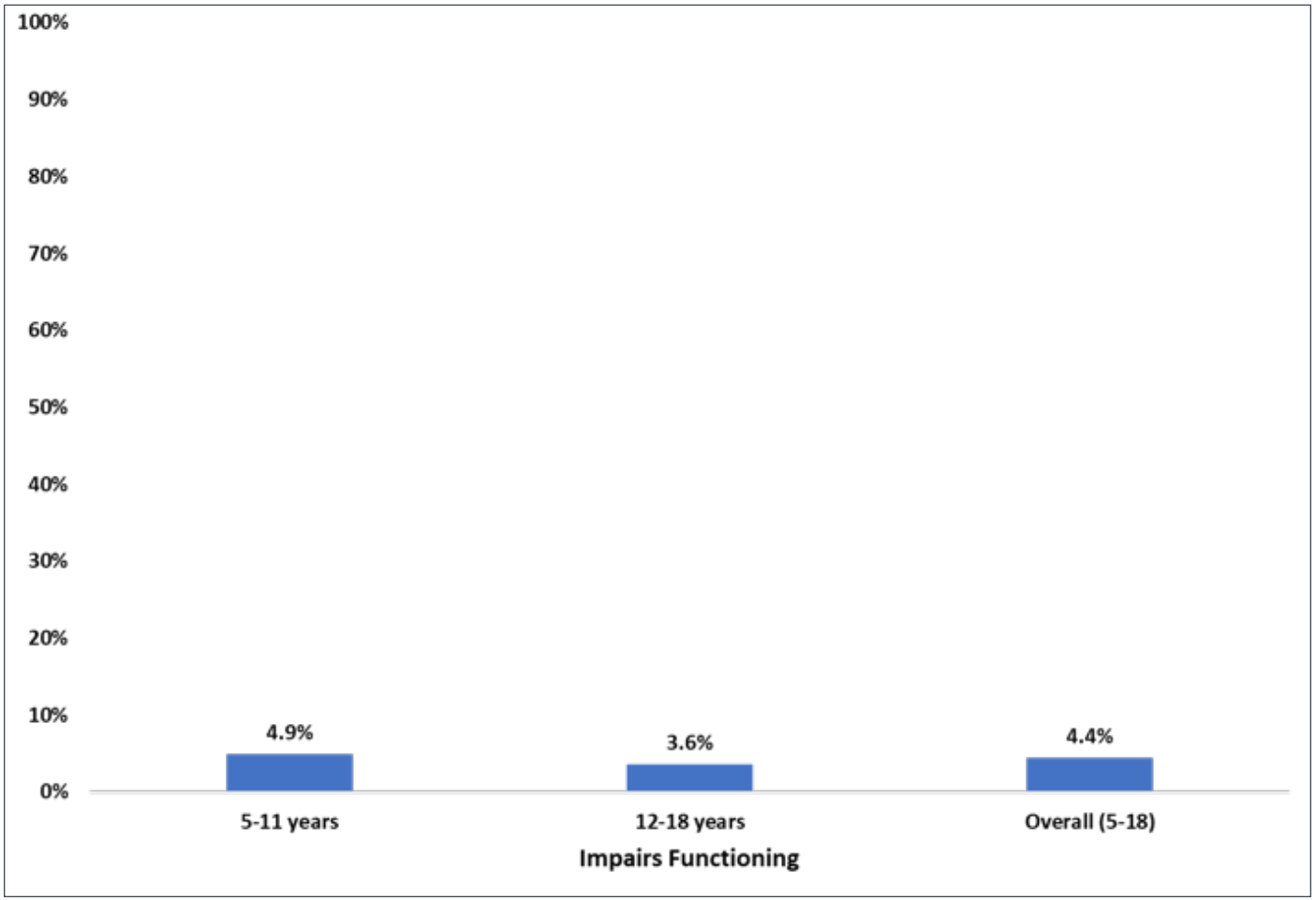
Figure 20: 7-12 Grade Students with Depression Issues Warranting Further Exploration by Mental Health Professional



Source: Ohio Healthy Youth Environments Survey

According to the Mental Health in Ohio Report, 2019, a small percentage of youth overall (4.4%) between the ages of 5 and 18 had frequent mental distress to the point that it impairs functioning. The rate is slightly higher for those 5-11 years (4.9%) and lower (3.6%) for those 12-18 years. This is illustrated in Figure 21.

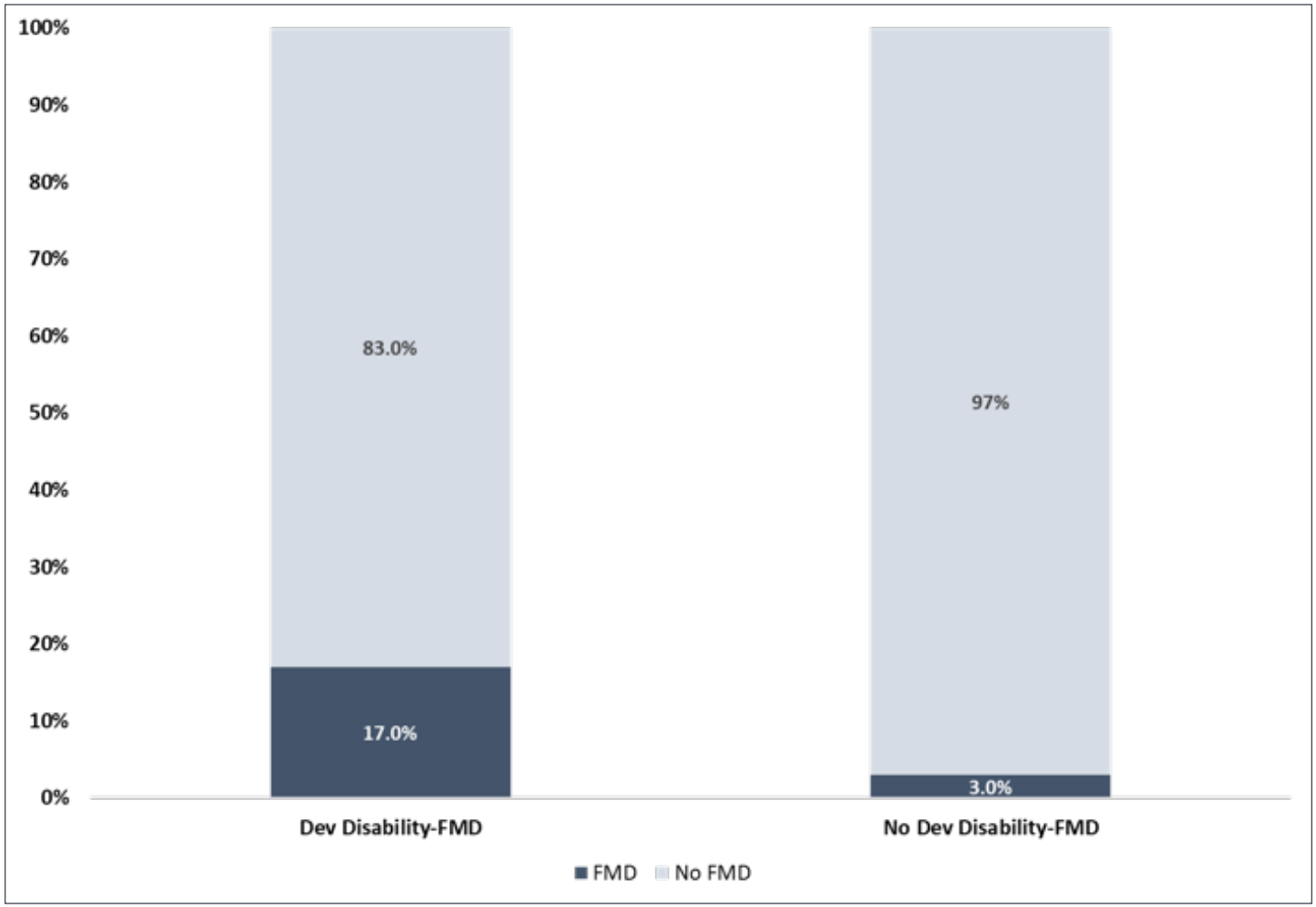
Figure 21: Ohio Youth With Frequent Mental Distress



Source: Mental Health in Ohio Report, 2019

Figure 22 shows that children ages 5-18 with developmental disabilities experience substantially higher levels of frequent mental distress (17.0%) than their peers without developmental disabilities (3.0%).

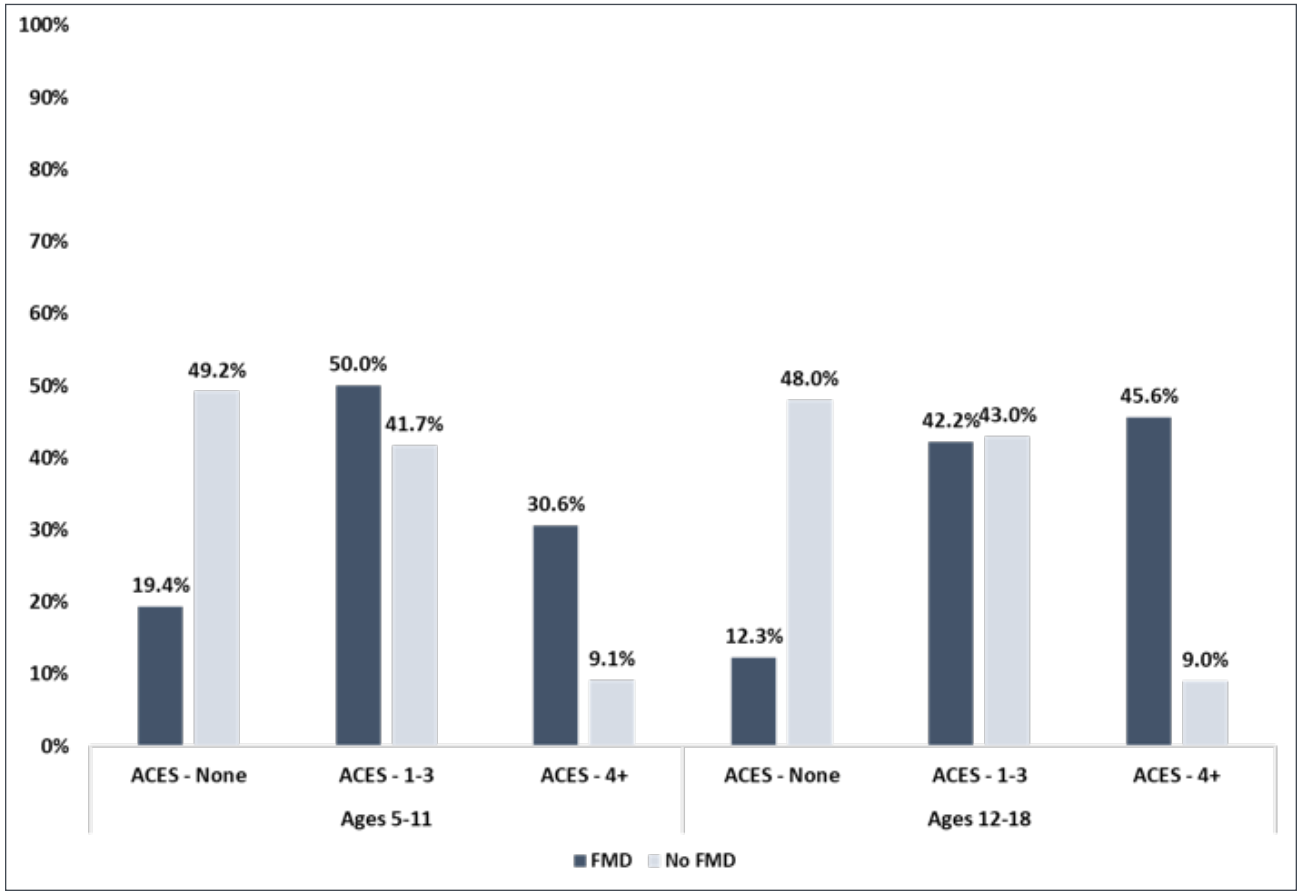
Figure 22: Prevalence of Frequent Mental Distress Among Children (5-18) with Developmental Disabilities



Source: Mental Health in Ohio Report, 2019

Adverse Childhood Experiences (ACES) are potentially traumatic events that occur in childhood (0-17 years) that have an impact on mental health and well-being. Figure 23 indicates that 19.4% of children ages 5-11 experience frequent mental distress when they have experienced no ACES. That percentage more than doubles to 50.0% when they have experienced between 1-3 ACES and increases to 30.6% when they have experienced 4+ ACES. For older children ages 12-18, 12.3% of those who have experienced no ACES have frequent mental distress. This percentage more than triples to 42.2% when youth experienced 1-3 ACES and increases again to 45.5% when they have experienced 4+ ACES.

Figure 23: Children with Mental Health Impairment by Adverse Childhood Event (ACEs) Categories



Source: Mental Health in Ohio Report, 2019

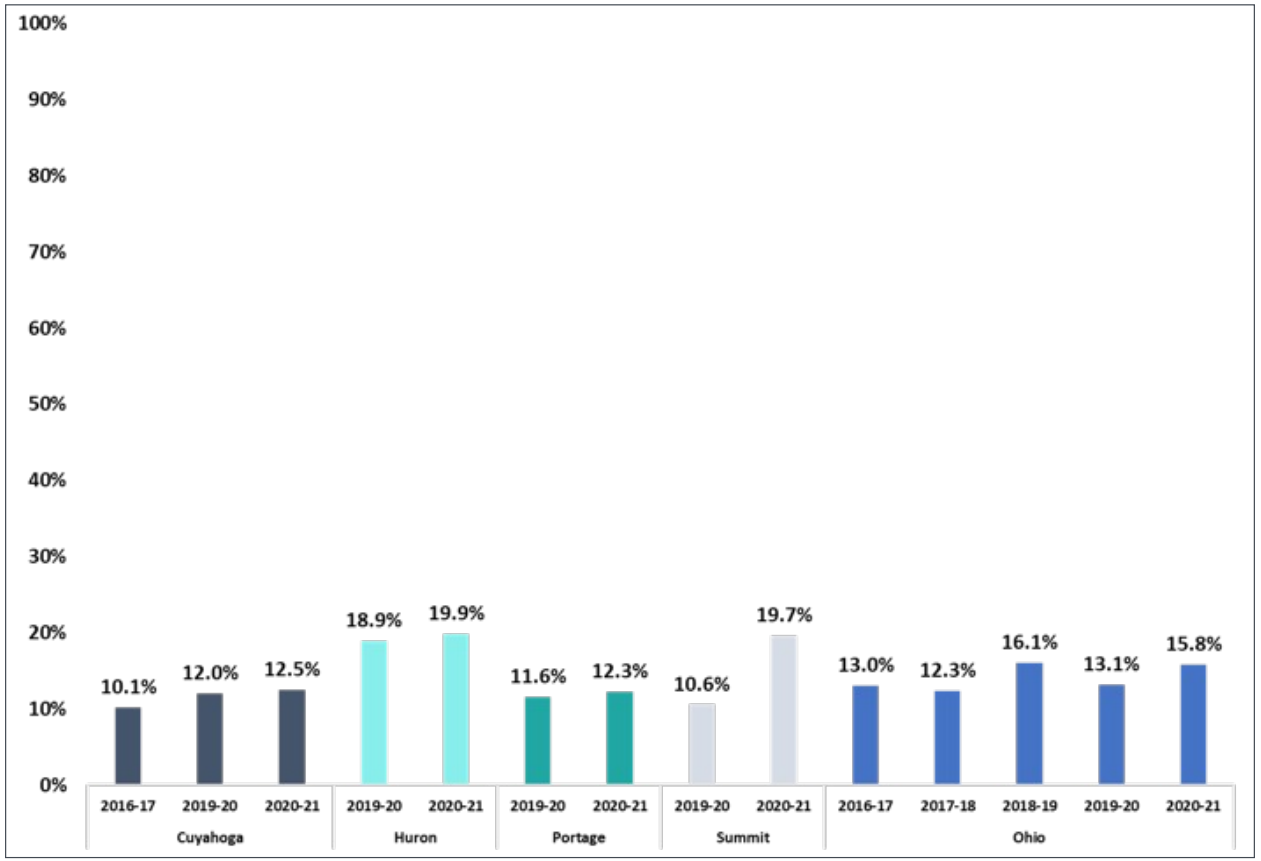
The National Alliance on Mental Illness (NAMI) reports that:

- 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.

Bluestone Private Room

The percentage of students in grades 7-12 seriously considering attempting suicide in the past 12 months has risen in the state of Ohio overall (13.0% to 15.8% between 2016 and 2021), as well as in all four of the service area counties with available data. The percentage is highest in Huron County (19.9%) and has increased most sharply in Summit County from 10.6% in 2019-20 to 19.7% in 2020-21. Portage County had the lowest percentage of the service area counties at 12.3% in 2020-21. Nationally the Youth Risk Behavior Survey (YRBS) does not ask suicide questions in the middle school survey, therefore available data for the nation is for students in grades 9-12, so it is not a direct comparison to the data reported for the state. In 2021, based on the available YRBS data 22.2% of students in grades 9-12 seriously considered attempting suicide.

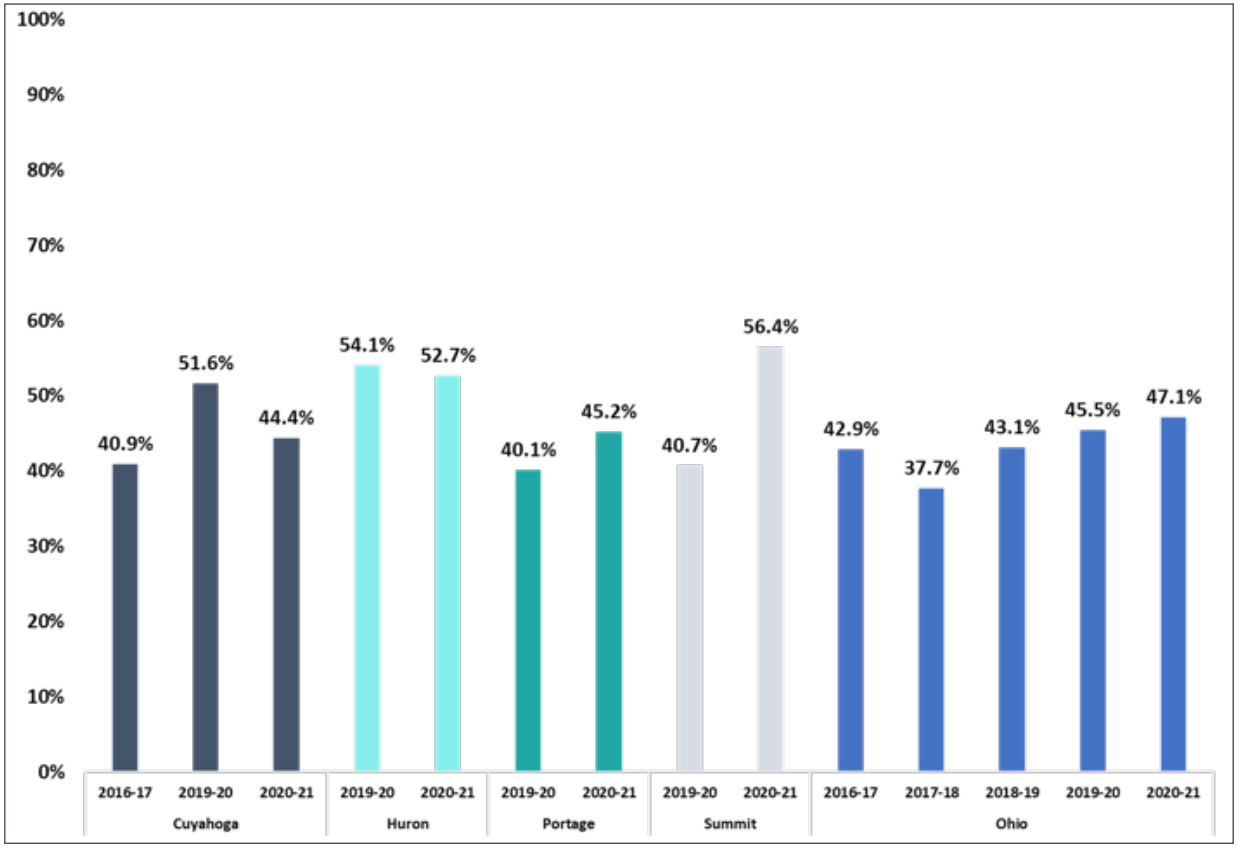
Figure 24: 7-12 Grade Students Seriously Considered Attempting Suicide, Past 12 Months



Source: Ohio Healthy Youth Environments Survey

Of those students in grades 7-12 who have seriously considered attempting suicide in the past 12 months, Figure 25 shows that almost half (47.1%) of students across the state in 2020-21 have actually attempted suicide. This is an increase from 42.9% in 2016-17. Of the service area counties, Summit County has the highest percentage (56.4%) of suicide attempts in 2020-21, a substantial increase from the year before (40.7%). Portage County's percentage also increased from 40.1% to 45.2%, while Cuyahoga County's rate decreased from 51.6% to 44.4% from 2019-20 to 2020-21. Huron County's percentage also decreased from 54.1% to 52.7% during the same period. Nationally the Youth Risk Behavior Survey (YRBS) does not ask suicide questions in the middle school survey, therefore available data for the nation is for students in grades 9-12, so it is not a direct comparison to the data reported for the state. In 2021, based on the available YRBS data 10.2% of students in grades 9-12 who seriously considered attempting suicide report that they have actually attempted suicide.

Figure 25: 7-12 Grade Students Who Attempted Suicide, Past 12 Months, of Those Who Seriously Considered

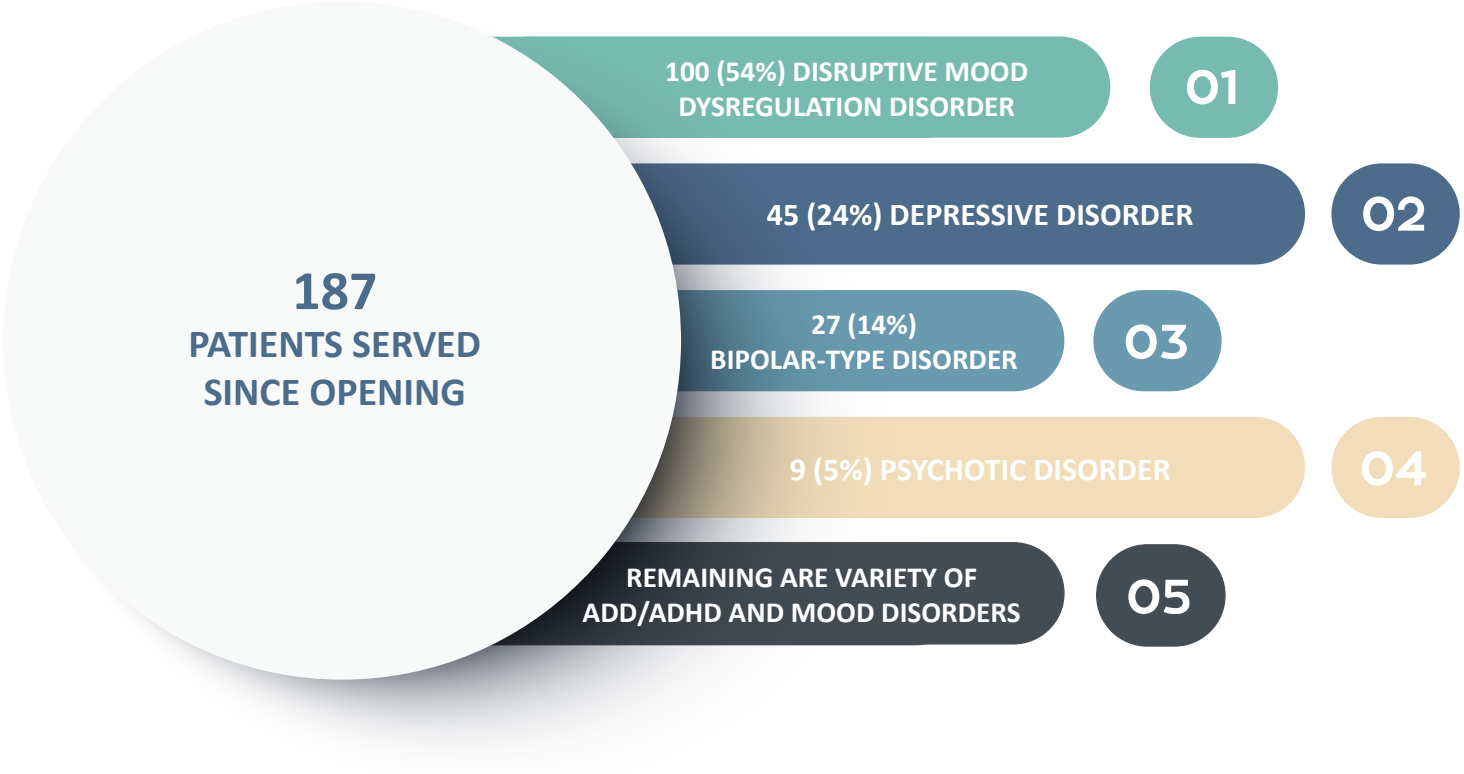


Source: Ohio Healthy Youth Environments Survey

Hospital Utilization

Bluestone Child & Adolescent Psychiatric Hospital opened its doors in January 2022. Since opening, the hospital has served 187 inpatients. 100 (54%) of the patients have had disruptive mood dysregulation disorder, 45 (24%) had depressive disorder), 27 (14%) had bi-polar type disorder, 9 (5%) had psychotic disorder and the remaining include a variety of ADD/ADHD and mood disorders.

Figure 26: Hospitalization



Source: Bluestone Child & Adolescent Psychiatric Hospital

Challenges Within the Field of Youth Mental Healthcare

Figure 27 outlines the challenges that exist in 2023 in youth mental health. The most frequently reported challenge, cited by all key informant interviewees, was the lack of service availability at all levels of care from in-patient psychiatric facilities and residential treatment to out-patient community mental health and private practice.

More capacity is needed to meet the high demand for child and adolescent mental healthcare. Long waitlists and workforce shortages combined with the increased prevalence and acuity of youth mental health concerns, has resulted in youth not being able to access care until they are in or near crisis, according to the majority of respondents interviewed.

Many respondents also bemoaned the issue of long wait times at Emergency Departments (ED). According to many interviewed, by the time an in-patient bed does become available, the youth is often deemed no longer 'at risk' and is sent home, still very much in need of service. Unfortunately, as already mentioned, community-based services are not readily available. As a result, youth languish on waitlists and families are often reluctant to return to the ED if/when their child is in crisis again because their needs were not met the first (or second…) time.

Figure 27: Youth Mental Health Challenges

A second frequently reported challenge within the field is addressing youth mental health issues when caregivers have untreated mental health needs themselves. Many respondents shared their observations that in general, adults are also not doing well. As youth and their mental health needs exist within a larger family system, interviewees described the challenges posed by unresolved generational trauma.

Several respondents talked about how caregivers often struggle to recognize that their child needs help because they themselves did not get the help they should have as a child. This results in the need to address caregivers' ongoing mental health needs and connect them with services as well as educate caregivers about risk assessment, signs and symptoms of mental health concerns, and when to seek care for their child.

Even in cases without generational trauma, caregivers can be overwhelmed by their child's mental health needs. Navigating the mental health care system can be incredibly difficult and frustrating. Families need:

1. help accessing services,
2. education about services available, and
3. how to advocate for their child in order to ensure they get the help they need.

One respondent also discussed the need to continue creating a 'no wrong door approach' to mental health care access such as youth can get connected to mental health services through a variety of avenues.

A third area of challenge within the field concerns the overall functioning of the mental healthcare system. Administrators interviewed repeatedly criticized Medicaid reimbursement rates, which they stated do not cover the actual cost of Medicaid billable services. As a result, non-profit agencies cannot offer certain services, such as Intensive Home-Based Treatment, a highly effective evidence-based intervention, nor ultimately stay afloat.

Agencies and organizations must then seek alternative funding, sources that are typically accompanied by burdensome administrative oversight. Remaining in compliance with funder requirements necessitates significant staff time and investment, taking away from direct service delivery.

Many respondents highlighted the inequitable pay scales across different types of institutions. For example, direct service professionals working in a community mental health care setting are often, according to interviewees, making approximately $10 to $15 thousand dollars less than their peers in hospital settings. Community mental health also cannot compete with Federal wage scales used in Federally Qualified Health Care (FQHC) settings. In addition to lower compensation, the community mental health practitioners with whom we spoke stated that they are seeing a higher acuity patient since the pandemic.

Youth who would have gone to detention or a residential facility are now being treated in the community due to a lack of service availability. These adolescents' needs do not match what community mental health can offer, sometimes contributing to worsening outcomes for youth and burnout among staff.

"There is a need to continue creating a "no wrong door approach' to mental health care access such as youth can get connected to mental health services through a variety of avenues.

When staff leave, patient care is disrupted, threatening patient outcomes. In addition, when new staff are eventually hired, they must be trained in evidence-based practices; however, implementing models to fidelity is costly. Eventually it becomes infeasible to continually train staff in evidence-based treatments that are not reimbursed at cost. It is a vicious and unsustainable cycle negatively affecting the most vulnerable among us, youth.

Unmet Need

One theme articulated repeatedly across interviews was that the field of child and adolescent mental health knows what works to treat youth mental health needs. There is no lack of knowledge or effective clinical technology. Rather, the issue is one of workforce shortages, not having the trained mental health professionals, social workers, counselors, psychiatrists, and nurse practitioners, to deliver effective services. Insufficient human capital results in a lack of services available across the care continuum. While calling for greater investment in workforce development, respondents also highlighted the need for a more diverse mental health workforce citing the importance of having a practitioner that 'looks like you.'

> Burdensome administrative tasks coupled with unreasonably high need/ acuity patients, and low pay (particularly in community mental health) contribute to staff burnout and ultimately, turnover.

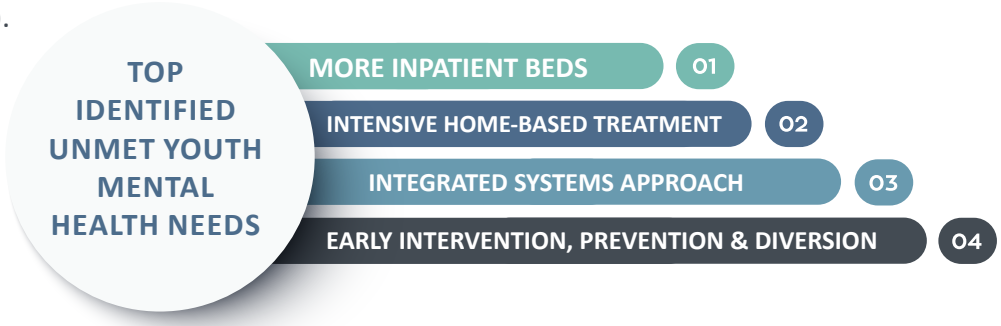
Looking specifically at the types of services lacking due to workforce shortages, the most frequently reported need was tied between more in-patient psychiatric beds (that are accessible at all hours of the day) and Intensive Home-Based Treatment (IHBT).

Closely following were calls for more services for multi-system involved youth, those with juvenile justice involvement, developmental disabilities, and severe behavioral concerns. According to those interviewed, these youth are often deemed 'too difficult' to serve or 'not appropriate' for a particular setting. As a result, they do not receive the treatment they need (an important equity issue within the field).

Both parents interviewed as part of this needs assessment talked at length about this issue. Professionals working in lower acuity settings also called for more feedback to the referring provider and family when a youth is denied service. Referring providers would like to know why the particular youth was deemed 'inappropriate' for the setting. The next most commonly reported need was for more prevention and diversion particularly in school-based settings (more on school-based collaboration below).

All respondents noted the importance of early intervention so as to prevent crises and acute mental health issues from emerging in the first place. In most cases, the goal is to serve youth in their homes and schools, maintaining their routines, surrounded by trusted adults, so that they never need a higher level of care (i.e., in-patient or residential treatment setting).

Figure 28: Top Identified Unmet Youth Mental Health Needs



Unmet Outpatient Needs

One reason for more in-patient psychiatric beds being cited most frequently among professionals interviewed is due to the lack of service availability at lower levels of the service continuum (i.e., prevention, community-based mental health care).

Although less frequent, the following services were identified as current needs within the field (presented in descending order):

- **Wrap-around services -** Interviewees highlighted how well this model works for youth and families as a result of its intensity, family systems focus, and multisystem collaborative approach. Once again, however, respondents explained that their organizations cannot afford to fund it and cannot find enough staff to implement it.
- **Long-term residential services** for youth who cannot be safely maintained in their home, school and community settings.
- **A place for youth to 'cool off' and stabilize -** A few interviewees noted the need for a new type of setting where youth in crisis can stabilize. For these youth, ED stays are not long enough, but the full suite of service delivered in an in-patient or residential setting is excessive.
- **Partial hospitalization and intensive outpatient programs** for children under age 13. A few interviewees talked about the younger age of onset for serious mental health issues and the lack of treatment options for older children and pre-teens.
- **A temporary residential/housing setting** where youth who do not have a home to return to can live while stepping down from in-patient care.

Unmet Financial Needs

The second category of need relates to funding. As highlighted in the previous section on challenges within the field, many participants talked about the need for funding to cover the cost of services for working poor families, those who make 'too much' to qualify for Medicaid, but too little to cover deductibles and copays. In addition, for privately insured families, regardless of income level, private insurance does not cover certain services such as IHBT.

Qualifying for and accessing services covered by a county waiver was also raised as a concern. According to some, it is nearly impossible for a family to meet the requirements to obtain a county waiver for services. These requirements need to change. For the few who have successfully obtained a waiver, they were critical of the availability of waivered providers.

They explained their understanding that the county does not reimburse waivered providers at an appropriate rate and therefore, providers choose not to provide waivered services.

Currently, families are not allowed to secure their own providers and seek reimbursement for care for their children. All three of these concerns speak

Bluestone Group Room

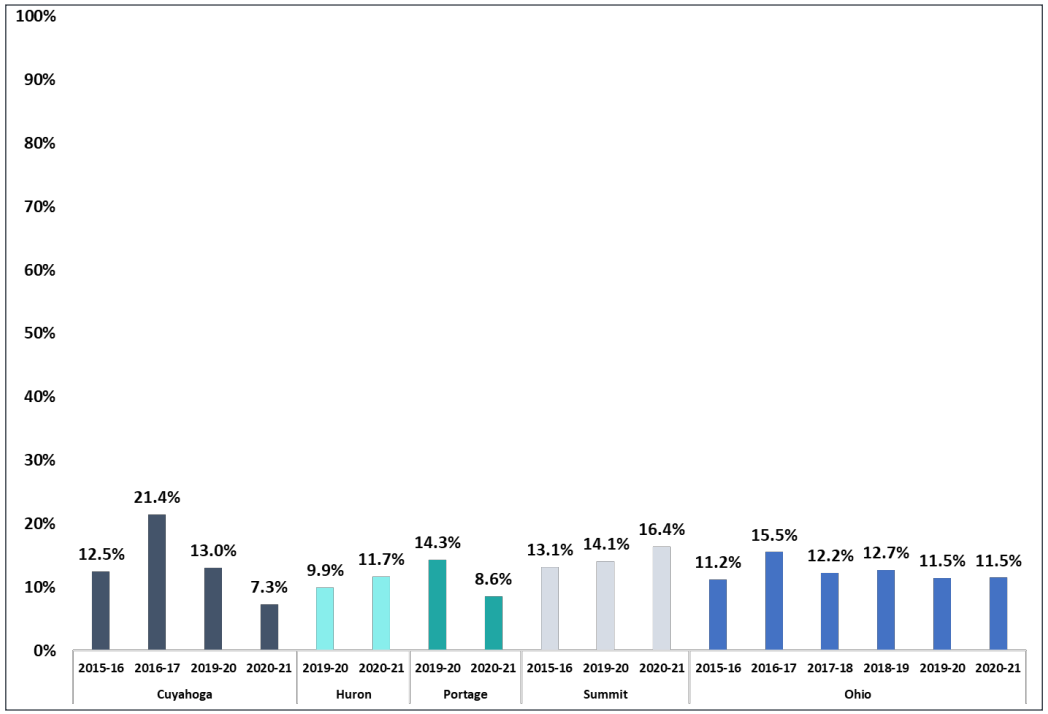
SUBSTANCE ABUSE

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 29 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. Overall, in the state of Ohio over the past six reporting years, the rate increased from 11.2% in 2015-16 to 11.5% in 2020-21 after increasing to as high as 15.5% in 2016-17. Summit County has had the largest increase from 13.1% in 2015-16 to 16.4% in 2020-21. Huron County also increased from 9.9% in 2019-20 to 11.7% in 2020-21. Cuyahoga County's rate declined substantially from 21.4% in 2016-17 to 7.3% in 2020-21 and Portage County also decreased from 14.3% to 8.6% between 2019 and 2021. Huron and Summit's percentages are higher than the state average, while Cuyahoga and Portage County's percentages are lower.

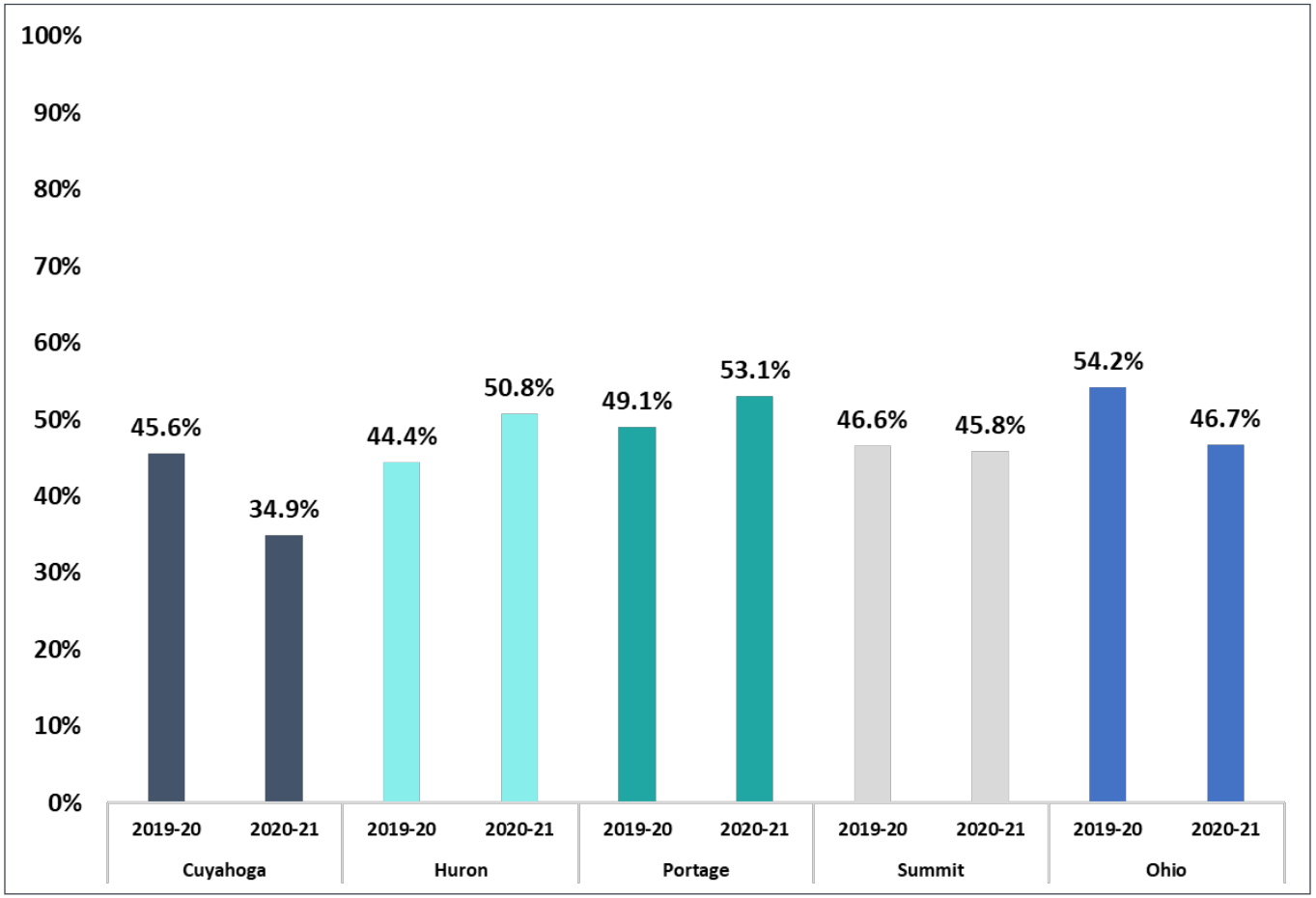
Figure 29: 7-12 Grade Students Drank 1 or More Alcoholic Beverages, Past 30 Days



[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.*

The percentage of 7-12 grade students who binge drank over the past 30 days (defined as 4+ drinks for females and 5+drinks in a row for males within a few hours) has declined from 54.2% in Ohio in 2019-20 to 46.7% in 2020-21. The percentages also declined in Cuyahoga from 45.6% to 24.9% and Summit County from 46.6% to 45.8% during the same time period. The rates increased in Huron County from 44.4% to 50.8% and Portage County from 49.1% to 52.1% respectively.

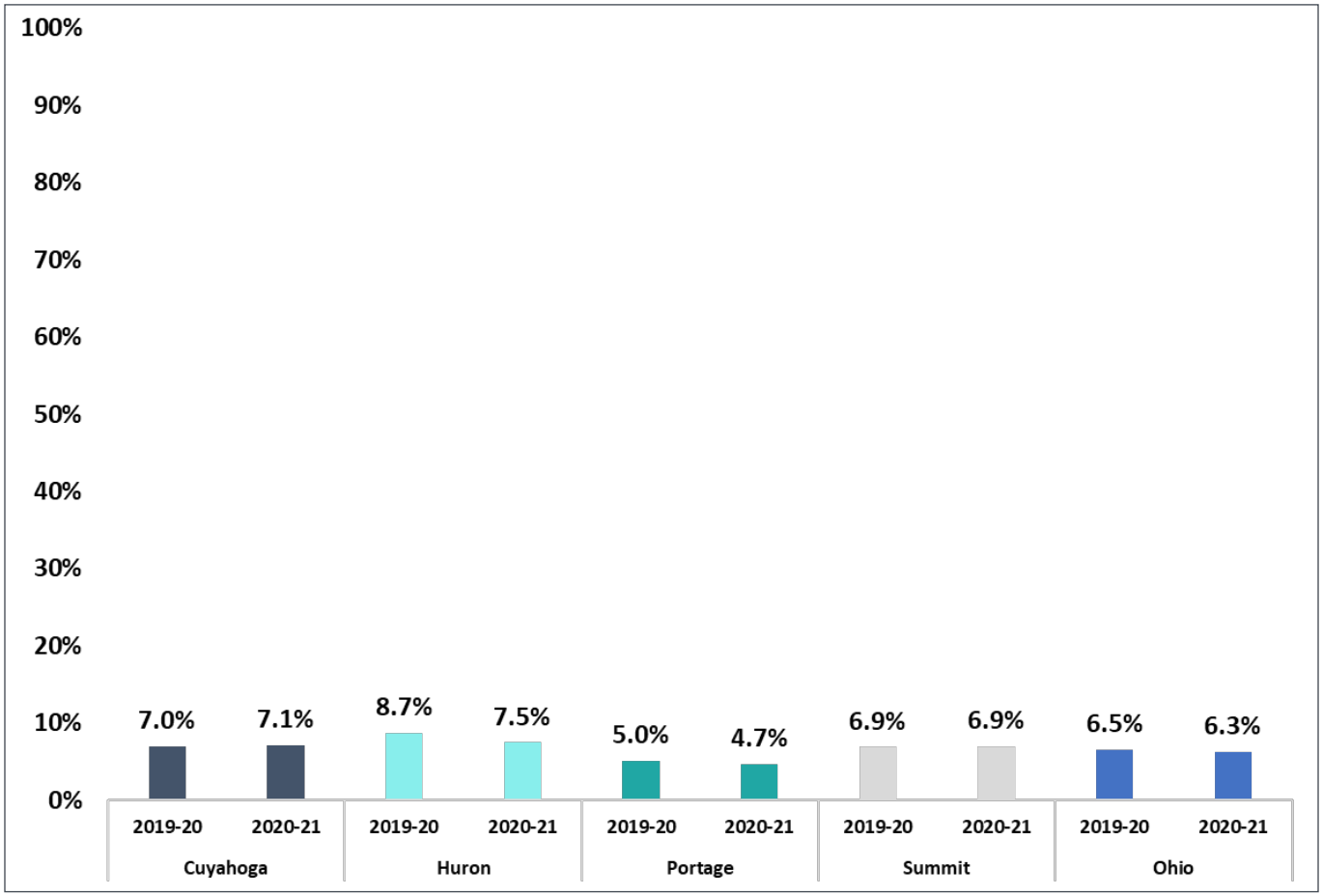
Figure 30: 7-12 Grade Students Binge Drank*, Past 30 Days



Source: Ohio Healthy Youth Environments Survey
** 4+ Drinks Females, 5+ Drinks Males in a Row, Within a Few Hours*

Figure 31 illustrates the percentage of 7-12 grade students' lifetime use of prescription drugs without a prescription or differently than prescribed for Ohio as well as for selected counties in the service area where data was available for the 2019-20 school year compared to the 2020-21 school year. The percentage in Ohio declined slightly from 6.5% to 6.3%, as did Huron County from 8.7% to 7.5%, and Portage County from 5.0% to 4.7%. The rate in Cuyahoga County increased slightly from 7.0% to 7.1% while the rate in Summit County remained steady at 6.9%. Cuyahoga, Horon and Summit County's percentages are higher than the state, while Portage County's percentage is lower.

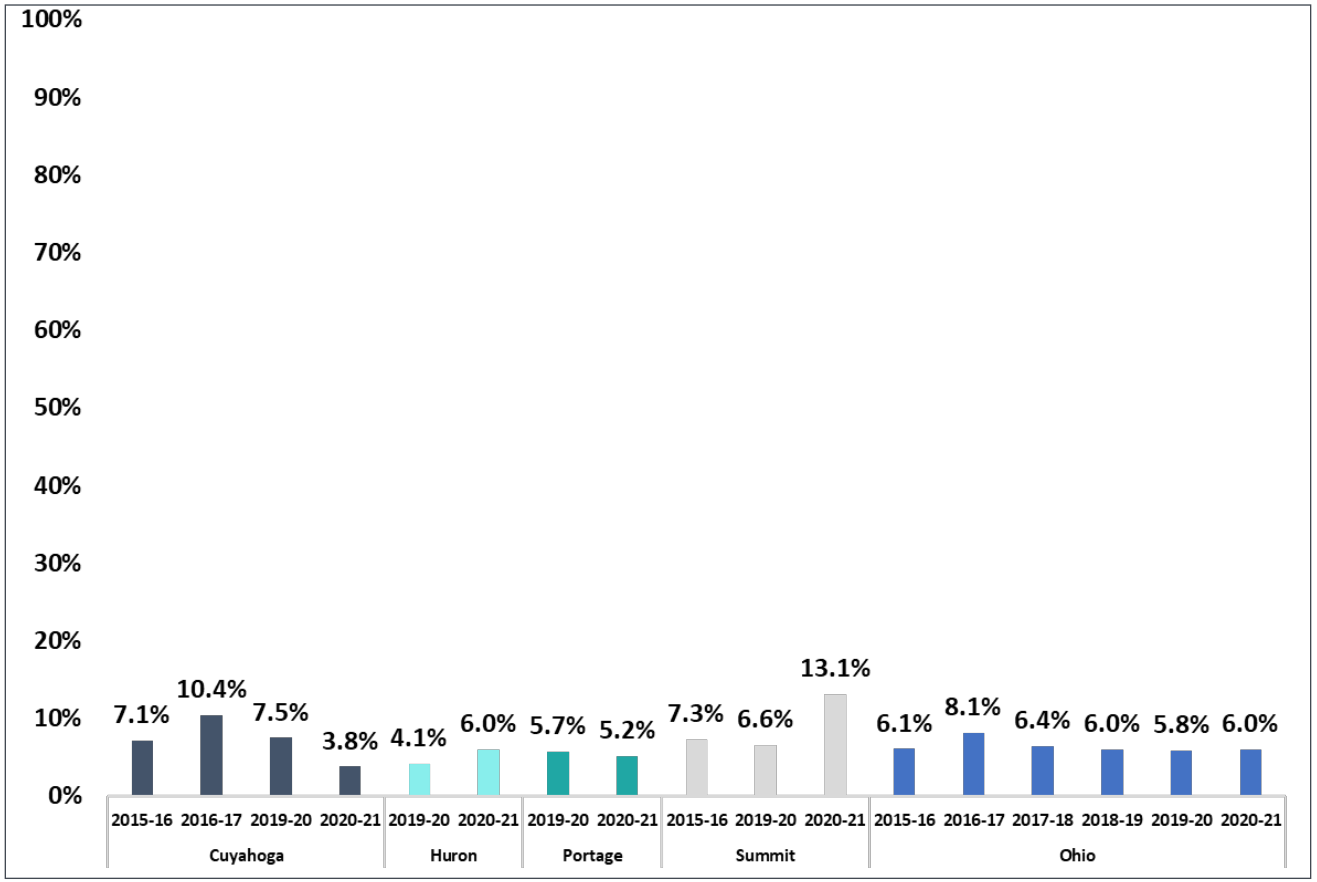
Figure 31: 7-12 Grade Students Lifetime Use of Prescription Drugs Without a Prescription or Differently Than Prescribed



Source: Ohio Healthy Youth Environments Survey

The percentage have students in grades 7 to 12 who have used or hashish in the past 30 days has fluctuated in the state of Ohio overall as well as in the selected counties of the service territory Over the past few years. As illustrated in Figure 32, the percentage in the state of Ohio has gone from 6.1% in the 2015-16 school year to 6.0% in the 2020-21 school year. The percentage in Summit County rose sharply between 2019-20 (6.6%) and 2020-21 (13.1%) and Huron County increased from 4.1% in 2019-20 to 6.0% in 2020-21. Cuyahoga County declined from 10.4% in 2016-17 to 2.8% in 2020-21 and Portage County declined from 5.7% in 2019-20 to 5.2% in 2020-21.

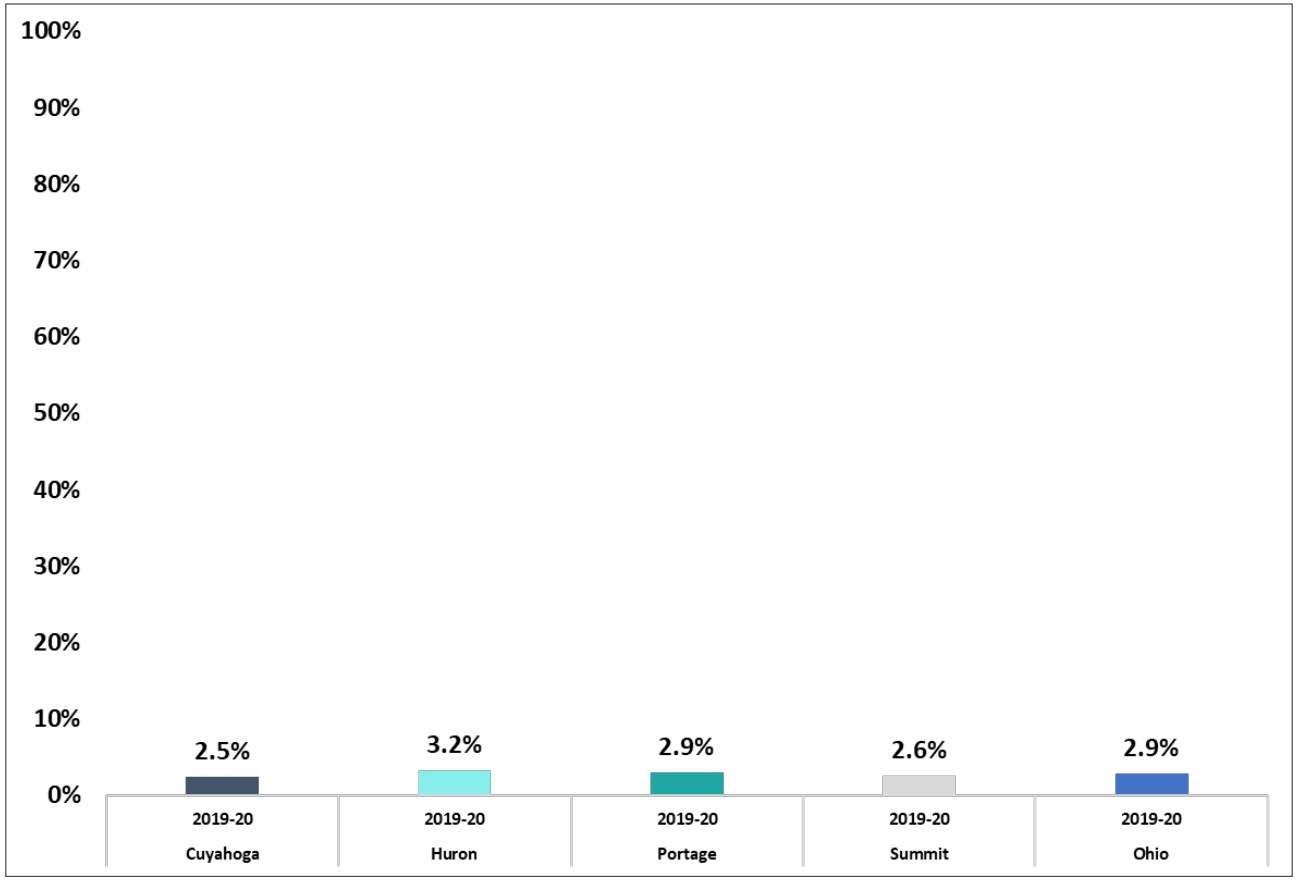
Figure 32: 7-12 Grade Students Used Marijuana or Hashish, Past 30 Days



Source: Ohio Healthy Youth Environments Survey

During the 2019-20 school year, 2.9% of Ohio students in grades 7-12 reported that they had used illicit substances during their lifetime, equivalent to Portage County as outlined in Figure 33. Cuyahoga County (2.5%) and Summit County (2.6%) students reported lower percentages while Huron County students reported higher percentages (3.2%).

Figure 33: 7-12 Grade Students Lifetime Use Illicit Substances



Source: Ohio Healthy Youth Environments Survey

Community Input

Community key informant stakeholders did not comment on issues related to substance use disorder.

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. 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
Erie County: https://www.211oh.org/how-we-help/services
Geauga County: https://www.211oh.org/how-we-help/services
Huron County: https://www.norwalkareaunitedfund.org/first-call-resources
Lake County: https://lclifeline.org/2-1-1/2-1-1-database/
Lorain County: https://211lorain.org/
Medina County: https://www.211summitmedina.org/
Portage County: https://211portage.org/
Summit County: https://www.211summitmedina.org/

Community Input

According to those interviewed, there are a number of things working within the field of child and adolescent mental health in Northeast Ohio. In addition to strong evidence-based clinical interventions, all respondents highlighted the effectiveness of collaboration and called for more of it. Youth exist within families, schools, and other community and institutional systems. As a result, silos must continue to be removed and partnerships developed so that youth are prioritized, and their care is made seamless.

One area in need of more focus, according to some, are formalized care pathways for youth stepping down from in-patient treatment settings. At a time when youth are particularly vulnerable, transition planning is essential to ensure safety and prevent readmission.

The administrators who participated in the interviews offered their observations of how funder requirements and resulting evaluation stipulations often contribute to silos and interfere with a collaborative approach.

School connections and providing mental health services within the educational setting were viewed as essential to serving youth. One respondent described how well she believes the new Wellness Coordinators, hired by the Educational Service Center (ESC) of Northeast Ohio, are working to continue establishing relationships between schools and community agencies.

Respondents were also very hopeful about how Ohio Rise and Care Management Entity (CME) participation will facilitate collaboration, ensure timely access to services, increase awareness of service availability, help families navigate the mental healthcare system, and formalize care pathways.

Overall, those interviewed viewed MRSS and mobile crisis services dedicated to youth as great and necessary additions to the field and would like to see them expanded. Some also talked about the need to educate schools about how to use mobile crisis appropriately. That is, providing psychoeducation about how to assess risk and mitigate mental health concerns before they reach a crisis level.

Currently, mobile crisis is generally limited in counties where it exists and respondents highlighted the need to ensure it is not used for 'everything,' such that it is not available when needed in a serious crisis.

Lastly, a few respondents working in integrated physical and behavioral healthcare settings shared their views on its effectiveness and called for more integrated care settings.

CONCLUSIONS

Quantitative Secondary Data

Improving Indicators

The percentage of 7-12th grade students with anxiety issues warranting further exploration by a mental health professional has decreased in Portage County (27.5% in 2019-2020 to 26.9% in 2020-2021). The percentage of 7-12th grade students who reported that they seriously considered attempting suicide that also reported actually attempting suicide decreased in Cuyahoga (51.6% in 2019-2020 to 44.4% in 2020-2021) and Huron counties (54.1% to 52.7%).

The percentage of 7-12th grade students who reported that they drank one or more alcoholic beverages in the past 30 days had decreased in Cuyahoga (12.5% in 2015-2016 to 7.3% in 2020-2021) and Portage (14.3% in 2019-2020 to 8.6% in 2020-2021) counties. The percentage of 7-12th grade students who reported binge drinking in the past 30 days had decreased between 2019-2020 and 2020-2021 in Cuyahoga (45.6% to 34.9%) and Summit (46.6% to 45.8%) counties.

In 2020, the percentage of adults who reported excessive drinking was lower in Ashtabula (17.8%) and Summit (17.0%) counties in comparison to the state (19.0%).

During this time the percentage of 7-12th grade students who used prescription drugs without a prescription or differently than prescribed has decreased in Huron (8.7% to 7.5%) and Portage (5.0% to 4.7%) counties. The percentage of 7-12th grade students who reported using marijuana or hashish in the past 30 days had decreased in Cuyahoga (7.1% in 2015-2016 to 3.8% in 2020-2021) and Portage (5.7% to 5.2%) counties.

The child abuse and neglect rate per 1,000 is lower in Ashtabula (6.4), Geauga (1.7), Lake (3.8), Lorain (6.6), Portage (5.9) and Summit (4.4) counties in comparison to the state (6.9).

In 2021, a higher percentage of children have health insurance in Cuyahoga (97.3%), Lake (96.8%), Lorain (96.3%), Medina (97.2%) and Summit (97.1%) in comparison to Ohio (94.9%). A lower percentage of youth are living below the poverty level in Geauga (5.7%), Lake (10.3%), Medina (7.5%), Portage (13.4%) and Summit (17.7%) counties in comparison to Ohio (18.6%).

Community Needs

The percentage of 7-12th grade students with anxiety issues warranting further exploration by a mental health professional has increased in Cuyahoga (21.0% in 2015-2016 to 27.3% in 2020-2021), Huron (28.9% in 2019-2020 to 33.4% in 2020-2021) and Summit (22.1% in 2015-2016 to 36.1% in 2020-2021) counties. The percentage of 7-12th grade students with depression issues warranting further exploration by a mental health

professional has increased in Cuyahoga (14.4% in 2015-2016 to 19.7% in 2020-2021), Huron (23.0% in 2019-2020 to 27.7% in 2020-2021), Portage (18.3% in 2019-2020 to 18.7% in 2020-2021) and Summit (18.0% in 2015-2016 to 31.4% in 2020-2021) counties.

The percentage of 7-12th grade students seriously considering attempting suicide has increased in Cuyahoga (10.1% in 2016-2017 to 12.5% in 2020-2021), Huron (18.9% in 2019-2020 to 19.9% in 2020-2021) and Summit (10.6% in 2019-2020 to 19.7% in 2020-2021) counties. Of those who seriously considered attempting suicide, the percentage who reported they actually attempted suicide increased in Portage (40.1% in 2019-2020 to 45.2% in 2020-2021) and Summit (40.7% in 2019-2020 to 56.4%) counties.

Ohio youth with a mental health impairment experience four or more Adverse Childhood Events (ACEs) at a higher percentage than peers without a mental health impairment.

The percentage of 7-12th grade students who reported that they drank one or more alcoholic beverages in the past 30 days had increased in Huron (9.9% in 2019-2020 to 11.7% in 2020-2021) and Summit (13.1% in 2015-2016 to 16.4% in 2020-2021) counties. The percentage of 7-12th grade students who reported binge drinking in the past 30 days had increased between 2019-2020 and 2020-2021 in Huron (44.4% to 50.8%) and Portage (49.1% to 53.1%) counties.

In 2020, the percentage of adults who reported excessive drinking was higher in Cuyahoga (19.9%), Geauga (19.9%), Lake (19.5%), Lorain (19.6%), Medina (21.6%), and Portage (19.5%) in comparison to the state (19.0%).

During this timeframe, the percentage of 7-12th grade students who ed using marijuana or hashish in the past 30 days had increased in Huron (4.1% to 6.0%) and Summit (7.3% in 2015-2016 to 13.1% in 2020-2021) counties. Students in grades 7-12 who reported lifetime use of any illicit substance, was higher in Huron County (3.2%) in comparison to Ohio (2.9%).

The child abuse and neglect rate per 1,000 is higher in Cuyahoga (9.3), Erie (7.0), Huron (7.4) and Medina (7.8) counties in comparison to the state (6.9).

In 2021, a lower percentage of children have health insurance in Ashtabula (82.4%), Geauga (83.6%) and Portage (97.1%) in comparison to Ohio (94.9%). A higher percentage of youth are living below the poverty level in Ashtabula (26.7%), Cuyahoga (24.2%) and Lorain (19.4%) counties in comparison to Ohio (18.6%). There is a higher percentage of pre-term births in Cuyahoga (11.6%) and Lorain (11.4%) counties in comparison to Ohio (10.6%). The percentage of babies with low birthweight is higher in Cuyahoga (10.4%), Lorain (9.3%) and Summit (9.0%) in comparison to Ohio (8.7%). In 2021, the teen birth rate per 1,000 for females aged 15-17 was significantly higher in Cuyahoga (6.4), Lorain (5.3) and Summit (6.6) counties in comparison to Ohio (6.3). A higher percentage of children are considered food insecure in Ashtabula (20.8%), Cuyahoga (25.8%), Lorain (19.3%) and Summit (18.5%) counties in comparison to Ohio (15.9%).

Community Needs

Ashtabula County

- Children without health insurance
- Children living below poverty
- Children who are food insecure

Cuyahoga County

- Youth mental health requiring mental health professional
- Youth suicide
- Adult drinking
- Child abuse and neglect
- Children living below poverty
- Pre-term births
- Babies with low birthweight
- Teen birth rate
- Children who are food insecure

Erie County

- Child abuse and neglect

Geauga County

- Adult drinking
- Children without health insurance

Huron County

- Youth mental health requiring mental health professional
- Youth suicide
- Youth substance use

Lake County

- Adult Drinking

Lorain County

- Adult drinking
- Children living below poverty
- Pre-term births
- Babies with low birthweight
- Teen birth rate
- Children who are food insecure

Medina County

- Adult drinking
- Child abuse and neglect

Portage County

- Youth mental health requiring mental health professional
- Youth suicide
- Youth substance use
- Adult drinking
- Children without health insurance

Summit County

- Youth mental health requiring mental health professional
- Youth suicide
- Youth substance use
- Babies with low birthweight
- Teen birth rate
- Children who are food insecure

Community Input

After reviewing the qualitative feedback on unmet needs, more in-patient hospital beds emerged as a solution to long wait times in EDs and waitlists for in-patient settings within the realm of Bluestone Child & Adolescent Psychiatric Hospital. However, it is also important to consider how the current mismatch between in-patient bed supply and demand exists within the workforce shortage of the larger mental healthcare system.

Greater availability of prevention services and intervention at lower levels of the treatment continuum would likely reduce the need for in-patient and residential treatment according to those interviewed. Making sure transition planning for youth leaving in-patient settings is as good as it possibly could be increases the likelihood that youth will successfully reintegrate into the community and not need readmission in the near term, thus freeing up in-patient beds.

These solutions focus on effective collaboration and eliminating silos among entities serving youth, thereby improving the functioning of the system as a whole. Bluestone may also want to consider how they can focus on retaining qualified staff, addressing burnout and turnover through a variety of means such as compensation and benefits, continuing education and professional development, and workload evaluations. Or, they may want to explore opportunities for advocacy at the Federal, state or local level to change Medicaid reimbursement rates. Ultimately, any one of these changes could positively impact the larger mental healthcare system within Northeast Ohio.

Bluestone Nurses' Station

PRIORITIZATION

On June 6, 2023, 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 4 possible needs and issues were identified and rated against the 2 criteria. Within these 4 areas 11 potential areas of focus were identified and were rated in terms of importance by the Steering Committee. The Steering Committee decided to exclude: suicide prevention, addressing Social Determinants of Health and child abuse and neglect from the list of potential priorities due to the lack of hospital resources or expertise to address. Two criteria, including magnitude of the problem and system resources, were identified that the group would use to evaluate identified needs and issues. Table 5 identified the selection criteria.

Table 5: Prioritization Criteria

		Scoring		
Item	Definition	Low (1)	Medium	High (10)
Magnitude of the problem	The degree to which the problem leads to death, disability, or impaired quality of life and/or could be an epidemic based on the rate or % of population that is impacted by the issue	Low numbers/percent of people affected; no risk for epidemic	Moderate numbers/ percent of people affected and/or moderate risk for epidemic	High numbers/percent of people affected and/or risk for epidemic
System Resources	The extent to which the system is already in place and functioning to address the issue/ problem	No system in place	System is in place but could be improved	System is in place and functioning well

The following areas were rated against the identified criteria:

- Youth mental health (including substance use)
- Autism
- Access to mental health services
- Workforce shortages

The Steering Committee expanded on the potential priorities and identified the following list which was used in the prioritization exercise to identify the importance of pursuing each over the next 3 years.

- Youth mental health (including substance use)
  - IOP groups with different specialties (substance abuse, attempted suicide, victim of rape, trauma)
  - Telehealth
  - Transition of care support/case management
  - Parent engagement and education
- Autism services
  - Access to inpatient care for this population
  - Staff education/training to effectively work with this population
  - De-escalation techniques for caregivers
- Access to mental health services
  - Community education/outreach on available services at Bluestone
  - Outreach to autism providers on available services at Bluestone
  - Address issue of medical clearance to access services at Bluestone
- Workforce shortage
  - Develop internal strategies to employee retention, recruitment, job satisfaction

Following the meeting, Steering Committee members completed the prioritization exercise using SurveyMonkey to rate each of the needs and issues on a one to ten scale by each of the selected criteria listed above. Table 6 illustrates the needs of the Bluestone service area ranked by members of the Steering Committee based on the two criteria. The prioritization ranking chosen for this assessment looked at the total of the magnitude of the problem combined with the system resources. The Steering Committee then rated the importance of possible implementation strategies on a 5-point scale where 5=Very Important, 3=Somewhat Important and 1=Not Important. The results can be found in Figure 34.

Table 6: Bluestone 2023 CHNA Prioritization Results By Criteria

	Magnitude of the Problem	System Resources	Total
Youth mental health (including substance use)	10.00	5.45	15.45
Access to mental health services	9.09	5.45	14.55
Autism	7.27	5.55	12.82
Workforce shortage	8.18	4.27	12.45