

2021

The State of Mental Health in America

Acknowledgments

Mental Health America (MHA) was founded in 1909 and is the nation's leading community-based nonprofit dedicated to helping all people 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 services and supports for those who need them, with recovery as the goal.

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

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Special Thanks To:

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

Why Gather this Information?

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

Ranking Overview and Guidelines

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

MHA Guidelines

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

- Data that are publicly available and as current as possible to provide up-to-date results.
- Data that are available for all 50 states and the District of Columbia.
- Data for both adults and youth.
- Data that 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 2021 Measures

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

A Complete Picture

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

Ranking

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

Factors to consider include geography and size. For example, California and New York are similar. Both are large states with densely populated cities. They are less comparable to less populous states like South Dakota North Dakota, Alabama, or Wyoming. Keep in mind that 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 2018. States with positive outcomes are ranked higher (closer to 1) than states with poorer outcomes. The overall, adult, youth, prevalence, and access rankings were analyzed by calculating a standardized score (Z score) for each measure and ranking the sum of the standardized scores. For most measures, lower percentages equated to more positive outcomes (e.g. lower rates of substance use or those who are uninsured). There are two measures where high percentages equate to better outcomes. These include Youth with Severe MDE (Major Depressive Episode) who Received Some Consistent Treatment, and Students Identified with Emotional Disturbance for an Individualized Education Program. Here, the calculated standardized score was multiplied by -1 to obtain a Reverse Z Score that was used in the sum. All measures were considered equally important, and no weights were given to any measure in the rankings.

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

The measure Adults with Disability who Could Not See a Doctor Due to Costs was previously calculated using the Behavioral Risk Factor Surveillance System (BRFSS) question: "Are you limited in any way in any activities because of physical, mental or emotional problems?" (QLACTLM2). The QLACTLM2 question was removed from the BRFSS questionnaire after 2016, and therefore could not be calculated using 2018 BRFSS data. For this report, the indicator was amended to Adults with Cognitive Disability who Could Not See a Doctor Due to Costs, using the BRFSS question: "Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?" (DECIDE). This indicator likely serves as a better measure for individuals who experience disability tied to mental, cognitive or emotional problems, as it is less likely to include people who experience limitations due to a physical disability and is therefore a more sensitive measure for the population we are attempting to count.

For the measure Students Identified with Emotional Disturbance for an Individualized Education Program, due to data suppression because of quality, the 2016-2018 figures for Wisconsin were not available. This report notes the 2015 figure for Wisconsin.

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.

In addition, these data were gathered through 2018. This means that they are the most current data reported by the states and available to the public. They are most useful in providing some comparative baselines in the states for the needs and systems that were in place prior to the COVID-19 pandemic and the increased awareness of ongoing racial injustices in the nation in 2020. MHA regularly reports on its real-time data gathered from more than 6 million completed mental health screenings (through August 2020), featured in the Spotlight of this report. Based on these screening results from a help-seeking population, and both U.S. Census Bureau 2020 Pulse Survey data, which included brief depression and anxiety screening questions, and survey data reported by the Centers for Disease Control and Prevention (CDC), it appears that (1) the data in this report likely under-reports the current prevalence of mental illnesses in the population, both among children and adults, (2) higher-ranked states may have been better prepared to deal with the mental health effects of the pandemic at its start, and (3) because of its nationwide effect, nothing in the pandemic by itself would suggest that the relative rankings of the states would have changed solely because of the pandemic.

Major Findings

EVEN BEFORE COVID-19,

19%

OF ADULTS
EXPERIENCED
A MENTAL
ILLNESS,

▲ 1.5 M

PEOPLE OVER LAST YEAR'S DATASET.

SUICIDAL IDEATION AMONG ADULTS IS **INCREASING**

▲ .15%

OR OVER 460,000 PEOPLE FROM LAST YEAR.

24%

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

9.7%

OF YOUTH IN THE U.S. HAVE
SEVERE MAJOR DEPRESSION.
THIS RATE WAS **HIGHEST AMONG**
YOUTH WHO IDENTIFY AS MORE
THAN ONE RACE, AT

12.4%

60%

OF YOUTH WITH
DEPRESSION **DO NOT**
RECEIVE ANY MENTAL
HEALTH TREATMENT.

EVEN IN STATES WITH THE GREATEST ACCESS,

1 IN 3

ARE GOING
WITHOUT TREATMENT.

EVEN AMONG **YOUTH WITH SEVERE**
DEPRESSION WHO RECEIVE SOME TREATMENT,

ONLY 27%

RECEIVE CONSISTENT CARE.

10.8%

OF AMERICANS WITH A MENTAL ILLNESS ARE **UNINSURED.**
THIS **INCREASED** FOR THE FIRST TIME SINCE THE PASSAGE OF THE
AFFORDABLE CARE ACT (ACA) – THE FIRST NUMBERS THAT
REFLECT THE TRUMP ADMINISTRATION.

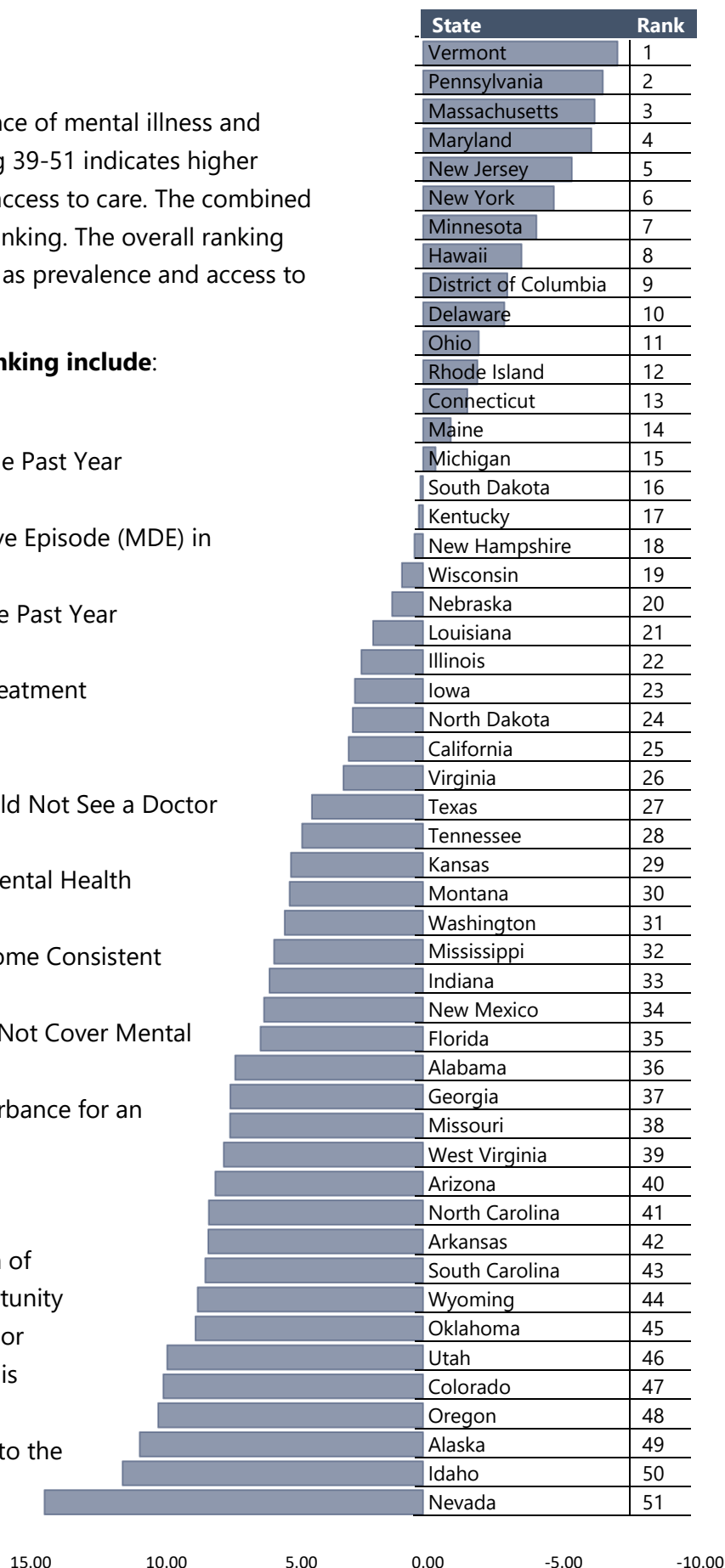
Overall Ranking

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

The 15 measures that make up the overall ranking include:

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

The chart is a visual representation of the sum of the scores for each state. It provides an opportunity to see the difference between ranked states. For example, Vermont (ranked 1) has a score that is higher than Rhode Island (ranked 12). South Dakota (ranked 16) has a score that is closest to the average.

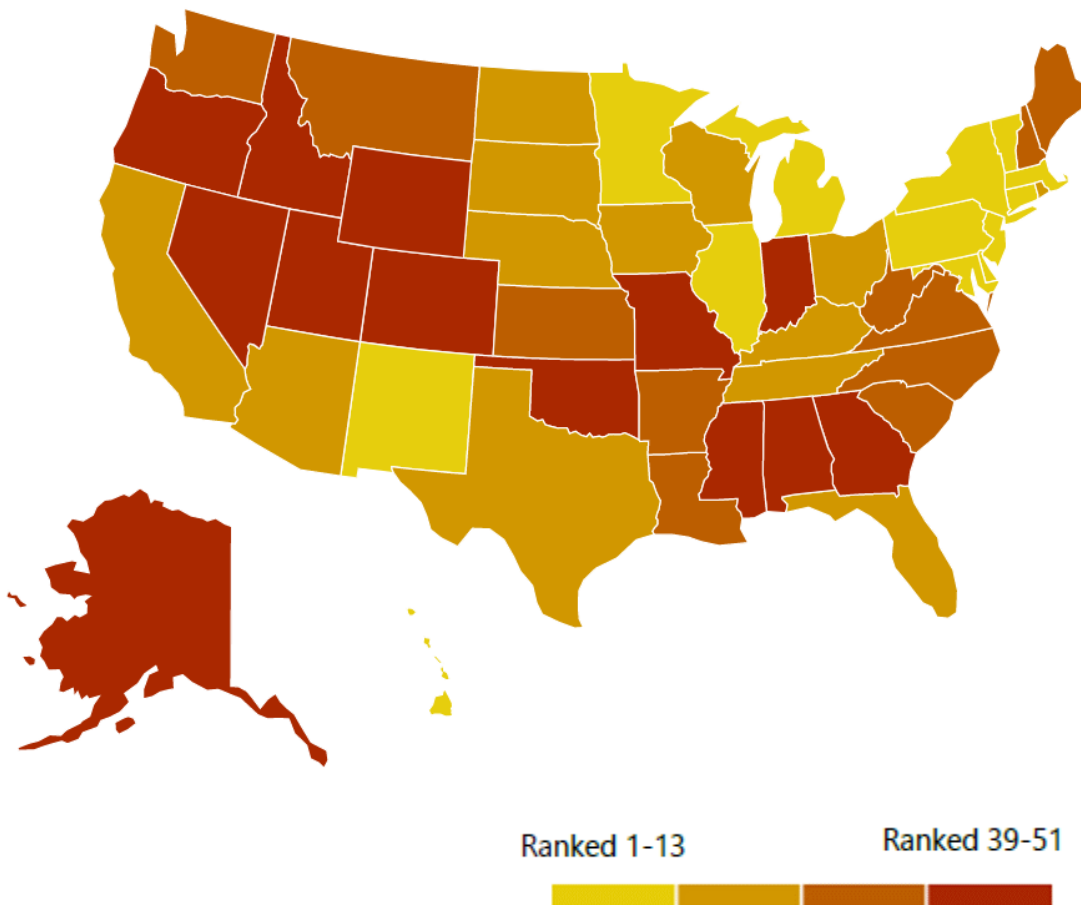


Adult Rankings

States that are ranked 1-13 have lower prevalence of mental illness and higher rates of access to care for adults. States that are ranked 39-51 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 Cognitive Disability who Could Not See a Doctor Due to Costs



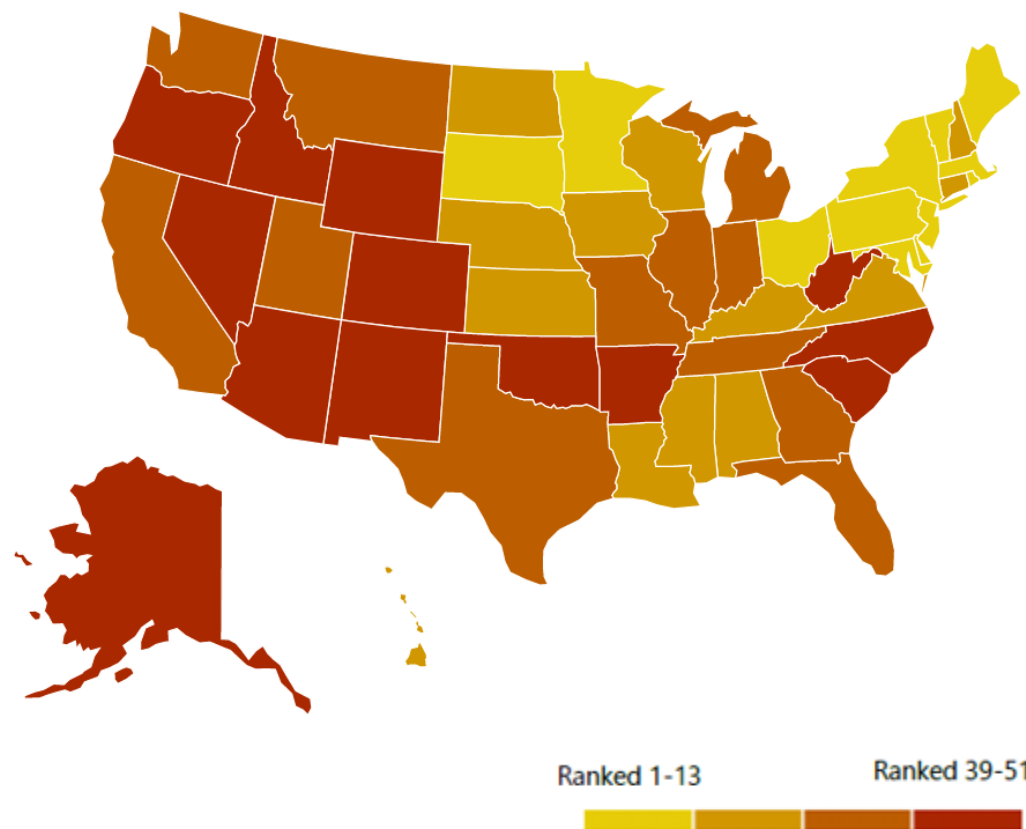
Rank	State
1	Hawaii
2	New York
3	New Jersey
4	Minnesota
5	Pennsylvania
6	Michigan
7	Maryland
8	New Mexico
9	Massachusetts
10	Vermont
11	Illinois
12	Connecticut
13	Delaware
14	Ohio
15	Texas
16	Kentucky
17	Arizona
18	Tennessee
19	Iowa
20	South Dakota
21	California
22	Nebraska
23	North Dakota
24	Wisconsin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

Youth Rankings

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



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

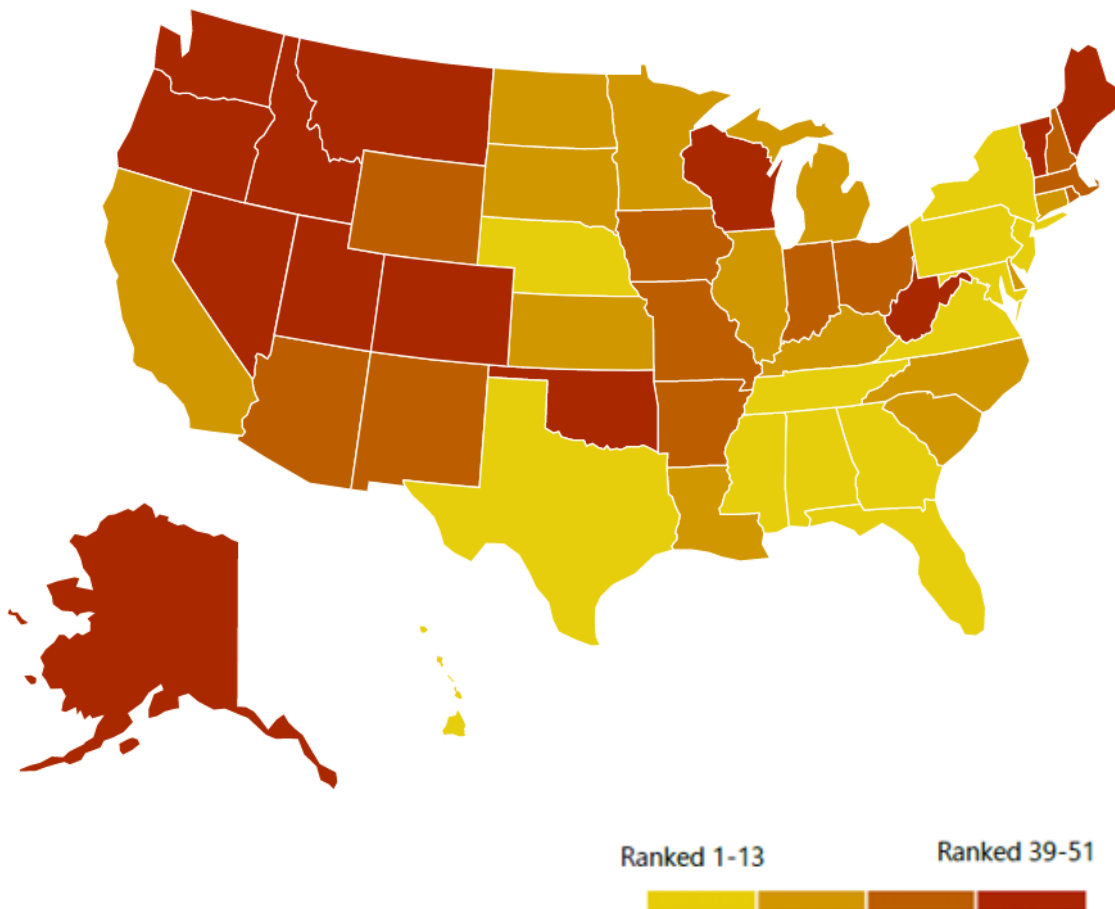
Prevalence of Mental Illness

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



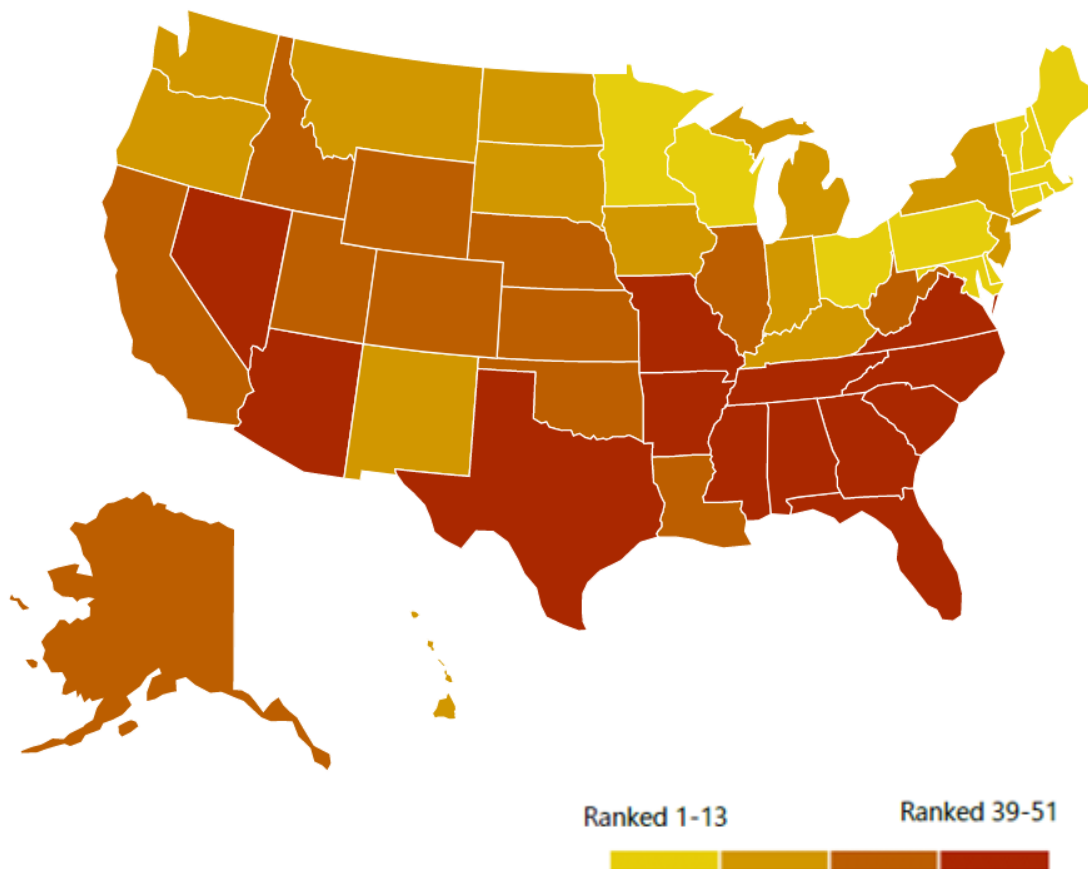
Rank	State
1	New Jersey
2	Texas
3	New York
4	Pennsylvania
5	Georgia
6	Maryland
7	Mississippi
8	Florida
9	Tennessee
10	Hawaii
11	Alabama
12	Virginia
13	Nebraska
14	California
15	South Dakota
16	Minnesota
17	South Carolina
18	Louisiana
19	Illinois
20	Connecticut
21	Michigan
22	Kansas
23	Kentucky
24	North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

Access to Care Rankings

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

The 9 measures that make up the Access Ranking include:

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



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

Largest Changes in Overall Ranking: 2020-2021

MONTANA ▲ (43 TO 30)

The indicator that had the largest effect on Montana's Overall Ranking was a decrease in Youth with MDE Who Did Not Receive Treatment, from 63.2% in 2016-2017 to 55.6% in 2017-2018.

WASHINGTON ▲ (45 TO 31)

The indicator that had the largest effect on Washington's Overall Ranking was a decrease in Youth with MDE Who Did Not Receive Treatment, from 59.1% in 2016-2017 to 47.0% in 2017-2018.

IOWA ▼ (9 TO 23)

Largest effects on the overall ranking for Iowa were an increase in the percent of Adults reporting Unmet Need, from 18.2% in 2016-2017 to 25.5% in 2017-2018 and the percent of Adults who are uninsured, from 3.3% in 2016-2017 to 8.4% in 2017-2018.

MISSOURI ▼ (25 TO 38)

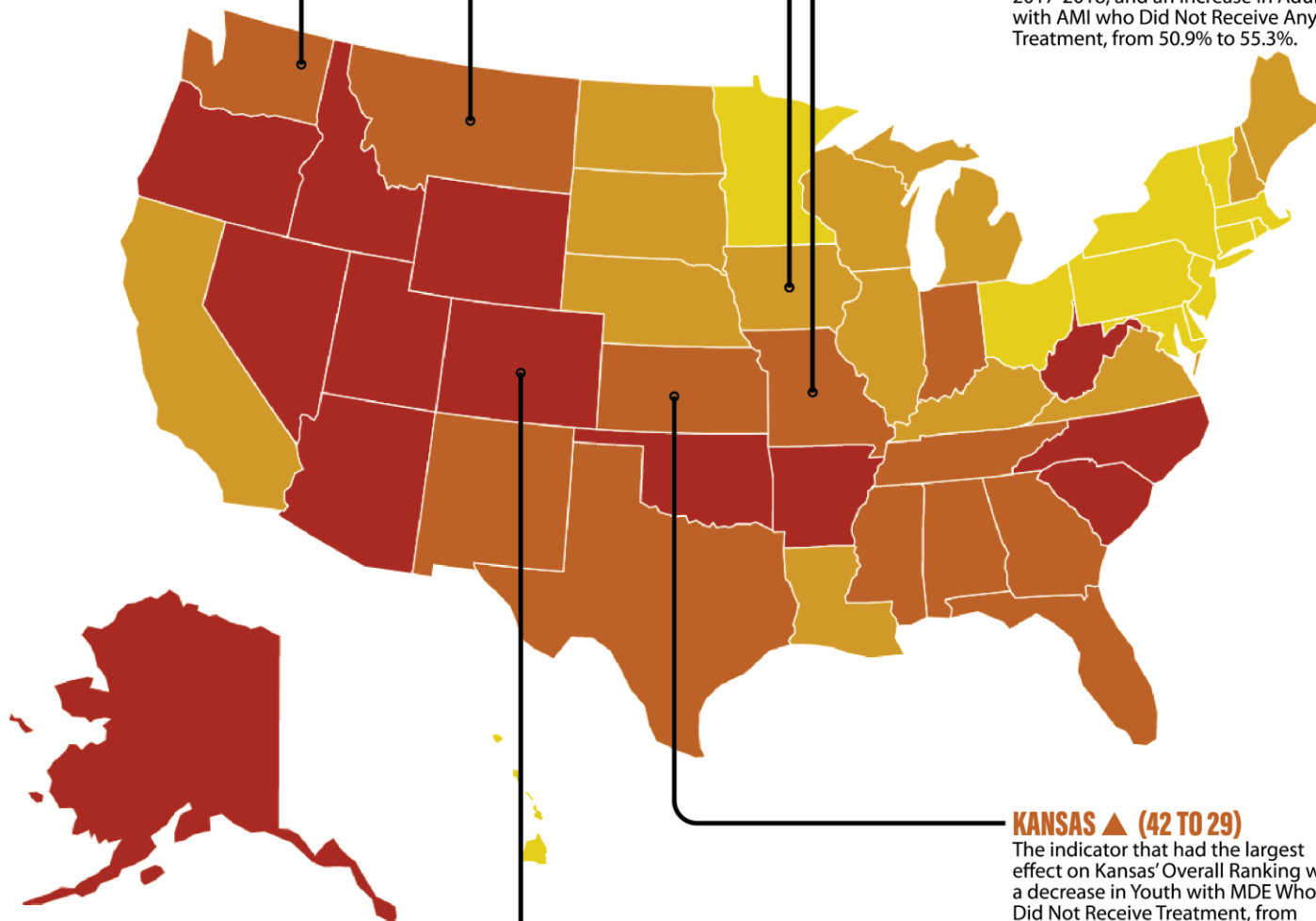
The largest effects on the Overall Ranking for Missouri were a decrease in Youth with Severe MDE who Received Some Consistent Treatment, from 36.7% in 2016-2017 to 19.0% in 2017-2018, and an increase in Adults with AMI who Did Not Receive Any Treatment, from 50.9% to 55.3%.

KANSAS ▲ (42 TO 29)

The indicator that had the largest effect on Kansas' Overall Ranking was a decrease in Youth with MDE Who Did Not Receive Treatment, from 70.8% in 2016-2017 to 54.7% in 2017-2018.

COLORADO ▼ (29 TO 47)

The largest effect on the overall ranking for Colorado was an increase in the prevalence of Adults with Substance Use Disorder, from 9.07% in 2016-2017 to 11.9% in 2017-2018.



Changes in Overall Ranking: State of Mental Health in America 2020-2021

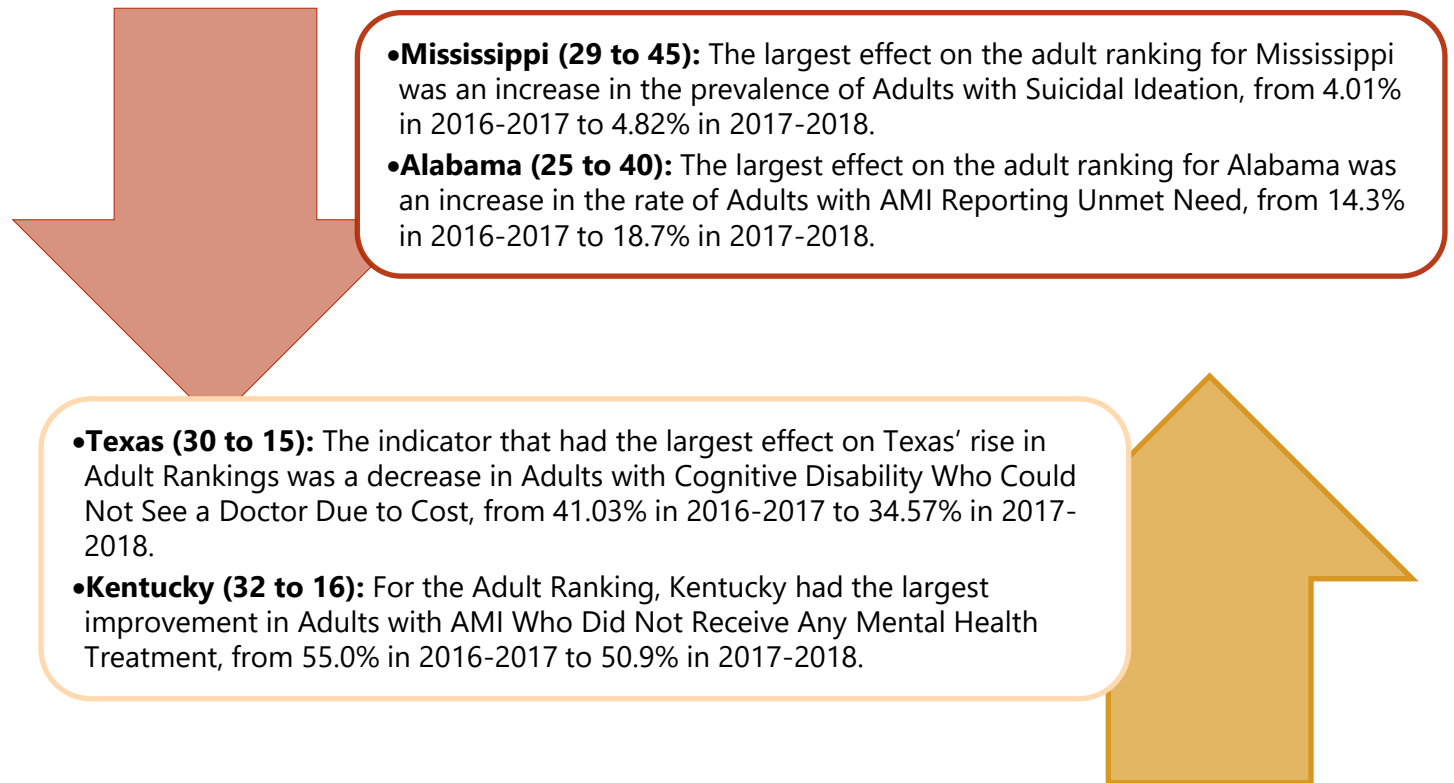
State	Overall Ranking (2020)*	Overall Ranking (2021)*
Alabama	40	36
Alaska	46	49
Arizona	28	40
Arkansas	33	42
California	22	25
Colorado	29	47
Connecticut	10	13
Delaware	11	10
District of Columbia	16	9
Florida	32	35
Georgia	36	37
Hawaii	12	8
Idaho	49	50
Illinois	20	22
Indiana	26	33
Iowa	9	23
Kansas	42	29
Kentucky	21	17
Louisiana	30	21
Maine	19	14
Maryland	5	4
Massachusetts	7	3
Michigan	17	15
Minnesota	6	7
Mississippi	34	32
Missouri	25	38

State	Overall Ranking (2020)*	Overall Ranking (2021)*
Montana	43	30
Nebraska	23	20
Nevada	51	51
New Hampshire	14	18
New Jersey	8	5
New Mexico	31	34
New York	2	6
North Carolina	35	41
North Dakota	15	24
Ohio	18	11
Oklahoma	41	45
Oregon	50	48
Pennsylvania	1	2
Rhode Island	4	12
South Carolina	44	43
South Dakota	24	16
Tennessee	39	28
Texas	38	27
Utah	48	46
Vermont	3	1
Virginia	27	26
Washington	45	31
West Virginia	37	39
Wisconsin	13	19
Wyoming	47	44

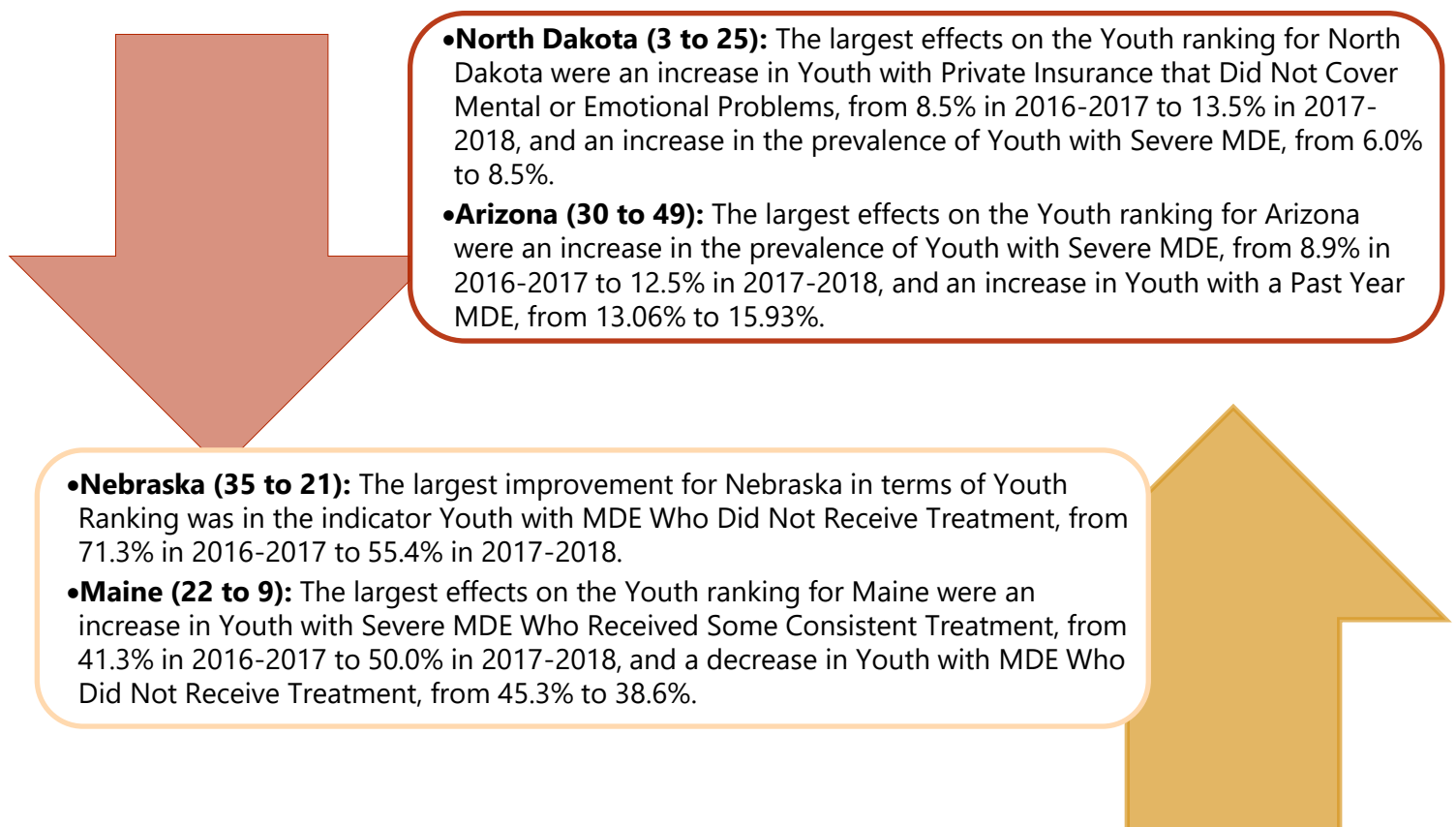
■ Decrease in Ranking
 ■ Ranking Remained the Same
 ■ Increase in Ranking

*2020 Overall Ranking is taken from the State of Mental Health in America 2020 Report, based on data from 2016-2017. 2021 Overall Ranking is taken from this report, based on data from 2017-2018.

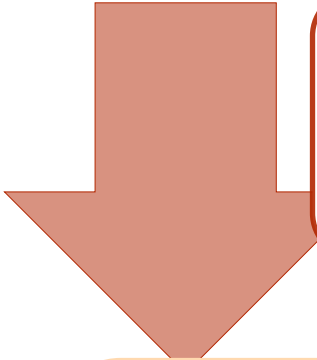
Largest Changes in Adult Rankings: State of Mental Health in America 2020-2021

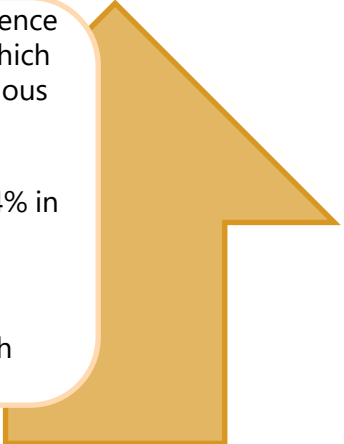


Largest Changes in Youth Rankings: State of Mental Health in America 2020-2021

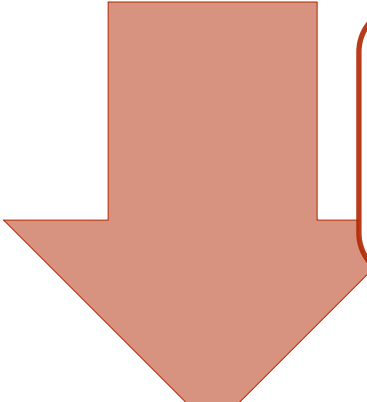


Largest Changes in Need/Prevalence Ranking: 2020-2021

- 
- Oklahoma (25 to 40):** The largest effect on the Need/Prevalence Ranking for Oklahoma was an increase in Youth with Severe MDE, from 8.4% in 2016-2017 to 12.7% in 2017-2018.
 - North Carolina (10 to 24):** The largest effects on the Need/Prevalence Ranking for North Carolina were an increase in Youth with Past Year MDE, from 12.03% in 2016-2017 to 15.05% in 2017-2018, and an increase in Youth with Severe MDE, from 9.8% to 12.6%.

- 
- South Dakota (29 to 15):** South Dakota's largest improvements in Need/Prevalence Ranking were decreases in the indicators Adults with Substance Use Disorder, which decreased from 9.56% in 2016-2017 to 9.17% in 2017-2018, and Adults with Serious Thoughts of Suicide, from 4.40% to 4.21%.
 - Tennessee (22 to 9):** The largest effect on the Need/Prevalence Ranking for Tennessee was an improvement in the rate of Youth with Severe MDE, from 10.4% in 2016-2017 to 9.2% in 2017-2018.
 - Massachusetts (42 to 30):** In Massachusetts, the largest improvements in Need/Prevalence Ranking were decreases in the rate of Youth with Severe MDE, which decreased from 10.5% in 2016-2017 to 8.5% in 2017-2018, and Adults with Substance Use Disorder, from 10.13% to 9.34%.

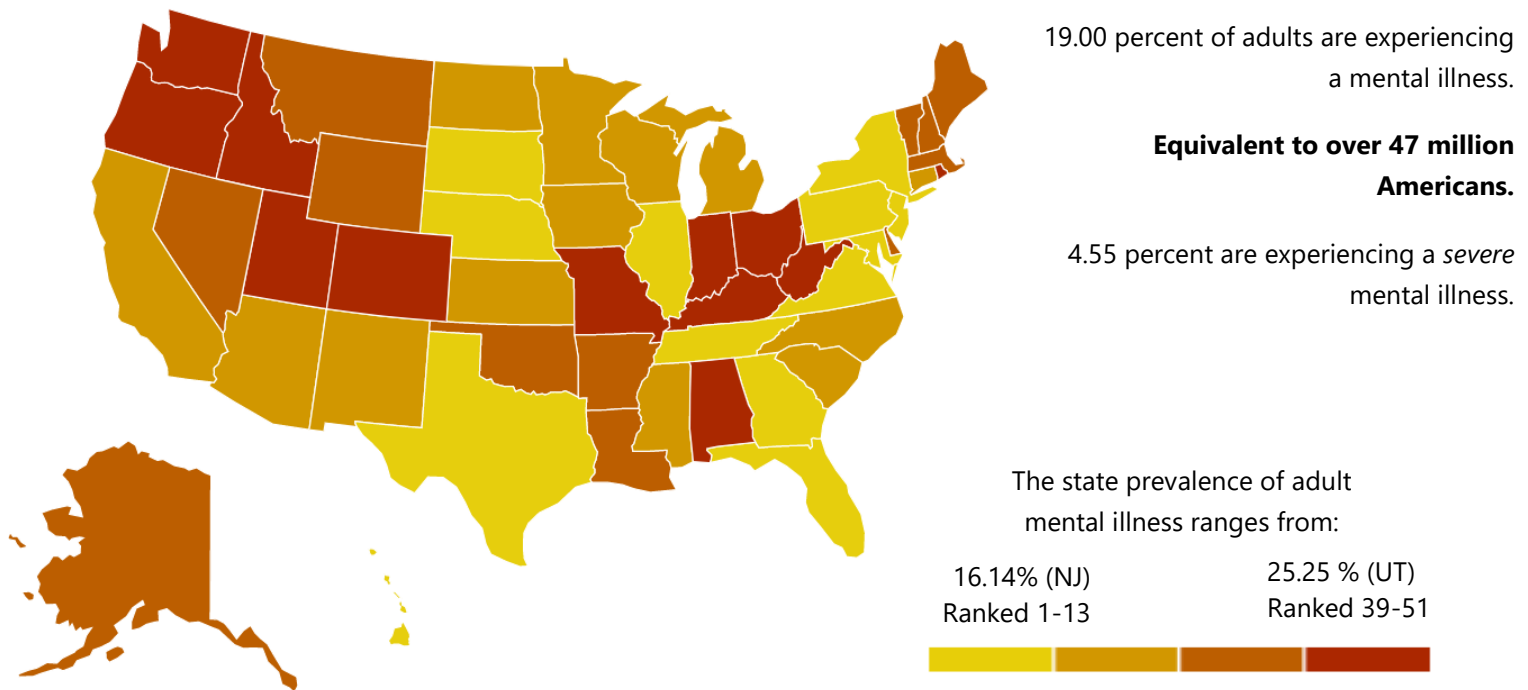
Largest Changes in Access to Care Ranking: 2020-2021

- 
- Missouri (26 to 41):** The largest effects on the Access to Care Ranking for Missouri were a decrease in Youth with Severe MDE who Received Some Consistent Treatment, from 36.7% in 2016-2017 to 19.0% in 2017-2018, and an increase in Adults with AMI who Did Not Receive Any Treatment, from 50.9% to 55.3%.
 - Colorado (17 to 31):** The largest effect on the Access to Care Ranking for Colorado was an increase in Adults with AMI who Report Unmet Need for Treatment, from 22.2% in 2016-2017 to 28.2% in 2017-2018.

- 
- Louisiana (30 to 15):** (41 to 27): Louisiana's largest improvements in Access to Care Ranking were a decrease in Youth with Private Insurance That Did Not Cover Mental or Emotional Problems, from 16.5% to 7.6%; a decrease in Adults with Cognitive Disability Who Could Not See a Doctor Due to Cost, from 38.23% to 28.08%; and a decrease in Adults with AMI Who are Uninsured, from 14.7% to 9.7%.
 - Kentucky (31 to 18):** The largest effect on the Access to Care Ranking for Kentucky was an improvement in Youth with MDE Who Did Not Receive Treatment, from 62.0% in 2016-2017 to 49.3% in 2017-2018.

Adult Prevalence of Mental Illness

Adults with Any Mental Illness (AMI)

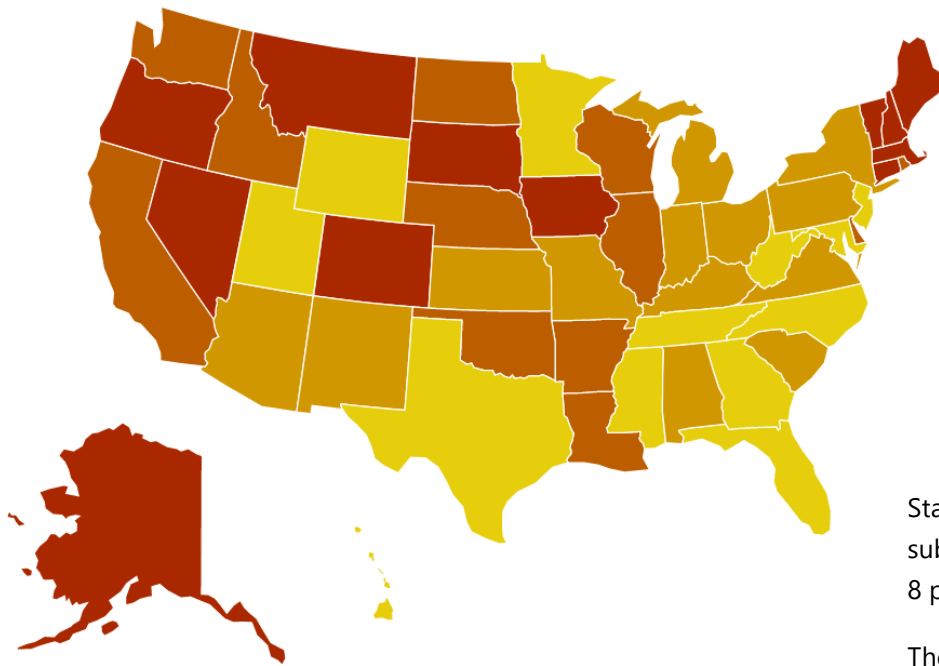


Rank	State	%	#
1	New Jersey	16.14	1,112,000
2	Texas	16.21	3,347,000
3	Maryland	16.96	781,000
4	Virginia	17.38	1,115,000
5	Florida	17.39	2,889,000
6	South Dakota	17.49	112,000
7	Hawaii	17.58	187,000
8	Illinois	18.06	1,754,000
9	Nebraska	18.08	257,000
10	Georgia	18.09	1,405,000
11	Pennsylvania	18.23	1,814,000
12	New York	18.25	2,802,000
13	Tennessee	18.26	937,000
14	South Carolina	18.31	706,000
15	California	18.54	5,566,000
16	North Carolina	18.77	1,469,000
17	Connecticut	19.03	531,000
18	Michigan	19.07	1,469,000
19	New Mexico	19.10	300,000
20	North Dakota	19.13	108,000
21	Arizona	19.24	1,030,000
22	Wisconsin	19.26	859,000
23	Minnesota	19.32	819,000
24	Mississippi	19.49	431,000
25	Kansas	19.59	420,000
26	Iowa	19.89	473,000

Rank	State	%	#
27	Montana	20.00	163,000
28	Delaware	20.03	149,000
29	Arkansas	20.27	457,000
30	Wyoming	20.34	88,000
31	Oklahoma	20.43	592,000
32	Alaska	20.50	108,000
33	New Hampshire	20.56	221,000
34	Louisiana	20.63	715,000
35	Vermont	20.65	104,000
36	Nevada	20.67	474,000
37	Maine	20.82	223,000
38	Massachusetts	21.22	1,155,000
39	Rhode Island	21.32	178,000
40	Alabama	21.39	794,000
41	Ohio	21.40	1,906,000
42	Missouri	21.44	993,000
43	Colorado	21.50	924,000
44	Kentucky	22.14	746,000
45	District of Columbia	22.21	125,000
46	Washington	22.23	1,269,000
47	Oregon	22.45	731,000
48	Indiana	22.51	1,129,000
49	West Virginia	23.80	337,000
50	Idaho	24.46	311,000
51	Utah	25.25	550,000
	National	19.00	47,132,000

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

Adults with Substance Use Disorder in the Past Year



The state prevalence of adults with substance use disorder ranges from:
 6.34% (TX) Ranked 1-13
 13.01% (D.C.) Ranked 39-51



7.67 percent of adults in America reported having a substance use disorder in the past year.

2.87 percent of adults in America reported having an illicit drug use disorder in the past year.

5.74 percent of adults in America reported having an alcohol use disorder in the past year.

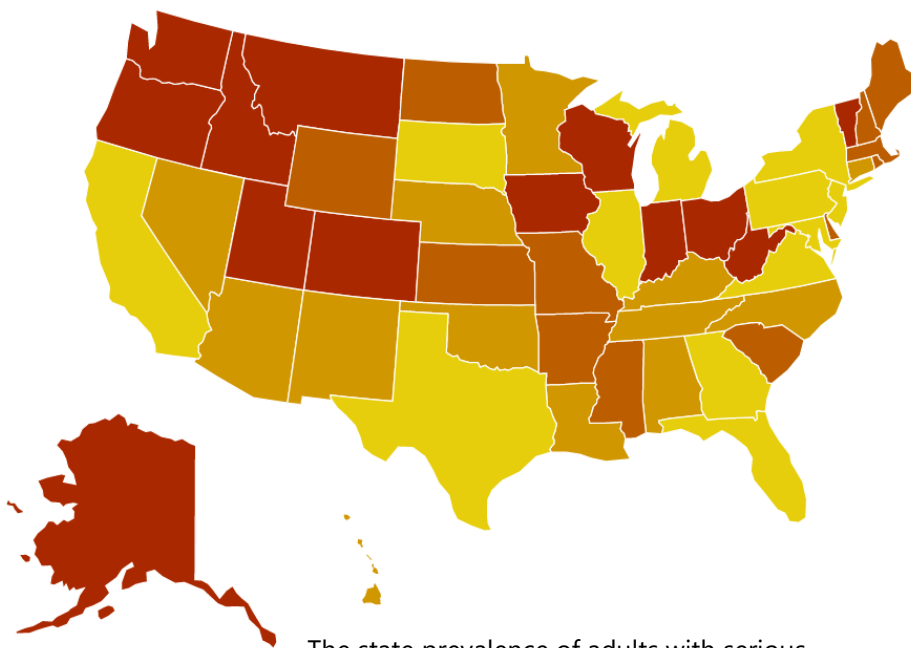
States in the southeast had the lowest rates of substance use disorder among adults (less than 8 percent), with the exception of Louisiana.

The largest increases in prevalence of adults with substance use disorder were in Colorado (2.83%) and the District of Columbia (1.46%). The largest decreases were in Maryland (1.00%) and Wyoming (0.80%)

Rank	State	%	#
1	Texas	6.34	1,308,000
2	Utah	6.42	140,000
3	Florida	6.68	1,109,000
4	West Virginia	6.76	96,000
5	Georgia	6.77	526,000
6	Mississippi	6.77	150,000
7	Maryland	6.89	317,000
8	North Carolina	6.95	544,000
9	Tennessee	6.95	357,000
10	New Jersey	7.01	483,000
11	Hawaii	7.13	76,000
12	Minnesota	7.24	307,000
13	Wyoming	7.25	31,000
14	Kansas	7.27	156,000
15	Pennsylvania	7.30	727,000
16	Virginia	7.32	470,000
17	Arizona	7.36	394,000
18	Indiana	7.39	371,000
19	Kentucky	7.46	251,000
20	Alabama	7.46	277,000
21	Michigan	7.47	576,000
22	New Mexico	7.53	118,000
23	New York	7.57	1,162,000
24	Missouri	7.57	351,000
25	South Carolina	7.60	293,000
26	Ohio	7.64	680,000

Rank	State	%	#
27	Idaho	7.76	99,000
28	Nebraska	8.01	114,000
29	Arkansas	8.02	181,000
30	California	8.12	2,437,000
31	Illinois	8.16	793,000
32	Washington	8.53	487,000
33	Oklahoma	8.54	248,000
34	Wisconsin	8.68	387,000
35	Louisiana	8.69	301,000
36	Delaware	8.76	65,000
37	North Dakota	8.79	50,000
38	Rhode Island	8.80	74,000
39	Connecticut	8.82	246,000
40	Nevada	9.00	206,000
41	New Hampshire	9.09	98,000
42	Iowa	9.13	217,000
43	South Dakota	9.17	59,000
44	Maine	9.27	99,000
45	Massachusetts	9.34	508,000
46	Montana	9.41	76,000
47	Alaska	9.76	51,000
48	Oregon	9.94	323,000
49	Vermont	10.51	53,000
50	Colorado	11.90	511,000
51	District of Columbia	13.01	73,000
	National	7.67	19,026,000

Adults with Serious Thoughts of Suicide



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

3.47% (NJ) 6.47% (UT)
Ranked 1-13 Ranked 39-51



The percentage of adults reporting serious thoughts of suicide is 4.34 percent. The estimated number of adults with serious suicidal thoughts is over 10.7 million—**an increase of over 460,000 people from last year's data set.**

The rate of adults experiencing suicidal ideation increased by 0.15% from 2016-2017 to 2017-2018.

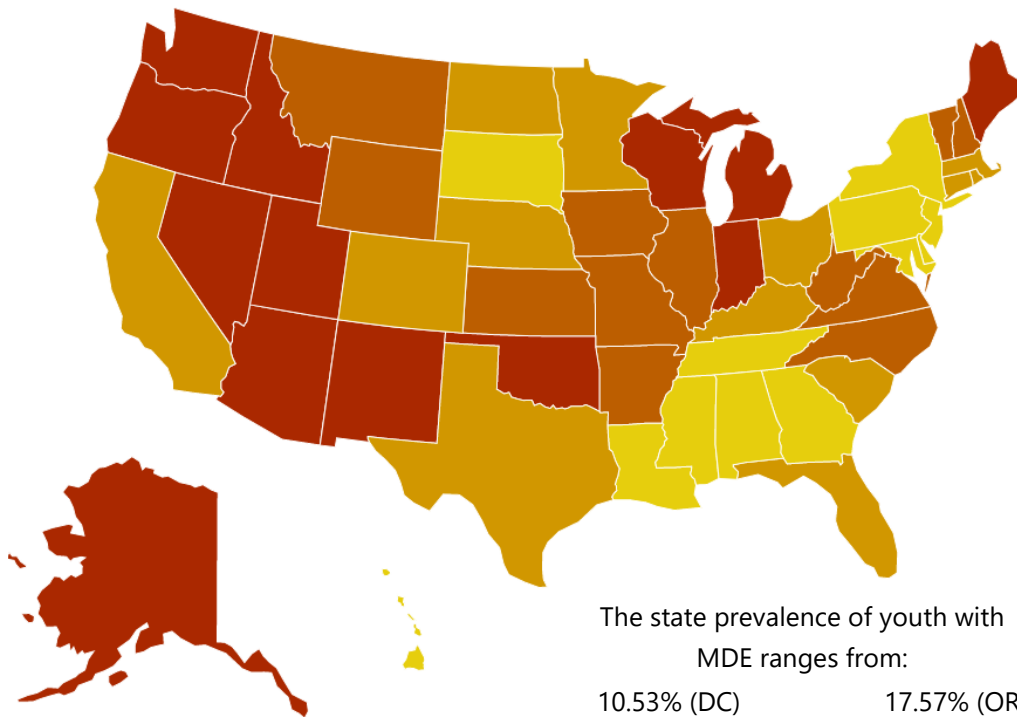
States with the highest increases in suicidal ideation were Delaware (0.90%), Maine (0.82%) and Mississippi (0.81%). Utah has had the highest rate of suicidal ideation among adults every year since 2012-2013.

Rank	State	%	#
1	New Jersey	3.47	239,000
2	New York	3.63	558,000
3	Texas	3.66	756,000
4	Florida	3.67	610,000
5	Illinois	3.87	376,000
6	Georgia	4.03	314,000
7	Maryland	4.07	188,000
8	California	4.10	1,232,000
9	Michigan	4.13	319,000
10	Virginia	4.16	267,000
11	District of Columbia	4.17	23,000
12	Pennsylvania	4.17	416,000
13	South Dakota	4.21	27,000
14	New Mexico	4.25	67,000
15	Nebraska	4.29	61,000
16	Arizona	4.43	237,000
17	Alabama	4.45	165,000
18	Tennessee	4.48	230,000
19	Connecticut	4.48	125,000
20	Oklahoma	4.53	132,000
21	North Carolina	4.57	358,000
22	Louisiana	4.57	159,000
23	Minnesota	4.59	195,000
24	Hawaii	4.59	49,000
25	Kentucky	4.65	157,000
26	Nevada	4.65	107,000

Rank	State	%	#
27	Rhode Island	4.66	39,000
28	Arkansas	4.71	106,000
29	Missouri	4.72	219,000
30	Maine	4.81	52,000
31	Mississippi	4.82	107,000
32	Kansas	4.82	103,000
33	South Carolina	4.90	189,000
34	New Hampshire	4.91	53,000
35	Massachusetts	4.92	268,000
36	Wyoming	5.04	22,000
37	Delaware	5.06	38,000
38	North Dakota	5.11	29,000
39	Wisconsin	5.17	231,000
40	Ohio	5.18	461,000
41	Montana	5.21	42,000
42	Vermont	5.22	26,000
43	Indiana	5.23	262,000
44	West Virginia	5.26	75,000
45	Washington	5.30	303,000
46	Oregon	5.36	175,000
47	Iowa	5.40	129,000
48	Idaho	5.45	69,000
49	Colorado	5.51	237,000
50	Alaska	5.85	31,000
51	Utah	6.47	141,000
	National	4.34	10,770,000

Youth Prevalence of Mental Illness

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



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

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

The number of youths experiencing MDE increased by 206,000 from last year's dataset.

The state prevalence of youth with MDE ranges from:

10.53% (DC) 17.57% (OR)
Ranked 1-13 Ranked 39-51

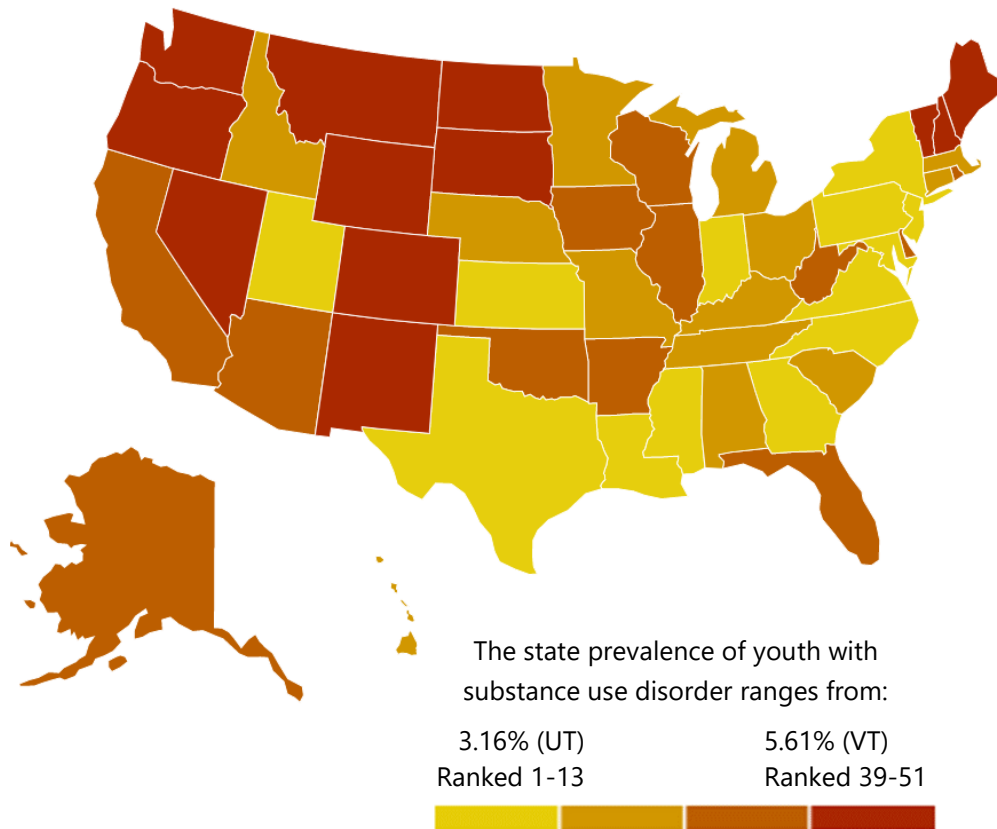


Rank	State	%	#
1	District of Columbia	10.53	3,000
2	New York	11.40	157,000
3	Pennsylvania	11.88	109,000
4	New Jersey	11.95	82,000
5	Mississippi	12.15	29,000
6	Tennessee	12.27	63,000
7	Georgia	12.52	108,000
8	South Dakota	12.53	9,000
9	Louisiana	12.84	46,000
10	Hawaii	12.93	12,000
11	Maryland	13.02	59,000
12	Delaware	13.05	9,000
13	Alabama	13.13	49,000
14	Florida	13.17	189,000
15	Texas	13.20	325,000
16	Rhode Island	13.40	10,000
17	South Carolina	13.56	51,000
18	Kentucky	13.61	46,000
19	California	13.71	415,000
20	Ohio	13.73	123,000
21	North Dakota	13.75	7,000
22	Massachusetts	13.86	67,000
23	Colorado	13.99	60,000
24	Minnesota	14.04	61,000
25	Nebraska	14.20	22,000
26	Connecticut	14.24	39,000

Rank	State	%	#
27	Virginia	14.28	90,000
28	Montana	14.40	11,000
29	Vermont	14.65	6,000
30	West Virginia	14.66	18,000
31	Arkansas	14.74	35,000
32	Missouri	14.78	69,000
33	Illinois	14.86	148,000
34	Wyoming	14.91	7,000
35	Kansas	14.95	35,000
36	North Carolina	15.05	119,000
37	New Hampshire	15.08	14,000
38	Iowa	15.09	37,000
39	Nevada	15.11	35,000
40	Alaska	15.21	9,000
41	Wisconsin	15.31	68,000
42	Michigan	15.36	117,000
43	Maine	15.45	14,000
44	Washington	15.66	85,000
45	Indiana	15.71	84,000
46	Arizona	15.93	89,000
47	Oklahoma	16.48	52,000
48	Utah	16.64	51,000
49	Idaho	16.70	26,000
50	New Mexico	17.43	29,000
51	Oregon	17.57	52,000
	National	13.84	3,449,000

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

Youth with Substance Use Disorder in the Past Year



3.83 percent of youth in the U.S. reported a substance use disorder in the past year.

1.69 percent had an alcohol use disorder in the past year, while 2.85 percent had an illicit drug use disorder.

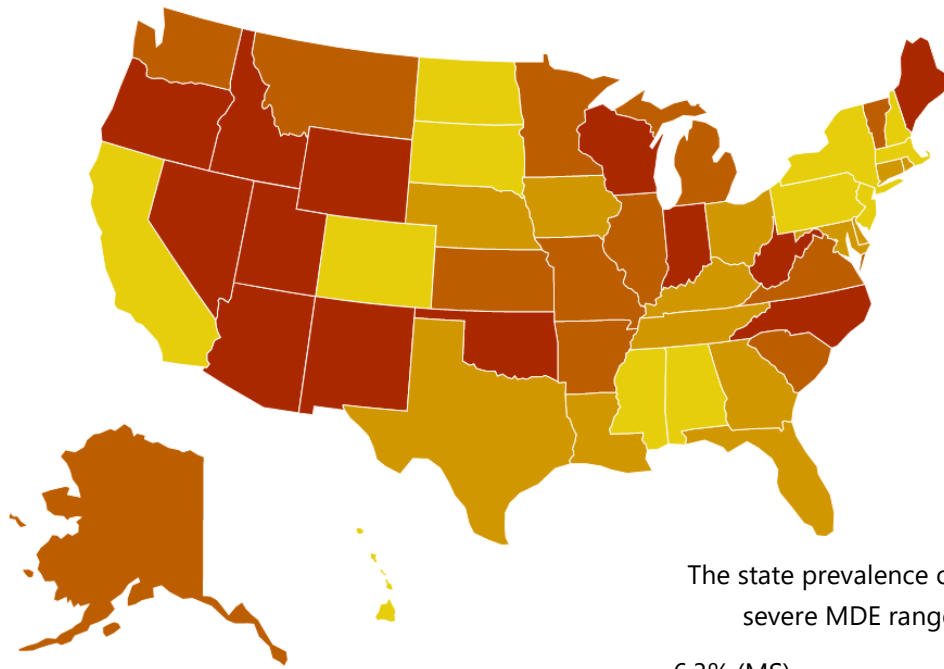
The rate of youth with substance use disorder decreased 0.3 percent from last year's dataset. The largest decreases were in Alaska (2.17%), New Mexico (1.21%) and Montana (1.12%).

The largest increases were in the District of Columbia (0.28%) and Pennsylvania (0.23%).

Rank	State	%	#
1	Utah	3.16	10,000
2	Georgia	3.20	28,000
3	Texas	3.24	80,000
4	Maryland	3.26	15,000
5	Mississippi	3.30	8,000
6	Indiana	3.37	18,000
7	New York	3.41	47,000
8	New Jersey	3.42	23,000
9	Pennsylvania	3.42	31,000
10	Virginia	3.56	22,000
11	North Carolina	3.57	28,000
12	Louisiana	3.58	13,000
13	Kansas	3.63	9,000
14	Alabama	3.63	14,000
15	Michigan	3.64	28,000
16	Missouri	3.69	17,000
17	Nebraska	3.69	6,000
18	Kentucky	3.77	13,000
19	Minnesota	3.86	17,000
20	Connecticut	3.86	11,000
21	Tennessee	3.91	20,000
22	Massachusetts	3.92	19,000
23	South Carolina	3.95	15,000
24	Idaho	3.97	6,000
25	Ohio	3.97	36,000
26	Hawaii	4.04	4,000

Rank	State	%	#
27	California	4.04	122,000
28	Illinois	4.04	40,000
29	Rhode Island	4.05	3,000
30	Wisconsin	4.07	18,000
31	Arizona	4.08	23,000
32	West Virginia	4.08	5,000
33	Arkansas	4.11	10,000
34	Delaware	4.15	3,000
35	Oklahoma	4.19	13,000
36	Iowa	4.21	10,000
37	Florida	4.34	62,000
38	Alaska	4.37	3,000
39	North Dakota	4.38	2,000
40	New Hampshire	4.41	4,000
41	Maine	4.59	4,000
42	Wyoming	4.63	2,000
43	Oregon	4.65	14,000
44	South Dakota	4.78	3,000
45	New Mexico	4.80	8,000
46	Washington	5.01	27,000
47	Nevada	5.09	12,000
48	Colorado	5.12	22,000
49	Montana	5.18	4,000
50	District of Columbia	5.42	2,000
51	Vermont	5.61	2,000
	National	3.83	954,000

Youth with Severe Major Depressive Episode



9.7 percent of youth (over 2.3 million youth) cope with severe major depression.

The number of youths experiencing Severe MDE increased by 126,000 from last year's dataset.

Rates of severe major depressive episode were highest among youth who identified as more than one race, at 12.4 percent (about 98,000 youth).

The state prevalence of youth with severe MDE ranges from:



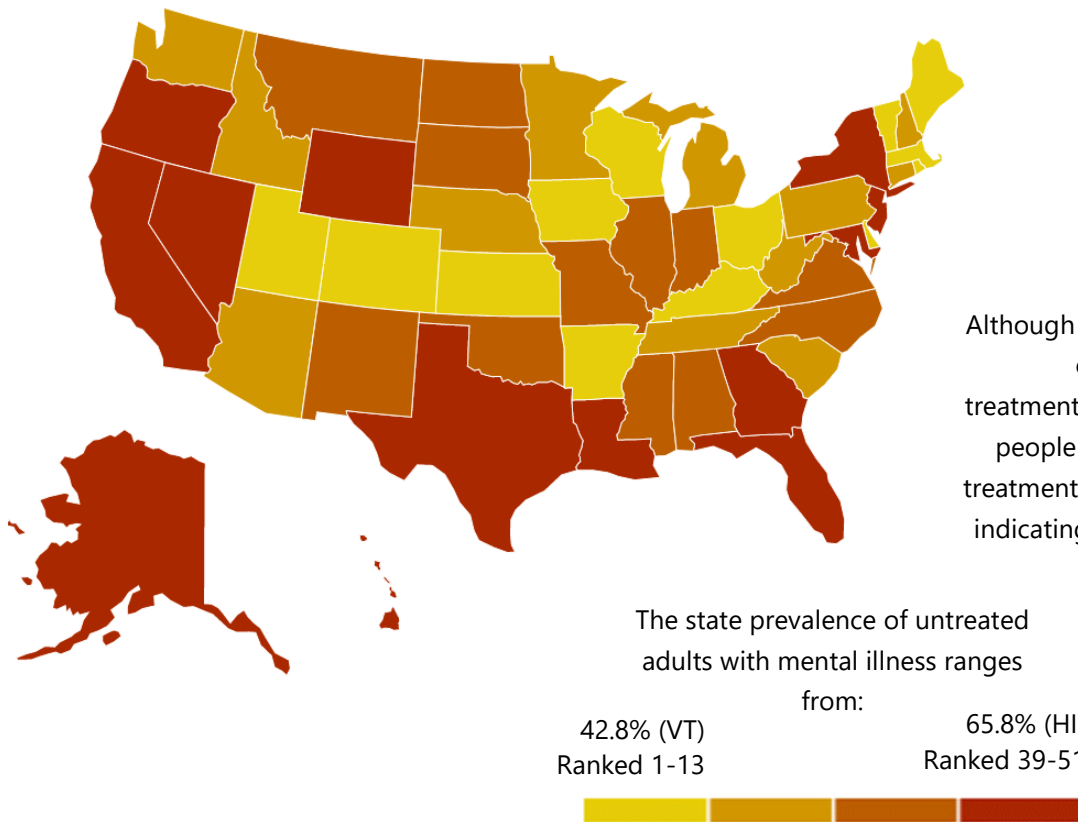
Rank	State	%	#
1	Mississippi	6.3	15,000
2	Alabama	6.4	23,000
3	District of Columbia	6.8	2,000
4	Pennsylvania	7.1	64,000
5	New York	7.8	105,000
6	South Dakota	8.0	5,000
7	New Jersey	8.1	54,000
8	Hawaii	8.5	8,000
9	North Dakota	8.5	4,000
10	Massachusetts	8.5	40,000
11	California	8.7	256,000
12	Colorado	8.7	36,000
13	New Hampshire	8.7	8,000
14	Connecticut	9.0	24,000
15	Nebraska	9.0	14,000
16	Ohio	9.1	79,000
17	Texas	9.2	219,000
18	Louisiana	9.2	33,000
19	Tennessee	9.2	46,000
20	Florida	9.3	128,000
21	Georgia	9.3	78,000
22	Delaware	9.3	6,000
23	Rhode Island	9.5	7,000
24	Kentucky	9.6	31,000
25	Iowa	9.8	23,000
26	Maryland	9.8	42,000

Rank	State	%	#
27	Minnesota	9.8	41,000
28	South Carolina	9.8	36,000
29	Kansas	9.9	23,000
30	Virginia	10.2	62,000
31	Washington	10.3	53,000
32	Montana	10.4	8,000
33	Missouri	10.4	47,000
34	Alaska	10.7	6,000
35	Vermont	10.7	4,000
36	Arkansas	10.7	25,000
37	Illinois	11.0	104,000
38	Michigan	11.3	84,000
39	Nevada	11.8	26,000
40	Utah	11.9	36,000
41	Wyoming	12.0	5,000
42	West Virginia	12.5	15,000
43	Arizona	12.5	66,000
44	North Carolina	12.6	98,000
45	Idaho	12.7	19,000
46	Indiana	12.7	66,000
47	Oklahoma	12.7	39,000
48	Oregon	13.1	37,000
49	New Mexico	13.1	21,000
50	Wisconsin	13.4	58,000
51	Maine	13.5	12,000
	National	9.7	2,343,000

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

Adult Access to Care

Adults with AMI who Did Not Receive Treatment



57 percent of adults with a mental illness receive no treatment.

Over 26 million individuals experiencing a mental illness are going untreated.

Although adults who did not have insurance coverage were less likely to receive treatment than those who did, 86 percent of people who did not receive mental health treatment were covered by health insurance, indicating that ensuring coverage is not the same as ensuring access to care.

Rank	State	%	#
1	Vermont	42.8	45,000
2	Arkansas	47.5	221,000
3	Rhode Island	49.0	89,000
4	Wisconsin	49.2	412,000
5	Massachusetts	49.5	597,000
6	Delaware	49.7	75,000
7	Iowa	49.8	231,000
8	Maine	49.9	114,000
9	Ohio	50.7	978,000
10	Kentucky	50.9	392,000
11	Colorado	50.9	475,000
12	Kansas	51.1	213,000
13	Utah	51.2	294,000
14	South Carolina	51.4	349,000
15	Tennessee	51.7	463,000
16	New Hampshire	51.9	116,000
17	West Virginia	52.2	193,000
18	District of Columbia	52.2	68,000
19	Minnesota	52.6	416,000
20	Arizona	52.7	535,000
21	Pennsylvania	53.0	953,000
22	Nebraska	53.0	128,000
23	Washington	53.5	704,000
24	Idaho	53.5	177,000
25	Michigan	53.8	779,000
26	Connecticut	53.9	287,000

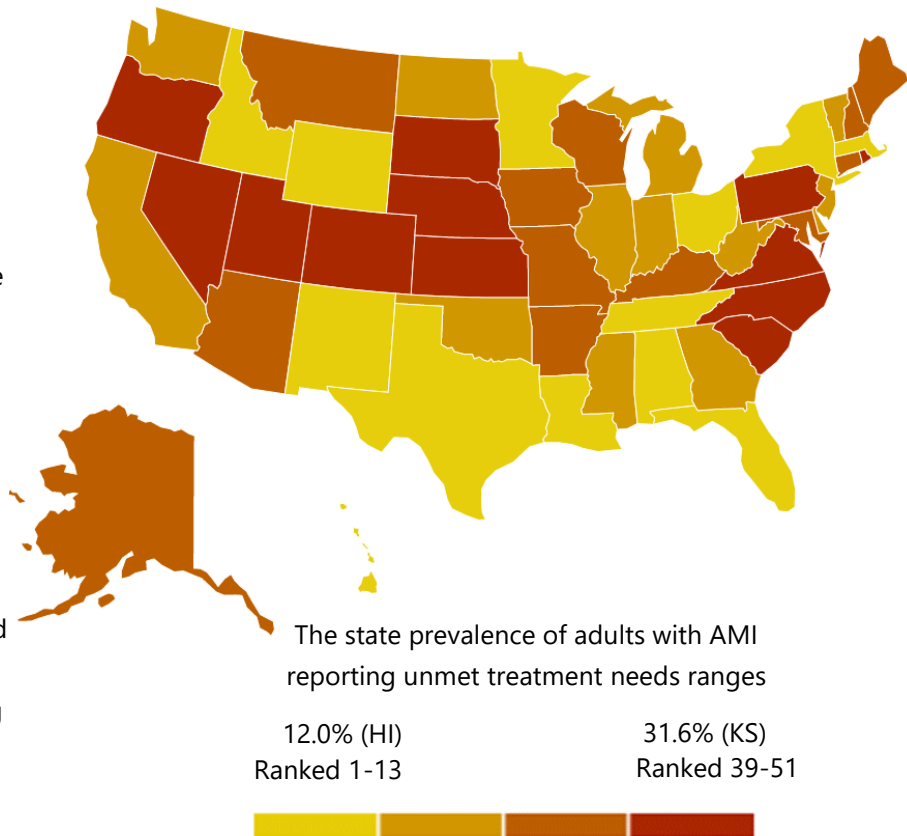
Rank	State	%	#
27	Montana	54.2	89,000
28	Virginia	54.5	589,000
29	North Dakota	54.5	56,000
30	South Dakota	54.8	57,000
31	Missouri	55.3	576,000
32	Illinois	55.8	946,000
33	Indiana	55.9	653,000
34	North Carolina	56.5	833,000
35	New Mexico	56.6	167,000
36	Alabama	56.7	463,000
37	Mississippi	57.7	247,000
38	Oklahoma	58.9	340,000
39	Maryland	59.1	459,000
40	Oregon	59.3	442,000
41	Texas	59.6	1,960,000
42	New Jersey	60.0	644,000
43	New York	60.3	1,655,000
44	Nevada	60.3	282,000
45	Louisiana	62.0	459,000
46	Florida	63.0	1,816,000
47	Wyoming	64.8	60,000
48	Georgia	64.9	888,000
49	California	65.0	3,620,000
50	Alaska	65.5	70,000
51	Hawaii	65.8	124,000
	National	57.0	26,797,000

Adults with AMI Reporting Unmet Need

Almost a quarter (23.6 percent) of all adults with a mental illness reported that they were not able to receive the treatment they needed. **This number has not declined since 2011.**

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

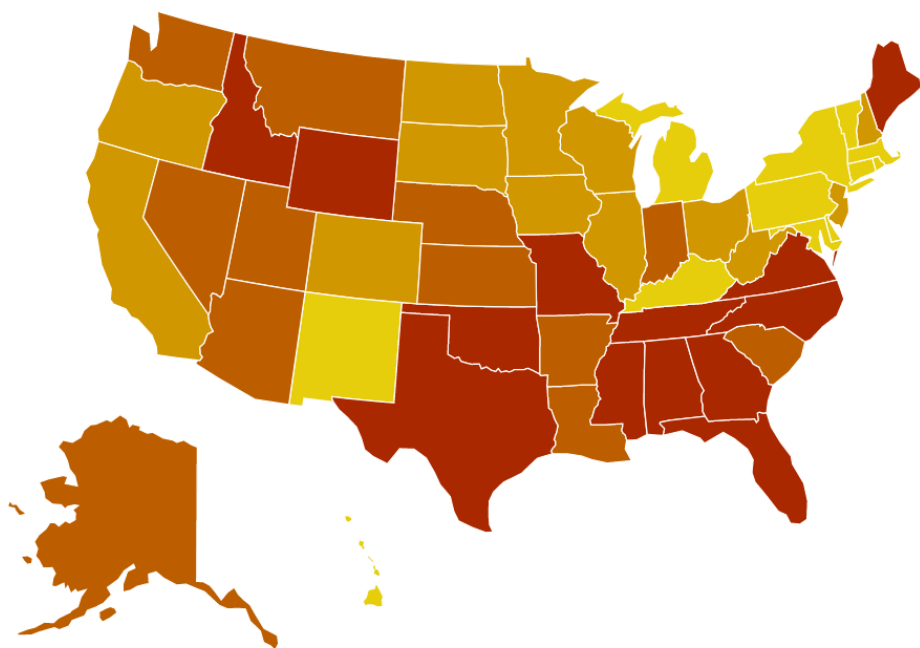
- 1) No insurance or limited coverage of services.
- 2) Shortfall in psychiatrists, and an overall undersized mental health workforce.
- 3) Lack of available treatment types (inpatient treatment, individual therapy, intensive community services).
- 4) Disconnect between primary care systems and behavioral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



Rank	State	%	#
1	Hawaii	12.0	23,000
2	Alabama	18.7	153,000
3	Texas	19.9	655,000
4	Wyoming	19.9	18,000
5	Minnesota	20.7	163,000
6	New Mexico	20.8	61,000
7	Tennessee	20.9	188,000
8	Louisiana	21.0	155,000
9	New York	21.4	585,000
10	Massachusetts	21.6	263,000
11	Florida	21.9	633,000
12	Ohio	22.1	427,000
13	Idaho	22.1	73,000
14	Vermont	22.5	24,000
15	California	22.8	1,272,000
16	Illinois	22.9	388,000
17	West Virginia	22.9	84,000
18	Delaware	23.0	35,000
19	Georgia	23.1	317,000
20	North Dakota	23.3	24,000
21	Oklahoma	23.5	136,000
22	Washington	23.7	310,000
23	Mississippi	23.8	102,000
24	Indiana	23.9	281,000
25	Michigan	24.4	353,000
26	New Jersey	24.4	262,000

Rank	State	%	#
27	Alaska	24.4	26,000
28	Kentucky	24.5	189,000
29	Montana	24.6	41,000
30	Maine	24.8	57,000
31	New Hampshire	24.8	55,000
32	Wisconsin	24.9	209,000
33	Maryland	25.2	196,000
34	Connecticut	25.4	135,000
35	Iowa	25.5	117,000
36	Arizona	25.8	259,000
37	Arkansas	26.0	122,000
38	Missouri	26.1	272,000
39	Nevada	26.1	122,000
40	Nebraska	26.2	63,000
41	South Dakota	26.4	28,000
42	North Carolina	26.5	391,000
43	South Carolina	26.6	181,000
44	Pennsylvania	26.8	480,000
45	Rhode Island	27.9	50,000
46	Colorado	28.2	263,000
47	Virginia	28.6	309,000
48	District of Columbia	29.4	38,000
49	Utah	30.1	172,000
50	Oregon	30.2	225,000
51	Kansas	31.6	132,000
	National	23.6	11,119,000

Adults with AMI who are Uninsured



The state prevalence of uninsured adults
with mental illness ranges from:
2.5% (DC) 23.0% (WY)
Ranked 1-13 Ranked 39-51



10.8 percent (over 5.1 million) of adults with a mental illness are uninsured.

The rankings for this indicator used data from the 2017-2018 NSDUH. In December 2017, the Congress passed the Tax Cuts and Jobs Act, which eliminated the individual mandate penalty from the ACA.

There was a 0.5 percent **increase** from last year's dataset, the first time this indicator has increased since the passage of the Affordable Care Act (ACA).

The increase in this indicator is consistent with data from the U.S. Census Bureau, which found that in 2018, the rate of uninsured Americans rose for the first time since the ACA took effect.¹

Only twenty states saw a reduction in Adults with AMI who are uninsured in this year's dataset. The largest reductions were seen in Louisiana (5.0 percent), South Dakota (3.3 percent), Kentucky (2.4 percent) and Kansas (2.2 percent).

The largest increases were seen in Iowa (5.1 percent), Mississippi (3.9 percent), Arkansas (3.7) and Missouri (3.2 percent).

Rank	State	Rate	#
1	District of Columbia	2.5	3,000
2	Vermont	3.9	4,000
3	Massachusetts	4.2	51,000
4	Connecticut	4.6	25,000
5	Kentucky	4.8	37,000
6	New York	5.1	139,000
7	Rhode Island	5.8	11,000
8	Pennsylvania	6.0	108,000
9	Michigan	6.4	93,000
10	New Mexico	6.4	19,000
11	Hawaii	6.4	12,000
12	Delaware	6.8	10,000
13	Maryland	7.0	55,000
14	Ohio	7.1	138,000
15	Minnesota	7.3	58,000
16	Wisconsin	7.4	62,000
17	New Hampshire	7.5	17,000
18	California	7.8	434,000
19	South Dakota	8.2	9,000
20	West Virginia	8.3	31,000
21	Iowa	8.4	39,000
22	New Jersey	8.8	94,000
23	North Dakota	8.8	9,000
24	Illinois	8.9	151,000
25	Colorado	9.0	84,000
26	Oregon	9.0	67,000
27	Arizona	9.6	97,000
28	Louisiana	9.7	72,000
29	Nebraska	10.3	25,000
30	Montana	10.3	17,000
31	Nevada	10.5	51,000
32	Washington	10.6	140,000
33	Arkansas	10.9	51,000
34	Indiana	11.4	134,000
35	Alaska	11.6	12,000
36	Utah	11.7	67,000
37	Kansas	12.4	52,000
38	South Carolina	12.5	85,000
39	Maine	12.7	29,000
40	Virginia	13.5	147,000
41	Idaho	13.7	46,000
42	North Carolina	13.8	204,000
43	Oklahoma	15.9	92,000
44	Missouri	16.2	169,000
45	Florida	17.4	503,000
46	Georgia	18.5	255,000
47	Alabama	18.8	154,000
48	Tennessee	19.0	171,000
49	Texas	20.1	664,000
50	Mississippi	22.2	95,000
51	Wyoming	23.0	21,000
	National	10.8	5,114,000

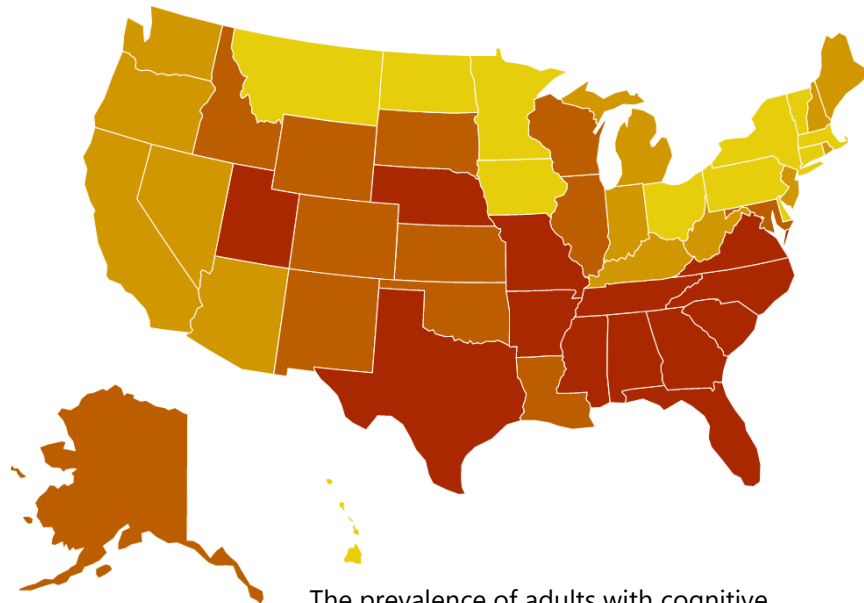
Adults with Cognitive Disability who Could Not See a Doctor Due to Costs

28.69 percent of adults with a cognitive disability were not able to see a doctor due to costs.

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

According to the Centers for Disease Control (CDC), 11.5 percent of people in the United States had a cognitive disability in 2018, even when adjusted for age. The percentage of people with cognitive disability ranged from 7.9 percent in some states to 17.9 percent.

A 2017 study found that compared to working-age adults without disabilities, those with disabilities are more likely to live below the federal poverty level and to use public insurance. Their average health costs were also 3-7 times higher than those without disabilities.²



The prevalence of adults with cognitive disability who could not see a MD due to cost ranges from:

17.10% (DC)

41.92% (GA)

Ranked 1-13

Ranked 39-51



Rank	State	%	#
1	District of Columbia	17.10	8,373
2	Iowa	17.54	37,774
3	Hawaii	17.63	16,639
4	Massachusetts	18.56	109,857
5	Vermont	19.02	9,542
6	New York	20.97	314,383
7	Delaware	20.98	18,284
8	Ohio	21.02	236,528
9	Connecticut	21.61	53,913
10	Pennsylvania	22.48	277,857
11	Montana	22.85	20,088
12	North Dakota	23.74	12,428
13	Minnesota	24.20	91,135
14	Maine	24.37	33,492
15	Washington	24.84	141,746
16	Michigan	25.18	252,279
17	New Jersey	25.19	177,138
18	Nevada	25.27	76,372
19	Rhode Island	25.71	26,383
20	Kentucky	25.85	137,755
21	West Virginia	25.99	65,433
22	Oregon	26.03	108,294
23	New Hampshire	26.91	28,858
24	California	27.05	796,447
25	Indiana	27.10	157,334
26	Arizona	27.17	153,262

Rank	State	%	#
27	Wyoming	27.44	12,362
28	Colorado	27.45	88,135
29	Maryland	27.45	111,740
30	Louisiana	28.08	160,506
31	Oklahoma	28.18	115,914
32	Wisconsin	28.20	119,187
33	New Mexico	28.23	54,533
34	South Dakota	28.36	17,869
35	Illinois	29.66	249,140
36	Kansas	30.27	70,938
37	Alaska	30.90	17,348
38	Idaho	31.04	43,794
39	Nebraska	31.66	39,724
40	Tennessee	31.86	245,411
41	Utah	31.92	75,977
42	Missouri	32.87	190,827
43	South Carolina	33.75	179,775
44	Arkansas	34.16	111,986
45	Virginia	34.24	223,528
46	Texas	34.57	690,102
47	Mississippi	35.20	130,909
48	North Carolina	35.23	343,530
49	Florida	35.36	754,413
50	Alabama	36.70	212,868
51	Georgia	41.92	410,646
	National	28.69	8,153,779

Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Division of Human Development and Disability. Disability and Health Data System (DHDS) Data [online]. (2018). Available at <https://dhds.cdc.gov>

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

Youth Access to Care

Youth with MDE who Did Not Receive Mental Health Services

59.6 percent of youth with major depression do not receive any mental health treatment.

Youth experiencing MDE continue to go untreated. Even among the states with greatest access for youth, over 1 in 3 youth are still not receiving the mental health services they need.

The state prevalence of untreated youth with depression ranges from:

38.6% (ME)

Ranked 1-13

71.0% (NV)

Ranked 39-51



Rank	State	%	#
1	Maine	38.6	6,000
2	District of Columbia	38.8	1,000
3	Vermont	40.7	2,000
4	Maryland	41.3	23,000
5	Utah	45.2	22,000
6	Washington	47.0	38,000
7	Wisconsin	47.2	33,000
8	Delaware	47.9	4,000
9	Kentucky	49.3	19,000
10	South Dakota	49.7	3,000
11	Ohio	52.2	59,000
12	Virginia	53.0	51,000
13	Indiana	53.0	48,000
14	Iowa	53.0	20,000
15	North Dakota	53.4	3,000
16	Rhode Island	53.4	5,000
17	Oregon	53.9	30,000
18	Kansas	54.7	19,000
19	Louisiana	54.9	24,000
20	Minnesota	55.4	32,000
21	Nebraska	55.4	12,000
22	Montana	55.6	5,000
23	Michigan	55.7	66,000
24	New Jersey	55.7	40,000
25	Hawaii	56.2	5,000
26	Wyoming	56.6	4,000

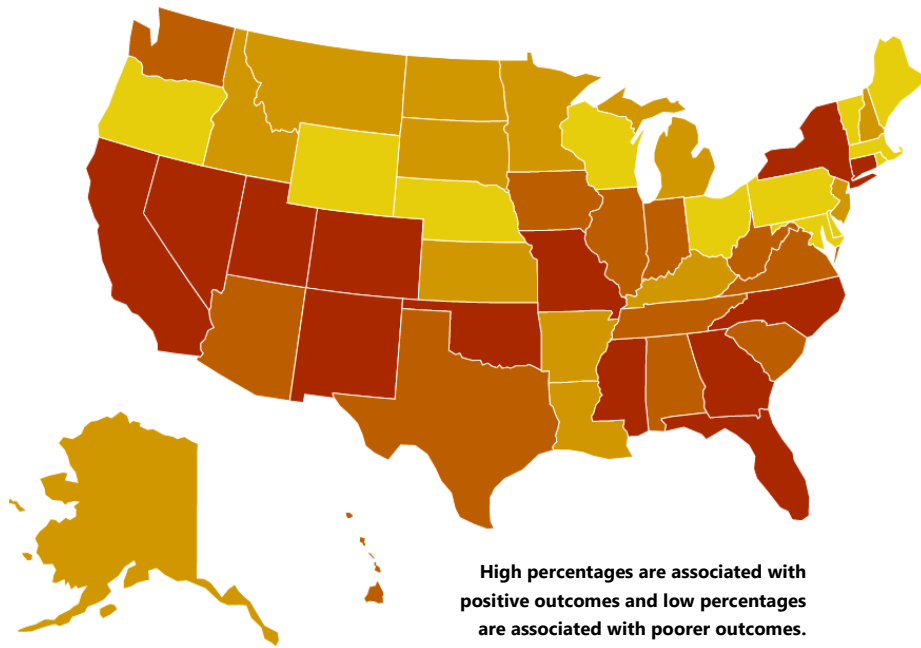
Rank	State	%	#
27	New Hampshire	56.9	9,000
28	Pennsylvania	57.5	56,000
29	Alaska	57.8	5,000
30	Missouri	58.8	40,000
31	New York	59.1	85,000
32	Connecticut	59.1	24,000
33	West Virginia	59.3	11,000
34	Arizona	59.6	52,000
35	North Carolina	60.2	77,000
36	Colorado	60.9	29,000
37	Oklahoma	61.1	35,000
38	Idaho	61.2	15,000
39	Massachusetts	61.2	41,000
40	Tennessee	61.5	35,000
41	Illinois	62.1	90,000
42	New Mexico	62.9	20,000
43	Arkansas	63.9	23,000
44	Florida	64.7	116,000
45	California	66.0	259,000
46	Mississippi	66.3	18,000
47	Texas	67.1	209,000
48	South Carolina	68.0	36,000
49	Alabama	69.7	31,000
50	Georgia	70.4	73,000
51	Nevada	71.0	23,000
	National	59.6	1,988,000

Youth with Severe MDE who Received Some Consistent Treatment

Nationally, only 27.3 percent of youth with severe depression receive some consistent treatment (7-25+ visits in a year).

Consistent treatment is determined if a youth visits a specialty outpatient mental health service, including a day treatment facility, mental health clinic, private therapist or in-home therapist, more than 7 times in the previous year. It does not consider the quality of the care – for example, whether the mental health service was specialized toward youth, what the outcomes of treatment were, or whether the child was offered a continuum of supports.

Even with simply measuring the number of visits, less than 1 in 3 youth with severe depression meet this determination of consistent care.



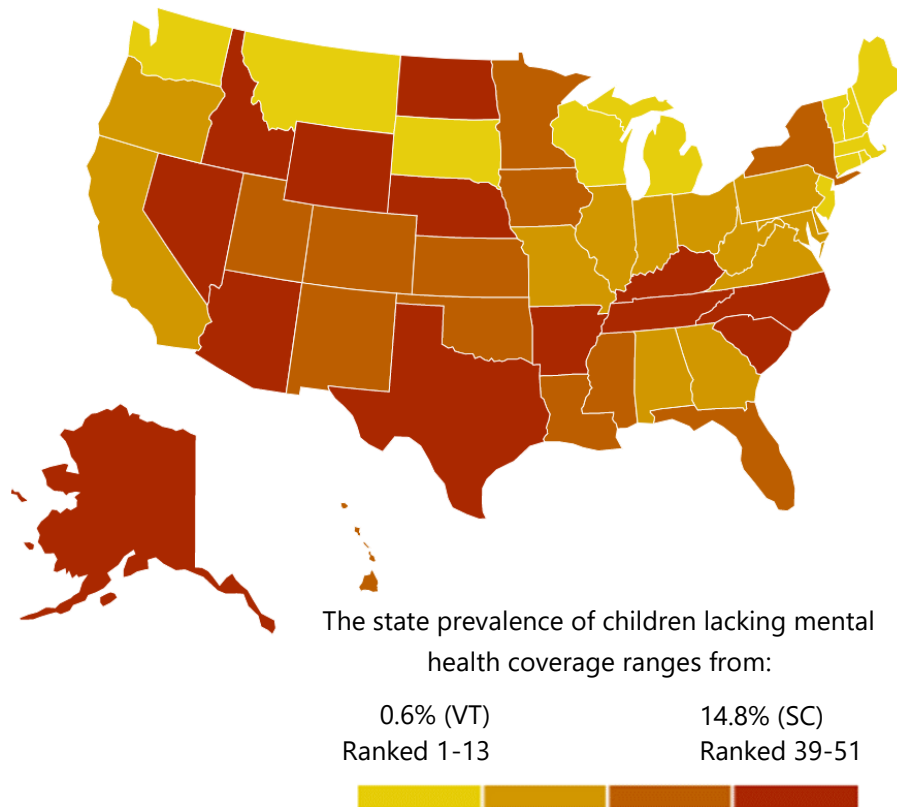
The state prevalence of youth with severe depression who received some outpatient treatment ranges from:



Rank	State	%	#
1	Maine	50.0	5,000
2	Maryland	49.2	21,000
3	Vermont	45.4	2,000
4	Delaware	41.5	2,000
5	Rhode Island	41.2	3,000
6	Wisconsin	40.4	23,000
7	Oregon	37.9	14,000
8	Massachusetts	37.7	15,000
9	District of Columbia	37.3	1,000
10	Pennsylvania	37.1	23,000
11	Wyoming	36.3	2,000
12	Ohio	36.0	28,000
13	Nebraska	35.9	5,000
14	Idaho	35.8	6,000
15	New Hampshire	34.9	3,000
16	Kentucky	34.2	10,000
17	Minnesota	33.7	13,000
18	North Dakota	33.0	1,000
19	New Jersey	32.5	16,000
20	Louisiana	32.0	9,000
21	Kansas	31.1	7,000
22	Arkansas	30.0	7,000
23	Alaska	29.9	2,000
24	Michigan	29.8	24,000
25	Montana	29.3	2,000
26	South Dakota	29.2	1,000

Rank	State	%	#
27	Iowa	28.8	7,000
28	South Carolina	28.3	9,000
29	Hawaii	28.3	2,000
30	West Virginia	27.8	4,000
31	Tennessee	27.3	12,000
32	Washington	26.7	13,000
33	Indiana	26.1	16,000
34	Virginia	26.1	16,000
35	Alabama	25.9	6,000
36	Texas	25.0	54,000
37	Illinois	25.0	26,000
38	Arizona	24.7	15,000
39	California	24.6	59,000
40	Utah	24.5	8,000
41	Oklahoma	23.5	8,000
42	New Mexico	22.6	5,000
43	New York	21.9	22,000
44	North Carolina	21.9	21,000
45	Connecticut	21.6	5,000
46	Colorado	21.5	8,000
47	Florida	19.7	24,000
48	Georgia	19.2	15,000
49	Missouri	19.0	9,000
50	Mississippi	14.9	2,000
51	Nevada	11.2	3,000
	National	27.3	614,000

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



The Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted in 2008 and promised the equal coverage of mental health and substance use services. The rate of children with private insurance that does not cover mental or emotional problems decreased 0.3 percent from last year's dataset. However, there are still 901,000 youth without coverage for their behavioral health.

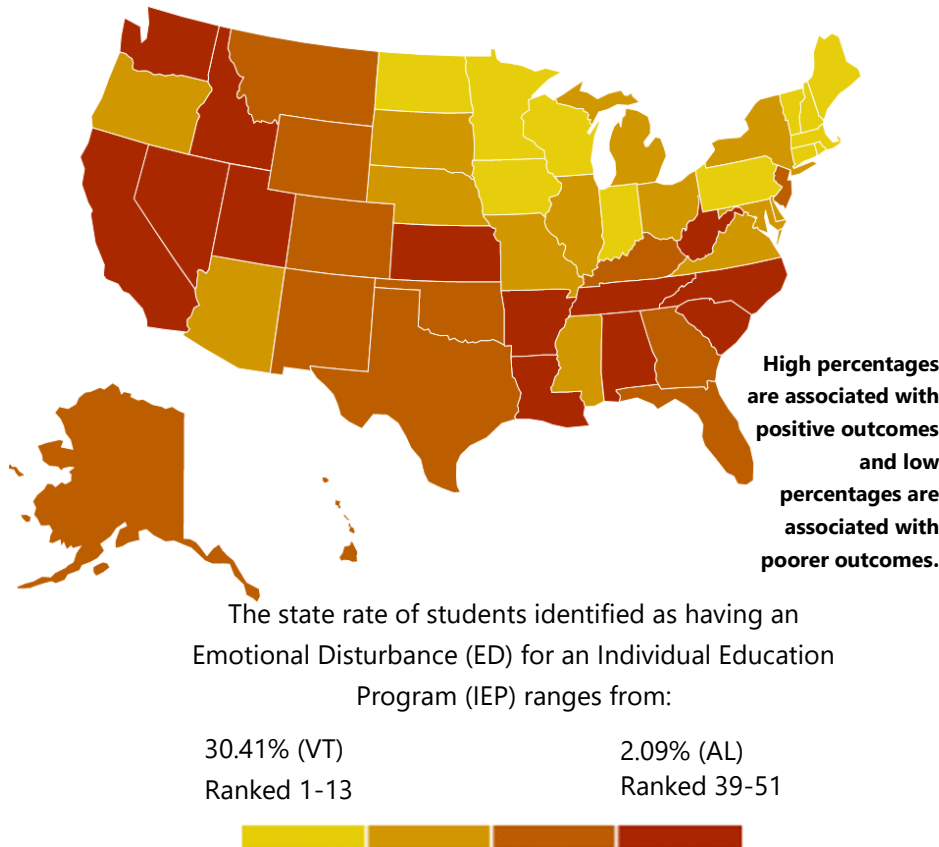
In 2019, a Milliman research report¹ found large disparities between behavioral health and medical/surgical services, including that patients saw out-of-network behavioral health providers at much higher rates than physical health providers. It also found that these disparities were worse for children. In 2017, a behavioral health visit for a child was over 10 times more likely to be out-of-network than a primary care office visit. This was over two times the disparity shown for adults.

To improve the worsening mental health of children and adolescents in the U.S., insurance companies must not only achieve parity in coverage of services, but also in network adequacy, so people are able to access those services when they need them.

Rank	State	%	#
1	Vermont	0.6	0
2	Massachusetts	1.2	4,000
3	New Hampshire	2.5	1,000
4	Connecticut	3.3	5,000
5	Maine	3.4	2,000
6	New Jersey	4.0	14,000
7	District of Columbia	4.6	1,000
8	Washington	5.2	16,000
9	Rhode Island	5.3	2,000
10	Montana	5.4	2,000
11	South Dakota	5.4	2,000
12	Michigan	5.5	23,000
13	Wisconsin	5.5	16,000
14	Ohio	5.9	26,000
15	Missouri	5.9	14,000
16	Alabama	5.9	7,000
17	Pennsylvania	6.1	29,000
18	Georgia	6.5	23,000
19	Virginia	6.6	21,000
20	Oregon	6.7	10,000
21	Delaware	6.9	3,000
22	Indiana	7.1	22,000
23	Illinois	7.2	34,000
24	Maryland	7.2	18,000
25	West Virginia	7.2	4,000
26	California	7.5	100,000
27	Minnesota	7.5	20,000
28	Mississippi	7.5	6,000
29	Iowa	7.5	10,000
30	Louisiana	7.6	10,000
31	Utah	7.8	16,000
32	New Mexico	7.8	4,000
33	Oklahoma	7.9	11,000
34	Kansas	7.9	9,000
35	New York	8.3	49,000
36	Colorado	8.3	17,000
37	Hawaii	9.2	3,000
38	Florida	9.4	52,000
39	North Carolina	10.0	33,000
40	Alaska	10.3	2,000
41	Kentucky	11.0	17,000
42	Texas	11.5	108,000
43	Wyoming	12.0	3,000
44	Arizona	12.1	32,000
45	Nevada	12.6	13,000
46	Nebraska	12.6	10,000
47	Idaho	12.7	10,000
48	North Dakota	13.5	5,000
49	Tennessee	13.5	27,000
50	Arkansas	14.4	13,000
51	South Carolina	14.8	23,000
	National	7.8	901,000

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

Students Identified with Emotional Disturbance for an Individualized Education Program



Rank*	State	Rate	#
1	Vermont	30.41	2,233
2	Minnesota	20.69	16,510
3	Massachusetts	19.51	16,935
4	Wisconsin	16.18	*
5	Pennsylvania	15.76	25,166
6	Maine	14.35	2,328
7	Indiana	13.41	12,838
8	Iowa	13.31	5,896
9	New Hampshire	12.77	2,095
10	Rhode Island	12.38	1,615
11	District of Columbia	12.32	827
12	Connecticut	11.94	5,691
13	North Dakota	11.85	1,183
14	Illinois	10.19	18,237
15	Nebraska	10.06	2,846
16	Ohio	9.97	15,377
17	South Dakota	9.89	1,213
18	Oregon	9.81	5,286
19	Delaware	9.25	1,152
20	New York	9.15	22,553
21	Missouri	8.66	7,072
22	Michigan	8.45	11,458
23	Virginia	8.38	9,782
24	Maryland	7.64	6,107
25	Mississippi	7.62	3,326
26	Arizona	7.61	7,742
27	Kentucky	7.45	4,524
28	Oklahoma	6.89	4,142
29	Colorado	6.88	5,596
30	Wyoming	6.72	579
31	Texas	6.60	31,519
32	Montana	6.50	881
33	Georgia	6.45	10,286
34	Alaska	6.26	745
35	New Mexico	6.16	1,853
36	New Jersey	5.98	7,485
37	Hawaii	5.74	947
38	Florida	5.68	14,604
39	Kansas	5.53	2,436
40	Washington	5.25	5,324
41	Idaho	4.95	1,372
42	West Virginia	4.80	1,133
43	Nevada	4.43	1,959
44	California	4.42	25,118
45	Tennessee	3.76	3,381
46	North Carolina	3.72	5,275
47	Utah	3.17	1,918
48	South Carolina	3.04	2,112
49	Louisiana	2.70	1,715
50	Arkansas	2.42	1,070
51	Alabama	2.09	1,406
	National	7.57	344,473

Only .757 percent* of students are identified as having an ED for IEP.

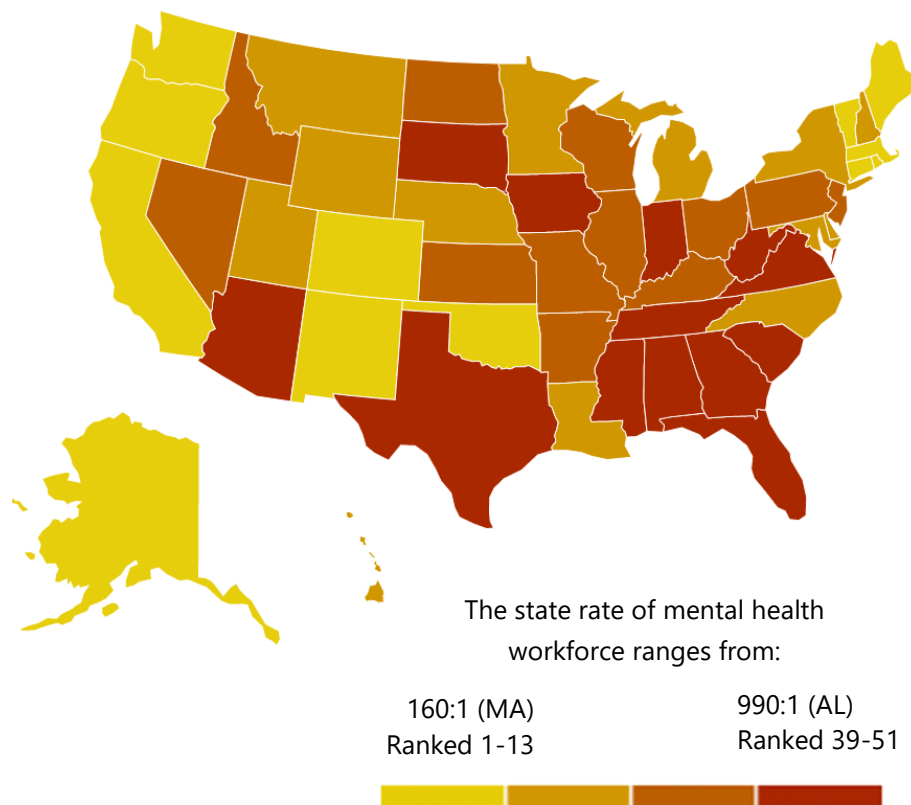
Early identification for IEPs is critical. IEPs provide the services, accommodations and support students with ED need to receive a quality education. For purposes of an IEP, the term “Emotional Disturbance” is used to define youth with a mental illness that is affecting their ability to succeed in school. In 2017-2018, nearly 10 percent of youth had severe MDE, reporting the maximum level of interference over four role domains including school, yet less than 1 percent were identified for an IEP under ED.

In addition to ensuring that students in need of accommodations and supports in school receive them through an IEP, improvements in the implementation of the special education mandate must be made to ensure appropriate identification of students, without creating further disparities. The federal eligibility criteria to identify students as having an emotional disturbance for an IEP have indicated extremely poor reliability among school psychologists,² and therefore must be revised to adequately identify students in need of more supports.

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

¹ Scardamalia, K., Bentley-Edwards, K.L. & Grasty, K. (April 2019). Consistently inconsistent: An examination of the variability in the identification of emotional disturbance. *Psychology in the Schools*, 56(4): 569-581. Available at <https://onlinelibrary.wiley.com/doi/pdf/10.1002/pits.22213>

Mental Health Workforce Availability



Rank	State	#
1	Massachusetts	160:1
2	Oregon	190:1
3	District of Columbia	210:1
4	Maine	210:1
5	Vermont	220:1
6	Alaska	230:1
7	Rhode Island	240:1
8	Connecticut	250:1
9	Oklahoma	250:1
10	New Mexico	260:1
11	Washington	270:1
12	California	280:1
13	Colorado	280:1
14	Utah	300:1
15	Wyoming	300:1
16	Montana	330:1
17	New Hampshire	330:1
18	Louisiana	340:1
19	New York	350:1
20	Michigan	370:1
21	Delaware	380:1
22	Nebraska	380:1
23	Maryland	390:1
24	Hawaii	400:1
25	Minnesota	400:1
26	North Carolina	410:1
27	Ohio	410:1
28	Arkansas	440:1
29	Illinois	440:1
30	Kentucky	440:1
31	New Jersey	450:1
32	Nevada	470:1
33	Idaho	480:1
34	Pennsylvania	480:1
35	Wisconsin	490:1
36	Kansas	510:1
37	Missouri	510:1
38	North Dakota	530:1
39	South Dakota	550:1
40	South Carolina	570:1
41	Virginia	570:1
42	Florida	620:1
43	Indiana	620:1
44	Mississippi	630:1
45	Iowa	640:1
46	Tennessee	660:1
47	Georgia	730:1
48	Arizona	750:1
49	West Virginia	770:1
50	Texas	880:1
51	Alabama	990:1

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

The rate of mental health providers has improved in nearly every state since last year’s report. However, the need for mental health care will greatly outpace these additions to the workforce, especially as rates of depression, anxiety and other mental health concerns increase in response to the coronavirus pandemic and increased awareness of ongoing racial injustice in 2020.

However, the COVID-19 pandemic has also shown that these workforce shortages can be mitigated through different models of care delivery. The Center for Medicare and Medicaid Services (CMS) encouraged states to reduce barriers to tele-mental health under Medicaid, and Medicare allowed audio-only tele-mental health visits during the pandemic. If these changes to care delivery be made permanent and coverage for peer support specialists and other paraprofessionals is expanded, these could help mitigate some of the effects of provider shortages in the future.

COVID-19 and Mental Health: 2020 Data

Executive Summary

From January to September 2020, 1,560,288 people took a screen and accessed immediate resources and supports through the MHA Online Screening Program.

From those screens, we have found:

- **The number of people looking for help with anxiety and depression has skyrocketed.** From January to September 2020, 315,220 people took the anxiety screen, a 93 percent increase over the 2019 total number of anxiety screens. 534,784 people took the depression screen, a 62 percent increase over the 2019 total number of depression screens.
- **The number of people screening with moderate to severe symptoms of depression and anxiety has continued to increase throughout 2020 and remains higher than rates prior to COVID-19.** In September 2020, the rate of moderate to severe anxiety peaked, with over 8 in 10 people who took an anxiety screen scoring with moderate to severe symptoms. Over 8 in 10 people who took a depression screen have scored with symptoms of moderate to severe depression consistently since the beginning of the pandemic in March 2020.
- **More people are reporting frequent thoughts of suicide and self-harm than have ever been recorded in the MHA Screening program since its launch in 2014.** Since the COVID-19 pandemic began to spread rapidly in March 2020, over 178,000 people have reported frequent suicidal ideation. 37 percent of people reported having thoughts of suicide more than half or nearly every day in September 2020.
- **Young people are struggling most with their mental health.** The proportion of youth ages 11-17 who accessed screening was 9 percent higher than the average in 2019. Not only are the number of youth searching for help with their mental health increasing, but throughout the COVID-19 pandemic youth ages 11-17 have been more likely than any other age group to score for moderate to severe symptoms of anxiety and depression.
- **Rates of suicidal ideation are highest among youth, especially LGBTQ+ youth.** In September 2020, over half of 11-17-year-olds reported having thoughts of suicide or self-harm more than half or nearly every day of the previous two weeks. From January to September 2020, 77,470 youth reported experiencing frequent suicidal ideation, including 27,980 LGBTQ+ youth.
- **People screening at risk for mental health conditions are struggling most with loneliness or isolation.** From April to September 2020, among people who screened with moderate to severe symptoms of anxiety or depression, 70 percent reported that one of the top three things contributing to their mental health concerns was loneliness or isolation.
- **People who identify as Asian or Pacific Islander are searching for mental health resources more in 2020 than ever before.** The proportion of screeners identifying as Asian or Pacific Islander increased 7 percent, from 9 percent of screeners in 2019 to 16 percent in 2020.
- **While rates of anxiety, depression, and suicidal ideation are increasing for people of all races and ethnicities, there are notable differences in those changes over time.** Black or African American screeners have had the highest average percent change over time for anxiety and depression, while

Native American or American Indian screeners have had the highest average percent change over time for suicidal ideation.

A Growing Crisis

The State of Mental Health in America report is designed to create a complete picture of mental health throughout the United States that can be used to track the successes and failures of federal and state policy initiatives aimed at affecting mental health outcomes over time. In 2015 when this initiative was created, we did not anticipate that there would be a population-level health crisis that would change the landscape of mental health in every community throughout the United States, with effects of for years to come.

As COVID-19 spread throughout the United States, it not only resulted in greater morbidity and mortality in terms of physical health but also had disastrous effects on the mental health of the nation. As opposed to previous disasters in the United States that affected certain specific regions or populations where aid and trauma response could be concentrated, the COVID-19 pandemic has affected the entire population of the country. While the risk of contracting the disease itself is a population-wide traumatizing event, our physical and social environments have changed as well, leading to greater rates of isolation and loneliness, financial hardship, housing and food insecurity, and interpersonal violence. Further, the COVID-19 pandemic has highlighted and exacerbated existing inequities and injustices faced primarily by black, indigenous, and people of color (BIPOC) in the United States. Any of these factors by themselves can negatively affect the mental health of individuals, but in combination they have created a nationwide mental health crisis.

The data presented throughout the State of Mental Health in America 2021 report was collected in 2017-2018 and are the most current data reported by states and available to the public. While they are useful in providing comparative baselines in the states for needs and prevalence rates prior to COVID-19, they do not reflect the state of the nation since the onset of the pandemic.

In 2014, Mental Health America created the Online Screening Program (www.mhascreening.org), a collection of ten free, anonymous, confidential and clinically-validated screens that are among the most commonly used mental health screening tools in clinical settings.¹ Through September 2020, over 6 million people have taken a screen, including over 1.5 million people from January-September 2020. This makes it the largest dataset ever collected from a help-seeking population experiencing mental health conditions. The screening results also comprise one of the largest datasets collecting national mental health information in real-time, allowing us to recognize and react to changes in the mental health of the nation as they occur, including the mounting mental health crisis throughout the COVID-19 pandemic.

Strengths and Limitations

The MHA Screening dataset collects information from a help-seeking population, meaning people searching for mental health resources and supports online. As a result, users are more likely to screen positive or moderate to severe for mental health conditions than the general population. The MHA Screening Program also exists entirely online, and therefore does not reflect the mental health needs of people who do not have access to Internet

¹ These screens include the Patient Health Questionnaire-9 item (PHQ-9) for depression and the Generalized Anxiety Disorder-7 item (GAD-7) for anxiety, the long forms of the same tools used by the CDC to measure depression and anxiety in the U.S. Household Pulse Survey.

services, likely undercounting communities at higher risk of mental health challenges, such as people experiencing homelessness, poverty, and institutionalization, and communities that do not have broadband access.

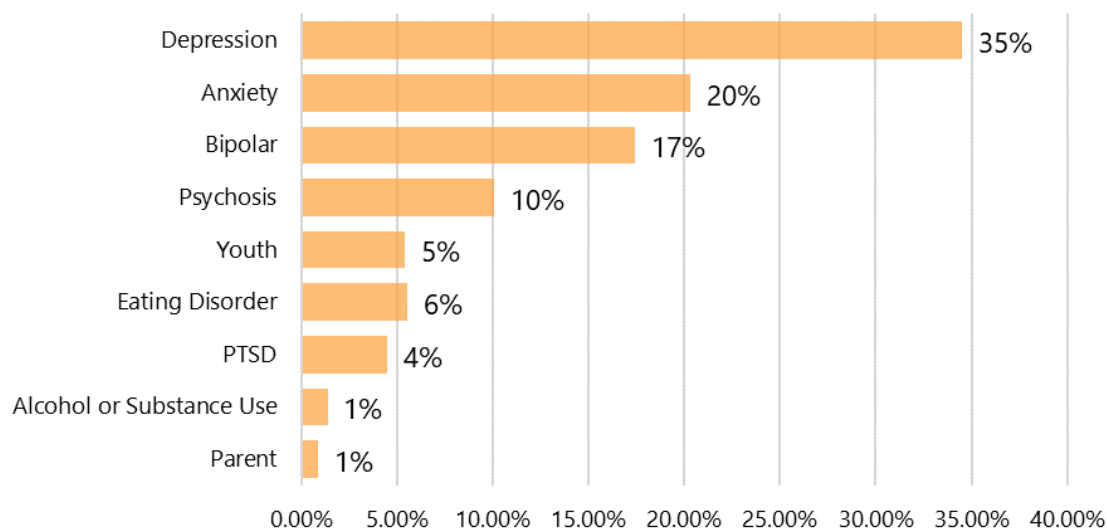
MHA Screening however, by existing in an online space, can capture information about individual's mental health needs earlier than other datasets. From January-September 2020, 66 percent of people who screen positive or moderate to severe for a mental health condition have never received a mental health diagnosis before, and 61 percent have never received any form of mental health treatment or support. When people first begin experiencing symptoms of a mental health condition, they often look for answers, resources and supports online, long before speaking to a provider. The average time between onset of mental health symptoms and diagnosis and treatment of a mental health condition is 11 years.² The data from MHA Screening capture the mental health needs of people who either may not have access to care or have not engaged in care in healthcare settings, which allows for it to be used for earlier intervention and detection of mental health concerns before they become crises.

The following analysis is of the data collected from over 1.5 million screeners who sought help from MHA Screening from January-September 2020.

Basic Demographics

1,560,288 people took a screen through MHA Screening from January-September 2020. Of those the majority took a depression screen (34 percent), followed by the anxiety screen (20 percent) and the bipolar screen (17 percent).

Largest Proportion of Screeners Take Depression, Anxiety Screens in 2020

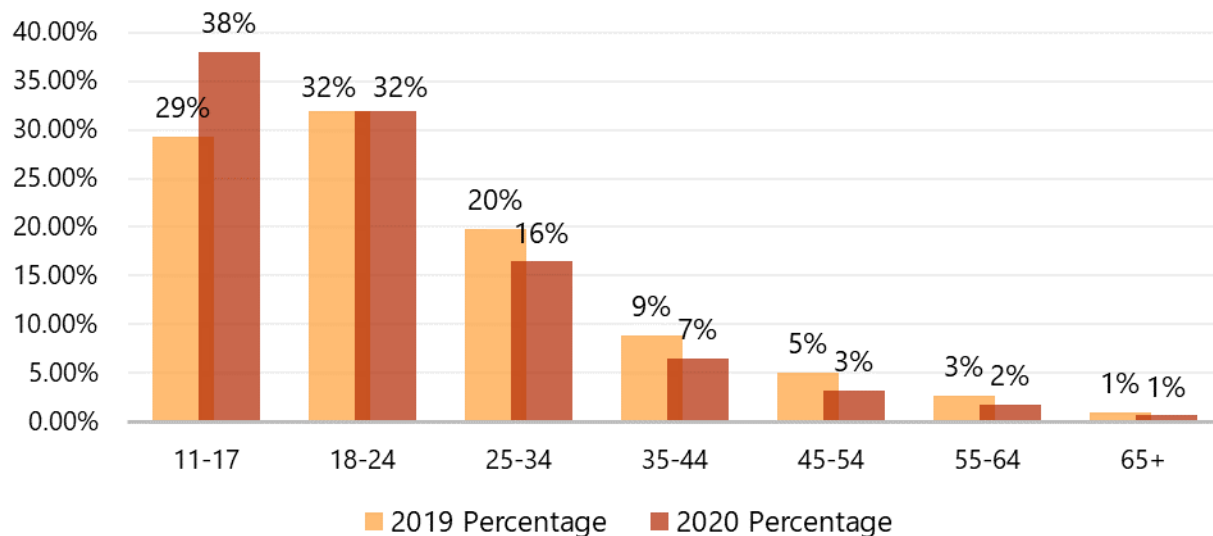


73 percent of screeners identified as female, 25 percent identified as male and 2 percent identified as another gender. In April 2020, we added a separate option to identify as transgender. 3 percent of screeners (N=38,090) from April to September 2020 identified as transgender.

² Wang, P.S. et al. (April 2004). Delays in initial treatment contact after first onset of a mental disorder. *Health Services Research*, 39(2): 393-416. Doi: [10.1111/j.1475-6773.2004.00234.x](https://doi.org/10.1111/j.1475-6773.2004.00234.x)

People who accessed screening in 2020 were younger than the 2019 average. 38 percent of screeners from January-September 2020 were youth ages 11-17, a 9 percent increase over 2019 (29 percent). While the MHA Screening population has always been young with over 60 percent of screeners under the age of 25, this indicates that youth under the age of 18 were even more likely to be searching for mental health resources and supports in 2020. The percentage of 18-24-year-olds remained the same from 2019 to 2020 (32 percent).

Greater Proportion of Youth Screeners in 2020



There have also been changes in the race/ethnicity of screeners in 2020, as compared to 2019. The proportion of screeners identifying as Asian or Pacific Islander increased 7 percent, from 9 percent of screeners in 2019 to 16 percent in 2020. Anti-Asian discrimination increased significantly in the U.S. during the COVID-19 pandemic, and the increase in Asian or Pacific Islander screeners is consistent with research predicting negative health effects among Asian Americans as a result of COVID-19.³ The percentage of screeners identifying their race as "Other" increased as well, from 3 percent to 5 percent. The proportion of White screeners decreased, from 60 percent to 53 percent.

Race/Ethnicity	2019 Count	2019 Percentage	2020 Count	2020 Percentage
Asian or Pacific Islander	35,021	9.13%	170,295	15.50%
Black or African American (non-Hispanic)	33,696	8.79%	91,170	8.30%
Hispanic or Latino	47,414	12.36%	134,790	12.27%
More than one of the above	20,883	5.45%	55,277	5.03%
Native American or American Indian	5,020	1.31%	12,888	1.17%
Other	12,893	3.36%	51,611	4.70%
White (non-Hispanic)	228,596	59.60%	582,308	53.02%
Grand Total	383,523	100.00%	1,098,339	100.00%

³ Chen, J.A., Zhang, E. & Liu, C.H. (June 2020). Potential impact of COVID-19-related racial discrimination on the health of Asian Americans. *American Journal of Public Health*, pp. e1-e4. Doi: <https://doi.org/10.2105/AJPH.2020.305858>

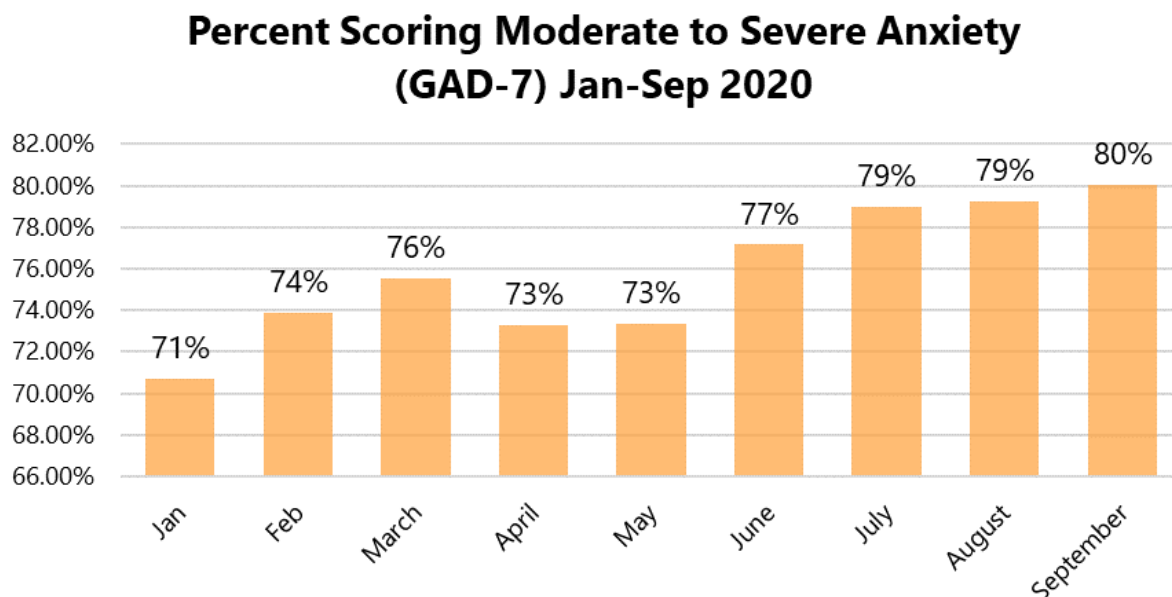
Screeners from January-September 2020 reported slightly higher household incomes than those in 2019 as well. Half (50 percent) of screeners reported a household income less than \$40,000 in 2020, compared to 52 percent in 2019. Over 24 percent reported a household income greater than \$80,000, compared to 22 percent in 2019.

Across all screens, 74 percent (N=1,158,429) scored moderate to severe for the mental health condition for which they screened. This was consistent with the 2019 average. However, there were notable differences in rates of positive or moderate to severe screens among anxiety and depression screens over time.

Mounting Anxiety, Depression and Suicidal Ideation

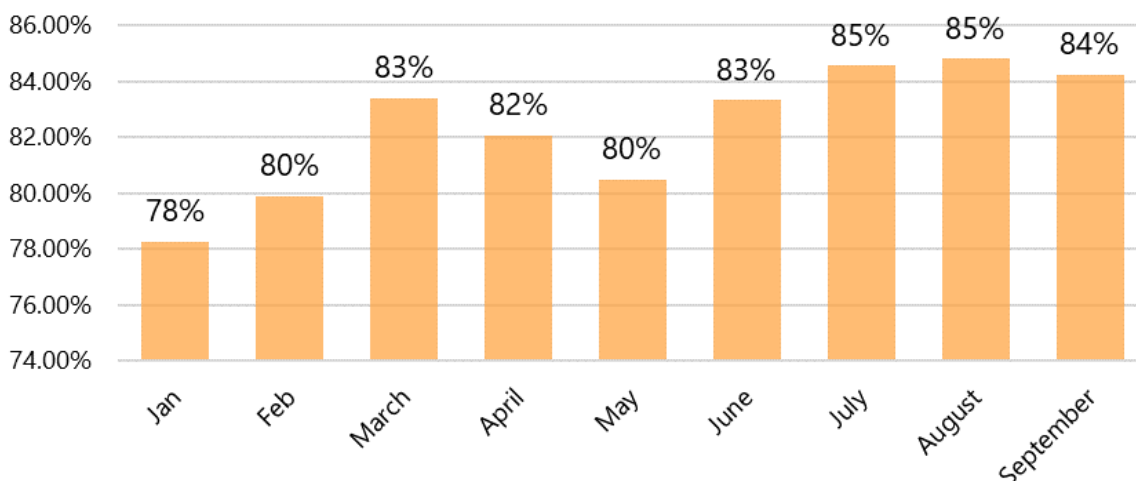
MHA uses the Generalized Anxiety Disorder 7-item (GAD-7) tool to screen for anxiety. From January to September 2020, 315,220 people took the anxiety screen, a 93 percent increase over the 2019 total number of anxiety screens (N=162,958). In September 2020, an average of 2,262 anxiety screens were taken per day.

Despite the dramatic increase in the number of people taking anxiety screens in 2020, the rate of people screening with moderate to severe symptoms of anxiety remained higher than rates prior to the COVID-19 pandemic. In September 2020, 80 percent (N=54,315) of people who took an anxiety screen scored for moderate to severe anxiety, with 48 percent (N=32,870) scoring for symptoms of severe anxiety.



MHA uses the Patient Health Questionnaire 9-item (PHQ-9) tool to screen for depression. From January to September 2020, 534,784 people took the depression screen, a 62 percent increase over the 2019 total number of depression screens (N=331,089). In September 2020, an average of 4,321 depression screens were taken per day.

Percent Scoring Moderate to Severe Depression (PHQ-9) Jan-Sep 2020



Like the anxiety screen, the rate of people screening with moderate to severe symptoms of depression has remained higher than rates prior to the COVID-19 pandemic. In September 2020, 84 percent (N=109,232) of people who took a depression screen scored for moderate to severe depression, with 31 percent (N=40,139) scoring for symptoms of severe depression.

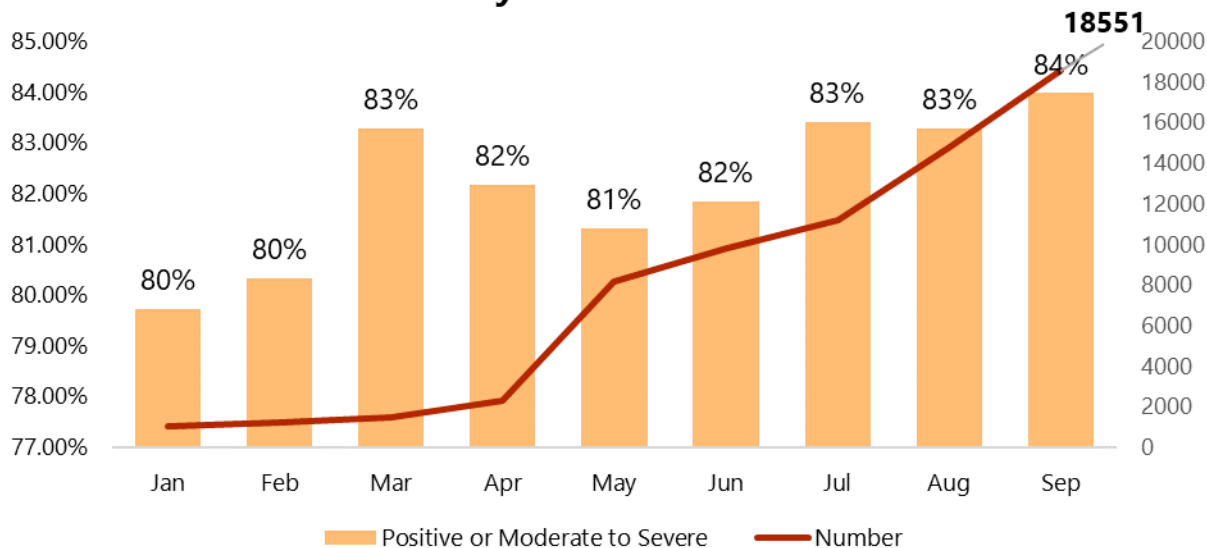
Anxiety and Depression Highest for Youth

Throughout the COVID-19 pandemic, youth ages 11-17 were more likely than any other age group to score for moderate to severe symptoms of anxiety and depression.

Age	Number Scoring Moderate to Severe Anxiety: January-September 2020	Percent Scoring Moderate to Severe Anxiety: January-September 2020	Number Scoring Moderate to Severe Depression: January-September 2020	Percent Scoring Moderate to Severe Depression: January-September 2020
11-17	68,584	82.88%	140,988	90.20%
18-24	62,657	79.72%	122,253	86.39%
25-34	32,284	75.86%	58,991	79.17%
35-44	12,841	72.45%	21,808	74.18%
45-54	6,381	68.72%	10,740	70.72%
55-64	3,257	61.70%	5,953	65.53%
65+	1,149	56.57%	2,183	60.19%

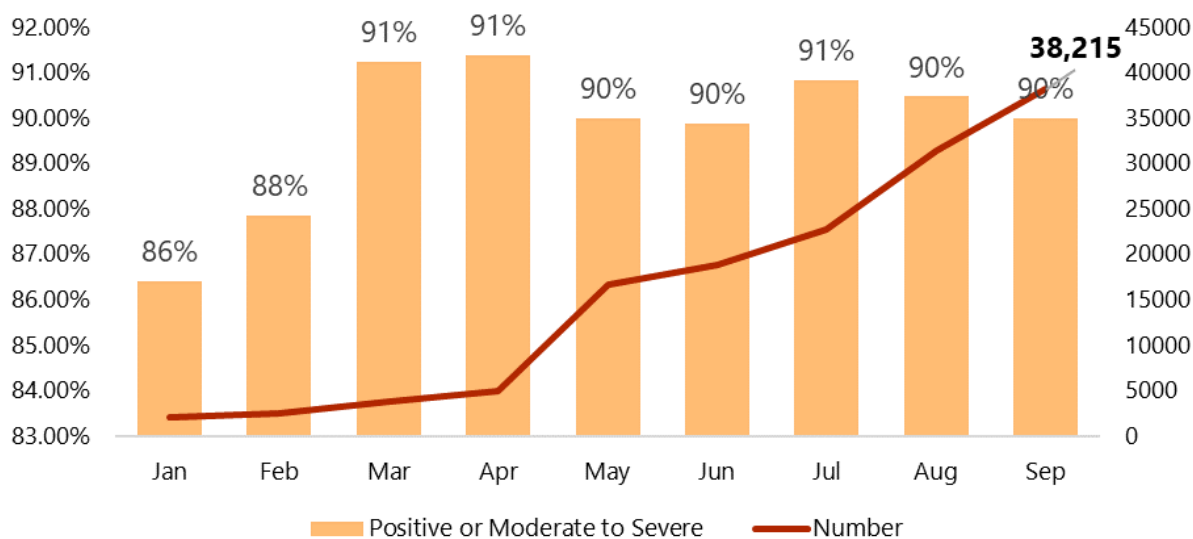
From March to September 2020, over 80 percent of 11-17-year-olds who took an anxiety screen scored for moderate to severe anxiety. In September 2020, 84 percent of 11-17-year-olds scored for moderate to severe anxiety, totaling 18,551 youth.

Over 8 in 10 Youth Screening Moderate to Severe Anxiety Since March 2020



From March to September 2020, at least 90 percent of 11-17-year-olds who took a depression screen scored for moderate to severe depression. In September 2020, 90 percent of 11-17-year-olds scored for moderate to severe depression, totaling 38,215 youth.

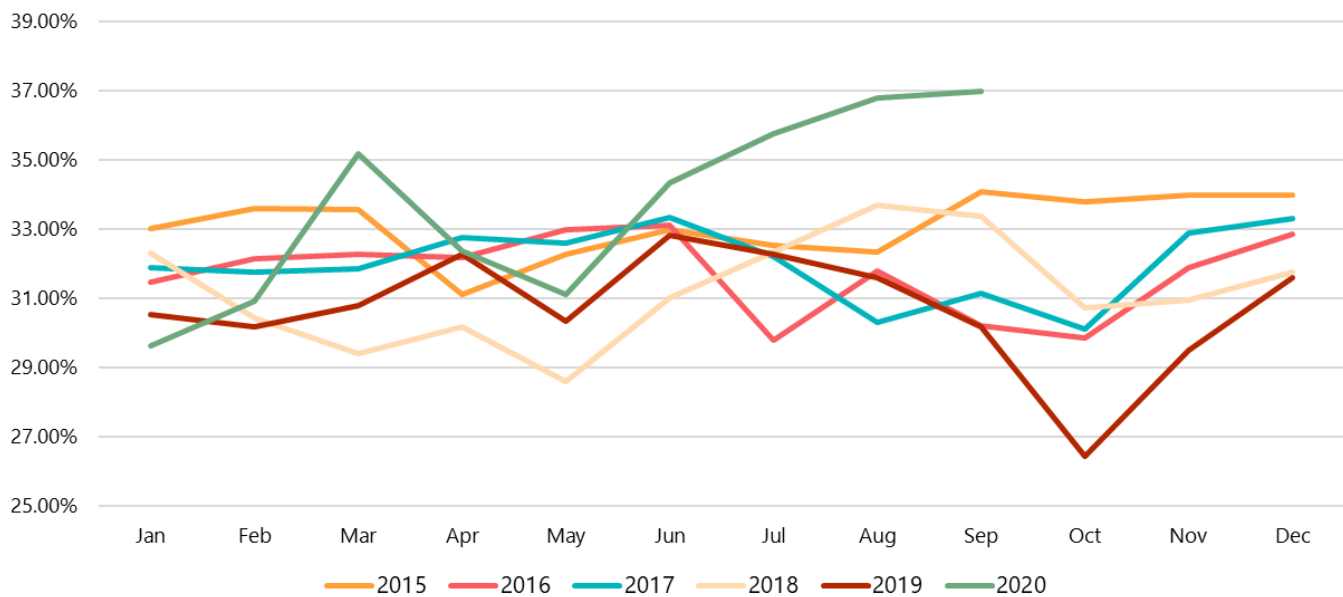
Over 9 in 10 Youth Screening Moderate to Severe Depression Since March 2020



Suicidal Ideation

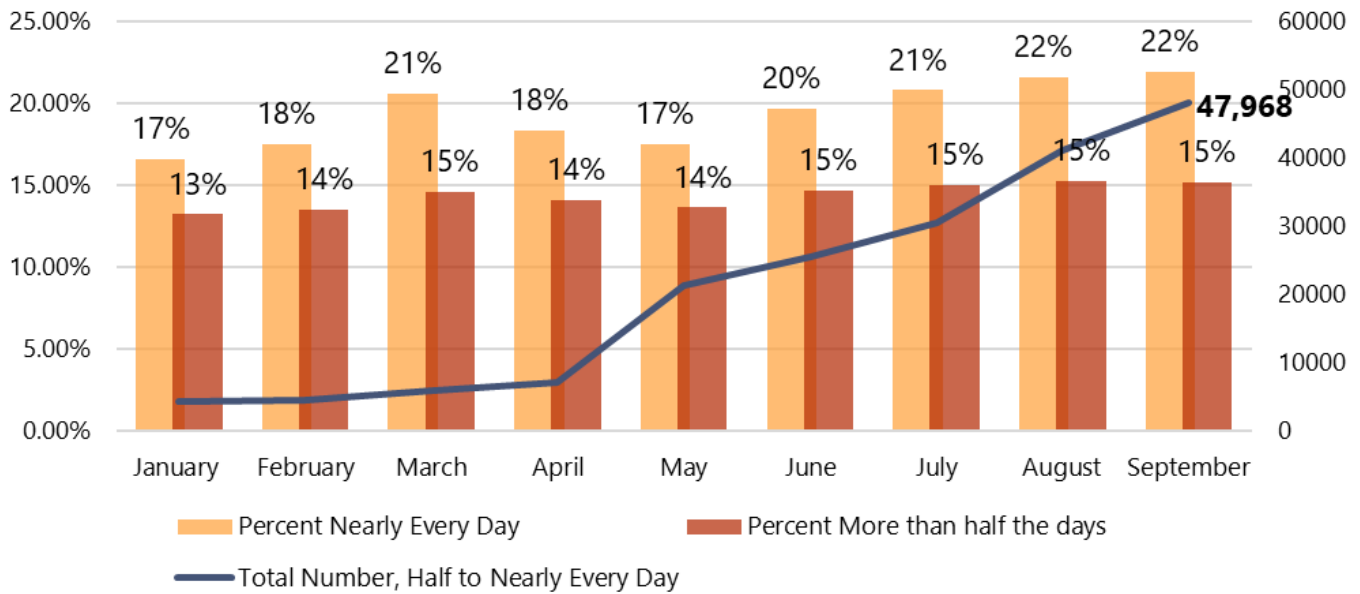
Question 9 of the PHQ-9 screen asks, “Over the last two weeks, how often have you been bothered thoughts that you would be better off dead, or of hurting yourself?” In 2020, the number and rate of people reporting frequent suicidal ideation has reached the highest level ever recorded in the MHA screening population.

Percentage Reporting Suicidal Ideation More Than Half or Nearly Every Day 2015-2020



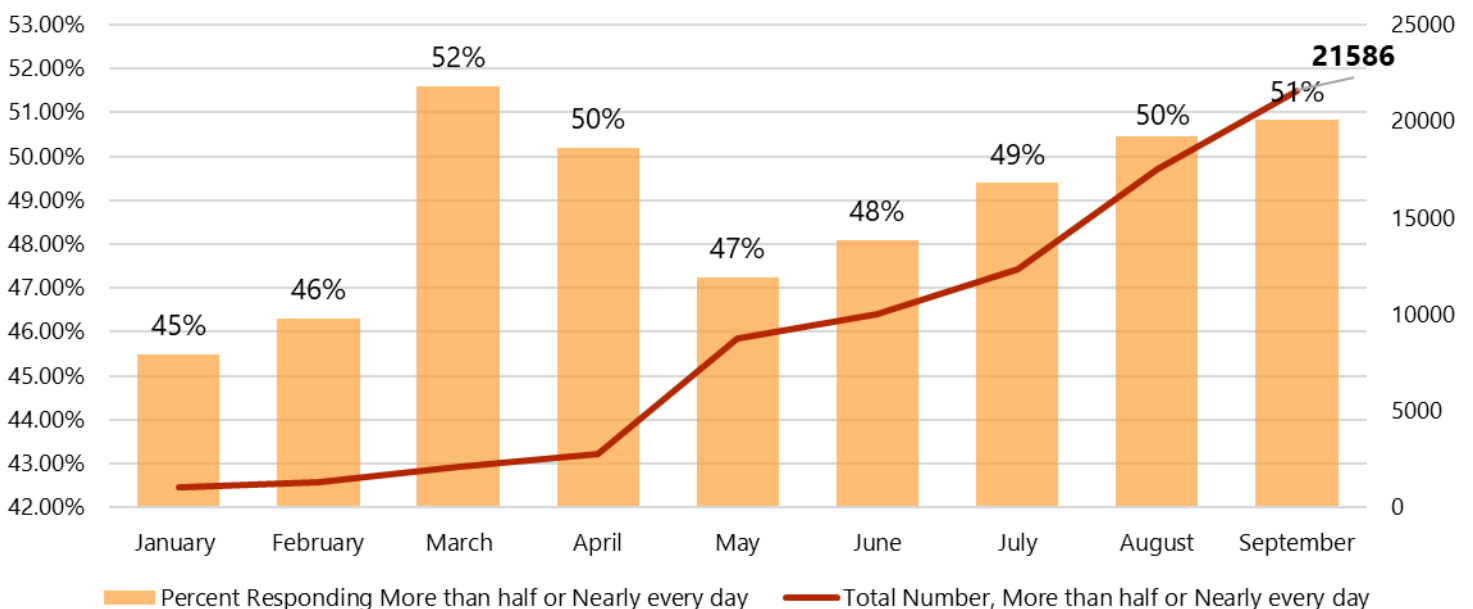
In September 2020, 37 percent (N=47,968) of people who screened for depression indicated that they experienced suicidal ideation more than half or nearly every day of the previous two weeks. 22 percent (N=28,356) indicated that they experienced thoughts of suicide or self-harm nearly every day. Since the COVID-19 pandemic began to spread rapidly in March 2020, over 178,000 people have reported frequent suicidal ideation on the PHQ-9.

Thoughts of Suicide or Self-Harm More than Half or Nearly Every Day, Jan-Sep 2020



As with rates of anxiety and depression, youth ages 11-17 report the highest rates of suicidal ideation of any age group. In September 2020, 51% (N=21,586) of 11-17-year-olds reported having thoughts of suicide or self-harm more than half or nearly every day of the previous two weeks. From January to September 2020, 77,470 youth reported experiencing frequent suicidal ideation, including 75,107 since the beginning of the pandemic in March.

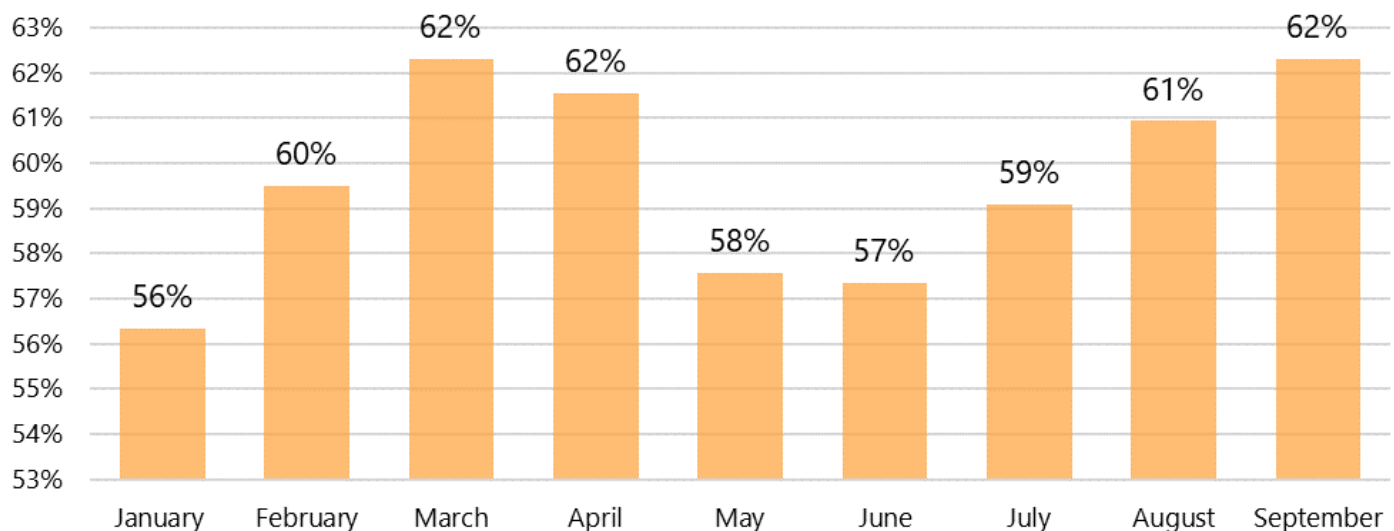
Thoughts of Suicide or Self-Harm More than Half or Nearly Every Day Among Youth Ages 11-17, Jan-Sep 2020



Suicidal ideation is also higher among people who identify as LGBTQ+, especially LGBTQ+ youth. In September 2020, 55 percent (N=11,865) of LGBTQ+ individuals reported frequent suicidal ideation, and 62 percent (N=7,988) of youth ages 11-17 who identified as LGBTQ+ reported suicidal ideation more than half the days or nearly every day. From January to September 2020, 27,980 LGBTQ+ youth reported experiencing frequent suicidal ideation.

All LGBTQ+ Respondents	2019 Average	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	June 2020	Jul 2020	Aug 2020	Sep 2020
Percent Reporting Frequent Suicidal Ideation	49% (N=15,586)	48% (781)	51% (901)	52% (1,218)	52% (1,745)	48% (4,822)	48% (5,622)	52% (7,058)	53% (9,657)	55% (11,865)

Suicidal Ideation More than Half or Nearly Every Day Among LGBTQ+ Youth, Jan-Sep 2020



Main Concerns of People Screening Positive for Mental Health Conditions

In April 2020, MHA added the question, “Think about your mental health test. What are the main things contributing to your mental health problems right now? Choose up to three.”

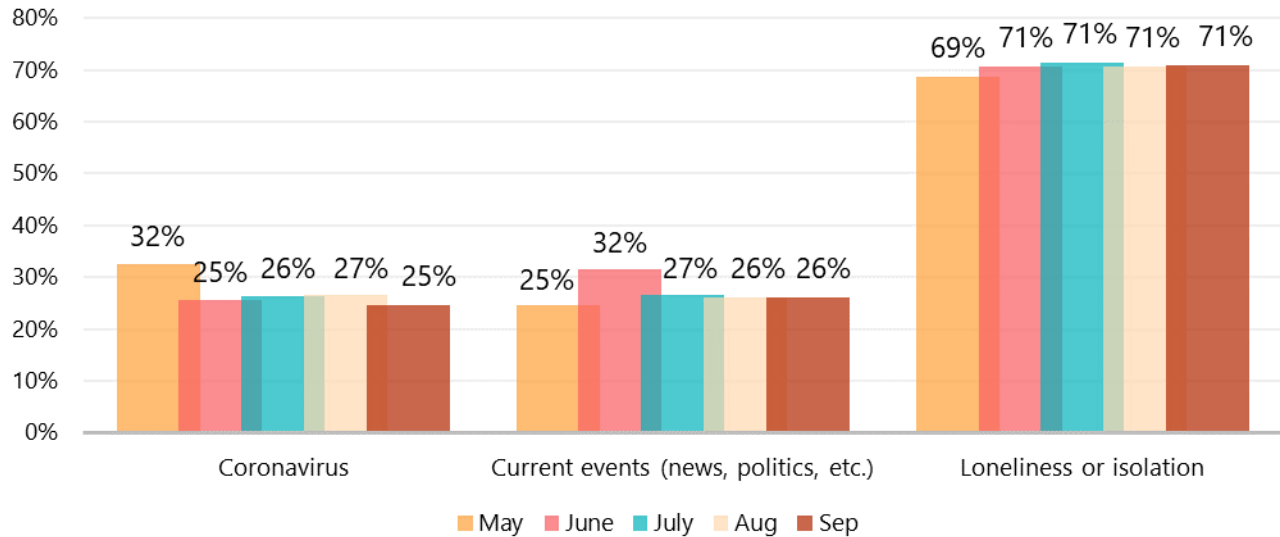
From April to September 2020, among people who screened with moderate to severe symptoms of anxiety or depression, 70 percent reported that one of the top three things contributing to their mental health concerns was loneliness or isolation. This was followed by 46 percent reporting past trauma and 43 percent reporting relationship problems. 27 percent of people who scored with moderate to severe symptoms of anxiety or depression reported coronavirus as one of the top three things affecting their mental health, and 27 percent reported current events, including news and politics.

Think about your mental health test. What are the main things contributing to your mental health problems right now? Choose up to 3.	Count, Individuals with Moderate to Severe Anxiety or Depression, Apr-Sep 2020	Percentage, Individuals with Moderate to Severe Anxiety or Depression, Apr-Sep 2020
Coronavirus	133259	26.97%
Current events (news, politics, etc.)	132338	26.79%
Financial Problems	118235	23.93%
Loneliness or isolation	348190	70.47%
Grief or loss of someone or something	130101	26.33%
Past trauma	228184	46.18%
Relationship problems	210251	42.56%
Racism	31345	7.65%*
Grand Total	494066	

*Racism was not added as an option until June 16, 2020. Percentage is reported from the total responses from June 16-September 2020 (N=409,678)

However, the main concerns among individuals who screened with moderate to severe symptoms of depression and anxiety have changed over time. The percentage of people reporting loneliness or isolation as one of the three things contributing to their mental health problems increased 2 percent from May to June 2020 and has remained at 71 percent through September (N=92,142). 32 percent of people selected coronavirus as one of their top three concerns in May 2020, but as increased media attention, awareness and protests began in response to racial injustice and police brutality in June, there was a 7 percent increase in people reporting current events as one of their three main concerns, mirrored by a 7 percent decrease in those reporting coronavirus. In September, 26 percent (N=34,109) reported current events, and 25 percent (N=31,979) reported coronavirus as one of their top three concerns.

Changes in Top Three Mental Health Concerns May-September 2020



Think about your mental health test. What are the main things contributing to your mental health problems right now? Choose up to 3.	Percentage, Individuals with Moderate to Severe Anxiety or Depression, May	Percentage, Individuals with Moderate to Severe Anxiety or Depression, June	Percentage, Individuals with Moderate to Severe Anxiety or Depression, July	Percentage, Individuals with Moderate to Severe Anxiety or Depression, August	Percentage, Individuals with Moderate to Severe Anxiety or Depression, September
Coronavirus	32.45%	25.50%	26.24%	26.64%	24.53%
Current events (news, politics, etc.)	24.53%	31.56%	26.58%	26.02%	26.17%
Financial Problems	23.19%	23.64%	24.27%	24.79%	23.46%
Loneliness or isolation	68.81%	70.70%	71.35%	70.77%	70.69%
Grief or loss of someone or something	26.63%	25.88%	26.22%	26.64%	26.27%
Past trauma	46.70%	45.55%	46.65%	46.56%	45.58%
Relationship problems	43.17%	42.74%	42.77%	42.61%	42.05%

Disproportionate Impact of Mental Health Concerns Among BIPOC Communities

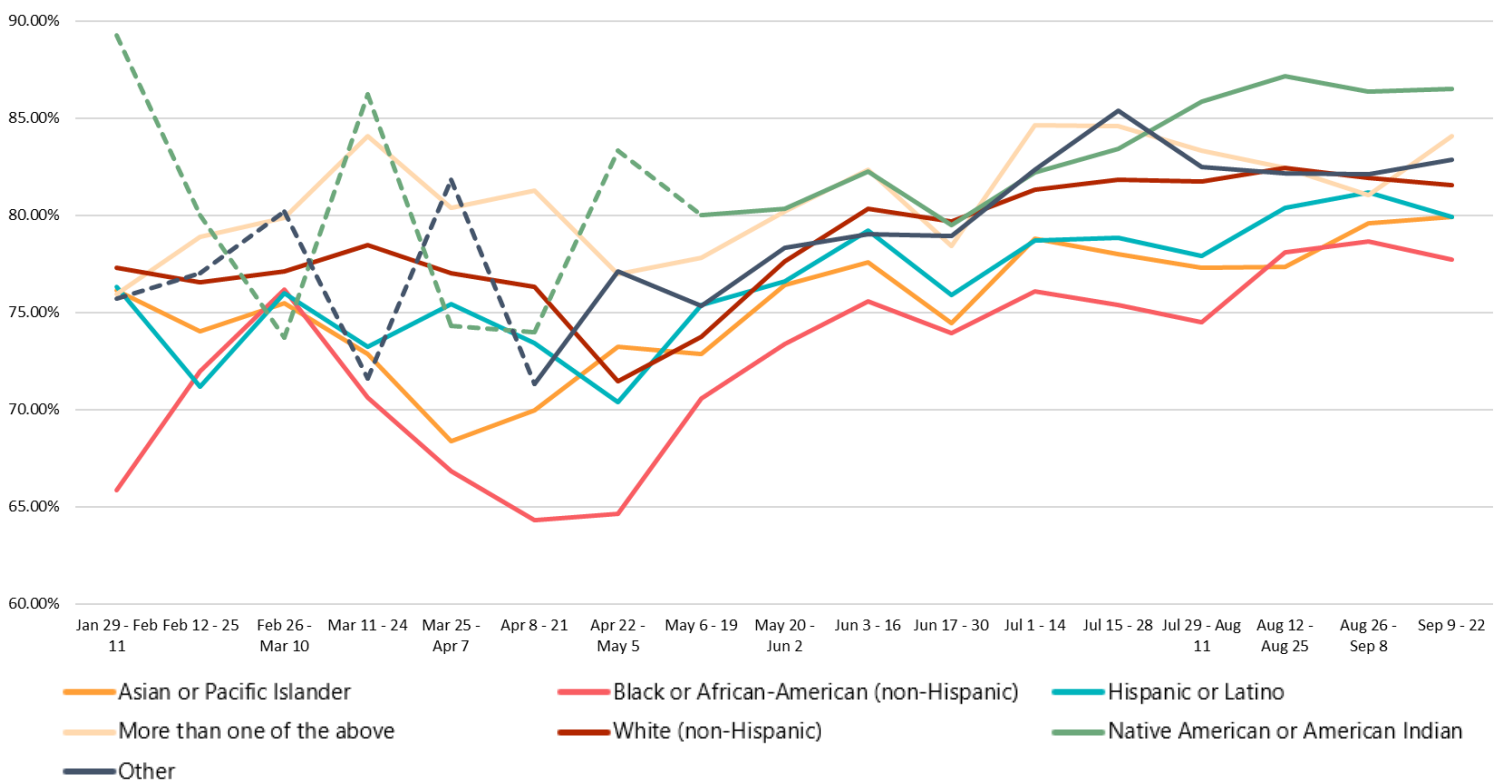
The COVID-19 pandemic and the secondary impacts of the pandemic such as effects on food, housing and economic security have had a disproportionate impact on black, indigenous, and other communities of color. These in turn can create larger impacts on the mental health of individuals within these communities. To better understand existing unmet needs, inequities in care, and the disproportionate impact of COVID-19 on the mental health of traditionally underserved populations, MHA conducted an analysis of the 579,793 screens for anxiety and depression where race/ethnicity was reported from January 1st to September 22, 2020. For more detailed data tables accompanying each chart, [click here](#).

Anxiety

For nearly all racial/ethnic groups, rates of moderate to severe anxiety increased during the last few days of February 2020 and into the beginning of March, as people became more aware of the pandemic and its spread into the United States. All racial/ethnic groups also experienced an increase in the rate of moderate to severe anxiety from the first weeks of May into the first weeks of June.

The September average for moderate to severe anxiety was higher than the monthly average for May-August for nearly every racial/ethnic group (excluding screeners who identified as more than one race and screeners who identified as another race, whose July averages were higher, and White screeners, whose August average was higher). Native American or American Indian screeners had the highest rate of anxiety in August and September, with 87% scoring with moderate to severe anxiety. However, Black or African American screeners had the highest average percent change over time for anxiety, at 0.74 percent, followed by screeners who identified with more than one race at 0.51 percent. From February to September, the average rate of moderate to severe anxiety among Black or African American screeners increased from 70 percent to 78 percent.

Percent Scoring Moderate to Severe Anxiety (GAD-7)

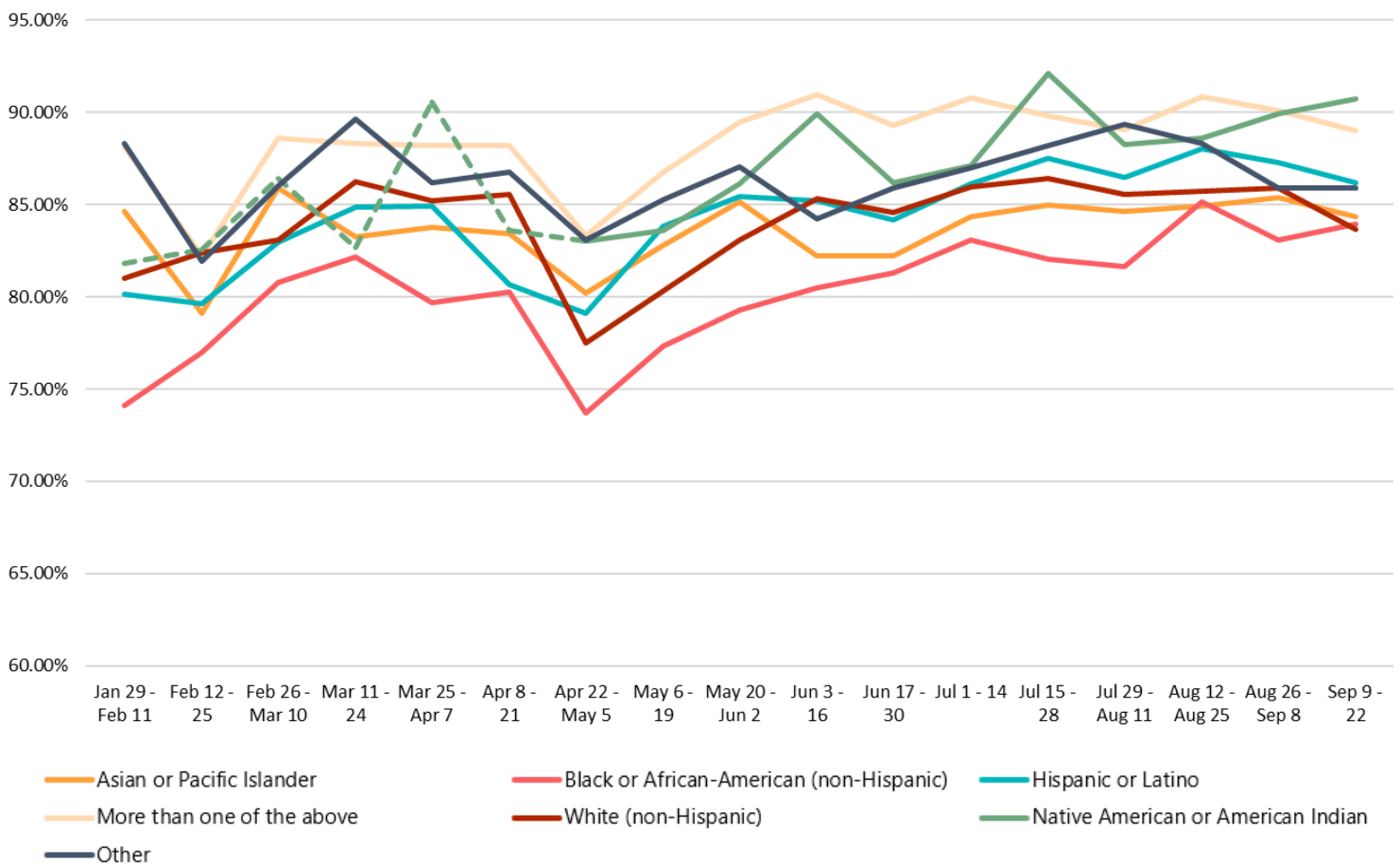


*Dotted line to represent where N < 100 people.

Depression

The September average for moderate to severe depression among Black or African American and Native American or American Indian screeners was higher than the monthly average for August 2020 (September averages were lower than August for every other race/ethnicity). Native American or American Indian screeners and screeners who identify with more than one race have the highest overall rates of depression, with 90 percent of screeners scoring with moderate to severe symptoms of depression in August and September. However, Black or African American screeners had the highest average percent change over time for depression at 0.62 percent, followed by Native American or American Indian screeners at 0.56 percent and Hispanic or Latino screeners at 0.38 percent. From February to September, the percentage of Black or African American screeners scoring with symptoms of moderate to severe depression increased from 77 percent to 84 percent.

Percent Scoring Moderate to Severe Depression (PHQ-9)



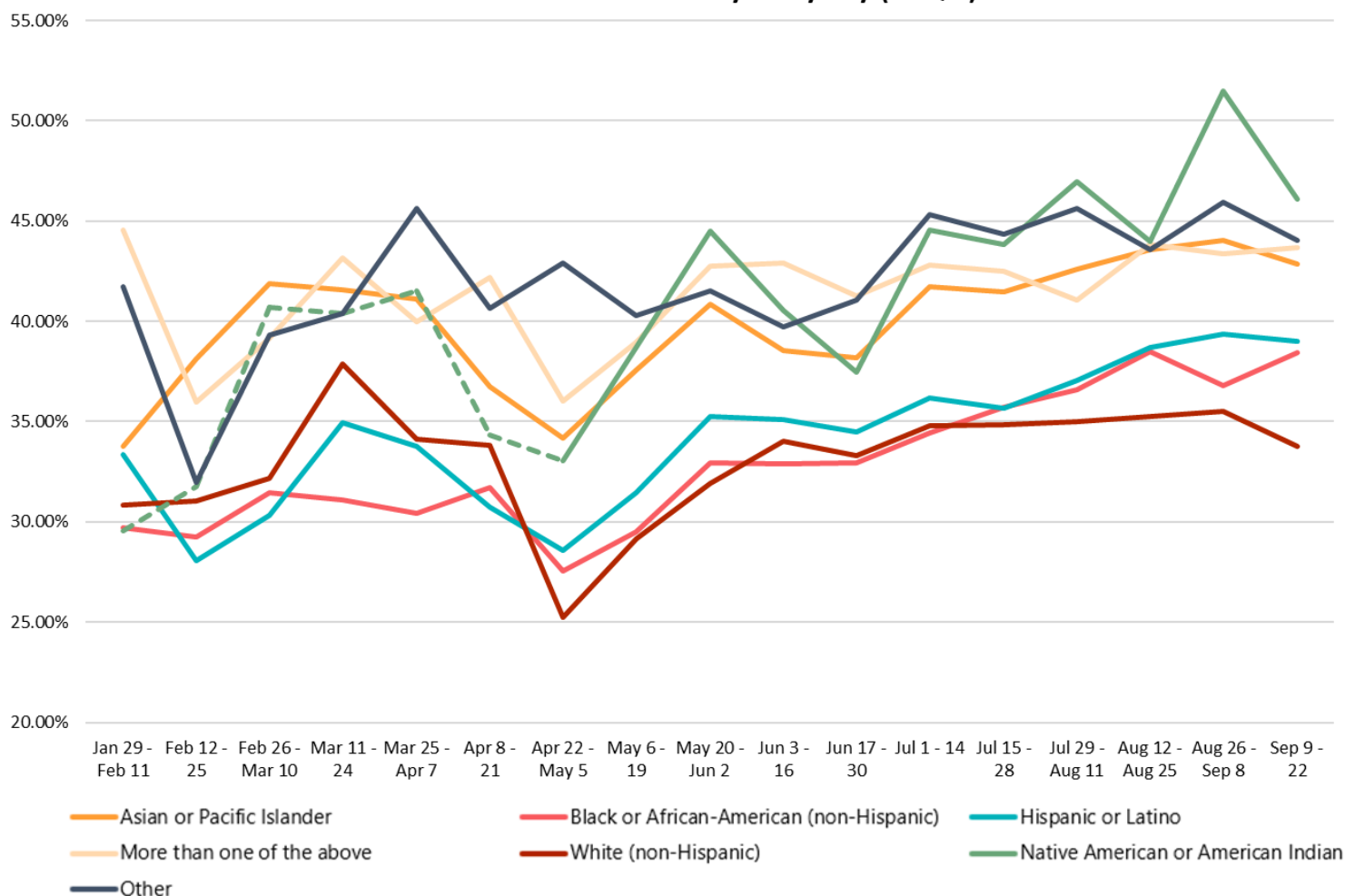
*Dotted line to represent where N < 100 people.

Suicidal Ideation

The September average for suicidal ideation was higher than the May-August averages, as well as the 2019 average for nearly every racial/ethnic group (excluding Asian or Pacific Islander and White screeners, whose August averages were higher). Since the end of May 2020, nearly every racial/ethnic group has been experiencing consistently higher rates of suicidal ideation than the 2019 average (excluding Native American or American Indian screeners and screeners who identified as another race/ethnicity, who experienced consistently higher rates of suicidal ideation than the 2019 average beginning in July).

Native American or American Indian screeners had the highest average percent change over time for suicidal ideation at 1.03 percent, followed by Asian or Pacific Islander screeners at 0.57 percent and Black or African American screeners at 0.55 percent. From February to September, rates of frequent suicidal ideation among Native American or American Indian screeners increased from 29 percent to 47 percent, although sample sizes of Native American or American Indian screeners were low until April. From February to September, the percentage of Asian or Pacific Islander screeners reporting suicidal ideation more than half or nearly every day increased from 36 percent to 43 percent, and among Black or African American screeners increased from 29 percent to 38 percent.

Percent Reporting "Thoughts that you would be better off dead, or of hurting yourself" More Than Half or Nearly Every Day (PHQ-9)



*Dotted line to represent where N < 100 people.

MHA will continue to report on real time analyses of data collected from MHA Screening on [our website](#).

For more detailed information on the above analyses, and for more resources related to COVID-19, visit:

- [Mental Health and COVID-19 Information and Resources](#): A compilation of resources and information to aid individuals and communities during the COVID-19 pandemic, including crisis resources, information for people with existing mental health conditions and resources for specific populations such as parents, caregivers, LGBTQ+ individuals, and older adults, among others.
- [Mental Health Information and Resources for Frontline Workers](#): A compilation of resources on mental health during COVID-19 specifically created for frontline workers.
- [MHA Center for Research and Innovation](#): to learn more about the MHA Screening Program and access other research and reports published using screening data, including rapid analyses of COVID-19 data.
- [MHA News](#): to access MHA Press Releases, including monthly analyses of screening data during COVID-19.
- [Screening 2 Supports](#): an interactive online space providing resources and supports for individuals to better their mental health in four domains: information and psychoeducation ("Learn"); information about treatment options and referrals to care ("Treatment"); do-it-yourself tools ("DIY"); and online engagement with peers ("Connect").
- [MHA Screening Tools](#): a collection of ten clinically validated screening tools for individuals to check on their mental health. [Click here](#) to take a screen.

Glossary

Indicator	Description of Measure	Source
Adults with Any Mental Illness (AMI)	Any Mental Illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, assessed by the Mental Health Surveillance Study (MHSS) Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders (MHSS-SCID), which is based on the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). For details, see Section B of the "2017-2018 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology" at https://www.samhsa.gov/data/. Data survey years: 2017-2018.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHMethodsSummDefs2018/NSDUHMethodsSummDefs2018.htm#appa
Adults with AMI Reporting Unmet Need	AMIYR_U, is an indicator for Any Mental Illness (AMI) based on the 2012 revised predicted probability of SMI (SMIPP_U). If SMIPP_U is greater than or equal to a specified cutoff point (0.0192519810) then AMIYR_U=1, and if SMIPP_U is less than the cutoff point then AMIYR_U=0. This indicator based on the 2012 model is not comparable with the indicator based on the 2008 model. AMI is defined as having Serious, Moderate, or Mild Mental Illness. Specific details about this variable can be found in the Recoded Mental Health Appendix. AMHTXND2 is defined as feeling a perceived need for mental health treatment/counseling that was not received. This is often referred to as "unmet need." Mental Health Treatment/Counseling is defined as having received inpatient treatment/counseling or outpatient treatment/counseling or having used prescription medication for problems with emotions, nerves, or mental health. Respondents were not to include treatment for drug or alcohol use. Respondents with unknown treatment/counseling information were excluded. Data survey years: 2017-2018.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health. https://www.datafiles.samhsa.gov/info/nsduh-rdas-codebooks-nid17216
Adults with AMI Who are Uninsured	For IRINSUR4, a respondent is classified as having any health insurance (IRINSUR4=1) if they satisfied ANY of the following conditions. (1) Covered by private insurance (IRPRVHLT=1) (2) Covered by Medicare (IRMEDICR=1) (3) Covered by Medicaid/CHIPCOV (IRMCDCHP=1) (4) Covered by Champus, ChampVA, VA, or Military (IRCHMPUS=1) (5) Covered by other health insurance (IROTHHLT=1) A respondent is classified as NOT having any health insurance (IRINSUR4=2) if they meet EVERY one of the following conditions. (1) Not covered by private insurance (IRPRVHLT=2) (2) Not covered by Medicare (IRMEDICR=2) (3) Not covered by Medicaid/CHIPCOV (IRMCDCHP=2) (4) Not covered by Champus, ChampVA, VA, or Military (IRCHMPUS=2) (5) Not covered by other health insurance (IROTHHLT=2) Data survey years: 2017-2018.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health. https://www.datafiles.samhsa.gov/info/nsduh-rdas-codebooks-nid17216

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. Data survey years: 2017-2018.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/report/2018-nsduh-detailed-tables
Adults with Cognitive Disability Who Could Not See a Doctor Due to Costs	Disability questions were added to the Behavioral Risk Factor Surveillance System (BRFSS) core questionnaire in 2004. The question: "Are you limited in any way in any activities because of physical, mental or emotional problems?" (QLACTLM2), which was previously used to calculate this indicator, was removed in 2016. Disability was determined using the following BRFSS question: "Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?" (DECIDE). Respondents were defined as having a cognitive disability if they answered "Yes" to this question. Respondents were also asked: "Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?" (MEDCOST). The measure was calculated based on individuals who answered Yes to MEDCOST among those who answered Yes to DECIDE. Data survey year 2018.	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, 2018. https://www.cdc.gov/brfss/annual_data/annual_2018.html Downloaded and calculated on 5/27/20.
Adults with Serious Thoughts of Suicide	Adults aged 18 or older were asked, "At any time in the past 12 months, did you seriously think about trying to kill yourself?" If they answered "Yes," they were categorized as having serious thoughts of suicide in the past year. Data survey year: 2017-2018.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/report/2018-nsduh-detailed-tables
Children with private insurance that did not cover mental or emotional problems	Children with private insurance that did not cover mental or emotional problems is defined as any child age 12-17 responding NO to HLTINMNT. HLTINMNT is defined as: "Does [SAMPLE MEMBER POSS] private health insurance include coverage for treatment for mental or emotional problems?" Data survey years: 2017-2018.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.datafiles.samhsa.gov/info/nsduh-rdas-codebooks-nid17216

Adults with AMI who did not receive mental health treatment	AMHTXRC-3 is a recoded variable with levels 1=Yes (Received any mental health treatment in past year) and 2=No (Did not receive any mental health treatment in past year). Recoded from variable AMHSVTYP, classifies what type of mental health treatment/counseling was received in the past year. Respondents who reported receiving treatment for mental health were classified in one of seven mutually exclusive categories. A respondent was assigned to level one if they reported receiving inpatient treatment only (AMHINP2=1 and AMHOUTP3=2 and AMHRX2=2), to level two if they reported receiving outpatient treatment only (AMHINP2=2 and AMHOUTP3=1 and AMHRX2=2), to level three if they reported receiving prescription medication treatment only (AMHINP2=2 and AMHOUTP3=2 and AMHRX2=1), to level four if they reported receiving both inpatient and outpatient treatment only (AMHINP2=1 and AMHOUTP3=1 and AMHRX2=2), to level five if they reported receiving inpatient and prescription medication treatment only (AMHINP2=1 and AMHOUTP3=2 and AMHRX2=1), to level six if they reported receiving outpatient and prescription medication treatment only (AMHINP2=2 and AMHOUTP3=1 and AMHRX2=1), or to level seven if they reported receiving inpatient, outpatient, and prescription medication treatment (AMHINP2=1 and AMHOUTP3=1 and AMHRX2=1). Respondents who did not receive mental health treatment in the past year were assigned to level eight (AMHINP2=2 and AMHOUTP3=2 and AMHRX2=2). Adults with AMI who did not receive mental health treatment was calculated, where AMHTXRC-3= 2 (No treatment) and AMIYR_U indicates AMI. Data survey years: 2017-2018.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.datafiles.samhsa.gov/info/nsduh-rdas-codebooks-nid17216

Indicator	Description of Measure	Source
Mental Health Workforce Availability	Mental health workforce availability is the ratio of the county population to the number of mental health providers including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental health care. In 2015, marriage and family therapists and mental health providers that treat alcohol and other drug abuse were added to this measure. Survey data year: 2019.	County Health Rankings & Roadmaps. http://www.countyhealthrankings.org/ This data comes from the National Provider Identification data file, which has some limitations. Providers who transmit electronic health records are required to obtain an identification number, but very small providers may not obtain a number. While providers have the option of deactivating their identification number, some mental health professionals included in this list may no longer be practicing or accepting new clients.
Students Identified with Emotional Disturbance for Individualized Education Program	Percent of Children Identified as having an 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. Data years 2017-2018.	IDEA Data Center, 2017 – 2018 IDEA Section 618, State Level Data Files, Child Count and Educational Environments. https://www2.ed.gov/programs/osepidea/618-data/state-level-data-files/index.html#bccee US Department of Education, National Center for Education Statistics, Common Core of Data. https://nces.ed.gov/ccd/stnfis.asp Downloaded and calculated on 5/27/2020.

Indicator	Description of Measure	Source
Youth with At Least One Past Year Major Depressive Episode (MDE)	Among youth age 12-17, Major Depressive Episode (MDE) is defined as in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which specifies a period of at least 2 weeks when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. For details, see Section B of the "2017-2018 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology" at https://www.samhsa.gov/data/. Data survey year 2017-2018.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2017-2018. https://www.samhsa.gov/data/report/2018-nsduh-detailed-tables
Youth with Substance Abuse Disorder in the Past Year.	Among youth 12-17, substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine. Misuse of prescription psychotherapeutics is defined as use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs. Data survey years: 2017-2018	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, https://www.samhsa.gov/data/report/2018-nsduh-detailed-tables
Youth with MDE who Did Not Receive Mental Health Services	Youth with Past Year MDE who Did Not Receive Treatment is defined as those who apply to having Past Year MDE as defined above ("Youth with At Least One Past Year Major Depressive Episode," YMDEYR) and respond NO to ANYSMH2. ANYSMH2 indicates whether a youth reported receiving specialty mental health services in the past year from any of 6 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 a day treatment facility (YDAYTRT), received treatment from a mental health clinic (YCLIN), from a private therapist (YTHER), and from an in-home therapist (YHOME). Youths who reported a positive response (source variable=1) to one or more of the 6 questions were included in the yes category regardless of how many of the 6 questions they answered. Youths who did not report a positive response but answered all 6 of the questions were included in the no category. Youths who did not report a positive response and did not answer all the questions, and adults were included in the unknown/18+ category. Data survey year 2017-2018.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health https://www.datafiles.samhsa.gov/info/nsduh-rdas-codebooks-nid17216

Indicator	Description of Measure	Source
Youth with Severe MDE	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. "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 2017-2018.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health https://www.datafiles.samhsa.gov/info/nsduh-rdas-codebooks-nid17216
Youth with Severe MDE who Received Some Consistent Treatment	The following variable calculated as how many youths 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 (YUDYTXNR, YUMHCRNR, YUTPSTNR, YUIHTPNR 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 YUDYTXNR, YUMHCRNR, YUTPSTNR, YUIHTPNR=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 0-6 Visits, and 7-25+ Visits. Some consistent treatment was considered 7-25+ visits in a year. Data survey years 2017-2018.	Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and Quality. https://www.datafiles.samhsa.gov/info/nsduh-rdas-codebooks-nid17216