2022 The State of Mental Health in America

Mental Health America

Acknowledgments

Mental Health America (MHA) was founded in 1909 and is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and promoting the overall mental health of all. Our work is driven by our commitment to promote mental health as a critical part of overall wellness, including prevention services for all, early identification and intervention for those at risk, integrated services and supports for those who need them, with recovery as the goal.

MHA dedicates this report to mental health advocates who fight tirelessly to help create parity and reduce disparities and inequities for people with mental health concerns. To our affiliates, thank you for your incredible state-level advocacy and dedication to promoting recovery and protecting consumer rights!

This publication was made possible by the generous support of Alkermes, Neurocrine Biosciences, Inc., and Otsuka America Pharmaceutical Companies.

Special Thanks To:

The Substance Abuse and Mental Health Services Administration (SAMHSA), The Centers for Disease Control and Prevention (CDC), and the Department of Education (DoE) who every year invest time and money to collect the national survey data without which this report would not be possible.

This report was researched, written, and prepared by Maddy Reinert, Theresa Nguyen, and Danielle Fritze.

Citation: Reinert, M, Fritze, D. & Nguyen, T. (October 2021). "The State of Mental Health in America 2022" Mental Health America, Alexandria VA.

500 Montgomery Street, Suite 820
Alexandria, VA 22314-1520
www.mhanational.org

Table of Contents

Mental Health America (MHA) is the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and promoting the overall mental health of all. MHA's work is driven by its commitment to promote mental health as a critical part of overall wellness, including prevention services for all; early identification and intervention for those at risk; integrated care, services, and supports for those who need them; with recovery as the goal.

Our report is a collection of data across all 50 states and the District of Columbia and seeks to answer the following questions**:**

- How many adults and youth have mental health issues?
- How many adults and youth have substance use issues?
- How many adults and youth have access to insurance?
- How many adults and youth have access to adequate insurance?
- How many adults and youth have access to mental health care?
- Which states have higher barriers to accessing mental health care?

Our Goal:

- To provide a snapshot of mental health status among youth and adults for policy and program planning, analysis, and evaluation;
- To track changes in the prevalence of mental health issues and access to mental health care;
- To understand how changes in national data reflect the impact of legislation and policies; and
- To increase dialogue with and improve outcomes for individuals and families with mental health needs.

Why Gather This Information?

- Using national survey data allows us to measure a community's mental health needs, access to care, and outcomes regardless of the differences between the states and their varied mental health policies.
- Rankings explore which states are more effective at addressing issues related to mental health and substance use.
- Analysis may reveal similarities and differences among states to begin assessing how federal and state mental health policies result in more or less access to care.

Ranking Overview and Guidelines

This chart book presents a collection of data that provides a baseline for answering some questions about how many people in America need and have access to mental health services. This report is a companion to the online interactive data on the MHA website (https://www.mhanational.org/issues/state-mental-health-america). The data and tables include state and national data and sharable infographics.

MHA Guidelines

Given the variability of data, MHA developed guidelines to identify mental health measures that are most appropriate for inclusion in our ranking. Indicators were chosen that met the following guidelines:

- Data that are publicly available and as current as possible to provide up-to-date results.
- Data that are available for all 50 states and the District of Columbia.
- Data for both adults and youth.
- Data that captures information regardless of varying utilization of the private and public mental health system.
- Data that could be collected over time to allow for analysis of future changes and trends.

Our 2022 Measures

1. Adults With Any Mental Illness (AMI)
2. Adults With Substance Use Disorder in the Past Year
3. Adults With Serious Thoughts of Suicide
4. Youth With At Least One Major Depressive Episode (MDE) in the Past Year
5. Youth With Substance Use Disorder in the Past Year
6. Youth With Severe MDE
7. Adults With AMI Who Did Not Receive Treatment
8. Adults With AMI Reporting Unmet Need
9. Adults With AMI Who Are Uninsured
10. Adults With Cognitive Disability Who Could Not See a Doctor Due to Costs
11. Youth With MDE Who Did Not Receive Mental Health Services
12. Youth With Severe MDE Who Received Some Consistent Treatment
13. Children With Private Insurance That Did Not Cover Mental or Emotional Problems
14. Students Identified With Emotional Disturbance for an Individualized Education Program
15. Mental Health Workforce Availability

A Complete Picture

While the above 15 measures are not a complete picture of the mental health system, they do provide a strong foundation for understanding the prevalence of mental health concerns, as well as issues of access to insurance and treatment, particularly as that access varies among the states. MHA will continue to explore new measures that allow us to capture more accurately and comprehensively the needs of those with mental illness and their access to care.

Ranking

To better understand the rankings, it is important to compare similar states.

Factors to consider include geography and size. For example, California and New York are similar. Both are large states with densely populated cities. They are less comparable to less populous states like South Dakota, North Dakota, Alabama, or Wyoming. Keep in mind that the size of states and populations matter, both New York City and Los Angeles alone have more residents than North Dakota, South Dakota, Alabama, and Wyoming combined.

The rankings are based on the percentages, or rates, for each state collected from the most recently available data. For most indicators, the data represent data collected up to 2019. States with positive outcomes are ranked higher (closer to one) than states with poorer outcomes. The overall, adult, youth, prevalence, and access rankings were analyzed by calculating a standardized score (Z score) for each measure and ranking the sum of the standardized scores. For most measures, lower percentages equated to more positive outcomes (e.g., lower rates of substance use or those who are uninsured). There are two measures where high percentages equate to better outcomes. These include "Youth With Severe MDE (Major Depressive Episode) Who Received Some Consistent Treatment" and "Students Identified With Emotional Disturbance for an Individualized Education Program." Here, the calculated standardized score was multiplied by -1 to obtain a reverse Z score that was used in the sum. All measures were considered equally important, and no weights were given to any measure in the rankings.

Along with calculated rankings, each measure is ranked individually with an accompanying chart and table. The table provides the percentage and estimated population for each ranking. The estimated population number is weighted and calculated by the agency conducting the applicable federal survey. The ranking is based on the Z scores. Data are presented with two decimal places when available.

The measure "Adults With Disability Who Could Not See a Doctor Due to Costs" was previously calculated using the Behavioral Risk Factor Surveillance System (BRFSS) question: "Are you limited in any way in any activities because of physical, mental, or emotional problems?" (QLACTLM2). The QLACTLM2 question was removed from the BRFSS questionnaire after 2016, and therefore could not be calculated using 2019 BRFSS data. For this report, the indicator was amended to "Adults With Cognitive Disability Who Could Not See a Doctor Due to Costs," using the BRFSS question: "Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?" (DECIDE). This indicator likely serves as a better measure for individuals who experience disability tied to mental, cognitive, or emotional problems, as it is less likely to include people who experience limitations due to a physical disability and is therefore a more sensitive measure for the population we are attempting to count.

For the measure "Students Identified With Emotional Disturbance for an Individualized Education Program," due to data suppression because of quality, the 2016-2019 figures for Wisconsin were not available. This report notes the 2015 figure for Wisconsin. The 2019 figure for Iowa was also not available because Iowa no longer captures disability category data, and therefore the number of students identified with emotional disturbance could not be determined. This report notes the 2018 figure for Iowa.

Survey Limitations

Each survey has its own strengths and limitations. For example, strengths of both SAMHSA's *National Survey of Drug Use and Health* (NSDUH) and the CDC's *Behavioral Risk Factor Surveillance System* (BRFSS) are that they include national survey data with large sample sizes and utilize statistical modeling to provide weighted estimates of each state population. This means that the data is more representative of the general population. An example limitation of particular importance to the mental health community is that the NSDUH does not collect information from persons who are experiencing homelessness and who do not stay at shelters, are active-duty military personnel, or are institutionalized (i.e., in jails or hospitals). This limitation means that those individuals who have a mental illness who are also experiencing homelessness or are incarcerated are not represented in the data presented by the NSDUH. If the data did include individuals who were experiencing homelessness and/or incarcerated, we would possibly see prevalence of behavioral health issues increase and access to treatment rates worsen. It is MHA's goal to continue to search for the best possible data in future reports. Additional information on the methodology and limitations of the surveys can be found online as outlined in the glossary.

In addition, these data were gathered through 2019. This means that they are the most current data reported by the states and available to the public. They are most useful in providing some comparative baselines in the states for the needs and systems that were in place prior to the COVID-19 pandemic, as data reflective of the COVID-19 pandemic will not be made available until next year. MHA regularly reports on its real-time data gathered from more than 11 million completed mental health screenings (through September 2021). Based on these screening results from a help-seeking population, and both U.S. Census Bureau 2020-2021 Pulse Survey data, which included brief depression and anxiety screening questions, and survey data reported by the Centers for Disease Control and Prevention (CDC), it appears that (1) the data in this report likely under-reports the current prevalence of mental illnesses in the population, both among children and adults, (2) higher-ranked states may have been better prepared to deal with the mental health effects of the pandemic at its start, and (3) because of its nationwide effect, nothing in the pandemic by itself would suggest that the relative rankings of the states would have changed solely because of the pandemic.

Spotlight 2022

The two spotlights within this report provide a deeper dive into two of Mental Health America's policy priorities in 2021-2022: suicide prevention and access to crisis care and prevention and early intervention for children, youth, and young adults. The first spotlight, "Suicidal Ideation and 988 Implementation," discusses the need for states to pass legislation to support a continuum of crisis services. With the passage of the new 988 number for suicide prevention and mental health crises, there is an opportunity to create a continuum of crisis care with adequate funding that ensures mental health responses to mental health crises and prioritizes equity, particularly for BIPOC individuals. The second spotlight, "Disparities in Mental Health Treatment for Youth of Color," examines data from SAMHSA's 2018-2019 National Survey on Drug Use and Health (NSDUH), to examine disparities in the kinds of care youth with depression are able to receive and where they receive it. Students of color disproportionally access their mental health care at school, often because they don't have access to specialty mental health services. Given this data, increasing access to school-based mental health services can promote equity and reduce disparities in access to care.

NEARLY **50 M**

OR 19.86% OF AMERICAN ADULTS EXPERIENCED A MENTAL ILLNESS IN 2019.

4.58% OF ADULTS REPORT HAVING SERIOUS THOUGHTS OF SUICIDE. THIS HAS INCREASED EVERY YEAR SINCE 2011-2012.

15.08% OF YOUTH EXPERIENCED A MAJOR DEPRESSIVE EPISODE IN THE PAST YEAR.

24.7%

OF ADULTS WITH A MENTAL ILLNESS REPORT AN UNMET NEED FOR TREATMENT. THIS NUMBER HAS NOT DECLINED SINCE 2011.

OVER **60%** OF YOUTH WITH MAJOR DEPRESSION DO NOT RECEIVE ANY MENTAL HEALTH TREATMENT.

EVEN IN STATES WITH THE GREATEST ACCESS, NEARLY **1 IN 3** ARE GOING WITHOUT TREATMENT.

MORE THAN HALF

OF ADULTS WITH A MENTAL ILLNESS DO NOT RECEIVE TREATMENT, TOTALING OVER 27 MILLION U.S. ADULTS.

10.6%

OR OVER 2.5 MILLION YOUTH IN THE U.S. HAVE SEVERE MAJOR DEPRESSION.

THIS RATE WAS HIGHEST AMONG YOUTH WHO IDENTIFY AS MORE THAN ONE RACE, AT **14.5%**

EVEN AMONG YOUTH WITH SEVERE DEPRESSION WHO RECEIVE SOME TREATMENT, ONLY **27%** RECEIVE CONSISTENT CARE.

IN STATES WITH THE LEAST ACCESS, ONLY **12%** RECEIVE CONSISTENT CARE.

11.1%

OF AMERICANS WITH A MENTAL ILLNESS ARE UNINSURED, THE SECOND YEAR IN A ROW THAT THIS INDICATOR INCREASED SINCE THE PASSAGE OF THE AFFORDABLE CARE ACT (ACA).

8.1% OF CHILDREN HAD PRIVATE INSURANCE THAT DID NOT COVER MENTAL HEALTH SERVICES, TOTALING 950,000 YOUTH.

Overall Ranking

An overall ranking 1-13 indicates lower prevalence of mental illness and higher rates of access to care. An overall ranking 39-51 indicates higher prevalence of mental illness and lower rates of access to care. The combined scores of all 15 measures make up the overall ranking. The overall ranking includes both adult and youth measures as well as prevalence and access to care measures.

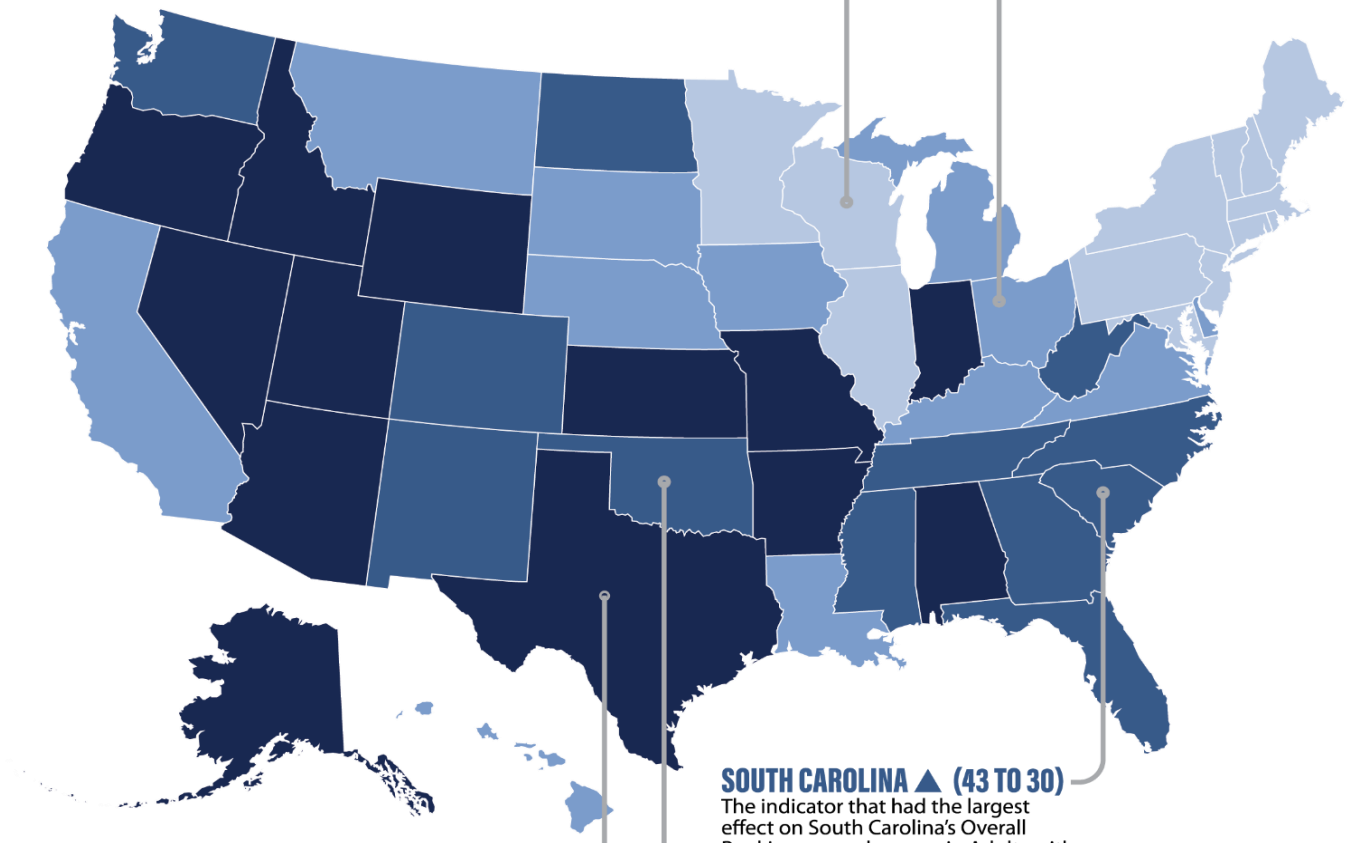
The 15 measures that make up the overall ranking include:

1. Adults With Any Mental Illness (AMI)
2. Adults With Substance Use Disorder in the Past Year
3. Adults With Serious Thoughts of Suicide
4. Youth with At Least One Major Depressive Episode (MDE) in the Past Year
5. Youth With Substance Use Disorder in the Past Year
6. Youth With Severe MDE
7. Adults With AMI Who Did Not Receive Treatment
8. Adults With AMI Reporting Unmet Need
9. Adults With AMI Who Are Uninsured
10. Adults With Cognitive Disability Who Could Not See a Doctor Due to Costs
11. Youth With MDE Who Did Not Receive Mental Health Services
12. Youth With Severe MDE Who Received Some Consistent Treatment
13. Children With Private Insurance That Did Not Cover Mental or Emotional Problems
14. Students Identified With Emotional Disturbance for an Individualized Education Program
15. Mental Health Workforce Availability

The chart is a visual representation of the sum of the scores for each state. It provides an opportunity to see the difference between ranked states. For example, Massachusetts (ranked one) has a score that is higher than Illinois (ranked 12). Virginia (ranked 20) has a score that is closest to the average.

State	Rank
Massachusetts	1
New Jersey	2
Pennsylvania	3
Connecticut	4
Vermont	5
New York	6
Wisconsin	7
Maine	8
Maryland	9
Minnesota	10
Rhode Island	11
Illinois	12
New Hampshire	13
Hawaii	14
Kentucky	15
District of Columbia	16
South Dakota	17
Michigan	18
Louisiana	19
Virginia	20
Montana	21
Delaware	22
Iowa	23
California	24
Ohio	25
Nebraska	26
Georgia	27
Florida	28
North Dakota	29
South Carolina	30
North Carolina	31
Washington	32
Oklahoma	33
Tennessee	34
New Mexico	35
Mississippi	36
Colorado	37
West Virginia	38
Arkansas	39
Missouri	40
Kansas	41
Indiana	42
Utah	43
Texas	44
Alabama	45
Oregon	46
Alaska	47
Wyoming	48
Arizona	49
Idaho	50
Nevada	51

Largest Changes in Overall Ranking



WISCONSIN ▲ (19 TO 7)
The indicators that had the largest effect on Wisconsin's Overall Ranking were a decrease in Adults with Serious Thoughts of Suicide, from 5.17% in 2017-2018 to 4.66% in 2018-2019, and a decrease in the percent of Adults with Cognitive Disability Who Could Not See a Doctor Due to Cost, from 28.20% in 2017-2018 to 22.28% in 2018-2019.

OHIO ▼ (11 TO 25)
The largest effect on the overall ranking for Ohio were an increase in Youth with MDE Who Did Not Receive Mental Health Services, from 52.2% in 2017-2018 to 63.3% in 2018-2019, and a decrease in the percent of Youth with Severe MDE who Received Some Consistent Treatment, from 36.0% in 2017-2018 to 25.1% in 2018-2019.

SOUTH CAROLINA ▲ (43 TO 30)
The indicator that had the largest effect on South Carolina's Overall Ranking was a decrease in Adults with AMI Reporting Unmet Need, from 26.6% in 2017-2018 to 19.7% in 2018-2019.

TEXAS ▼ (27 TO 44)
Largest effects on the overall ranking for Texas were an increase in the percent of Adults with Cognitive Disability Who Could Not See a Doctor Due to Cost, from 34.57% in 2017-2018 to 40.65% in 2018-2019 and Adults with AMI Reporting Unmet Need, from 19.9% in 2017-2018 to 24.0% in 2018-2019.

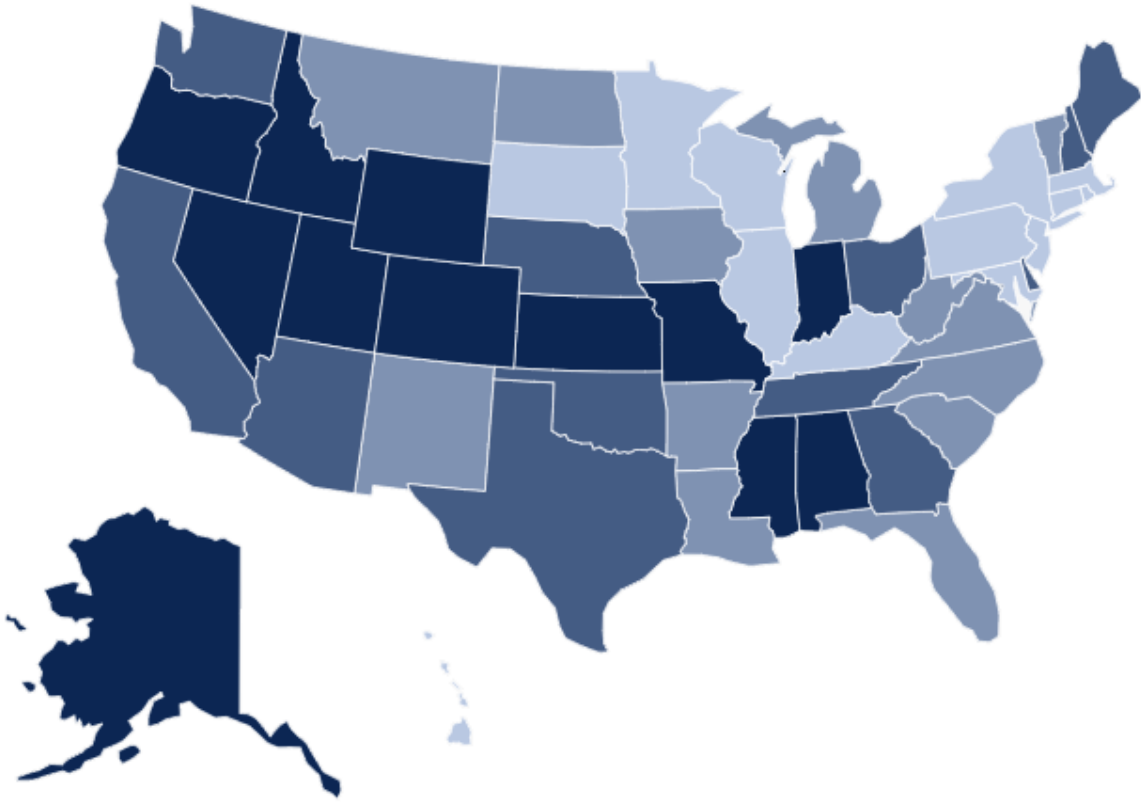
OKLAHOMA ▲ (45 TO 33)
The indicators that had the largest effect on Oklahoma's Overall Ranking were a decrease in Children with Private Insurance that Did Not Cover Mental or Emotional Problems, from 7.9% in 2017-2018 to 4.4% in 2018-2019, and an increase in Youth with Severe MDE who Received Some Consistent Treatment, from 23.5% in 2017-2018 to 33.6% in 2018-2019.

Adult Rankings

States that are ranked 1-13 have a lower prevalence of mental illness and higher rates of access to care for adults. States that are ranked 39-51 indicate that adults have a higher prevalence of mental illness and lower rates of access to care.

The seven measures that make up the Adult Ranking include:

1. Adults With Any Mental Illness (AMI)
2. Adults With Substance Use Disorder in the Past Year
3. Adults With Serious Thoughts of Suicide
4. Adults With AMI Who Did Not Receive Treatment
5. Adults With AMI Reporting Unmet Need
6. Adults With AMI Who Are Uninsured
7. Adults With Cognitive Disability Who Could Not See a Doctor Due to Costs



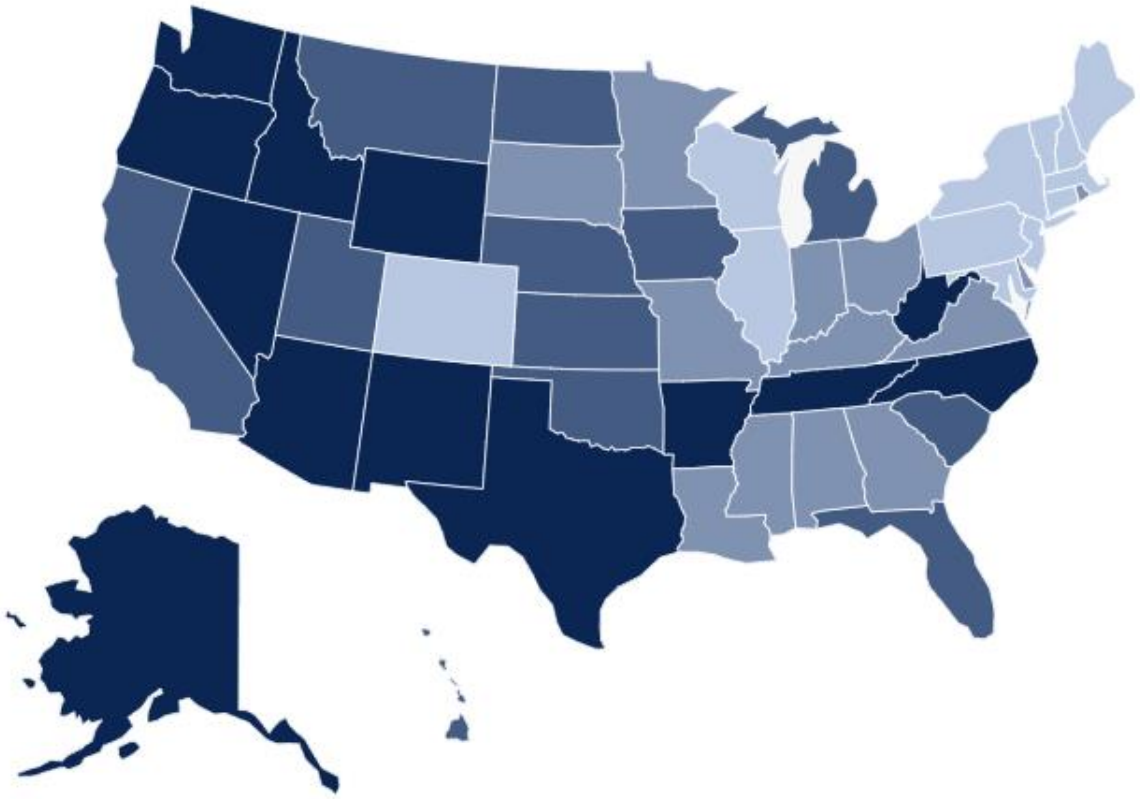
Rank	State
1	New Jersey
2	Wisconsin
3	Massachusetts
4	Connecticut
5	New York
6	Minnesota
7	Hawaii
8	Pennsylvania
9	Maryland
10	Illinois
11	Rhode Island
12	South Dakota
13	Kentucky
14	Iowa
15	New Mexico
16	Arkansas
17	Montana
18	Michigan
19	Vermont
20	Virginia
21	North Carolina
22	South Carolina
23	West Virginia
24	North Dakota
25	Florida
26	Louisiana
27	Nebraska
28	California
29	Tennessee
30	New Hampshire
31	Georgia
32	Washington
33	Texas
34	Delaware
35	Arizona
36	Ohio
37	Maine
38	Oklahoma
39	Idaho
40	Nevada
41	Mississippi
42	Kansas
43	Indiana
44	Missouri
45	District of Columbia
46	Alaska
47	Alabama
48	Utah
49	Oregon
50	Wyoming
51	Colorado

Youth Rankings

States with rankings 1-13 have a lower prevalence of mental illness and higher rates of access to care for youth. States with rankings 39-51 indicate that youth have a higher prevalence of mental illness and lower rates of access to care.

The seven measures that make up the Youth Ranking include:

1. Youth With At Least One Major Depressive Episode (MDE) in the Past Year
2. Youth With Substance Use Disorder in the Past Year
3. Youth With Severe MDE
4. Youth With MDE Who Did Not Receive Mental Health Services
5. Youth With Severe MDE Who Received Some Consistent Treatment
6. Children With Private Insurance That Did Not Cover Mental or Emotional Problems
7. Students Identified With Emotional Disturbance for an Individualized Education Program



Rank	State
1	Pennsylvania
2	Maine
3	District of Columbia
4	Vermont
5	Massachusetts
6	New Hampshire
7	New Jersey
8	Connecticut
9	New York
10	Maryland
11	Wisconsin
12	Illinois
13	Colorado
14	Minnesota
15	Rhode Island
16	Mississippi
17	Georgia
18	Delaware
19	Ohio
20	Alabama
21	Virginia
22	Missouri
23	South Dakota
24	Kentucky
25	Louisiana
26	Indiana
27	Michigan
28	Oklahoma
29	Hawaii
30	Florida
31	Iowa
32	Utah
33	Kansas
34	North Dakota
35	South Carolina
36	California
37	Nebraska
38	Montana
39	Washington
40	Tennessee
41	Texas
42	North Carolina
43	Wyoming
44	West Virginia
45	Oregon
46	Alaska
47	New Mexico
48	Arkansas
49	Arizona
50	Idaho
51	Nevada

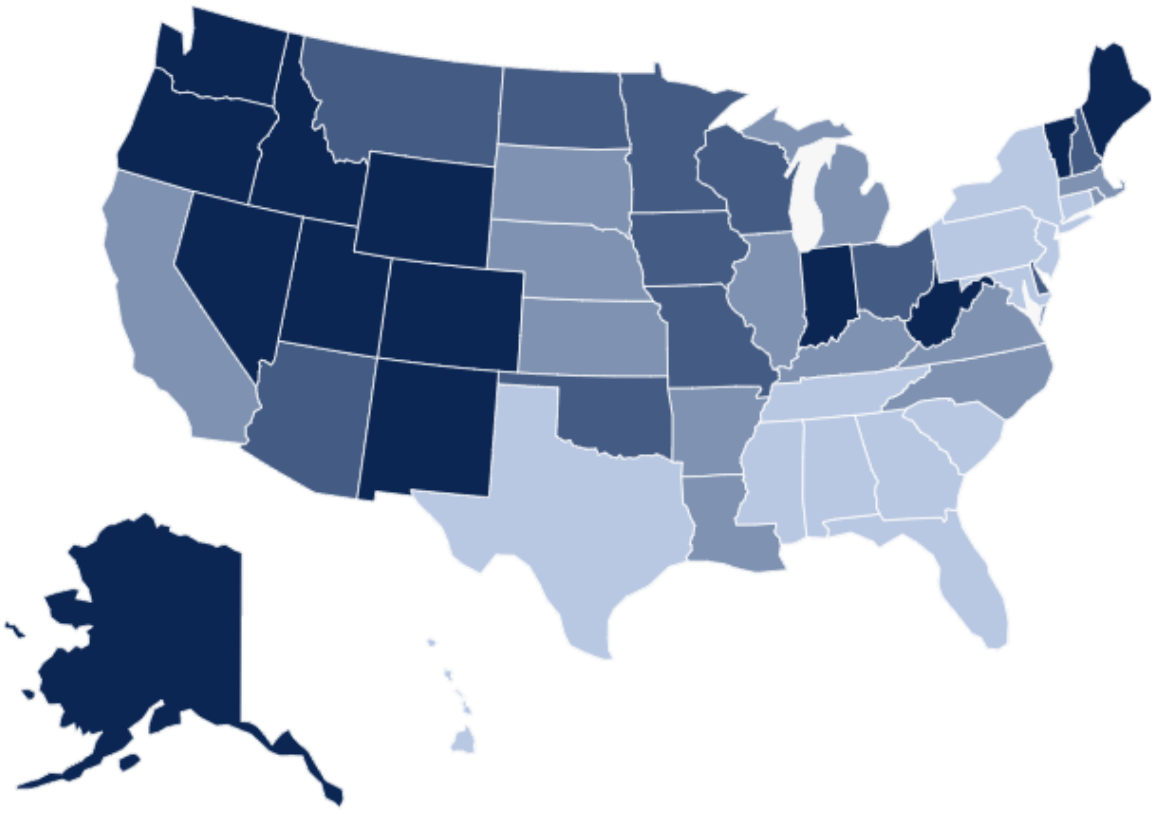
Prevalence of Mental Illness

The scores for the six prevalence measures make up the Prevalence Ranking.

The six measures that make up the Prevalence Ranking include:

1. Adults With Any Mental Illness (AMI)
2. Adult With Substance Use Disorder in the Past Year
3. Adults With Serious Thoughts of Suicide
4. Youth With At Least One Major Depressive Episode (MDE) in the Past Year
5. Youth With Substance Use Disorder in the Past Year
6. Youth With Severe MDE

A ranking of 1-13 for Prevalence indicates a lower prevalence of mental health and substance use issues compared to states that ranked 39-51.



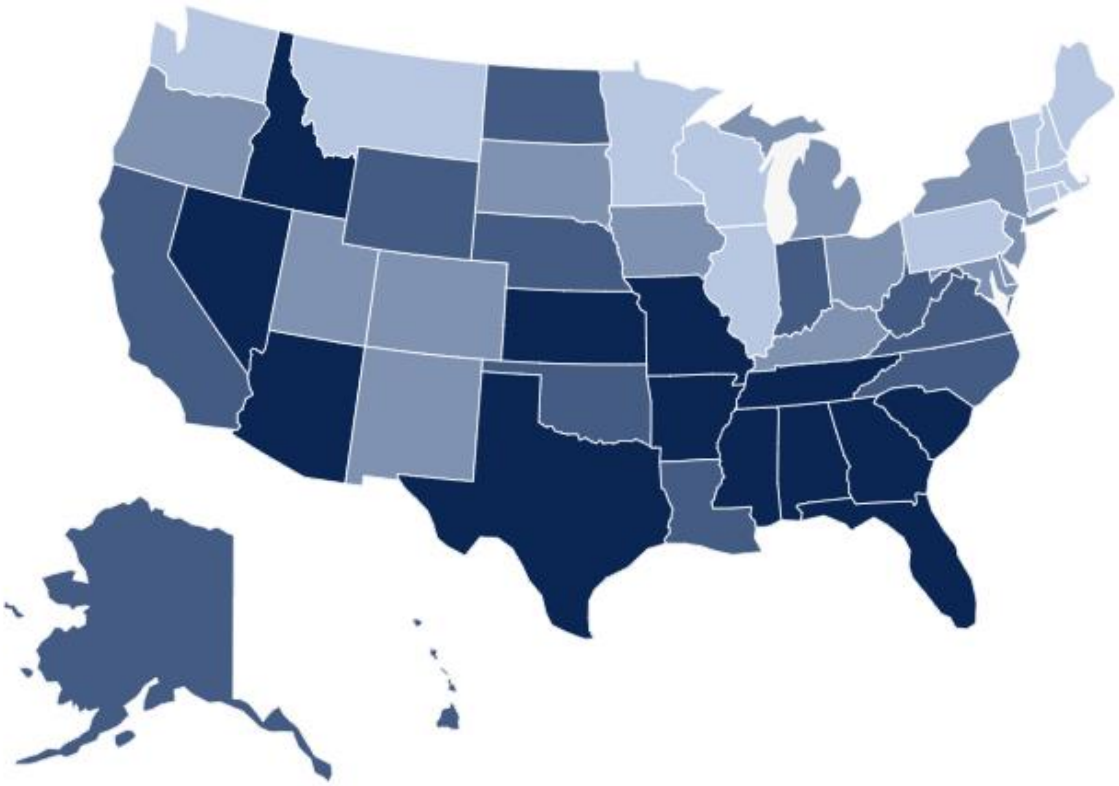
Rank	State
1	New Jersey
2	Florida
3	Georgia
4	Texas
5	New York
6	Pennsylvania
7	Mississippi
8	Hawaii
9	Connecticut
10	South Carolina
11	Maryland
12	Alabama
13	Tennessee
14	Louisiana
15	Virginia
16	Illinois
17	North Carolina
18	South Dakota
19	Kentucky
20	California
21	Michigan
22	Nebraska
23	Rhode Island
24	Kansas
25	Arkansas
26	Massachusetts
27	Minnesota
28	Missouri
29	Wisconsin
30	District of Columbia
31	New Hampshire
32	Arizona
33	North Dakota
34	Ohio
35	Delaware
36	Iowa
37	Oklahoma
38	Montana
39	West Virginia
40	Maine
41	Idaho
42	Indiana
43	New Mexico
44	Washington
45	Colorado
46	Nevada
47	Utah
48	Wyoming
49	Alaska
50	Vermont
51	Oregon

Access to Care Rankings

The Access Ranking indicates how much access to mental health care exists within a state. The access measures include access to insurance, access to treatment, quality and cost of insurance, access to special education, and mental health workforce availability. A high Access Ranking (1-13) indicates that a state provides relatively more access to insurance and mental health treatment.

The nine measures that make up the Access Ranking include:

1. Adults With AMI Who Did Not Receive Treatment
2. Adults With AMI Reporting Unmet Need
3. Adults With AMI Who Are Uninsured
4. Adults With Cognitive Disability Who Could Not See a Doctor Due to Costs
5. Youth With MDE Who Did Not Receive Mental Health Services
6. Youth With Severe MDE who Received Some Consistent Treatment
7. Children with Private Insurance that Did Not Cover Mental or Emotional Problems
8. Students Identified with Emotional Disturbance for an Individualized Education Program
9. Mental Health Workforce Availability



Rank	State
1	Vermont
2	Massachusetts
3	Maine
4	Wisconsin
5	Minnesota
6	New Hampshire
7	Rhode Island
8	Pennsylvania
9	Connecticut
10	District of Columbia
11	Washington
12	Montana
13	Illinois
14	Maryland
15	New York
16	Kentucky
17	Delaware
18	Iowa
19	Oregon
20	New Mexico
21	Colorado
22	Ohio
23	South Dakota
24	New Jersey
25	Michigan
26	Utah
27	North Dakota
28	Oklahoma
29	West Virginia
30	California
31	Hawaii
32	Indiana
33	Nebraska
34	Alaska
35	Louisiana
36	Wyoming
37	Virginia
38	North Carolina
39	Nevada
40	Arkansas
41	Missouri
42	Idaho
43	South Carolina
44	Kansas
45	Tennessee
46	Arizona
47	Mississippi
48	Georgia
49	Florida
50	Alabama
51	Texas

Largest Changes in Adult Rankings: State of Mental Health in America 2021-2022

Largest Improvements in Ranking:

Wisconsin (24 to 2): In Wisconsin, the percentage of Adults With Serious Thoughts of Suicide decreased from 5.17% in 2017-2018 to 4.66% in 2018-2019.

Montana (34 to 17): Montana's percentage of Adults With Serious Thoughts of Suicide decreased from 5.21% in 2017-2018 to 4.63% in 2018-2019, and the percentage of Adults With AMI Reporting Unmet Need decreased from 24.6% in 2017-2018 to 21.5% in 2018-2019.

Rhode Island (26 to 11): In Rhode Island, the percentage of Adults With Cognitive Disability Who Could Not See a Doctor Due to Cost decreased from 25.71% in 2017-2018 to 18.48% in 2018-2019, and the percentage of Adults With AMI Reporting Unmet Need decreased from 27.9% in 2017-2018 to 25.4% in 2018-2019.

Largest Declines in Ranking:

Ohio (14 to 36): In Ohio, the percentage of Adults With Serious Thoughts of Suicide increased from 5.18% in 2017-2018 to 6.09% in 2018-2019.

Delaware (13 to 34): Delaware's rate of Adults With AMI Who Did Not Receive Treatment increased from 49.7% in 2017-2018 to 54.2% in 2018-2019 and the rate of Adults With AMI Reporting Unmet Need increased from 23.0% in 2017-2018 to 28.1% in 2018-2019.

Arizona (17 to 35): In Arizona, the percentage of Adults With AMI Who Did Not Receive Treatment increased from 52.7% in 2017-2018 to 57.0% in 2018-2019.

Texas (15 to 33): Texas' percentage of Adults With Cognitive Disability Who Could Not See a Doctor Due to Cost increased from 34.57% in 2017-2018 to 40.65% in 2018-2019, a reversal from the improvement in last year's report.

Largest Changes in Youth Rankings: State of Mental Health in America 2021-2022

Largest Improvements in Ranking:

Colorado (42 to 13): Colorado's percentage of Youth With Past Year MDE Who Did Not Receive Treatment decreased from 60.4% in 2017-2018 to 39.3% in 2018-2019.

Illinois (36 to 12): In Illinois, the percentage of Youth With Severe MDE Who Received Some Consistent Treatment increased from 25.0% in 2017-2018 to 38.3% in 2018-2019.

Oklahoma (46 to 28): Oklahoma had an increase in insurance coverage and access to care for youth. The percentage of Children With Private Insurance That Did Not Cover Mental or Emotional Problems decreased in Oklahoma from 7.9% in 2017-2018 to 4.4% in 2018-2019, and the percentage of Youth With Severe MDE Who Received Some Consistent Treatment increased from 23.5% in 2017-2018 to 33.6% in 2018-2019.

Largest Declines in Ranking:

Nebraska (21 to 37): In Nebraska, the percentage of Youth With Severe MDE increased from 9.0% in 2017-2018 to 12.4% in 2018-2019 and the percentage of Youth With Severe MDE Who Received Some Consistent Treatment decreased from 35.9% in 2017-2018 to 27.8% in 2018-2019.

Texas (30 to 41): Texas' percentage of Children With Private Insurance That Did Not Cover Mental or Emotional Problems increased from 11.5% in 2017-2018 to 13.8% in 2018-2019.

Delaware (8 to 18): In Delaware, the percentage of Youth With Severe MDE increased from 9.3% in 2017-2018 to 12.8% in 2018-2019.

South Dakota (13 to 23): South Dakota's percentage of Youth With Severe MDE increased from 8.0% in 2017-2018 to 12.0% in 2018-2019 and the percentage of Youth With Past Year MDE Who Did Not Receive Treatment increased from 49.7% in 2017-2018 to 59.6% in 2018-2019.

Largest Changes in Need/Prevalence Rankings: State of Mental Health in America 2021-2022

Largest Improvements in Ranking:

Connecticut (20 to 9): Connecticut's percentage of Youth With Severe MDE decreased from 9.0% in 2017-2018 to 7.8% in 2018-2019.

Wisconsin (39 to 29): In Wisconsin, the percentage of Adults With Serious Thoughts of Suicide decreased from 5.17% in 2017-2018 to 4.66% in 2018-2019.

Idaho (49 to 41): In Idaho, the percentage of Adults With Any Mental Illness decreased from 24.46% in 2017-2018 to 22.48% in 2018-2019, and the percentage of Adults With Serious Thoughts of Suicide decreased from 5.45% in 2017-2018 to 5.30% in 2018-2019.

Largest Declines in Ranking:

Wyoming (35 to 48): In Wyoming, the percentage of Adults With Serious Thoughts of Suicide increased from 5.04% in 2017-2018 to 5.74% in 2018-2019 and the percentage of Youth With Past Year MDE increased from 14.91% in 2017-2018 to 17.59% in 2018-2019.

Minnesota (16 to 27): Minnesota's percentage of Youth With Substance Use Disorder in the Past Year increased from 3.86% in 2017-2018 to 4.62% in 2018-2019.

Delaware (25 to 35): In Delaware, the percentage of Youth With Severe MDE increased from 9.3% in 2017-2018 to 12.8% in 2018-2019.

Nebraska (13 to 22): In Nebraska, the percentage of Youth With Severe MDE increased from 9.0% in 2017-2018 to 12.4% in 2018-2019.

Largest Changes in Access to Care Rankings: State of Mental Health in America 2021-2022

Largest Improvements in Ranking:

Illinois (28 to 13): Illinois' largest improvements in Access to Care were for youth. In Illinois, the percentage of Youth With Severe MDE Who Received Some Consistent Treatment increased from 25.0% in 2017-2018 to 38.3% in 2018-2019 and the percentage of Youth With MDE Who Did Not Receive Mental Health Services decreased from 62.1% in 2017-2018 to 55.2% in 2018-2019.

Colorado (31 to 21): In Colorado, the largest effects on the Access to Care Ranking were also for youth. The percentage of Youth With Past Year MDE Who Did Not Receive Treatment decreased from 60.4% in 2017-2018 to 39.3% in 2018-2019 and the percentage of Youth With Severe MDE Who Received Some Consistent Treatment increased from 21.5% in 2017-2018 to 43.1% in 2018-2019.

Nevada (46 to 39): In Nevada, the percentage of Children With Private Insurance That Did Not Cover Mental or Emotional Problems decreased from 12.6% in 2017-2018 to 7.1% in 2018-2019.

Largest Declines in Ranking:

Hawaii (14 to 31): In Hawaii, the percentage of Youth With MDE Who Did Not Receive Mental Health Services increased from 56.2% in 2017-2018 to 71.0% in 2018-2019 and the percentage of Youth With Severe MDE Who Received Some Consistent Treatment decreased from 28.3% in 2017-2018 to 13.3% in 2018-2019.

Ohio (9 to 22): Ohio's percentage of Youth With MDE Who Did Not Receive Mental Health Services increased from 52.2% in 2017-2018 to 63.3% in 2018-2019.

Delaware (5 to 17): In Delaware, the percentage of Adults With AMI Who Did Not Receive Treatment increased from 49.7% in 2017-2018 to 54.2% in 2018-2019.

Changes in Overall Ranking: State of Mental Health in America 2021-2022

State	Overall Ranking (2021)*	Overall Ranking (2022)*
Alabama	36	45
Alaska	49	47
Arizona	40	49
Arkansas	42	39
California	25	24
Colorado	47	37
Connecticut	13	4
Delaware	10	22
District of Columbia	9	16
Florida	35	28
Georgia	37	27
Hawaii	8	14
Idaho	50	50
Illinois	22	12
Indiana	33	42
Iowa	23	23
Kansas	29	41
Kentucky	17	15
Louisiana	21	19
Maine	14	8
Maryland	4	9
Massachusetts	3	1
Michigan	15	18
Minnesota	7	10
Mississippi	32	36
Missouri	38	40

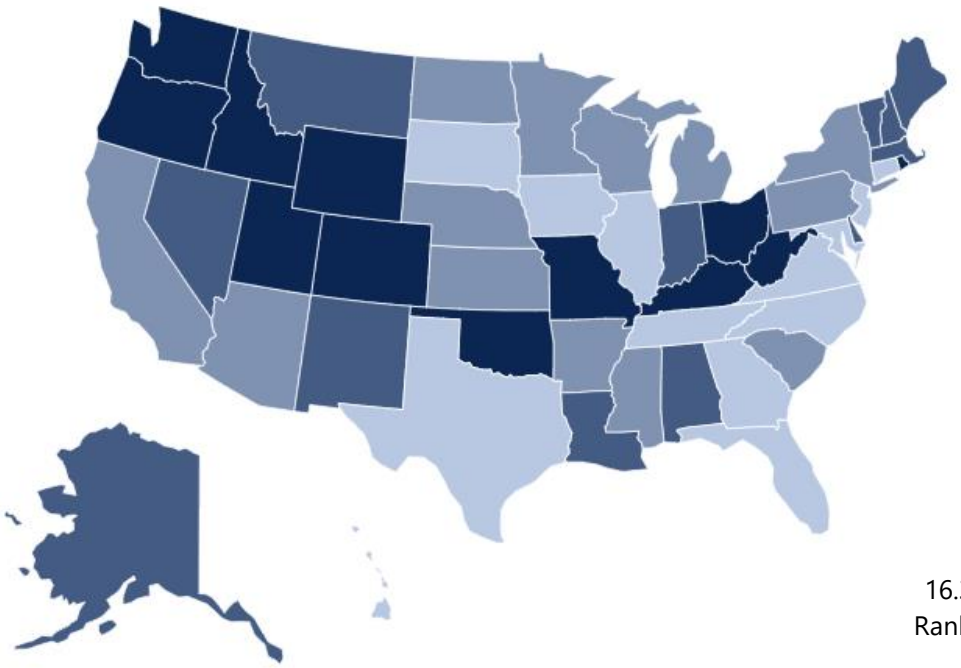
State	Overall Ranking (2021)*	Overall Ranking (2022)*
Montana	30	21
Nebraska	20	26
Nevada	51	51
New Hampshire	18	13
New Jersey	5	2
New Mexico	34	35
New York	6	6
North Carolina	41	31
North Dakota	24	29
Ohio	11	25
Oklahoma	45	33
Oregon	48	46
Pennsylvania	2	3
Rhode Island	12	11
South Carolina	43	30
South Dakota	16	17
Tennessee	28	34
Texas	27	44
Utah	46	43
Vermont	1	5
Virginia	26	20
Washington	31	32
West Virginia	39	38
Wisconsin	19	7
Wyoming	44	48

Ranking Worsened **Ranking Remained the Same** **Ranking Improved**

*2021 Overall Ranking is taken from The State of Mental Health in America 2021 Report, based on data from 2017-2018. 2022 Overall Ranking is taken from this report, based on data from 2018-2019.

Adult Prevalence of Mental Illness

Adults With Any Mental Illness (AMI)



19.86% of adults are experiencing a mental illness.

Equivalent to nearly 50 million Americans.

4.91% are experiencing a *severe* mental illness.

The states with the largest increases in Adults With Any Mental Illness (AMI) were Ohio (2.24%), Nebraska (2.22%), Wyoming (2.22%), and Oklahoma (2.11%).

The state prevalence of adult mental illness ranges from:

16.37% (NJ)
Ranked 1-13

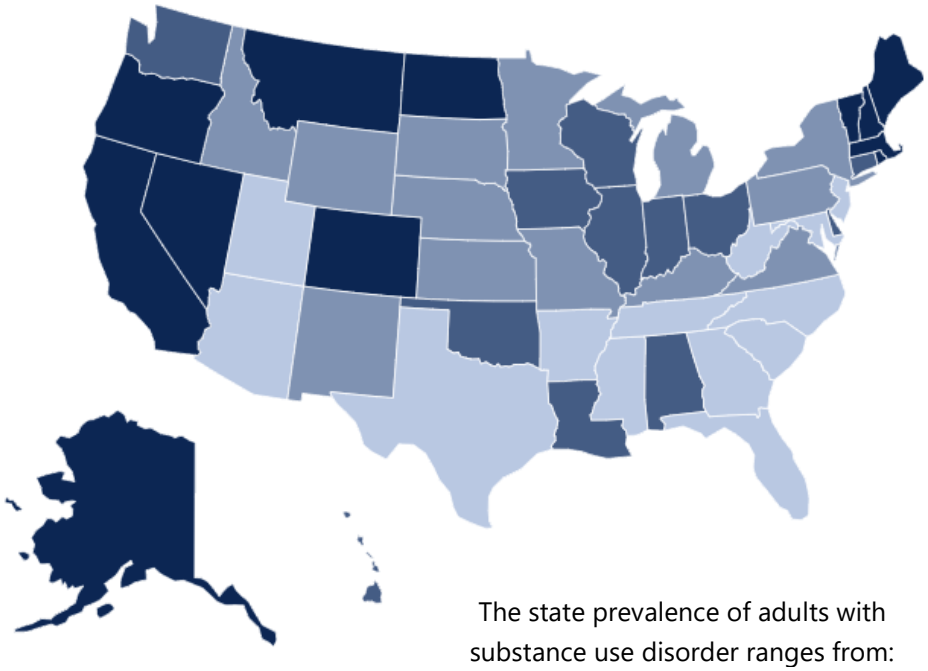
26.86 % (UT)
Ranked 39-51

Rank	State	%	#
1	New Jersey	16.37	1,122,000
2	Texas	17.17	3,602,000
3	Florida	17.23	2,903,000
4	Hawaii	17.45	185,000
5	Maryland	17.57	810,000
6	Georgia	17.88	1,406,000
7	South Dakota	18.26	118,000
8	Iowa	18.50	441,000
9	Virginia	18.58	1,199,000
10	Connecticut	18.85	526,000
11	Illinois	19.18	1,858,000
12	North Carolina	19.31	1,532,000
13	Tennessee	19.40	1,006,000
14	South Carolina	19.43	760,000
15	California	19.49	5,864,000
16	New York	19.52	2,972,000
17	Pennsylvania	19.70	1,963,000
18	Arizona	20.06	1,099,000
19	Mississippi	20.16	446,000
20	Wisconsin	20.19	904,000
21	Nebraska	20.30	290,000
22	Michigan	20.32	1,571,000
23	Arkansas	20.34	460,000
24	North Dakota	20.50	116,000
25	Minnesota	20.53	876,000
26	Kansas	20.56	442,000

Rank	State	%	#
27	Montana	20.81	171,000
28	Delaware	20.92	157,000
29	Massachusetts	21.15	1,157,000
30	Louisiana	21.21	734,000
31	Alabama	21.29	794,000
32	New Mexico	21.39	338,000
33	Alaska	21.47	113,000
34	Nevada	21.97	512,000
35	Maine	22.10	238,000
36	Vermont	22.25	112,000
37	Indiana	22.29	1,125,000
38	New Hampshire	22.37	243,000
39	Rhode Island	22.38	187,000
40	Idaho	22.48	293,000
41	Oklahoma	22.54	657,000
42	Kentucky	22.54	762,000
43	Wyoming	22.56	98,000
44	Missouri	22.71	1,056,000
45	District of Columbia	22.83	129,000
46	Colorado	23.20	1,014,000
47	Washington	23.43	1,360,000
48	Ohio	23.64	2,112,000
49	Oregon	23.75	783,000
50	West Virginia	24.62	347,000
51	Utah	26.86	599,000
	National	19.86	49,564,000

According to SAMHSA, "Any Mental Illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, assessed by the Mental Health Surveillance Study (MHSS) Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders (MHSS-SCID), which is based on the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)."

Adults With Substance Use Disorder in the Past Year



The state prevalence of adults with substance use disorder ranges from:

5.98% (FL) Ranked 1-13

12.30% (D.C.) Ranked 39-51

7.74% of adults in America reported having a substance use disorder in the past year.

2.97% of adults in America had an illicit drug use disorder in the past year.

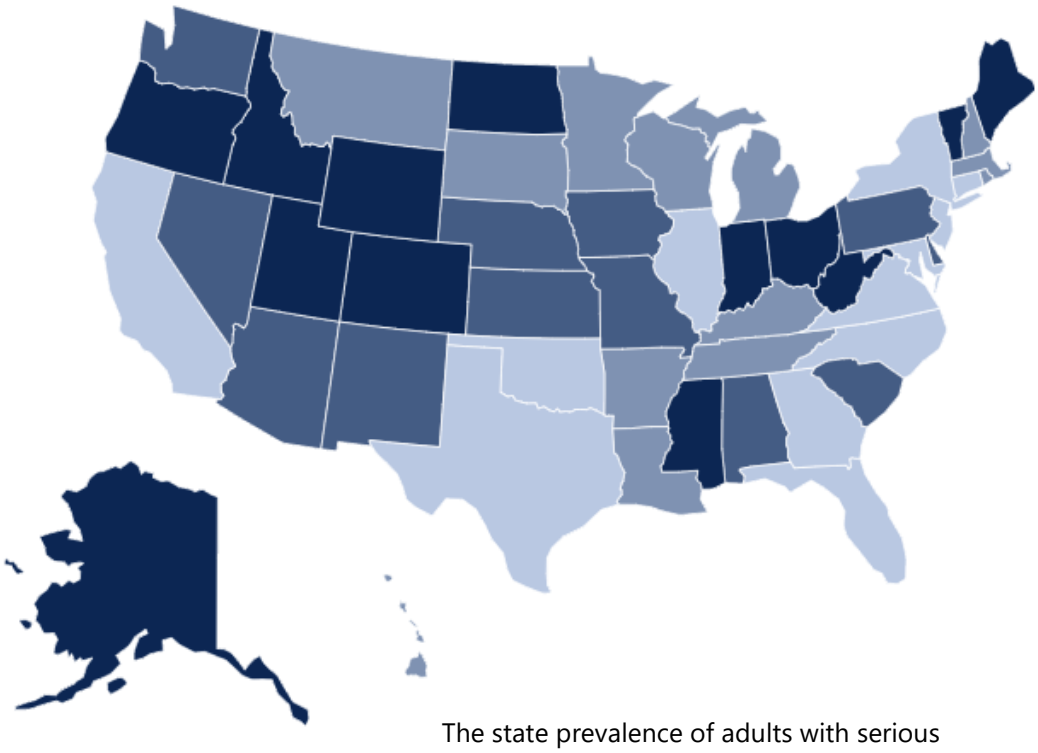
5.71% of adults in America had an alcohol use disorder in the past year.

The largest increases in the prevalence of adults with substance use disorder were in Hawaii (1.32%) and California (1.11%). The largest decreases were in South Dakota (1.48%) and Iowa (1.08%).

Rank	State	%	#
1	Florida	5.98	1,007,000
2	West Virginia	6.29	89,000
3	Texas	6.48	1,360,000
4	Utah	6.56	146,000
5	Georgia	6.60	519,000
6	New Jersey	6.71	459,000
7	South Carolina	6.73	263,000
8	Maryland	7.01	323,000
9	Arizona	7.11	390,000
10	Mississippi	7.15	158,000
11	Arkansas	7.16	162,000
12	Tennessee	7.22	375,000
13	North Carolina	7.26	576,000
14	Kansas	7.29	157,000
15	Pennsylvania	7.31	728,000
16	Virginia	7.33	473,000
17	New York	7.43	1,131,000
18	Michigan	7.56	585,000
19	Minnesota	7.62	325,000
20	Idaho	7.67	100,000
21	South Dakota	7.69	50,000
22	New Mexico	7.70	122,000
23	Missouri	7.71	358,000
24	Nebraska	7.71	110,000
25	Wyoming	7.84	34,000
26	Kentucky	7.87	266,000

Rank	State	%	#
27	Alabama	7.89	294,000
28	Ohio	7.94	709,000
29	Wisconsin	7.98	358,000
30	Oklahoma	8.01	234,000
31	Illinois	8.02	777,000
32	Iowa	8.05	192,000
33	Louisiana	8.06	279,000
34	Indiana	8.42	425,000
35	Connecticut	8.43	235,000
36	Hawaii	8.45	90,000
37	Washington	8.62	500,000
38	Delaware	8.79	66,000
39	Massachusetts	8.83	483,000
40	New Hampshire	8.84	96,000
41	North Dakota	8.88	50,000
42	Maine	8.89	96,000
43	Rhode Island	8.95	75,000
44	California	9.23	2,778,000
45	Nevada	9.32	217,000
46	Oregon	9.78	322,000
47	Montana	10.04	83,000
48	Vermont	10.10	51,000
49	Alaska	10.23	54,000
50	Colorado	11.75	514,000
51	District of Columbia	12.30	70,000
	National	7.74	19,314,000

Adults With Serious Thoughts of Suicide



The state prevalence of adults with serious thoughts of suicide ranges from:

3.79% (NJ) Ranked 1-13

6.19% (UT) Ranked 39-51

The percentage of adults reporting serious thoughts of suicide is 4.58%. The estimated number of adults with serious suicidal thoughts is over 11.4 million—**an increase of 664,000 people from last year's data set.**

The national rate of adults experiencing suicidal ideation has increased every year since 2011-2012.

States with the highest increases in suicidal ideation were Ohio (0.92%), Wyoming (0.70%), and Pennsylvania (0.66%).

Utah has had the highest rate of suicidal ideation among adults every year since 2012-2013.

Rank	State	%	#
1	New Jersey	3.79	260,000
2	Georgia	3.85	303,000
3	Texas	3.86	812,000
4	North Carolina	3.87	307,000
5	Illinois	4.00	388,000
6	Florida	4.04	682,000
7	New York	4.21	642,000
8	Virginia	4.22	272,000
9	Maryland	4.34	200,000
10	District of Columbia	4.43	25,000
11	Connecticut	4.46	125,000
12	California	4.55	1,370,000
13	Oklahoma	4.58	134,000
14	Rhode Island	4.59	38,000
15	Michigan	4.61	357,000
16	South Dakota	4.62	30,000
17	Montana	4.63	38,000
18	Wisconsin	4.66	209,000
19	Tennessee	4.68	243,000
20	Kentucky	4.68	158,000
21	New Hampshire	4.68	51,000
22	Arkansas	4.71	107,000
23	Louisiana	4.72	163,000
24	Minnesota	4.74	202,000
25	Hawaii	4.74	50,000
26	Massachusetts	4.77	261,000

Rank	State	%	#
27	New Mexico	4.81	76,000
28	Pennsylvania	4.83	482,000
29	Alabama	4.83	180,000
30	Nebraska	4.88	70,000
31	South Carolina	4.89	191,000
32	Washington	4.92	286,000
33	Iowa	4.94	118,000
34	Nevada	4.94	115,000
35	Kansas	4.96	107,000
36	Arizona	5.01	275,000
37	Missouri	5.05	235,000
38	Delaware	5.18	39,000
39	North Dakota	5.28	30,000
40	Idaho	5.30	69,000
41	Mississippi	5.31	118,000
42	West Virginia	5.44	77,000
43	Maine	5.44	59,000
44	Colorado	5.54	242,000
45	Indiana	5.62	284,000
46	Oregon	5.65	187,000
47	Vermont	5.66	29,000
48	Wyoming	5.74	25,000
49	Ohio	6.09	545,000
50	Alaska	6.11	32,000
51	Utah	6.19	138,000
	National	4.58	11,434,000

Spotlight: Suicidal Ideation and 988 Implementation

In July 2020, the Federal Communications Commission (FCC) designated 988 as the new three-digit number for the National Suicide Prevention Lifeline. This three-digit phone number was created to increase access to immediate crisis supports and provide a nationwide, easy-to-remember alternative to calling 911 for mental health crises. Traditionally, when an in-person crisis response was necessary, law enforcement was dispatched to provide support. Mental health crisis calls may result in potentially dangerous and traumatizing outcomes when police are called, especially in historically marginalized communities. According to a 2015 study, people with untreated mental illness are 16 times more likely to be killed in a police encounter than other civilians.[1] Implementing 988 ensures that mental health crises can be met with a mental health response while resulting in substantial cost-savings and allowing for law enforcement resources to be saved for non-mental health-related emergencies.

By July of 2022, all telecommunications companies will have to make the necessary changes so calls to 988 will be directed to the current National Suicide Prevention Lifeline call centers. However, full implementation of 988 requires each state to submit its own legislation to fund and implement 988 infrastructure. The current National Suicide Prevention Lifeline serves about 4 million callers each year. According to Vibrant Emotional Health, the administrator of the Lifeline, even in a low scenario with a minimal growth rate, it is estimated that 988 will be serving 13 million callers by the fifth year following implementation.[2] Additional resources for 988 are necessary to scale supports to meet that projected call volume with a reliable and timely response, as well as to develop a better system of crisis care. A comprehensive 988 crisis system necessitates: training call staff to provide empowering, linguistically, and culturally appropriate supports to callers, ensuring the inclusion of appropriate care for subpopulations like LGBTQ+ individuals, making appropriate and accessible referrals, creating a system of mobile crisis teams that can be deployed to respond to individuals in crisis in place of law enforcement, and offering crisis stabilization programs that connect people to a continuum of care when it is needed most.

In October 2020, Congress passed the National Suicide Hotline Designation Act, which allows states to administer small user fees to pay for: the efficient and effective routing of calls, personnel, and the provision of acute mental health crisis outreach and stabilization services. Each state must pass individual legislation to generate the funding necessary for 988 to be implemented effectively such that every call from a person in crisis can be answered and callers can be connected to appropriate and available mental health care when needed.

The designation of 988 as the new suicide prevention and mental health crisis hotline created an opportunity for an equitable health care response to mental health crises with better outcomes as people receive the services and supports they need to remain in their communities and thrive.

However, of the 13 states (ranked 39-51) with the highest rates of suicidal ideation, only four have successfully passed state legislation for 988 implementation: Utah, Oregon, Indiana, and Colorado.

Of these, only one currently includes user fees.

[1] Fuller, DA, Lamb, HR, Biasotti, M & Snook J. (2015). Overlooked in the Undercounted: The Role of Mental Illness in Fata Law Enforcement Encounters. *Treatment Advocacy Center.* https://www.treatmentadvocacycenter.org/overlooked-in-the-undercounted

[2] Vibrant Emotional Health (2020). 988 Serviceable Populations and Contact Volume Projections. https://www.vibrant.org/wp-content/uploads/2020/12/Vibrant-988-Projections-Report.pdf?_ga=2.62739180.1718066263.1611784352-1951259024.1604696443

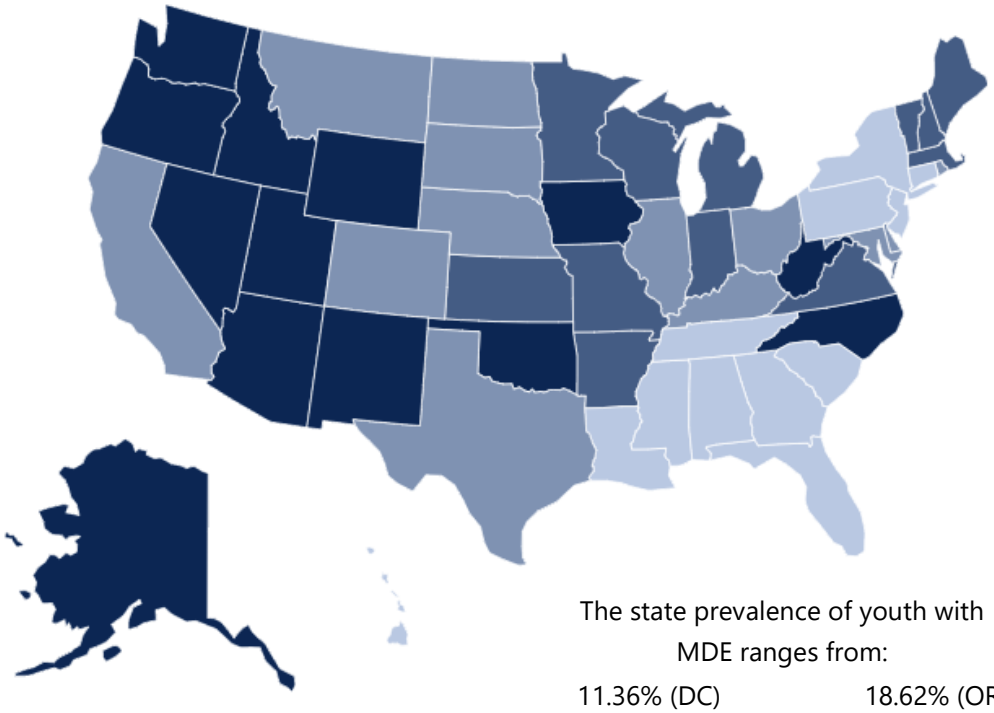
Policy Implications for 988 Implementation

While it is imperative to build out a system to respond to individuals in a mental health crisis, we should not wait until people reach crisis before providing them with mental health care. The following are a list of policy recommendations for consideration as part of any 988 implementation:

- The 988 system should be built as a continuum of crisis care that includes resources for the prevention of mental health conditions.
- Data should be collected on why people get into a crisis and continual planning and analysis should identify ways to avoid crises.
- Peer teams for unhoused people and others at high risk of crisis and police involvement must be added to conduct outreach and connect individuals to services before they experience mental health crises.
- Data collected through 988 can be used to identify individuals at high risk of mental health crisis and proactive peer supports and other community-based resources should be deployed to coordinate with 988 and prevent crises.
- Supportive housing, supportive education, Assertive Community Treatment (ACT) teams, and early psychosis programs may also be helpful in avoiding crises and can be employed in continuous care following interaction with the mental health crisis system.

Youth Prevalence of Mental Illness

Youth With At Least One Major Depressive Episode (MDE) in the Past Year



The state prevalence of youth with MDE ranges from:

11.36% (DC) Ranked 1-13

18.62% (OR) Ranked 39-51

15.08% of youth (age 12-17) report suffering from at least one major depressive episode (MDE) in the past year.

Childhood depression is more likely to persist into adulthood if gone untreated, but only half of children with pediatric major depression are diagnosed before adulthood.[1]

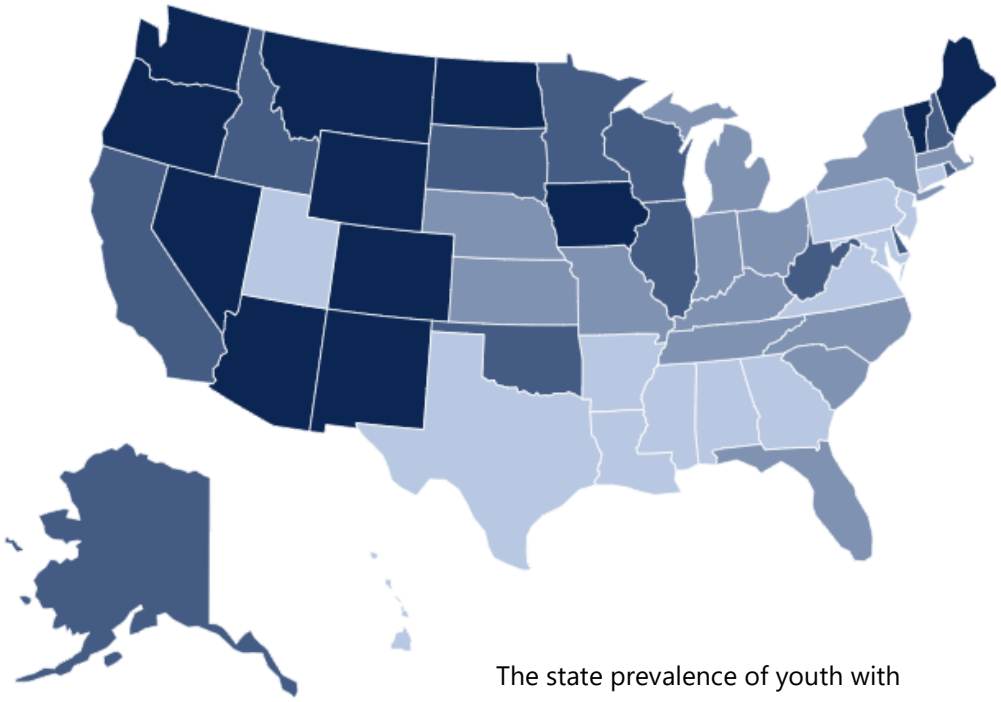
The number of youths experiencing MDE increased by 306,000 (1.24 percent) from last year's dataset.

Rank	State	%	#
1	District of Columbia	11.36	4,000
2	Mississippi	12.64	31,000
3	New Jersey	12.71	86,000
4	Pennsylvania	12.88	117,000
5	Florida	13.25	191,000
6	New York	13.29	179,000
7	Tennessee	13.72	70,000
8	Georgia	13.75	119,000
9	South Carolina	13.82	52,000
10	Louisiana	14.14	51,000
11	Hawaii	14.16	13,000
12	Connecticut	14.41	39,000
13	Alabama	14.51	54,000
14	Texas	14.60	363,000
15	Rhode Island	14.64	11,000
16	Ohio	14.73	131,000
17	Maryland	14.93	67,000
18	Colorado	15.02	65,000
19	North Dakota	15.07	8,000
20	Montana	15.11	12,000
21	Kentucky	15.15	51,000
22	Illinois	15.15	149,000
23	California	15.22	459,000
24	South Dakota	15.41	11,000
25	Delaware	15.48	11,000
26	Nebraska	15.50	24,000

Rank	State	%	#
27	Missouri	15.54	72,000
28	Virginia	15.57	98,000
29	Maine	15.60	14,000
30	Massachusetts	15.61	75,000
31	New Hampshire	15.85	15,000
32	Minnesota	15.94	70,000
33	Wisconsin	15.99	71,000
34	Arkansas	16.27	39,000
35	Vermont	16.36	7,000
36	Kansas	16.53	39,000
37	Michigan	16.55	125,000
38	Indiana	16.61	89,000
39	West Virginia	16.62	21,000
40	North Carolina	16.68	132,000
41	Iowa	16.69	41,000
42	Oklahoma	17.01	54,000
43	Arizona	17.41	98,000
44	Idaho	17.44	27,000
45	Wyoming	17.59	8,000
46	Utah	17.77	56,000
47	Nevada	17.93	42,000
48	Alaska	17.93	10,000
49	Washington	18.22	99,000
50	New Mexico	18.60	31,000
51	Oregon	18.62	55,000
	National	15.08	3,755,000

[1] Mullen, S. (2018). Major depressive disorder in children and adolescents. *The Mental Health Clinician,* 8(6):275-283. Doi: 10.9740/mhc.2018.11.275

Youth With Substance Use Disorder in the Past Year



4.08% of youth in the U.S. reported a substance use disorder in the past year.

1.64% had an alcohol use disorder in the past year, while 3.16% had an illicit drug use disorder.

The rate of youth with substance use disorder increased 0.26% from last year's dataset. The largest decreases were in Arkansas (0.48%), Florida (0.48%), and Alabama (0.44%).

The largest increases were in Oregon (1.12%) and Iowa (0.87%).

The state prevalence of youth with substance use disorder ranges from:

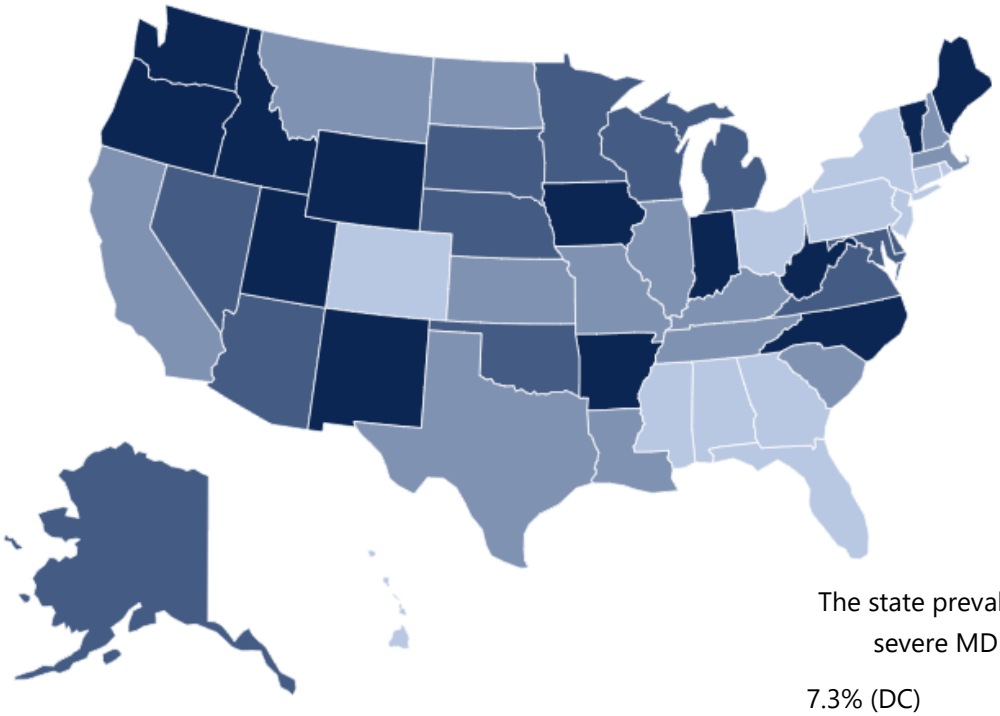
3.19% (AL)
Ranked 1-13

5.77% (OR)
Ranked 39-51

Rank	State	%	#
1	Alabama	3.19	12,000
2	Louisiana	3.29	12,000
3	Mississippi	3.32	8,000
4	New Jersey	3.33	22,000
5	Georgia	3.45	30,000
6	Texas	3.49	87,000
7	Pennsylvania	3.52	32,000
8	Arkansas	3.63	9,000
9	Maryland	3.70	17,000
10	Virginia	3.71	23,000
11	Connecticut	3.74	10,000
12	Hawaii	3.75	4,000
13	Utah	3.77	12,000
14	Florida	3.86	56,000
15	New York	3.87	52,000
16	North Carolina	3.91	31,000
17	Nebraska	3.94	6,000
18	South Carolina	3.95	15,000
19	Michigan	3.98	30,000
20	Tennessee	4.00	21,000
21	Kansas	4.02	10,000
22	Missouri	4.04	19,000
23	Kentucky	4.10	14,000
24	Massachusetts	4.10	20,000
25	Indiana	4.20	23,000
26	Ohio	4.23	38,000

Rank	State	%	#
27	Illinois	4.25	42,000
28	Delaware	4.31	3,000
29	Wisconsin	4.34	19,000
30	Oklahoma	4.36	14,000
31	West Virginia	4.44	6,000
32	Idaho	4.47	7,000
33	California	4.55	137,000
34	New Hampshire	4.57	4,000
35	Rhode Island	4.58	3,000
36	South Dakota	4.60	3,000
37	Minnesota	4.62	20,000
38	Alaska	4.63	3,000
39	Maine	4.67	4,000
40	Arizona	4.83	27,000
41	Washington	4.84	26,000
42	Iowa	5.07	12,000
43	North Dakota	5.08	3,000
44	Wyoming	5.22	2,000
45	New Mexico	5.43	9,000
46	Colorado	5.44	24,000
47	Vermont	5.50	2,000
48	District of Columbia	5.57	2,000
49	Nevada	5.59	13,000
50	Montana	5.68	4,000
51	Oregon	5.77	17,000
	National	4.08	1,017,000

Youth With Severe Major Depressive Episode



10.6% of youth (over 2.5 million youth) cope with severe major depression.

The number of youths experiencing severe MDE increased by 197,000 from last year's dataset.

Rates of a severe major depressive episode were highest among youth who identified as more than one race, **at 14.5%** (about 119,000 youth).

The state prevalence of youth with severe MDE ranges from:

7.3% (DC) Ranked 1-13 — 14.8% (WY) Ranked 39-51

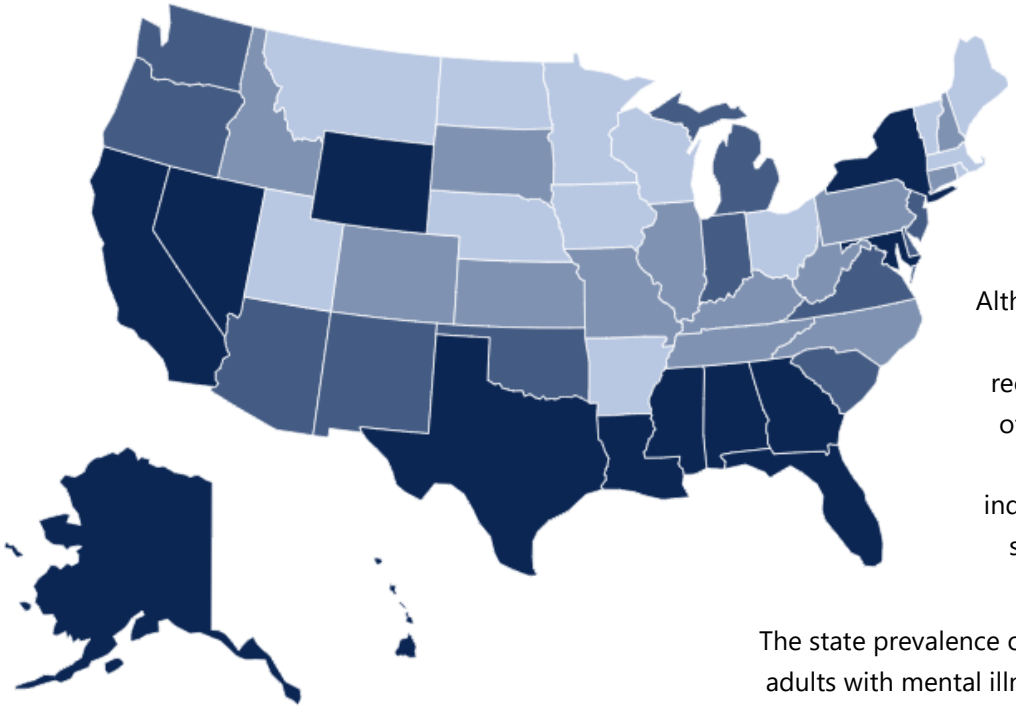
Rank	State	%	#
1	District of Columbia	7.3	2,000
2	Alabama	7.5	27,000
3	Connecticut	7.8	20,000
4	Mississippi	8.0	19,000
5	Pennsylvania	8.2	73,000
6	New York	8.3	109,000
7	Rhode Island	8.3	6,000
8	Hawaii	8.4	8,000
9	New Jersey	8.4	55,000
10	Colorado	9.0	38,000
11	Florida	9.0	124,000
12	Ohio	9.0	78,000
13	Georgia	9.1	76,000
14	South Carolina	9.1	33,000
15	Texas	9.7	234,000
16	California	9.8	284,000
17	Kentucky	9.9	32,000
18	Louisiana	10.2	36,000
19	New Hampshire	10.2	9,000
20	North Dakota	10.3	5,000
21	Tennessee	10.3	51,000
22	Missouri	10.4	47,000
23	Massachusetts	10.5	48,000
24	Illinois	11.0	104,000
25	Kansas	11.2	26,000
26	Montana	11.4	8,000

Rank	State	%	#
27	Minnesota	11.6	49,000
28	Arizona	11.9	64,000
29	Michigan	11.9	87,000
30	South Dakota	12.0	8,000
31	Alaska	12.1	7,000
32	Maryland	12.3	54,000
33	Nebraska	12.4	19,000
34	Wisconsin	12.7	55,000
35	Delaware	12.8	9,000
36	Oklahoma	12.8	39,000
37	Virginia	13.0	79,000
38	Nevada	13.2	29,000
39	West Virginia	13.3	16,000
40	Iowa	13.5	32,000
41	Washington	13.5	69,000
42	Maine	13.6	12,000
43	Vermont	13.7	5,000
44	New Mexico	13.8	22,000
45	Oregon	14.1	40,000
46	North Carolina	14.2	110,000
47	Arkansas	14.3	33,000
48	Indiana	14.5	76,000
49	Utah	14.5	45,000
50	Idaho	14.7	22,000
51	Wyoming	14.8	6,000
	National	10.6	2,540,000

According to SAMHSA, youth who experience a Major Depressive Episode (MDE) in the last year with severe role impairment (Youth With Severe MDE) reported the maximum level of interference over four role domains including: chores at home, school or work, family relationships, and social life.

Adult Access to Care

Adults With AMI Who Did Not Receive Treatment



Over half (56%) of adults with a mental illness receive no treatment.

Over 27 million individuals experiencing a mental illness are going untreated.

Although adults who did not have insurance coverage were significantly less likely to receive treatment than those who did, 54% of people covered by health insurance still did not receive mental health treatment, indicating that ensuring coverage is not the same as ensuring access to mental health care.

The state prevalence of untreated adults with mental illness ranges from:

42.6% (VT) Ranked 1-13

67.1% (HI) Ranked 39-51

Rank	State	%	#
1	Vermont	42.6	49,000
2	Iowa	44.2	181,000
3	Massachusetts	44.7	526,000
4	Wisconsin	44.8	400,000
5	Minnesota	46.1	401,000
6	Maine	47.7	117,000
7	Nebraska	48.8	134,000
8	Arkansas	49.6	228,000
9	Utah	49.7	307,000
10	North Dakota	50.1	56,000
11	Ohio	50.3	1,088,000
12	Rhode Island	51.0	99,000
13	Montana	51.1	89,000
14	Kansas	51.2	229,000
15	North Carolina	51.6	801,000
16	West Virginia	51.7	191,000
17	Pennsylvania	51.9	1,012,000
18	New Hampshire	52.3	131,000
19	South Dakota	52.3	56,000
20	Illinois	52.6	958,000
21	Missouri	53.3	575,000
22	Idaho	53.4	161,000
23	Kentucky	53.5	420,000
24	Tennessee	53.5	514,000
25	Colorado	53.6	558,000
26	Connecticut	54.0	276,000

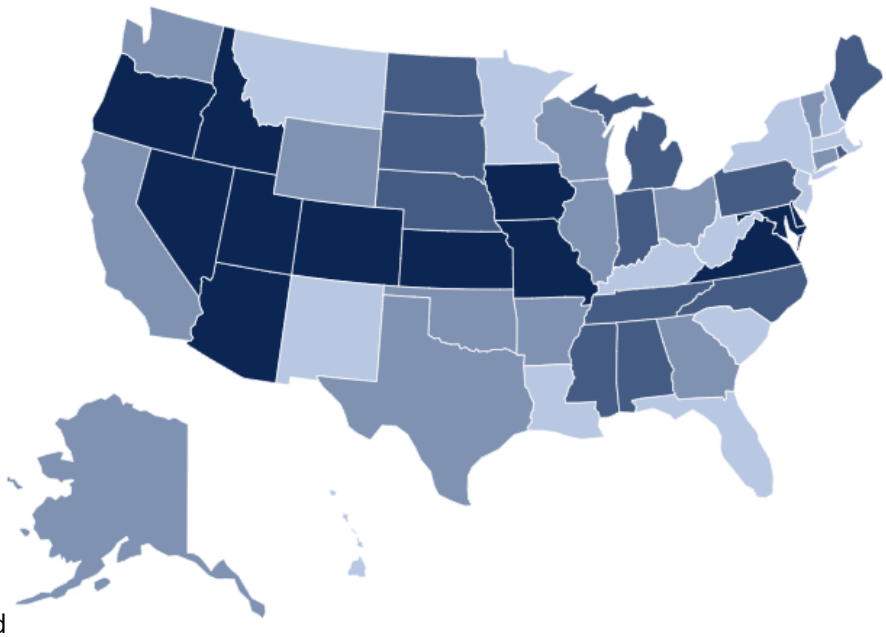
Rank	State	%	#
27	Delaware	54.2	86,000
28	New Mexico	54.2	185,000
29	Washington	54.3	778,000
30	Oregon	54.5	439,000
31	Virginia	54.7	645,000
32	District of Columbia	55.2	74,000
33	Michigan	55.4	866,000
34	South Carolina	56.1	427,000
35	Oklahoma	56.6	376,000
36	Indiana	56.7	643,000
37	Arizona	57.0	619,000
38	New Jersey	57.1	627,000
39	Alabama	57.3	454,000
40	Maryland	58.0	452,000
41	Nevada	58.0	305,000
42	New York	58.3	1,690,000
43	Alaska	58.7	66,000
44	Mississippi	59.3	265,000
45	Louisiana	59.6	453,000
46	Texas	60.7	2,148,000
47	Wyoming	61.7	64,000
48	California	61.8	3,617,000
49	Florida	63.5	1,823,000
50	Georgia	63.5	860,000
51	Hawaii	67.1	127,000
	National	55.9	27,646,000

Adults With AMI Reporting Unmet Need

Almost a quarter (24.7%) of all adults with a mental illness reported that they were not able to receive the treatment they needed. **This number has not declined since 2011.**

Individuals reporting unmet need are those seeking treatment and facing barriers to getting the help they need, including:

1) No insurance or limited coverage of services.
2) Shortfall in psychiatrists and an overall undersized mental health workforce.
3) Lack of available treatment types (inpatient treatment, individual therapy, intensive community services).
4) Disconnect between primary care systems and behavioral health systems.
5) Insufficient finances to cover costs – including copays, uncovered treatment types, or when providers do not take insurance.



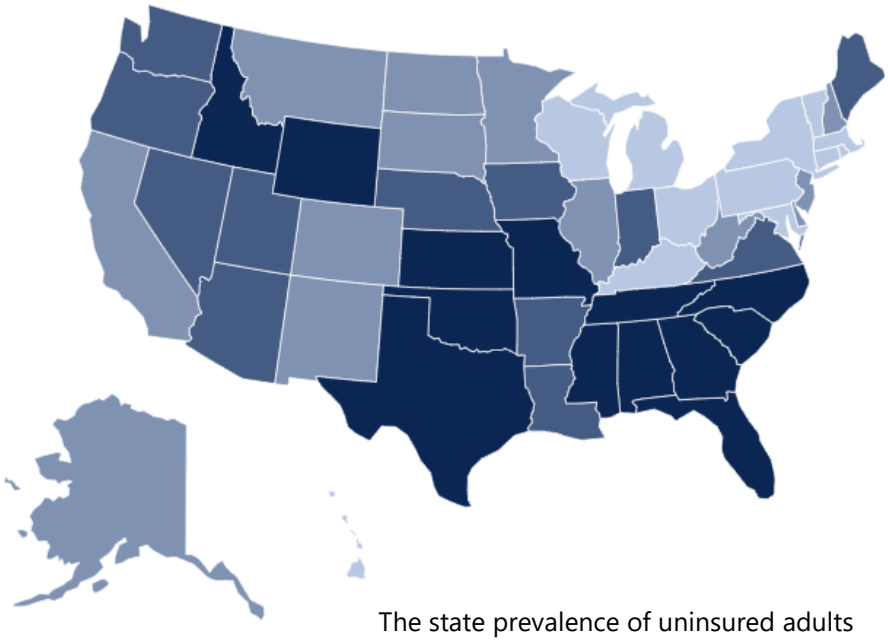
The state prevalence of adults with AMI reporting unmet treatment needs ranges from:

14.9% (HI) Ranked 1-13 — 37.1% (DC) Ranked 39-51

Rank	State	%	#
1	Hawaii	14.9	28,000
2	Louisiana	18.4	139,000
3	South Carolina	19.7	150,000
4	Montana	21.5	37,000
5	Minnesota	21.6	187,000
6	New Jersey	21.6	238,000
7	Massachusetts	21.7	255,000
8	New York	21.7	628,000
9	West Virginia	22.2	82,000
10	Florida	22.4	643,000
11	New Hampshire	22.4	56,000
12	New Mexico	22.7	78,000
13	Kentucky	22.9	181,000
14	Oklahoma	22.9	152,000
15	Wisconsin	22.9	204,000
16	Illinois	23.2	422,000
17	California	23.5	1,379,000
18	Connecticut	23.5	120,000
19	Texas	24.0	845,000
20	Washington	24.0	341,000
21	Georgia	24.1	326,000
22	Alaska	24.4	28,000
23	Wyoming	24.5	25,000
24	Arkansas	24.7	114,000
25	Ohio	24.8	540,000
26	Vermont	25.2	29,000

Rank	State	%	#
27	Mississippi	25.3	113,000
28	South Dakota	25.3	27,000
29	Rhode Island	25.4	50,000
30	North Dakota	25.6	29,000
31	Pennsylvania	25.7	499,000
32	Tennessee	25.7	249,000
33	Maine	25.9	63,000
34	Alabama	26.7	212,000
35	Indiana	26.8	306,000
36	Michigan	26.8	419,000
37	North Carolina	27.2	423,000
38	Nebraska	27.6	76,000
39	Virginia	27.7	326,000
40	Utah	27.9	172,000
41	Delaware	28.1	45,000
42	Arizona	28.4	306,000
43	Oregon	28.8	231,000
44	Idaho	29.1	88,000
45	Nevada	29.3	154,000
46	Missouri	30.1	325,000
47	Maryland	30.2	236,000
48	Colorado	31.8	331,000
49	Kansas	32.6	145,000
50	Iowa	32.9	134,000
51	District of Columbia	37.1	50,000
	National	24.7	12,236,000

Adults With AMI Who Are Uninsured



The state prevalence of uninsured adults with mental illness ranges from:

3.8% (MA) Ranked 1-13 — 21.5% (TX) Ranked 39-51

11.1% (over 5.5 million) of adults with a mental illness are uninsured.

The rankings for this indicator used data from the 2018-2019 NSDUH. There was a 0.3 percent **increase** from last year's dataset, the second year in a row that this indicator increased since the passage of the Affordable Care Act (ACA).

Data from the U.S. Census Bureau found that the percentage of Americans with Medicaid coverage decreased from 20.5% in 2018 to 19.8% in 2019.[1] Medicaid is the largest payer for mental health services in the U.S. Studies have shown that Medicaid expansion is associated with a significant reduction in the percentage of adults with depression who are uninsured, and in delaying mental health care because of cost.[2] Medicaid expansion is also an issue of mental health equity, as expansion has been found to reduce racial disparities in health coverage.[3]

Every state ranked 39-51 on this indicator is a state that had not expanded Medicaid by 2018-2019. Idaho implemented Medicaid expansion in 2020, and both Oklahoma and Missouri implemented Medicaid expansion in 2021, which may lead to a large change in coverage in future reports.

Rank	State	Rate	#
1	Massachusetts	3.8	45,000
2	Kentucky	4.2	33,000
3	Rhode Island	4.4	9,000
4	District of Columbia	4.7	6,000
5	Hawaii	4.7	9,000
6	Vermont	5.1	6,000
7	New York	5.2	151,000
8	Connecticut	5.4	28,000
9	Maryland	5.6	43,000
10	Pennsylvania	5.9	115,000
11	Wisconsin	6.3	56,000
12	Michigan	6.9	108,000
13	Ohio	6.9	150,000
14	Illinois	7.1	130,000
15	Delaware	7.3	12,000
16	California	7.4	434,000
17	Minnesota	8.0	69,000
18	New Mexico	8.1	28,000
19	New Hampshire	8.8	22,000
20	Alaska	9.7	11,000
21	North Dakota	9.8	11,000
22	South Dakota	9.8	10,000
23	Montana	10.0	17,000
24	West Virginia	10.1	37,000
25	New Jersey	10.6	116,000
26	Colorado	10.8	113,000
27	Arkansas	11.3	52,000
28	Iowa	11.3	46,000
29	Utah	11.3	70,000
30	Nevada	11.5	61,000
31	Arizona	11.6	127,000
32	Nebraska	11.6	32,000
33	Washington	11.6	165,000
34	Oregon	11.8	95,000
35	Louisiana	12.4	95,000
36	Virginia	12.4	147,000
37	Maine	12.6	31,000
38	Indiana	13.4	153,000
39	Idaho	14.0	42,000
40	Kansas	14.0	63,000
41	Georgia	15.2	207,000
42	Tennessee	15.3	148,000
43	North Carolina	15.4	240,000
44	South Carolina	15.6	119,000
45	Oklahoma	17.6	117,000
46	Florida	17.8	512,000
47	Wyoming	18.0	19,000
48	Mississippi	18.2	81,000
49	Alabama	19.3	154,000
50	Missouri	19.3	209,000
51	Texas	21.5	759,000
	National	11.1	5,514,000

[1] Keisler-Starkey, K. & Bunch, L.N. (September 2020). Health Insurance Coverage in the United States: 2019. *U.S. Census Bureau Current Population Reports, P60-271.*. Available at https://www.census.gov/library/publications/2020/demo/p60-271.html

[2] Fry, C.E. & Sommers, B.D. (August 2018). Effect of Medicaid Expansion on Health Insurance Coverage and Access to Care Among Adults with Depression. *Psychiatric Services, 69(11): 1146-1152.* https://doi.org/10.1176/appi.ps.201800181

[3] Guth, M., Artiga, S., & Pham, O. (September 2020). Effects of the ACA Medicaid Expansion on Racial Disparities in Health and Health Care. *Kaiser Family Foundation,* https://www.kff.org/medicaid/issue-brief/effects-of-the-aca-medicaid-expansion-on-racial-disparities-in-health-and-health-care/

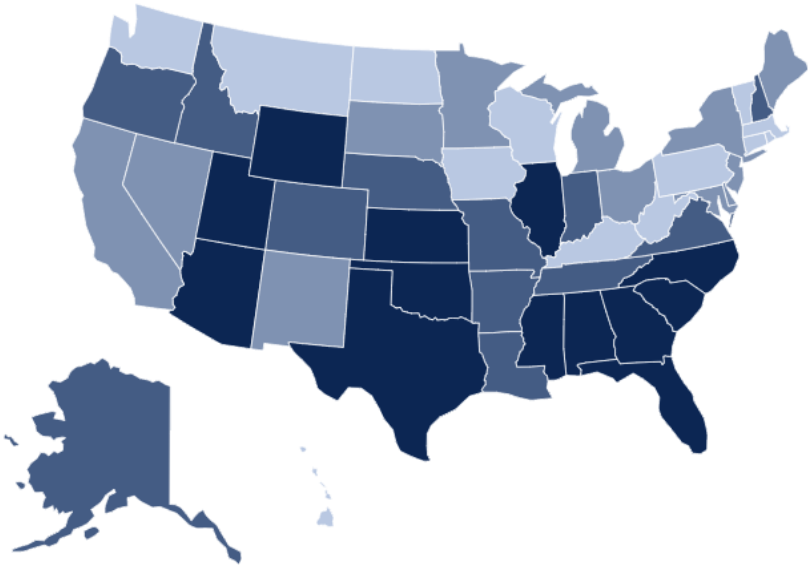
Adults With Cognitive Disability Who Could Not See a Doctor Due to Costs

29.67% of adults with a cognitive disability were not able to see a doctor due to costs.

Cognitive disability is defined as having serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional disability.

According to the Centers for Disease Control (CDC), 12% of people in the U.S. had a cognitive disability in 2019, even when adjusted for age. The percentage of people with cognitive disability ranged from 8.9 percent in some states to 19.6 percent.[1]

A 2017 study found that compared to working-age adults without disabilities, those with disabilities are more likely to report problems of affordability and access to care, including problems or inability to pay medical bills and delaying medical care due to cost. While implementation of the ACA reduced some issues of access, adults with disabilities were still over three times more likely to report an access problem.[2]



The prevalence of adults with cognitive disability who could not see an M.D. due to cost ranges from:

18.48% (RI) Ranked 1-13

40.65% (TX) Ranked 39-51

Rank	State	%	#
1	Rhode Island	18.48	18,204
2	Vermont	20.33	9,346
3	Connecticut	20.59	52,774
4	Iowa	21.22	47,967
5	Massachusetts	21.68	122,701
6	North Dakota	22.25	12,879
7	Wisconsin	22.28	94,587
8	Hawaii	22.90	24,832
9	Kentucky	23.34	132,541
10	West Virginia	23.35	63,123
11	Washington	23.45	129,850
12	Montana	23.68	24,375
13	Pennsylvania	23.77	269,121
14	Maryland	23.87	102,734
15	Nevada	24.31	72,956
16	New York	24.53	351,676
17	District of Columbia	24.59	13,849
18	New Jersey	25.19	*
19	California	25.54	798,630
20	South Dakota	26.14	17,659
21	New Mexico	26.15	54,176
22	Minnesota	26.19	102,491
23	Ohio	26.99	290,259
24	Maine	27.34	39,967
25	Michigan	27.50	281,553
26	Delaware	27.59	21,424

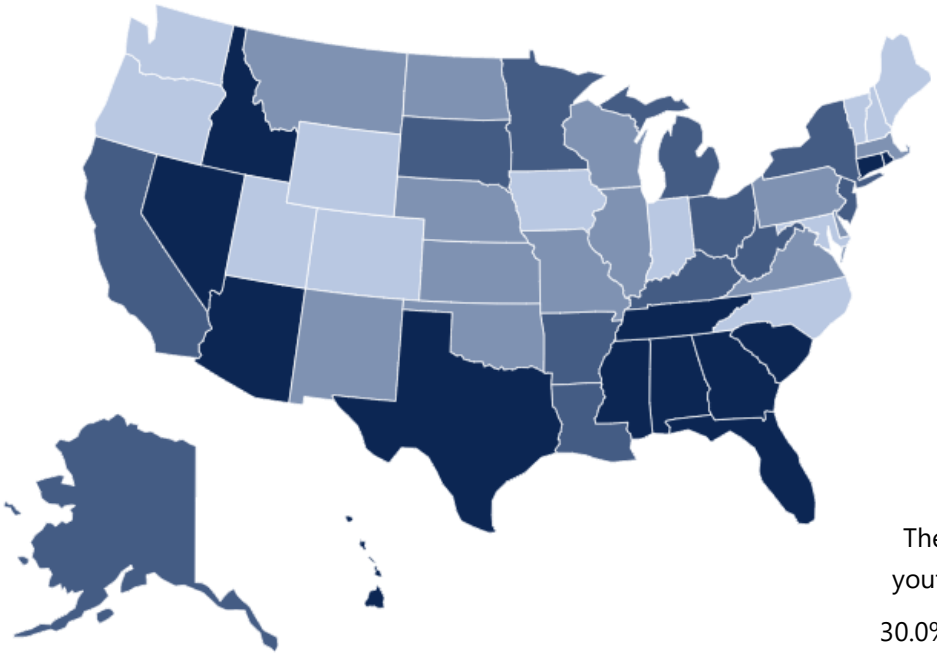
Rank	State	%	#
27	Louisiana	27.79	155,929
28	Idaho	28.05	43,386
29	Colorado	28.69	111,500
30	Nebraska	29.48	37,445
31	Alaska	29.49	17,492
32	Tennessee	29.93	224,845
33	New Hampshire	30.40	35,528
34	Arkansas	30.53	117,147
35	Indiana	30.53	191,026
36	Oregon	30.67	118,469
37	Virginia	30.71	198,169
38	Missouri	30.88	192,461
39	Arizona	31.35	203,838
40	Oklahoma	31.52	138,679
41	South Carolina	31.70	161,528
42	Illinois	32.25	306,123
43	North Carolina	32.94	356,776
44	Wyoming	32.94	14,280
45	Utah	33.31	81,119
46	Mississippi	33.37	121,330
47	Florida	34.90	733,738
48	Alabama	38.35	233,440
49	Kansas	38.74	97,643
50	Georgia	39.18	370,081
51	Texas	40.65	954,935
	National	29.67	8,496,389

[1] Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Division of Human Development and Disability. Disability and Health Data System (DHDS) Data [online]. (2019). Available at https://dhds.cdc.gov

[2] Kennedy, J., Geneva Wood, E. & Frieden, L. (2017). Disparities in insurance coverage, health services use, and access following implementation of the Affordable Care Act: A comparison of disabled and nondisabled working-age adults. *Inquiry,* 54. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5798675/

Youth Access to Care

Youth With MDE Who Did Not Receive Mental Health Services



60.3% of youth with major depression do not receive any mental health treatment.

Youth experiencing MDE continue to go untreated. Even among the states with greatest access for youth, one in three youth are still not receiving the mental health services they need.

In Texas (ranked 51), nearly **three-quarters** of youth with major depression did not receive mental health treatment, nearly two-and-a-half times the rate in Maine (ranked one).

The state prevalence of untreated youth with depression ranges from:

30.0% (ME) Ranked 1-13

73.1% (TX) Ranked 39-51

Rank	State	%	#
1	Maine	30.0	4,000
2	Colorado	39.3	20,000
3	District of Columbia	41.0	1,000
4	Vermont	42.6	3,000
5	Maryland	44.7	32,000
6	Wyoming	44.9	4,000
7	Utah	45.4	25,000
8	New Hampshire	46.6	7,000
9	Iowa	49.3	21,000
10	Oregon	49.7	29,000
11	Washington	49.8	50,000
12	Indiana	51.5	50,000
13	North Carolina	51.9	74,000
14	Delaware	52.3	6,000
15	Nebraska	52.6	12,000
16	Montana	53.5	6,000
17	Kansas	54.5	21,000
18	North Dakota	54.6	4,000
19	Wisconsin	55.1	36,000
20	Illinois	55.2	77,000
21	Pennsylvania	55.2	57,000
22	Virginia	55.2	58,000
23	New Mexico	55.9	18,000
24	Oklahoma	56.0	30,000
25	Massachusetts	56.8	44,000
26	Missouri	57.3	37,000

Rank	State	%	#
27	Minnesota	58.3	42,000
28	Arkansas	58.9	23,000
29	New Jersey	58.9	42,000
30	Kentucky	59.3	27,000
31	South Dakota	59.6	6,000
32	Michigan	59.7	74,000
33	New York	60.9	103,000
34	Louisiana	62.5	32,000
35	Ohio	63.3	76,000
36	Alaska	63.4	6,000
37	West Virginia	63.9	13,000
38	California	64.5	278,000
39	Rhode Island	64.9	6,000
40	Nevada	65.2	28,000
41	Connecticut	65.6	24,000
42	Tennessee	66.5	40,000
43	Alabama	66.8	34,000
44	Idaho	67.1	19,000
45	Florida	67.3	117,000
46	South Carolina	67.6	34,000
47	Georgia	67.8	75,000
48	Arizona	70.1	67,000
49	Hawaii	71.0	7,000
50	Mississippi	71.7	20,000
51	Texas	73.1	255,000
	National	60.3	2,173,000

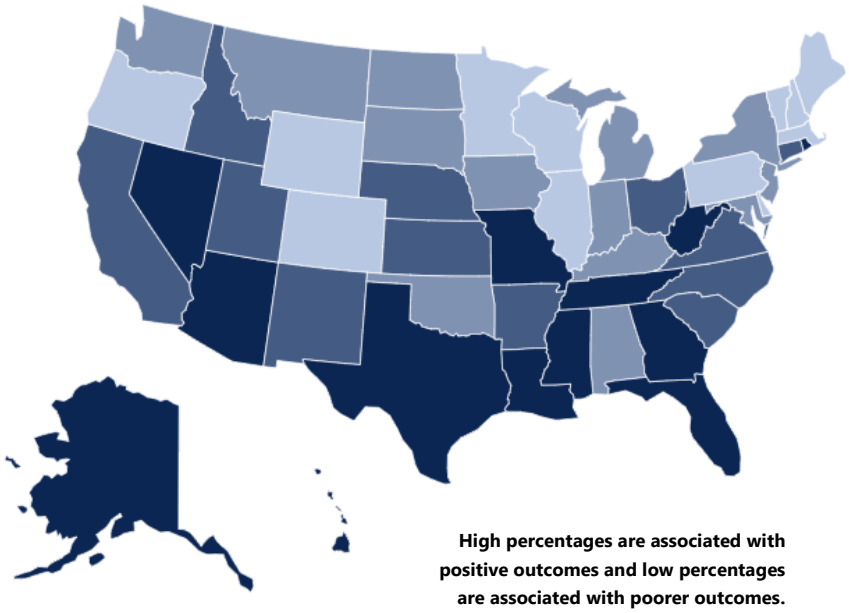
Youth With Severe MDE Who Received Some Consistent Treatment

Nationally, **only 27.2% of youth** with severe depression receive some consistent treatment (7-25+ visits in a year).

Consistent treatment is determined if a youth visits a specialty outpatient mental health service, including a day treatment facility, mental health clinic, private therapist, or in-home therapist, more than seven times in the previous year.

It does not consider the quality of the care – for example, whether the mental health service was specialized toward youth, whether the provider was representative of the youth being served, what the outcomes of treatment were, or whether the child was offered a continuum of supports.

Even with simply measuring the number of visits, fewer than one in three youth with severe depression meet this determination of



High percentages are associated with positive outcomes and low percentages are associated with poorer outcomes.

The state prevalence of youth with severe depression who received some outpatient treatment ranges from:

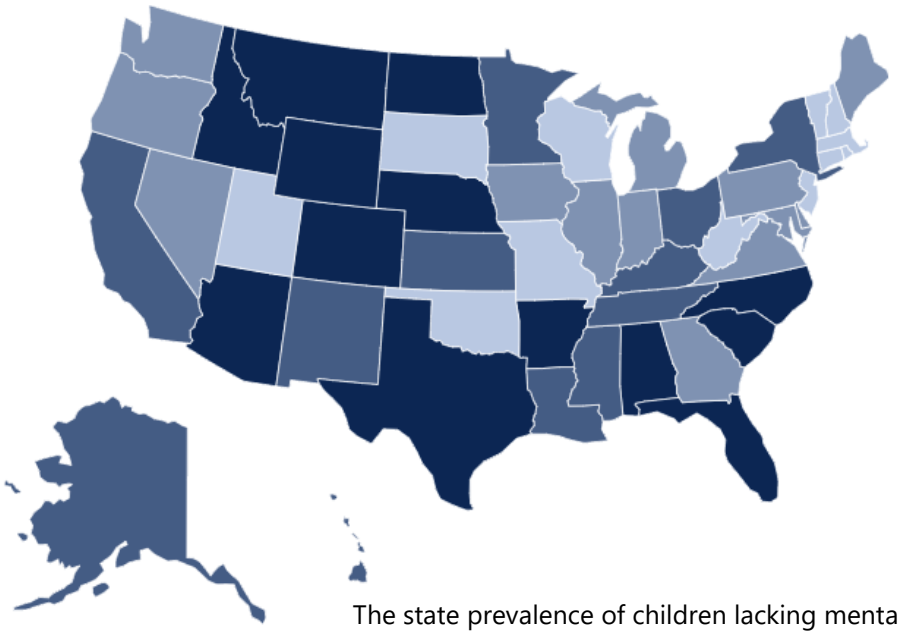
65.6% (ME) Ranked 1-13

12.2% (TN) Ranked 39-51

Rank	State	%	#
1	Maine	65.6	7,000
2	Vermont	49.7	3,000
3	New Hampshire	47.6	4,000
4	Wyoming	45.6	3,000
5	Colorado	43.1	16,000
6	Massachusetts	42.2	19,000
7	Pennsylvania	39.9	28,000
8	Illinois	38.3	38,000
9	Oregon	36.6	14,000
10	Wisconsin	36.4	19,000
11	Delaware	36.3	3,000
12	Minnesota	35.9	17,000
13	District of Columbia	35.8	1,000
14	Washington	35.7	24,000
15	Montana	35.5	3,000
16	Maryland	34.5	18,000
17	Oklahoma	33.6	12,000
18	North Dakota	33.0	2,000
19	Indiana	32.9	23,000
20	Alabama	31.3	8,000
21	Michigan	30.4	26,000
22	Iowa	29.5	9,000
23	South Dakota	29.3	2,000
24	Kentucky	28.6	9,000
25	New Jersey	28.4	14,000
26	New York	28.3	29,000

Rank	State	%	#
27	Nebraska	27.8	5,000
28	Idaho	27.7	6,000
29	Utah	27.3	11,000
30	California	26.1	72,000
31	Ohio	25.1	19,000
32	Virginia	25.0	19,000
33	North Carolina	24.9	27,000
34	South Carolina	24.2	8,000
35	Connecticut	23.6	5,000
36	Arkansas	22.7	7,000
37	Kansas	22.7	6,000
38	New Mexico	22.5	5,000
39	Louisiana	21.1	7,000
40	West Virginia	20.9	3,000
41	Rhode Island	20.4	1,000
42	Alaska	20.2	1,000
43	Georgia	20.1	14,000
44	Texas	19.2	44,000
45	Nevada	18.7	5,000
46	Florida	17.0	20,000
47	Arizona	16.1	10,000
48	Mississippi	13.5	2,000
49	Hawaii	13.3	1,000
50	Missouri	12.6	5,000
51	Tennessee	12.2	6,000
	National	27.2	661,000

Children With Private Insurance That Did Not Cover Mental or Emotional Problems



The state prevalence of children lacking mental health coverage ranges from:

1.9% (MA) Ranked 1-13 — 17.7% (AR) Ranked 39-51

The Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted in 2008 and promised the equal coverage of mental health and substance use services. However, despite increasing pressure and parity enforcement action from the Department of Labor, the rate of children with private insurance that does not cover mental or emotional problems increased 0.3 percent from last year's dataset, and there are still 950,000 youth without coverage for their behavioral health.

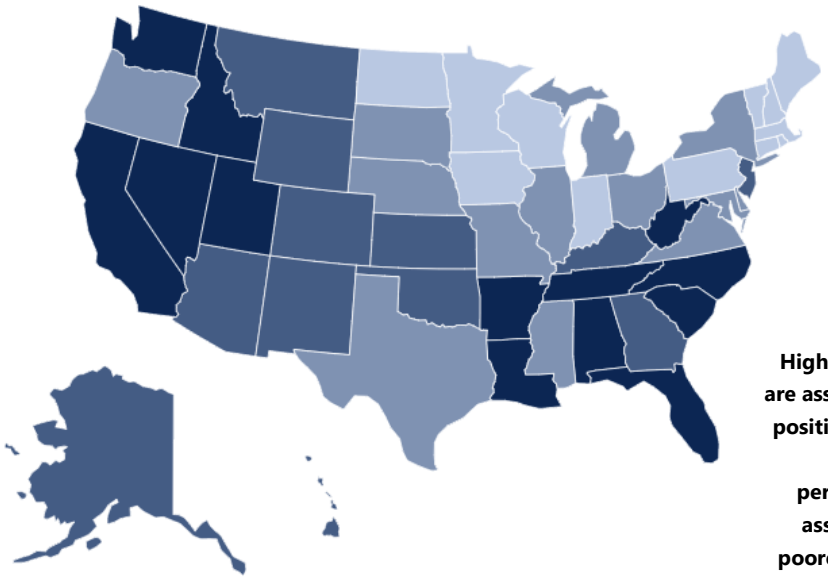
In 2019, a Milliman research report[1] found large disparities between behavioral health and medical/surgical services, including that patients saw out-of-network behavioral health providers at much higher rates than physical health providers. It also found that these disparities were worse for children. In 2017, a behavioral health visit for a child was over 10 times more likely to be out-of-network than a primary care office visit. This was over two times the disparity shown for adults.

Ensuring that mental health care is covered by insurance is a baseline and does not mean that an individual can access care. In the lowest ranked states, over 15% of children do not have that baseline of insurance coverage for mental health services. This indicator does not account for whether those with coverage have a provider in their area, or for the network adequacy of the insurance they have.

Rank	State	%	#
1	Massachusetts	1.9	5,000
2	Vermont	2.1	0
3	Connecticut	3.5	5,000
4	Rhode Island	3.8	1,000
5	Missouri	4.2	9,000
6	New Hampshire	4.3	2,000
7	Oklahoma	4.4	6,000
8	District of Columbia	4.5	1,000
9	West Virginia	4.5	2,000
10	Wisconsin	4.5	12,000
11	South Dakota	4.7	2,000
12	Utah	4.7	10,000
13	New Jersey	5.0	18,000
14	Washington	5.2	15,000
15	Maine	5.4	3,000
16	Michigan	6.1	27,000
17	Virginia	6.4	22,000
18	Maryland	6.5	15,000
19	Illinois	6.6	33,000
20	Oregon	6.6	10,000
21	Pennsylvania	6.8	32,000
22	Delaware	7.0	3,000
23	Georgia	7.0	25,000
24	Nevada	7.1	8,000
25	Indiana	7.4	22,000
26	Iowa	7.4	10,000
27	Ohio	7.4	33,000
28	Alaska	7.5	2,000
29	New York	7.7	48,000
30	New Mexico	7.8	5,000
31	Kansas	7.9	8,000
32	Minnesota	8.0	20,000
33	California	8.2	111,000
34	Mississippi	8.2	6,000
35	Hawaii	8.3	3,000
36	Tennessee	8.8	19,000
37	Louisiana	9.0	11,000
38	Kentucky	9.3	15,000
39	Montana	9.5	3,000
40	Colorado	9.6	22,000
41	North Carolina	10.0	34,000
42	Arizona	10.2	27,000
43	Florida	11.7	65,000
44	Idaho	12.2	11,000
45	South Carolina	12.4	19,000
46	Alabama	12.5	16,000
47	Wyoming	12.7	3,000
48	Texas	13.8	135,000
49	Nebraska	15.4	13,000
50	North Dakota	15.6	5,000
51	Arkansas	17.7	17,000
	National	8.1	950,000

[1] Melek, S., Davenport, S. & Gray, T.J. (November 19, 2019). Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement. *Milliman Research Report.* Available at https://us.milliman.com/en/insight/worldwide-insight

Students Identified With Emotional Disturbance for an Individualized Education Program



High percentages are associated with positive outcomes and low percentages are associated with poorer outcomes.

The state rate of students identified as having an Emotional Disturbance (ED) for an Individual Education Program (IEP) ranges from:

32.23% (VT) Ranked 1-13

2.13% (AL) Ranked 39-51

Only .759 percent* of students are identified as having an ED for IEP.

Early identification for IEPs is critical. IEPs provide the services, accommodations, and support students with ED need to receive a quality education. For purposes of an IEP, the term "Emotional Disturbance" is used to define youth with a mental illness that is affecting their ability to succeed in school. In 2018-2019, 10.6% of youth had severe MDE, reporting the maximum level of interference over four role domains including school, yet less than 1% were identified for an IEP under ED.

In addition to ensuring that students in need of accommodations and supports in school receive them through an IEP, we must work toward prevention of mental health problems that may necessitate an Emotional Disturbance IEP. Youth identified with ED were more likely to live in households below the poverty line, with multiple risk factors that may affect their mental health.[1] It is imperative that we continue to work toward prevention of mental health conditions by improving the social safety net for families and addressing the social determinants of mental health that may contribute to the emergence of mental health problems.

The rate for this measure is shown as a rate per 1,000 students. The calculation was made this way for ease of reading. Unfortunately, doing so hides the fact that the percentages are significantly lower. If states were doing a better job of identifying whether youth had emotional difficulties that could be better supported through an IEP – the rates would be closer to .8 percent.

Rank*	State	Rate	#
1	Vermont	32.23	2326
2	Minnesota	21.20	17016
3	Massachusetts	20.22	17455
4	Pennsylvania	16.33	26105
5	Wisconsin	16.18	*
6	Maine	15.32	2468
7	Indiana	13.36	12712
8	Iowa	13.31	*
9	New Hampshire	13.24	2132
10	Connecticut	12.43	5824
11	Rhode Island	12.34	1610
12	North Dakota	11.99	1240
13	District of Columbia	11.54	802
14	Illinois	10.59	18381
15	Oregon	10.30	5568
16	South Dakota	10.04	1251
17	Ohio	10.03	15281
18	Nebraska	9.98	2861
19	Delaware	9.47	1211
20	New York	9.10	22063
21	Missouri	8.87	7188
22	Michigan	8.52	11314
23	Virginia	8.47	9913
24	Maryland	7.61	6180
25	Mississippi	7.53	3193
26	Texas	7.41	35851
27	Arizona	7.39	7756
28	Kentucky	7.39	4501
29	Colorado	6.98	5687
30	Wyoming	6.80	589
31	Montana	6.68	906
32	Oklahoma	6.66	4057
33	Alaska	6.48	765
34	Georgia	6.35	10124
35	New Mexico	6.15	1830
36	New Jersey	5.84	7313
37	Hawaii	5.80	959
38	Kansas	5.60	2459
39	Washington	5.49	5633
40	Florida	5.43	14062
41	Idaho	4.95	1412
42	Nevada	4.64	2085
43	California	4.51	25424
44	West Virginia	4.45	1025
45	Tennessee	3.84	3470
46	North Carolina	3.65	5187
47	Utah	3.12	1933
48	South Carolina	3.05	2143
49	Louisiana	2.74	1727
50	Arkansas	2.54	1123
51	Alabama	2.13	1420
	National	**7.59**	345,160

[1] Wagner, M., Kutash, K., Duchnowski, A.J., Epstein, M.H. & Sumi, W.C. (2005). The Children and Youth We Serve: A National Picture of the Characteristics of Students with Emotional Disturbances Receiving Special Education. *Journal of Emotional and Behavioral Disorders,* 13(2): 79-96. Retrieved from https://journals.sagepub.com/doi/abs/10.1177/10634266050130020201?journalCode=ebxa

Spotlight: Disparities in Mental Health Treatment for Youth of Color

The following analyses are based on data from the 2018-2019 Substance Use and Mental Health Services Administration's (SAMHSA's) National Survey on Drug Use and Health (NSDUH).[3]

While rates of mental health treatment are low for all youth with major depression, youth of color are significantly less likely to receive depression treatment than white youth. Asian youth were least likely to have seen a health professional or received medication for their depression (8.30%), followed by Black or African American youth (9.40%) and Hispanic youth (9.50%).

Of Youth With MDE: Did you see a Health Professional or Receive Medication for Depression in the Past Year?		Asian	Black or African American (non-Hispanic)	Hispanic	More than one race	White (non-Hispanic)	Native American or Alaska Native	Native Hawaiian or Other Pacific Islander
Yes	**Percentage**	8.30%	9.40%	9.50%	15.60%	22.00%	15.20%	*
	Count	16,000	33,000	89,000	25,000	424,000	4,000	*
No	**Percentage**	91.70%	90.60%	90.50%	84.40%	78.00%	84.80%	*
	Count	175,000	316,000	849,000	133,000	1,503,000	21,000	*

*Data suppressed due to small sample size.

These analyses not only reflect disparities in who gets to receive mental health treatment, but what kinds of services they are able to receive and where they can access care. Youth of color with major depression were less likely to receive specialty mental health care than white youth. Specialty mental health treatment is defined as staying overnight in a hospital, staying in a residential treatment facility, spending time in a day treatment facility, receiving treatment from a mental health clinic, receiving treatment from a private therapist, or receiving treatment from an in-home therapist. Asian youth with a past year major depressive episode were least likely to have received specialty mental health care (71% did not receive care), followed by Native American or Alaska Native youth (68%), and Black or African American Youth (68%). White youth with MDE were most likely to receive specialty mental health care, but still over half of white youth with a past year major depressive episode did not receive treatment (54%).

[3] U.S. Department of Health and Human Services, Substance Abuse and mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality. (2018-2019). *National Survey on Drug Use and Health 2018-2019*. Retrieved from https://rdas.samhsa.gov/

Of Youth With MDE: Did You Receive Specialty Mental Health Care in the Past Year?		Asian	Black or African American (non-Hispanic)	Hispanic	More than one race	White (non-Hispanic)	Native American or Alaska Native	Native Hawaiian or Other Pacific Islander	Total
Yes	**Percentage**	29.00%	32.00%	32.40%	40.50%	45.80%	31.90%	36.90%	**39.70%**
	Count	55,000	111,000	306,000	63,000	883,000	8,000	6,000	**1,432,000**
No	**Percentage**	71.00%	68.00%	67.60%	59.50%	54.20%	68.10%	63.10%	**60.30%**
	Count	135,000	235,000	638,000	93,000	1,045,000	17,000	10,000	**2,173,000**

Native American, Black, and multiracial youth were all more likely to receive non-specialty mental health care than white youth. Non-specialty mental health care is defined as receiving services from a school social worker, school psychologist, or school counselor; special school or program within a regular school for students with emotional or behavioral problems; pediatrician or other family doctor; juvenile detention center, prison, or jail; or foster care or therapeutic foster care.

Native American or Alaska Native youth with major depression were most likely to receive non-specialty mental health care (43%), followed by youth identifying with more than one race (39%), and Black or African American youth (39%).

Of Youth With MDE: Did You Receive Non-Specialty Mental Health Care in the Past Year?		Asian	Black or African American (non-Hispanic)	Hispanic	More than one race	White (non-Hispanic)	Native American or Alaska Native	Native Hawaiian or Other Pacific Islander	Total
Yes	**Percentage**	24.40%	38.80%	32.10%	39.00%	35.70%	43.30%	10.70%	**34.60%**
	Count	46,000	135,000	299,000	61,000	687,000	11,000	2,000	**1,241,000**
No	**Percentage**	75.60%	61.20%	67.90%	61.00%	64.30%	56.70%	89.30%	**65.40%**
	Count	144,000	213,000	632,000	96,000	1,238,000	14,000	13,000	**2,350,000**

Of the 18.1% of youth who received non-specialty mental health services in 2019, most (15.4%) received those services in school. Despite the fact that youth of color comprise less than half of the total population of youth with MDE, 52% of youth with MDE who only received care in educational settings were youth of color.[4] Of youth with MDE, Black youth were most likely to receive school mental health services (37%), followed by Native American or Alaska Native youth (35%), and multiracial youth (34%).

[4] Ali, M. M., West, K., Teich, J. L., Lynch, S., Mutter, R., & Dubenitz, J. (2019). Utilization of Mental Health Services in Educational Setting by Adolescents in the United States. The Journal of school health, 89(5), 393–401. https://doi.org/10.1111/josh.12753

Among Youth With MDE Who Received Non-Specialty Mental Health Services:

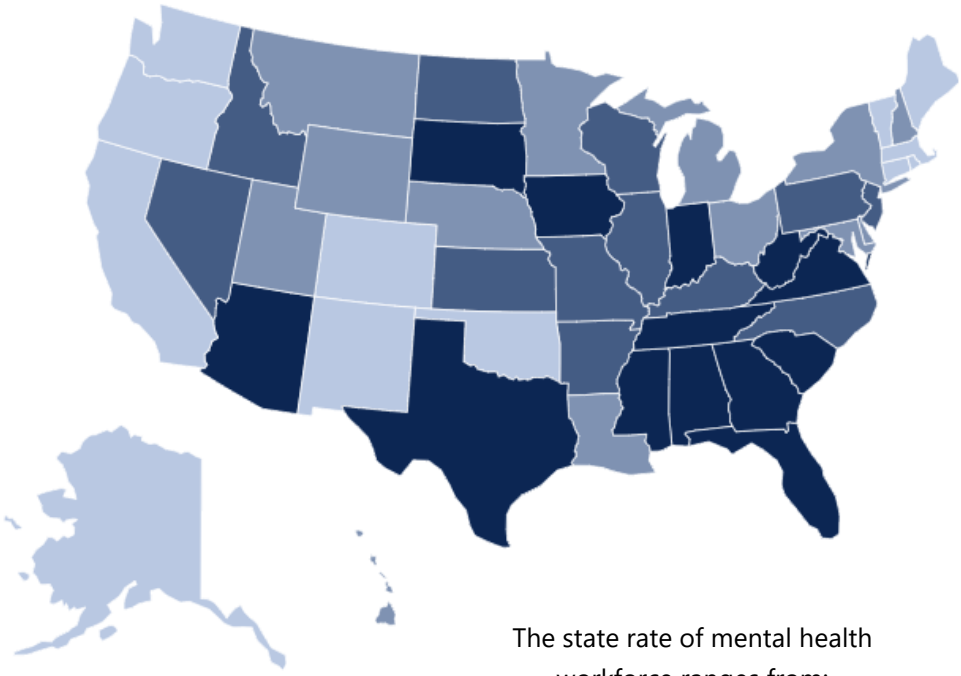
Did You Receive Mental Health Services From Education Sources?		Asian	Black or African American (non-Hispanic)	Hispanic	More than one race	White (non-Hispanic)	Native American or Alaska Native	Native Hawaiian or Other Pacific Islander
Yes	**Percentage**	20.30%	37.30%	26.80%	34.30%	29.00%	34.70%	*
	Count	39,000	130,000	250,000	54,000	558,000	9,000	*
No	**Percentage**	79.70%	62.70%	73.20%	65.70%	71.00%	65.30%	*
	Count	152,000	219,000	682,000	103,000	1,367,000	16,000	*

*Data was suppressed due to small sample size

Students of color disproportionally access their mental health care at school, often because they don't have access to specialty mental health services. Given this data, increasing access to school-based mental health services can promote equity and reduce disparities in access to care. However, there is not sufficient federal funding for local education agencies to meet the mental health needs of students. To create healthier communities and to better serve students of color who may only receive mental health services in educational settings, schools need long-term financial support to build up sustained and sufficient school infrastructure. This infrastructure should include, at minimum, implementing comprehensive mental health education, increasing the number of mental health providers in schools, creating connections and coordinating with community-based mental health services, identifying processes and supports for screening and treating students, and reducing the gap in care when students transition from school to college and college to the workforce.

Although some states have adopted innovative practices to improve mental health education and access to mental health services and supports in schools, no state has fully enacted a set of laws and policies to improve youth mental health. MHA has compiled a report on innovative state policies and recommendations for future state legislative work geared toward serving the mental health needs of students and advancing equitable access to supports in schools.

Mental Health Workforce Availability



The state rate of mental health workforce ranges from:

150:1 (MA)
Ranked 1-13

920:1 (AL)
Ranked 39-51

Rank	State	#
1	Massachusetts	150:1
2	Oregon	180:1
3	District of Columbia	190:1
4	Alaska	200:1
5	Maine	200:1
6	Vermont	210:1
7	Connecticut	240:1
8	Oklahoma	240:1
9	Rhode Island	240:1
10	New Mexico	250:1
11	Washington	250:1
12	California	270:1
13	Colorado	270:1
14	Utah	290:1
15	Wyoming	290:1
16	New Hampshire	310:1
17	Montana	320:1
18	Louisiana	330:1
19	New York	330:1
20	Delaware	350:1
21	Maryland	360:1
22	Michigan	360:1
23	Nebraska	360:1
24	Minnesota	370:1
25	Hawaii	380:1
26	Ohio	380:1
27	North Carolina	390:1
28	Illinois	410:1
29	Arkansas	420:1
30	Kentucky	420:1
31	New Jersey	420:1
32	Pennsylvania	450:1
33	Idaho	460:1
34	Nevada	460:1
35	Wisconsin	470:1
36	Kansas	490:1
37	Missouri	490:1
38	North Dakota	510:1
39	South Dakota	530:1
40	Virginia	530:1
41	South Carolina	550:1
42	Florida	590:1
43	Indiana	590:1
44	Mississippi	590:1
45	Iowa	610:1
46	Tennessee	630:1
47	Georgia	690:1
48	Arizona	710:1
49	West Virginia	730:1
50	Texas	830:1
51	Alabama	920:1

The term "mental health provider" includes psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care, but not yet certified peer specialists (because peer specialists are primarily covered only by Medicaid, and qualifications for them vary by state).

The rate of mental health providers has improved in nearly every state since last year's report. However, the need for mental health care is greatly outpacing these additions to the workforce. The mental health workforce shortage affects more people than primary care and dental workforce shortages combined, according to data from the Health Resources and Services Administration, with only 27% of mental health need being met in health professional shortage areas.[1]

One of the primary barriers to establishing a robust, diverse mental health workforce is low provider reimbursement. Payment affects the diversity of the workforce, especially in a field that requires high levels of education and certification. Provider reimbursement should take into account workforce shortages and promote equity in access. This could be accomplished at the level of individual health insurers and states through assessments of network adequacy and offering additional incentives when providers practice in areas with few appropriate providers taking new clients. This could also be accomplished more systemically by including an additional incentive in payment fee schedules based on shortages to incentivize growth in the mental health provider pipeline.

[1] Health Resources and Services Administration (HRSA) Bureau of Health Workforce (June 2021). Third Quarter of Fiscal Year 2021 Designated Health Professional Shortage Area Quarterly Summary. Retrieved from https://data.hrsa.gov/topics/health-workforce/shortage-areas

Glossary

Indicator	Description of Measure	Source
Adults With Any Mental Illness (AMI)	Any Mental Illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, assessed by the Mental Health Surveillance Study (MHSS) Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders (MHSS-SCID), which is based on the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). For details, see Section B of the "2018-2019 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology" at https://www.samhsa.gov/data/. Data survey years: 2018-2019.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables
Adults With AMI Reporting Unmet Need	AMIYR_U, is an indicator for Any Mental Illness (AMI) based on the 2012 revised predicted probability of SMI (SMIPP_U). If SMIPP_U is greater than or equal to a specified cutoff point (0.0192519810), then AMIYR_U=1, and if SMIPP_U is less than the cutoff point, then AMIYR_U=0. This indicator based on the 2012 model is not comparable with the indicator based on the 2008 model. AMI is defined as having serious, moderate, or mild mental illness. Specific details about this variable can be found in the Recoded Mental Health Appendix. AMHTXND2 is defined as feeling a perceived need for mental health treatment/counseling that was not received. This is often referred to as "unmet need." Mental health treatment/counseling is defined as having received inpatient treatment/counseling or outpatient treatment/counseling or having used prescription medication for problems with emotions, nerves, or mental health. Respondents were not to include treatment for drug or alcohol use. Respondents with unknown treatment/counseling information were excluded. Data survey years: 2018-2019.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.datafiles.samhsa.gov/dataset/national-survey-drug-use-and-health-2019-nsduh-2019-ds0001
Adults With AMI Who Are Uninsured	For IRINSUR4, a respondent is classified as having any health insurance (IRINSUR4=1) if they satisfied ANY of the following conditions: (1) Covered by private insurance (IRPRVHLT=1), (2) Covered by Medicare (IRMEDICR=1), (3) Covered by Medicaid/CHIPCOV (IRMCDCHP=1), (4) Covered by Champus, ChampVA, VA, or Military (IRCHMPUS=1), (5) Covered by other health insurance (IROTHHLT=1). A respondent is classified as NOT having any health insurance (IRINSUR4=2) if they meet EVERY one of the following conditions: (1) Not covered by private insurance (IRPRVHLT=2), (2) Not covered by Medicare (IRMEDICR=2), (3) Not covered by Medicaid/CHIPCOV (IRMCDCHP=2), (4) Not covered by Champus, ChampVA, VA, or Military (IRCHMPUS=2), (5) Not covered by other health insurance (IROTHHLT=2). Data survey years: 2018-2019.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.datafiles.samhsa.gov/dataset/national-survey-drug-use-and-health-2019-nsduh-2019-ds0001

Indicator	Description of Measure	Source
Adults With Substance Use Disorder in the Past Year	Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Illicit drug use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs. Data survey years: 2018-2019.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables
Adults With Cognitive Disability Who Could Not See a Doctor Due to Costs	Disability questions were added to the Behavioral Risk Factor Surveillance System (BRFSS) core questionnaire in 2004. The question: "Are you limited in any way in any activities because of physical, mental, or emotional problems?" (QLACTLM2), which was previously used to calculate this indicator, was removed in 2016. Disability was determined using the following BRFSS question: "Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?" (DECIDE). Respondents were defined as having a cognitive disability if they answered "yes" to this question. Respondents were also asked: "Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?" (MEDCOST). The measure was calculated based on individuals who answered "yes" to MEDCOST among those who answered "yes" to DECIDE. Data survey year 2019.	Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2019, https://www.cdc.gov/brfss/annual_data/annual_2019.html Downloaded and calculated on 7/1/21.
Adults With Serious Thoughts of Suicide	Adults aged 18 or older were asked, "At any time in the past 12 months, did you seriously think about trying to kill yourself?" If they answered "yes," they were categorized as having serious thoughts of suicide in the past year. Data survey year: 2018-2019.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables

Indicator	Description of Measure	Source
Children With Private Insurance That Did Not Cover Mental or Emotional Problems	Children with private insurance that did not cover mental or emotional problems is defined as any child age 12-17 responding NO to HLTINMNT. HLTINMNT is defined as: "Does [SAMPLE MEMBER POSS] private health insurance include coverage for treatment for mental or emotional problems?" Data survey years: 2018-2019.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.datafiles.samhsa.gov/dataset/national-survey-drug-use-and-health-2019-nsduh-2019-ds0001
Adults With AMI Who Did Not Receive Mental Health Treatment	AMHTXRC-3 is a recoded variable with levels 1=Yes (received any mental health treatment in past year) and 2=No (did not receive any mental health treatment in past year). Recoded from variable AMHSVTYP, it classifies what type of mental health treatment/counseling was received in the past year. Respondents who reported receiving treatment for mental health were classified in one of seven mutually exclusive categories. A respondent was assigned to level one if they reported receiving inpatient treatment only (AMHINP2=1 and AMHOUTP3=2 and AMHRX2=2), to level two if they reported receiving outpatient treatment only (AMHINP2=2 and AMHOUTP3=1 and AMHRX2=2), to level three if they reported receiving prescription medication treatment only (AMHINP2=2 and AMHOUTP3=2 and AMHRX2=1), to level four if they reported receiving both inpatient and outpatient treatment only (AMHINP2=1 and AMHOUTP3=1 and AMHRX2=2), to level five if they reported receiving inpatient and prescription medication treatment only (AMHINP2=1 and AMHOUTP3=2 and AMHRX2=1), to level six if they reported receiving outpatient and prescription medication treatment only (AMHINP2=2 and AMHOUTP3=1 and AMHRX2=1), or to level seven if they reported receiving inpatient, outpatient, and prescription medication treatment (AMHINP2=1 and AMHOUTP3=1 and AMHRX2=1). Respondents who did not receive mental health treatment in the past year were assigned to level eight (AMHINP2=2 and AMHOUTP3=2 and AMHRX2=2). Adults with AMI who did not receive mental health treatment was calculated, where AMHTXRC-3= 2 (No treatment) and AMIYR_U indicates AMI. Data survey years: 2018-2019.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.datafiles.samhsa.gov/dataset/national-survey-drug-use-and-health-2019-nsduh-2019-ds0001

Indicator	Description of Measure	Source
Mental Health Workforce Availability	Mental health workforce availability is the ratio of the county population to the number of mental health providers, including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care. In 2015, marriage and family therapists and mental health providers that treat alcohol and other drug abuse were added to this measure. Survey data year: 2020.	County Health Rankings & Roadmaps. http://www.countyhealthrankings.org/ This data comes from the National Provider Identification data file, which has some limitations. Providers who transmit electronic health records are required to obtain an identification number, but very small providers may not obtain a number. While providers have the option of deactivating their identification number, some mental health professionals included in this list may no longer be practicing or accepting new clients.
Students Identified With Emotional Disturbance for an Individualized Education Program	This measure was calculated from data provided by IDEA Part B Child Count and Educational Environments, Common Core of Data. Under IDEA regulation, Emotional Disturbance is identified as a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: (A) An inability to learn that cannot be explained by intellectual, sensory, or health factors, (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers, (C) Inappropriate types of behavior or feelings under normal circumstances, (D) A general pervasive mood of unhappiness or depression, (E) A tendency to develop physical symptoms or fears associated with personal or school problems. Emotional disturbance includes schizophrenia. The term does not apply to children who are socially maladjusted unless it is determined that they have an emotional disturbance. Percent of Students Identified With Emotional Disturbance for an Individualized Education Program was calculated as the percent of children identified as having an emotional disturbance among all enrolled students grades 1-12 and "ungraded." Data years 2019-2020.	IDEA Data Center, 2019 – 2020 IDEA Section 618, State Level Data Files, Child Count and Educational Environments. https://www2.ed.gov/programs/osepidea/618-data/state-level-data-files/index.html#bccee U.S. Department of Education, National Center for Education Statistics, Common Core of Data. https://nces.ed.gov/ccd/files.asp Downloaded and calculated on 6/22/2021.

Indicator	Description of Measure	Source
Youth With At Least One Past Year Major Depressive Episode (MDE)	Among youth age 12-17, Major Depressive Episode (MDE) is defined in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), which specifies a period of at least two weeks when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. For details, see Section B of the "2018-2019 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology" at https://www.samhsa.gov/data/. Data survey year 2018-2019.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables
Youth With Substance Abuse Disorder in the Past Year.	Among youth 12-17, Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Illicit drug use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs. Data survey years: 2018-2019.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/report/2019-nsduh-detailed-tables
Youth With MDE Who Did Not Receive Mental Health Services	Youth With Past Year MDE Who Did Not Receive Treatment is defined as those who apply to having past year MDE as defined above ("Youth With At Least One Past Year Major Depressive Episode," YMDEYR) and respond NO to ANYSMH2. ANYSMH2 indicates whether a youth reported receiving specialty mental health services in the past year from any of six specific inpatient/residential or outpatient specialty sources for problems with behavior or emotions that were not caused by alcohol or drugs. This variable was created based on the following seven sources of treatment variables: stayed overnight in a hospital (YHOSP), stayed in a residential treatment facility (YRESID), spent time in a day treatment facility (YDAYTRT), received treatment from a mental health clinic (YCLIN), from a private therapist (YTHER), and from an in-home therapist (YHOME). Youths who reported a positive response (source variable=1) to one or more of the six questions were included in the yes category regardless of how many of the six questions they answered. Youths who did not report a positive response but answered all six of the questions were included in the no category. Youths who did not report a positive response and did not answer all the questions and adults were included in the unknown/18+ category. Data survey year 2018-2019.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.datafiles.samhsa.gov/dataset/national-survey-drug-use-and-health-2019-nsduh-2019-ds0001

Indicator	Description of Measure	Source
Youth With Severe MDE	"Youth With Severe MDE" is defined as the following variable MDEIMPY. MDEIMPY is derived from the maximum severity level of MDE role impairment (YSDSOVRL) and is restricted to adolescents with past year MDE (YMDEYR). Youth met criteria for MDEIMPY if they answered YES to YSDSOVRL and YES to YMDEYR. Youth who answer "yes" to YMDEYR are asked questions from the SDS to measure the level of functional impairment in major life activities reported to be caused by the MDE in the past 12 months (Leon, Olfson, Portera, Farber, & Sheehan, 1997). The SDS measures mental health-related impairment in four major life activities or role domains. The following variable, YSDSOVRL, is assigned the maximum level of interference over the four role domains of SDS: chores at home (YSDSHOME), school or work (YSDSWRK), family relationships (YSDSREL), and social life (YSDSSOC). Each module consists of four questions that are assessed on a 0 to 10 visual analog scale with categories of "none" (0), "mild" (1-3), "moderate" (4-6), "severe" (7-9), and "very severe" (10). The four SDS role domain variables were recoded so that no interference = 1, mild = 2, moderate = 3, severe = 4, and very severe = 5. A maximum level of interference over all four domains was then defined as YSDSOVRL. A maximum impairment score (YSDSOVRL) is defined as the single highest severity level of role impairment across all four SDS role domains. Ratings greater than or equal to seven on the scale YSDSOVRL=4, 5 were considered severe impairment. Data survey years 2018-2019.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.datafiles.samhsa.gov/dataset/national-survey-drug-use-and-health-2019-nsduh-2019-ds0001
Youth With Severe MDE Who Received Some Consistent Treatment	The following variable was calculated as how many youths who answered YES to MDEIMPY from "Youth With Severe MDE" defined above received consistent treatment, which is determined by the variable SPOUTVST. The variable SPOUTVST indicates how many times a specialty outpatient mental health service was visited in the past year. The number of visits is calculated by adding the number of visits to a day treatment facility (YUDYTXNM), mental health clinic (YUMHCRNM), private therapist (YUTPSTNM), and an in-home therapist (YUIHTPNM). A value of six (no visits) was assigned whenever a respondent said they had used none of the services (YUDYTXYR, YUMHCRYR, YUTPSTYR, YUIHTPYR all equal two). A value of missing was assigned when the response to whether they received treatment or the number of visits was unknown for any of the four locations (any of YUDYTXYR, YUMHCRYR, YUTPSTYR, YUIHTPYR=85, 94, 97, 98 OR any of YUDYTXNM, YUMHCRNM, YUTPSTNM, YUIHTPNM=985, 994, 997, 998), unless the sum of the visits for services with non-missing information was greater than or equal to 25, in which case a value of 5 (25 or more visits) was assigned. A missing value was also assigned for respondents aged 18 or older. The variable SPOUTVST was recoded for visit distribution as 0-6 visits, and 7-25+ visits. Some consistent treatment was considered 7-25+ visits in a year. Data survey years 2018-2019.	Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality, https://www.datafiles.samhsa.gov/dataset/national-survey-drug-use-and-health-2019-nsduh-2019-ds0001