Transforming crisis response in Ohio

Policy analysis and recommendations for behavioral health services

THE CENTER FOR COMMUNITY SOLUTIONS

Introduction

In 2020, the Federal Communications Commission passed the National Suicide Hotline Designation Act. This policy changed the 10-digit suicide crisis line to 988, a shorter three-digit code. Two years later in July 2022, the U.S. transitioned to the new Lifeline. The change came with immense support for the shift to the shorter number, and many mental health advocacy groups across the country celebrated the change.

Still, the federal government did not provide states with any funding to coordinate the implementation of 988, leaving states with the responsibility to fund the lifeline. In Ohio, H.B. 33 of the 135th General Assembly appropriated $25 million for the Lifeline in FY 2025, supporting statewide implementation.[1] Since then, Ohio has seen substantive efforts to develop social marketing for the 988 Lifeline. The state has also done work to revamp the structure of crisis centers to support intervention needs and longer-term care.

An analysis on the current infrastructure of crisis centers on a federal and state level may demonstrate how future policy recommendations can improve care.

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Mental Health: A brief history of thought and treatment

Turn of the century changes to mental health care in the U.S.

In 1908, Adolf Meyer theorized the concept of "mental hygiene" as a pathological or biological explanation of mental illness.[2] That same year, Clifford Beers wrote a book titled "A Mind that Found Itself," which detailed his challenges with bipolar disorder and the treatment he and other people with mental illness endured. In 1909, Clifford Beers, William James, and Adolf Meyer developed the National Committee for Mental Hygiene, which then evolved later into Mental Health America. Supporters of this framework argued that mental health hospitals should be established across the U.S. as entities of acute care attached to universities or research organizations to blend Moral Treatment methods with science.

Mid-20th century approach: community mental health

The decades following World War II gave rise to alternative models of care and helped initiate the Community Mental Health Movement.[3] Public perception around institutional care also began to shift. Sending World War II veterans to institutions removed from general society was not an agreed upon solution by legislators or citizens at the time.[4]

In the 1940s, the psychiatrist Eric Lindemann conceptualized a framework of direct care in community psychology called "crisis theory," which focused on supporting individuals experiencing grief. Lindemann created this concept of care when a 1942 fire erupted in Boston's Cocoanut Grove Melody Lounge, killing close to 500 people. Through Lindemann's work, the first crisis intervention techniques were developed to assist bereaved family members and friends through the grieving process. Work by other pioneers like Gerald Caplan at Harvard University cemented and helped formalize the mental health profession. Caplan's theories were also instrumental in the development of the suicide prevention movement,[5] which expanded heavily in the 1960s.

The spread of crisis theory played a major role influencing the creation of the Community Mental Health System in the United States. In 1963, President John F. Kennedy passed the Community Mental Health Act, which focused on shifting care from state run institutions to Community Mental Health Centers (CMHCs). The Community Mental Health Act also crystalized crisis intervention and 24-hour emergency services in community environments[6] and harkened efforts to deinstitutionalize moving away from hospital-based care.

In the 1960s and 1970s, crisis intervention systems were further bolstered by the development of suicide prevention sites, the creation of hotlines, and other institutions

working in crisis intervention.[7] In 1980, the Mental Health Systems Act was passed under the Carter Administration, creating a robust model of federal-state care. The following year in 1981, President Reagan passed the Omnibus Budget Reconciliation Act (OBRA) which cut many of the policies established by the Mental Health Systems Act and combined remaining funds for mental health into block grants. OBRA also repealed the Community Mental Health Act of 1963. The lack of funding created by this policy change resulted in less federal funding for mental health services, which accelerated deinstitutionalization.[8]

Late 20th century to new millennium: community support and reform

At the turn of the millennium, advances in neuroscience, digital health, and psychology helped practitioners and scholars understand crisis and mental health better, with greater emphasis on social and community supports to improve the wellbeing of individuals with severe mental illness. In the 1970s, the National Institute of Mental Health created the Community Support Program (CSP) which invested in work by states to provide psychiatric illness and disability support to vulnerable populations. The 1980s and 1990s had increased influence on consumer and patient advocacy in mental health policy. During the 1990s, consumer advocates began to push for increasing the benefits for parity on the federal and state level.

The creation of SAMHSA in 1992, the 1999 Surgeon General's Report, and the 2003 President's New Freedom Commission emphasized the importance of person-centered treatment with a focus on recovery.[9] In the 21st century, federal mental health policy focuses on these same principles, along with incorporating person-centered, trauma-informed, culturally competent care.[10] In 2008, the Mental Health Parity and Addiction Equity Act (MHPAEA) was passed. This policy prevented health plans of groups and health insurance providers from imposing unfavorable limitations on mental health or substance use disorder benefits.[11] The MHPAEA replaced the Mental Health Parity Act of 1996, which required parity for annual and lifetime dollar limits, but did not apply to substance use disorders.

Mental health and substance use disorder statistics

The extensive work by advocates, clinicians, and government officials helped form the building blocks of our national crisis care system today. In this section, additional analysis on the behavioral health workforce and vulnerable populations in need of mental health services will be provided.

By far, Medicaid is the largest payor for mental health and substance use disorder treatment and typically covers both a wider range of disorders and treatment services.

Thirty-five percent of nonelderly adults enrolled in Medicaid have a mental illness, and 10 percent have a serious mental illness. The rates for these figures are much higher compared to adults with no coverage or private insurance.[12] One in three enrollees in Medicaid have a mental illness, and 10 percent of enrollees have a severe mental illness.[13] In 2023, 59 percent of Medicaid enrolled adults received mental health treatment. This percentage is higher than adults with private insurance (55 percent) and no insurance (37 percent).

Mental health

In 2022, suicide was the eleventh leading cause of death in America. That same year, suicide was the second leading cause of death for people between the ages of 10 - 34. In 2022, 62 percent of uninsured adults struggling with depression or anxiety did not receive treatment, compared to adults on Medicaid (35 percent) and private insurance (37 percent).[14] As a result of inadequate treatment and lack of access to services, many individuals decide to forgo care which exacerbates existing health challenges.

In 2023, there were an estimated 1.5 million suicide attempts by adults in the United States. Men had a fatality rate at 3.8 times more than women. Overall, white men account for almost all suicide deaths (approximately 68 percent) in 2023. In 2024,[15] 5.5 percent of adults 18 and older in the United States had serious thoughts of suicide. Among adults, the highest prevalence of suicidal thoughts were young adults between the ages of 18-25 (12.6 percent). During that same time, 14.3 million adults 18 and older had serious thoughts of suicide, and 2.2 million adults attempted suicide.

In 2024, over two million adolescents (10.1 percent) between the ages of 12 to 17 had serious thoughts of suicide in the past year. Of that population, two fifths of adolescents attempted suicide, made a suicide plan or did both.[16] Despite this, the rate of adolescents between the ages of 12 to 17 with serious thoughts of suicide decreased from 3.4 million (12.9 percent) in 2021 to 2.6 million (10.1 percent) in 2024. The attempted suicide rates of adolescents also declined from 3.6 percent (940,000 people) in 2021 to 2.7 percent (700,000 people) in 2024.

Substance use disorders

Men account for more overdose deaths compared to women, whereas women progress from first use to addiction quicker than men. Men also historically account for overdose fatality significantly more than women and have some of the highest rates of Alcohol Use Disorder. Women are more likely to abuse substances with an intimate partner, while men are likely to do it with other friends.[17]

Geographically, Southern states (Mississippi, Arkansas, Alabama) tend to have some of the lowest rates of SUD, whereas Northeastern and Western states (Oregon, Maine, Alaska, Colorado) have the highest rates of substance use disorders.[18] Some variation in substance use disorders also ranges based on availability and treatment access. Urban areas often have high rates of illicit drug use, whereas rural areas struggle with opioid abuse, illicit drug use (methamphetamine), binge drinking, and tobacco use.

In 2024, 48.4 million individuals in the United States aged 12 or older (16.8 percent) had a substance use disorder.[19] This includes 28.2 million people with a drug use disorder (DUD) and 27.9 million people with an alcohol use disorder (AUD). Additionally, 16.4 percent of adults 26 or older and 25.9 percent of young adults had a substance use disorder in the past year.

Overall, the percentage of individuals with a drug use disorder in the past year increased from 24.5 million people (8.7 percent) in 2021 to 28.2 million people (9.8 percent) in 2024. In 2024, 48.4 million people 12 and older with a SUD had a mild disorder (55.8 percent) and 1 in 5 (21.3 percent) had a severe disorder. Across age groups, adolescents aged 12 to 17 had a slightly higher percentage (26.4 percent) of SUD compared to adults 26 or older (20.4 percent). During the same year, individuals who had an opioid use disorder had a mild disorder (42.4 percent) and 37.1 percent had a severe disorder.

The current crisis care model

In 2025, the Substance Abuse and Mental Health Services Administration (SAMHSA) released a report on best practices for states developing crisis services. SAMSHA's report will be referenced substantially throughout this portion of the paper to connect principles to Ohio's work in crisis care in the next section of this report.

SAMHSA states that there should be three elements to a crisis system:

1. Someone to **Contact** (988 Suicide and Crisis Lifeline or other BH lines)
2. Someone to **Respond** (crisis mobile team response)
3. A **Safe Place** for Help (crisis stabilization/receiving services)

These three elements serve as structural components of behavioral health crisis services. The guidelines introduced by SAMHSA accomplish three things: they create standards for transforming the behavioral health crisis system, define and identify elements that make up the crisis care continuum, and finally, offer guidance to support the collaboration of these elements to develop and bolster behavioral health crisis systems.

Someone to contact: 988 Lifeline and other mental health lines

Crisis lines are the first of the three principles outlined by SAMHSA for developing the essential components of a behavioral health crisis service system. Emphasis on proper training among staffers working across all lines is crucial to provide proper response and care. Consideration for needs of children and families is also needed to create quality points of contact across the crisis care continuum.

Meeting needs of children can be effective by staffing crisis contact centers with interdisciplinary teams, ensuring that responders have proper crisis training, an understanding of reporting requirements, and knowledge on relevant services that are available in communities. Emergency call centers form a fundamental element to behavioral health care by offering free resources to individuals experiencing crisis, seeking support, or facing critical behavioral health challenges.

The 988 Lifeline is a major element of the Connect framework, providing 24/7 mental and behavioral health services for individuals. Connection to the 988 Lifeline allows callers contact the Veteran Crisis Line, the Spanish language subnetwork, or to connect to a local trained counselor by pressing zero. 988 contact can be made via text, video, or call.

There are other behavioral health crisis hotlines that council individuals undergoing emotional distress, function as peer-operated warmlines dedicated to support, and lines offering emotional support that provide connection to wellness as well. Peer operated warmlines provide continuous phone, chat, or text support to individuals. Warmlines are staffed by trained personnel often with lived experience based on the purpose of the service, who will work to support individuals experiencing severe distress.

Peer operated warmlines typically operate locally within the caller's state or regional location, however there are also national warmlines dedicated to specific populations of individuals such as older adults, teens, or LGBT individuals.

911 and 988 coordination

Coordination between 911 and 988 is a critical component of the crisis care continuum. Knowing when to call 911 and when to call 988 is the subject of ongoing public education, because each service line meets specific needs that may sometimes overlap in some cases but are distinct in other cases.

In essence, 988 is designed specifically for behavioral health matters, including suicidal ideation, substance use challenges, and acute emotional distress. 911 on the other hand

is dedicated to medical emergencies or events that could cause or have caused physical danger.

Another component to coordination is the position of law enforcement. Law enforcement entities such as the police or EMS commonly function as the first responder when an individual contacts 911. BH crisis responders are important to providing lifesaving care as well. Law enforcement also play a role in crisis response, so it is therefore necessary for policies to be established for law enforcement and EMS to receive training and resources to properly engage individuals in crisis. This will help improve practices when responding to a behavioral health emergency.

SAMSHA provides four components for interoperability:

1. Well defined decisions regarding the networking of calls between institutions
2. Quality planning and implementation across stakeholders should focus on shared language, engaging different partners, collaboration, and respect amongst entities
3. A local advocate for interoperability that can assist in implementation and planning
4. Protocols for transferring between 988 and 911 should be decided through collaboration, whose standards vary state to state

Evaluation and improvement

The evaluation and improvement of 988 or other behavioral health lines will be conducted using assessments on response times, demographics of users, call volume, and the prevalence of successful follow-up. Data insights will also provide centers with patterns in the types of crises reported in communities, which can help in the development of interventions, service support development, and the provision of resources.

Someone to respond: Mobile crisis and outreach services

Mobile crisis and outreach services provide aid where the individual in need is located. Mobile crisis services first developed in the United States during the deinstitutionalization movement of the 1960s, which was intended to address needs of individuals with significant behavioral health needs, many of whom had previously spent years living in isolation or in institutional settings.

Mobile crisis and outreach services are delivered by a team of trained health professionals representing diverse professions in mental/behavioral health (e.g., social workers, psychologists, and nurses). Some models or mobile response services also include law enforcement acting as co-responders with trained BH professionals. Regarding mobile

crisis teams, SAMSHA recommends that "…Communities have mobile crisis services available that do not involve law enforcement, recognizing the potential harm and stigma associated with police involvement in behavioral health crises" (pg. 36).

Many mobile crisis response teams are managed by hospitals, community mental health organizations, or other governmental entities such as a health department. Mobile crisis teams (MCT) are important in the crisis care continuum because treatment can be delivered directly to a community, which has the added benefit of reducing arrests, suicides, and unnecessary psychiatric emergency department admissions. A national survey conducted by SAMHSA in 2023 revealed seven findings about the state of mobile crisis teams:

1. Mobile crisis teams (MCTs) across the US serve diverse populations based on the geography, population, and demographics of a region
2. MCTs have diverse operational and administrative capacities
3. There is a gap between the vision and reality for MCT scale and overall reach
4. Integration of operations between the crisis continuum and MCTs are limited
5. MCTs work with law enforcement to facilitate multiple key functions to populations
6. MCT metrics are incomplete
7. Best practices for clinical partnerships are unevenly adopted across MCTs

Mobile crisis and outreach services consist of three models of service. These models are co-responder MCTs involving law enforcement, MCT treatment delivered through mobile response and stabilization services, and behavioral health practitioner-only services. MCTs have a variation of configurations, however there are four components that these services must meet to meet SAMHSA's definition. These components are:

- **Mobile**: The MCT meets an individual in crisis at a community-based locality
- **On demand and rapid**: the MCT response begins after accepting a dispatch request from contact via call, chat, or electronic message
- **In-person**: At minimum, one staff person meets face-to-face with an individual
- **Inclusive of a credentialed provider**: MCT response includes engagement by credentialed or licensed clinician involved in assessment of needs

Co-responder MCT

Co responder teams are a collaborative approach to behavioral health crisis which is meant for local adaptation. These models can sometimes differ based on setting, but they usually consist of specialized law enforcement professionals or public health first responders paired with a behavioral health professional.

A benefit of co-responder MCTs is that it can leverage the partnership between law enforcement officers and behavioral health providers. Law enforcement may also have the capability to travel across difficult terrain or distances quicker or engage in scenarios where civilian BHP safety is of issue. SAMHSA recommends implementation of this model of service delivery as an additional service, not as a replacement to behavioral health provider led MCTs. SAMSHA recommends that communities using co-response models should base team composition on existing needs.

MCT treatment through mobile response

Mobile response and stabilization services (MRSS) are a family and child focused intervention. MRSS considers the developmental needs of children, family role in care, and the significance of avoiding out-of-home placements of youth. MRSS allows families to determine the crisis and provides face-to-face response.

The framework of MRSS services allows for universal access to prevent setbacks to care, which can exacerbate worse outcomes for health. MRSS offers stabilization services such as safety planning, assessment, de-escalation, referrals to care, transitions to hospital or destabilization settings, and additional follow up services if needed.

Behavioral health practitioner only services

Behavioral health only (BHP) MCTs provide on-demand, rapid response comprised of a team of solely behavioral health practitioners. The response requires a licensed practitioner who may also be paired with trained behavioral health paraprofessional practitioners, and/or peer workers. Services include community-based stabilization supports and clinical assessments to reduce risk of danger, emotional distress, and any harm that could happen to individuals who are undergoing a mental health or substance use crisis. BHP-only MCTs are considered the best practice for mobile crisis services.

Quality improvement

There are several metrics available for governments to use when measuring the quality of mobile crisis services. Governments must verify that the metrics used are driven by the quality assurance framework and vision of BH coordinated system of crisis care. This includes metrics such as demographic information, response time, language, number of service requests, and law enforcement involvement. SAMHSA also recommends developing a strategy to collect feedback with interviews or surveys to build response centered on communities receiving services.

A safe place to go: Emergency crisis stabilization services

Emergency crisis stabilization services are comprised of a range of models of care to aid individuals through behavioral health needs. These supports include home, community and facility-based services that administer stabilization and care for youth and adults. The range of services offered in this modality range from no-barrier, referral-based services, and low-barrier services.

No barrier services are typically available regardless of severity and are accessible at any time. This can include individuals who walk in or are brought in by law enforcement. Referral-based services do not allow walk ins and have explicit protocols for admittance to ensure that the environment can meet the individual's needs. Low-barrier services allow walk ins or people who voluntarily admit themselves, however individuals may be screened out if needs cannot be safely supported in the care environment. Each service type will be elucidated in further detail below.

No- or low-barrier services

No-barrier services are a form of crisis stabilization assistance designed for youth and adults experiencing behavioral health emergencies. Treatment takes the form of short-term crisis stabilization services (usually under 24 hours) and this offers opportunities for diversion into first responder treatment or law enforcement. Stabilization services focus on triage, screening, assessment, intervention, and initial response. No-barrier services are effective because they support equitable behavioral health services in crisis care. Typically, crisis assistance in no-to-low barrier settings are most effective when combined with other stabilization services. This provides caregivers and individuals with more options in the environment they receive their treatment.

Behavioral health urgent care falls under a low barrier service, acting as an alternative to the use of hospital emergency departments or other intensive crisis care. BH urgent care operates in community-based settings with extended operating hours, offering the ability of unscheduled, immediate assessment. These centers can also work as an outpatient resource to accept walk-in crisis referrals. BH urgent care can also identify individual's needs related to substance use disorder and connects individuals to needed support.

Peer respite is another example of a low barrier, voluntary service. The duration is typically short-term. Services typically promote socialization, recovery, self-advocacy, development of natural supports, identification of strengths, skill building, and engagement. All services are voluntary.

Sobering centers are community-based institutions operating 24/7 that provide oversight and monitoring for individuals in a crisis that is substance-related. The main goal of these centers are to deliver sobriety in a clinical setting. Intoxicated individuals can be referred by law enforcement, ED, paramedics and other ambulatory clinics. The goal of sobering centers is to reduce the amount of alcohol in an individual's system.

Referral-based services

Residential settings for crisis services are referral based and have voluntary lengths of stay lasting from a duration of a few days to several weeks. The focus of these services is to support recovery, rehabilitation, and resilience while connecting individuals to wraparound care. The focus of these services is to structure programs designed to foster resilience, support rehabilitation, and advance recovery. Wraparound care is also provided.

One example of a referral-based service is crisis stabilization services, also referred to as emergency stabilization centers. These institutions are capable of providing effective care to individuals that are assessed for hospitalization at substantially lower cost. Another example of a referral-based service is crisis residential programs. These are like crisis stabilization services, with outcomes being as strong as receiving hospital-based care with lower costs.

In-home stabilization

Collaborative crisis safety and care planning helps families and individuals divert from restrictive services and instead support them in their homes and community. In this context, in-home stabilization works as a link to transfer youth from crisis facilities to continuous care in the community. In-home stabilization is suitable, and service delivery can continue for weeks.

Youth and family crisis respite

Youth and family crisis respite is an alternative to hospitalization for youth experiencing emotional distress. These services provide a warm, secure, and supportive, space to recover. These services are distinct from adult respite services because treatment is designed to fit natural supports and families. Services for youth and their family relate to System of Care principles, which are trauma-informed, youth and family-driven and oriented to recovery and resiliency. Cultural and linguistic competency is also a focus to ensure maximum responsiveness and quality.

Crisis stabilization facilities

Crisis stabilization facilities are designed to assist youth with more intensive safety needs that can normally be provided through community-based services. Examples of these types of services include 23-hour beds/observation centers, walk-in services, crisis emergency, and stabilization. Treatment duration tends to range, with residential environments providing longer out-of-home positioning, and crisis stabilization having varied times to less than a day to several weeks (up to 2-3). Medication management, service linkages, and assessment are all services that can be provided.

Short term residential for youth and children

These services offer short-term placement that is out-of-home for youth. This allows families to avoid psychiatric impatient treatment or extensive out-of-home placement. The overall purpose of these services are to address significant mental health needs that can successfully return the child back to the family at the earliest time possible, accompanied by high-quality, community and home-based services.

Four pillars of crisis care in Ohio

Ohio's crisis services system has four pillars: Connect, Respond, Stabilize, and Thrive. **Connect** is the act of linking people to services when they are in crisis; **Respond** is the capacity to send or provide access to services to individuals with minimum challenges; **Stabilize** is where people go to receive care for an extended period; **Thrive** is the provision of long-term support and treatment to reduce the potential of a future crisis. Through these four pillars, community capacity can be developed to care for individuals and avoid reliance on criminal justice systems.

Work building out these components of service began with work from the Ohio Crisis Task Force. The task force analyzed the current infrastructure of the crisis care system in Ohio. From there, the task force proposed considerations that could be used for change to improve the crisis care system in Ohio. The Task force also worked to propose principles and values that would undergird operation of the crisis system and build a shared language for how it is discussed. In 2023, the Ohio Department of Behavioral Health (DBH, formerly the Department of Mental Health and Addiction Services) released a report detailing the landscape of behavioral health in Ohio which defined the components of the crisis care continuum.

Source: *Ohio Behavioral Health Crisis Systems 2023 Landscape Analysis. Published by the Ohio Department of Behavioral Health.*

Connect

One of the primary goals that Ohio is working to meet under this pillar of the crisis continuum is bolstering the 988 Lifeline and increasing knowledge about Lifeline amongst stakeholders. 988 was established in 2023 as the national Lifeline number under federal law and services are delivered by 19 providers covering all 88 counties of Ohio.

There are three considerations that comprise needs for crisis services[20], which will help meet needs of individuals getting access to services. Doing so helps integrate services with other facets of the crisis care continuum and promotes connection of 988 with these systems of care. The three considerations are linkages, quality, and marketing.

Linkage considerations

Linkage considerations can be best described as how calls can be appropriately linked to the right places to provide aid for people in need of services. Developing and sustaining relationships with partners across the state to meet the needs of Ohioans is increasingly important. Linkages help ensure effective, integrated crisis response. Cooperation between stakeholders in the behavioral health space is crucial, and the implementation of the right technology can ensure that any text, chat, call, or warm handoffs across various crisis lines can be upheld.

Increasingly, interoperability with 911 is important to support connecting individuals with a mental health response when it would best meet the needs of the caller. Emphasis on the correct use of technology is also important so that information shared between partners can track outcomes, provide successful outcomes, and increase effective care. In this context, stakeholders refer to ADAMHS Boards, NSPL/988 call centers, crisis care providers, and local hotlines that provide behavioral health services.

Porting calls is also important to determine who can best respond to outreach. Callers from different counties and different states who have ported their number need support through established systems that can accommodate needs. Finally, the resource directory is significant in its maintenance and upkeep so that Ohioans can receive quality crisis care. Proper maintenance of the director also guarantees that call lines and 988 lines have updated contacts.

Quality considerations

Quality considerations are focused on developing standards that guide how calls are routed to provide care.[21] These standards create consistency in services, satisfaction for those who use the crisis line, and increase community access. From a connect perspective, standards demonstrate how to incorporate efficient care practices into responding and transferring calls.

Accessible and reliable trainings can also help maintain appropriate standards for care so that professionals working in crisis care can perform adequately. Training would emphasize population-relevant information, best practices education, and staff onboarding procedures. In 2025, DBH announced a partnership with the National Organization for Victim Advocacy to host regional trainings in Ohio to help communities address behavioral health needs.

Quality metrics also help assess the quality of services and understand the experiences of individuals. Call center standards should build on national models and should not increase administrative load.

Marketing considerations

Marketing considerations help solidify consistent messaging regarding the strategy to communicate to stakeholders about how to create a comprehensive element of the crisis continuum related to connecting individuals to services. In 2024, DBH launched a public awareness campaign to increase knowledge of the 988 Lifeline and its relevance to supporting individuals in crisis. This included a 988 Ohio toolkit and style guide to customize information and messaging around 988 across organizational settings.

Respond

Under Respond, the crisis system for Ohio consists of two categories of service: Mobile Response Stabilization Services (MRSS) and BH emergency care. These two interventions work to reduce crisis and to prevent further behavioral health incidents impacting Ohioans.

Mobile Response and Stabilization (MRSS)

MRSS started as a grant-funded pilot program by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2018. Northwest and Southwest Ohio were the only two states that were serviced under the pilot. The northwest counties included Lucas, Wood, Allen, Auglaize, Hardin, Hancock, Putnam, and Paulding counties. The Southwest counties included Butler, Warren, Clinton, Clermont, and Preble counties. Currently, MRSS is operating in all of Ohio's counties.[22]

There are some differences across the state with how MRSS is designed to treat respective populations. A variety of these differences can be understood as infrastructural or environmental, with workforce and funding being a major part of service design. OhioRISE covers MRSS services for all youth enrolled. All Medicaid plans cover MRSS services.

Part of the benefit of MRSS is its ability to provide services that are less restrictive to families and less reliant upon law enforcement to intervene with complex behavioral health challenges. Services for MRSS are available 24/7, every day of the year, and provided where the emergency takes place or at a community-based location as requested by family members or other contactor. A referral for MRSS can be initiated by the young person, school staff, family member, law enforcement, or other emergency departments.

The team responding to the crisis assists the family to bolster resiliency and develop skills and resources to support long term wellbeing. MRSS allows up to six weeks of stabilization marked by the initial date of mobile response. Access to a psychiatrist, clinical nurse specialist, or nurse practitioner is available based on need.

MRSS staff

MRSS teams include MRSS trained licensed clinical supervisors, a peer supporter, Qualified Behavioral Health Specialist (QBHS), and a licensed clinical staff member. The team should also have a connection to a psychiatrist, clinical nurse specialist, or nurse practitioner to assist if needed. Oversight for MRSS staff requires administrative and clinical management that can be provided by one person or multiple supervisors with the qualifications and licensure needed to conduct tasks. One supervisor at a minimum must be independently licensed as a behavioral health professional in Ohio.

Cultural and linguistic competency is a requirement of any MRSS service provider. Institutions are directed to hire multilingual or bilingual MRSS staff members that reflect accurately the demographics of the population serviced. Written materials, resources, consent forms, and safety plans that are at an adequate reading level for families is also a requirement.

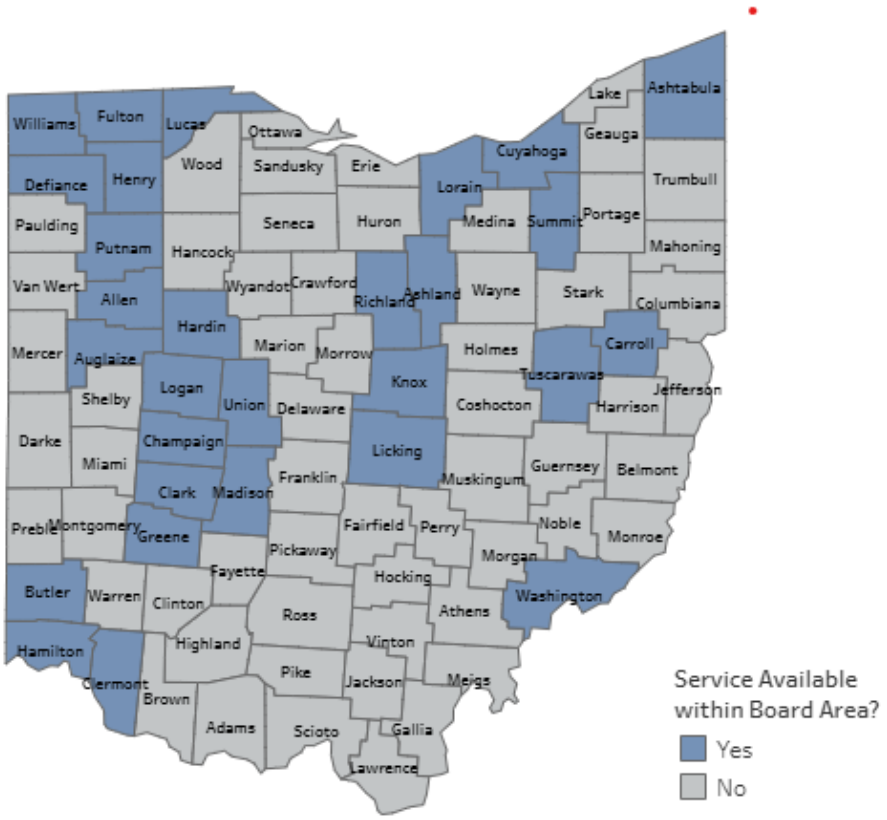
When possible, these resources should also be distributed in the language of the family or youth receiving the service. Incorporation of cultural needs and preferences of the young person are also expected, with services designed to connect to community supports. Information on disparities impacting respective populations is also expected.

BH urgent care

Behavioral Health (BH) urgent care centers in Ohio provide triage, assessment, crisis assessment and safety planning, psychiatric and substance use disorder intervention – like urgent care for physical health issues. In Ohio, BH Urgent Care centers are usually staffed with a diverse group of professionals, paraprofessionals, and peers. from different backgrounds to ensure that treatment is effective.

Funding can be a challenge because most payers do not recognize or cover BH urgent care whereas most BH urgent care centers accept Medicaid as an option to bill for services and local ADAMHS Board provide funding. Ohio has a goal to develop BH urgent care walk-in services for every Ohio county. As of 2024, BH urgent care is offered in 29 out of Ohio's 88 counties. Below is a list of the counties with BH urgent care.

Availability of Behavioral Health Urgent Care: CY 2024

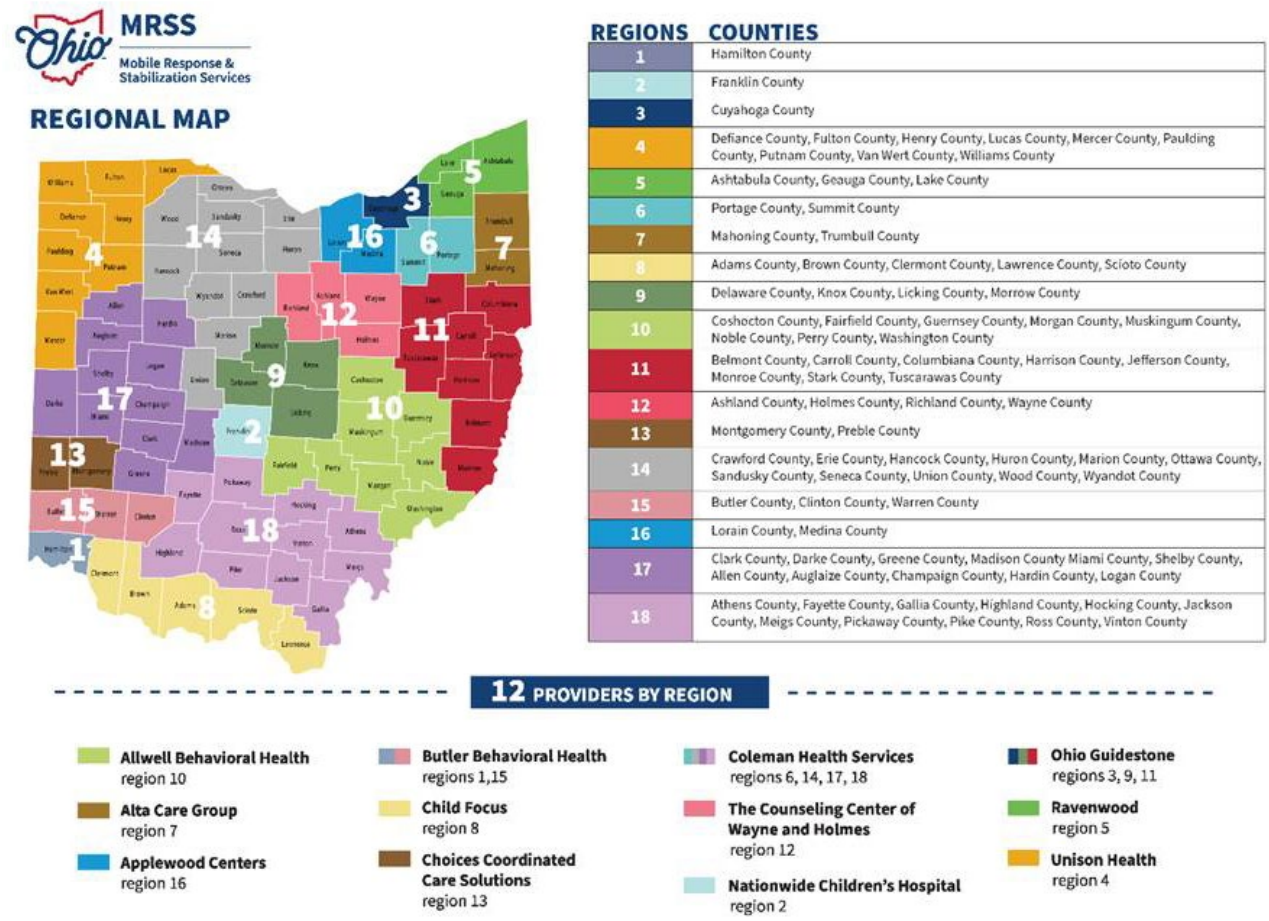


Source:
DBH Crisis Services Providers Dashboard data for FY2024.

MRSS expansion

In 2025, the Department of Behavioral Health (DBH) announced a collaboration with Department of Medicaid (ODM) and a network of partners regionally to expand MRSS. This partnership would make MRSS available in all 88 counties in Ohio for all youth under age 21 regardless of payer. There are twelve organizations in total that will provide MRSS across the state, and organizations will cover 18 regions.

Every Regional MRSS Provider will be tasked with all facets of MRSS, from dispatch to de-escalation, stabilization, quality care, and data monitoring. Below is a map of the regions covered by respective counties. DBH, in collaboration with ODM, have developed a firehouse funding model to support MRSS under this regional model. These regional providers contract with Aetna OhioRISE, who serves as the fiscal intermediary to support payment and account for services delivered.



Source: Ohio Department of Behavioral Health MRSS Statewide Expansion. Retrieved from: https://mha.ohio.gov/get-help/crisis-systems/mobile-response-and-stabilization-services-mrss/mrss-statewide-expansion

Stabilize

Stabilize reflects the places that people go when undergoing a behavioral health crisis. This includes crisis stabilization centers that offer crisis assessments and may offer 23-hour observation and crisis residential services. The vision of "Stabilize" is to create a community-based, no-wrong-door access to mental health and substance use care – one that operates like a hospital emergency department that accepts all walk-ins, ambulance, fire and police drop-offs.

The emphasis is on services provided locally or in an adjacent county to fully support needs of a community and reducing unneeded ED visits or arrests. Several counties have opened 24/7 crisis focused facilities in the past few years.

2025 projects

Allen County opened the Crossroads Crisis Center, offering court advocacy, 24/7 text/chat, education, mobile advocacy, and residency services. The website also has a list of area resources for individuals to receive additional treatment and care.

Richland County (Mansfield) opened Danielle's Lighthouse. Coleman Health Services was chosen by the Richland County Mental Health and Recovery Services Board to manage and operate the center. Danielle's Lighthouse provides short-term treatment for individuals stepping down from a crisis stabilization unit, hospital, or local emergency department. A 16 residential center with ties to the Mansfield facility opened in Lucas County (Toledo) as well. Unison Health is the sponsor of the facility.

Franklin County opened a 24/7 Crisis Care Center, which will provide mental health and addiction assistance. Cuyahoga County has also allocated $7 million acquired from Opioid Settlement Funds to build a new BH Crisis Center. This development is done in partnership with the Cuyahoga County ADAMH Board and the Centers.

Hamilton County opened a crisis center in Avondale to support mental health crisis and as an option for fire departments and police to bring residents in need of aid. The facility also has on-site care coordination establishing a connected system for crisis to recovery.

Lorain County opened a 30,000 square foot facility with 16 beds for mental health stabilization and 16 beds for addiction care. The new facility is open 24/7 and individuals can admit themselves or connect via law enforcement assistance. The $19 million facility is also the site for the 988 suicide and crisis lifeline.

Warren, Ohio (Trumbull County) opened a new Behavioral Health Crisis Center and Sister Jean's Lighthouse. The multi service facility was opened for supportive housing, providing 24/7 supportive housing and crisis intervention serving anyone who is experiencing a mental health crisis, struggling with homelessness, or substance use disorder. The Crisis Access Center contains MRSS offices, provides counseling, private intake, prescreening, and pharmaceutical services. Sister Jean's Lighthouse will offer eight apartments: Six two-bedroom units for women and children, and two one-bedroom units for single women. Short term supportive housing will be provided for families in crisis.

2024 projects

Development began for a new BH Urgent Care and Crisis Stabilization center in St. Clairsville, which would serve Belmont, Harrison, and Monroe Counties. The project was part of a $90 million investment made by Governor DeWine to award ARPA funds to strengthen mental health and addiction throughout Ohio. In Fairfield County,

OhioGuidestone and the Fairfield County ADAMH Board opened the STARLight Center, a 24/7 voluntary residential crisis center with OhioGuidestone operating as the providing agency. The crisis center was created by a tax levy that passed in a 2019 election.

Licking County also began building a crisis stabilization center that would assist individuals experiencing mental health or addiction crisis. The county plans to have the crisis stabilization center completed by 2026. Licking County's project is part of a three year Community Health Improvement Plan (CHIP) created by the Licking County Community Health Improvement Committee (CHIC). The duration of the health improvement plan goes from 2023 to 2026.

ARPA funds

The American Rescue Plan Act (ARPA) was instrumental in providing funds to state and local governments across the country to support recovery efforts from the COVID-19 pandemic. Community Solutions produced extensive work on ARPA from encouraging community engagement, updating the public on ARPA throughout the process, and providing subsequent policy analysis on its long term budgeting impact.

In 2023, the DeWine Administration announced that $90 million would be distributed to the Ohio Department of Behavioral Health to build out Ohio's crisis infrastructure. This funding was split in half, with $45 million dedicated to mental health rehabilitation facilities, and the second portion dedicated to bolstering Crisis Services to bridge gaps in crisis care continuums on a regional/local level. Regarding the "Stabilize" pillar of Ohio's crisis care model, identified gaps include the need for Crisis Stabilization Centers, which provide short-term treatment for needs that are unmet in-home environments, and BH Urgent care. Awards for different projects were announced that same year.

Thrive

Thrive is the final component of Ohio's crisis care continuum. The vision for "thrive" is to assist every person or family with family-centered services to help them reach their highest potential.[23] Following a crisis event, Thrive makes the connection between crisis support services and community services that support continued wellness and recovery. Thrive connects people with treatment services and creates supportive interventions.

Ohio has identified five goals to support individuals in sustaining recovery and thriving. These are connection with "Thrive" services, ongoing crisis intervention by linking individuals with services after a crisis episode, quality peer support, persistent care

coordination regardless of where the individual lives or the payer, and consistent access to models of service established around moving individuals from despair to hope.

Continuum of thrive services

Thrive services include a full array of supports for housing, employment, education, social connection, meaning, and joy, as well as appropriate continuing treatment for BH and medical conditions. It is a local network of support for everyone and family to help them on their journey that is focused on belongingness, connection, and the human need for hope, joy, fun and personal growth. Thrive services are person and family centered and often supported by high quality peer support.

Across the continuum: Peer support and OhioRISE

Peer support and OhioRISE span across the entire crisis care continuum. Peer support specialists have been crucial in the ongoing work to support individuals that have experienced a BH crisis in Ohio. SAMHSA describes peer support as a diverse set of interactions with individuals that have experienced similar conditions dealing with mental health or substance abuse disorder (or both). Peer supporters can foster connections with people in need of service and can provide understanding.

Peer supporters provide non-clinical support from a strength-based approach by emphasizing their own journey and fostering hope. To become a certified peer support specialist, individuals must self-identify as someone with lived experience with mental health or substance use treatment, be 18 years of age or older, have at least a high school diploma, complete a 40-hour training, and pass a background check. Family peer support requires similar training and self-disclosure of caregiving for a child or youth that experienced mental health or substance use conditions.

Peer support providers are viewed as essential team members in BH crisis services, serving to engage, connect and guide individuals throughout the crisis experience and transition into “thrive.”

OhioRISE

OhioRISE is a managed care Medicaid program for youth with behavioral health needs involved with multiple systems such as child protection, developmental disabilities, or juvenile justice that aims to better coordinate care. The target population of MRSS is any young person under the age of 21 who is experiencing escalating emotional behavioral health challenges that have impacted their capacity to operate and thrive day-to-day.

OhioRISE is distinct from other Medicaid coverage programs for behavioral health by providing coverage for expanded behavioral health services. Enrollees in OhioRISE can get their service from Aetna, while physical health is provided through another managed care organization or fee-for-service Medicaid.

MRSS services are reimbursed through OhioRISE or other Ohio Medicaid Managed Care Entities. Prior authorization is required for MRSS services extending past 42 days. There is no need for previous behavioral health treatment or current involvement in a system to access MRSS. Other services offered include Intensive Home-Based Treatment (IHBT), behavioral health respite, and Psychiatric Residential Treatment Facilities (PRTF).

The Center for Community Solutions has published research on OhioRISE, it's function, and potential ways that individuals could engage with OhioRISE. Community Solutions also advocated for the implementation of OhioRISE in the budget for FY2024-2025, and was a major budget priority going into the fiscal year for the biennium.

As of 2025, OhioRISE passed a three-year milestone, with enrollment rates increasing from 5,500 on the first day to nearly 50,000 youth enrolled as of July 2025.[24] The county with the highest enrollment is Franklin County with 7,138 enrolled, followed by Cuyahoga (4,782), Hamilton (2,684), and Lucas (2,405).[25]

Policy recommendations

Ohio has engaged in significant planning efforts and made recent investments to improve the landscape of crisis services. There are three recommendations to strengthen crisis systems in Ohio. These three recommendations are: Addressing stigma, bolstering the crisis care workforce, and closing Medicaid gaps.

Addressing stigma

The history of mental health has shifted drastically throughout time, with innovations in technology and medicine improving treatment options and opportunities. Despite the various transformations in treating behavioral health, stigma remains a persistent factor in how individuals with mental health or SUD experience care.

The National Center on Substance Abuse and Child Welfare (NCSACW) identified three major types of stigma:[26]

1. **Structural**: Policies, laws, or legislation in general that creates differences in how people are treated across service delivery.
2. **Public**: Attitudes, biases, and perspectives that produce a negative outlook on a group of people or individuals.

3. **Self**: Individuals internalizing harmful stereotypes about themselves and their condition.

In the past decade, there has been noted change in stigma against depression,[27] however much more work needs to be done to address the larger scale problems associated with mental health and substance use disorder. Each of the three stigmas identified by NCSACW can be addressed by prioritizing the individual and community context of mental health and substance use disorder, especially within the lens of crisis services.

Structural

HB 96 of the 136th General Assembly creates state block grants, which use appropriations from the General Revenue Fund to create dollars for ADAMH boards to use. The creation of state block grants is a new approach to supporting behavioral health in Ohio through the creation of flexible funds. State block grants are only part of the picture when it comes to addressing behavioral health. The aim of the block grant structure is to form a continuum of care that directs state dollars to local agencies that can work on projects to improve wellbeing. Parity is a significant piece of the conversation regarding structural forms of stigma.

Medicaid and commercial insurance are crucial components of behavioral health treatment. Funding cuts from HR 1 creates tremendous challenges for individuals in need of treatment. In Ohio, work requirement implementation also intensifies economic challenges facing Ohioans enrolled in Medicaid. Similarly, commercial insurance models may not fully cover certain components of crisis care. The implications of these challenges create structural stigma reinforced by policy decisions straining systems designed to treat vulnerable communities.

Structural recommendations

Language within the state budget notes that the Department of Behavioral Health is responsible for defining the criteria for eligible uses of the block grants. One of the criterion should be that agencies have programming that seeks to address stigma. In doing so, dollars that are provided to agencies are fiscally awarded based on their competency in targeting disparities. Additionally, Ohio needs to consider opportunities to promote access to crisis care through insurance parity. This structural stigma in healthcare coverage is pervasive, and lack of payment for crisis services is but one example.

Public

The Department of Behavioral Health continues to combat public stigma around behavioral health by creating public awareness campaigns around mental health and substance abuse. In addition to this work, the 988 webpage includes resources that can be shared by providers, organizations, and nonprofits seeking to raise awareness. Finally, the budget process included ample appropriations to 988 through General Revenue Fund (GRF) dollars. GRF funds are flexible and can be used for any purpose with a public facing orientation.

988 was funded at $48,500,000 across FY 2026 and FY 2027. This is significantly less than Governor DeWine's proposed budget, which appropriated the 988 lifeline at $34,191,840 in FY 2026 and $41,298,200 in FY 2027. These dollars allow DBH to define flexibly the function of appropriations of 988 dollars where needed. In September, the Department of Behavioral Health posted a press release about the importance of 988 and work the state is doing to improve mental health. The theme was across three key messages, including knowing the number, spreading the word, and supporting the system. The press release includes Ohio in a national conversation on the importance of the Lifeline, which continues the overall work Ohio is doing to make the importance of 988 known to the public.

Public recommendations

Overall, Ohio is doing well to create public information and resources for providers to stay informed about the 988 Lifeline. Ongoing work in Ohio should include other crisis line numbers with emphasis to how they connect to the crisis continuum/the 988 Lifeline. Region specific information should also be made available in other languages as well in accordance to Culturally Linguistic Appropriate Services (CLAS). Lastly, Ohio should devote more effort to increase public knowledge on when to call 911 vs. 988.

Self

Individuals dealing with substance abuse disorders/mental health challenges can face great weight navigating challenges. Public perception of mental health can interfere with individuals getting help or seeking help.

Self recommendations

Combating stigma on mental health is important to build more knowledge, awareness, and capacity to address its significance. Substance use conditions and mental health challenges are diseases that require healthcare treatment integrated into healthcare services.

There are an abundance of mental health programs that schools, universities, and families can use to improve mental health needs, however much work also has to be done on the societal level to improve stigma. Additional resources will also be provided at the end of the report.

Behavioral health workforce

The next policy recommendation is to strengthen the behavioral health workforce. Within the last several years, there has been a major shrinkage of the behavioral health workforce, with an increase in Mental Health Professional Shortage Areas (MHPSA) by 10 percent. Over 85 percent of the state has been designated as a MHPSA.

Research from the Center for Community Solutions on the BH workforce has discussed investments to the BH workforce that temporarily supported recruitment of professionals such as the Great Minds Fellowship,[28] which was an infusion of one-time funds aimed at recruiting and retaining more professional to the BH workforce, but it is not enough to address the challenge.

Primarily, a consistent, strong workforce of behavioral health professionals is needed to provide care to *all* Ohioans. Research from the Ohio Council of Behavioral Health and Family Service Providers shows that there has been a 353 percent increase in the need for behavioral health treatment from 2013 to 2019.[29] Despite this, the available workforce increased to 174 percent,[30] which underserves populations in Ohio needing help. There are an estimated 2.4 million Ohioans in need of behavioral health professionals.

Behavioral health workforce recommendations

Ohio should further invest in initiatives that value and grow the BH workforce. The Great Minds Fellowship was one example of a program to invest in the behavioral health workforce by offering tuition reimbursement, student loan repayment, stipends, and support for academic and non-academic barriers to participating in internships or entry level work.

Training and educational programs need to improve or develop academic and non-academic career pathways building entry level programs, apprenticeships, career-tech opportunities, and address gaps in the credentialing structure. In addition to this, compensation for behavioral health positions is low and often services are not covered by payors other than Medicaid.

Insurance parity for crisis services would be an important first step in addressing the crisis workforce challenges. This would provide competitive salaries in a demanding field where the work is community-based and required 24/7 and help retain Ohio's talent.

Payor models for crisis services

Currently, Medicaid is the only payor for community-based crisis services. Mobile Crisis Teams are covered by Medicaid. Commercial insurance also provides limited coverage for crisis services, and it does not cover mobile crisis or crisis stabilization. In addition to this, the 988 Lifeline has no major funding source outside of appropriations made by the state budget. Federal block grants, Medicaid and ADAMH boards make up the large part of community-based crisis services, leaving a major challenge in how these services can be provided.

HR 1 and the upcoming implementation of Medicaid work requirements puts strain on the program which will then impact enrollees. New work requirements would affect Ohioans enrolled in Medicaid expansion and while people in treatment for mental health and substance use disorders may qualify for exemptions, it is currently unclear exactly how the exemption criteria will be defined. Overall, there may be approximately 337,000 Medicaid recipients who will lose coverage. This is a 10.7 percent decrease from the baseline enrollment.

Over the next 10 years, Ohio will see a $53.3 billion reduction in Medicaid spending. Broadly, changes to Medicaid financing were made in HR1, with further unknown impacts. Medicaid is a significant payor for behavioral health services; therefore, these changes must be watched closely.

Improved payor models recommendations

The overall goal is to make services incorporated into other areas of financial transaction. Incorporating a Lifeline tax for the 988 Lifeline is potentially one way to improve payor models for crisis services. In Illinois, a telecommunications excise tax was created to support the 988 Lifeline by creating a 1.65 percent increase on the tax rate of intrastate/interstate communications via telephone.

Other states such as Minnesota and Virginia have also introduced fees for 988 that are charged per line. This is similar to how 911 is paid for, with individuals paying a small monthly fee to uphold the line. 988 similarly could be supported by basic charges that are paid for by individuals on monthly phone bills.

Conclusion

Ohio's work to build crisis infrastructure has made significant strides, and further policy changes can improve areas where Ohio is doing well. HB 96 of the 136th General Assembly introduces new opportunities for care in Ohio, including the creation of state block grants to support issues in mental health, substance abuse, criminal justice, recovery efforts, and continued funding for the 988 Lifeline.

More awareness of mental health and substance abuse can help introduce the public with further opportunities to address present issues, and investment into the behavioral health workforce can train professionals to educate the public and provide services. Finally, improved payor models that provide affordable care can make services accessible for recipients.

This report is a snapshot of the national standards for crisis care, the work Ohio is currently doing, while contextualizing the broad history of crisis care treatment. Historically, there have been many changes to how individuals in need of crisis services have been treated.

Ohio's work ushers in a new period of crisis care for the state that can close gaps and provide easier access to needed help for behavioral health and substance abuse disorders. To continue this work, advocates, healthcare providers, clinicians, and legislators will be important to create a healthier Ohio.

Resources

- Suicide and Depression Screening Tool
- Coping with Stress
- Ohio Suicide Prevention Foundation Resources Page
- S. Department of Veteran Affairs Suicide Prevention- Central Ohio
- 988 Ohio Toolkit
- CDC Suicide Prevention Social Media Graphics
- Resources for LGBTQ+ Individuals and Healthcare Providers, 2025 — Maternal Mental Health Leadership Alliance: MMHLA

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Transforming crisis response in Ohio

Policy analysis and recommendations for behavioral health services

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