



THE STATE OF MENTAL HEALTH IN AMERICA

2019

Acknowledgments

Mental Health America (MHA) was founded in 1909 and is the nation's leading community-based nonprofit dedicated to helping all Americans achieve wellness by living mentally healthier lives. Our work is driven by our commitment to promote mental health as a critical part of overall wellness, including prevention services for all, early identification and intervention for those at risk, integrated care and treatment for those who need it, with recovery as the goal.

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

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Special Thanks To:

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Table of Contents

- 05 Key Facts and Findings
- 06 Ranking Overview and Guidelines
- 09 State Rankings
- 14 Adult Prevalence of Mental Illness
- 17 Youth Prevalence of Mental Illness
- 20 Adult Access to Care
- 24 Youth Access to Care
- 28 Mental Health Workforce Availability
- 29 MHA Affiliates' Impact
- 34 Spotlight: Addressing Trauma in Youth
- 50 Appendix
- 52 Glossary

MHA is committed to promoting mental health as a critical part of overall wellness. We advocate for prevention services for all, early identification and intervention for those at risk, integrated health, behavioral health and other services for those who need them, with recovery as the goal. We believe that gathering and providing up-to-date data and information about disparities faced by individuals with mental health problems is a tool for change.

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 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 and improve outcomes for individuals and families with mental health needs.

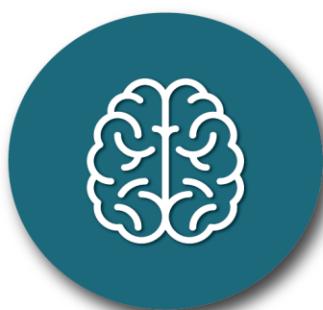
Why Gather this Information?

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

Since the release of MHA's first State of Mental Health in America report four years ago, we have seen:

ENCOURAGING DECREASES

in the amount of American adults who have mental health and substance use problems.



18.19%



18.07%



8.76%



7.93%

ALARMING INCREASES

in adult suicidal ideation and major depressive episodes in youth.



4.04%



3.77%



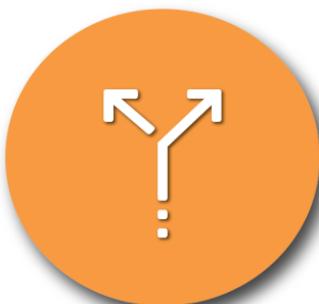
12.63%



8.66%

Since the release of last year's State of Mental Health in America report:

The difference between youth experiencing a major depressive episode is



becoming more pronounced between the highest and lowest ranked states.

Ranking Overview and Guidelines

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

MHA Guidelines

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

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

Our 2018 Measures

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

A Complete Picture

While the above fifteen 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 more accurately and comprehensively capture the needs of those with mental illness and their access to care.

Ranking

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

Factors to consider include geography, size, and political affiliation. 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 size of states and populations matter, both New York City and Los Angeles alone have more residents than North Dakota, South Dakota, Alabama, and Wyoming combined.

The rankings are based on the percentages, or rates, for each state collected from the most recently available data. For most indicators, the data represent data collected up to 2015. States with positive outcomes are ranked higher than states with poorer outcomes. The overall, adult, youth, prevalence and access rankings were analyzed by calculating a standardized score (Z score) for each measure and ranking the sum of the standardized scores. For most measures, lower percentages equated to more positive outcomes (e.g. lower rates of substance use or those who are uninsured). There are two measures where high percentages equate to better outcomes. These include Youth with Severe MDE (Major Depressive Episode) who Received Some Consistent Treatment, and Students Identified with Emotional Disturbance for an Individualized Education Program. Here, the calculated standardized score was multiplied by -1 to obtain a Reverse Z Score that was used in the sum. All measures were considered equally important, and no weights were given to any measure in the rankings.

Along with calculated rankings, each measure is ranked individually with an accompanying chart and table. The table provides the percentage and estimated population for each ranking. The estimated population number is weighted and calculated by the agency conducting the applicable federal survey. The ranking is based on the percentage or rate. Data are presented with 2 decimal places when available.

Due to limitations in sample size for youth, measures for Youth with MDE who Did Not Receive Mental Health Services and Youth with Severe MDE who Received Some Consistent Treatment include data from various annual averages. Youth with MDE who Did Not Receive Mental Health Services includes data annual averages 2014 – 2016 and 2011-2016. Data for Youth with Severe MDE who Received Some Consistent Treatment include annual averages 2014 – 2016, 2011-2015, and 2010 – 2013. Annual averages are indicated in the Appendix, Table 1 and Table 2.

The data for the measure Adults with Disability who Could Not See a Doctor Due to Costs could not be calculated for 2016 data. Data from the [2018 State of Mental Health in America](#) report was used to determine final rankings.

For the measure Students Identified with Emotional Disturbance for an Individualized Education Program, due to limitations in sample size, the 2014- 2016 figure for the state of Wisconsin was not available. This report notes the 2014-2015 figure.

Survey Limitations

Each survey has its own strengths and limitations. For example, strengths of both SAMHSA's *National Survey of Drug Use and Health* (NSDUH) and the CDC's Behavioral Risk Factor Surveillance System (BRFSS) are that they include national survey data with large sample sizes and utilized statistical modeling to provide weighted estimates of each state population. This means that the data is more representative of the general population. An example limitation of particular importance to the mental health community is that the NSDUH does not collect information from persons who are homeless 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 homeless or incarcerated are not represented in the data presented by the NSDUH. If the data did include individuals who were homeless 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.

Overall Ranking

A high overall ranking indicates lower prevalence of mental illness and higher rates of access to care. A low overall ranking indicates higher prevalence of mental illness and lower rates of access to care. The combined scores of all 15 measures make up the overall ranking. The overall ranking includes both adult and youth measures as well as prevalence and access to care measures.

The 15 measures that make up the overall ranking include:

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

The chart is a visual representation of the sum of the scores for each state. It provides an opportunity to see the difference between ranked states. For example, Minnesota (ranked 1) has a score that is higher than New York (ranked 12). Nebraska (ranked 23) has a score that is closest to the average.

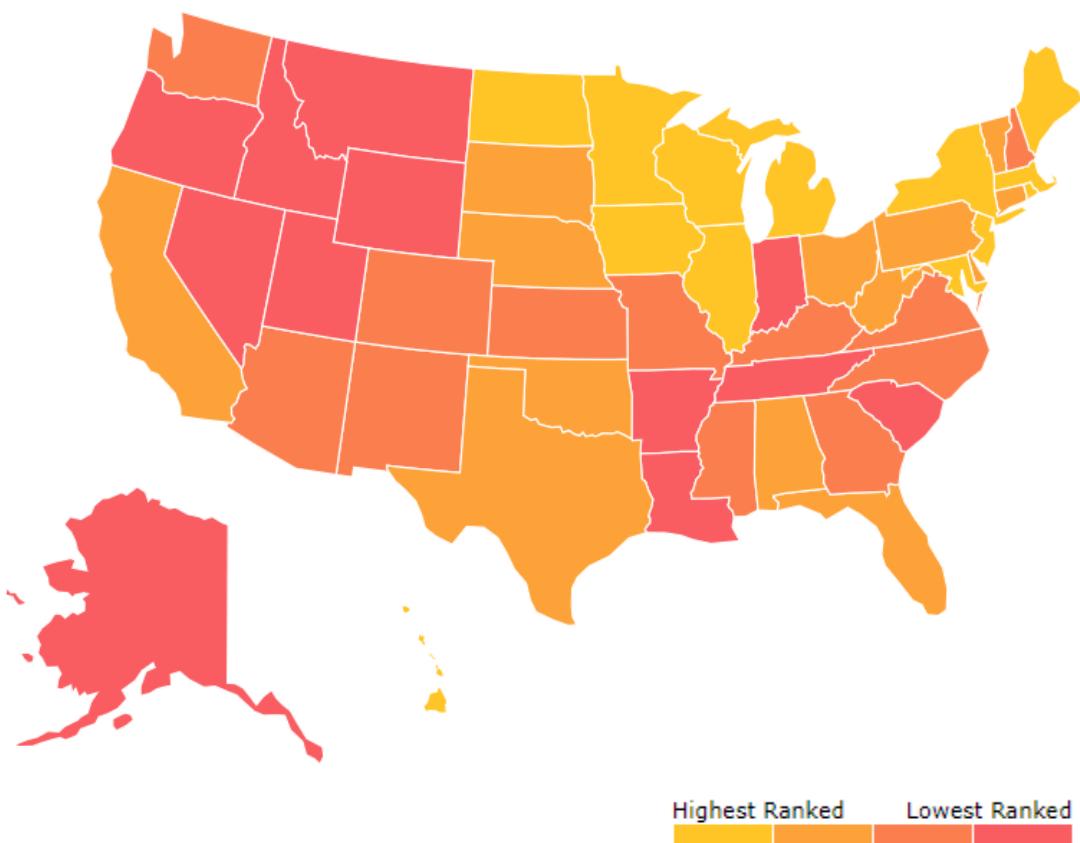


Adult Rankings

States with high rankings have lower prevalence of mental illness and higher rates of access to care for adults. Lower rankings indicate that adults have higher prevalence of mental illness and lower rates of access to care.

The 7 measures that make up the Adult Ranking include:

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



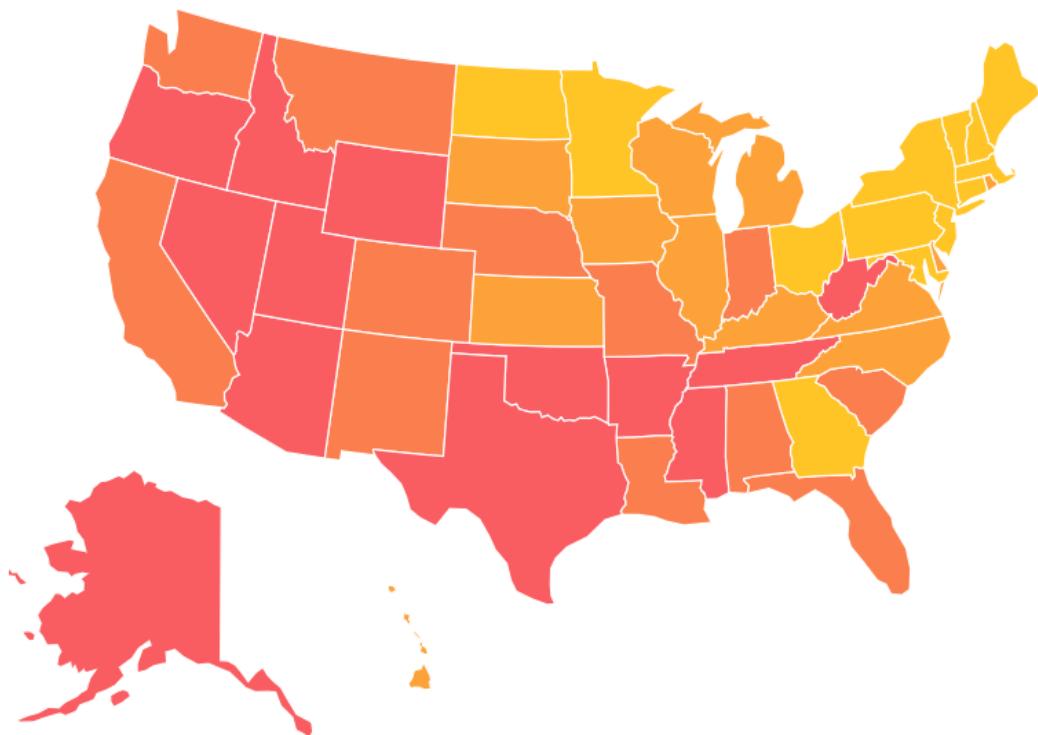
Rank	State
1	Maine
2	Hawaii
3	Iowa
4	Minnesota
5	New Jersey
6	Illinois
7	Massachusetts
8	Rhode Island
9	Michigan
10	Maryland
11	North Dakota
12	New York
13	Wisconsin
14	Delaware
15	Connecticut
16	South Dakota
17	Alabama
18	West Virginia
19	Nebraska
20	Ohio
21	Pennsylvania
22	California
23	Vermont
24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

Youth Rankings

States with high rankings have lower prevalence of mental illness and higher rates of access to care for youth. Lower rankings indicate that youth have higher prevalence of mental illness and lower rates of access to care.

The 7 measures that make up the Youth Ranking include:

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



Highest Ranked Lowest Ranked

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

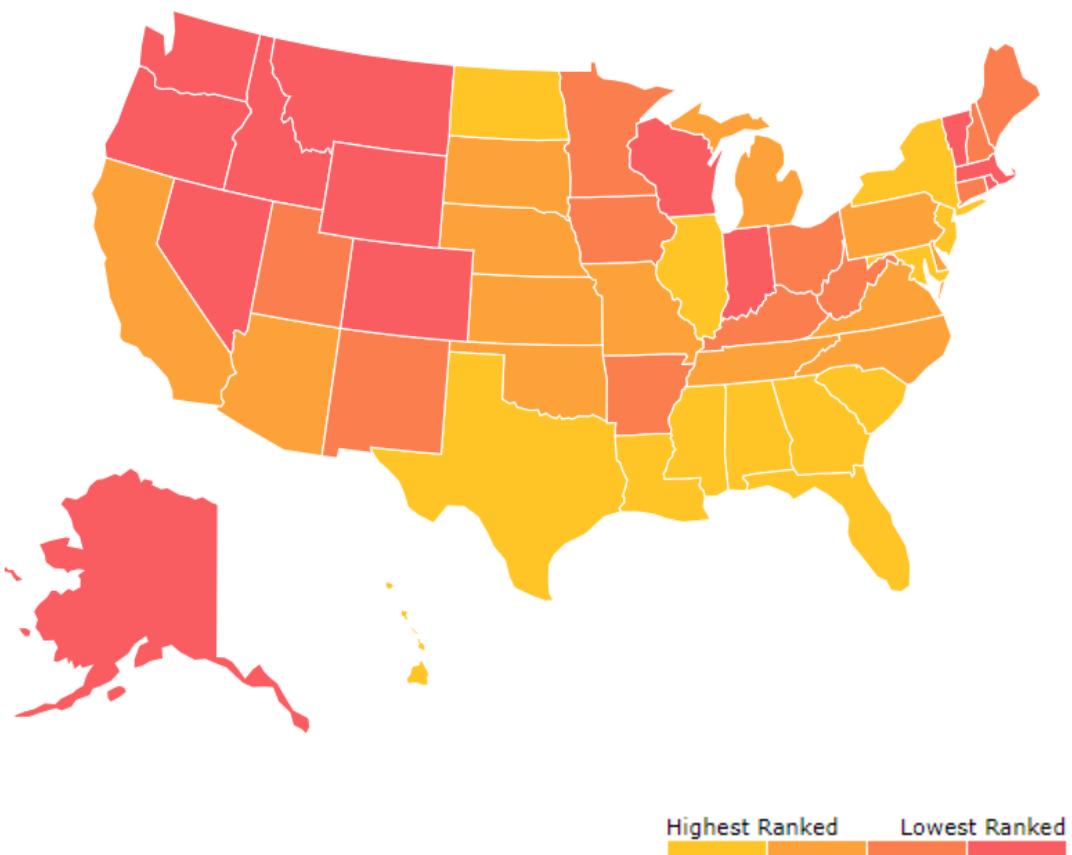
Prevalence of Mental Illness

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

The 6 measures that make up the Prevalence Ranking include:

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

A high ranking on the Prevalence Ranking indicates a lower prevalence of mental health and substance use issues. For example, states that rank 1-10 have lower rates of mental health and substance use problems compared to states that ranked 42-51.



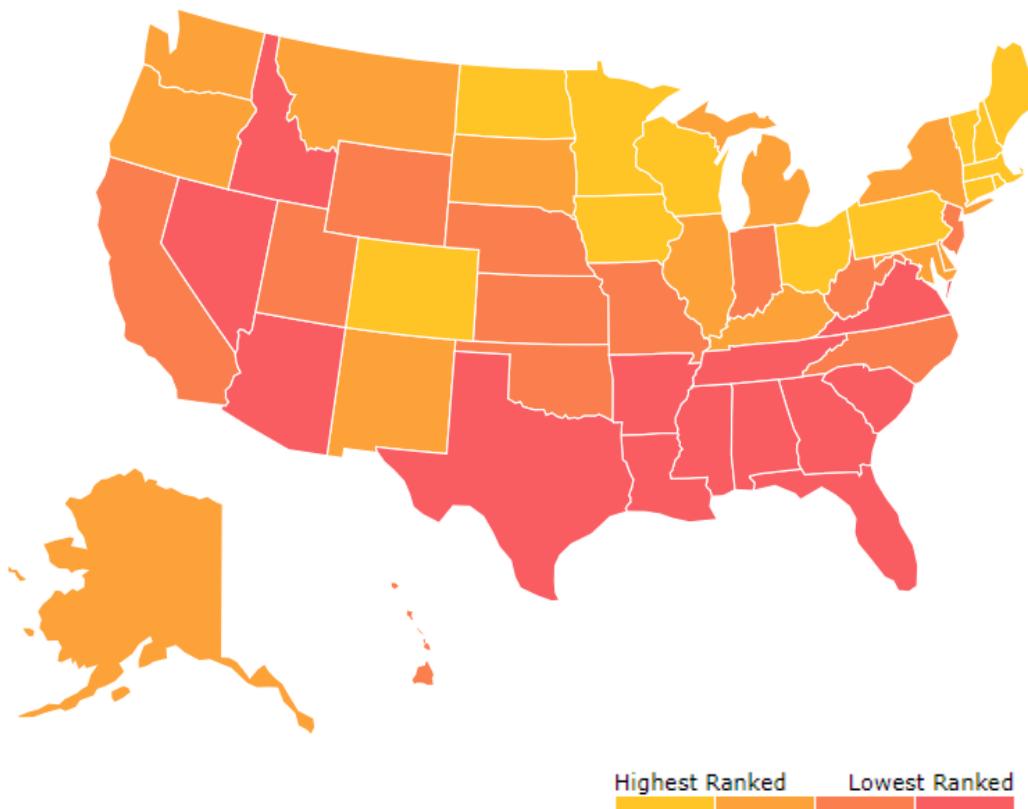
Rank	State
1	New Jersey
2	Georgia
3	Hawaii
4	Texas
5	Alabama
6	Mississippi
7	South Carolina
8	Louisiana
9	Florida
10	Illinois
11	New York
12	North Dakota
13	Maryland
14	North Carolina
15	Pennsylvania
16	South Dakota
17	Oklahoma
18	Delaware
19	Michigan
20	Tennessee
21	Kansas
22	Virginia
23	California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

The 9 measures that make up the Access Ranking include:

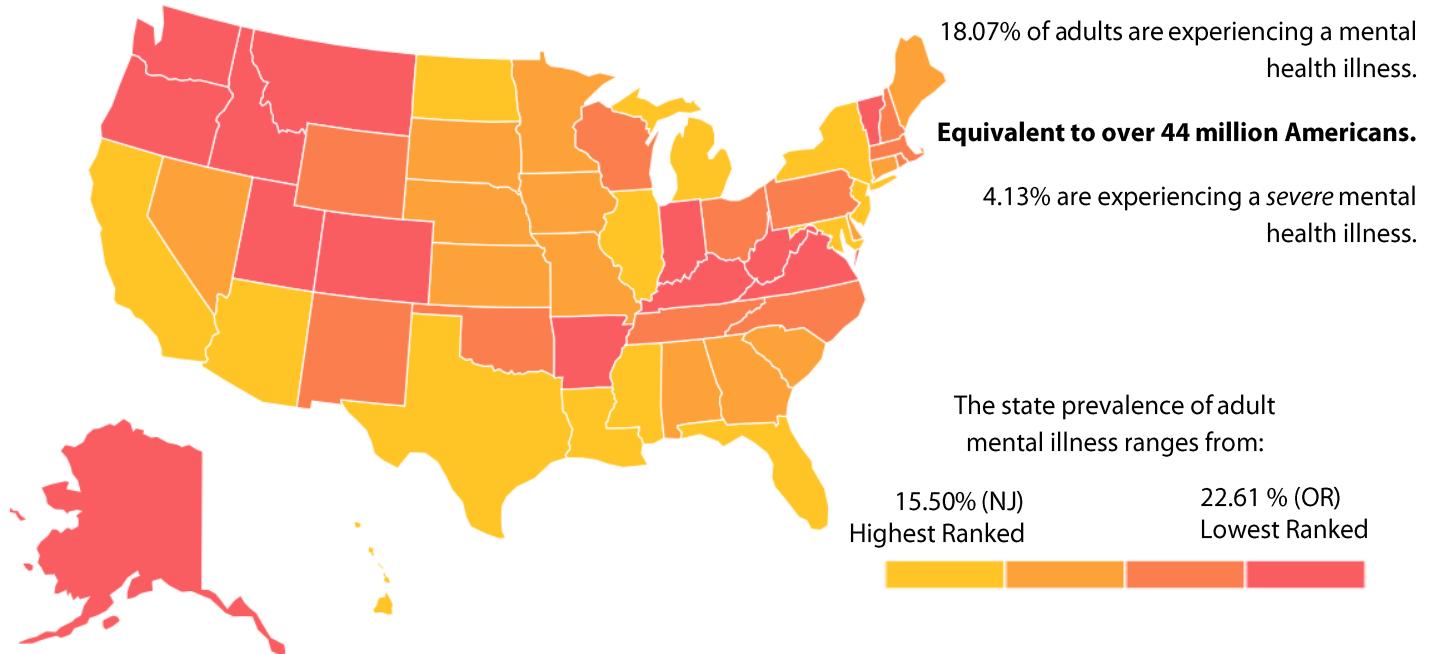
- | | |
|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| 1. Adults with AMI who Did Not Receive Treatment | 6. Youth with Severe MDE who Received Some Consistent Treatment |
| 2. Adults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



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

Adult Prevalence of Mental Illness

Adults with Any Mental Illness (AMI)

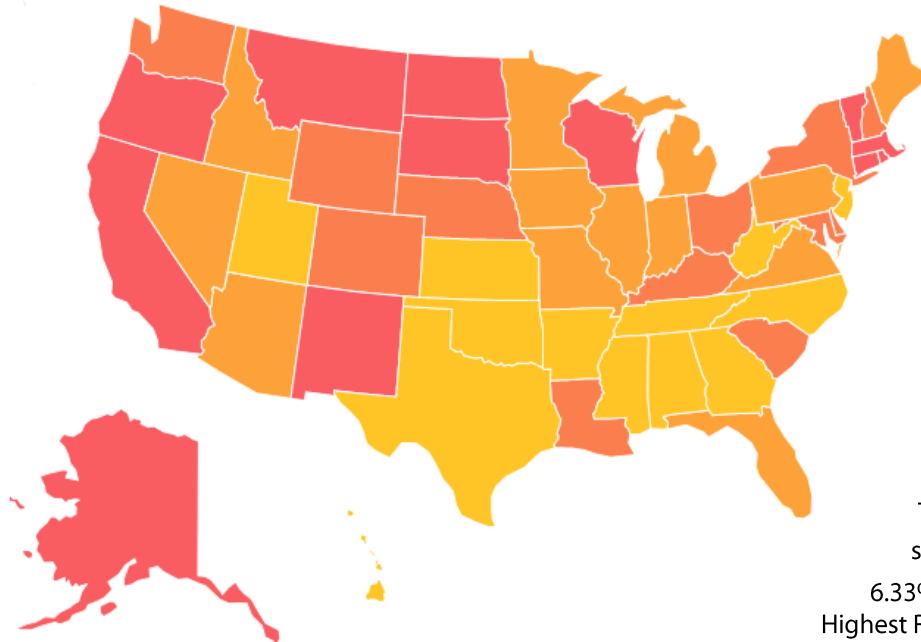


Rank	State	%	#
1	New Jersey	15.50	1,062,000
2	Hawaii	15.55	165,000
3	Illinois	15.73	1,526,000
4	Texas	16.04	3,196,000
5	Maryland	16.59	758,000
6	North Dakota	17.06	97,000
7	California	17.15	5,072,000
8	Florida	17.30	2,769,000
9	Louisiana	17.31	599,000
10	Michigan	17.33	1,320,000
11	Mississippi	17.49	385,000
12	Arizona	17.52	902,000
13	New York	17.54	2,692,000
14	Maine	17.62	187,000
15	Delaware	17.71	129,000
16	Iowa	17.72	418,000
17	Georgia	17.74	1,341,000
18	South Dakota	17.83	113,000
19	Connecticut	18.00	500,000
20	Missouri	18.03	828,000
21	South Carolina	18.12	677,000
22	Kansas	18.17	387,000
23	Minnesota	18.24	759,000
24	Nevada	18.33	404,000
25	Nebraska	18.39	258,000
26	Alabama	18.47	680,000

Rank	State	%	#
27	Wisconsin	18.51	817,000
28	Pennsylvania	18.76	1,861,000
29	District of Columbia	18.82	103,000
30	Oklahoma	18.93	545,000
31	North Carolina	18.98	1,440,000
32	New Mexico	19.19	298,000
33	Rhode Island	19.23	160,000
34	Massachusetts	19.34	1,034,000
35	New Hampshire	19.36	204,000
36	Wyoming	19.46	85,000
37	Tennessee	19.63	986,000
38	Ohio	19.72	1,741,000
39	Indiana	19.95	988,000
40	Virginia	19.96	1,261,000
41	Alaska	20.01	105,000
42	Colorado	20.05	832,000
43	Montana	20.57	164,000
44	Washington	20.72	1,139,000
45	Vermont	20.85	104,000
46	West Virginia	20.90	300,000
47	Arkansas	21.02	468,000
48	Idaho	21.62	262,000
49	Kentucky	22.08	737,000
50	Utah	22.27	464,000
51	Oregon	22.61	714,000
	National	18.07	44,035,000

According to SAMHSA, "Any Mental Illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. Any mental illness includes persons who have mild mental illness, moderate mental illness, and serious mental illness."

Adult with Substance Use Disorder in the Past Year



7.93% of adults in America reported having a substance use disorder in the past year.

2.76% of adults in America reported having an illicit drug use disorder in the past year.

6.09% of adults in America reported having an alcohol use disorder in the past year.

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

6.33% (WV)

Highest Ranked

10.59% (D.C.)

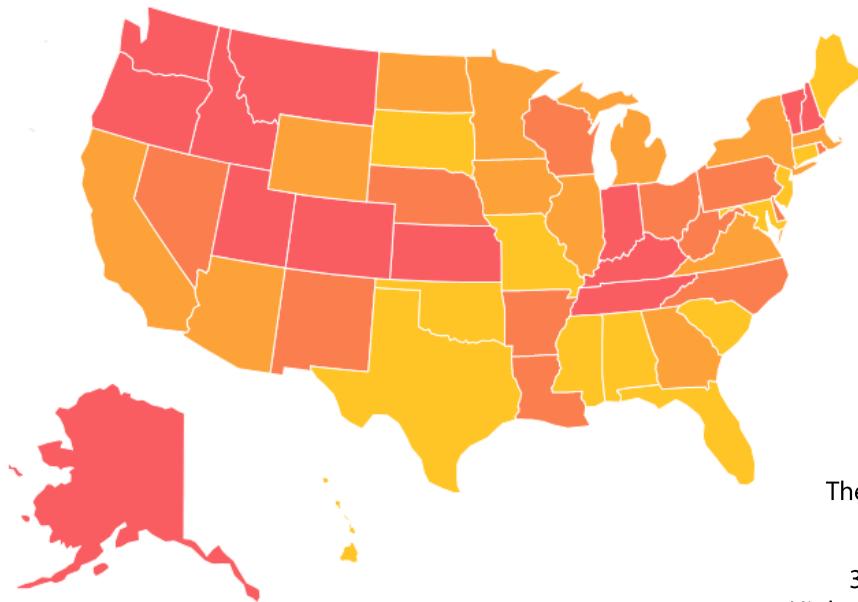
Lowest Ranked



Rank	State	%	#
1	West Virginia	6.33	91,000
2	Utah	6.35	132,000
3	New Jersey	6.53	447,000
4	Georgia	6.54	494,000
5	Alabama	6.60	243,000
6	Mississippi	6.69	147,000
7	Texas	6.93	1,382,000
8	Arkansas	6.94	155,000
9	North Carolina	7.03	533,000
10	Kansas	7.04	150,000
11	Tennessee	7.14	359,000
12	Oklahoma	7.15	206,000
13	Hawaii	7.23	77,000
14	Florida	7.35	1,176,000
15	Indiana	7.43	368,000
16	Nevada	7.44	164,000
17	Virginia	7.74	489,000
18	Arizona	7.78	400,000
19	Illinois	7.80	757,000
20	Pennsylvania	7.80	774,000
21	Maine	7.85	83,000
22	Idaho	7.90	96,000
23	Missouri	7.99	367,000
24	Minnesota	7.99	332,000
25	Iowa	8.03	190,000
26	Michigan	8.08	615,000

Rank	State	%	#
27	South Carolina	8.10	302,000
28	Kentucky	8.10	270,000
29	Nebraska	8.23	115,000
30	Ohio	8.25	728,000
31	Delaware	8.26	60,000
32	New York	8.33	1,278,000
33	Wyoming	8.43	37,000
34	Washington	8.43	463,000
35	Louisiana	8.48	293,000
36	Maryland	8.62	394,000
37	New Hampshire	8.66	91,000
38	Colorado	8.67	360,000
39	California	8.80	2,603,000
40	North Dakota	8.98	51,000
41	New Mexico	9.09	141,000
42	Wisconsin	9.10	402,000
43	Montana	9.14	73,000
44	Rhode Island	9.22	77,000
45	South Dakota	9.29	59,000
46	Vermont	9.59	48,000
47	Connecticut	9.59	266,000
48	Alaska	9.72	51,000
49	Oregon	9.88	312,000
50	Massachusetts	10.31	552,000
51	District of Columbia	10.59	58,000
	National	7.93	19,313,000

Adults with Serious Thoughts of Suicide



The percentage of adults reporting serious thoughts of suicide is 4.04%. The estimated number of adults with serious suicidal thoughts is over 9.8 million—an increase of 200,000 people from last year's data set.

The state prevalence of adult with serious thoughts of suicide range from:

3.34% (FL)
Highest Ranked

5.62% (UT)
Lowest Ranked

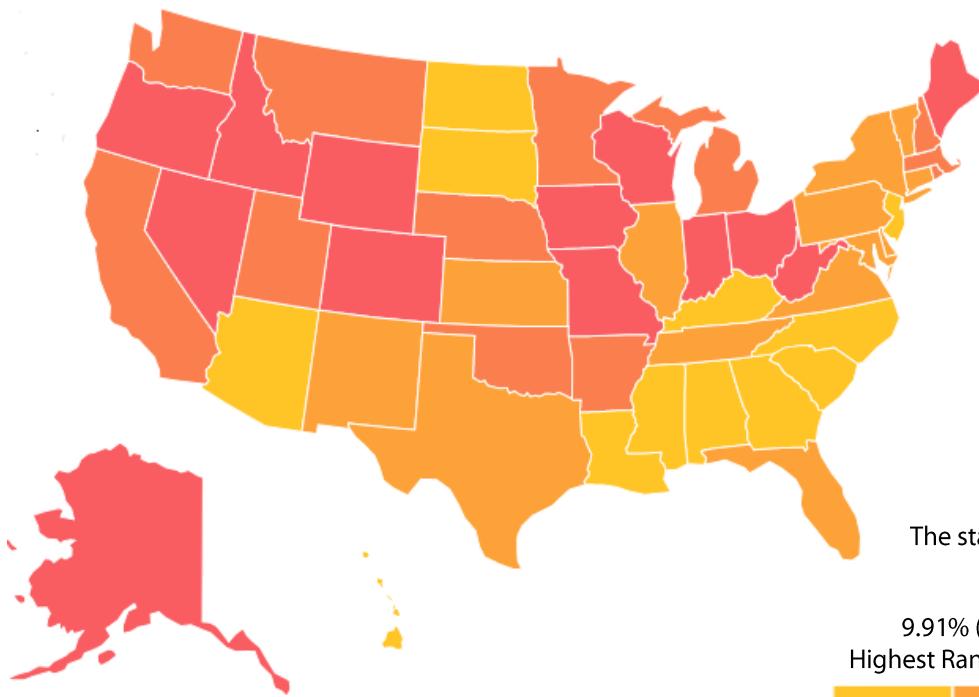


Rank	State	%	#
1	Florida	3.34	535,000
2	Missouri	3.47	160,000
3	Texas	3.51	699,000
4	Alabama	3.57	132,000
5	New Jersey	3.58	246,000
6	South Carolina	3.73	139,000
7	Maine	3.74	40,000
8	Connecticut	3.76	104,000
9	Oklahoma	3.77	109,000
10	Mississippi	3.78	83,000
11	Hawaii	3.79	40,000
12	South Dakota	3.82	24,000
13	Maryland	3.82	175,000
14	Illinois	3.89	377,000
15	Michigan	3.91	298,000
16	New York	3.94	605,000
17	Iowa	3.94	93,000
18	Georgia	3.94	298,000
19	California	3.96	1,173,000
20	Virginia	3.96	251,000
21	Massachusetts	3.97	212,000
22	Arizona	4.01	206,000
23	Wyoming	4.14	18,000
24	Minnesota	4.15	173,000
25	North Dakota	4.17	24,000
26	District of Columbia	4.22	23,000

Rank	State	%	#
27	North Carolina	4.23	321,000
28	Louisiana	4.24	147,000
29	New Mexico	4.28	66,000
30	Nevada	4.29	95,000
31	West Virginia	4.31	62,000
32	Delaware	4.35	32,000
33	Pennsylvania	4.41	438,000
34	Wisconsin	4.41	195,000
35	Nebraska	4.42	62,000
36	Arkansas	4.47	100,000
37	Ohio	4.47	394,000
38	Rhode Island	4.49	37,000
39	Tennessee	4.55	229,000
40	Indiana	4.58	227,000
41	Kansas	4.72	101,000
42	Washington	4.73	260,000
43	Idaho	4.84	59,000
44	Colorado	4.88	203,000
45	New Hampshire	5.01	53,000
46	Oregon	5.07	160,000
47	Kentucky	5.08	170,000
48	Alaska	5.15	27,000
49	Montana	5.29	42,000
50	Vermont	5.48	27,000
51	Utah	5.62	117,000
	National	4.04	9,860,000

Youth Prevalence of Mental Illness

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



12.63% of youth (age 12-17) report suffering from at least one major depressive episode (MDE) in the past year.

Childhood depression is more likely to persist into adulthood if gone untreated.

The number of youths experiencing MDE increased by 175,000 from last years' dataset.

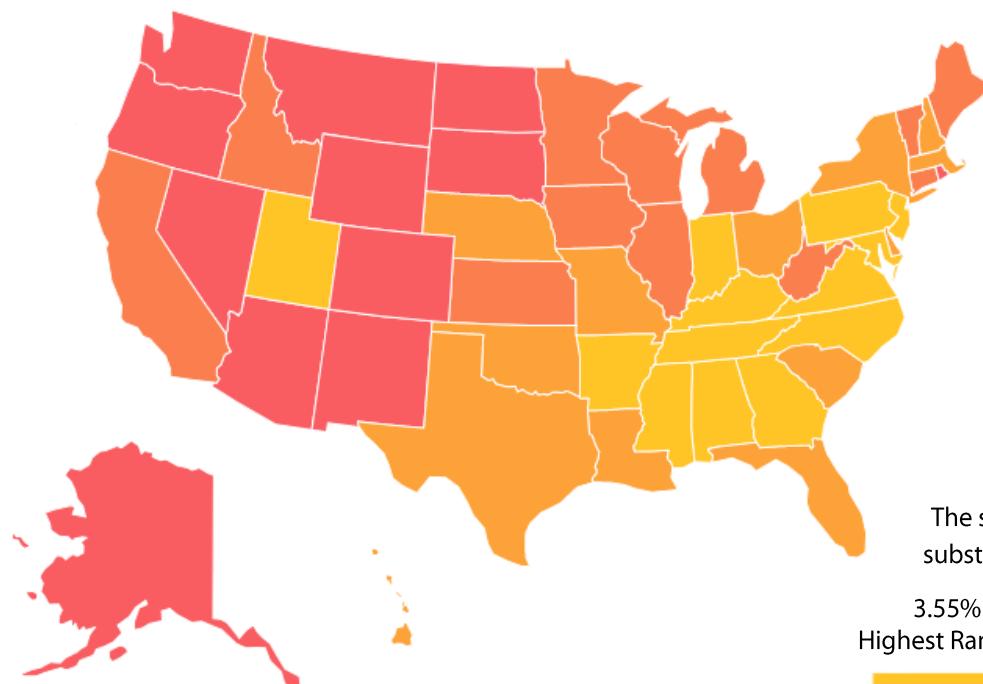
The state prevalence of youth with MDE ranges from:

9.91% (DC) 15.93% (ID)
Highest Ranked Lowest Ranked

Rank	State	%	#
1	District of Columbia	9.91	3,000
2	Georgia	10.14	87,000
3	Louisiana	10.15	37,000
4	New Jersey	10.39	72,000
5	Mississippi	10.78	26,000
6	South Carolina	10.83	40,000
7	Hawaii	10.99	11,000
8	Alabama	11.18	42,000
9	North Dakota	11.25	6,000
10	Arizona	11.68	64,000
11	North Carolina	11.70	92,000
12	Kentucky	11.72	40,000
13	South Dakota	11.79	8,000
14	New York	11.91	169,000
15	Delaware	11.94	8,000
16	Texas	11.95	286,000
17	Tennessee	12.13	62,000
18	Pennsylvania	12.33	114,000
19	Vermont	12.45	5,000
20	Illinois	12.46	126,000
21	Connecticut	12.52	35,000
22	Kansas	12.53	30,000
23	Virginia	12.56	79,000
24	New Mexico	12.61	21,000
25	Maryland	12.69	58,000
26	Florida	12.84	180,000

Rank	State	%	#
27	California	12.93	393,000
28	Nebraska	12.97	20,000
29	Arkansas	13.05	31,000
30	Washington	13.23	70,000
31	Michigan	13.27	103,000
32	Minnesota	13.39	57,000
33	New Hampshire	13.40	13,000
34	Oklahoma	13.53	43,000
35	Montana	13.56	10,000
36	Massachusetts	13.72	67,000
37	Rhode Island	13.72	10,000
38	Utah	13.81	41,000
39	West Virginia	13.90	18,000
40	Ohio	13.98	127,000
41	Iowa	14.09	34,000
42	Maine	14.25	13,000
43	Missouri	14.28	67,000
44	Wisconsin	14.45	64,000
45	Colorado	14.59	62,000
46	Indiana	14.70	79,000
47	Wyoming	15.00	7,000
48	Alaska	15.22	9,000
49	Oregon	15.66	46,000
50	Nevada	15.66	35,000
51	Idaho	15.93	23,000
	National	12.63	3,144,000

Youth with Substance Use Disorder in the Past Year



4.61% of youth reported a substance use disorder in the past year.

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

3.55% (PA)
Highest Ranked

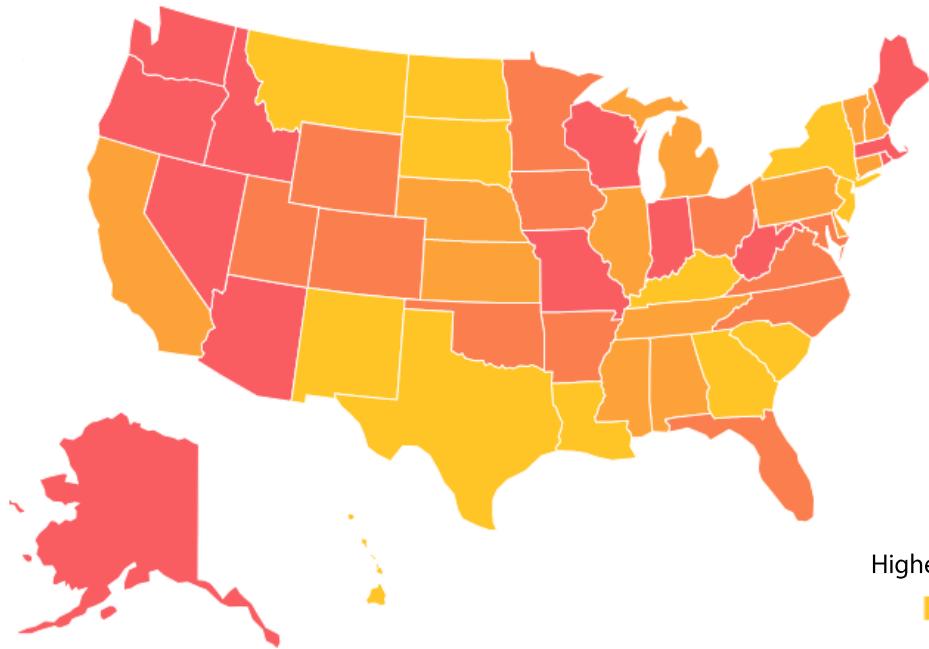
8.33% (AK)
Lowest Ranked



Rank	State	%	#
1	Pennsylvania	3.55	33,000
2	Virginia	3.71	23,000
3	Georgia	3.74	32,000
4	New Jersey	3.83	27,000
5	Alabama	3.87	15,000
6	Mississippi	3.87	9,000
7	Maryland	3.98	18,000
8	Tennessee	4.04	21,000
9	Kentucky	4.10	14,000
10	North Carolina	4.13	32,000
11	Utah	4.16	12,000
12	Arkansas	4.16	10,000
13	Indiana	4.23	23,000
14	Hawaii	4.28	4,000
15	Ohio	4.29	39,000
16	South Carolina	4.29	16,000
17	Florida	4.30	60,000
18	Delaware	4.32	3,000
19	Louisiana	4.34	16,000
20	Oklahoma	4.35	14,000
21	Nebraska	4.43	7,000
22	Missouri	4.44	21,000
23	New York	4.46	63,000
24	Texas	4.54	109,000
25	Massachusetts	4.54	22,000
26	New Hampshire	4.56	4,000

Rank	State	%	#
27	Michigan	4.75	37,000
28	Iowa	4.78	12,000
29	Kansas	4.88	12,000
30	Minnesota	5.00	21,000
31	West Virginia	5.00	6,000
32	Connecticut	5.00	14,000
33	Maine	5.02	5,000
34	California	5.07	154,000
35	Wisconsin	5.16	23,000
36	Illinois	5.21	53,000
37	Idaho	5.39	8,000
38	Vermont	5.41	2,000
39	North Dakota	5.43	3,000
40	Washington	5.43	29,000
41	Nevada	5.45	12,000
42	Arizona	5.62	31,000
43	Rhode Island	5.62	4,000
44	District of Columbia	5.72	2,000
45	South Dakota	5.78	4,000
46	Oregon	5.98	17,000
47	Wyoming	6.37	3,000
48	Montana	6.39	5,000
49	Colorado	6.73	28,000
50	New Mexico	7.15	12,000
51	Alaska	8.33	5,000
	National	4.61	1,148,000

Youth with Severe Major Depressive Episode



8.7% of youth (over 2 million youth) cope with severe major depression. Depression in youth often co-occur with other disorders like substance abuse, anxiety and disorderly behavior.

The number of youths experiencing Severe MDE increased by 100,000
from last year's dataset.

The state prevalence of youth with severe MDE ranges from:

6.1% (NJ)
Highest Ranked

12.7% (NV)
Lowest Ranked



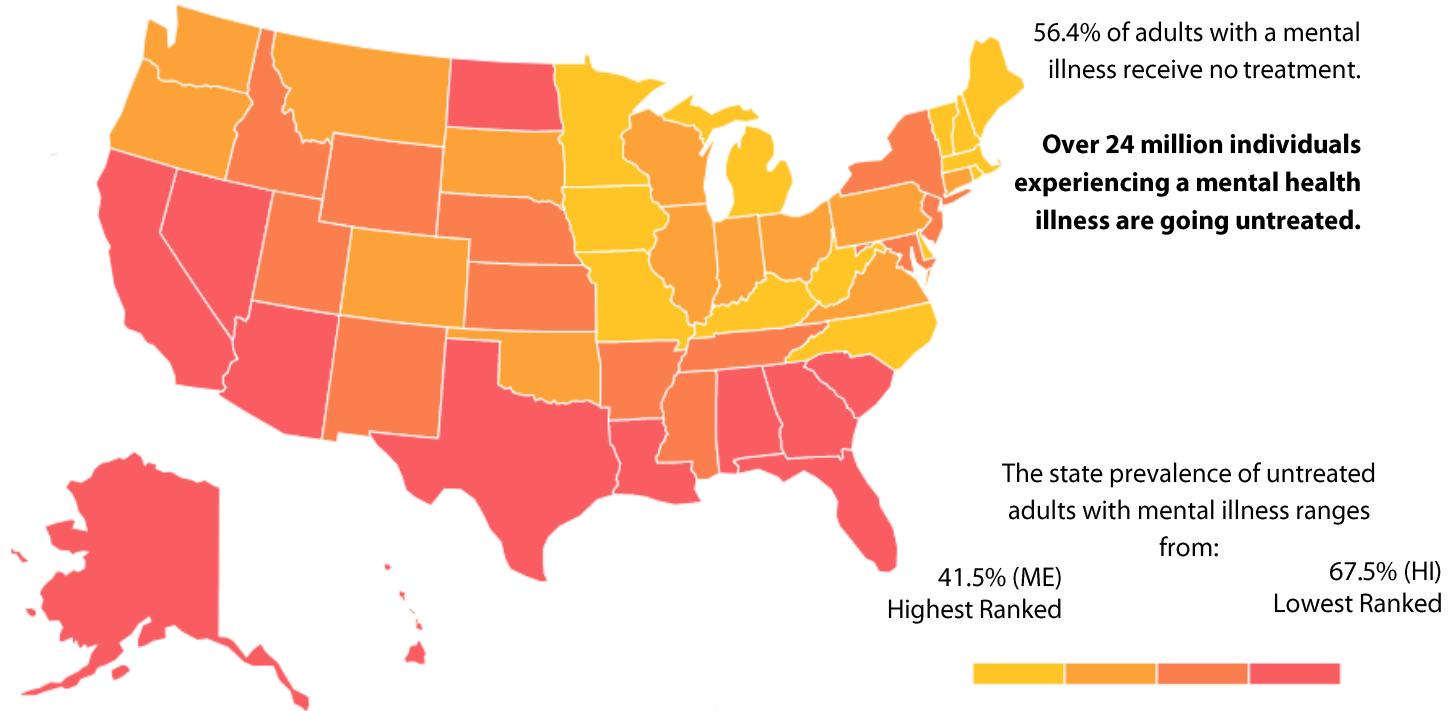
Rank	State	%	#
1	New Jersey	6.1	41,000
2	North Dakota	6.2	3,000
3	South Dakota	6.2	4,000
4	Georgia	6.3	52,000
5	Kentucky	6.3	21,000
6	Hawaii	7.1	7,000
7	Montana	7.1	5,000
8	New Mexico	7.1	11,000
9	Louisiana	7.4	26,000
10	New York	7.5	103,000
11	South Carolina	7.5	27,000
12	District of Columbia	7.6	2,000
13	Texas	7.8	181,000
14	Vermont	7.9	3,000
15	California	8.0	237,000
16	Connecticut	8.0	22,000
17	Kansas	8.0	18,000
18	Alabama	8.1	30,000
19	Nebraska	8.2	12,000
20	Illinois	8.3	82,000
21	Tennessee	8.5	41,000
22	Michigan	8.6	66,000
23	Delaware	8.7	6,000
24	Pennsylvania	8.8	79,000
25	Mississippi	8.9	21,000
26	New Hampshire	8.9	9,000

Rank	State	%	#
27	Utah	9.1	26,000
28	Florida	9.2	125,000
29	Iowa	9.2	22,000
30	Oklahoma	9.2	28,000
31	Arkansas	9.3	22,000
32	Ohio	9.3	83,000
33	Maryland	9.5	42,000
34	North Carolina	9.5	72,000
35	Virginia	9.5	57,000
36	Minnesota	9.7	40,000
37	Wyoming	9.7	4,000
38	Colorado	9.8	40,000
39	Arizona	9.9	53,000
40	Missouri	9.9	45,000
41	Maine	10.0	9,000
42	Washington	10.0	52,000
43	Alaska	10.1	6,000
44	Wisconsin	10.2	45,000
45	Massachusetts	10.6	50,000
46	West Virginia	10.7	13,000
47	Idaho	11.2	16,000
48	Rhode Island	11.8	8,000
49	Oregon	12.2	35,000
50	Indiana	12.3	64,000
51	Nevada	12.7	27,000
	National	8.7	2,096,000

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

Adult Access to Care

Adults with AMI who Did Not Receive Treatment



Rank	State	%	#
1	Maine	41.5	82,000
2	Minnesota	43.0	326,000
3	Vermont	45.5	49,000
4	Iowa	45.7	175,000
5	New Hampshire	46.1	106,000
6	Rhode Island	47.7	82,000
7	Delaware	47.8	64,000
8	Massachusetts	48.6	502,000
9	North Carolina	50.7	725,000
10	Kentucky	50.9	384,000
11	West Virginia	51.8	166,000
12	Missouri	52.4	425,000
13	Michigan	52.6	702,000
14	Wisconsin	52.6	417,000
15	South Dakota	53.3	55,000
16	Ohio	53.4	949,000
17	Colorado	53.5	445,000
18	Illinois	53.5	788,000
19	Montana	53.5	85,000
20	Connecticut	53.6	258,000
21	Virginia	53.7	684,000
22	Washington	53.7	619,000
23	Pennsylvania	53.9	977,000
24	Oregon	54.8	408,000
25	Oklahoma	55.1	303,000
26	Indiana	55.4	558,000

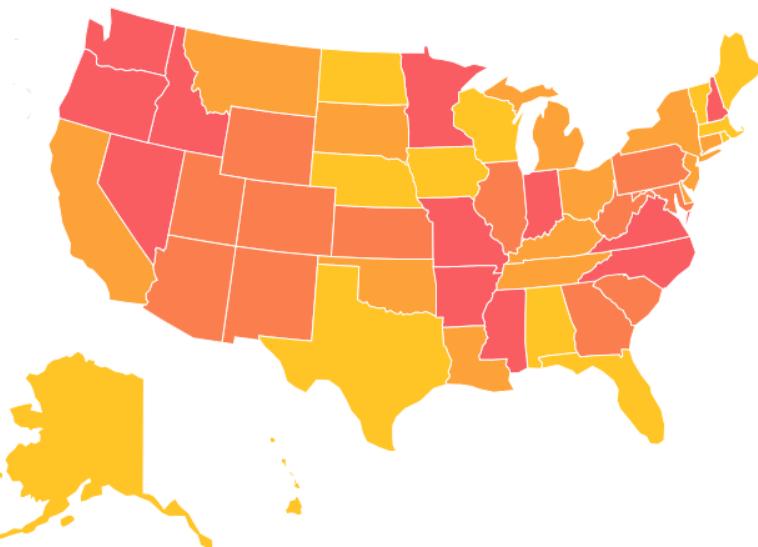
Rank	State	%	#
27	Idaho	55.5	148,000
28	Wyoming	55.9	49,000
29	New Mexico	56.0	177,000
30	Kansas	56.1	207,000
31	Nebraska	56.2	142,000
32	Maryland	56.4	429,000
33	Tennessee	56.5	560,000
34	Arkansas	56.6	259,000
35	New York	56.9	1,493,000
36	New Jersey	57.0	602,000
37	Utah	57.1	258,000
38	Mississippi	57.4	227,000
39	North Dakota	57.9	51,000
40	District of Columbia	58.2	59,000
41	Alabama	58.8	407,000
42	Georgia	59.0	775,000
43	South Carolina	59.8	398,000
44	Louisiana	60.6	372,000
45	Florida	61.4	1,643,000
46	Alaska	61.8	63,000
47	Texas	62.2	1,925,000
48	California	62.3	3,157,000
49	Arizona	62.6	564,000
50	Nevada	63.1	253,000
51	Hawaii	67.5	111,000
	National	56.4	24,663,000

Adults with AMI Reporting Unmet Need

One out of five (20.6%) adults with a mental illness reported that were not able to receive the treatment they needed. **This number has not declined since 2011.**

Individuals seeking treatment but still not receiving needed services face the same barriers that contribute to the number of individuals not receiving treatment:

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



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

15.8% (HI)

Highest Ranked

26.3% (DC)

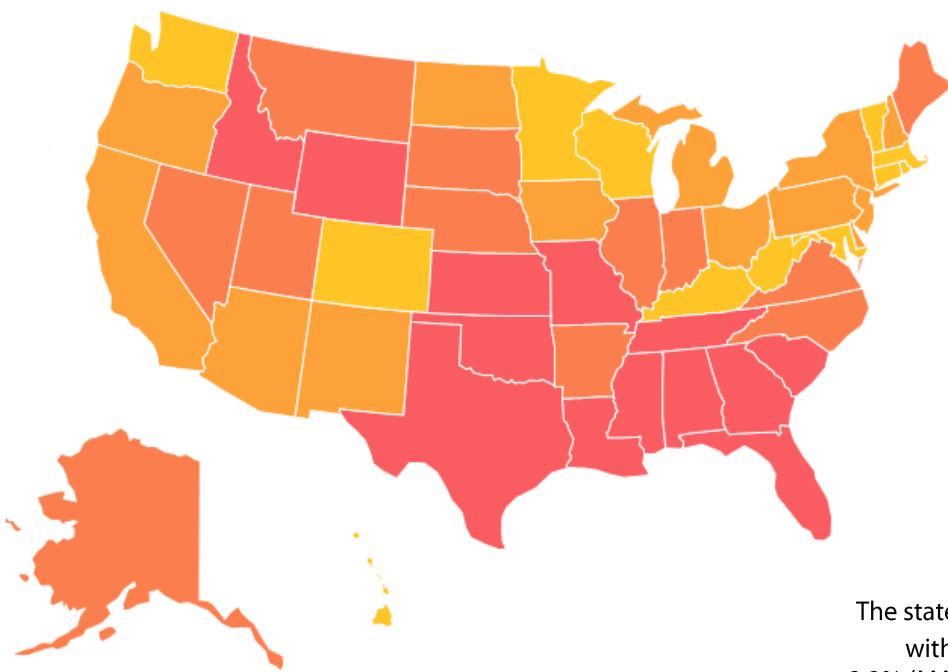
Lowest Ranked



Rank	State	%	#
1	Hawaii	15.8	26,000
2	Alabama	16.6	115,000
3	Texas	16.7	518,000
4	Nebraska	17.0	43,000
5	Maine	17.3	34,000
6	Rhode Island	17.4	30,000
7	Wisconsin	18.1	143,000
8	Alaska	18.3	19,000
9	Florida	18.5	495,000
10	Massachusetts	18.8	193,000
11	North Dakota	18.8	17,000
12	Vermont	18.8	20,000
13	Iowa	19.2	73,000
14	Louisiana	19.6	121,000
15	Michigan	19.7	263,000
16	New Jersey	19.7	210,000
17	Oklahoma	19.8	109,000
18	California	19.9	1,009,000
19	New York	19.9	524,000
20	Kentucky	20.0	152,000
21	South Dakota	20.1	21,000
22	Ohio	20.2	361,000
23	Tennessee	20.5	203,000
24	Montana	20.7	33,000
25	Connecticut	20.8	101,000
26	Delaware	20.8	28,000

Rank	State	%	#
27	Georgia	20.9	275,000
28	Utah	20.9	95,000
29	Kansas	21.0	78,000
30	Wyoming	21.2	19,000
31	Arizona	21.3	193,000
32	South Carolina	21.3	142,000
33	Illinois	21.5	318,000
34	Pennsylvania	21.5	390,000
35	New Mexico	21.6	69,000
36	Colorado	21.8	181,000
37	Maryland	21.8	166,000
38	West Virginia	21.9	70,000
39	Minnesota	22.3	170,000
40	Mississippi	22.6	89,000
41	Arkansas	22.7	104,000
42	Virginia	23.6	300,000
43	Missouri	24.1	194,000
44	North Carolina	24.1	344,000
45	Washington	24.3	280,000
46	Indiana	24.5	247,000
47	Idaho	24.7	66,000
48	Oregon	24.9	185,000
49	New Hampshire	25.1	57,000
50	Nevada	26.2	105,000
51	District of Columbia	26.3	26,000
	National	20.6	9,024,000

Adults with AMI who are Uninsured



12.2% (over 5.3 million) of adults with a mental illness remain uninsured.

Under the Affordable Care Act (ACA), the U.S. continues to see a decline in Americans who are uninsured. There was a 2.5% reduction from last year's dataset.

46 states saw a reduction in Adults with AMI who are uninsured. The largest reductions were seen in South Carolina (7.1%), Missouri (6.3%), Arkansas (6.7%), Arizona (5.6%).

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

2.2% (MA)

Highest Ranked

23.0% (TX)

Lowest Ranked



Rank	State	%	#
1	Massachusetts	2.2	23,000
2	District of Columbia	4.3	4,000
3	Rhode Island	5.1	9,000
4	Minnesota	5.3	41,000
5	Hawaii	5.6	9,000
6	Maryland	5.9	45,000
7	Connecticut	6.3	31,000
8	Kentucky	6.3	48,000
9	Vermont	6.6	7,000
10	Wisconsin	6.9	55,000
11	Colorado	7.1	59,000
12	Washington	7.3	85,000
13	West Virginia	7.7	24,000
14	Iowa	7.9	30,000
15	New Hampshire	8.0	18,000
16	Ohio	8.0	143,000
17	New Mexico	8.3	26,000
18	Pennsylvania	8.3	151,000
19	Michigan	8.5	114,000
20	New York	8.7	230,000
21	New Jersey	9.2	98,000
22	Arizona	10.3	93,000
23	Oregon	10.3	76,000
24	North Dakota	10.4	9,000
25	California	10.7	545,000
26	Delaware	11.1	15,000

Rank	State	%	#
27	Arkansas	11.4	52,000
28	Illinois	11.8	175,000
29	South Dakota	11.8	12,000
30	Indiana	12.3	124,000
31	Maine	13.0	26,000
32	Alaska	13.1	13,000
33	Montana	13.3	21,000
34	Virginia	13.7	174,000
35	Nebraska	13.9	35,000
36	Utah	14.0	64,000
37	North Carolina	14.5	208,000
38	Nevada	15.1	60,000
39	Oklahoma	15.4	85,000
40	Kansas	15.8	58,000
41	Missouri	16.2	132,000
42	Idaho	16.6	45,000
43	South Carolina	16.7	111,000
44	Tennessee	17.0	169,000
45	Alabama	17.5	121,000
46	Mississippi	18.0	71,000
47	Georgia	18.5	244,000
48	Florida	19.1	513,000
49	Louisiana	20.0	123,000
50	Wyoming	20.1	18,000
51	Texas	23.0	713,000
	National	12.2	5,359,000

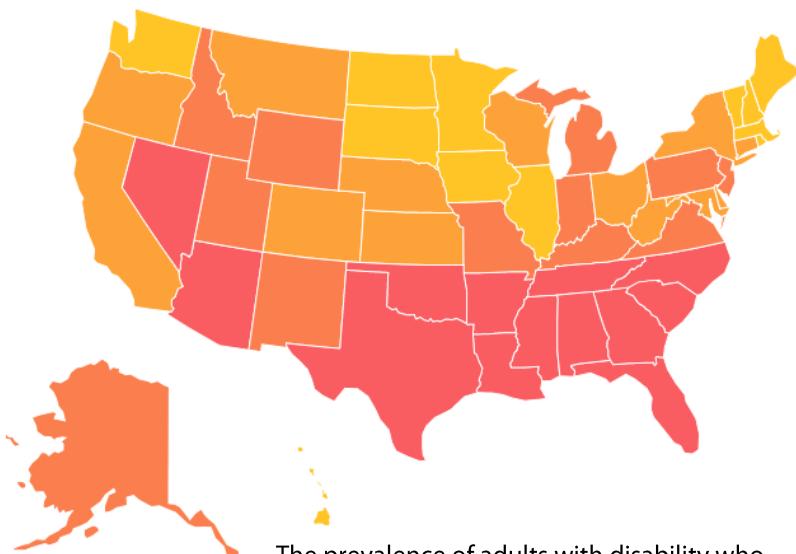
Adults with Disability who Could Not See a Doctor Due to Costs

21.62% of adults with a disability were not able to see a doctor due to costs.

According to the US Census Bureau (2010) 56.7 million individuals had a level of disability, with more than half reporting that their disability was severe.

Of adults (15-64) who were uninsured, 21% had a severe disability.¹

A literature review on the barriers to healthcare services faced by individuals with disabilities revealed that the most common barriers were lack of insurance, limited coverage of services, and no primary source of care.²



The prevalence of adults with disability who couldn't see a MD due to cost ranges from:

12.45% (HI)
Highest Ranked

30.91% (MS)
Lowest Ranked



Rank	State	%	#
1	Hawaii	12.45	177,535
2	Iowa	12.64	54,455
3	Vermont	12.66	13,144
4	North Dakota	13.26	12,981
5	New Hampshire	13.47	28,019
6	Massachusetts	13.64	141,320
7	District of Columbia	14.19	13,597
8	Minnesota	14.38	104,523
9	Illinois	15.38	262,507
10	Maine	15.89	40,150
11	South Dakota	16.11	21,437
12	Rhode Island	16.18	27,887
13	Washington	17.30	219,597
14	Colorado	17.30	133,762
15	Connecticut	17.53	93,597
16	Wisconsin	17.53	146,005
17	Ohio	17.59	319,279
18	Montana	18.21	34,492
19	Maryland	18.27	143,733
20	California	18.46	1,006,308
21	New York	18.79	531,331
22	Kansas	19.02	79,714
23	Oregon	19.23	152,156
24	Nebraska	19.39	48,379
25	Delaware	19.48	28,943
26	West Virginia	20.03	82,178

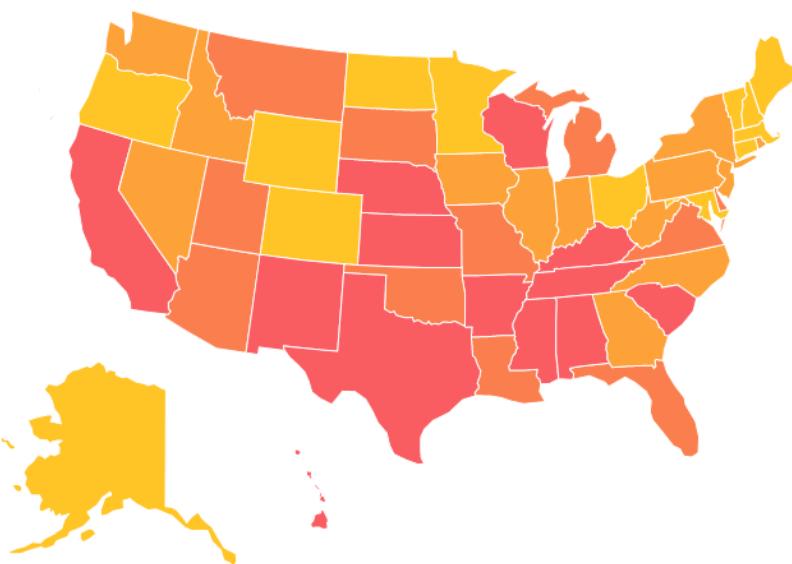
Rank	State	%	#
27	Pennsylvania	20.17	392,965
28	Idaho	20.74	56,031
29	Alaska	20.98	23,610
30	New Mexico	21.09	72,475
31	Kentucky	21.21	188,778
32	Wyoming	21.30	20,759
33	Michigan	21.43	363,203
34	Virginia	21.65	243,521
35	Utah	22.06	77,733
36	New Jersey	22.35	258,348
37	Indiana	22.86	237,916
38	Missouri	23.54	272,719
39	Arkansas	24.11	146,714
40	Arizona	24.14	249,660
41	Nevada	24.75	109,424
42	Tennessee	25.21	309,380
43	North Carolina	25.40	418,833
44	Oklahoma	25.45	188,785
45	Alabama	25.65	261,471
46	Georgia	26.96	407,162
47	Florida	27.11	875,479
48	South Carolina	28.12	244,082
49	Louisiana	28.73	225,771
50	Texas	29.19	956,390
51	Mississippi	30.91	170,133
	National	21.62	10,663,174

¹ <https://www.census.gov/newsroom/releases/archives/miscellaneous/cb12-134.html>

² Peterson-Besse, Jana J. MPH, PhD*; Walsh, Emily S. MPH†; Horner-Johnson, Willi PhD‡; Goode, Tawara D. MA§; Wheeler, Barbara PhD|| Medical Care: October 2014 - Volume 52 - Issue - p S51–S63 doi: 10.1097/MLR.0000000000000195. Literature Review

Youth Access to Care

Youth with MDE who Did Not Receive Mental Health Services



61.5% of youth with major depression do not receive any mental health treatment.

Youth experiencing MDE continue to go untreated. Among the top ranked states almost 50% of youth are not receiving the mental health services they need.

The state prevalence of untreated youth with depression ranges from:

45.8% (CT)
Highest Ranked

71.3% (TX)
Lowest Ranked



Rank*	State	%	#
1	Connecticut	45.8	12,000
2	Minnesota	46.5	21,000
3	Maine	48.5	5,000
4	New Hampshire	51.5	6,000
5	Ohio	51.6	59,000
6	Massachusetts	53.8	30,000
7	Oregon	53.9	25,000
8	Alaska	54.2	3,000
9	Vermont	54.4	2,000
10	Colorado	55.4	33,000
11	Wyoming	55.8	3,000
12	Maryland	55.9	28,000
13	North Dakota	56.0	2,000
14	Idaho	57.1	10,000
15	Rhode Island	57.2	5,000
16	Georgia	57.5	43,000
17	Iowa	58.3	16,000
18	West Virginia	58.6	9,000
19	Illinois	59.4	69,000
20	New York	59.6	98,000
21	Nevada	59.8	22,000
22	Pennsylvania	59.8	65,000
23	New Jersey	60.6	37,000
24	Indiana	61.6	50,000
25	Washington	61.7	39,000
26	North Carolina	62.2	57,000

Rank*	State	%	#
27	District of Columbia	62.3	1,000
28	Florida	62.4	108,000
29	Oklahoma	62.6	20,000
30	Delaware	62.8	4,000
31	Virginia	63.1	48,000
32	Montana	63.3	5,000
33	Louisiana	63.4	21,000
34	South Dakota	63.4	4,000
35	Utah	63.8	21,000
36	Arizona	64.0	39,000
37	Michigan	64.3	61,000
38	Missouri	64.6	32,000
39	California	65.1	243,000
40	Kansas	65.3	15,000
41	Arkansas	66.0	18,000
42	Wisconsin	66.4	38,000
43	Mississippi	67.1	15,000
44	New Mexico	67.3	12,000
45	Alabama	67.4	25,000
46	Nebraska	67.4	10,000
47	Hawaii	67.5	6,000
48	Kentucky	67.5	20,000
49	South Carolina	69.0	23,000
50	Tennessee	70.7	33,000
51	Texas	71.3	190,000
	National	61.5	1,809,000

* Due to data limitations, figures were taken from two sets of data: annual averages from 2014-2016 and 2011-2016. Data set denoted for each state in the Appendix-Table 1

Youth with Severe MDE who Received Some Consistent Treatment

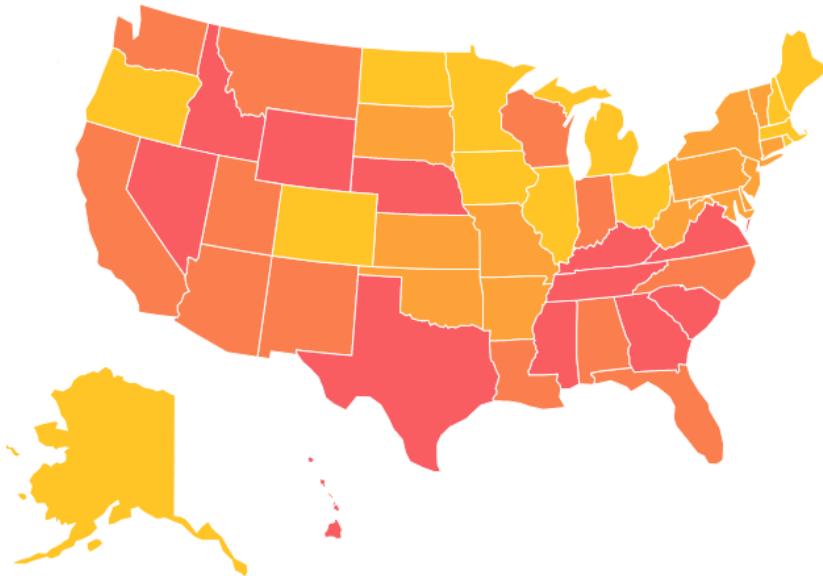
Nationally, only 25.1% of youth with severe depression receive some consistent treatment (7-25+ visits in a year).

Late recognition in primary care settings and limited coverage of mental health services often prevent youth from receiving timely and effective treatment.

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

39.7 % (MN)
Highest Ranked

12.2% (SC)
Lowest ranked



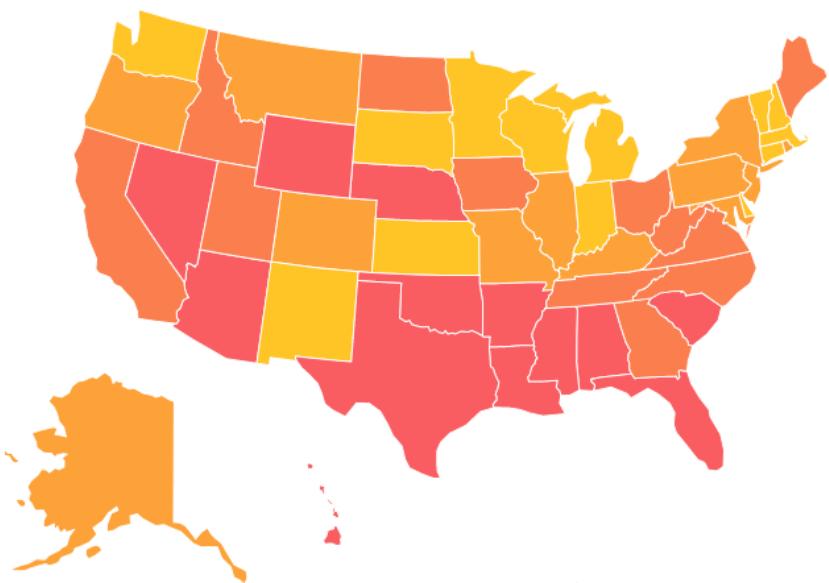
High percentages are associated with positive outcomes and low percentages are associated with poorer outcomes.

Rank*	State	%	#
1	Minnesota	39.7	12,000
2	Maine	38.7	3,000
3	New Hampshire	38.3	3,000
4	Massachusetts	37.3	14,000
5	Ohio	33.0	27,000
6	Alaska	32.3	1,000
7	North Dakota	31.6	1,000
8	Colorado	31.4	10,000
9	Michigan	31.0	20,000
10	Rhode Island	29.5	2,000
11	Iowa	29.4	6,000
12	Oregon	29.4	8,000
13	Illinois	29.3	23,000
14	Pennsylvania	28.7	21,000
15	Vermont	28.1	1,000
16	Maryland	28.0	10,000
17	West Virginia	28.0	3,000
18	New York	27.2	27,000
19	Missouri	26.7	10,000
20	Kansas	26.5	4,000
21	South Dakota	26.5	1,000
22	Delaware	26.2	1,000
23	Arkansas	26.1	5,000
24	Oklahoma	25.8	6,000
25	Connecticut	25.6	5,000

Rank*	State	%	#
27	North Carolina	25.5	15,000
28	Washington	24.5	12,000
29	California	23.9	55,000
30	Indiana	23.7	11,000
31	New Mexico	23.5	3,000
32	Utah	23.1	5,000
33	Wisconsin	23.0	9,000
34	Alabama	22.7	5,000
35	Louisiana	22.5	5,000
36	Arizona	22.3	10,000
37	Florida	21.7	26,000
38	Montana	21.5	1,000
39	Nebraska	21.4	2,000
40	Wyoming	21.0	1,000
41	Virginia	20.4	11,000
42	Idaho	19.5	2,000
43	Hawaii	18.8	1,000
44	Kentucky	18.4	4,000
45	Nevada	16.0	3,000
46	District of Columbia	15.9	0
47	Texas	14.3	25,000
48	Georgia	12.9	6,000
49	Mississippi	12.8	2,000
50	Tennessee	12.4	4,000
51	South Carolina	12.2	3,000

* Due to data limitations, figures were taken from three sets of data: annual averages from 2014-2016, 2011-2016, 2010-2015, 2010-2013
Data set denoted for each state in the Appendix-Table 2

Children with Private Insurance that Did Not Cover Mental or Emotional Problems



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

3.2 % (Massachusetts)
Highest Ranked

21.9 % (Mississippi)
Lowest Ranked

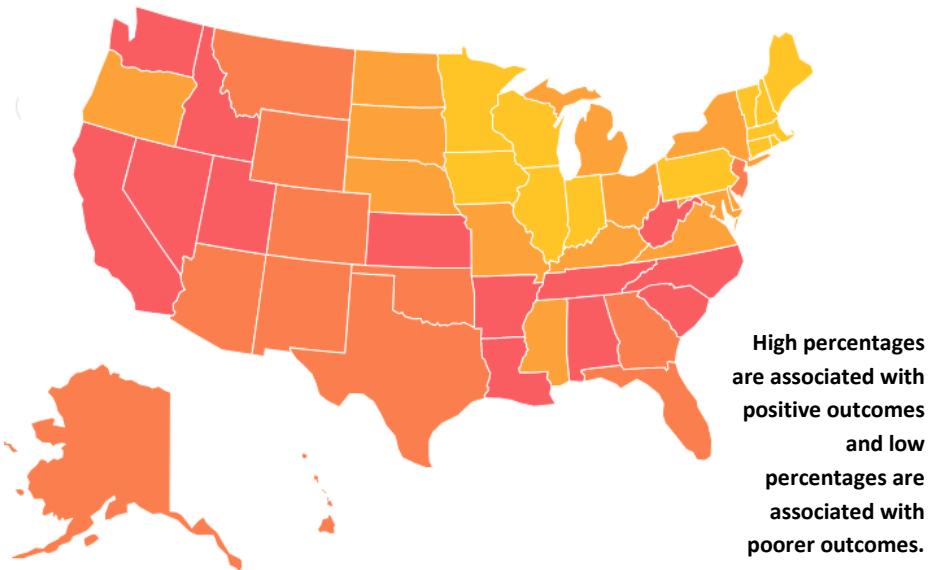


Despite the enactment of the Mental Health Parity and Addiction Equity law (MHPAE), private insurances have found subtle ways to limit coverage of mental health services. Insurance arbitrarily define what services are “medically necessary” and should receive coverage. A survey conducted by the National Alliance of Mental Illness showed that 29% of respondents reported that they or a family member were denied treatment because they were not deemed medically necessary. Additionally, the MHPAE did not remove limitations on patient visits and number of co-payments imposed by insurers.

Finally, contributing to lack of coverage is the severed relationship between mental health providers and insurers. Many health providers refuse to accept insurances primarily because insurers continue to underpay them for their services. As a result, insured individuals are left with two options: costly, out-of-network services or no treatment.

Rank	State	%	#
1	Massachusetts	3.2	9,000
2	Connecticut	4.1	7,000
3	Washington	4.2	11,000
4	New Hampshire	4.3	3,000
5	Wisconsin	4.6	12,000
6	New Mexico	4.7	3,000
7	Michigan	5.0	21,000
8	South Dakota	5.1	2,000
9	Minnesota	5.2	12,000
10	Kansas	5.5	7,000
11	Delaware	5.7	2,000
12	Indiana	5.7	16,000
13	Vermont	5.7	1,000
14	Alaska	5.8	1,000
15	Maryland	5.8	15,000
16	Pennsylvania	5.8	28,000
17	Missouri	6.0	14,000
18	Colorado	6.1	13,000
19	Montana	6.2	2,000
20	Oregon	6.3	8,000
21	Rhode Island	6.3	3,000
22	Illinois	6.5	31,000
23	New York	6.8	47,000
24	Kentucky	6.9	11,000
25	New Jersey	7.4	29,000
26	District of Columbia	7.5	1,000
27	Maine	7.5	4,000
28	Iowa	7.6	11,000
29	Tennessee	7.6	18,000
30	Idaho	7.7	5,000
31	North Dakota	8.0	2,000
32	Georgia	8.2	31,000
33	North Carolina	8.2	26,000
34	California	8.5	110,000
35	Utah	8.6	16,000
36	Virginia	8.6	28,000
37	Ohio	8.7	42,000
38	West Virginia	9.0	5,000
39	Arkansas	9.2	8,000
40	Nebraska	9.4	7,000
41	South Carolina	9.4	15,000
42	Florida	9.9	52,000
43	Arizona	10.1	25,000
44	Hawaii	11.0	4,000
45	Nevada	11.2	12,000
46	Texas	11.5	103,000
47	Wyoming	11.5	3,000
48	Oklahoma	12.9	15,000
49	Alabama	13.6	21,000
50	Louisiana	16.8	24,000
51	Mississippi	21.9	13,000
	National	7.8	910,000

Students 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:

27.72% (VT)
Highest Ranked

1.97% (AL)
Lowest Ranked



Only .763%* of students are identified as having an ED for IEP.

For purposes of an IEP, the term "Emotional Disturbance" is used to define youth with a mental illness that is affecting their ability to succeed in school.

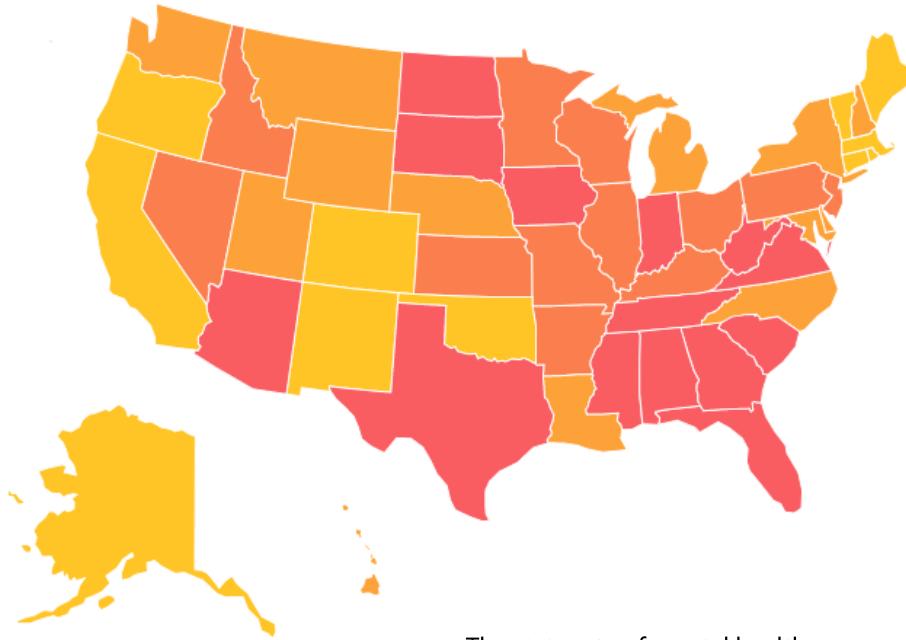
Early identification for IEPs is critical. IEPs provide the services and support students with ED need to receive a quality education. Inadequate education leads to poor outcomes such as low academic achievement, social isolation, unemployment, and involvement in the juvenile system.³

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

Rank	State	Rate	#
1	Vermont	27.72	2,071
2	Minnesota	19.34	15,192
3	Massachusetts	17.95	15,593
4	Wisconsin	16.18	12,217
5	Pennsylvania	15.13	24,033
6	Maine	13.73	2,243
7	Indiana	13.35	12,698
8	District of Columbia	13.17	848
9	Iowa	12.91	5,680
10	New Hampshire	12.25	2,052
11	Rhode Island	12.14	1,574
12	Connecticut	11.27	5,440
13	Illinois	10.24	18,623
14	Ohio	9.73	15,172
15	New York	9.71	23,924
16	South Dakota	9.60	1,148
17	North Dakota	9.32	909
18	Oregon	9.24	4,944
19	Nebraska	8.99	2,489
20	Virginia	8.17	9,470
21	Michigan	8.11	11,144
22	Missouri	8.00	6,554
23	Maryland	7.96	6,239
24	Mississippi	7.88	3,506
25	Delaware	7.59	936
26	Kentucky	7.37	4,495
27	Arizona	7.17	7,315
28	Georgia	7.01	11,090
29	Colorado	6.90	5,535
30	Oklahoma	6.76	4,038
31	Wyoming	6.39	552
32	New Mexico	6.27	1,897
33	Florida	6.16	15,613
34	Montana	6.16	817
35	New Jersey	6.16	7,718
36	Hawaii	5.91	978
37	Texas	5.82	27,233
38	Alaska	5.59	663
39	Kansas	5.35	2,355
40	Idaho	5.21	1,401
41	West Virginia	5.09	1,232
42	Washington	4.97	4,942
43	Nevada	4.31	1,841
44	California	4.29	24,460
45	North Carolina	3.83	5,404
46	Tennessee	3.63	3,258
47	South Carolina	3.37	2,305
48	Utah	3.10	1,813
49	Louisiana	2.74	1,746
50	Arkansas	2.09	918
51	Alabama	1.97	1,333
	National	7.36	345,651

³ Lee, Madeline Y., and Melissa Jonson-Reid. "Needs and Outcomes for Low Income Youth in Special Education: Variations by Emotional Disturbance Diagnosis and Child Welfare Contact." Children and youth services review 31.7 (2009): 722–731. PMC. Web. 25 July 2018.

Mental Health Workforce Availability



The state rate of mental health workforce ranges from:

180:1 (MA)
Highest Ranked 1,180:1 (AL)
Lowest Ranked

Rank	State	#
1	Massachusetts	180:1
2	District of Columbia	230:1
3	Maine	230:1
4	Oregon	230:1
5	Vermont	240:1
6	Oklahoma	260:1
7	New Mexico	270:1
8	Rhode Island	270:1
9	Alaska	280:1
10	Connecticut	290:1
11	California	320:1
12	Colorado	330:1
13	Washington	330:1
14	Wyoming	330:1
15	Utah	350:1
16	New Hampshire	370:1
17	Montana	380:1
18	New York	390:1
19	Louisiana	420:1
20	Nebraska	420:1
21	Delaware	430:1
22	Michigan	430:1
23	Hawaii	440:1
24	Maryland	460:1
25	North Carolina	460:1
26	Minnesota	470:1
27	Arkansas	490:1
28	Idaho	520:1
29	Kentucky	520:1
30	Illinois	530:1
31	New Jersey	530:1
32	Nevada	540:1
33	Kansas	560:1
34	Ohio	560:1
35	Pennsylvania	560:1
36	Wisconsin	560:1
37	Missouri	590:1
38	North Dakota	610:1
39	South Dakota	610:1
40	South Carolina	640:1
41	Virginia	680:1
42	Florida	700:1
43	Indiana	700:1
44	Tennessee	740:1
45	Iowa	760:1
46	Mississippi	760:1
47	Arizona	820:1
48	Georgia	830:1
49	West Virginia	890:1
50	Texas	1010:1
51	Alabama	1180:1

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.

A shortage in mental health providers has resulted in many individuals not accessing care and/or relying on emergency services for psychiatric care. The National Council for Behavioral Health reported during a recent three year period there was a 42% increase in the use of these emergency services.

Integrating primary care and behavioral health services is key for early identification and intervention but is only part of the solution. Primary care providers cannot fill the void created by a lack of psychiatrists. More than 50% of psychiatrists are expected to reach retirement by 2025, and the number of physicians willing to enter psychiatry continues to decline. This is primarily due to inadequate reimbursement by payers, pushing psychiatrists into private practices that do not accept insurance.

Affiliate Impact

MHA's Affiliate Network is comprised of local and state mental health organizations working to influence public policy and ensure access to fair and effective treatment for the millions of Americans suffering from mental health conditions. With more than 200 affiliates in 42 states, 6,500 affiliate staff, and over 10,000 volunteers, MHA's Affiliate Network is committed to bringing support and advocacy to communities around the country. They are key agents of change across the country.

Each MHA affiliate offers a unique blend of services and programs focused on meeting the needs of their community and/or states. In many cases, affiliates function as information and referral hubs, provide direct mental health treatment, run rehabilitative and recovery programs, and conduct outreach and public education. Many also provide family advocacy services to parents and children with serious emotional disturbances, mentoring relationships for adults recovering from mental illnesses, and professional education to those working in the mental health field.

This year we note some of the work that is being done by MHA affiliates on the ground. Through their endless efforts they are impacting trends in prevalence and access to care and improving the state of mental health in their communities, one indicator at a time.



MHA of the MidSouth (formerly MHA of Middle Tennessee) is a strong, reliable partner creating better tomorrows for Tennesseans who need prevention, early intervention, treatment, recovery, or social inclusion. There is no health without mental health.

MHA of the MidSouth recently received a 3-year grant to train first responders through 2021 in Mental Health First Aid, so they will know how to identify and respond to someone with a mental illness, addiction, or suicidal tendencies. Suicide is the 10th leading cause of death in Tennessee, and half of this affiliate's staff is comprised of the Tennessee Suicide Prevention Network (TSPN). TSPN reaches 30,000 Tennesseans annually by implementing the state's suicide prevention strategy. MHA of the MidSouth annually teaches 25,000 students how to manage bullies, bad days, and negative emotions (i.e., anger management). Additionally, MHA of the MidSouth provides information and resources to over 7,000 Tennesseans through health fairs, provides over 10,000 mental health screenings each year, and increases the working knowledge of 1,200 professionals through continuing education programs for doctors, nurses, social workers, first responders, attorneys, mediators, and other professionals.

Alzheimer's disease is the 6th leading cause of death in Tennessee. In training family and professional caregivers, MHA of the MidSouth is fortifying family caregivers and building resilience. In doing so, they are delaying nursing homes admissions by 18 months, resulting in a \$100,000 savings to families and taxpayers. Finally, MHA of the MidSouth serves on several advocacy coalitions and provide back-office administrative and financial services to other behavioral health nonprofits like Tennessee Psychiatric Association, Association for Infant Mental Health in Tennessee, and the Tennessee Coalition for Better Aging.



Mental Health America of Franklin County's Pro Bono Counseling Program (PBCP) offers short-term counseling for uninsured/under-insured individuals, or those unable to afford sliding scale fees. Even with Ohio Medicaid expansion, the PBCP is a necessary part of access to mental health treatment by licensed, clinical professionals. Over the last seven years, the PBCP has provided treatment for over 1,500 individuals who otherwise would not have had access.

The Franklin County Suicide Prevention Coalition (FCSPC) seeks to reduce the number of adults experiencing suicidal ideation and the number of youth and adults with any mental illness who do not receive treatment. Through the provision of evidence-based programs including QPR Gatekeeper Training, Signs of Suicide Prevention Program, and Mental Health First Aid, the FCSPC aims to increase the number of gatekeepers in our community who identify and connect at-risk youth and adults with help.

A diverse menu of support groups addresses specific disorders or issues and connects participants to the most appropriate care. Through the encouragement of peers and facilitators, participants gain insight, find stability, and more easily access relevant resources throughout the length of their recovery.

Perinatal Outreach & Encouragement for Moms (POEM) is a comprehensive, free-of-charge maternal mental health (MMH) support program in Central Ohio—the only one of its kind in the state and one of the largest and longest-running in the U.S. Program outcomes show a reduction in MMH symptoms, increased coping skills, and verified successful connections to appropriate health and social service programs.

The agency is a trusted provider of both the adult and youth modules of Mental Health First Aid, a public education program that introduces non-clinical individuals to risk factors and warning signs of mental illnesses, builds understanding of their impact, and overviews common supports.

The Ombudsman Program provides specialized information and referral to mental health providers and other community agencies for individuals with a mental health or substance use disorder.



With the support of Mental Health America of Indiana, the Indiana Manufacturers Association, the Indiana Chamber of Commerce, and others, language was inserted by Representative Steve Davisson and Representative Cindy Kirchhofer into HEA 1007 that would create a voluntary program for employers who wish to assist new hires and tenured employees with addiction treatment as a condition of continued employment.

Additionally, Indiana also passed legislation, now called "Recovery Works," to provide for treatment in lieu of incarceration, when appropriate, for nonviolent crimes involving individuals with behavioral health disorders. The Indiana General Assembly made available to the Division of Mental Health and Addiction \$30M in its first biennium and \$40M in the subsequent biennium to develop the Recovery Works program. The funding is made available to fund vouchers for mental health, addiction, and cognitive behavior treatment programs for persons on probation, supervised by a community corrections program, or participating in a pretrial diversion program.

MHA of Indiana's effort in responding to the opioid crisis in the employment, criminal justice, and healthcare systems are all predicated on Healthy Indiana Plan (HIP). Indiana has recognized that the opioid epidemic and SUD generally will only be overcome by comprehensive treatment with all health treatment options available in the healthcare setting, the criminal justice setting in lieu of incarceration, as well as the employment setting. Indiana's plan to provide comprehensive integrated treatment across state silos make Indiana a model for the country.



As Indiana's mental health continues to rank poorly compared to the rest of the nation, Mental Health America of Northeast Indiana (MHANI) offers several great programs and services to affect change in 11 northeastern counties. These programs include: training and education (workshops, evidence-based trainings, and other opportunities for professionals and consumers to learn more about mental illness and well-being, best practices, and recognizing and responding to crisis); Parent Café (structured meetings for parents to learn about five protective factors and support each other in order to build stronger, healthier, and safer families for their children); Cedars Hope (permanent supported housing for homeless women with mental illness which provides case management, supportive services, and other assistance with space for up to 16 residents); and guardianship (person-centered advocacy for individuals deemed incapacitated by the courts and unable to make sound medical decisions on their own). Together, these programs impact hundreds of people in Northeast Indiana every year.

Through these services, MHANI intends to have an impact on the following measures: Adults with Serious Thoughts of Suicide, Youth with At Least one Past Year Major Depressive Episode (MDE), Youth with Severe MDE, Adults with AMI who Did Not Receive Treatment, Adults with AMI Reporting Unmet Need, and Youth with MDE who Did Not Receive Mental Health Services. All of MHANI's services have the capacity to impact any of these measures. By improving the mental health of parents, MHANI can improve the mental health of their children; by offering trainings, MHANI can ensure that community members recognize and respond when someone needs help; by offering housing, MHANI is helping women with mental illness overcome their challenges and regain their independence. By educating the public (including professionals and current/future mental health consumers), reducing stigma around mental health, and providing informal mental health supports, MHANI hopes to encourage individuals to seek treatment, reduce mental health symptoms, and foster growth of mental health services in the Northeast Indiana community.



Mental Health America of Greater Houston's (MHA Houston) Center for School Behavioral Health works to improve the prevention, identification, and treatment of behavioral health issues among students. Launched in 2012 as the School Behavioral Health Initiative, our Center utilizes a collective impact, systems-change approach to advance policies and practices that impact students' behavioral health. MHA Houston's School Behavioral Health Collaborative maximizes opportunities to bring new behavioral health services into schools and improve existing programs and policies. Key components of the Center at MHA Houston's work include advocacy and public policy, professional development, stigma reduction activities, and incubation of innovative best practices.

Professional development for educators and other child-serving professionals is another core component of MHA Houston's work through the Center for School Behavioral Health. Since its initiation, 10,000 teachers and child-serving personnel have received training providing participants with the knowledge and skills to recognize signs of behavioral health issues, respond appropriately, and link students to behavioral health services

The affiliate's related advocacy work takes place at both the local/regional and state levels. At the local/regional level, staff works with school districts to shift district policies to better support behavioral health. MHA Houston was instrumental in the passage of a bill which mandated that teacher training candidates, as well as current educators, be trained in signs and symptoms of mental health issues in students and how to assist students needing help. MHA Houston's work contributes to a greater number of children and adolescents with behavioral health issues being identified and provided with the services they need. Over time, MHA of Greater Houston believes that the work can impact several State of Mental Health in America measures, particularly #11 (youth with MDE who did not receive mental health services), #12 (youth with severe MDE who received some consistent treatment), and #14 (students identified with emotional disturbance for an Individualized Education Program).



Mental Health America of Greater Dallas (MHA Dallas) works to lead the community in improving mental health through advocacy, consumer programs, and education.

MHA Dallas advocates for mental health through the Coalition on Mental Illness, its public policy program, and its boarding home initiative. The goal is to create a community of elected officials, advocates, providers, and more to address the issues of mental health services and more. Also, MHA Dallas creates and hosts free-peer lead groups and mental health first aid. These programs have been proven to reduce stigma, decrease hospitalization, and encourage consumers to continue in their treatment.

Lastly, MHA Dallas improves the community by providing educational programs and hosting conferences. These educational programs consist of WHO 'We Help Ourselves,' Parents as Teachers, and Adolescent Symposium. These programs prevent victimization, promote optimal early development, reduce child abuse, and more.



Mental Health America of Hawai'i (MHA Hawaii) serves the community by promoting mental wellness through advocacy, education, and service. Mental health conditions are extremely common (ex: 1 in 5 adults) but less than 35% of people in Hawaii who need treatment are getting it.

Suicide in Hawaii, particularly among Hawaii's youth is also a significant concern. The stigma associated with mental health and lack of understanding and awareness prevents people from getting help. MHA Hawaii is advocating for sound public policy and spending in mental health, providing training to stakeholders and providing direct assistance connecting people with resources. In the past year we've reached over 3,000 people with our trainings and direct assistance.

MHA Hawaii has reached thousands more through community outreach, advocacy, and media appearances. The affiliate has produced a suicide prevention mobile app called Kokua Life. MHA Hawaii plans to have a similar reach in the coming year, targeting at-risk youth, mental health consumers, their family members, and elected officials as it continues to collaborate with other organizations.



Looking below the surface of Arizona's overall ranking provides a slightly different story. Arizona's state Medicaid program (AHCCCS) has seen great improvement attributable to Medicaid restoration/expansion and the efforts that were undertaken to enroll individuals into the ACA health plans. Here are just a few of those highlights:

Today, the majority of the 1.9 million AHCCCS members are enrolled in integrated managed care health plans that provide both physical and behavioral health services under each plan's provider network. This system reform reduces fragmentation and lends to more streamlined and coordinated care for the member. MHA AZ continues to outreach our community and assist them in obtaining integrated health care.

In the last five years (FYE 2013 –FYE 2017) Behavioral Health spending in Arizona has increased from \$1.4 billion to \$2.3 billion, spending that covers the Medicaid and non-Medicaid populations. MHA AZ played a valuable role in advocating for increased spending and continues to advocate that such safety nets stay in place.

Using a strategic approach to reach the most affected communities in our state, AHCCCS has addressed the Opioid Use Disorder epidemic on several fronts. Grant dollars are helping to extend services to individuals who are not Medicaid eligible. MHA AZ has been part of the planning process in determining where these funds go, along with advocating for the use of peer throughout this strategic approach.

Arizona continues to maintain a robust, 24/7 crisis system serving all Arizonans with telephone, mobile, observation, and inpatient access to crisis care. MHA AZ continues to monitor the crisis response time to ensure our community is receiving the care they need where they are at, versus in the emergency room or our jails.

Highlights of other initiatives that continue to expand access to quality health care include (but are not limited to) First Episode Psychosis centers, continued increase of access to Assertive Community Treatment (ACT) teams for individuals with Serious Mental Illness, increase in access to peer and family support throughout our system, increase in access to supportive housing, initiatives to address individuals with Autism Spectrum Disorder (ASD) for more expedient referrals to treatment, increased oversight and monitoring for children in foster care. MHA AZ has a formal partnership with a First Episode Psychosis center where we provide mental health resources to folks entering St. Joseph's Emergency Room. In addition, MHA AZ connects the community to these valuable initiatives through our information and referral line, community presentations, and our annual Seeds Conference. While MHA AZ recognizes there is still a lot of work to be done, we are extremely proud of where Arizona has come over the past few years.

Addressing Trauma in Youth

Not every child is afforded security or safety during their most formative years. The Centers for Disease Control and Prevention (CDC) estimates that 1 in 4 children will experience maltreatment in their lifetime, while 1 in 7 will experience it in the past year. The Children's Bureau of the United States Department of Health and Human Service reported that, between the years 2011-2015, there was an 3.8% increase in reported childhood abuse cases.¹ Many cases of child mistreatment will go unreported. This can happen for many reasons. Children cannot always advocate for themselves and rely on adults to act on their behalf; often abuse is taking place within their communities or in private settings. Inaction can result from those witnessing the abuse not wanting to get involved with matters that are perceived as private or being fearful of the consequences that community members may face (e.g. incarceration or removal of child from household). Abuse in the form of neglect is not always perceived as abuse, and/or those that engage in the abuse lack awareness of how environmental factors (e.g. incarceration of family member or parent separation) contribute to trauma. We can therefore assume that the percentage of children who experience trauma is higher.

The effects of trauma have been well documented. Trauma can cause permanent changes in the structure and chemical activity in the human brain. These changes are more significant in children's brains because they are still maturing. The main areas affected by trauma are those associated with learning and problem-solving, emotional regulation, and assessing and responding to environmental threats.² Disruptions in the maturation of these regions also place children at risk for developing mood, anxiety, psychotic and substance abuse disorders, throughout their lifetime. In 2012, the Proceedings of the National Sciences of the United States of America published the results of study that identified child maltreatment or abuse as a major risk factor for the development of mood and anxiety disorders. More than half of participants who had experienced three or more forms of trauma developed MDD and almost a quarter met the criteria for PTSD. Regardless of whether participants met the criteria for a mental health condition, the damage created by traumatic stress remained.³

The CDC estimates that
1 in 4 children will experience maltreatment in their lifetime



¹ <https://www.medicalnewstoday.com/articles/319566.php>

² https://www.childwelfare.gov/pubPDFs/brain_development.pdf

³ Teicher MH, Anderson CM, Polcari A: Childhood maltreatment is associated with reduced volume in the hippocampal subfields CA3, dentate gyrus, and subiculum. Proc Natl Acad Sci USA 2012; 109

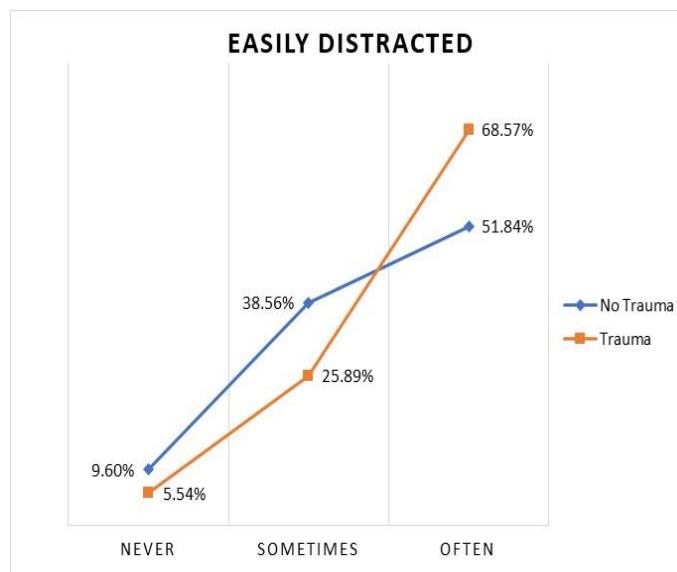
Youth Trauma Survivors and Schools

The cognitive, emotional, and behavioral effects of trauma are often heightened as a child enters the school system and becomes integrated in a classroom setting. This change in their environment and routine can cause emotional, psychological or physical distress, and often leads to issues related to attention, mood, and conduct. These emotional and behavioral irregularities are not often viewed as symptoms of trauma but mistaken for, and treated as, defiant behavior or emotional disorders.

In 2015, MHA offered the Pediatric Symptoms Checklist (PSC) for young screeners online. The PSC has been used to evaluate children for psychosocial problems. The youth form is 35 questions long and questions measure on a scale of Often, Sometimes, and Never, and focus on one of three buckets of symptoms:

- Attention Problems
- Mood Problems
- Conduct Problems

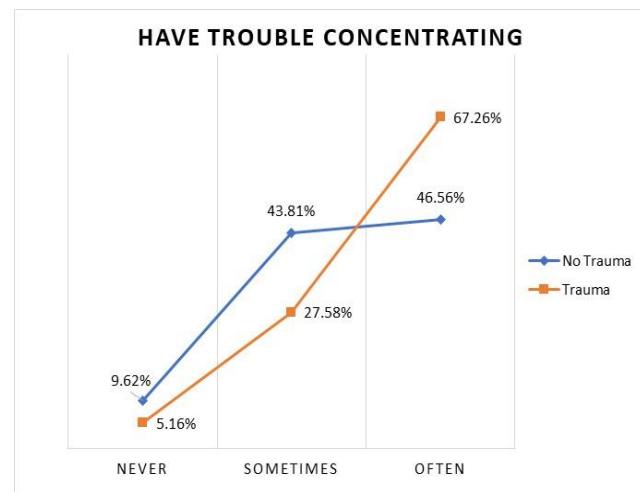
Since the Youth Screening launched, 116,683 youths have been screened. In February 2018, the option "trauma survivor" was added to the demographic question "Which of the following populations do you belong to?" The following data was collected from 569 youth trauma survivors who took the PSC. It should be noted that youth visiting MHA's screening page are a help-seeking population looking to address mental health concerns and in need of support. Although significant differences in percentages may exist between trauma-impacted youth and non-trauma youth, data from the Youth Screen demonstrates that overall a large percentage of youth are at-risk of developing a mental health condition and adopting unhealthy behavioral coping mechanisms. As a result, they are facing social and academic challenges.



Attention

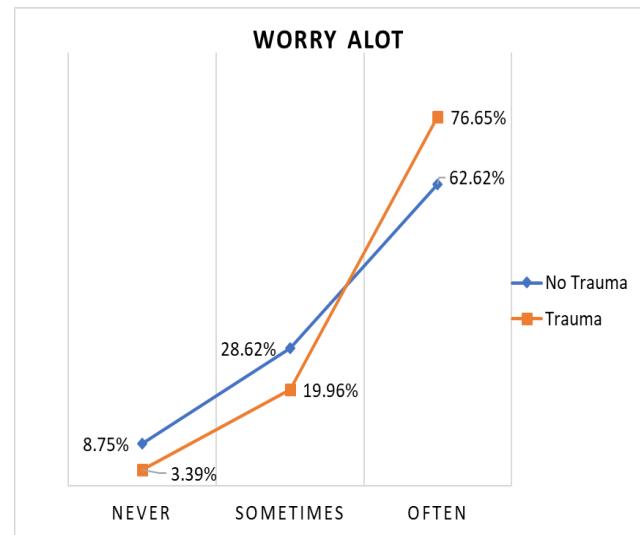
Research shows that early life trauma impacts a child's ability to pay attention as well as process and attain new information. Children impacted by trauma often become hypervigilant or hypersensitive to changes in environments, more specifically changes in the behaviors of the adults around them.¹ In the classroom, a trauma-impacted youth may become overly concerned about environmental threats, which may result in the youth being unable to focus or easily distracted. Sixty-seven percent of screeners stated that they *often* had trouble concentrating, compared to 47% of non-trauma survivors. Additionally, 51% *often* found it difficult to remain still and 69% percent stated that they *often* were easily distracted in the classroom; this was the case for 37% and 52% of non -trauma youth, respectively.

For youth to learn, they must be able to listen, memorize, and apply new information. This can be difficult if they are unable to focus. The inability to focus leads to higher levels of frustration and anxiety in the classroom, which has shown to result in lower self-esteem and learned helplessness.⁴ Although a larger percentage of trauma-impacted youth reported having trouble paying attention in the classroom, data shows that a significant percentage of non-trauma youth also face the same challenges.



Mood

A child that is exposed to chronic trauma, such as abuse in their household, will often experience intense emotions, such as sadness, fear or anger. Without the skills to identify, control or protect themselves from these emotions, they learn that this state of being is natural. Additionally, they begin to associate difficult and/or negative emotions with escalated emotions. Negative emotions, such as sadness, fear, or anger become ruling emotions. Without the presence of positive emotions to counteract the negative ones, trauma-impacted youth give negative emotions greater meaning than positive ones. These emotions are often accompanied with negative core beliefs about self.

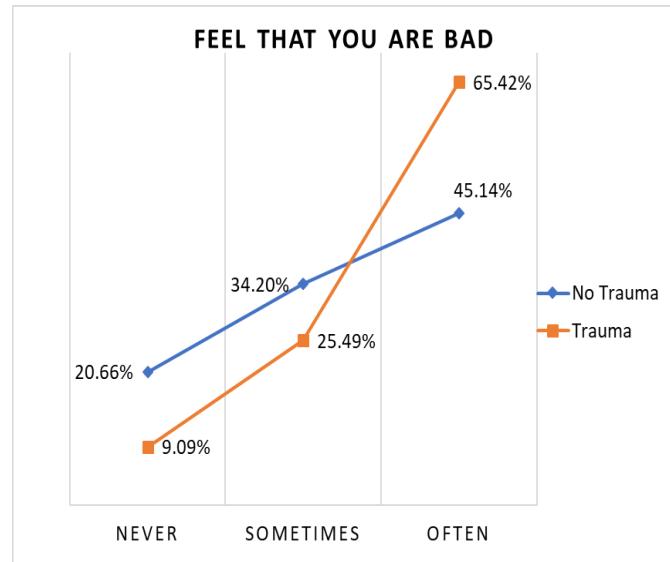


⁴ Bussing, Regina et al. (2010) Self-Esteem in Special Education Children With ADHD: Relationship to Disorder Characteristics and Medication Use. Journal of the American Academy of Child & Adolescent Psychiatry , Volume 39 , Issue 10 , 1260 - 1269

These lingering emotions and thoughts will often lead to the development of mood or anxiety disorders.⁵ Seventy-three percent of youth trauma survivors reported that they *often* felt sad or unhappy and 64% reported *often* feeling hopeless. Seventy-seven percent of youth trauma survivors also reported that they *often* worried a lot. Across all three measures, trauma-impacted youth were more likely to be experiencing symptoms of a mood disorder or anxiety. Overall, a significant percentage of youth were at-risk of developing a mental health condition.

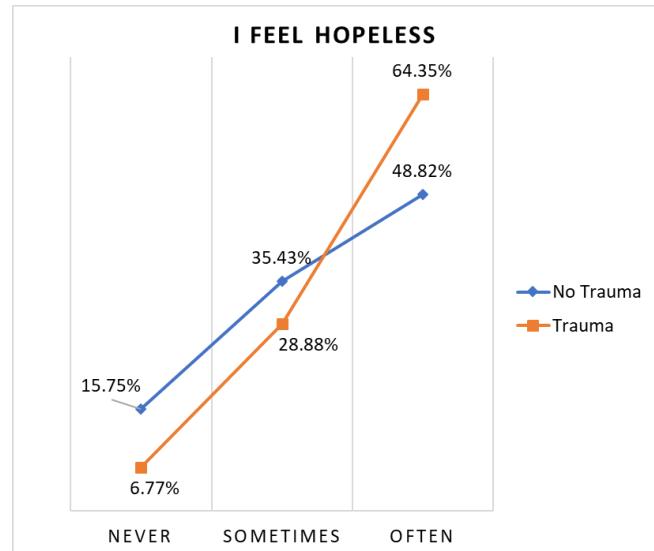
Conduct

Trauma-impacted youth often live in a state of “flight or fight (or freeze),” experiencing higher levels of arousal and hypersensitivity to environmental stimuli. Whether at home or in the classroom, they hold the same view: the world is an unpredictable and unsafe place. Research shows that intense, negative emotions lead to either internalizing or externalizing behavioral problems in children. Trauma-impacted children who internalize the effects of their trauma are likely to place a greater blame on themselves under the assumption that they are flawed.



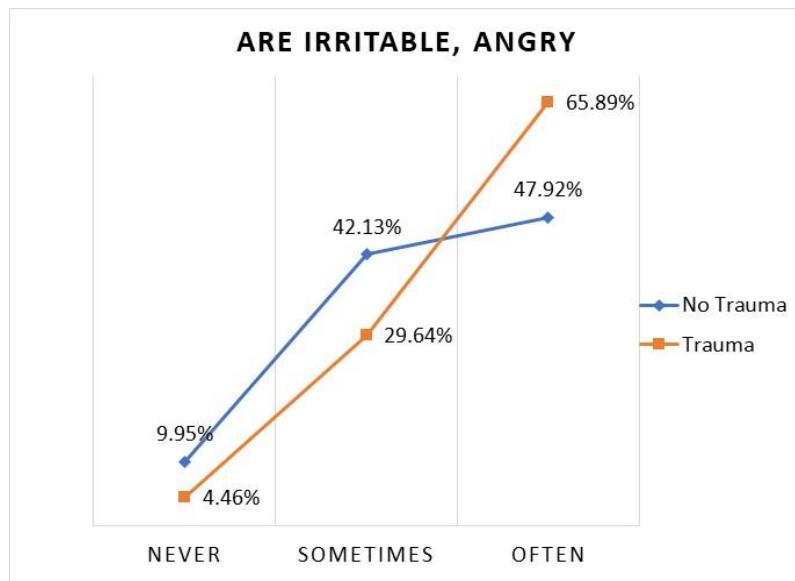
Sixty-five percent of youth trauma survivors reported that they *often* felt as if they were bad, 20% higher than non-trauma youth. Youth who externalize the effects of their trauma assign blame outwardly and tend to adopt a more *fight* response to perceived environmental threats.

Fifty-eight percent of trauma-impacted youth that took the MHA Youth Screen stated that they had experienced trouble with their teachers. The same percentage reported that they had engaged in fights with other children. Internalization is associated with underactive behaviors, due to child’s tendency to overemphasize and ruminate over negative emotions and associated negative beliefs. It is the fear of failure or punishment that deters youth from trying new things, asserting themselves or engaging socially.



⁵ Stefan G. Hofmann, Alice T. Sawyer, Angela Fang, Anu Asnaani. (2012). Emotion dysregulation model of mood and anxiety disorders. *Depressed Anxiety*. May; 29(5): 409–416. Published online 2012 Mar 16. doi: 10.1002/da.21888

Externalization has been associated with child's inability to control impulse, think things through (memory and learning) or remain present (attention span). Their reaction to a perceived threat is instinctual and defensive. Youth that have adopted this behavioral coping skill tend to more confrontational, displaying higher degrees of anger or aggression.⁶ Sixty-six percent of youth trauma survivors reported they often felt irritable or angry. A third stated that they took unnecessary risks, which is nearly twice the figure of non-trauma youth who reported taking unnecessary risks. Studies have shown that externalizing behaviors are associated with individuals who are experiencing PTSD.⁷



Although trauma-impacted youth were more likely to struggle with both internalizing and externalizing behaviors, non-trauma youth appear to also have a need for support in learning to regulate their emotions and behaviors. In the classroom, this behavior can look like social withdrawal, fear of taking risks or fear of new situations. Seventy percent of youth trauma survivors reported that they often spend more time alone, and 58% stated they often felt fearful of new situations. Children who adopt this behavioral coping mechanism, in response to negative emotions or situations, are more likely to experience depression or anxiety and complain of psychosomatic symptoms.

Children will develop these behavioral coping mechanisms because they are feeling unsafe, unloved, or lacking control. Unfortunately, school teachers and administrators often view behavioral issues in trauma-impacted youth as an isolated issue or personality trait, not as symptom of trauma. In overlooking or misinterpreting these outward expressions of trauma, they are overlooking this populations' emotional, social, and educational needs, and in many instances exposing them to more trauma.

⁶ Nancy Eisenberg, Amanda Cumberland, Tracy L. Spinrad, Richard A. Fabes, Stephanie A. Shepard, Mark Reiser, Bridget C. Murphy, Sandra H. Losoya and Ivanna K. Guthrie. (2001). The Relations of Regulation and Emotionality to Children's Externalizing and Internalizing Problem Behavior. *Child Development*, Vol. 72, No. 4 (Jul. - Aug., 2001), pp. 1112-1134

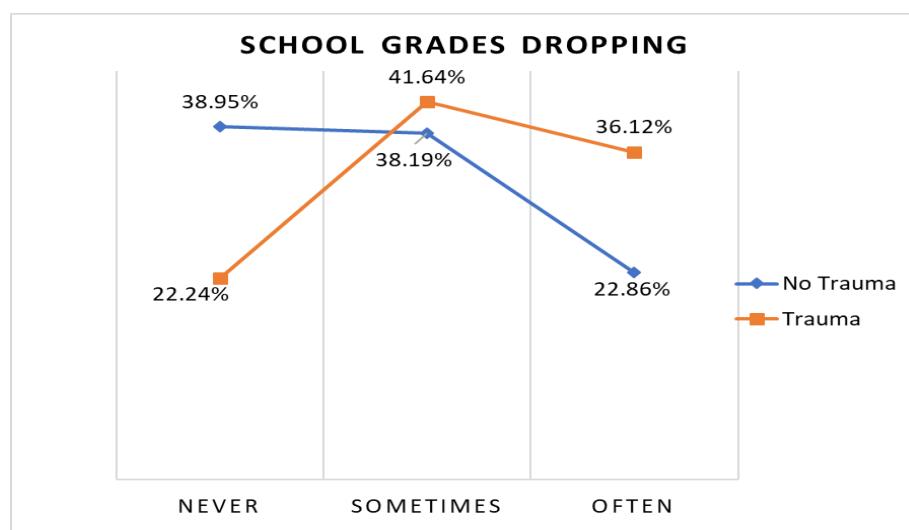
⁷ Carliner, Hannah et al. (2017). Trauma Exposure and Externalizing Disorders in Adolescents: Results From the National Comorbidity Survey Adolescent Supplement. *Journal of the American Academy of Child & Adolescent Psychiatry*, Volume 56 , Issue 9 , 755 - 764.e3

School Practices and Policies and Trauma

It is not uncommon for teachers to use behavioral management charts in the classroom to encourage and reward good behavior. For a child finding it too difficult to understand or regulate both emotion and behavior, these charts become a form of public shaming. For some children, they can become daily reminders of their inability to integrate or succeed in the classroom, affirming their negative core beliefs. If this weren't distressing enough, there is the added element of shame.

These classroom practices reinforce negative emotions and defiant behavior, impeding academic achievement. Teachers who seek to improve behavior and performance in the classroom must recognize the importance of fostering positive relationships and adopting practices that nurture individual talents and skills.⁸

Many schools continue to adhere to archaic suspension and expulsion practices to deal with behavioral issues. These practices are more commonly adopted in middle school and high school. Regardless of age, expulsion or suspension from a classroom/school has been shown to be more detrimental than beneficial to a child's cognitive, behavioral, and emotional development.



In a recent report, the US Department of Health and Human Services and Department of Education argued that early child suspension or expulsion was likely to lead to expulsion and suspension in later school grades. Additionally, youth that were expelled or suspended were more likely to drop out of high school, fall behind in school, and end up in the juvenile system.⁹ This is commonly known as the school-to-prison pipeline, which disproportionately affects people of color from low-income households, those that identify as LGBTQ, and those with disabilities. These are individuals who are also more likely to be victims of chronic trauma.

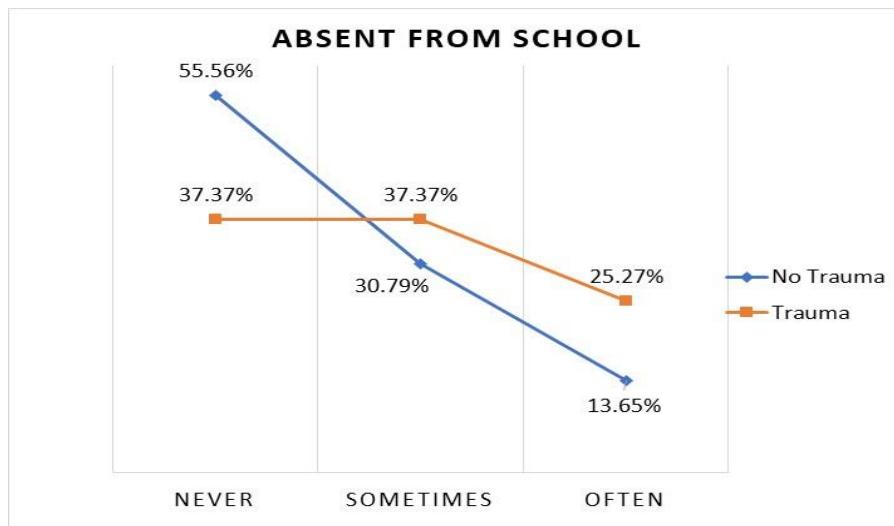
⁸ https://www.washingtonpost.com/news/parenting/wp/2016/09/29/the-darkside-of-classroom-behavior-management-charts/?noredirect=on&utm_term=.560658260404

⁹ <https://www2.ed.gov/policy/gen/guid/school-discipline/policy-statement-ece-expulsions-suspensions.pdf>

Punitive in-classroom and school policies and practices ignore the primary reason why many children are unable to develop behavioral mechanisms that are conducive to learning or forming healthy relationships. Aggression, anxiety, irritability, depression, and social withdrawal are common ways in which trauma-impacted youth express psychological or emotional distress. It is also the way in which they communicate a need for adult support. Schools practices that adhere to punitive practices are placing the burden on children to make the appropriate changes, even though they lack the capacity and skills to do so.

Reversing School-to-Pipeline Practices

Schools are well positioned to provide trauma-impacted youth with a safe and supportive learning environment that builds resilience and enhances academic performance. Through the implementation of programs centered on positive-behavioral strategies, school staff can help trauma-impacted youth strengthen their social-emotional skills, particularly those that allow them to self-soothe and control their impulses in difficult situations. Without these skills, this population is more likely to engage in defiant and disruptive behavior, which often results in disciplinary action. Disciplinary measures often affirm core beliefs that something is inherently wrong and foster feelings of mistrust and being unsafe. Positive behavioral strategy programs encourage teachers to work with students to set clear expectations, acknowledge emotions and concerns, strengthen coping skills, and decide on personal rewards. Studies have shown that these programs reinforce good behaviors, enhance classroom performance, and decrease disciplinary referrals.¹⁰



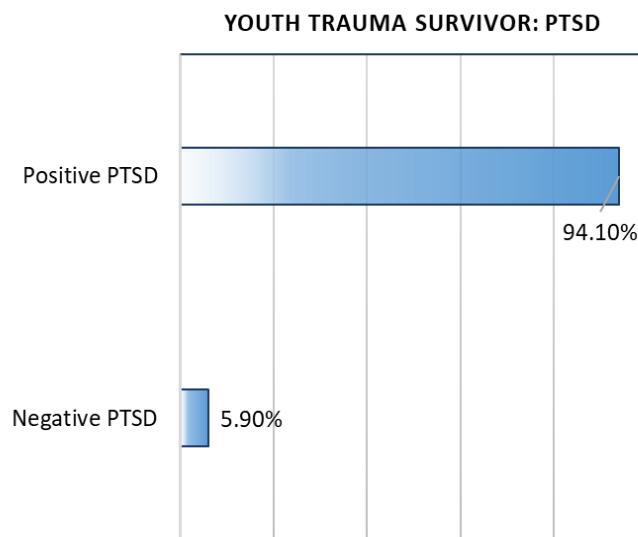
¹⁰ <https://jjie.org/2017/09/07/alternative-discipline-strategies-for-dismantling-the-school-to-prison-pipeline/>

Trauma is one of the greatest barriers to academic achievement. Trauma-impacted youth are more likely to be absent from schools, find themselves removed from their classrooms, or display sub-optimal academic performance. A quarter of trauma-impacted youth reported that they were often absent from school, compared to 14% of non-trauma youth. Forty-one percent trauma-impacted youth reported that their school grades had dropped. In moving away from practices that criminalize youth experiencing emotional and behavioral difficulties, school staff can spend less time managing behavior and more time fostering engagement and reducing loss of opportunity to learn.

Mental Health Needs

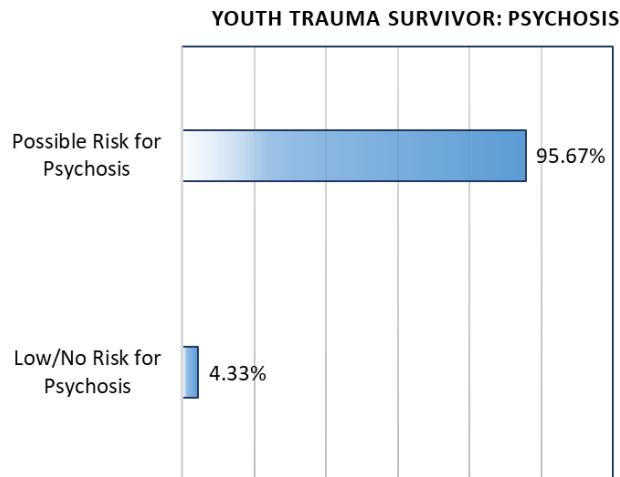
Among our Pediatric Symptoms Checklist (PSC) screeners, youth are more likely to self-identify as having emotional difficulties than conduct problems. More likely than not, this means that by the time teachers are noticing a disruption in the classroom, there have been ongoing mood problems or an existing mental health condition.

Youth who identify as trauma survivors also took the following mental health screens: PTSD, Depression, Psychosis and Bipolar screens. Ninety-four percent of youth scored positive for PTSD, and 68% screened for Severe Depression. Additionally, 96% of youth trauma survivors screened at risk for Psychosis, and 63% screened positive for Bipolar.



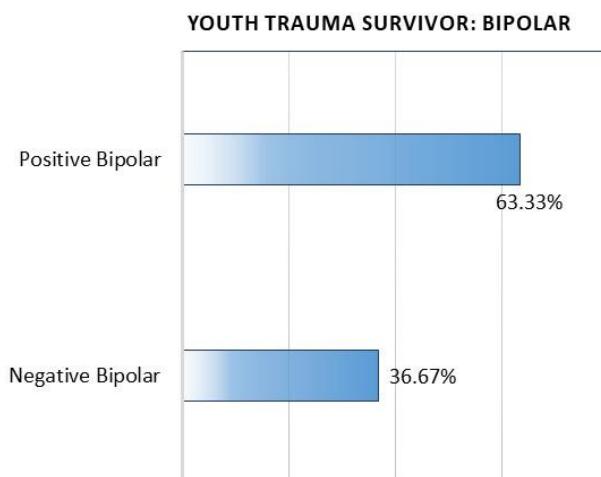
A lack of knowledge of the effects of trauma can lead to the misdiagnosis or underdiagnosis of youth. Symptoms can stem from a variety of conditions and can often overlap. For example, trauma symptoms or PTSD can look similar like those of ADHD. Symptoms can also be mistaken for personality traits, such as social withdrawal and difficulty making decisions, while others can be labeled as defiant.

With the proper training, school staff can play a key role in ensuring that children are receiving the proper in-classroom resources and support, as well as any mental health services that they may need. Their constant contact with children allows them to note any academic challenges that youth may be facing, as well as any changes in their mood or behaviors. They should not be expected to take on a diagnostic role in the classroom, but rather serve as advocates for youth facing emotional or behavioral issues. Doing so can reduce the risk of youth falling behind in school, engaging in self-destructive behavior, and not receiving the appropriate support or treatment.



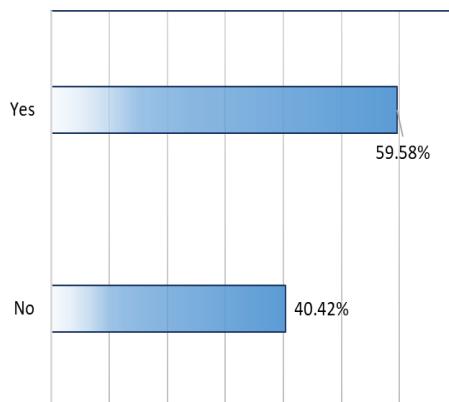
Increasing Access to Mental Health Services

Given the increase in the number of children who are impacted by trauma, there is growing demand for mental health support services. Forty-three percent of youth who identified as trauma survivors were not receiving mental health treatment or support. Forty percent had never received any mental health treatment or support. In addition to equalizing access to education, schools are well positioned to equalize access to mental health services.



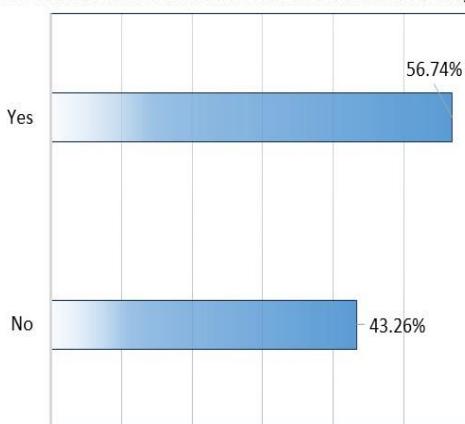
Children who experience trauma often struggle with mental health conditions that prevent them from becoming fully engaged in the classroom. Schools can increase engagement by offering mental health services and mitigate symptoms associated with mood disorders and anxiety. Mental health interventions have shown to shorten episodes of mental health conditions and prevent the development of more severe conditions in adulthood.

YOUTH TRAUMA SURVIVOR: EVER GET MH TREATMENT/SUPPORT



Integrating mental health services into the education system has many challenges, including student and caretaker understanding of mental health needs and the willingness to make use of mental health services when available; poor engagement of school staff; and poor coordination of services. Many of these challenges can be overcome by developing and adopting practices and policies that create a more trauma-sensitive climate through increased staff training, greater involvement of school community members, and the establishment of a mental health referral system that integrates school-based services and community-based mental health services.¹¹

YOUTH TRAUMA SURVIVOR: CURRENT MH TREATMENT/SUPPORT



¹¹ Fazel, M., Hoagwood, K., Stephan, S., & Ford, T. (2014). Mental health interventions in schools 1: Mental health interventions in schools in high-income countries. *The Lancet. Psychiatry*, 1(5), 377–387. [http://doi.org/10.1016/S2215-0366\(14\)70312-8](http://doi.org/10.1016/S2215-0366(14)70312-8)

Social Emotional Learning in Schools

Social Emotional Learning (SEL) refers to a child's ability to process, express, and manage their emotions, as well as foster relationships that are both positive and rewarding. Because they often experience a disruption in their social emotional development, trauma-impacted youth find it hard to tap into positive emotions that can counteract negative ones. As they progress through the education system, emotional and behavioral issues associated with social emotional impairment worsen over time.

In recent years, SEL programs have developed in response to research findings that show emotional and social development are just as critical as cognitive development. In fact, strong emotional and social skills can help improve cognitive function. SEL programs focus on the development of "self-awareness, self-management, social awareness, relationship skills and responsible decision making" skills. Children who are given the skills to strengthen positive behaviors have an easier time adjusting to their environment, forming healthy relationships, and creating positive experiences. Most importantly, they become more reliant on positive beliefs and values, which increase feelings of self-worth and confidence.¹² School-based interventions that prioritized SEL are beneficial for all youth, but of greater service to those youth impacted by trauma. SEL can both mitigate and reverse the effects or impact of traumatic stress.

Trauma-Informed Schools

Despite research confirming the link between trauma, emotional and behavioral issues, and low academic performance, trauma-impacted youth often do not receive the services they need to achieve academic success or respond to their mental health needs. Schools practices and policies continue to cultivate school climates that reinforce negative beliefs and behaviors, widening the achievement gap and increasing mental health disparities. Addressing the needs of children with trauma in schools requires active participation by school staff in adopting trauma-informed practices that promote resilience and enhance academic performance.

The Trauma and Learning Policy Initiative's Flexible Framework, developed by Massachusetts Advocates for Children (MAC) and an interdisciplinary of psychologist, educators, and lawyers, is a leading guide to implementing trauma-informed practices and fostering a trauma-sensitive culture in schools. It is structured according to what they identify as the 6 operational functions of schools.

¹² Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D. & Schellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child Development*, 82: 405–432.

- **School Culture and Infrastructure:** Schools must assess the needs of their student population to ensure that their practices and policies foster a trauma-sensitive culture. Staff training needs must also be determined, as staff play an active role in classroom implementation. Moreover, the role of the community cannot be overlooked. Schools must establish community partnerships and identify available community resources.
- **Staff Training:** For staff to be equipped to address the needs of this population and foster a trauma-informed culture, staff training must focus on building teacher-student-caregiver rapport, expanding knowledge of outside support services, and helping students develop emotional and behavioral regulation skills.
- **Links to Mental Health Professionals:** Students who have experienced trauma may require outside services provided by a mental health professional. Developing and implementing a referral system ensures that students and their families are connected to the resources they need in a timely manner. Relationships with community-based organizations should be established during the strategic planning process to facilitate the referral process.
- **Academic Instruction for Students who have Experienced Trauma:** Schools must ensure that teachers are incorporating teaching practices that address youths' learning needs. Teachers should be trained on how to create a classroom routine, communicate expectations, and provide positive reinforcement. For example, adopting a language-based approach allows for the use of multiple ways of communicating information. For trauma-impacted children who have experienced this is critical because they often are more receptive to non-verbal cues and require support in verbally expressing their needs. Conducting school evaluations are key in determining the learning needs of students affected by trauma.
- **Nonacademic Strategies:** Children can learn so much outside of classroom curriculum, including how to build relationships, recognize hobbies and nonacademic interests and talents. Schools should offer and encourage participation in extracurricular activities and peer relationships.
- **School Policies, Procedures, and Protocols:** School policies, procedures and protocols can become barriers to creating a trauma-sensitive school climate. Administrators should review and amend practices to ensure that they promote accountability but do not reinforce traumatic behavior. Schools must create a culture that is nonviolent and safe for children who often see the world as threatening and associate punishment with being inherently flawed.¹³

In 2008, the San Francisco Unified School District (SFUSD) developed a multi-tiered strategic plan that resulted in the development of the Healthy Environments Response to Trauma in Schools (HEARTS) program. HEARTS was first implemented in four schools that largely served students of color who lived in low-income, trauma-impacted communities. Exposure to chronic trauma had resulted in several behavioral and emotional issues affecting academic performance.

¹³ <https://www.elc-pa.org/wp-content/uploads/2015/06/Trauma-Informed-in-Schools-Classrooms-FINAL-December2014-2.pdf>

HEARTS aimed to increase staff education on the effects of trauma and end the overuse of disciplinary measures in responding to defiant behaviors. Staff members were trained on how to create a safe and supportive environment, implement practices that addressed students' learning needs, and assist trauma-impacted students in strengthening emotional and behavioral regulation skills. Mental health services were also embedded within the school system and behavior plans and procedures were amended to align with trauma-informed practices. An evaluation of the program showed an increase in staff knowledge on the effects of trauma and the use of trauma-informed practices, an increase in student engagement, and a decrease in problematic behaviors. Most notably students experienced a reduction in trauma-related symptoms.

An evaluation of a trauma-informed intervention within a youth residential facility schools in 2012, showed similar promise. The Heart of Teaching and Learning: Compassion, Resiliency, and Academic Success (HTL) curriculum was piloted in a public charter school that exclusively served court-involved children receiving residential treatment. Most of these children had a history of abuse or neglect and showed high rates of complex trauma or post-traumatic stress, making them vulnerable to "self-harm behavior...delinquency and perpetuation of violence...and low educational attainment." The HTL was an intervention designed to guide the development and implementation of trauma-informed practices in education settings. It provided staff training in defining trauma and understanding its effects, creating safe and secure environments, self-care, collaborative problem-solving techniques and teaching tools to increase learning and engagement. To determine effectiveness, students were asked to complete the following before and after the implementation of the curriculum: The Student Needs Survey (SNS), The Child Report of Post-traumatic Symptoms (CROPS), and The Rosenberg Self-Esteem Scale (RSE). These instruments were used to measure students' perception of whether their needs were being met, trauma symptoms, and self-esteem, respectively. Similarly, students saw a reduction of PTSD symptoms with the implementation of the HTL curriculum.

Findings from the HEARTS and Youth Facilities Intervention studies show that trauma-informed practices allow for a better learning environment and lead to more positive life outcomes, increasing student engagement and enhancing academic success. Staff members are trained to understand how learning and behavior are affected by trauma and are encouraged to use this information to guide their teaching practices and classroom management strategies. A trauma-informed culture also fosters positive relationships between students and teachers, which has been shown to improve student conduct and classroom performance, while nurturing positive emotions.¹⁴ Finally, trauma-informed schools become gateways to mental health services for children impacted by trauma. They promote the early identification of symptoms, such as social withdrawal and aggression or hostility towards others, and timely intervention. In supporting services that address mental health concerns, trauma-informed schools are increasing the

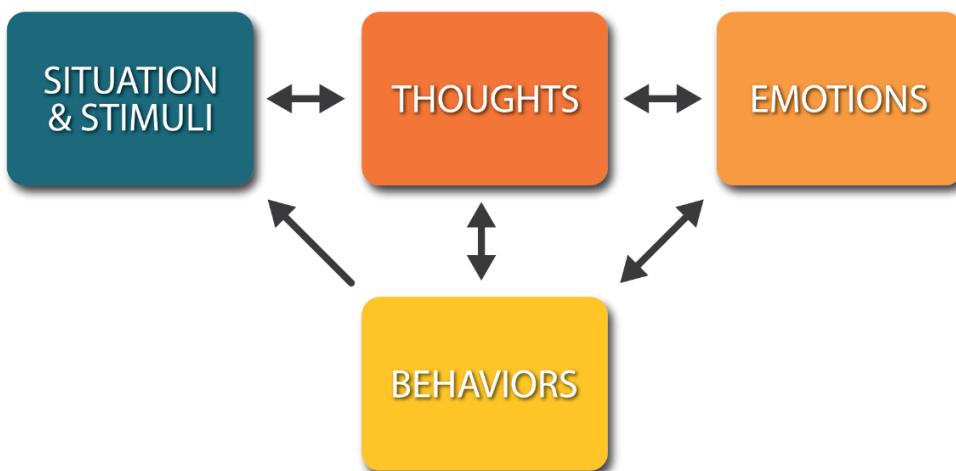
¹⁴ Angelique G. Day, Cheryl L. Somers, Beverly A. Baroni, Shantel D. West, Laura Sanders & Cynthia D. Peterson (2015) Evaluation of a Trauma-Informed School Intervention with Girls in a Residential Facility School: Student Perceptions of School Environment, Journal of Aggression, Maltreatment & Trauma, 24:10, 1086-1105, DOI: 10.1080/10926771.2015.1079279

number of children who can access the resources and treatment that they need. Addressing trauma and its symptoms at an earlier stage can reduce children's risk of developing more severe mental health conditions.

Conclusion

One in four children will experience maltreatment in their lifetime, with 1 in 7 experiencing trauma in the past year. Trauma can lead to a permanent restructuring of a child's brain, affecting the way in which they process and retain information, regulate negative emotions, and behave. The effects of trauma become more prominent when a child enters the education system. In addition to being placed in an environment that is unknown, they are expected to adhere to practices and policies that conflict with their emotional and behavioral functionalities.

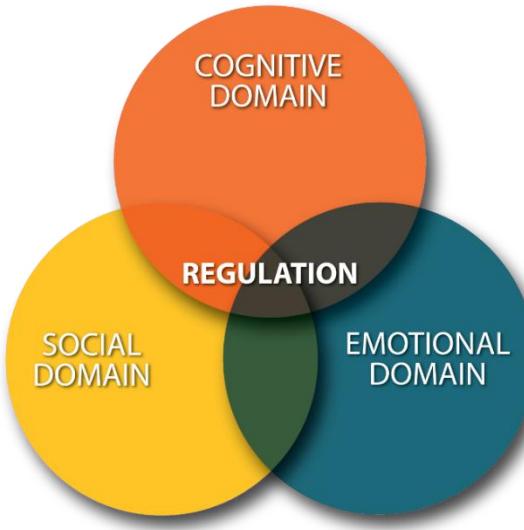
A large percentage of trauma-impacted youth are experiencing symptoms of mood disorder or anxiety before entering the classroom. MHA's youth screening data (n=561) showed that, in addition to struggling with concentration, youth trauma survivors showed signs of depression and anxiety. Most youth screeners reported feeling hopeless, believed that they were inherently bad, and worried a lot. Moreover, data collected from MHA's Post Trauma Stress Disorder, Bipolar, and Depression screens showed that a large percentage of youth trauma survivors were at high risk for developing all three conditions. A deeper analysis of this data showed that mood disorders often precede behavioral issues.



How the effects of trauma manifest themselves differs from youth to youth. Some will adopt externalizing behaviors while others will adopt internalizing behaviors. Commonly, those who adopt externalizing behavior appear to be more aggressive or hostile, while those who adopt internalizing behavior often withdraw socially or are fearful of new experiences. In the classroom, the latter regularly are overlooked while the former are repeatedly punished. Traditional school practices that aim to address defiant behavior through disciplinary measures reinforce the negative beliefs that trauma impacted youth often hold. This leads to further defiant behavior and fosters an unsafe environment exposing youth to additional trauma.

Schools can play a critical role in early identification and intervention. If unaddressed, short-term symptoms of trauma in youth are likely to become more severe in adulthood. In helping to mitigate the effects of trauma, schools can offer trauma-impacted youth the opportunity to build resilience and improve life outcomes. This can be done through the implementation of trauma-informed practices and policies that create trauma-sensitive climates. Evaluations of school-based, trauma-informed programs have shown that trauma-sensitive climates foster positive relationships between staff and students, leading to an improvement in conduct. More notably, trauma-sensitive climates have been shown to reduce symptoms of trauma in youth by increasing feelings of safety and support.

A lack of knowledge concerning the effects of trauma has allowed many trauma-impacted youths to fall through the cracks of the education system. This is primarily due to the criminalization of defiant behavior that is often indicative of trauma. Expulsion, suspensions, or classroom removals contributes to huge losses in learning and higher levels of disengagement or detachment. These are hostile and damaging practices that result in the re-traumatization of youth, the exacerbation of emotional and behavioral issues, and lower academic performance. Staff should be trained on how to respond to children experiencing emotional, behavioral and academic difficulties. Effective strategies include supporting youth in the development of emotional regulation and coping skills.



In most cases mood disorders precede behavioral issues. School-based mental health services programs can meet a growing demand for resources among trauma-impacted youth. School-employed mental health professionals are trained to provide mental health services in a learning environment, addressing mental health issues before they become chronic. Some youth require services outside of the scope of school-based mental health professionals. Schools can increase access to care by establishing relationships with community-based mental health services. Additionally, schools can ensure that trauma-impacted youth can access services by developing a referral system that connects youth to mental health services in their community. A critical component of a referral system is the creation of referral staff that receive continual training and updates on procedures and protocol.

Schools can also play an active role in helping *all* youth build resilience and improve academic performance by fostering social emotional development. MHA's youth screening data shows that a large majority of non-trauma youth were also experiencing issues with attention, mood, and conduct. Fifty-two percent of non-trauma youth stated that they *often* found themselves easily distracted, 47% stated that they *often* found it difficult to concentrate, and 37% *often* found it difficult to sit still. A large percentage of non-trauma youth also experienced symptoms of a mental health condition. Forty-nine percent reported *often* feeling hopeless, 63% stated that they *often* worry a lot, and 48% *often* felt angry or irritable. Emotional difficulties were accompanied by behavioral ones, including defiant behavior or social withdrawal. Both non-traumatized and trauma-impacted youth reported that they *often* saw their grades dropping or were absent from school, indicating a lack of effective support services in schools.

Regardless of exposure to trauma, Social Emotional Learning (SEL) programs have shown to cultivate a learning experience that promotes positive behavior, academic success, and emotional well-being in youth. Although trauma-informed care and SEL are often viewed as separate, they have many interrelated components. In most cases the emotional and behavioral symptoms of trauma worsen because trauma-impacted youth do not possess the necessary restorative skills. With a focus on self-awareness, self-management, social awareness, relationships skills, and responsible decision making, SEL programs complement trauma-informed practices in mitigating the effects of trauma and its behavioral manifestations. Schools interested in creating trauma-sensitive climates should not only focus on treating the trauma itself but also creating an environment that allows for it. Combining SEL and trauma-informed practices allows for just that.

Appendix

Youth with MDE Who DID NOT Receive Treatment

Table 1

Rank	State	%	#
1	Connecticut	45.8	12,000
2	Minnesota	46.5	21,000
3	Maine	48.5	5,000
4	New Hampshire	51.5	6,000
5	Ohio*	51.6	59,000
6	Massachusetts	53.8	30,000
7	Oregon*	53.9	25,000
8	Alaska	54.2	3,000
9	Vermont	54.4	2,000
10	Colorado*	55.4	33,000
11	Wyoming	55.8	3,000
12	Maryland	55.9	28,000
13	North Dakota	56.0	2,000
14	Idaho	57.1	10,000
15	Rhode Island	57.2	5,000
16	Georgia*	57.5	43,000
17	Iowa	58.3	16,000
18	West Virginia	58.6	9,000
19	Illinois*	59.4	69,000
20	New York*	59.6	98,000
21	Nevada*	59.8	22,000
22	Pennsylvania*	59.8	65,000
23	New Jersey*	60.6	37,000
24	Indiana*	61.6	50,000
25	Washington	61.7	39,000
26	North Carolina*	62.2	57,000

Rank	State	%	#
27	District of Columbia	62.3	1,000
28	Florida*	62.4	108,000
29	Oklahoma	62.6	20,000
30	Delaware	62.8	4,000
31	Virginia*	63.1	48,000
32	Montana	63.3	5,000
33	Louisiana	63.4	21,000
34	South Dakota	63.4	4,000
35	Utah	63.8	21,000
36	Arizona	64.0	39,000
37	Michigan*	64.3	61,000
38	Missouri	64.6	32,000
39	California*	65.1	243,000
40	Kansas	65.3	15,000
41	Arkansas	66.0	18,000
42	Wisconsin	66.4	38,000
43	Mississippi	67.1	15,000
44	New Mexico	67.3	12,000
45	Alabama	67.4	25,000
46	Nebraska	67.4	10,000
47	Hawaii	67.5	6,000
48	Kentucky	67.5	20,000
49	South Carolina	69.0	23,000
50	Tennessee	70.7	33,000
51	Texas*	71.3	190,000
	National*	61.5	1,809,000

* Measures collected from Annual Averages based on 2014-2016.

Unmarked states: measures collected from annual averages based on 2011-2016

Youth with Severe MDE Who Received Some Consistent Treatment

Table 2

Rank	State	%	#	Rank	State	%	#
1	Minnesota	39.7	12,000	27	North Carolina	25.5	15,000
2	Maine	38.7	3,000	28	Washington	24.5	12,000
3	New Hampshire	38.3	3,000	29	California*	23.9	55,000
4	Massachusetts	37.3	14,000	30	Indiana	23.7	11,000
5	Ohio*	33.0	27,000	31	New Mexico	23.5	3,000
6	Alaska	32.3	1,000	32	Utah	23.1	5,000
7	North Dakota	31.6	1,000	33	Wisconsin	23.0	9,000
8	Colorado	31.4	10,000	34	Alabama	22.7	5,000
9	Michigan*	31.0	20,000	35	Louisiana**	22.5	5,000
10	Rhode Island	29.5	2,000	36	Arizona	22.3	10,000
11	Iowa	29.4	6,000	37	Florida*	21.7	26,000
12	Oregon	29.4	8,000	38	Montana	21.5	1,000
13	Illinois*	29.3	23,000	39	Nebraska	21.4	2,000
14	Pennsylvania*	28.7	21,000	40	Wyoming	21.0	1,000
15	Vermont	28.1	1,000	41	Virginia*	20.4	11,000
16	Maryland	28.0	10,000	42	Idaho**	19.5	2,000
17	West Virginia	28.0	3,000	43	Hawaii	18.8	1,000
18	New York*	27.2	27,000	44	Kentucky	18.4	4,000
19	Missouri	26.7	10,000	45	Nevada	16.0	3,000
20	Kansas	26.5	4,000	46	District of Columbia**	15.9	<1000
21	South Dakota	26.5	1,000	47	Texas*	14.3	25,000
22	Delaware	26.2	1,000	48	Georgia	12.9	6,000
23	Arkansas	26.1	5,000	49	Mississippi	12.8	2,000
24	Oklahoma	25.8	6,000	50	Tennessee	12.4	4,000
25	Connecticut	25.6	5,000	51	South Carolina	12.2	3,000
26	New Jersey	25.5	9,000		National*	25.1	505,000

*Measures collected from annual averages based on 2014-2016

** Measures collected from annual averages based on 2010-2013

Unmarked states: measures collected from annual averages based on 2011-2016

Glossary

Indicator	Description of Measure	Source
Adults with Any Mental Illness (AMI)	<p>Any mental illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, assessed by the Mental Health Surveillance Study (MHSS) Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders (MHSS-SCID), which is based on the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Three categories of mental illness severity are defined based on the level of functional impairment: mild mental illness, moderate mental illness, and serious mental illness. AMI includes individuals in any of the three categories. For details on the methodology, see Section B.4.3 in Appendix B of the Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings. http://www.samhsa.gov/data/.</p> <p>Data survey years: 2013-2015.</p>	<p>SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/nsduh/reports-detailed-tables-2017-NSDUH</p>
Adults with AMI Reporting Unmet Need	<p>Adults with AMI reporting unmet need is defined as feeling a perceived need for mental health treatment/counseling that was not received. This is often referred to as "unmet need." Mental Health Treatment/Counseling is defined as having received inpatient treatment/counseling or outpatient treatment/counseling or having used prescription medication for problems with emotions, nerves, or mental health. Respondents were not to include treatment for drug or alcohol use. Respondents with unknown treatment/counseling information were excluded. Data survey years: 2013-2015.</p>	<p>SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health. https://www.samhsa.gov/data/nsduh/reports-detailed-tables-2017-NSDUH</p>
Adults with AMI Who are Uninsured	<p>Adults with AMI who are uninsured is calculated from variable IRINSUR4 and AMIYR_U. AMIYR_U is defined as above in Adults with AMI. A respondent is classified as NOT having any health insurance (IRINSUR4=2) if they meet EVERY one of the following conditions. (1) Not Covered by private insurance (IRPRVHLT=2) (2) Not Covered by Medicare (IRMEDICR=2) (3) Not Covered by Medicaid/CHIPCOV (IRMCDCHP=2) (4) Not Covered by Champus, ChampVA, VA, or Military (IRCHMPUS=2) (5) Not Covered by other health insurance (IROTHHLT=2). Data survey year: 2013-2015.</p>	<p>SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health. https://www.samhsa.gov/data/nsduh/reports-detailed-tables-2017-NSDUH</p>

Indicator	Description of Measure	Source
Adult with Substance Abuse Disorder in the Past Year.	Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/nsduh/reports-detailed-tables-2017-NSDUH
Adults with Disability Who Could Not See a Doctor Due to Costs	Disability questions were added to the Behavioral Risk Factor Surveillance System (BRFSS) core questionnaire in 2004. Disability was determined using the following BRFSS question: "Are you limited in any way in any activities because of physical, mental or emotional problems?" (QLACTLM2). Respondents were defined as having a disability if they answered "Yes" to this question. Respondents were also asked: "Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?" (MEDCOST). The measure was calculated based on individuals who answered Yes to MEDCOST among those who answered Yes to QLACTLM2. Data survey year 2015.	Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2016. http://www.cdc.gov/brfss/annual_data/annual_2014.html Downloaded and calculated on 8/24/17.
Adults with Serious Thoughts of Suicide	Adults aged 18 or older were asked whether they had seriously thought about, made any plans, or attempted to kill themselves at any time during the past 12 months, or if they had received medical attention from a health professional or stayed overnight in a hospital in the past 12 months because of a suicide attempt. Data survey year: 2013-2015.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/nsduh/reports-detailed-tables-2017-NSDUH
Children with private insurance that did not cover mental or emotional problems	Children with private insurance that did not cover mental or emotional problems is defined as any child age 0-17 responding YES to HLTINMNT. HLTINMNT is defined as: "Does [SAMPLE MEMBER POSS] private health insurance include coverage for treatment for mental or emotional problems?	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/nsduh/reports-detailed-tables-2017-NSDUH

Indicator	Description of Measure	Source
Mental Health Workforce Availability	<p>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.</p> <p>Survey data year: 2017.</p>	<p>County Health Rankings & Roadmaps. http://www.countyhealthrankings.org/</p> <p>This data comes from the National Provider Identification data file, which has some limitations. Providers who transmit electronic health records are required to obtain an identification number, but very small providers may not obtain a number. While providers have the option of deactivating their identification number, some mental health professionals included in this list may no longer be practicing or accepting new clients.</p>
Students Identified with Emotional Disturbance for Individualized Education Program Individualized Education Program	<p>Percent of Children Identified as having a Emotional Disturbance among enrolled students Grade 1-12 and Ungraded. This measure was calculated from data provided by IDEA Part B Child Count and Educational Environments, Common Core of Data. Under IDEA regulation, Emotional Disturbance is identified as a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: (A) An inability to learn that cannot be explained by intellectual, sensory, or health factors. (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers. (C) Inappropriate types of behavior or feelings under normal circumstances. (D) A general pervasive mood of unhappiness or depression. (E) A tendency to develop physical symptoms or fears associated with personal or school problems. Emotional disturbance includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance under paragraph (c)(4)(i) of this section. Data year 2015-2016</p>	<p>IDEA Data Center, 2015 – 2016 IDEA Section 618, State Level Data Files, Child Count and Educational Environments. http://www2.ed.gov/programs/osepidea/618-data/state-level-data-files/index.html#bccee.</p> <p>US Department of Education, National Center for Education Statistics, Common Core of Data. http://nces.ed.gov/ccd/stnfs.asp</p> <p>Downloaded and calculated on 7/31/2018.</p>

Indicator	Description of Measure	Source
Youth with At Least One Past Year Major Depressive Episode (MDE)	<p>Among youth age 12-17, major depressive episode (MDE) is defined as in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), which specifies a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. For details, see Section B of the "2011-2012 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology" at http://www.samhsa.gov/data/population-data-nsduh/reports?tab=33. Data survey year 2014-2015.</p>	<p>SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014-2015.</p> <p>https://www.samhsa.gov/data/nsduh/reports-detailed-tables-2017-NSDUH</p>
Youth with Substance Abuse Disorder in the Past Year.	<p>Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.</p>	<p>SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health,</p> <p>https://www.samhsa.gov/data/nsduh/reports-detailed-tables-2017-NSDUH</p>
Youth with MDE who Did Not Receive Mental Health Services	<p>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") and respond NO to ANYSMH. ANYSMH indicates whether a youth reported receiving specialty mental health services in the past year from any of 7 specific inpatient/residential or outpatient specialty sources for problems with behavior or emotions that were not caused by alcohol or drugs. This variable was created based on the following 7 source of treatment variables: stayed overnight in a hospital (YHOSP), stayed in a residential treatment facility (YRESID), spent time in foster care (YFOST), spent time in a day treatment facility (YDAYRT), received treatment from a mental health clinic (YCLIN), from a private therapist (YTHER), and from an in-home therapist (YHOME).</p> <p>Youths who reported a positive response (source variable=1) to one or more of the 7 questions were included in the yes category regardless of how many of the 7 questions they answered. Youths who did not report a positive response, but answered all 7 of the questions were included in the no category. Youths who did not report a positive response and did not answer all the questions, and adults were included in the unknown/18+ category.</p> <p>Data survey year 2014-2015.</p>	<p>SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health</p> <p>https://www.samhsa.gov/data/nsduh/reports-detailed-tables-2017-NSDUH</p>

Indicator	Description of Measure	Source
Youth with Severe MDE	<p>Youth with severe MDE is defined as having had MDE in the past year were then asked questions from the SDS to measure the level of functional impairment in major life activities reported to be caused by the MDE in the past 12 months (Leon, Olfson, Portera, Farber, & Sheehan, 1997). The SDS measures mental health-related impairment in four major life activities or role domains. The following variable, YSDSOVRL, is assigned the maximum level of interference over the four role domains of SDS: chores at home (YSDSHOME), school or work (YSDSWRK), family relationships (YSDSREL), and social life (YSDSSOC). Each module consists of four questions that are assessed on a 0 to 10 visual analog scale with categories of "none" (0), "mild" (1-3), "moderate" (4-6), "severe" (7-9), and "very severe" (10). The four SDS role domain variables were recoded so that no interference = 1, mild = 2, moderate = 3, severe = 4, and very severe = 5. A maximum level of interference over all four domains was then defined as YSDSOVRL. A maximum impairment score (YSDSOVRL) is defined as the single highest severity level of role impairment across all four SDS role domains. Ratings greater than or equal to 7 on the scale YSDSOVRL=4, 5 were considered severe impairment.</p> <p>"Youth with Severe MDE" is defined as the following variable MDEIMPY. MDEIMPY is derived from the maximum severity level of MDE role impairment (YSDSOVRL) and is restricted to adolescents with past year MDE (YMDEYR). Youth met criteria for MDEIMPY if they answered YES to YSDSOVRL and YES to YMDEYR. Data survey years 2010-2015 and 2013-2015.</p>	<p>SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health https://www.samhsa.gov/data/nsduh/reports-detailed-tables-2017-NSDUH</p>
Youth with Severe MDE who Received Some Consistent Treatment	<p>The following variable calculated as how many youth who answered YES to MDEIMPY from "Youth with severe MDE" defined above and SPOUTVST. The variable SPOUTVST, indicates how many times a specialty outpatient mental health service was visited in the past year. The number of visits is calculated by adding the number of visits to a day treatment facility (YUDYTXNM), mental health clinic (YUMHCRNM), private therapist (YUTPSTNM), and an in-home therapist (YUIHTPNM). A value of 6 (No Visits) was assigned whenever a respondent said they had used none of the services (YUDYTXYR, YUMHCRYR, YUTPSTYR, YUIHTPYR all equal 2). A value of missing was assigned when the response to whether received treatment or number of visits was unknown for any of the 4 locations (any of YUDYTXYR, YUMHCRYR, YUTPSTYR, YUIHTPYR=85, 94, 97, 98 OR any of YUDYTXNM, YUMHCRNM, YUTPSTNM, YUIHTPNM=985, 994, 997, 998), unless sum of the visits for services with non-missing information was greater than or equal to 25, in which case a value of 5 (25 or more visits) was assigned. A missing value was also assigned for respondents aged 18 or older. The variable SPOUTVST was recoded for visit distribution as 0 Visits, 1-6 Visits, and 7-25+ Visits. Data survey years 2010-2013, 2010-2015, and 2013-2015</p>	<p>Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. https://www.samhsa.gov/data/nsduh/reports-detailed-tables-2017-NSDUH</p>