Mental Health America

THE STATE OF **MENTAL HEALTH IN AMERICA**

2024 Edition

Acknowledgments

Mental Health America (MHA) was founded in 1909 and is the leading national nonprofit dedicated to the promotion of mental health, well-being, and illness prevention. Our work is informed, designed, and led by the lived experience of those most affected. Operating nationally and in communities across the country, Mental Health America advocates for closing the mental health equity gap, while increasing nationwide awareness and understanding through public education, direct services, tools, and research, making MHA a national standard bearer in public mental health advocacy and community-based solutions.

MHA dedicates this report to mental health advocates who fight tirelessly to help expand access to care 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 the rights of all.

Special thanks to:

The Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control and Prevention (CDC), the University of Wisconsin Population Health Institute, the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB), 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, Danielle Fritze and Theresa Nguyen.

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Mental Health America (MHA) is the nation's leading national nonprofit dedicated to the promotion of mental health, well-being, and illness prevention. Our work is informed, designed, and led by the lived experience of those most affected. Mental Health America advances the mental health and well-being of all people living in the U.S. through public education, research, advocacy and public policy, and direct service. We envision a world in which all people and communities have equitable opportunity for mental well-being and are enabled to flourish and live with purpose and meaning.

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, allowing for assessment of how federal and state mental health policies result in more or less access to care.

Ranking Overview and Guidelines

This report 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 (www.mhanational.org/issues/state-mental-health-america). The data and tables include state and national data.

MHA Guidelines

Given the variability of data, MHA developed guidelines to identify mental health measures that are most appropriate for inclusion in our ranking. Chosen indicators 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 annually over time to allow for analysis of future changes and trends.

Our 2024 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 Serious Thoughts of Suicide
7. Youth Flourishing
8. Adults with SUD Who Needed but Did Not Receive Treatment
9. Adults with AMI Who Are Uninsured
10. Adults Reporting 14+ Mentally Unhealthy Days a Month Who Could Not See a Doctor Due to Costs
11. Adults with AMI with Private Insurance That Did Not Cover Mental or Emotional Problems
12. Youth with MDE Who Did Not Receive Mental Health Services
13. Youth 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

Data is also presented for Youth with MDE Who Reported Treatment or Counseling Helped Them, but this indicator was not included in the rankings because data for South Carolina and South Dakota was suppressed in 2021-2022.

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 for each state collected from the most recently available data. The majority of indicators represent data collected up to 2022. States with positive outcomes are ranked higher (closer to one) than states with poorer outcomes (closer to 51). 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 three measures where high percentages equate to better outcomes. These include "Youth Flourishing," "Students Identified with Emotional Disturbance for an Individualized Education Program," and "Youth with MDE Who Reported Treatment or Counseling Helped Them." 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.

Major Changes to This Year's Report Indicators

The COVID-19 pandemic had a serious impact on the ability to collect national surveillance data in 2020. During this time, federal agencies updated the measures they collect and how they are collected. As a result, the indicators in this year's State of Mental Health in America report cannot be compared to previous years. The following summarizes how this year's report has been updated from previous reports.

The measures "Youth with Severe MDE," "Youth with Severe MDE Who Received Some Consistent Treatment," "Adults with AMI Who Did Not Receive Treatment," and "Adults with AMI Reporting Unmet Need" were removed from this year's report.

Each of these measures were calculated using data from the Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Survey on Drug Use and Health (NSDUH). The indicator "Youth with Severe MDE" was removed because it did not differ significantly from the measure "Youth with at Least One Major Depressive Episode (MDE) in the Past Year." In 2022, SAMHSA made changes to the mental health and substance use treatment questions. This report relies on state-level data, which is only available in a two-year pair. The changes to the 2022 mental health treatment measures meant that the dataset was not comparable to the 2021 measures and could not be combined into a two-year pair. These measures may return to the indicator list in next year's report once the 2022-2023 NSDUH data are available.

The measures "Youth with Serious Thoughts of Suicide," "Youth Flourishing," "Adults with SUD Who Needed but Did Not Receive Treatment," and "Adults with AMI with Private Insurance That Did Not Cover Mental or Emotional Problems" were added to the indicator list in this year's report.

The measure "Youth with Serious Thoughts of Suicide" was added because SAMHSA began gathering data on youth suicidality for the first time in 2020, and this is the first report published since that data has been made available. "Youth Flourishing" captures data on flourishing among children and adolescents ages 6-17, and was added as an upstream, protective measure for youth as part of the Prevalence ranking. "Adults with SUD Who Needed but Did Not Receive Treatment" and "Adults with AMI with Private Insurance That Did Not Cover Mental or Emotional Problems" were added to capture more nuanced information about access to behavioral health care in the U.S.

For the measure "Students Identified with Emotional Disturbance for an Individualized Education Program," data for Iowa on the number of students with Emotional Disturbance was not available. Iowa does not collect disability category data and therefore was excluded from the ranking for that indicator.

Survey Limitations

Eleven of the 15 indicators used in this report are collected from SAMHSA's national survey, the NSDUH. Historically, the NSDUH was collected through in-person interviews in the respondent's residence. However, in 2020 data collection shifted to both in-person interviews and online questionnaires due to the COVID-19 pandemic. Since 2020, SAMHSA discovered that these changes to data collection created a mode effect such that estimates from the web and in-person interviews cannot be compared to estimates from in-person interviews alone. As a result, **SAMHSA has determined that 2021 will represent a trend break from previous years, meaning the results of the NSDUH moving forward will not be comparable to data collected before 2021. This means that the rankings presented throughout this year's State of Mental Health in America report cannot be reliably compared to the rankings of previous years' reports, and therefore should be interpreted as a snapshot in time ranking rather than a reflection of trends over time.**

Additionally, each survey has its own strengths and limitations. For example, strengths of both SAMHSA's 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 are 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. As a result, these data likely represent the minimum number of individuals experiencing behavioral health conditions and/or lacking access to care in each state. 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.

Finally, most of these data were gathered through 2022. This means that they are the most current data reported by the states and available to the public.

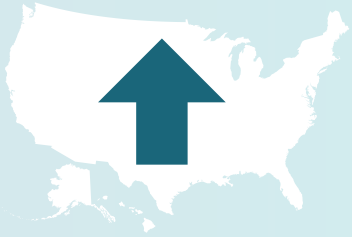
2024 KEY FINDINGS

23% OF ADULTS EXPERIENCED A MENTAL ILLNESS IN THE PAST YEAR. EQUIVALENT TO NEARLY 60 MILLION AMERICANS.

5% OF ADULTS & **13%** OF YOUTH

REPORTED EXPERIENCING SERIOUS THOUGHTS OF SUICIDE.

2022 HAD THE HIGHEST NUMBER OF DEATHS BY SUICIDE EVER RECORDED IN THE U.S.



1 IN 5 YOUTH HAD AT LEAST ONE MAJOR DEPRESSIVE EPISODE (MDE) IN THE PAST YEAR.

OVER 1/2 (NEARLY 3 MILLION YOUTH) DID NOT RECEIVE TREATMENT.

OF THOSE WHO DID RECEIVE TREATMENT, ONLY **65%** SAID IT HELPED THEM.

18% OF ADULTS IN THE U.S. HAD A SUBSTANCE USE DISORDER IN THE PAST YEAR.

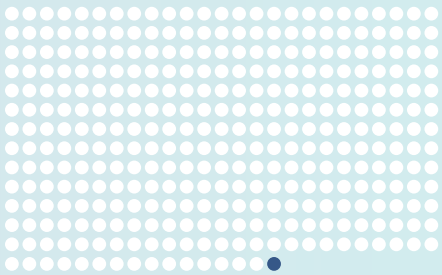
77% OF THEM DID NOT RECEIVE TREATMENT.

1 IN 4 ADULTS WITH FREQUENT MENTAL DISTRESS COULD NOT SEE A DOCTOR DUE TO COST, A 2% INCREASE OVER THE LAST REPORT.

10% OF ADULTS & **8.5%** OF YOUTH

STILL HAVE PRIVATE INSURANCE THAT DOES NOT COVER MENTAL HEALTH.

THERE ARE **340 PEOPLE FOR EVERY 1 MENTAL HEALTH PROVIDER** IN THE U.S.



Overall Ranking

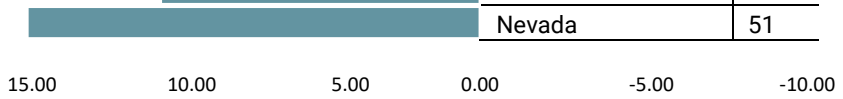
An overall ranking of 1-13 indicates lower prevalence of mental illness and higher rates of access to care. An overall ranking of 39-51 indicates higher prevalence of mental illness and lower rates of access to care. The combined scores of all 15 measures make up the overall ranking. The overall ranking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

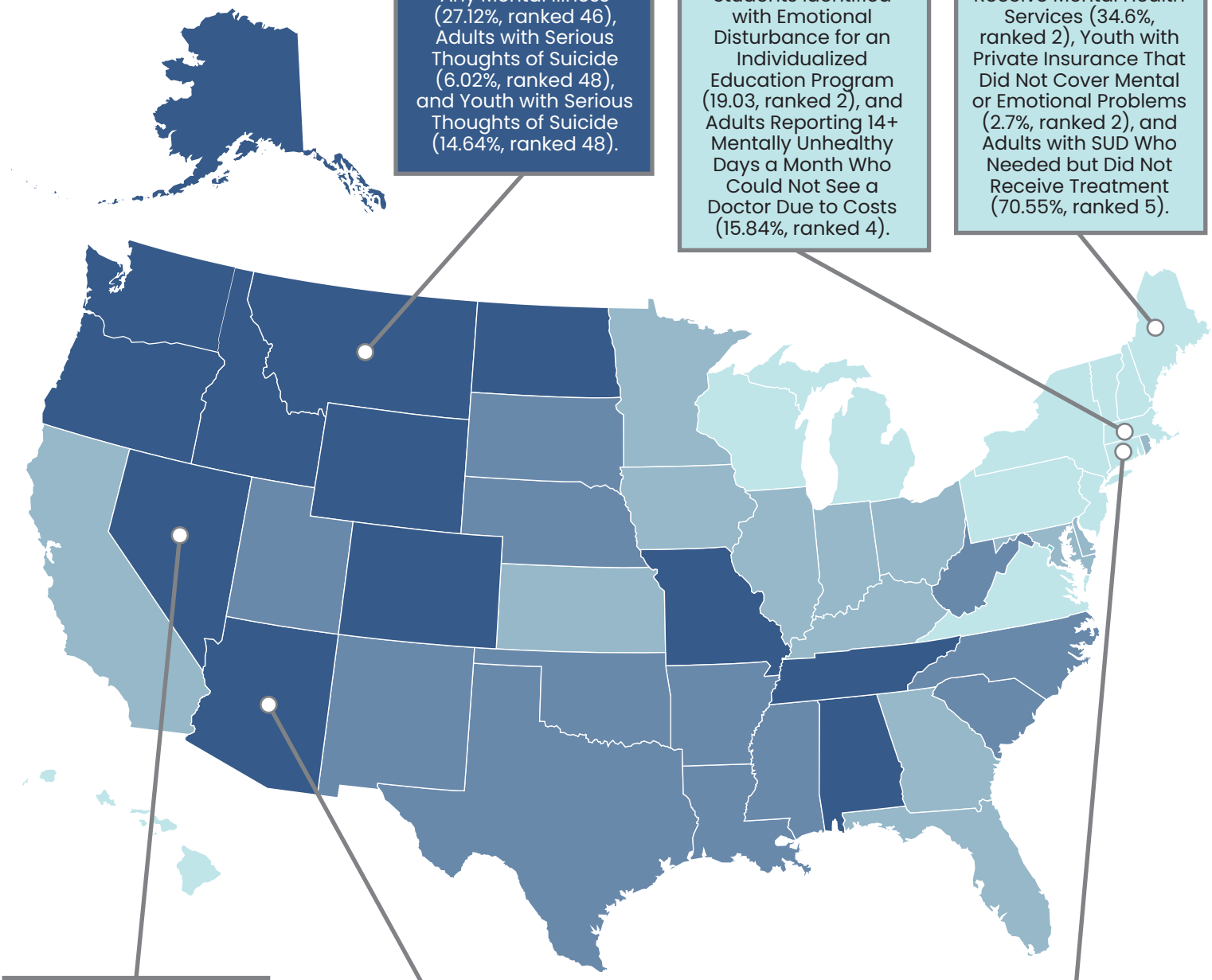
1. Adults with Any Mental Illness (AMI)
2. Adults with Substance Use Disorder in the Past Year
3. Adults with Serious Thoughts of Suicide
4. Youth with at Least One Major Depressive Episode (MDE) in the Past Year
5. Youth with Substance Use Disorder in the Past Year
6. Youth with Serious Thoughts of Suicide
7. Youth (Ages 6-17) Flourishing
8. Adults with SUD Who Needed But Did Not Receive Treatment
9. Adults with AMI Who Are Uninsured
10. Adults Reporting 14+ Mentally Unhealthy Days a Month Who Could Not See a Doctor Due to Costs
11. Adults with AMI with Private Insurance That Did Not Cover Mental or Emotional Problems
12. Youth with MDE Who Did Not Receive Mental Health Services
13. Youth with Private Insurance That Did Not Cover Mental or Emotional Problems
14. Students (K+) 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 lower (better than the average) than Virginia (ranked 12). Ohio (ranked 20) has a score that is closest to zero (the average).

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



OVERALL RANKING



MONTANA (RANKED 49):
The indicators that affected Montana's Overall Ranking the most were Adults with Any Mental Illness (27.12%, ranked 46), Adults with Serious Thoughts of Suicide (6.02%, ranked 48), and Youth with Serious Thoughts of Suicide (14.64%, ranked 48).

MASSACHUSETTS (RANKED 1):
The indicators that had the largest effects on Massachusetts' Overall Ranking were Students Identified with Emotional Disturbance for an Individualized Education Program (19.03, ranked 2), and Adults Reporting 14+ Mentally Unhealthy Days a Month Who Could Not See a Doctor Due to Costs (15.84%, ranked 4).

MAINE (RANKED 3):
The indicators that Maine performed best on were Youth with MDE Who Did Not Receive Mental Health Services (34.6%, ranked 2), Youth with Private Insurance That Did Not Cover Mental or Emotional Problems (2.7%, ranked 2), and Adults with SUD Who Needed but Did Not Receive Treatment (70.55%, ranked 5).

NEVADA (RANKED 51):
The indicators that had the largest effects on Nevada's Overall Ranking were Youth with Substance Use Disorder in the Past Year (14.09%, ranked 50), Youth with at Least One Major Depressive Episode (MDE) in the Past Year (23.51%, ranked 49), and Youth with Private Insurance That Did Not Cover Mental or Emotional Problems (14.80%, ranked 49).

ARIZONA (RANKED 50):
The indicators that affected Arizona's Overall Ranking the most were Youth with at Least One Major Depressive Episode (MDE) in the Past Year (23.96%, ranked 50), Youth with Private Insurance That Did Not Cover Mental or Emotional Problems (14.8%, ranked 48), and Mental Health Workforce Availability (590:1, ranked 47).

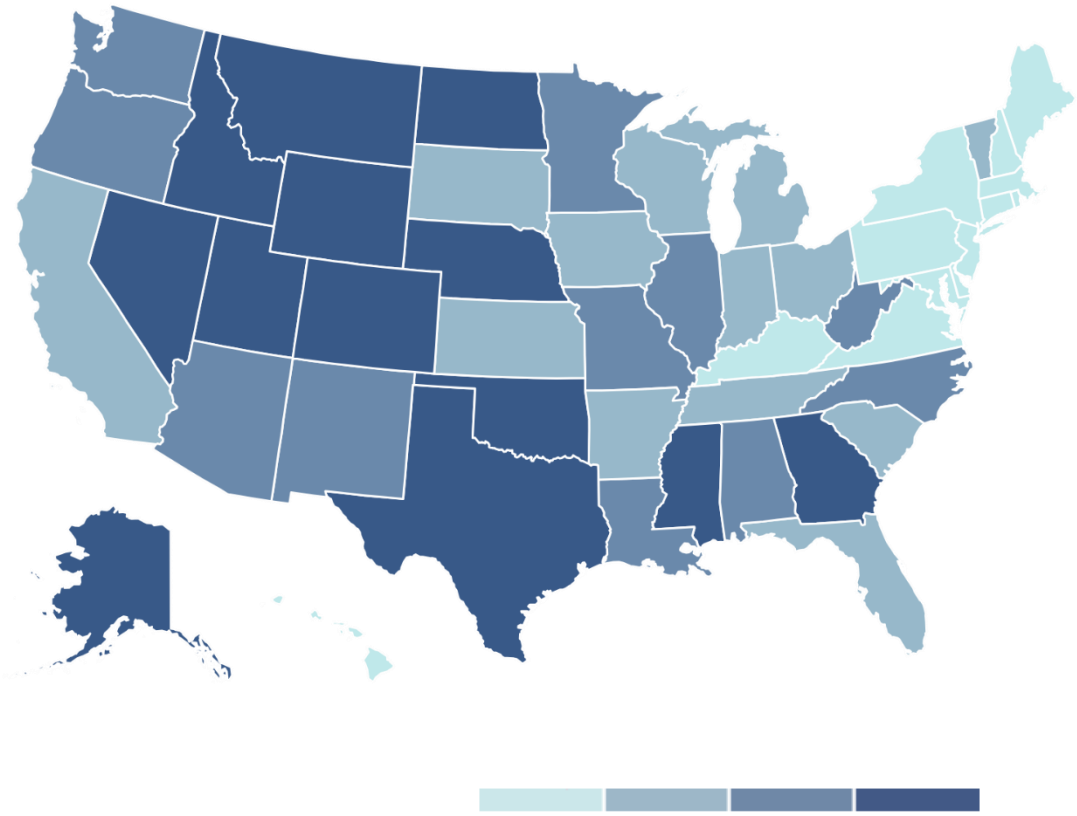
CONNECTICUT (RANKED 2):
The indicators that affected Connecticut's Overall Ranking the most were Youth with Serious Thoughts of Suicide (11%, ranked 2), Youth with Private Insurance That Did Not Cover Mental or Emotional Problems (2.3%, ranked 1), and Adults with Serious Thoughts of Suicide (4.16%, ranked 1).

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 SUD Who Needed but Did Not Receive Treatment
5. Adults with AMI Who Are Uninsured
6. Adults Reporting 14+ Mentally Unhealthy Days a Month Who Could Not See a Doctor Due to Costs
7. Adults with AMI with Private Insurance That Did Not Cover Mental or Emotional Problems



Ranked 1-13 Ranked 39-51

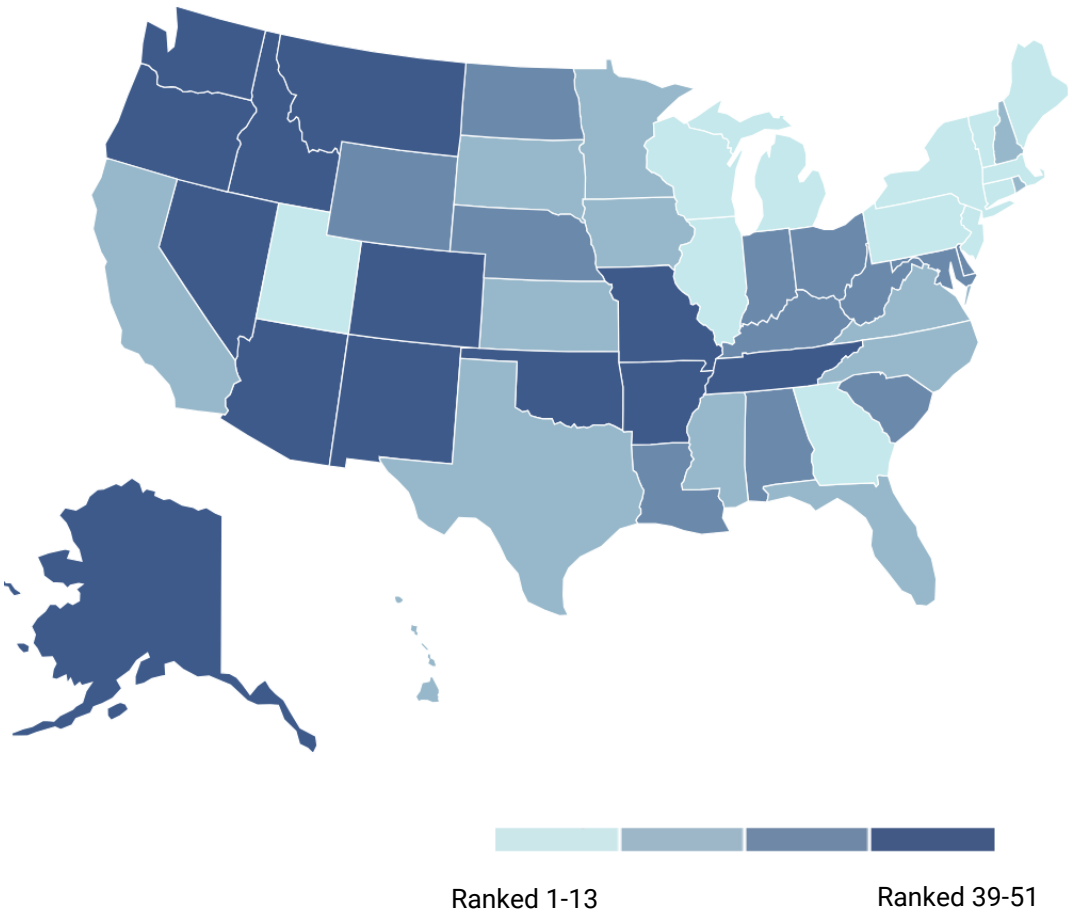
Rank	State
1	New York
2	New Jersey
3	Massachusetts
4	Hawaii
5	Maine
6	Maryland
7	Pennsylvania
8	Connecticut
9	Virginia
10	New Hampshire
11	Delaware
12	Kentucky
13	Rhode Island
14	Wisconsin
15	Michigan
16	Indiana
17	Ohio
18	Florida
19	Vermont
20	Arkansas
21	Iowa
22	California
23	Tennessee
24	Kansas
25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

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 Serious Thoughts of Suicide
4. Youth (Ages 6-17) Flourishing
5. Youth with MDE Who Did Not Receive Mental Health Services
6. Youth with Private Insurance That Did Not Cover Mental or Emotional Problems
7. Students (K+) Identified with Emotional Disturbance for an Individualized Education Program



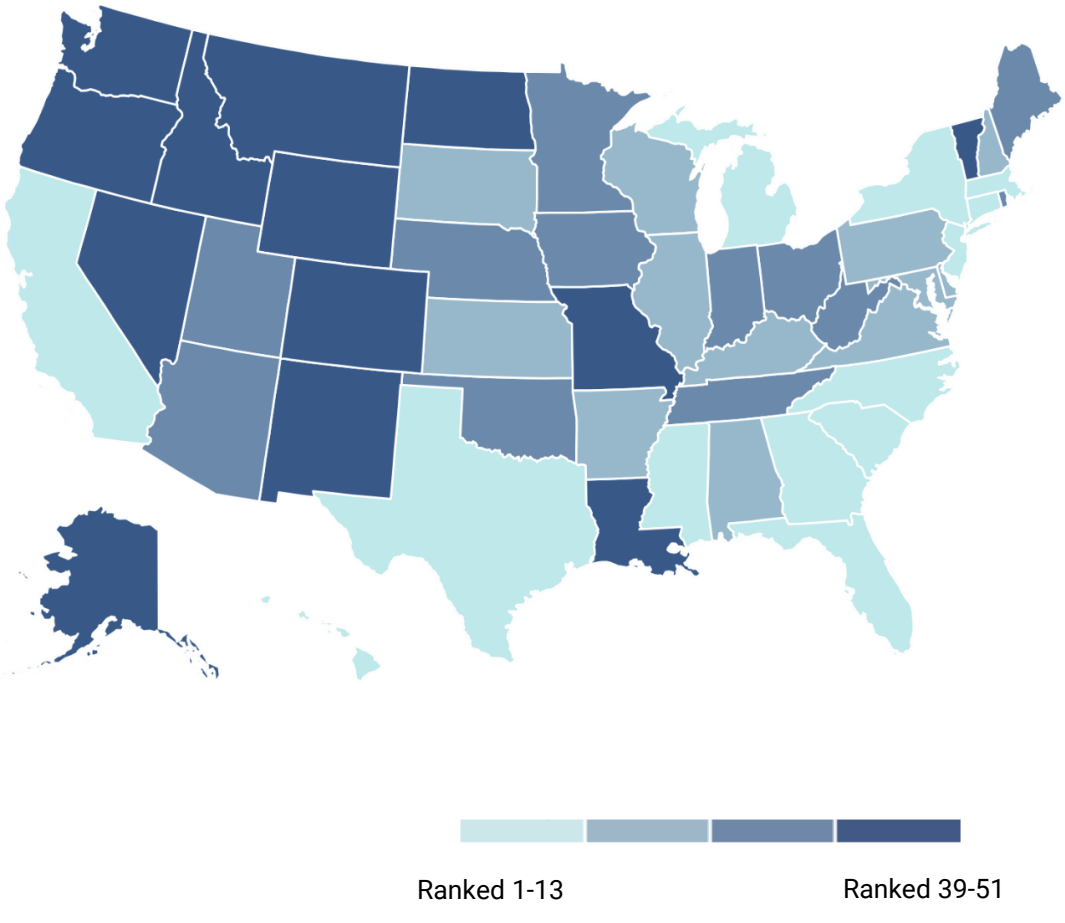
Rank	State
1	District of Columbia
2	Connecticut
3	Massachusetts
4	Illinois
5	Georgia
6	Vermont
7	Maine
8	Utah
9	Michigan
10	New Jersey
11	New York
12	Wisconsin
13	Pennsylvania
14	New Hampshire
15	Texas
16	Kansas
17	Virginia
18	Mississippi
19	Minnesota
20	California
21	Hawaii
22	Florida
23	Rhode Island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

Prevalence of Mental Illness

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.

The seven measures that make up the Prevalence 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 Serious Thoughts of Suicide
7. Youth (Ages 6-17) Flourishing



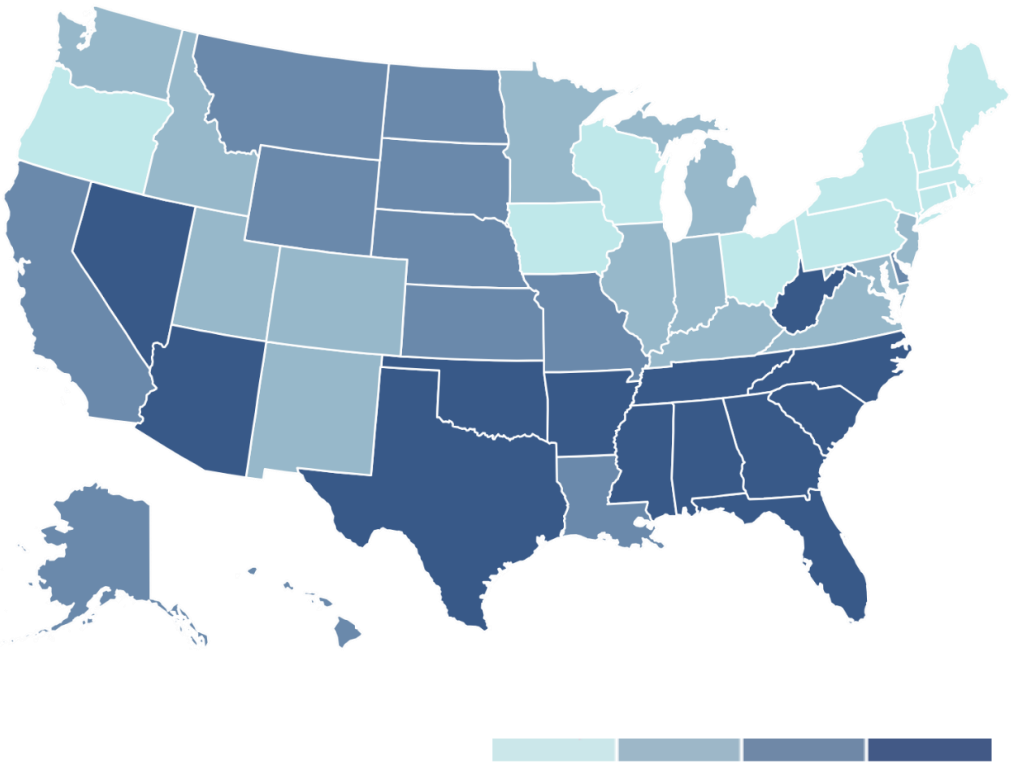
Rank	State
1	Connecticut
2	New Jersey
3	Georgia
4	South Carolina
5	Texas
6	Mississippi
7	Hawaii
8	New York
9	Massachusetts
10	North Carolina
11	Florida
12	Michigan
13	California
14	Illinois
15	Maryland
16	Virginia
17	Delaware
18	Pennsylvania
19	Kansas
20	New Hampshire
21	Alabama
22	District of Columbia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

The eight measures that make up the Access Ranking include:

1. Adults with SUD Who Needed but Did Not Receive Treatment
2. Adults with AMI Who Are Uninsured
3. Adults Reporting 14+ Mentally Unhealthy Days a Month Who Could Not See a Doctor Due to Costs
4. Adults with AMI with Private Insurance That Did Not Cover Mental or Emotional Problems
5. Youth with MDE Who Did Not Receive Mental Health Services
6. Youth with Private Insurance That Did Not Cover Mental or Emotional Problems
7. Students (K+) Identified with Emotional Disturbance for an Individualized Education Program
8. Mental Health Workforce Availability

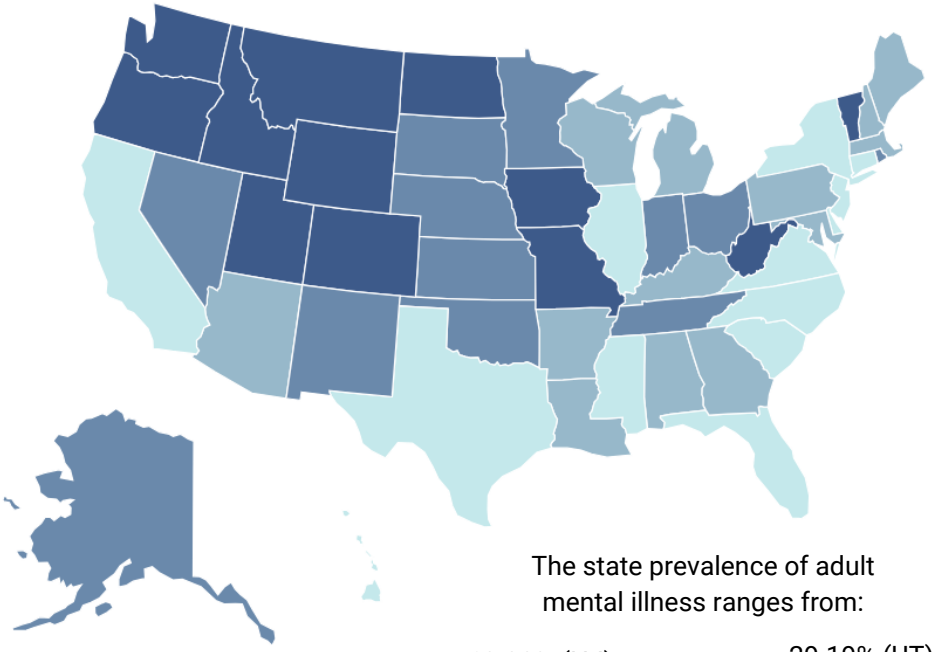


Ranked 1-13 Ranked 39-51

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

Adult Prevalence of Mental Illness

Adults with Any Mental Illness (AMI)



The state prevalence of adult mental illness ranges from:

19.38% (NJ)
Ranked 1-13

29.19% (UT)
Ranked 39-51

23.08% of adults experienced a mental illness in the past year, **equivalent to nearly 60 million Americans.**

5.86% experienced a *severe* mental illness.

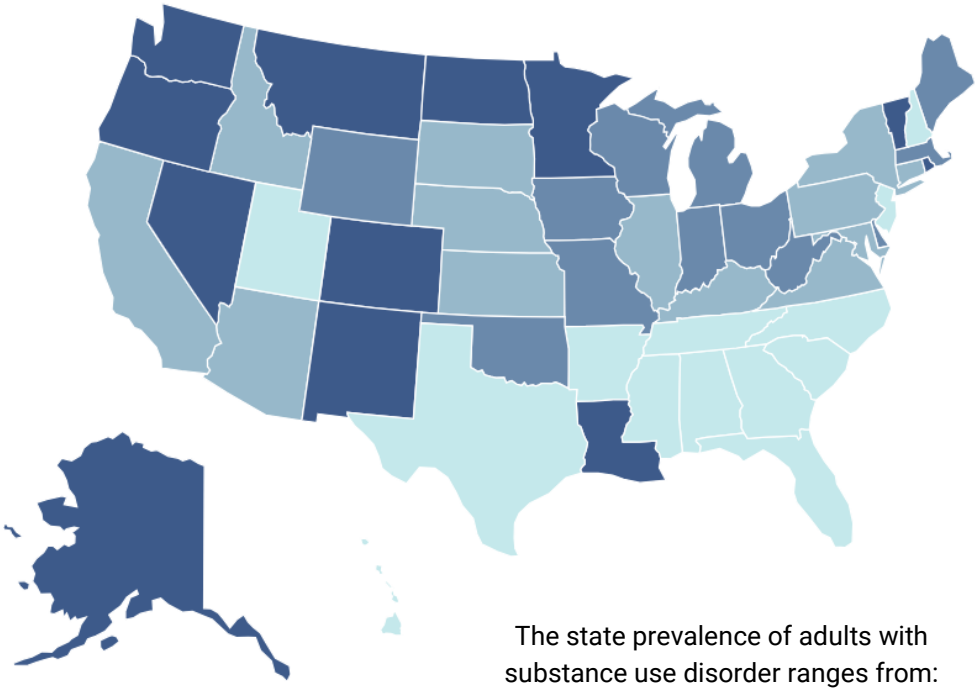
In 2022, completely rural counties had the highest percentage of adults reporting AMI (25.7%). Large metro counties had the lowest percentage of adults with AMI (22.1%).[1] While rural communities are resilient and can provide residents with more connection, they often face increased risk factors for poor mental health and barriers to accessing care. In many states, families in rural communities are more likely to experience poverty,[2] face food insecurity,[3] and have less access to preventative services and providers than those in non-rural areas.[4]

Rank	State	%	#
1	New Jersey	19.38	1,389,000
2	Florida	20.45	3,563,000
3	Delaware	20.93	165,000
4	Connecticut	21.05	599,000
5	New York	21.11	3,273,000
6	Hawaii	21.47	234,000
7	Texas	21.94	4,797,000
8	Illinois	22.01	2,136,000
9	Mississippi	22.16	487,000
10	California	22.19	6,665,000
11	North Carolina	22.19	1,804,000
12	Virginia	22.28	1,470,000
13	South Carolina	22.35	902,000
14	Maryland	22.37	1,056,000
15	Georgia	22.52	1,836,000
16	Michigan	22.89	1,789,000
17	New Hampshire	23.06	259,000
18	Massachusetts	23.18	1,292,000
19	Pennsylvania	23.18	2,352,000
20	Arizona	23.26	1,308,000
21	Wisconsin	23.66	1,082,000
22	Kentucky	23.77	813,000
23	Arkansas	23.86	546,000
24	Maine	24.07	268,000
25	Alabama	24.09	931,000
26	Louisiana	24.34	838,000

Rank	State	%	#
27	Kansas	24.41	532,000
28	Indiana	24.44	1,260,000
29	Ohio	24.52	2,214,000
30	Nevada	24.65	600,000
31	Rhode Island	24.67	216,000
32	Minnesota	24.74	1,077,000
33	South Dakota	24.89	166,000
34	Alaska	24.96	132,000
35	Tennessee	25.47	1,370,000
36	New Mexico	25.67	414,000
37	Nebraska	25.71	376,000
38	Oklahoma	25.88	768,000
39	North Dakota	25.95	150,000
40	West Virginia	26.28	367,000
41	Colorado	26.30	1,186,000
42	Missouri	26.50	1,248,000
43	District of Columbia	26.63	143,000
44	Iowa	26.71	649,000
45	Vermont	26.80	141,000
46	Montana	27.12	234,000
47	Washington	27.14	1,629,000
48	Wyoming	27.44	121,000
49	Oregon	27.48	922,000
50	Idaho	28.02	402,000
51	Utah	29.19	700,000
	National	23.08	58,867,000

According to SAMHSA, "Any Mental Illness (AMI) aligns with Diagnostic and Statistical Manual of Mental Disorders, 4th edition criteria and is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. These estimates are based on indicators of AMI rather than direct measures of diagnostic status."

Adults with Substance Use Disorder in the Past Year



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

14.15% (UT)
Ranked 1-13

24.30% (AK)
Ranked 39-51

17.82% of adults in the U.S. had a substance use disorder in the past year, totaling **over 45 million people.**

11.28% of adults had an alcohol use disorder in the past year.

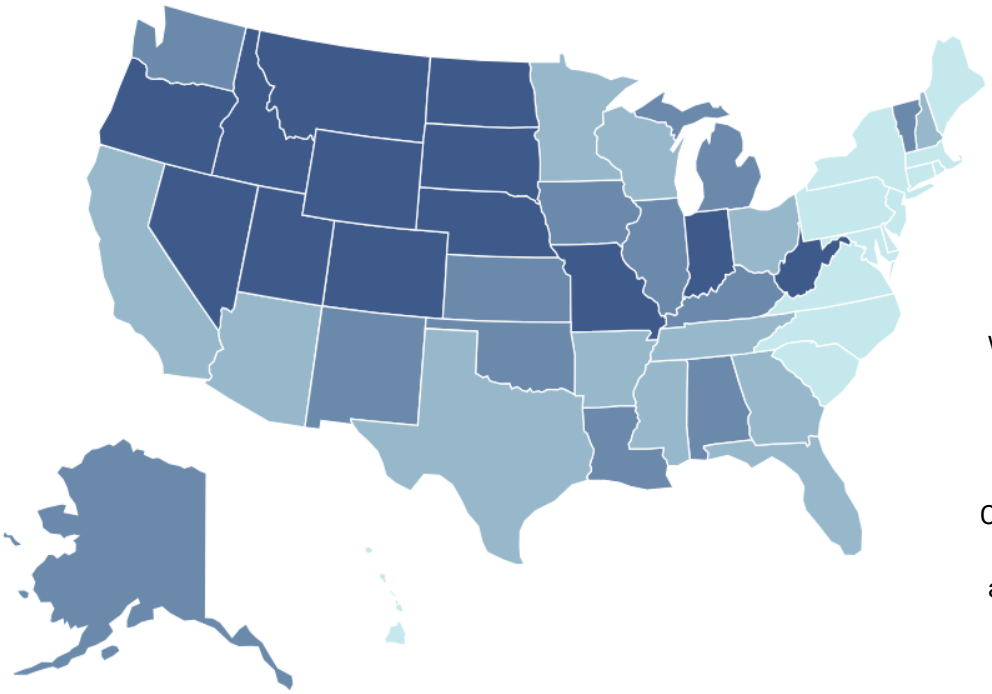
9.41% of adults in the U.S. had a drug use disorder in the past year. In 2022, marijuana was the most common substance identified for those with a drug use disorder. 6.9% of adults with a drug use disorder had a marijuana use disorder in 2022.[5]

Rank	State	%	#
1	Utah	14.15	340,000
2	Alabama	15.19	587,000
3	Florida	15.30	2,665,000
4	South Carolina	15.42	622,000
5	Texas	15.45	3,380,000
6	North Carolina	15.71	1,277,000
7	Arkansas	15.76	361,000
8	New Jersey	16.34	1,171,000
9	Hawaii	16.35	178,000
10	Tennessee	16.49	887,000
11	Mississippi	16.82	370,000
12	Georgia	16.99	1,385,000
13	New Hampshire	17.37	195,000
14	Kentucky	17.41	596,000
15	Nebraska	17.58	257,000
16	Kansas	17.69	386,000
17	Maryland	17.73	837,000
18	Virginia	17.79	1,173,000
19	New York	17.81	2,762,000
20	Illinois	17.86	1,733,000
21	Arizona	17.97	1,011,000
22	Pennsylvania	18.01	1,827,000
23	California	18.04	5,418,000
24	Idaho	18.17	260,000
25	South Dakota	18.24	121,000
26	Connecticut	18.39	523,000

Rank	State	%	#
27	Michigan	18.42	1,440,000
28	Wisconsin	18.44	844,000
29	West Virginia	18.68	261,000
30	Maine	18.80	209,000
31	Delaware	18.81	148,000
32	Missouri	18.89	889,000
33	Indiana	19.08	983,000
34	Massachusetts	19.16	1,068,000
35	Ohio	19.19	1,733,000
36	Iowa	19.32	469,000
37	Oklahoma	19.66	584,000
38	Wyoming	20.21	89,000
39	Washington	20.23	1,214,000
40	Minnesota	20.43	890,000
41	Louisiana	20.62	710,000
42	North Dakota	20.80	120,000
43	Montana	21.00	181,000
44	Nevada	21.60	525,000
45	Rhode Island	22.61	198,000
46	Oregon	22.71	762,000
47	Vermont	22.79	120,000
48	Colorado	23.08	1,040,000
49	New Mexico	23.55	380,000
50	District of Columbia	24.22	130,000
51	Alaska	24.30	128,000
	National	17.82	45,438,000

According to SAMHSA, "Substance Use Disorder (SUD) estimates are based on Diagnostic and Statistical Manual of Mental Disorders, 5th edition criteria. SUD is defined as meeting the criteria for drug or alcohol use disorder. Beginning with the 2021 National Survey on Drug Use and Health, questions on prescription drug use disorder were asked of all past year users of prescription drugs, regardless of whether they misused prescription drugs."

Adults with Serious Thoughts of Suicide



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

4.16% (CT) Ranked 1-13

7.12% (UT) Ranked 39-51

5.04% of adults reported experiencing serious thoughts of suicide. The estimated number of adults with serious suicidal thoughts in the U.S. is **over 12.8 million.**

After slight decreases in suicide deaths in 2019 and 2020, the number of individuals who died by suicide in 2022 was the highest number ever recorded in the U.S.[6]

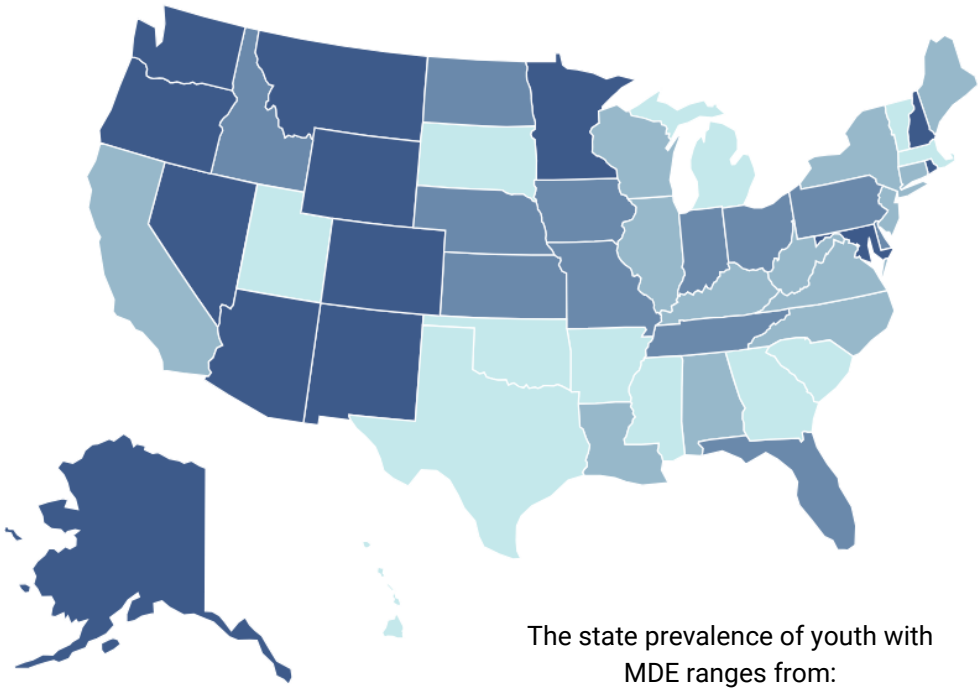
Only 15% of adults experiencing suicidal ideation reported that it was because of the COVID-19 pandemic in 2022. However, these rates were significantly higher among Black and Hispanic adults, who experienced some of the highest rates of death and greatest socioeconomic impacts of the pandemic. 27% of Black adults and 16% of Hispanic adults reported their suicidal ideation was because of COVID-19 in 2022, compared to 11% of white adults.[7]

Rank	State	%	#
1	Connecticut	4.16	118,000
2	New York	4.29	665,000
3	Massachusetts	4.36	243,000
4	New Jersey	4.37	313,000
5	Maryland	4.41	208,000
6	Maine	4.56	51,000
7	Hawaii	4.64	50,000
8	South Carolina	4.67	188,000
9	North Carolina	4.70	382,000
10	Rhode Island	4.74	41,000
11	Pennsylvania	4.74	481,000
12	Delaware	4.75	37,000
13	Virginia	4.76	314,000
14	Florida	4.80	836,000
15	New Hampshire	4.87	55,000
16	Mississippi	4.94	109,000
17	California	4.97	1,491,000
18	Texas	4.98	1,090,000
19	Georgia	5.02	410,000
20	Minnesota	5.07	221,000
21	Tennessee	5.11	275,000
22	Arizona	5.15	290,000
23	Wisconsin	5.16	236,000
24	Ohio	5.21	470,000
25	Arkansas	5.23	120,000
26	District of Columbia	5.25	28,000

Rank	State	%	#
27	Illinois	5.26	511,000
28	Kansas	5.31	116,000
29	Vermont	5.35	28,000
30	Kentucky	5.41	185,000
31	Michigan	5.42	424,000
32	Alabama	5.44	210,000
33	Oklahoma	5.47	162,000
34	Alaska	5.47	29,000
35	Louisiana	5.51	190,000
36	Iowa	5.51	134,000
37	Washington	5.51	331,000
38	New Mexico	5.55	90,000
39	Indiana	5.56	287,000
40	South Dakota	5.59	37,000
41	Missouri	5.61	264,000
42	Oregon	5.61	188,000
43	North Dakota	5.68	33,000
44	West Virginia	5.71	80,000
45	Nevada	5.75	140,000
46	Wyoming	5.84	26,000
47	Colorado	5.91	266,000
48	Montana	6.02	52,000
49	Nebraska	6.15	90,000
50	Idaho	6.68	96,000
51	Utah	7.12	171,000
	National	5.04	12,860,000

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:

16.02% (DC)
Ranked 1-13

24.96% (OR)
Ranked 39-51

20.17% of youth (ages 12-17) reported suffering from at least one major depressive episode (MDE) in the past year.

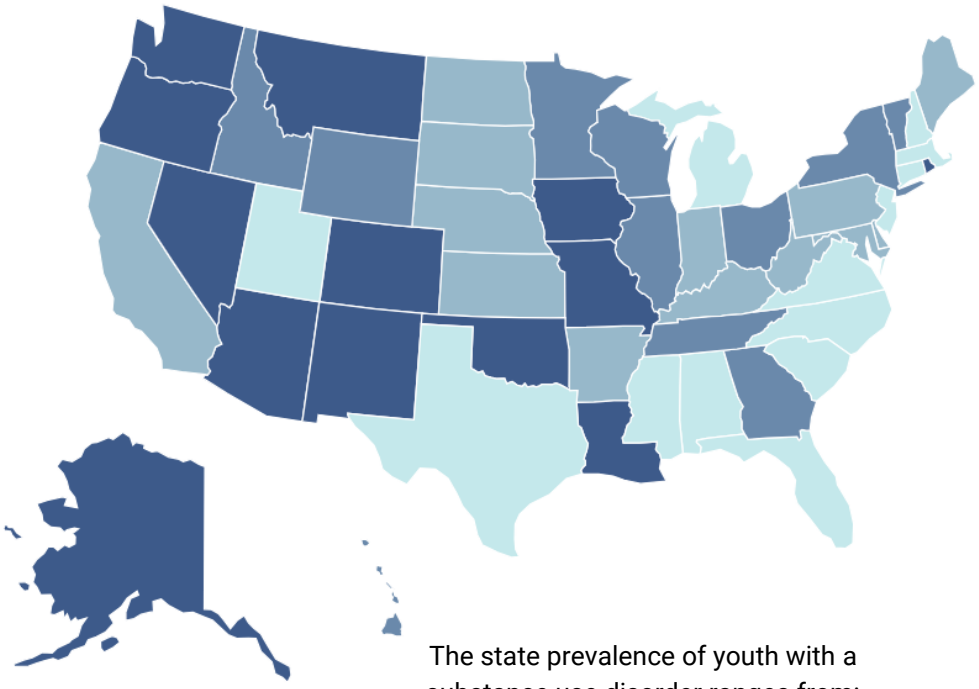
15% of youth in the U.S. experienced an MDE with severe impairment, meaning it severely impacted their functioning at work, school, or home.

While this indicator measures the percentage of youth who met the criteria for depression under the DSM-V, other datasets suggest that distress among youth is much more prevalent. According to the 2021 Youth Risk Behavior Survey (YRBS), 42% of high school students reported persistent feelings of sadness or hopelessness.[8]

Rank	State	%	#
1	District of Columbia	16.02	5,000
2	Hawaii	17.15	17,000
3	Georgia	17.39	159,000
4	South Carolina	17.88	72,000
5	Utah	18.33	62,000
6	Texas	18.40	483,000
7	Michigan	18.65	142,000
8	Mississippi	18.73	47,000
9	Oklahoma	18.76	63,000
10	Arkansas	18.97	47,000
11	Massachusetts	19.18	93,000
12	South Dakota	19.21	14,000
13	Vermont	19.25	8,000
14	Alabama	19.41	76,000
15	Wisconsin	19.41	89,000
16	North Carolina	19.46	160,000
17	Kentucky	19.50	69,000
18	New York	19.58	272,000
19	New Jersey	19.70	141,000
20	Connecticut	19.83	54,000
21	West Virginia	19.85	25,000
22	Louisiana	19.91	74,000
23	Maine	19.93	18,000
24	California	20.01	616,000
25	Illinois	20.21	202,000
26	Virginia	20.22	133,000

Rank	State	%	#
27	Kansas	20.34	50,000
28	Indiana	20.44	114,000
29	Tennessee	20.50	111,000
30	Pennsylvania	20.50	193,000
31	Delaware	20.55	15,000
32	Ohio	20.79	190,000
33	Iowa	20.88	54,000
34	Nebraska	21.12	35,000
35	Florida	21.43	325,000
36	Idaho	21.50	37,000
37	North Dakota	21.56	13,000
38	Missouri	21.59	105,000
39	New Hampshire	21.63	20,000
40	Wyoming	21.70	10,000
41	Alaska	21.72	13,000
42	Montana	21.89	18,000
43	Minnesota	22.07	102,000
44	Rhode Island	22.15	16,000
45	Maryland	22.17	105,000
46	New Mexico	23.23	40,000
47	Colorado	23.32	103,000
48	Washington	23.39	135,000
49	Nevada	23.51	58,000
50	Arizona	23.96	139,000
51	Oregon	24.96	76,000
	National	20.17	5,217,000

Youth with Substance Use Disorder in the Past Year



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

5.43% (UT)
Ranked 1-13

16.01% (NM)
Ranked 39-51

8.95% of youth in the U.S. had a substance use disorder in the past year.

3.32% had an alcohol use disorder in the past year, while 7.17% had a drug use disorder.

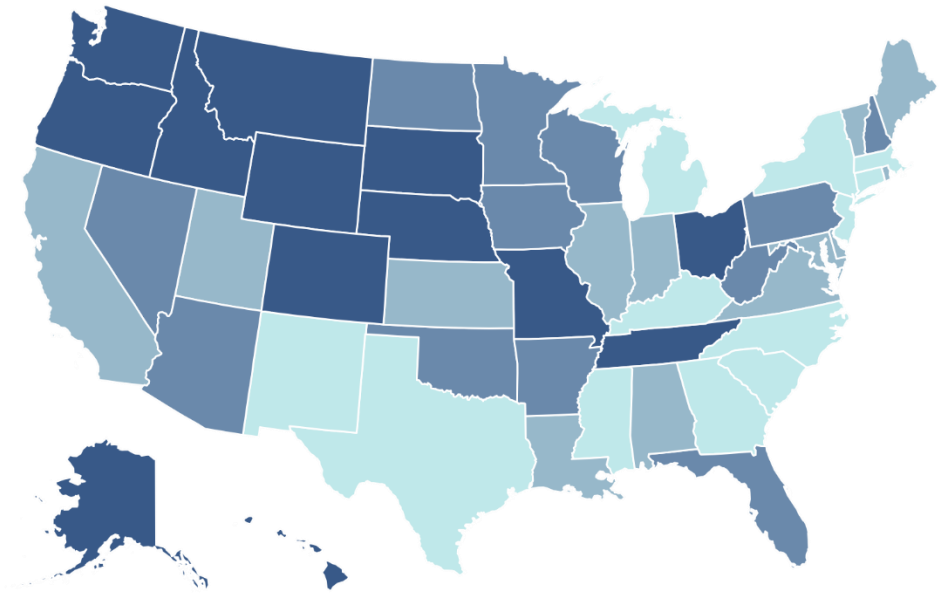
According to a survey of youth ages 13-18 being assessed for substance use disorder treatment from 2014-2022, the most common reasons youth reported using substances were to feel mellow, calm or relaxed (73%), to have fun or experiment (50%), to sleep better or to fall asleep (44%), and to stop worrying about a problem or to forget bad memories (44%). Forty percent reported they used substances to help with depression or anxiety.[9] Upstream substance use prevention strategies could focus on these motivations by better addressing underlying stressors faced by youth, helping families improve sleep habits or hygiene, and promoting mental wellness or healthy coping skills.

Rank	State	%	#
1	Utah	5.43	18,000
2	New Hampshire	7.13	7,000
3	New Jersey	7.25	52,000
4	North Carolina	7.42	61,000
5	South Carolina	7.44	30,000
6	Connecticut	7.66	21,000
7	Mississippi	7.69	19,000
8	Virginia	7.69	50,000
9	Texas	7.79	204,000
10	Alabama	7.82	31,000
11	Michigan	8.12	62,000
12	Massachusetts	8.14	39,000
13	Florida	8.19	124,000
14	California	8.21	253,000
15	South Dakota	8.23	6,000
16	Maryland	8.31	39,000
17	Kentucky	8.40	30,000
18	Pennsylvania	8.55	80,000
19	Maine	8.66	8,000
20	Arkansas	8.77	22,000
21	Indiana	8.78	49,000
22	Kansas	8.81	22,000
23	Nebraska	8.86	15,000
24	West Virginia	8.96	11,000
25	North Dakota	8.97	5,000
26	Delaware	9.09	7,000

Rank	State	%	#
27	Georgia	9.29	85,000
28	Illinois	9.33	93,000
29	Ohio	9.41	86,000
30	Wyoming	9.43	5,000
31	Hawaii	9.44	9,000
32	Tennessee	9.47	51,000
33	New York	9.53	132,000
34	Idaho	9.86	17,000
35	Vermont	10.10	4,000
36	Wisconsin	10.28	47,000
37	Minnesota	10.30	47,000
38	District of Columbia	10.34	4,000
39	Arizona	10.68	62,000
40	Montana	10.93	9,000
41	Iowa	10.95	28,000
42	Washington	10.96	63,000
43	Rhode Island	11.03	8,000
44	Missouri	11.15	54,000
45	Colorado	11.27	50,000
46	Oklahoma	11.49	38,000
47	Alaska	11.51	7,000
48	Oregon	12.52	38,000
49	Louisiana	13.40	50,000
50	Nevada	14.09	35,000
51	New Mexico	16.01	27,000
	National	8.95	2,316,000

According to SAMHSA, "Substance Use Disorder (SUD) estimates are based on Diagnostic and Statistical Manual of Mental Disorders, 5th edition criteria. SUD is defined as meeting the criteria for drug or alcohol use disorder. Beginning with the 2021 National Survey on Drug Use and Health, questions on prescription drug use disorder were asked of all past year users of prescription drugs, regardless of whether they misused prescription drugs."

Youth with Serious Thoughts of Suicide



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

10.68% (DC)
Ranked 1-13

15.00% (OR)
Ranked 39-51

13.16% of youth (over 3.4 million youth) are experiencing serious thoughts of suicide.

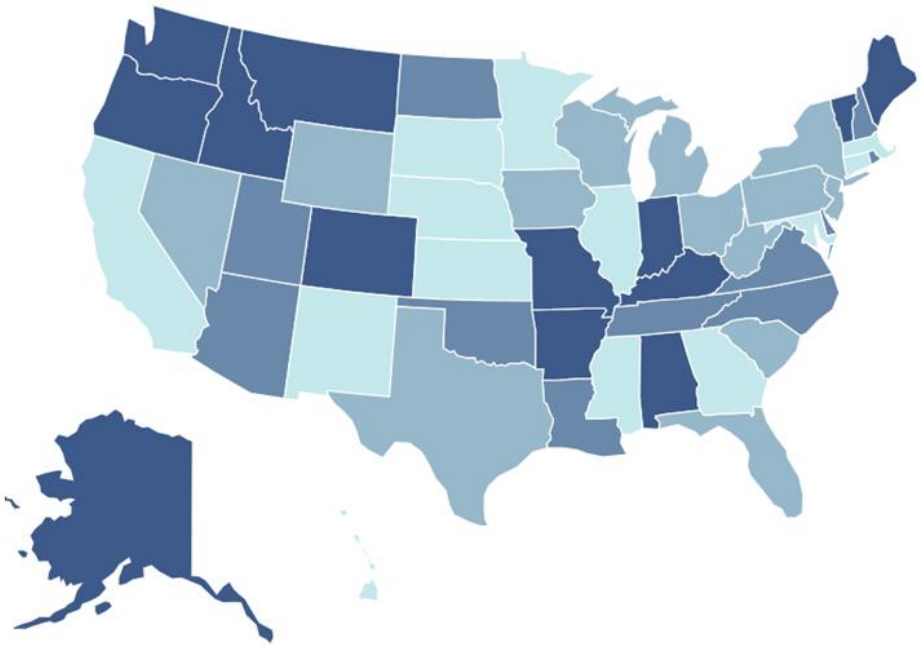
There are significant racial disparities for youth suicidality. In 2021-2022, the percentage of youth reporting suicidal ideation was highest among youth who identified as Native Hawaiian or Other Pacific Islander (25%) and as more than one race (20%). Suicide rates are highest for American Indian and Alaska Native youth and young adults ages 10-24 (36.3 per 100,000). From 2018-2021, the suicide rate among Black youth and young adults increased 37%, the highest increase across race/ethnicity.[10]

There are also disparities among LGBQ+ students in the U.S. According to the 2021 YRBS, 45% of LGBQ+ high school students reported seriously considering attempting suicide, compared to 15% of heterosexual students.[11]

Rank	State	%	#
1	District of Columbia	10.68	4,000
2	Connecticut	11.00	30,000
3	Michigan	11.85	90,000
4	Texas	12.05	316,000
5	Massachusetts	12.24	59,000
6	New York	12.25	170,000
7	Georgia	12.34	113,000
8	Mississippi	12.37	31,000
9	South Carolina	12.55	50,000
10	New Jersey	12.71	91,000
11	North Carolina	12.79	105,000
12	Kentucky	12.94	46,000
13	New Mexico	12.95	22,000
14	Rhode Island	12.98	10,000
15	Utah	13.04	44,000
16	Delaware	13.06	10,000
17	Vermont	13.07	6,000
18	Kansas	13.09	32,000
19	Louisiana	13.20	49,000
20	Illinois	13.21	132,000
21	Alabama	13.23	52,000
22	Maryland	13.32	63,000
23	Maine	13.34	12,000
24	Indiana	13.34	74,000
25	California	13.34	411,000
26	Virginia	13.37	88,000

Rank	State	%	#
27	Florida	13.40	203,000
28	Pennsylvania	13.46	127,000
29	New Hampshire	13.58	13,000
30	Arizona	13.61	79,000
31	North Dakota	13.63	8,000
32	Wisconsin	13.69	63,000
33	Oklahoma	13.71	46,000
34	Nevada	13.80	34,000
35	Iowa	13.80	36,000
36	West Virginia	13.90	18,000
37	Minnesota	13.94	64,000
38	Arkansas	14.03	35,000
39	Hawaii	14.04	14,000
40	Tennessee	14.16	77,000
41	Nebraska	14.18	24,000
42	Ohio	14.25	130,000
43	Colorado	14.26	63,000
44	South Dakota	14.33	11,000
45	Wyoming	14.34	7,000
46	Missouri	14.43	70,000
47	Alaska	14.52	9,000
48	Montana	14.64	12,000
49	Washington	14.79	85,000
50	Idaho	14.89	25,000
51	Oregon	15.00	46,000
	National	13.16	3,406,000

Youth (Ages 6-17) Flourishing



The state prevalence of youth flourishing ranges from:

67.30% (GA)
Ranked 1-13

54.30% (KY)
Ranked 39-51

Only 60.5% of youth ages 6-17 across the U.S. meet all three criteria for flourishing.

Flourishing is determined as a positive indicator of mental health and wellbeing by the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau.[12] The criteria for flourishing were designed to assess children and adolescents' learning, resilience, and self-regulation. Youth who were flourishing were those who always or usually showed interest and curiosity in learning new things, work to finish tasks they started, and stayed calm and in control when faced with a challenge. Rates of flourishing are associated with school engagement and other positive outcomes for youth.[13]

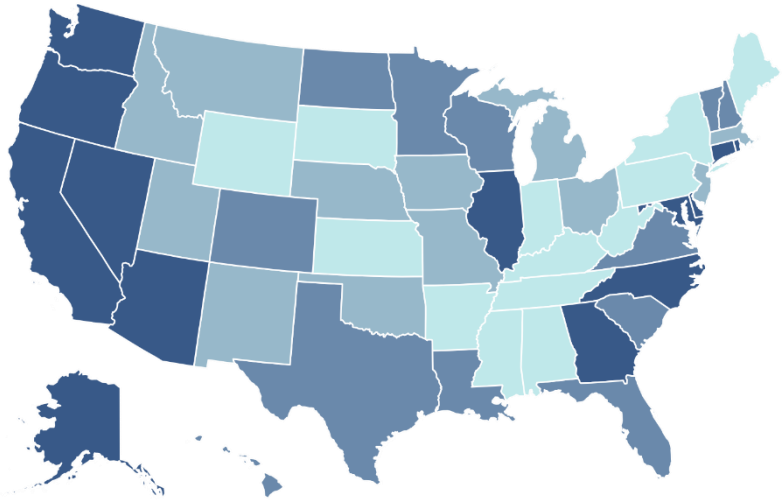
A 2019 study found that the prevalence of flourishing was associated with increases in family resilience and connection, even across youth who had experienced higher levels of adversity such as multiple adverse childhood experiences (ACEs) or lower household incomes.[14] This suggests that state investment in early interventions and supports for parents and families can result in greater flourishing.

Rank	State	%	#
1	Georgia	67.30	1,140,135
2	Illinois	65.10	1,227,071
3	Hawaii	64.80	128,879
4	New Mexico	64.00	209,545
5	Kansas	63.00	300,226
6	Mississippi	63.00	297,462
7	Nebraska	63.00	200,239
8	California	62.70	3,729,267
9	Connecticut	62.70	314,841
10	Massachusetts	62.30	573,969
11	Maryland	62.10	558,711
12	South Dakota	62.10	90,027
13	Minnesota	61.80	544,795
14	New Jersey	61.80	816,222
15	Iowa	61.60	300,447
16	Florida	61.20	1,759,625
17	Wisconsin	61.20	529,575
18	New York	60.80	1,612,253
19	Ohio	60.70	1,059,324
20	Michigan	60.60	873,500
21	Texas	60.60	3,058,797
22	Pennsylvania	60.40	1,086,892
23	Wyoming	60.30	55,957
24	South Carolina	59.90	461,746
25	West Virginia	59.70	147,572
26	Nevada	59.60	278,526

Rank	State	%	#
27	Arizona	59.50	659,292
28	New Hampshire	59.50	105,697
29	District of Columbia	59.40	44,019
30	Rhode Island	59.10	82,001
31	Virginia	59.00	739,666
32	Delaware	58.60	81,622
33	Louisiana	58.10	416,806
34	North Dakota	58.00	68,132
35	North Carolina	57.90	911,184
36	Tennessee	57.60	590,681
37	Oklahoma	57.30	367,068
38	Utah	57.30	367,698
39	Alaska	57.20	67,381
40	Indiana	57.00	604,001
41	Missouri	57.00	529,779
42	Idaho	56.90	178,277
43	Alabama	56.70	420,313
44	Colorado	56.70	484,277
45	Montana	56.50	90,594
46	Arkansas	56.00	267,516
47	Vermont	55.20	44,448
48	Washington	54.80	611,376
49	Maine	54.40	91,980
50	Oregon	54.40	319,747
51	Kentucky	54.30	364,150
	National	60.50	29,863,306

Adult Access to Care

Adults with SUD Who Needed But Did Not Receive Treatment



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

67.24% (WV)
Ranked 1-13

83.99% (IL)
Ranked 39-51

Over three-quarters (76.9%) of all adults with a substance use disorder did not receive the treatment they needed.

Most adults with SUD who sought or thought about receiving treatment reported they didn't because they thought they should have been able to handle their drug or alcohol use on their own (75.4%).

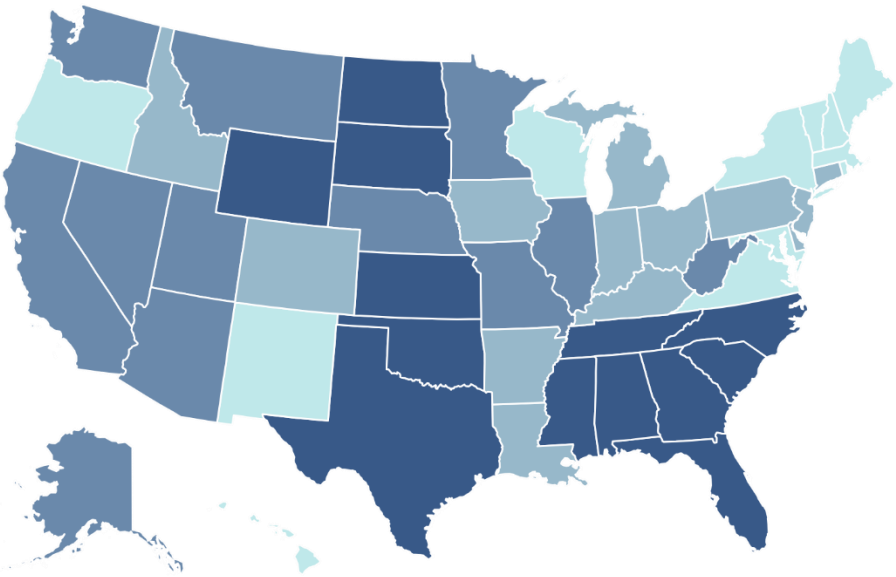
This was followed by:

- Not ready to start treatment (58.6%)
- Not ready to stop or cut back using alcohol or drugs (48.4%)
- Thought it would cost too much (47.7%)
- Did not know how or where to get treatment (47.3%).

A potential limitation of this measure is that SAMHSA's definition of treatment does not include receiving harm reduction services. Harm reduction is a critical part of the continuum of prevention and treatment for substance use disorders and can fill the gap between when individuals want help but are not ready to receive treatment or stop using substances.[15] Harm reduction strategies are proven to be effective in supporting individuals who are currently using drugs or alcohol by preventing overdose and infectious disease transmission, connecting individuals to peers, reducing stigma associated with substance use, and connecting individuals to education and healthcare or social services they may not otherwise have access to.[16] These programs can be even more effective when done in collaboration with other agencies to meet whole family's needs.[17] However, states vary significantly in their laws regarding harm reduction services,[18] limiting access for many throughout the U.S.

Rank	State	%	#
1	West Virginia	67.24	224,000
2	Kentucky	69.57	500,000
3	Wyoming	70.11	71,000
4	Arkansas	70.51	324,000
5	Maine	70.55	165,000
6	Tennessee	71.39	765,000
7	Indiana	71.49	688,000
8	Kansas	71.54	299,000
9	Mississippi	71.62	299,000
10	Alabama	72.15	510,000
11	New York	72.59	2,331,000
12	South Dakota	72.88	100,000
13	Pennsylvania	72.90	1,505,000
14	Montana	73.01	149,000
15	Missouri	73.11	766,000
16	Iowa	73.30	356,000
17	Utah	73.67	300,000
18	Idaho	73.74	225,000
19	Massachusetts	73.87	873,000
20	New Mexico	74.15	278,000
21	Oklahoma	74.44	479,000
22	Ohio	74.57	1,542,000
23	New Jersey	74.91	1,008,000
24	Michigan	74.98	1,251,000
25	District of Columbia	75.02	124,000
26	Nebraska	75.19	213,000
27	South Carolina	75.64	585,000
28	Vermont	75.70	92,000
29	Florida	75.97	2,329,000
30	New Hampshire	76.54	175,000
31	Louisiana	77.15	615,000
32	Virginia	77.45	1,006,000
33	North Dakota	77.62	94,000
34	Wisconsin	77.65	723,000
35	Colorado	78.36	907,000
36	Minnesota	78.40	757,000
37	Hawaii	78.52	151,000
38	Texas	78.54	3,099,000
39	Connecticut	79.14	478,000
40	Rhode Island	79.32	190,000
41	Delaware	79.32	129,000
42	Nevada	79.33	470,000
43	Washington	79.53	1,116,000
44	North Carolina	79.56	1,217,000
45	Arizona	79.59	894,000
46	Oregon	79.91	691,000
47	Maryland	80.01	691,000
48	Georgia	80.36	1,245,000
49	Alaska	81.51	109,000
50	California	82.77	4,963,000
51	Illinois	83.99	1,624,000
	National	76.90	39,692,000

Adults with AMI Who Are Uninsured



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

2.60% (DC) Ranked 1-13 — 22.90% (TX) Ranked 39-51

Rank	State	Rate	#
1	District of Columbia	2.60	4,000
2	Vermont	3.40	5,000
3	Oregon	4.40	43,000
4	Maine	4.50	12,000
5	Rhode Island	4.50	11,000
6	Hawaii	4.60	12,000
7	Wisconsin	4.70	48,000
8	Maryland	4.90	55,000
9	New Hampshire	4.90	13,000
10	New York	5.00	162,000
11	New Mexico	5.20	22,000
12	Massachusetts	5.30	68,000
13	Virginia	5.40	80,000
14	Kentucky	5.60	44,000
15	Pennsylvania	5.80	133,000
16	Iowa	6.40	45,000
17	New Jersey	6.40	84,000
18	Idaho	6.50	27,000
19	Michigan	6.50	115,000
20	Indiana	6.60	84,000
21	Delaware	7.10	11,000
22	Colorado	7.20	88,000
23	Connecticut	7.50	42,000
24	Louisiana	7.50	64,000
25	Ohio	7.50	164,000
26	Arkansas	7.80	40,000
27	California	7.80	522,000
28	Alaska	7.90	10,000
29	Washington	7.90	137,000
30	Nevada	8.70	55,000
31	Utah	8.70	64,000
32	Minnesota	9.10	100,000
33	Illinois	9.30	197,000
34	Nebraska	9.40	33,000
35	Missouri	9.50	127,000
36	West Virginia	10.50	41,000
37	Arizona	10.60	132,000
38	Montana	11.80	27,000
39	South Dakota	12.40	19,000
40	Tennessee	12.80	182,000
41	North Dakota	12.90	18,000
42	Kansas	13.50	70,000
43	South Carolina	13.60	111,000
44	Alabama	14.40	132,000
45	Florida	14.90	516,000
46	North Carolina	15.50	271,000
47	Oklahoma	16.10	121,000
48	Georgia	18.70	351,000
49	Wyoming	19.70	24,000
50	Mississippi	22.80	111,000
51	Texas	22.90	1,068,000
	National	10.10	5,916,000

10.1% of adults (over 5.9 million people) with a mental illness are uninsured, compared to 9.3% of adults without a mental illness.

In 2022, 64% of adults who were uninsured said that they did not have health insurance because they could not afford it.[19] Without health insurance, individuals often delay or forgo mental health care. In 2019, 62% of uninsured adults with anxiety or depression did not receive treatment, compared to 37% of those with private insurance and 35% of those with Medicaid.[20] When individuals forgo care, their conditions often worsen,[21] causing them to reach a crisis point in which they need to receive care. This is not only costly to the individual but also to medical providers, states, and the federal government, who are responsible for most uncompensated care costs.

States can improve health coverage rates for individuals with mental health conditions and reduce uncompensated care costs through Medicaid expansion. From 2013-2022, the uninsured rate among low-income adults decreased from 35% to 15% in states that expanded Medicaid, while the rate only decreased from 44% to 30% in non-expansion states.[22] From 2018-2019, uncompensated care costs increased 6% across all states, but decreased 14% in Virginia and Maine, the two states that expanded Medicaid that year.[23]

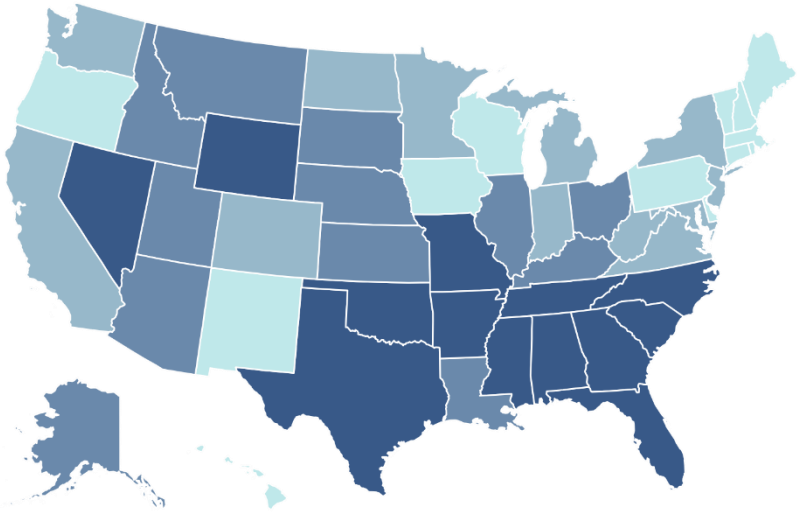
Nine of the 10 states that have not expanded Medicaid are ranked 39-51. Among these non-expansion states, 13-24% of the remaining uninsured population fall within the Medicaid coverage gap.[24] Wisconsin (ranked 7th) is the only non-expansion state that does not have a Medicaid coverage gap, as state policy ensures that all low-income residents are either covered by Medicaid or given subsidies to purchase private insurance.[25] Other states, like Tennessee, have created safety net programs to fill gaps in access to behavioral health care for uninsured residents. While the impacts of these programs are not reflected in this indicator, they are reflected in the other access to care indicators in this report.

Adults Reporting 14+ Mentally Unhealthy Days a Month Who Could Not See a Doctor Due to Costs

24.58% of adults who reported experiencing 14 or more mentally unhealthy days each month were not able to see a doctor due to costs. This was a 2% increase over last year's report.

High costs of mental health care are a critical barrier to access. In 2022, 58.9% of adults with a mental illness in the past year who sought or thought they should receive mental health care said the reason they did not receive it was because they thought it would cost too much.[26]

The largest increases in adults experiencing frequent mental distress* who could not see a doctor due to cost were in Nevada (10.46% increase), Kentucky (8.89%), and Tennessee (7.61%). However, decreasing health care affordability was not unique to these states – nationally between 2017 and 2021, prices for healthcare services increased 14%, with the greatest increases for inpatient services.[27]



The prevalence of adults with 14+ mentally unhealthy days who could not see a doctor due to cost ranges from:

12.88% (HI) Ranked 1-13

34.95% (GA) Ranked 39-51

Rank	State	%	#
1	Hawaii	12.88	16,793
2	Rhode Island	13.90	18,748
3	Vermont	15.04	12,752
4	Massachusetts	15.84	127,266
5	Oregon	17.44	103,696
6	Connecticut	18.34	75,156
7	Delaware	18.37	20,855
8	New Mexico	18.49	48,170
9	Pennsylvania	18.66	283,014
10	Wisconsin	18.84	138,097
11	Maine	18.85	33,832
12	Iowa	19.10	63,036
13	New Hampshire	19.41	36,583
14	Michigan	19.45	253,407
15	Maryland	19.48	134,072
16	Minnesota	19.55	125,782
17	New York	20.25	480,099
18	California	20.26	855,786
19	New Jersey	20.75	204,236
20	District of Columbia	20.87	15,247
21	West Virginia	21.17	62,187
22	Virginia	21.25	232,815
23	Washington	21.35	213,394
24	Indiana	21.90	190,222
25	Colorado	22.16	161,822
26	North Dakota	22.27	18,476

Rank	State	%	#
27	Ohio	22.76	375,207
28	South Dakota	22.90	19,731
29	Montana	23.00	32,700
30	Nebraska	23.52	42,413
31	Illinois	24.54	327,839
32	Alaska	25.15	20,818
33	Kentucky	25.28	141,765
34	Idaho	26.02	56,813
35	Louisiana	26.14	181,572
36	Arizona	26.25	245,891
37	Utah	27.74	110,845
38	Kansas	27.83	97,880
39	Florida	27.91	733,717
40	Tennessee	28.19	309,054
41	Missouri	29.17	236,191
42	South Carolina	29.22	186,625
43	Oklahoma	29.71	159,026
44	Arkansas	30.37	142,055
45	North Carolina	30.71	387,402
46	Mississippi	31.15	108,393
47	Nevada	32.26	115,706
48	Wyoming	32.97	21,562
49	Alabama	33.24	233,201
50	Texas	34.38	1,223,117
51	Georgia	34.95	462,803
	National	24.58	9,897,868

*Mentally unhealthy days are derived from the question, "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" Having 14 or more mentally unhealthy days each month is defined as experiencing frequent mental distress.[28]

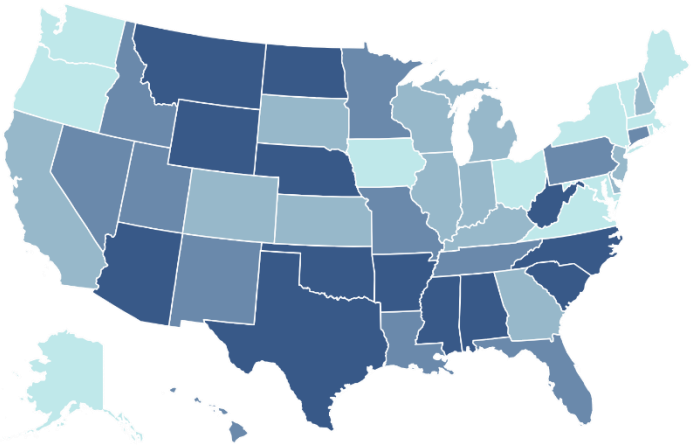
Adults with AMI with Private Insurance That Did Not Cover Mental or Emotional Problems

10.2% of adults who experienced a mental illness in the past year had private health insurance that did not cover mental or emotional problems.

The Mental Health Parity and Addiction Equity Act (MHPAEA), enacted in 2008, requires that a private insurer cannot have more restrictive requirements for mental health than for physical health (if benefits for mental health are included in the plan). It does not require private insurers to cover mental health services.

Even when people have some insurance coverage for their mental health, it does not guarantee they will be able to receive mental health care that is covered by insurance. Individuals are often forced to pay to see out-of-network providers because of a lack of mental health providers working in network. A 2024 study found that patients went out-of-network 3.5 times more often to see a behavioral health clinician, 10.6 times more often to see a psychologist, 8.9 times more often to see a psychiatrist, and 19.9 times more often for sub-acute behavioral health inpatient care than to see a medical/surgical clinician.[29] Many behavioral health providers practice out-of-network because they are reimbursed significantly less than medical/surgical clinicians.[30]

Under the revised parity rules proposed in 2023, plans would be required to collect and analyze data on practices including reimbursement rates and network composition, and if such practices created unequal access to individuals with mental health conditions, plans would have to take action to correct them.[31]



The prevalence of adults with AMI whose private insurance did not cover mental or emotional problems ranges from:

3.60% (VT) Ranked 1-13

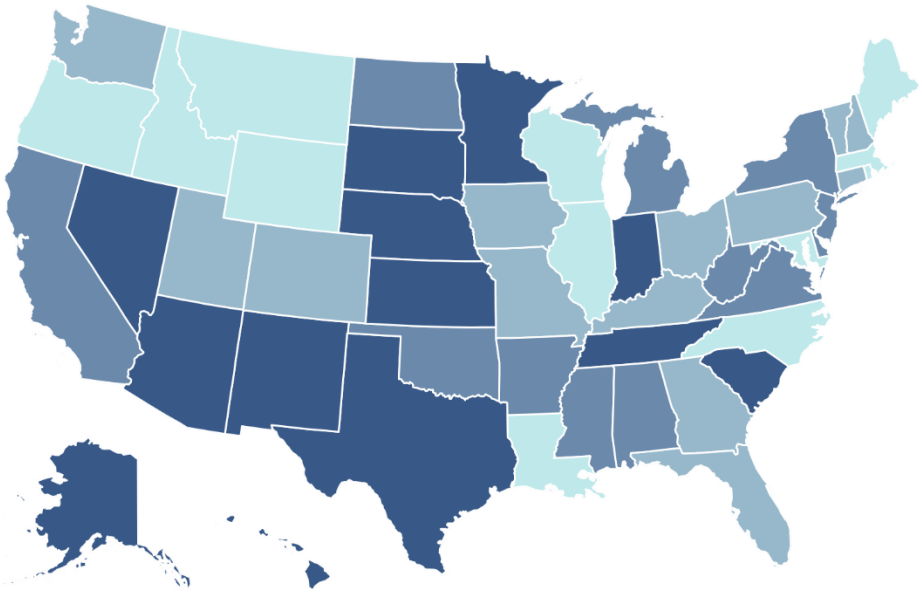
24.70% (MS) Ranked 39-51

Rank	State	%	#
1	Vermont	3.60	3,000
2	Washington	3.70	30,000
3	Rhode Island	3.80	5,000
4	Ohio	5.80	65,000
5	Maryland	6.10	35,000
6	New York	6.10	100,000
7	District of Columbia	6.60	6,000
8	Virginia	6.60	54,000
9	Massachusetts	6.70	47,000
10	Oregon	6.90	36,000
11	Iowa	7.00	25,000
12	Alaska	7.20	4,000
13	Maine	7.40	9,000
14	Indiana	8.00	51,000
15	Wisconsin	8.00	49,000
16	Colorado	8.10	57,000
17	Delaware	8.80	7,000
18	New Hampshire	8.80	14,000
19	Georgia	8.90	75,000
20	Illinois	9.30	98,000
21	Kansas	9.40	26,000
22	Michigan	9.40	80,000
23	Kentucky	9.50	31,000
24	New Jersey	9.50	78,000
25	South Dakota	9.60	8,000
26	California	10.30	316,000

Rank	State	%	#
27	Nevada	10.30	30,000
28	Connecticut	10.80	35,000
29	New Mexico	11.00	20,000
30	Hawaii	11.10	13,000
31	Tennessee	11.10	69,000
32	Minnesota	11.30	66,000
33	Missouri	11.30	73,000
34	Pennsylvania	11.40	135,000
35	Florida	11.80	194,000
36	Idaho	11.80	28,000
37	Louisiana	12.00	33,000
38	Utah	12.70	62,000
39	Arkansas	12.90	27,000
40	Wyoming	13.10	7,000
41	Oklahoma	13.20	41,000
42	North Carolina	13.40	109,000
43	Arizona	13.80	76,000
44	Alabama	15.80	66,000
45	North Dakota	15.90	13,000
46	Texas	16.50	350,000
47	Montana	16.70	14,000
48	South Carolina	16.80	58,000
49	Nebraska	17.60	39,000
50	West Virginia	20.00	23,000
51	Mississippi	24.70	42,000
	National	10.20	2,929,000

Youth Access to Care

Youth with MDE Who Did Not Receive Mental Health Services



The state prevalence of untreated youth with depression ranges from:

31.50% (DC)
Ranked 1-13

82.10% (SD)
Ranked 39-51

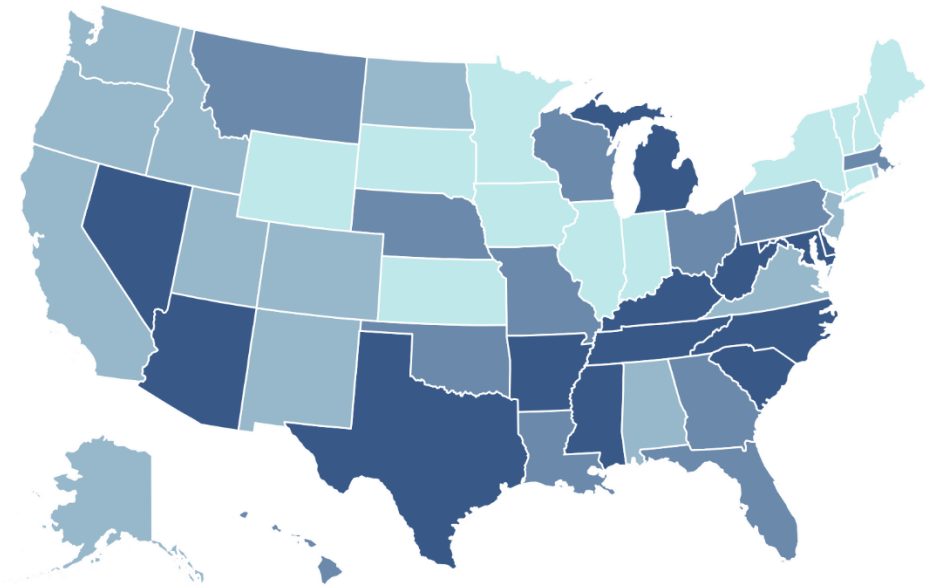
56.1% of youth with major depression did not receive any mental health treatment. This was defined as receiving treatment or counseling from a medical doctor or other professional or receiving medication for MDE.

In 2022, youth with MDE were asked whether they felt they had an unmet need for treatment and the main reasons why they did not receive it. **48.3% of youth with MDE reported an unmet need for treatment, totaling 987,000 youth in the U.S.**[32] The main reason youth reported not receiving care was they felt they should have been able to handle their mental health on their own (86.9%). That was followed by being worried what people would think or say if they got treatment (59.8%), being worried that the information they shared would not be kept private (57.8%), and not knowing how or where to get treatment (55.5%).[33]

Rank	State	%	#
1	District of Columbia	31.50	2,000
2	Maine	34.60	6,000
3	Louisiana	38.90	31,000
4	Illinois	39.30	79,000
5	Idaho	42.60	14,000
6	Rhode Island	43.20	8,000
7	Oregon	44.70	37,000
8	Maryland	46.00	49,000
9	Massachusetts	46.10	35,000
10	Montana	46.60	9,000
11	Wisconsin	47.00	37,000
12	North Carolina	47.20	71,000
13	Wyoming	47.20	4,000
14	Utah	47.90	24,000
15	Florida	49.70	155,000
16	Iowa	51.20	28,000
17	Ohio	52.00	97,000
18	Colorado	52.90	64,000
19	Connecticut	53.00	24,000
20	New Hampshire	53.00	11,000
21	Vermont	53.00	3,000
22	Missouri	53.30	65,000
23	Georgia	53.70	75,000
24	Pennsylvania	53.70	104,000
25	Washington	54.00	79,000
26	Kentucky	54.10	32,000

Rank	State	%	#
27	Virginia	54.50	75,000
28	Michigan	55.70	71,000
29	New Jersey	56.40	71,000
30	Mississippi	56.60	26,000
31	Oklahoma	56.60	28,000
32	Delaware	56.80	9,000
33	West Virginia	57.10	14,000
34	New York	57.20	149,000
35	Arkansas	58.30	24,000
36	Alabama	58.70	42,000
37	North Dakota	61.30	9,000
38	California	62.40	346,000
39	Tennessee	62.40	69,000
40	Minnesota	63.50	70,000
41	Nebraska	65.10	24,000
42	Indiana	66.40	65,000
43	Alaska	66.70	9,000
44	Kansas	66.70	34,000
45	Arizona	67.20	101,000
46	Texas	67.60	284,000
47	South Carolina	67.70	39,000
48	New Mexico	69.60	31,000
49	Hawaii	69.90	8,000
50	Nevada	73.70	47,000
51	South Dakota	82.10	8,000
	National	56.10	2,793,000

Youth with Private Insurance That Did Not Cover Mental or Emotional Problems



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

2.30% (CT) Ranked 1-13

17.00% (MS) Ranked 39-51

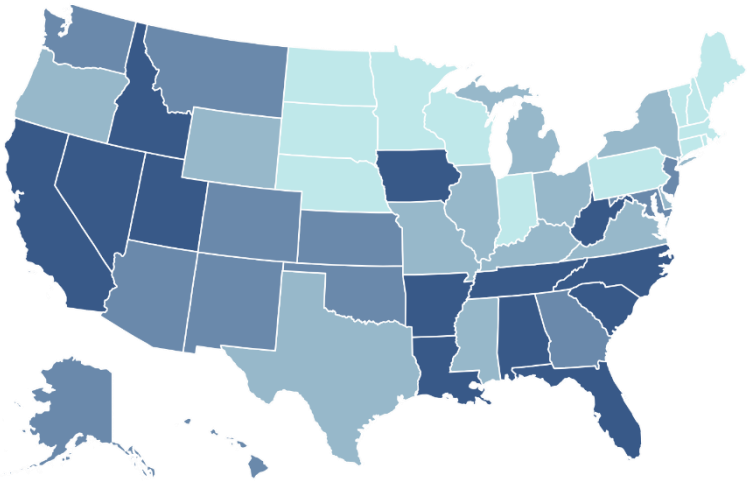
Nationally, **8.5%** of youth who are covered under private insurance do not have coverage for mental or emotional difficulties – **totaling over 1 million youth.**

While the Affordable Care Act (ACA), enacted in 2010, requires individual plans and small group coverage to include coverage for mental health services, it does not require large group plans for employers with more than 50 employees to cover mental health services as essential health benefits. Many state laws require these large group plans to cover mental health services, but there are still several states that do not have health insurance coverage mandates.

Even in states that do require health insurance coverage for large group plans to cover mental health services, these laws don't apply to large group plans that are self-insured (meaning the employer pays the costs of its health benefits rather than purchasing a health insurance policy). In 2023, the Employer Health Benefits Survey from Kaiser Family Foundation found that 65% of covered workers were in a self-funded plan.[34] As a result of MHPAEA not requiring mental health coverage and the ACA not requiring large group plans to cover mental health services, there are still many individuals who have private insurance plans that may not cover mental health services, significantly limiting their ability to access or afford care.

Rank	State	Rate	#
1	Connecticut	2.30	4,000
2	Maine	2.70	1,000
3	Kansas	3.90	5,000
4	South Dakota	4.90	2,000
5	New Hampshire	5.30	3,000
6	District of Columbia	5.50	1,000
7	New York	5.60	36,000
8	Minnesota	6.00	18,000
9	Vermont	6.00	1,000
10	Illinois	6.10	35,000
11	Wyoming	6.10	2,000
12	Indiana	6.20	20,000
13	Iowa	6.30	9,000
14	New Mexico	6.30	3,000
15	New Jersey	6.50	24,000
16	Virginia	6.50	23,000
17	Colorado	6.70	16,000
18	California	6.80	95,000
19	Utah	6.80	15,000
20	Washington	6.80	22,000
21	Idaho	6.90	6,000
22	Alaska	7.20	1,000
23	Rhode Island	7.20	2,000
24	Oregon	7.40	11,000
25	Alabama	7.50	11,000
26	North Dakota	7.60	2,000
27	Florida	7.70	48,000
28	Wisconsin	7.70	20,000
29	Ohio	8.00	39,000
30	Pennsylvania	8.20	40,000
31	Hawaii	8.30	4,000
32	Nebraska	8.30	8,000
33	Oklahoma	9.00	9,000
34	Missouri	9.10	20,000
35	Montana	9.20	4,000
36	Massachusetts	9.40	28,000
37	Louisiana	9.60	10,000
38	Georgia	10.40	42,000
39	Michigan	10.40	40,000
40	Kentucky	10.70	15,000
41	Texas	10.90	112,000
42	West Virginia	11.20	6,000
43	Delaware	12.00	5,000
44	Maryland	13.60	36,000
45	Tennessee	14.00	29,000
46	Arkansas	14.10	12,000
47	North Carolina	14.20	55,000
48	Arizona	14.80	30,000
49	Nevada	14.80	18,000
50	South Carolina	15.90	26,000
51	Mississippi	17.00	12,000
	National	8.50	1,039,000

Students (K+) Identified with Emotional Disturbance for an Individualized Education Program



The state rate of students identified as having an emotional disturbance (ED) for an individual education program (IEP) ranges from:

28.01 (VT) Ranked 1-13

1.55 (AL) Ranked 39-51

Only .667 percent of students are identified as having an emotional disturbance (ED) for an Individualized Education Program (IEP).** While there was an increase in mental distress among students from 2019-2021,[35] the percentage of students identified with emotional disturbance for an IEP decreased in all states except for Wyoming, Texas, and South Dakota.

IEPs are critical for ensuring that youth with disabilities can receive the individualized services, supports, and accommodations to succeed in a school setting. However, without sufficient funding, staffing, and guidance, identification of students with emotional disturbance may contribute to disparities for underserved youth. The federal eligibility criteria for ED have shown poor reliability among school psychologists,[36] allowing for students to be classified differently depending on where they attend school. Nationally, multiracial and Black students continue to be overrepresented among students identified with emotional disturbance. In 2022, 6.23% of all multiracial youth with a disability and 5.68% of Black youth with a disability were identified with emotional disturbance, compared to 4.52% of all students identified with a disability.[37] Students identified with ED may also be limited to learning in more restrictive environments, increasing stigma and leading to poorer educational outcomes. Nationally, students with ED were 1.31% more likely to spend less than 40% of their day inside a regular classroom than the average among all students with a disability in 2022 – in some states they were more than 10% more likely to spend most of their time outside of a regular classroom.[38]

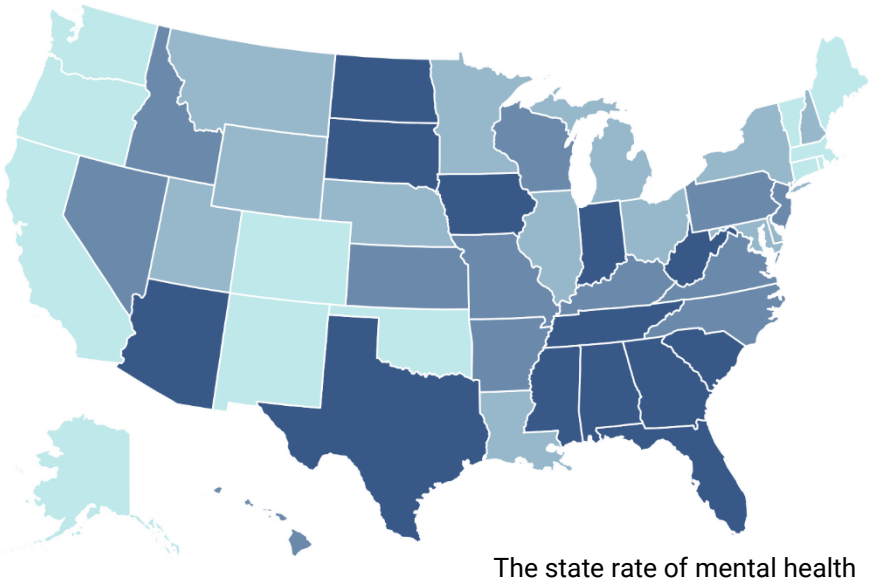
To keep students in the least restrictive settings while meeting their educational and mental health needs, schools must receive additional funding and staff. In 2022, 45% of schools reported vacancies in special education roles and 78% reported difficulty in hiring special education staff.[39] While funding has increased for schools through emergency school funds in recent years, a 2021-2022 survey of school principals by the National Center for Education Statistics found 39% of schools said inadequate funding and inadequate access to mental health professionals still significantly limited their school's ability to provide student mental health support.[40]

Rank	State	Rate	#
1	Vermont	28.01	2,122
2	Massachusetts	19.03	16,978
3	Minnesota	19.00	16,074
4	Pennsylvania	15.16	25,547
5	Maine	13.97	2,342
6	Wisconsin	13.09	10,111
7	Indiana	11.15	11,294
8	North Dakota	10.98	1,269
9	New Hampshire	10.79	1,774
10	Connecticut	10.29	5,090
11	Rhode Island	9.95	1,337
12	South Dakota	9.39	1,301
13	Nebraska	9.17	2,840
14	Illinois	8.78	15,585
15	Oregon	8.62	4,762
16	Delaware	8.03	1,117
17	Ohio	7.79	12,742
18	Texas	7.60	39,911
19	Missouri	7.47	6,401
20	Michigan	7.38	10,245
21	Virginia	7.08	8,676
22	New York	6.73	16,536
23	Wyoming	6.49	595
24	District of Columbia	6.46	511
25	Mississippi	6.31	2,726
26	Kentucky	6.17	3,910
27	Arizona	6.09	6,781
28	New Mexico	5.81	1,771
29	Alaska	5.73	731
30	Colorado	5.62	4,710
31	Maryland	5.49	4,717
32	Oklahoma	5.43	3,603
33	Montana	5.27	789
34	Georgia	5.17	8,792
35	Kansas	4.94	2,290
36	New Jersey	4.75	6,226
37	Washington	4.62	4,939
38	Hawaii	4.55	768
39	Idaho	4.08	1,280
40	Florida	4.01	11,263
41	Nevada	3.86	1,823
42	California	3.69	21,573
43	Tennessee	3.31	3,224
44	West Virginia	3.22	761
45	North Carolina	2.93	4,439
46	South Carolina	2.47	1,886
47	Louisiana	2.45	1,700
48	Utah	2.38	1,610
49	Arkansas	2.04	970
50	Alabama	1.55	1,127
51	Iowa	*	*
	National	6.67	320,828

*Data from Iowa was suppressed because Iowa does not use special education categories.

***The rates in the table for this measure are shown as a rate per 1,000 students. The calculation was made this way for ease of reading.*

Mental Health Workforce Availability



The state rate of mental health workforce ranges from:

140:1 (MA) Ranked 1-13

800:1 (AL) Ranked 39-51

Rank	State	#
1	Massachusetts	140:1
2	Alaska	150:1
3	District of Columbia	160:1
4	Oregon	160:1
5	Maine	190:1
6	Vermont	190:1
7	Connecticut	220:1
8	Rhode Island	220:1
9	Washington	220:1
10	Colorado	230:1
11	New Mexico	230:1
12	California	240:1
13	Oklahoma	240:1
14	Utah	270:1
15	Wyoming	270:1
16	Montana	280:1
17	New Hampshire	280:1
18	New York	300:1
19	Louisiana	310:1
20	Maryland	310:1
21	Delaware	320:1
22	Michigan	320:1
23	Minnesota	320:1
24	Nebraska	330:1
25	Ohio	330:1
26	Illinois	340:1
27	North Carolina	340:1
28	Hawaii	350:1
29	Kentucky	370:1
30	New Jersey	370:1
31	Arkansas	390:1
32	Pennsylvania	400:1
33	Idaho	420:1
34	Nevada	420:1
35	Wisconsin	420:1
36	Missouri	430:1
37	Kansas	450:1
38	Virginia	450:1
39	South Dakota	460:1
40	North Dakota	470:1
41	South Carolina	490:1
42	Mississippi	500:1
43	Florida	510:1
44	Indiana	530:1
45	Iowa	530:1
46	Tennessee	560:1
47	Arizona	590:1
48	Georgia	600:1
49	West Virginia	620:1
50	Texas	690:1
51	Alabama	800:1
	National	340:1

*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.

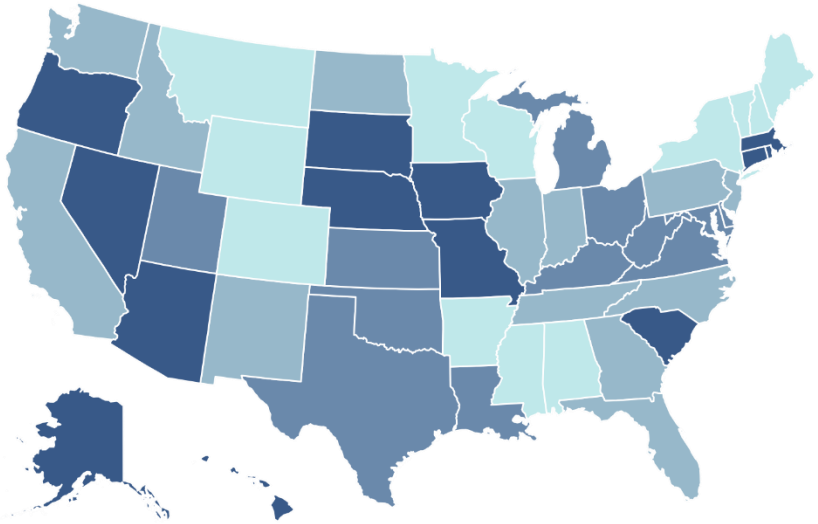
In the U.S., there are 340 individuals for every one mental health provider.* As of March 2024, over 122 million people lived in a mental health workforce shortage area, and only 27% of the mental health need in shortage areas was being met by mental health providers.[41] Over the next 15 years, the National Center for Health Workforce Analysis has projected increasing shortages for several behavioral health providers, including psychologists, psychiatrists, and mental health and addiction counselors.[42]

One of the ways to increase access to mental health providers is to expand the use of peer support specialists. SAMHSA recognizes peer support as an effective, evidence-based practice and peer support specialists as critical parts of treatment teams.[43] To further expand the use of peer support specialists there must be an increase in the settings in which they can practice, the services they can provide, and reimbursement for those services. First, the organizations that can provide Medicare-covered peer support services should be expanded to include rural health clinics, federally qualified health centers (FQHCs), and other community health centers through the passage of the PEERS in Medicare Act.[44] These community health centers are often providing care to underserved communities with limited access to other services, and peer support specialists can help to bolster their workforces.

States can also expand the use of peer support specialists in mental health promotion and early intervention services through the rehabilitative option in their Medicaid plans. In many states, individuals must have a mental health diagnosis to qualify for peer services, which limits the ability of peers to provide support before mental health concerns reach a point of crisis. The rehab option allows states to use peers for preventive non-clinical services in community settings, as has been done in Georgia.[45] To work toward prevention and early intervention, states can also expand their Medicaid plans to reimburse for parent and family peer support services (currently reimbursed in 27 states) and youth peer support services (currently reimbursed in 18 states). [46]

Finally, many peer specialists do not make a living wage and are forced to leave the workforce, further limiting access to mental health services. In 2022, 45% of state mental health agencies reported that Medicaid reimbursement for peers is too low. [47] To ensure that peers can remain in the workforce, states should raise their reimbursement rates, as was recently done in Virginia[48] and North Carolina.[49]

Youth with MDE Who Reported Treatment or Counseling Helped Them**



The state rate of youth with MDE reporting treatment helped them ranges from:

84.60% (DC)
Ranked 1-13

32.50% (IA)
Ranked 39-51

Nationally, 65.0% of youth with MDE who received mental health treatment or counseling reported that it helped them at least "some." Only a little over a third (36%) reported it helped them "a lot" or "extremely." Quality of care for youth with MDE varied significantly from the highest ranked to lowest ranked states – there was a 52% difference in the percentage of youth reporting treatment or counseling helped them between the District of Columbia (ranked 1) and Iowa (ranked 49).

While increasing access to mental health care is critical, ensuring people are receiving quality care is equally important. Ensuring access to care means little if individuals do not want to access it, do not want to continue utilizing care because they don't feel like it is helping them, or at worst, are experiencing harms as a result of their treatment.

There are few standardized, publicly available quality measures for mental health care. According to a 2021 environmental scan of quality measures by the National Committee for Quality Assurance (NCQA), most federal programs rely on process or non-standardized quality measures. The most frequently used quality measures across programs were screening for depression and follow-up, follow-up after hospitalization for mental illness, and initiation and engagement of alcohol and other drug abuse treatment.[50] These are all process measures, and do not include whether the individual felt that they received quality care or that it helped them. Quality measures should be codesigned with individuals with lived experience of mental health conditions to adequately capture what is meaningful to people receiving care. State mental health agencies should also include measures of patient experience data, including both inpatient and outpatient treatment experiences, as part of their quality measurement and reporting, and should use this data to increase the accountability of plans and providers licensed to operate in the state.

Rank	State	Rate	#
1	District of Columbia	84.60	3,000
2	Montana	84.50	8,000
3	New Hampshire	82.60	8,000
4	Arkansas	81.40	14,000
5	Mississippi	78.80	13,000
6	Maine	78.40	8,000
7	Colorado	77.60	42,000
8	Wisconsin	77.50	28,000
9	New York	77.20	77,000
10	Wyoming	77.00	4,000
11	Alabama	75.60	21,000
12	Vermont	75.60	2,000
13	Minnesota	75.30	30,000
14	Indiana	73.30	20,000
15	Washington	72.70	48,000
16	New Mexico	71.70	9,000
17	New Jersey	70.60	35,000
18	North Carolina	70.20	52,000
19	Florida	70.10	103,000
20	Tennessee	68.10	26,000
21	Idaho	67.70	9,000
22	California	66.80	134,000
23	Illinois	66.80	78,000
24	Georgia	66.30	38,000
25	North Dakota	64.80	3,000
26	Pennsylvania	64.50	57,000
27	Texas	64.30	79,000
28	Oklahoma	63.80	13,000
29	West Virginia	62.70	6,000
30	Maryland	61.90	34,000
31	Michigan	61.60	33,000
32	Louisiana	61.30	28,000
33	Virginia	59.20	33,000
34	Utah	58.70	13,000
35	Delaware	58.50	4,000
36	Kansas	58.20	8,000
37	Ohio	57.10	47,000
38	Kentucky	56.60	14,000
39	Alaska	55.10	2,000
40	Oregon	54.60	22,000
41	Rhode Island	54.10	3,000
42	Massachusetts	53.90	22,000
43	Nevada	51.70	8,000
44	Nebraska	48.10	6,000
45	Arizona	44.30	21,000
46	Connecticut	42.60	9,000
47	Hawaii	38.60	1,000
48	Missouri	36.50	16,000
49	Iowa	32.50	8,000
50	South Carolina	*	*
51	South Dakota	*	*
	National	65.00	1,301,000

*Data for South Carolina and South Dakota were suppressed due to limited sample sizes.

**This includes youth with MDE who received treatment or counseling in the past year and answered the question, "During the past 12 months, how much has treatment or counseling helped you?" with "some," "a lot," or "extremely."

Creating Supportive Communities: A Spotlight on Prevention

To reduce the negative impact of the mental health crisis, states must take an upstream public health approach focused on prevention of mental distress and promotion of well-being. In 2023, Mental Health America, along with the Association for State and Territorial Health Officials (ASTHO), the Centers for Disease Control and Prevention (CDC), and the Center for Law and Social Policy (CLASP) released a framework for the role of public health in mental health promotion and suicide prevention.[51] The goal of this framework was to outline strategies to prevent illness and promote well-being by improving the conditions in which individuals live, learn, work, and play.

Two of the core strategies identified through this framework were to improve the essential conditions for health and well-being and to promote protective environments and social connections. Social and community support are integral to overall health, where low levels of social support are associated with poor health outcomes and high levels have been found to improve both physical and mental health.[52] These strategies are reflected in federal initiatives like the National Strategy for Suicide Prevention and the objectives of Healthy People 2030, but little progress has been made in recent years. Of the nine objectives to increase social and community support in Healthy People 2030, five have gotten worse and one has shown little or no change over time.[53] According to data from the 2022 Behavioral Risk Factor Surveillance Survey, the most commonly reported adverse social determinants of health were social isolation or loneliness and a lack of social and emotional support, both identified as proxies for a lack of social connection.[54] In 2021-2022, only 56% of families in the U.S. reported that their children lived in supportive neighborhoods. A supportive neighborhood was defined as one in which people in the neighborhood helped each other, people in the neighborhood watched out for each other's children, and people knew where to go for help in their community when they encountered difficulties. Lacking community support is a risk factor for poor mental health outcomes.[55,56] Nevada, ranked last overall in this year's State of Mental Health in America report, had the lowest percentage of families reporting their children lived in supportive neighborhoods, at only 44%.[57]

State	Percentage of parents reporting their child lives in a supportive neighborhood, 2021-2022
Utah	69.50
South Dakota	66.00
Idaho	65.80
Vermont	65.60
Minnesota	65.50
North Dakota	65.30
Iowa	65.00
Wyoming	64.40
Nebraska	64.10
Maine	64.00
Kansas	63.90
Wisconsin	63.50
Missouri	63.10
Ohio	62.10
Kentucky	61.70
Michigan	61.00
Indiana	60.80
Massachusetts	60.70
Alabama	60.50
West Virginia	60.50
Pennsylvania	60.40
New Hampshire	60.30
New Jersey	60.20
Illinois	60.00
Tennessee	59.60
Montana	58.80
Virginia	58.30
Rhode Island	57.90
Colorado	57.80
Mississippi	57.70
Connecticut	57.40
Alaska	57.30
South Carolina	57.30
Georgia	56.40
Arkansas	56.00
Delaware	55.60
North Carolina	55.50
Maryland	55.30
Oklahoma	55.20
Louisiana	55.10
Washington	55.10
Hawaii	53.20
Florida	53.00
Oregon	52.60
New York	50.90
Texas	50.10
Arizona	48.90
California	48.70
New Mexico	46.80
District of Columbia	45.60
Nevada	44.20
National	56.00

To build social connection and promote mental well-being, states and localities must create communities in which people are able to thrive. Some prevention strategies, such as early childhood programs and family economic supports, have been found to have wide-reaching impact on both increased social support in communities[58] and reduction of poor mental health outcomes and adverse childhood experiences (ACEs).[59] Several of these evidence-based interventions are under the jurisdiction of state or local governments.[60] For example, states should continue to invest in early childhood home visiting programs and group-based parenting programs. Both of these interventions have been found to improve early childhood development, increase economic well-being, strengthen family and community connection,[61] and reduce the risk of ACEs.[62] States should also invest in economic supports for families, such as expansions of state earned income tax credit (EITC) laws and state child care subsidies. Research has found that both strategies can improve maternal and child health and well-being, increase economic and employment stability, and contribute to positive community-level outcomes such as increased school engagement and reductions in violence.[63,64] According to the National Academy of Sciences, economic supports like the EITC that help to stabilize families before they are experiencing financial crises can also reduce parental stress and lead to improvements in child health outcomes.[65] As of April 2024, there were still 15 states without any state EITC, including Nevada, North Dakota, Wyoming, Idaho, and Tennessee, all of which are ranked 39-51 overall in this year's State of Mental Health in America report.[66] To achieve long-term population-level improvements in mental health, states must invest in these upstream approaches to create more stable, thriving, and connected communities.

Keeping People in Communities: A Spotlight on Housing

A thriving and connected community has access to affordable and stable housing which helps to draw in new residents and reduces the impact of families facing homelessness during a financial crisis. Furthermore, residential stability has been associated with several measures of well-being and community cohesion, including greater life satisfaction, improved educational outcomes, better physical and mental health, and increased civic and social engagement within communities.[67] Once individuals and families face homelessness, the cascading impact is profound. Housing insecurity and homelessness are associated with higher risk of ACEs,[68] violence and victimization, depression, and suicidal ideation.[69]

The U.S. is currently facing a worsening housing crisis. In 2022, the number of renter households that spent more than 30% of their income on rent and utilities reached a record high of 22.4 million.[70] Additionally, the U.S. Department of Housing and Urban Development (HUD) reported that the number of families in 2021 with an unmet need for affordable rental housing, referred to as worst-case housing needs, was the highest ever recorded. The percentage of very low-income renters experiencing worst-case housing needs was also the highest ever recorded at 44.1%,[71] leaving many low-income individuals and families at risk of experiencing homelessness. In 2023, HUD reported 650,000 people were experiencing homelessness on a single night in January 2023, a 12% increase from 2022.[72]

This crisis has generated bipartisan support for increasing the availability of mental health services and finding solutions for homelessness. However, the solutions currently being proposed in many states to combat homelessness and housing insecurity are moving away from community-based care toward punitive or coercive approaches designed to remove individuals from their communities. In June 2024, the Supreme Court ruled that cities could ban people from sleeping and camping in public places, even if there are no available alternatives. This ruling criminalizes homelessness by allowing localities to charge fines or incarcerate individuals sleeping in public places. For people who cannot afford housing and for whom there are no alternative shelters, fines and incarceration will only exacerbate hardship. These policies will remove individuals from community and family connections, destabilize those who may already be receiving mental

health treatment or other services, and leave people with debts or criminal records that can further hamper their ability to find housing and employment opportunities.

Other states and localities have proposed the use of involuntary hospitalization or conservatorships as solutions to homelessness. In 2023, New York City Mayor Eric Adams announced a directive allowing for involuntary hospitalization of individuals showing signs of mental distress who seem unable to meet their own basic needs, which could include experiencing homelessness.[73] In California, the Lanterman-Petris-Short Act provides for involuntary commitment and treatment for individuals determined to be a danger to themselves or others or gravely disabled. In 2024, a law went into effect that expanded the definition of "gravely disabled." Someone can now be considered "gravely disabled" if they are unable to provide for their basic personal needs for food, clothing, shelter, personal safety, or necessary medical care as a result of a mental health disorder, chronic alcoholism, or a severe substance use disorder.[74] While these policies may be created in an effort to provide care to people who need it, often this policy approach, which targets unhoused people with mental illness, can cause more harm than help by starting cycles of hospitalization and creating unnecessary police interactions.[75]

Involuntary hospitalization does not resolve unmet needs like a lack of affordable housing or mental health services, and resources would be better spent addressing upstream causes to avoid rehospitalization and keep individuals in their communities. The rise of policies using involuntary hospitalization may also deter people from seeking mental health care when they need it. In 2022, 23.4% of adults with any mental illness (AMI)[76] and nearly half (45%) of youth who had experienced a major depressive episode (MDE)[77] in the past year reported that one of the reasons they did not receive mental health treatment was because they were afraid of being committed to a hospital or forced into treatment against their will.

Reason for Not Receiving Mental Health Treatment Among Youth Ages 12-17 With a Past-Year Major Depressive Episode, 2022	Percentage*
Thought they should have been able to handle their mental health, emotions, or behavior on their own	86.90
Worried about what people would think or say if they got treatment	59.80
Worried that information would not be kept private	57.80
Did not know how or where to get treatment	55.50
Thought no one would care if they got better	53.90
Did not think treatment would help them	51.50
Thought their family, friends, or religious group would not like it if they got treatment	48.20
Afraid of being committed to hospital or forced into treatment against their will	45.00
Not ready to start treatment	44.50
Thought they would be told they needed to take medication	39.40
Did not have enough time for treatment	34.80
Thought it would cost too much	33.30
Could not find treatment program or healthcare professional they wanted to go to	30.20
Had problems with things like transportation, childcare, or getting appointments at times that worked for them	24.20
Did not have health insurance coverage for mental health treatment	13.30
Thought that if people knew they were in treatment, bad things would happen, like losing their job, home, or children	13.30
No openings in treatment program or with healthcare professional they wanted to go to	11.70
Health insurance would not pay enough of costs for treatment	8.80

*Respondents were asked to choose all that apply.

Increasing Connection Through Enhanced Care, Peer Support, and Other Community-Based Services

In a supportive neighborhood, people are offered the services they need for stability and know where to go to find them. When recovering from disability, social connections allow people to receive support within their communities. Enhanced treatments or specialty care that provide connection, like supportive housing and peer support services, decrease the likelihood of hospitalizations and incarceration and increase long-term positive outcomes.[78,79,80]

When individuals have a stable place to live, they are more likely to engage in treatment services that allow them to stay in their communities. Research shows that individuals with chronic illnesses engaged in supportive housing and Housing First programs are more likely to stay housed than those who receive usual care. These programs provide individuals with immediate access to stable and affordable housing while they receive supportive services, including mental health or substance use services. Initial studies of Housing First also found that those in the program spent significantly less time hospitalized and less time homeless than those who received usual care.[81] In 2023, the U.S. Department of Veterans Affairs credited their Housing First programs with decreasing veteran homelessness by over 52% since 2010.[82] These programs are person-centered and recovery-oriented, and often include opportunities for social engagement, allowing for more socially-connected communities.[83] An analysis of Pathways Housing First in New York City found that chronically homeless individuals assigned to Housing First had greater social integration into their neighborhoods than those in shelters and other temporary living situations.[84] Rather than spending resources on punitive policies aimed at those experiencing homelessness, states can invest in supportive housing programs and other services to prevent homelessness and housing instability, including rental assistance programs, emergency housing funds, and tenant outreach and education about available community supports.[85]

Peer support specialists and community health workers can also help engage people experiencing housing instability and/or mental health challenges by providing social connection, emotional support, and linkages to resources to meet their needs within their communities. States and localities should work to implement successful peer support and outreach programs like the Intensive and Sustained Engagement Team (INSET) program in New York and the Richmond City Health District in Virginia. In 2017, the Mental Health Association of Westchester created the INSET program to connect with individuals who were ordered or were at risk of being court-ordered to receive Assisted Outpatient Treatment (AOT). Participants in the program are treated as partners with the INSET team and are empowered to determine their own goals in recovery, get the support they desire, and engage in shared decision-making. One of the primary goals of the INSET program is to create and maintain social connections, so that individuals can receive community support when needed, reducing the probability of future hospital stays, homelessness, or incarceration.[86] In Virginia, the Richmond City Health District partners with the housing authority to embed health resource centers in public housing developments in the city. These centers are run by community health workers with lived experience in public housing who work to connect residents with mental health, employment, and other supportive services in their community.[87]

Finally, community connections can be built through power-sharing with community members. Residents of communities often know best what the root causes of disconnection are within their communities and which investments can have the greatest impact. Cities and states should implement power-sharing practices like community participatory budgeting, in which residents can decide how to allocate portions of the state or local budget to various projects. The Department of Housing and Urban Development (HUD) has advised that these community participatory budgeting practices can be used by cities through HUD housing and community development funds to promote affordable housing and provide services to individuals in need within their

communities.[88] States can also engage in policy and programmatic co-design with individuals, including youth, with lived experience. Co-designing solutions with community members with lived experience can ensure solutions are more effective at addressing the root causes of problems within communities as well as increase engagement with those solutions.[89] These strategies of power-sharing and community co-design inherently build connection by bringing residents together to collaborate on solutions to improve their communities.[90]

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Glossary

Indicator	Description of Measure	Source
Adults with Any Mental Illness (AMI)	Any Mental Illness (AMI) aligns with Diagnostic and Statistical Manual of Mental Disorders, 4th edition criteria and is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. These estimates are based on indicators of AMI rather than direct measures of diagnostic status. For details, see Section B of 2021-2022 National Survey on Drug Use and Health: Guide to State Tables and Summary of Small Area Estimation Methodology at https://www.samhsa.gov/data/report/2021-2022-nsduh-guide-state-tables-and-summary-sae-methodology. Data survey years: 2021-2022.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/release/2022-national-survey-drug-use-and-health-nsduh-releases
Adults with SUD Needing But Not Receiving Treatment	Substance use disorder (SUD) estimates are based on DSM-5 criteria. SUD is defined as meeting the criteria for drug or alcohol use disorder. Beginning with the 2021 NSDUH, questions on prescription drug use disorder were asked of all past year users of prescription drugs, regardless of whether they misused prescription drugs. The estimates in this table include prescription drug use disorder data from all past year users of prescription drugs. Respondents were classified as needing substance use treatment if they met Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) criteria for a drug or alcohol use disorder or received treatment for drug or alcohol use through inpatient treatment/counseling, outpatient treatment/counseling, medication-assisted treatment, telehealth treatment, or treatment received in a prison, jail, or juvenile detention center. Substance use treatment questions are asked of respondents who used drugs or alcohol in their lifetime. Not receiving substance use treatment among those needing treatment (%) = 100 * [X1 ÷ (X1 + X2)], where X1 is the number of people not receiving treatment who needed treatment, X2 is the number people receiving treatment who needed treatment, and (X1+ X2) denotes the number of people who needed treatment. Data survey year: 2022.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/release/2022-national-survey-drug-use-and-health-nsduh-releases
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 Medicare (IRMEDICR=1); 2. Covered by Medicaid/CHIP (IRMCDCHP=1); 3. Covered by Tricare, Champus, ChampVA, VA, or Military (IRCHMPUS=1); 4. Covered by private insurance (IRPRVHLT=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 Medicare (IRMEDICR=2); 2. Not covered by Medicaid/CHIP (IRMCDCHP=2); 3. Not covered by Tricare, Champus, ChampVA, VA, or Military (IRCHMPUS=2); 4. Not covered by private insurance (IRPRVHLT=2); 5. Not covered by other health insurance (IROTHHLT=2). Data survey years: 2021-2022.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/release/2022-national-survey-drug-use-and-health-nsduh-releases

Adults with Substance Use Disorder in the Past Year	Substance Use Disorder (SUD) estimates are based on Diagnostic and Statistical Manual of Mental Disorders, 5th edition criteria. SUD is defined as meeting the criteria for drug or alcohol use disorder. Beginning with the 2021 National Survey on Drug Use and Health, questions on prescription drug use disorder were asked of all past year users of prescription drugs, regardless of whether they misused prescription drugs. Drug use includes the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine in the past year or any use (i.e., not necessarily misuse) of prescription pain relievers, tranquilizers, stimulants, or sedatives in the past year. Data survey years: 2021-2022.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/release/2022-national-survey-drug-use-and-health-nsduh-releases
Adults Reporting 14+ Mentally Unhealthy Days a Month Who Could Not See a Doctor Due to Costs	This indicator is derived from the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (BRFSS) core questionnaire. Mentally unhealthy days were determined using the calculated variable _MENT14D. _MENT14D is calculated from the following BRFSS question: "Now thinking about mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" (MENTHLTH). The calculated variable, _MENT14D, contains four values: Zero days when mental health was not good, 1-13 days when mental health was not good, 14+ days when mental health was not good, and don't know/refused/missing. 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 "14+ days when mental health was not good" to _MENT14D. Data survey year: 2022.	Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System Survey Data 2022, https://www.cdc.gov/brfss/annual_data/annual_2022.html Downloaded and calculated on 5/8/2024.
Adults with Serious Thoughts of Suicide	Adults ages 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 years: 2021-2022.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/release/2022-national-survey-drug-use-and-health-nsduh-releases
Youth with Private Insurance That Did Not Cover Mental or Emotional Problems	Youth with private insurance that did not cover mental or emotional problems is defined as any individual ages 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: 2021-2022.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/release/2022-national-survey-drug-use-and-health-nsduh-releases

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. These data come 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 patients. This may result in an overestimation of active mental health professionals in some communities. It is also true that mental health providers may be registered with an address in one county while practicing in another county. Data survey year: 2022.	County Health Rankings and Roadmaps. http://www.countyhealthrankings.org/
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, which adversely affects a child's educational performance: 1. an inability to learn, which cannot be explained by intellectual, sensory or health factors; 2. an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; 3. inappropriate behavior or feelings under normal circumstances; 4. a general pervasive mood of unhappiness or depression; or 5. a tendency to develop physical symptoms or fears associated with personal or school problems. This term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined 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 of "school age," which includes kindergarten, grades 1-12, and "ungraded." Data survey years: 2022-2023.	IDEA Data Center, 2022 IDEA Section 618, State Level Data Files, Child Count and Educational Environments. https://data.ed.gov/dataset/idea-section-618-state-part-b-child-count-and-educational-environments/resources 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 2/21/2024.
Youth with at Least One Past Year Major Depressive Episode (MDE)	Among youth ages 12-17, Major Depressive Episode (MDE) is based on the Diagnostic and Statistical Manual of Mental Disorders, 5th edition definition, which specifies a period of at least 2 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 2021-2022 National Survey on Drug Use and Health: Guide to State Tables and Summary of Small Area Estimation Methodology at https://www.samhsa.gov/data/report/2021-2022-nsduh-guide-state-tables-and-summary-sae-methodology. Data survey years: 2021-2022.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/release/2022-national-survey-drug-use-and-health-nsduh-releases

Youth with Substance Abuse Disorder in the Past Year	Among youth ages 12-17, substance use disorder (SUD) estimates are based on Diagnostic and Statistical Manual of Mental Disorders, 5th edition criteria. SUD is defined as meeting the criteria for drug or alcohol use disorder. Beginning with the 2021 National Survey on Drug Use and Health, questions on prescription drug use disorder were asked of all past year users of prescription drugs, regardless of whether they misused prescription drugs. Drug Use includes the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine in the past year or any use (i.e., not necessarily misuse) of prescription pain relievers, tranquilizers, stimulants, or sedatives in the past year. Data survey years: 2021-2022.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/release/2022-national-survey-drug-use-and-health-nsduh-releases
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 YMDETXRX. YMDETXRX is a recoded variable from combining the data from the variables YTXMDEYR and YRXMDEYR. YTXMDEYR is calculated from the question, "At any time in the past 12 months, did you see or talk to a medical doctor or other professional about your [FEELNOUN]?" YRXMDEYR is calculated from the question. "During the past 12 months, did you take prescription medication that was prescribed for [NUMPROBS]?" A response of "No" to YMDETXRX includes all youth 12-17 who answered "No" to both YTXMDEYR and YRXMDEYR. Data survey years: 2021-2022.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/release/2022-national-survey-drug-use-and-health-nsduh-releases
Youth with Serious Thoughts of Suicide	Youth ages 12-17 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 years: 2021-2022.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/release/2022-national-survey-drug-use-and-health-nsduh-releases
Youth Flourishing	For children ages 6-17 years, three questions were asked that aimed to capture curiosity and discovery about learning, resilience, and self-regulation. The survey question asked, "How often does this child: show interest and curiosity in learning new things (K6Q71_R), work to finish tasks they start (K7Q84_R), and (3) stay calm and in control when faced with a challenge?" (K7Q85_R). The "Always" or "Usually" responses to the question indicate the child meets the flourishing item criteria. Questions were developed based on a review of positive health indicators by a Technical Expert Panel (TEP). This TEP included a representative group of experts in the field of survey methodology, children's health, community organizations, and family leaders. Additionally, there was a public comment period which yielded more interest in this concept. Youth were considered to be flourishing on this measure if they reached all three flourishing items. Data survey years: 2021-2022.	Child and Adolescent Health Measurement Initiative. 2021-2022 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 5/1/2024 from www.childhealthdata.org

Adults with AMI with Private Insurance That Did Not Cover Mental or Emotional Problems	Adults with AMI with private insurance that did not cover mental or emotional problems is defined as adults ages 18+ with AMI responding "No" to HLTINMNT. For more information on what classifies adults with AMI, see the indicator Adults with Any Mental Illness (AMI). HLTINMNT is defined as: "Does [SAMPLE MEMBER POSS] private health insurance include coverage for treatment for mental or emotional problems?" Data survey years: 2021-2022.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/release/2022-national-survey-drug-use-and-health-nsduh-releases
Youth with MDE Reporting Treatment or Counseling Helped Them	Youth who reported receiving treatment or counseling for their mental health in the past 12 months were asked the question, "During the past 12 months, how much has treatment or counseling helped you?" [YOTMTHLP]. The options for this question were 1=Not at all, 2=A little, 3=Some, 4=A lot, and 5=Extremely. Youth with MDE Reporting Treatment or Counseling Helped Them was calculated from youth (ages 12-17) with at least one past year MDE and answered 3=Some, 4=A lot, or 5=Extremely to YOTMTHLP. For more information on what classifies youth with MDE, see the indicator Youth with at Least One Past Year Major Depressive Episode (MDE). Data survey years: 2021-2022.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/release/2022-national-survey-drug-use-and-health-nsduh-releases