hpio
health policy institute of ohio

Policy brief

3 Access to mental health care for Ohio children and youth

Executive summary

For young Ohioans with mental health needs, early treatment can prevent conditions from worsening, decrease financial costs and keep youth on a path to realizing their full potential.

However, many Ohio children and youth experiencing mental health challenges have difficulty getting the treatment they need. The youth mental health system can be difficult to navigate. Critical provider shortages, high cost-sharing and gaps in insurance coverage are among the barriers to accessing care. At the same time, Ohio lacks comprehensive data to demonstrate system capacity needs across the state.

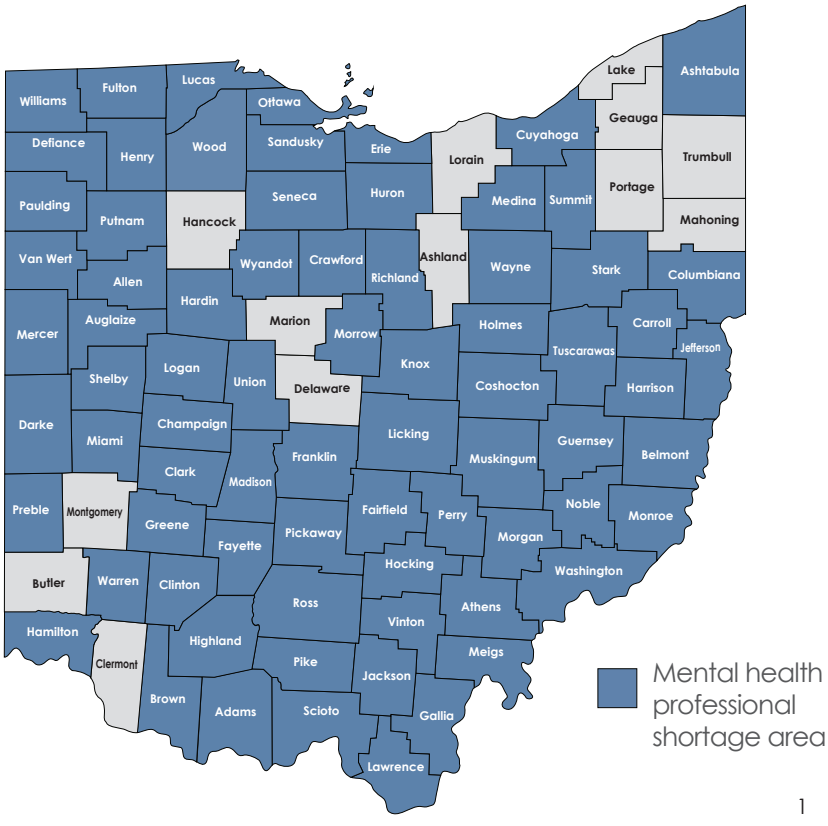
3 Key findings for policymakers

1. **Workforce challenges.** The continuum of mental health care services is broad, and there are workforce shortages at all levels, especially among clinicians trained to care for children with the most intensive needs.
2. **Difficulties with access to care.** Ohio families with young children and families with private (i.e., commercial) health insurance can face considerable difficulty accessing mental health care for their children.
3. **Lack of data.** There is a significant lack of data on mental healthcare access in Ohio. Increased data collection and analysis would allow Ohio policymakers to better understand gaps in access and more strategically direct attention and resources.

Workforce challenges

Figure 1. **Ohio counties designated as mental health professional shortage areas as of July 2025**

75 out of 88 Ohio counties were designated as mental health professional shortage areas in July 2025.



Note: Treating children and youth is a specialty in the mental health field, which means that workforce shortages are even more common for this population.
Source: U.S. Health Resources and Services Administration, as analyzed by the Rural Health Information Hub

Executive summary

Difficulties with access to care

According to experts interviewed for this brief, there are serious access challenges at all levels of care, but challenges can be particularly notable for children with higher levels of need (e.g., inpatient or residential treatment). As services needed become more specialized, there are generally fewer clinicians available, especially in rural areas. However, experts noted the positive impact school-based mental health services are having on access.

Groups with the most difficulty accessing care

Mental health access data indicates:

- Ohio families seeking mental health services for **young children**, **ages 6-11**, report more difficulty than for older children
- **Families with private (e.g., commercial) insurance** frequently experience greater difficulty finding treatment for their children than families with public insurance (e.g., Medicaid)
- At the same time, there is a higher percentage of **children with Medicaid** who do not receive needed care than children with commercial insurance

Experts commonly mentioned other groups that face particular difficulties accessing mental health care, including children with eating disorders, externalizing disorders (e.g., oppositional defiant disorder, conduct disorder), co-existing mental health conditions and intellectual or developmental disabilities, as well as those living in rural areas and children with the most complex needs.

Lack of data

There are considerable gaps in publicly available data related to mental health care access in Ohio, including the length of time families wait to receive care; at which levels of care families have the most difficulty accessing services; and how access varies geographically. Without this information, policymakers cannot make informed, data-driven decisions about where to allocate resources within the mental health care system.

Policy options

This brief includes a variety of policy options (starting on page 17), informed by expert opinions, to improve policymakers' understanding of Ohio's mental healthcare access challenges and get more youth the services and supports they need.

Areas for potential policy action

- Improve and utilize data collection and analysis
- Enhance coverage and accessibility of services
- Grow and strengthen the behavioral health workforce

HPIO's Child and Youth Mental Health policy brief series

released December 2024	Brief 1	**Mental health conditions among Ohio children and youth** presents prevalence data
released in July 2025	Brief 2	**Factors contributing to child and youth mental health struggles**
This brief ►	Brief 3	Focuses on access to mental healthcare services across levels of care
expected Spring 2026	Brief 4	Will examine health insurance coverage, cost and affordability of care and how they influence access to mental health services

Access to mental health care for Ohio children and youth

The World Health Organization defines mental health as "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn and work well, and contribute to their community."[1] For young Ohioans with mental health needs, early treatment can prevent conditions from worsening, decrease financial costs (for the individual or family and society), and keep youth on a path to realizing their full potential. Research has demonstrated that for every $1 invested in treatment for anxiety and depression, there is a return on investment of $3.30 to $5.70 due to improved health and productivity.[2]

However, many Ohio children and youth experiencing mental health challenges are having difficulty accessing the treatment they need. The youth mental health system is often difficult to navigate. Critical provider shortages, high cost-sharing and gaps in insurance coverage are among some of the barriers to accessing care, according to expert interviews and focus groups conducted for this brief. At the same time, Ohio lacks comprehensive quantitative data to demonstrate where system capacity is needed across the state, such as at which levels of care.

This brief is the third in a series of four HPIO policy briefs on child and youth mental health.

Inside

Subject matter expert and caregiver perspectives

To inform this policy brief, HPIO conducted interviews with a variety of subject-matter experts (e.g., mental health providers from different levels and settings of care; mental health and child advocacy organizations; health insurance representatives), noted as "experts" throughout, and hosted focus groups with parents and caregivers of children who have utilized mental healthcare services to discuss barriers encountered when seeking care for their child.

Ohio family experiences

Sections throughout highlight quotes from the parents and caregivers who participated in the focus groups. Additional findings from the focus groups are described in HPIO's **Uplifting community voice: Caregiver experiences with barriers to child and youth mental health care** publication.

Difficulty accessing mental health care

Ohio families frequently have trouble seeking mental health care for their children. Some challenges include navigating the complex health care and insurance systems; finding an appropriate, affordable provider; and getting the child to the provider's location. Workforce shortages exacerbate these issues, and youth may experience stigma and embarrassment that may dissuade them from seeking help.

Ohio family experiences

Caregiver focus group participants described feeling lost when trying to get their children the care they needed. Others described facing "red tape" when trying to figure out the necessary steps to getting their child mental health care.

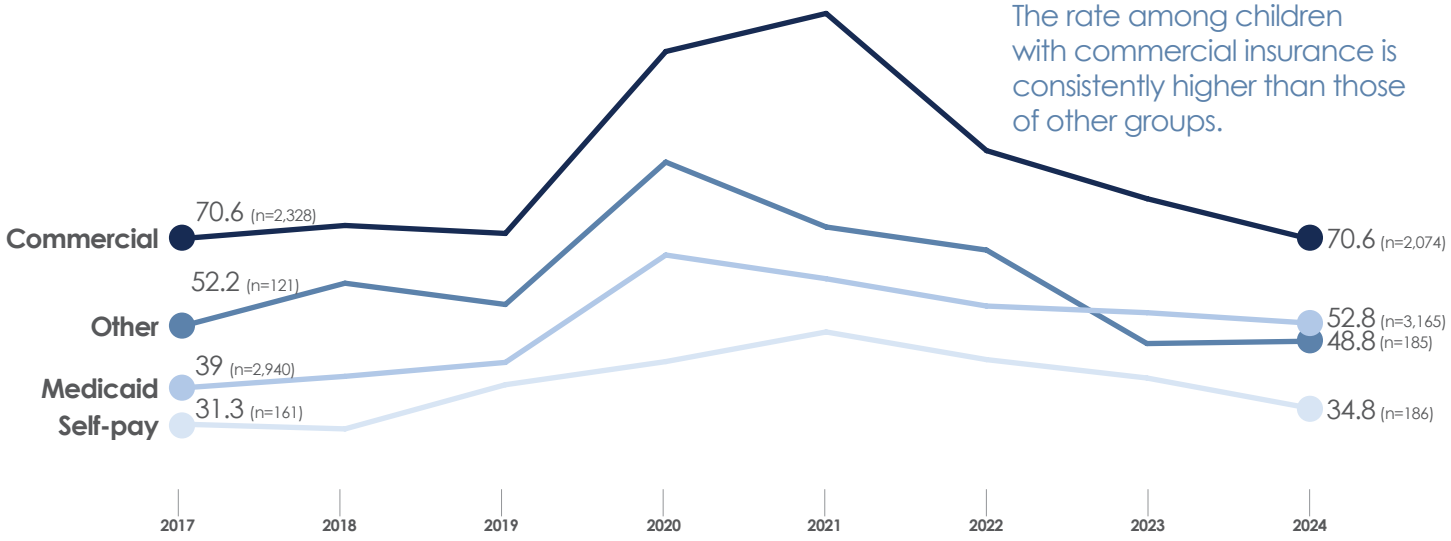
"…I needed some help [finding services]. And it's like everybody I asked, it was like, you can try this or you can try that. I mean, nobody really gave me a definite answer. So I had to wiggle through this whole thing to try to find, to get some kind of help. You know, so it's been a lot. It's been hard for me."

"I feel like I spend more time talking about forms than I do about what my kids actually need."

When children do not receive appropriate and timely mental health treatment, this can result in the need for crisis services or a visit to the emergency department (ED).[3] In 2024, 5,610 Ohio children had an ED visit for a suspected suicide attempt. Figure 2 displays the rate of ED visits among children for suspected suicide from 2017 to 2024.

Figure 2. **Emergency department visits for suspected suicide attempts among Ohio children (ages 0-17), by payer, 2017-2024**

Number of emergency department visits for suspected suicide attempts per 10,000 emergency department visits



Note: Data includes all short-term acute care and free standing ED hospitals. "Other" includes Medicare, other government payers (such as the VA), charity care, and the general "other payer" category which is used when no other payer group applies.
Source: Ohio Hospital Association

Mental health care access data gaps

There are significant gaps in publicly available data related to mental health care access in Ohio, including the length of time families wait to receive care, at which levels of care families have the most difficulty accessing services, and how access varies geographically. Insurance companies must have provider networks, but insurers do not generally know providers' capacity when listing their networks. Without this information, policymakers cannot make informed, data-driven decisions on where to allocate resources within the mental health care system.

Many parent and caregiver focus group participants reported experiencing considerable delays in care due to waitlists. Some caregivers reported two-year-long waitlists to access treatment from a certain provider organization.

A few other states have taken action on this issue. Illinois's state agencies have recently taken noteworthy, collaborative steps to improve the state's child behavioral health care system, including continuously collecting and analyzing mental health capacity data. Their **BEACON (Behavioral Health Care and Ongoing Navigation) Care Portal** is a centralized resource for families seeking mental health care. This is just one part of their **Blueprint for Transformation: A Vision for Improved Behavioral Healthcare for Illinois Children**, which was released in Feb. 2023. Other examples are **North Carolina's Child Behavioral Health Dashboard** and Minnesota's **FastTrackerMN.org**. Finally, Oregon has a **statute** requiring data collection on capacity for intensive youth behavioral health treatments.

Groups experiencing more difficulty accessing care

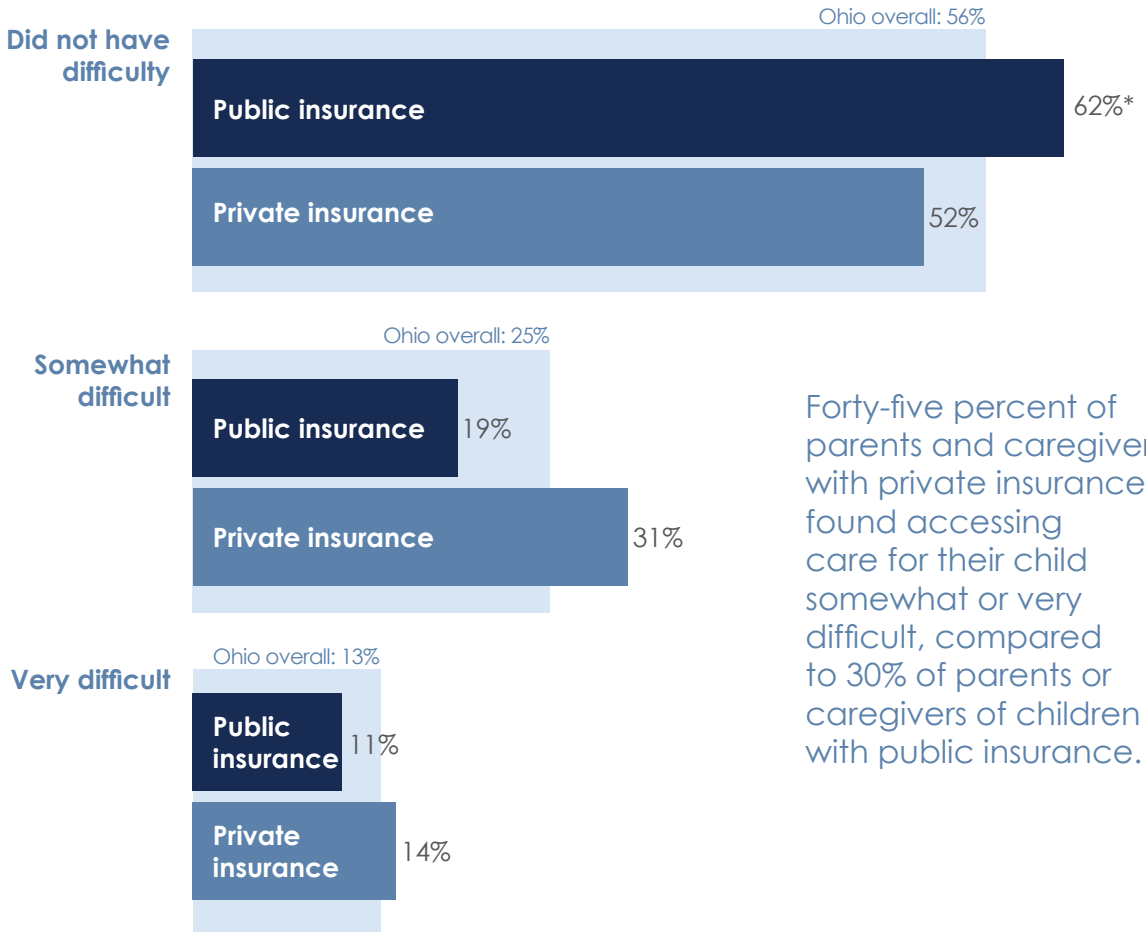
Children with commercial insurance and young children were two groups commonly mentioned by subject matter experts as frequently experiencing challenges accessing mental health care.

Children with commercial health insurance

In 2022-2023, among Ohio children needing mental health treatment, 38% found it somewhat or very difficult to access treatment (displayed in figure 3). Figure 3 also shows more difficulty among individuals with private (i.e., commercial) insurance.

Figure 3. **Difficulty accessing mental health care among Ohio children, ages 3-17, by insurance type, 2022-2023**

Level of difficulty reported by parents in obtaining mental health treatment or counseling



Forty-five percent of parents and caregivers with private insurance found accessing care for their child somewhat or very difficult, compared to 30% of parents or caregivers of children with public insurance.

* Small sample size; interpret with caution

Note: The other response was "It was not possible to obtain care." Sample sizes for this response were too small to report. In 2023, 44.2% of Ohio children ages 0-18 had private insurance, 44.2% had Medicaid insurance, 3.4% were uninsured, and 8.2% had some other form of health insurance. "Public insurance" in this graphic includes Medicaid, Medical Assistance or any kind of government assistance plan for those with low incomes or a disability.

Source: National Survey of Children's Health

As shown in figure 2 on page 4, this population also has higher rates of visiting the ED for suspected suicide attempts than children with other types of insurance. This could indicate that these children have more difficulty accessing care before a crisis occurs.[4]

Although there is variation across insurance plans, provider experts offered the following possible reasons for challenges common among families with commercial insurance:

- **Low reimbursement rates** causing some providers to stop accepting insurance.[5]
- **Generally, fewer types of services covered** by private insurance plans than Ohio Medicaid, such as crisis services.[6]
- **Restrictions in allowable settings of care**. For example, commercial plans generally do not cover services that are provided in schools or in the home.[7]

HPIO's final brief in this child and youth mental health policy brief series will further explore insurance coverage, affordability of care and how they influence access.

Ohio family experiences

When services are not covered or the family's portion of the cost of care is not affordable, children may not get the care they need.

"And then when you start looking at paying for stuff out of pocket, and the costs are adding up, it's like, where do we start cutting corners? How much credit card debt can we take on, get a loan, consolidate something to find the appropriate level of care for the issues that we are having?"

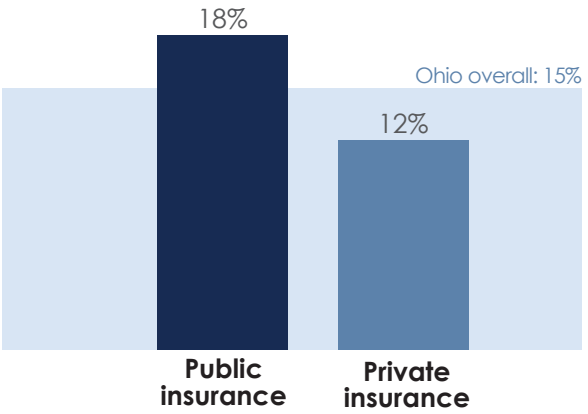
Children with Medicaid

While families with commercial insurance frequently experience difficulty getting mental health care for their children, data indicates that it is more common for children with Medicaid to not receive needed care, as displayed in figure 4.[8]

One possible reason for this is that people with Medicaid generally have low incomes, which can add additional barriers to accessing care. For example, families with Medicaid may have more transportation challenges or no paid sick leave at their job, making it harder to take time off for a child's appointments. They may also lack a reliable internet connection, impeding access to telehealth.

Additionally, a higher percentage of children and youth (ages 3-17) with Medicaid (17%) needed mental health treatment than children and youth with commercial insurance (12%) in 2023.[9]

Figure 4. **Percent of Ohio children needing to see a mental health professional, ages 3-17, who did not receive mental health treatment or counseling during the past 12 months, by insurance type, 2022-2023**



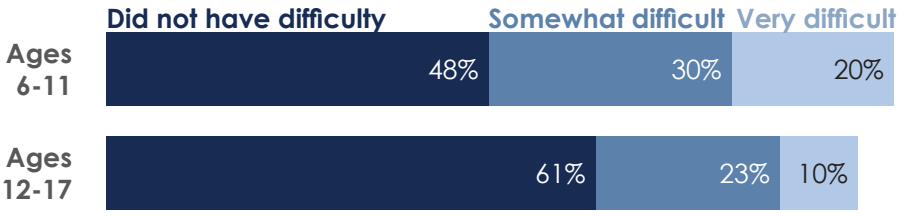
Note: This does not include children with both public and private insurance.
Source: National Survey of Children's Health

Young children

Experts also agreed that it is more challenging to access care for young children (i.e., under age 12) and noted that the number of young children experiencing mental health challenges is increasing, leading to longer waitlists. The data displayed in figure 5 aligns with the experts' observations of difficulty accessing care for young children.

Figure 5. **Difficulty accessing mental health care among Ohio children, by age, 2022-2023**

Level of difficulty reported by parents in obtaining mental health treatment or counseling



Families with children ages 6-11 more frequently reported difficulties accessing mental health care than those with youth ages 12-17. No data was available for the 3-5 age group.

Note: Sample sizes for the "it was not possible to obtain care" response were too small to report, as were estimates for children ages 3-5.
Source: National Survey of Children's Health

There is a critical shortage of providers who treat young children, especially infant and early childhood mental health professionals. Working with young children requires specialized training. For example, it generally involves more work with adults (e.g., the child's parents or caregivers) than when treating older children.

Children with eating disorders, externalizing disorders (e.g., oppositional defiant disorder, conduct disorder), co-existing mental health conditions and intellectual or developmental disabilities, as well as those living in rural areas and children with the most complex needs were other groups commonly mentioned by experts as having the most challenges accessing care.

Infant and early childhood mental health and House Bill 7

Children ages 0-5 years make up an important part of the child population needing services. Infant and early childhood mental health (IECMH) refers to the "growing ability of infants and young children to form secure, close relationships; experience and express a wide range of emotions; and engage with their surroundings."[10] Trained IECMH professionals work to promote social-emotional growth and prevent mental health issues from developing or worsening.[11] A key component of these services is relationship-building between the child and their caregivers. Ohio has already invested in **IECMH consultation** for professionals working in early learning and care settings across the state.

House Bill (HB) 7, which became law in 2025, required the Ohio Department of Medicaid (ODM) to begin recognizing mental health and developmental diagnoses for infants and toddlers (as outlined in Zero To Three's **DC: 0–5™ Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood)** and reimbursing for mental health and dyadic family therapy services, which involves treating the child and their caregivers together to strengthen their relationship.[12] Experts expect this reimbursement to help with workforce shortages. However, at the time this brief was published, this provision of HB 7 has not yet been implemented. ODM is required to submit an evaluation report to the General Assembly on this provision by June 30, 2027 including the number of families and children served; the number and types of services provided; and outcome metrics for families and children served.

Access challenges across levels of mental health care

The mental health continuum of care is very broad. Figure 6 displays the different types of mental health care that serve children and youth, as well as adults, from low-intensity outpatient services to high-intensity inpatient treatment.

In addition to the levels of care displayed in figure 6, supports for the child and family, such as **behavioral health respite**, are also important parts of the care continuum. Behavioral health respite, which is short-term, temporary relief for caregivers, can improve family well-being, reduce caregiver burnout and prevent out-of-home placements.[13]

No data is publicly available showing at which levels of care Ohio families have the most difficulty accessing services. According to experts, there are serious access challenges at all levels of care, but challenges can be particularly notable for children with higher levels of need. They explained that as the services needed become more specialized, there are fewer clinicians to provide those services, especially in rural areas. However, experts noted the positive impact school-based mental health services are having on access.

Figure 6. **Levels of mental health care**

Outpatient services	Intensive outpatient services	Intensive home-based treatment	Partial hospitalization programs	Residential treatment	Inpatient treatment
• Short, individual or group therapy sessions; medication management; or routine check-ins • Generally provided in private practices, schools, community-based behavioral health centers or hospital-based outpatient clinics	• Multiple sessions per week for several hours each • No overnight stays • Often used as a step-down from inpatient care • Provided in community-based behavioral health centers or hospital-based outpatient clinics	• Services are provided to youth with serious emotional disturbances in the child's home, school and community • Focuses on mental health issues that put youth at risk and promoting positive development and healthy family functioning	• Day-long programs with individual or group therapy, medication management and other structured activities • Patients return home or to another supportive facility in the evenings • Provided in hospital-based behavioral health units and community-based centers	• Non-hospital setting offering 24-hour support for an extended period of time • Therapy, medication management and help with daily living • Provided in free-standing or hospital-based treatment centers	• 24-hour psychiatric or substance use disorder treatment in a hospital-like setting for individuals with severe mental illness or experiencing acute behavioral health needs • Focuses on stabilization and crisis management • Provided in general hospitals or stand-alone psychiatric hospitals

Increasing intensity of services

Crisis services, such as the 988 crisis hotline and mobile response and stabilization services (MRSS), are also an important part of the mental health care continuum.

Source: Kona, Maanasa, Stacey Pogue and Kenneth Watts. Building Behavioral Health System Capacity. Georgetown University McCourt School of Public Policy Center on Health Insurance Reforms. March 2025. Also "Intensive Home-based Treatment." Ohio Department of Behavioral Health website. Accessed Oct. 1, 2025.

Workforce shortages

Workforce shortages in the mental health field are a primary reason why, experts say, many children are unable to access necessary care when they need it and face lengthy waitlists. Reimbursement rates for mental health providers are generally considerably lower than physical health providers, and burnout is common.[14]

As of July 2025, 75 entire Ohio counties (out of 88) were designated as mental health professional shortage areas[15], as displayed in figure 1 on page 1. Further, treating children and youth is a specialty in the mental health field, which means that workforce shortages are even more common for this population.

For example, there are significant shortages of child and adolescent psychiatrists (CAPs) in Ohio. According to the American Academy of Child and Adolescent Psychiatry, Ohio had a total of 365 child and adolescent psychiatrists in 2024. That equates to a ratio of one psychiatrist for every 7,105 Ohio children under age 18.[16] Fifty-three counties had no CAPs, and only seven counties had more than 10.[17] As described on page 16, Ohio now has a hotline that pediatric primary care clinicians can call to consult with a CAP. Addressing lower-intensity mental health concerns in primary care or school settings may be a way to alleviate workforce shortages.

In Oct. 2023, the Ohio Department of Mental Health and Addiction Services (now the Ohio Department of Behavioral Health) created a comprehensive plan for strengthening the workforce. This plan — the **Ohio Behavioral Health Workforce Roadmap** — includes 22 initiatives that will be implemented through 2027.

Inpatient and high-intensity care

Child and adolescent inpatient care is often difficult to access in Ohio. There are only 11 facilities around the state that offer youth inpatient services, and the ages served varies at each. There are no facilities in Southeastern Ohio that offer child and adolescent inpatient services.[18] Reimbursement rates for psychiatric inpatient units generally do not cover the cost of care, so the number of psychiatric inpatient beds has been steadily decreasing across the U.S.[19]

In recent years, Ohio has opened several psychiatric residential treatment facilities (PRTFs), which are alternatives to hospitals, providing intensive inpatient treatment to youth ages 20 and under. There are currently four operating in Ohio – one in central Ohio (Franklin county), one in southwest Ohio (Hamilton county) and two in northeast Ohio (Cuyahoga and Trumbull counties). However, these facilities are only available to OhioRISE members (see page 15 for more information), and according to one expert interviewed, payment models do not cover staffing needs. Additionally, some youth needing this level of care still need to be sent to facilities outside of Ohio.[20]

Given the shortages in inpatient care, some youth who go to the ED for mental health crises are "boarded."[21] This means they are kept in the ED, often without mental health treatment, until they can be assessed by a provider trained in child or adolescent mental health or until a spot becomes available in a residential or inpatient facility. Boarding is associated with negative outcomes for patients due to factors such as distress, delayed treatment and medication errors.[22]

Crisis services

Without access to the appropriate level of treatment at the necessary time, mental health conditions can worsen and lead to poorer outcomes. In 2024, there were 12,977 visits to Ohio EDs for children's mental health conditions.[23] Some children appear in non-children's hospitals, which may be less equipped to provide the necessary mental health care in these encounters.[24] Additionally, some children experience long wait times in the ED. In a national study of mental health ED visits, 32% of children waiting for an admission were in the ED more than 12 hours, and 13% waited more than 24 hours.

In recent years, other crisis services have become available to Ohio children and youth. 988, Ohio's Suicide and Crisis Lifeline, became available to Ohioans of all ages in July 2022, and mobile response and stabilization services (MRSS), which is explained on page 15, recently became available to children statewide. Both involve trained mental health professionals. The aim is for these options to reduce the number of children and youth going to the ED.

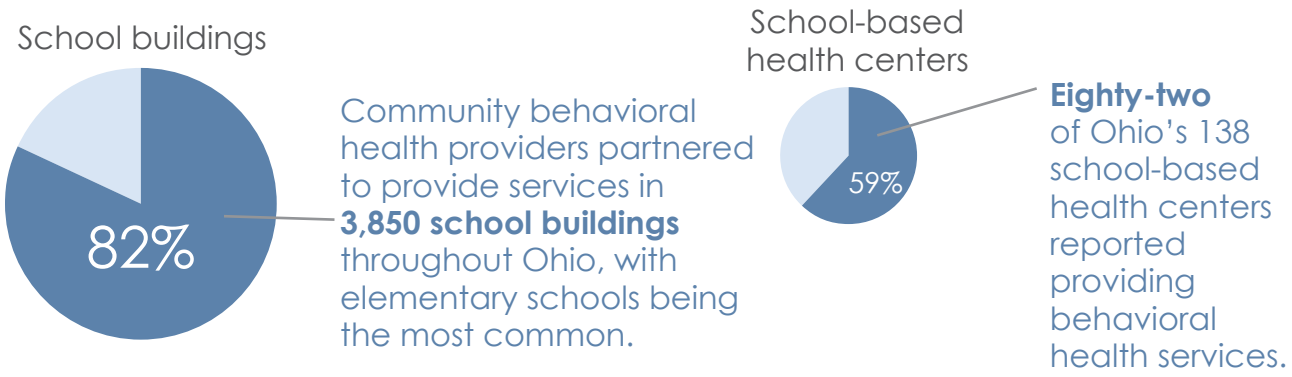
Just in August 2025, there were over 22,800 contacts (i.e., calls, texts and chats) to Ohio 988, and the number of 988 contacts has been increasing over time.[25] Beginning in Oct. 2022, there was a dedicated line within 988 for LGBTQ+ youth to connect to counselors with special training on this population. This line was discontinued in July 2025, although it had received nearly 1.6 million calls, text and online chats nationwide.[26]

Mental health services in schools

Schools are a common location for children to access mental health services. This can reduce stigma and prevent common barriers, such as transportation, parent/caregiver work schedules and cost.[27] Many experts interviewed for this brief described the positive impacts of schools offering mental health services and supports to Ohio students in recent years, primarily since the COVID-19 pandemic shutdowns. They specifically called out federal American Rescue Plan Act (ARPA) funds and Ohio's student wellness and success funds as being key to this improvement, as well as greater attention to and appreciation for student mental wellness among districts.

As shown in figure 7, **community behavioral health providers** and **school-based health centers** provided mental health services in many schools around the state during the 2024-2025 school year. Community behavioral health providers partnered to provide services in 3,850 school buildings throughout Ohio, with elementary schools being the most common. Additionally, 82 of Ohio's 132 school-based health centers (59%) reported providing behavioral health services.[28]

Figure 7. **Percent of Ohio schools in which community behavioral health providers and school-based health centers provided mental health services, 2024-2025 school year**



Note: There may be some overlap between these two. Also, the total number of school buildings used is for the 2023-2024 school year.
Sources: The Ohio Council of Behavioral Health & Family Services Providers 2025 School-Based Behavioral Health Services Summary Report; the Ohio School-Based Health Alliance June 2025 Census Report; Ohio Department of Education and Workforce data as reported by the Thomas B. Fordham Institute 2025 Ohio Education by the Numbers (school building data)

Providers reported offering a variety of services, with prevention services and individual counseling being some of the most common among community behavioral health providers.[29] Individual counseling and diagnosis and medication management were the most common services among school-based health centers.[30] Finally, nearly 80% of community behavioral health provider survey respondents said that crisis de-escalation and behavior management were the most needed services in school settings.[31]

Caregiver focus group participants described how their children's schools helped bridge the gap with direct mental health support and also helped caregivers access services for their children in other community settings.

"[My children] having that ability to access services in school and not have to constantly be missing school or me not having to constantly be missing work has been fantastic. And I need them to continue with that."

"I would say my granddaughter's school has really helped me through quite a few things. They've directed me to resources that helped."

Youth choosing not to seek care

Some youth choose not to seek help for mental health challenges. A 2022 survey asked youth (ages 12-17) who had experienced a major depressive episode in the past year why they had not received mental health treatment. With respondents being allowed to choose more than one, these were the top reasons:[32]

1. Thought they should have been able to handle their mental health, emotions or behavior on their own (87% of respondents)
2. Worried about what people would think or say if they got treatment (60%)
3. Worried that information would not be kept private (58%)

Effectiveness of care

In addition to being able to obtain care, it's important that the mental health care children receive is effective. Unfortunately, as shown in figure 8, only 57% of youth who received mental health treatment or counseling reported that it was at least somewhat helpful, compared to 65% in the overall U.S. Only 12 states had percentages lower than Ohio.[33]

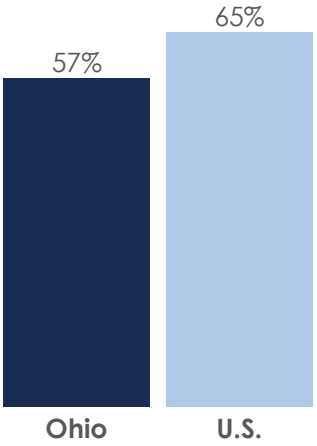
Effective mental health care is evidence-based, trauma-informed and culturally responsive. A few common reasons why care may not be effective are described below.

Inability to access the most appropriate type of care. Experts noted that while some Ohio children may technically be accessing care, they may not have access to the type of care they need or may not be receiving enough care. For example, one expert explained that some children may have access to support from a social worker at school, but they really may need a higher level of treatment. Alternatively, a child may need outpatient services once per week, but due to financial constraints or the family not being able to take time off work or travel for services that often, they may only be seen once a month.

Provider turnover. Experts mentioned that turnover is somewhat common in mental health professions due to burnout and low reimbursement rates. Multiple focus group participants mentioned the disruption that can be caused when a provider with whom the child has developed a relationship leaves their position. Additionally, a patient needs to tell their story again when beginning with a new provider, which can be time-consuming and emotionally difficult.

Figure 8. **Helpfulness of mental healthcare for youth, Ohio and U.S., 2021-2022**

Percent of youth who received mental health treatment or counseling in the past 12 months and reported that it helped at least "some"



Source: National Survey on Drug Use and Health via "The State of Mental Health in America" 2024 edition

Provider is not relatable to the child. Many adults and youth prefer a provider who is similar to them, such as by gender, race, ethnicity or being part of the LGBTQ+ community, due to commonalities and shared experiences. When possible, this has been found to improve care outcomes.[34] Ohio's current workforce does not reflect the population, with much lower proportions of Black and Hispanic staff members than the overall Ohio child population.[35]

Ohio family experiences

One caregiver in HPIO's focus group described their struggle to find a provider who could connect and communicate with their child:

"[My biggest difficulty was] finding a provider that's appropriate for my 17-year-old. He has level 2 autism and finding one that could talk to him in a meaningful way was very challenging. Even though we were told by many that they had experience with autism, there was a very large disconnect between their communication and his communication."

Other important youth mental health supports

There are ways to support children and youth experiencing mental health challenges that can augment treatment. An interviewee from a national analysis said, "It doesn't have to be therapy to be therapeutic."[36] Non-traditional approaches like community-based interventions, peer support and art can also have mental health benefits. Interventions that help youth form strong, supportive relationships or find a sense of purpose are also important.[37]

Ohio's **trauma-competent care regional collaboratives** offer Family Regulation Kits (developed by Focus on Youth) which include engaging mental health education and resources for families with children who are unable to or waiting to access formal mental health services.

In a youth focus group HPIO hosted in Feb. 2025, teenage participants emphasized the important role of other youth to one's mental health. One participant said, "Youth's strongest help is other youth." They also talked about the importance of having places and opportunities for youth to connect with one another.

What is Ohio doing to improve access to effective mental health treatment?

Child and family well-being and mental health have been priorities of the DeWine administration and many other Ohio policymakers in recent years. Below are select state-level initiatives aimed at improving access to mental health care and mental health outcomes for Ohio children and youth.

OhioRISE (Resilience through Integrated Systems and Excellence)

OhioRISE is a specialized managed care program for children and youth (ages 0-20) with complex behavioral health and multisystem needs. Launched in 2022, OhioRISE was designed based on the U.S. Substance Abuse and Mental Health Services Administration's **system of care framework**. Care coordination and cross-system collaboration are primary functions of OhioRISE. Care coordinators work with families, providers and community partners to develop a single, comprehensive care plan and ensure that all partners are working together efficiently, with the least amount of burden on the family.

OhioRISE members have access to intensive home-based treatments, behavioral health respite and various other services and supports that are generally not covered by other insurers. Eligibility is determined by the Child and Adolescent Needs and Strengths (CANS) assessment or by the child having a behavioral health inpatient hospital admission or MRSS (mobile response and stabilization services) crisis call.

OhioRISE is administered statewide by Aetna Better Health of Ohio, which partners with **18 regional care management entities** for members with more intensive care management needs. As of Oct. 2025, there were nearly 52,000 children and youth enrolled in OhioRISE.[38] According to ODM, OhioRISE has reduced ED visits by 41%, psychiatric hospital stays by 28% and residential treatment facility stays by 60%.[39]

Although OhioRISE is generally only available to children who qualify for Medicaid, children who do not meet all Medicaid eligibility requirements but are in need of high-intensive services can qualify through a **Medicaid waiver**. This waiver offers additional services to those children and youth in OhioRISE with the greatest needs. One of the driving factors for Ohio requesting this waiver from the federal government was to avoid custody relinquishments, which is when a family transfers custody to the state so the child can access the services they need.

Some focus group participants had positive things to say about OhioRISE, with several specifically mentioning the value of home-based treatment. Others felt that it was too complex, and some mentioned that their children needed to change providers to be in OhioRISE.

Mobile Response and Stabilization Services (MRSS)

MRSS provides immediate care for children and youth under age 20 at no cost to the child or family.[40] MRSS is provided by trained professionals, who respond to calls about behavioral health crises, trauma and mental distress within 60 minutes. MRSS assesses the safety of those involved, de-escalates the situation, stabilizes youth through appropriate treatment and support for up to 42 days after the initial contact, and connects youth and families to continued care and support.[41] MRSS is an effective alternative to ED visits or calling law enforcement, where youth may face longer wait times, inadequate behavioral healthcare or unnecessary incarceration.[42] MRSS has evidence of resulting in fewer psychiatric hospitalizations and lower costs.[43]

In State Fiscal Year (SFY) 2025, there were 58 counties with active MRSS teams. There were 6,094 episodes of care. Twenty-six percent of youth re-engaged with MRSS that year. Figure 9 shows the age distribution of youth who received MRSS services during SFY 2025. Over half were ages 13-17, with children ages 7-12 being the second most common.

Figure 9. **Percent of Ohio children and youth served by MRSS, by age, SFY 2025**

Note: Only 58 Ohio counties had active MRSS teams in SFY 2025
Source: Ohio Department of Behavioral Health MRSS Annual Report (SFY 2025) Executive Summary

When compared to the year prior to their initial MRSS contact, youth who received MRSS stabilization services had fewer inpatient hospitalizations, admissions to residential treatment centers and ED visits for mental health or substance use.[44] All of these are expensive treatment settings.

Notably, only 21% of children and youth served through MRSS in SFY 2025 had commercial insurance, while 66% had Medicaid coverage.[45] Experts wondered whether this was partially due to low levels of MRSS awareness among families with commercial insurance.

In Sept. 2025, MRSS expanded statewide, with 12 service providers covering 18 regions of the state.[46] MRSS can now be accessed by contacting 988. More information can be found on the **Department of Behavioral Health website**.

Outcomes Acceleration for Kids (OAK)

Launched in early 2024, the OAK Learning Network is a public-private collaboration between ODM and Ohio's Medicaid managed care entities and children's hospitals. It aims to achieve improvements in youth health and well-being through:

- Transforming care delivery
- Prioritizing outcomes and working collaboratively across the state
- Identifying opportunities to close gaps in outcomes and ensure whole child health

OAK includes six regional children's hospital-managed care teams working together to improve outcomes in four areas of care: asthma, behavioral health, sickle cell disease and well-child care. Each has specific outcome metrics for measuring progress. For behavioral health, OAK assesses two outcome measures: follow-up care within seven days after ED visits for mental health and follow-up care within seven days after ED visits for substance use.

The Southwest and Central regions of Ohio are piloting another behavioral health intervention aimed at improving linkages of children visiting the ED with a behavioral health provider for follow-up care. Using a health information exchange (HIE), community behavioral health providers upload their patient rosters. When a child visits the ED for mental health or substance use, the children's hospital is able to see whether the child is already receiving behavioral health services from one of the community providers, which facilitates follow-up care. Due to early indicators of success, OAK is currently working to expand this effort to all regions of the state.

Ohio pediatric psychiatric access line (OPPAL)

OPPAL is a telephone hotline which allows pediatric primary care clinicians to have same-day consults with a child psychiatrist. It is available to clinicians with prescribing authority (i.e., MD/DOs, nurse practitioners and physician assistants). The program also includes educational resources to support the behavioral health work of these clinicians and assist with referrals for patients that need a higher level of care. Launched in summer 2025, OPPAL is administered by the Ohio Department of Health but is a collaborative effort with ODM, the Ohio Chapter of the American Academy of Pediatrics and various Ohio medical organizations. The program is funded through the U.S. Health Resources and Services Administration.

Policy options

In addition to the programs and services described throughout this paper, more can be done to support children and youth struggling to access mental health services. Below are policy options, informed by expert opinions, to improve policymakers' understanding of Ohio's mental healthcare access challenges and get more children and youth the mental health services and supports they need.

Improve and utilize data collection and analysis

1. Ohio policymakers can invest in collecting and analyzing more data from behavioral health providers to better understand capacity and identify key access gaps among groups of Ohio children, geographic locations and types of mental healthcare services. They can look to recent work on Illinois' **Blueprint for Transformation: A Vision for Improved Behavioral Healthcare for Illinois Children**.[47]
2. Ohio policymakers, behavioral health funders and other behavioral health stakeholders can use the data collected for the previous recommendation to collaboratively develop a strategy for building out Ohio's system of care for all children and youth with mental health challenges. For example, state agencies could take an approach similar to that required by **HB 96** to collaboratively identify needs of multi-system youth and develop recommendations to meet those needs.

Enhance coverage and accessibility of services

3. Building on the current work of the Ohio Departments of Insurance and Behavioral Health, state policymakers can enhance enforcement of the federal Mental Health Parity and Addiction Equity Act, which prohibits health insurance plans from practices that make accessing mental health services more difficult than physical health services, such as with the actions highlighted in the Commonwealth Fund's issue brief, **Enforcing Mental Health Parity: State Options to Improve Access to Care**.
4. The Ohio Department of Medicaid (ODM) can maintain the mental health provider rate increases that went into effect in 2024.
5. ODM can expand the population of Ohio students for whom Medicaid can reimburse for school-based mental healthcare services to include all Medicaid-enrolled students, not only those with an individualized education program (IEP).
6. Ohio policymakers can advance **integrated care models** (such as with grants similar to **Washington's Behavioral Health Integration grant program**) and electronic health record (EHR) compatibility to improve care coordination and keep families from needing to tell their stories to many different providers. This can also include further expansion of certified community behavioral health centers.
7. Commercial insurers and self-insured employers can expand mental health services covered to align with Ohio Medicaid and to reimburse for mental health services delivered in schools.
8. Ohio policymakers can identify a sustainable funding source for 988, such as a small surcharge on phone bills as twelve other states have done.[48]
9. Given the high rates of depression and suicidality among LGBTQ+ youth identified in **HPIO's child and youth mental health data brief**, Ohio policymakers can pursue training for 988 counselors on how to support this group and other high-risk groups, as Illinois and several other states have done.[49]
10. Ohio policymakers can fund formal evaluations of OhioRISE and the state's MRSS program to ensure they are improving access to care and decreasing ED utilization.
11. Ohio policymakers, school districts and community organizations can supplement treatment and support mental wellness of students by prioritizing funding for peer-led initiatives, which can decrease stigma and enhance social engagement[50], and other opportunities for youth to connect with one another.

Policy options (cont.)

Grow and strengthen the behavioral health workforce

12. State policymakers can further support individuals entering mental health professions, especially those who intend to treat children; work in rural areas; are training to become a child and adolescent psychiatrist or other position in high demand; or with backgrounds that are currently underrepresented in Ohio's workforce. A few ways this could happen include:
    - Expanding the **state's loan repayment program**
    - Providing stipends during training for aspiring professionals, similar to **Michigan's student mental health apprenticeship retention and training** grant program
13. State policymakers can create an entry-level Qualified Mental Health credential as a pathway into the mental health field and provide funding and technical assistance for high schools to implement and scale programs for students to earn a Qualified Behavioral Health Specialist certificate.
14. Ohio policymakers could join neighboring states Pennsylvania and Michigan by participating in the **Counseling Compact**, which allows professional counselors to practice in other member states without needing multiple state licenses.
15. Medical schools can ensure ED doctors and pediatric primary care clinicians receive more education and training on mental health care.
16. Ohio policymakers can create a public-private partnership with an external entity, such as an academic institution, to create a behavioral health workforce center, such as the **Behavioral Health Education Center of Nebraska**, whose purpose is to analyze workforce data and recruit, retain and increase the competency of the behavioral health workforce.

Conclusion

As shown in **HPIO's child and youth mental health data brief**, many Ohio children and youth are struggling with mental health conditions. Early identification and treatment can keep them on a path toward well-being and realizing their full potential. However, families around the state are encountering various barriers to getting children the treatment they need, including critical provider shortages, high costs of care and difficulties navigating the health and insurance systems. Further, significant gaps in data availability are limiting policymakers' ability to make data-driven decisions regarding how to improve access to mental health care, which could improve the well-being of young Ohioans and decrease costs for years to come.

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