Parity or Disparity: The State of Mental Health in America 2015

Mental Health America

Acknowledgements

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

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

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Message from MHA's President & CEO

November, 2014

I am so pleased to share Mental Health America's **Parity or Disparity: The State of Mental Health in America 2015** first annual report with you.

For many years, Mental Health America has wanted to identify a common set of data indicators for mental health that would give us a more complete picture of mental health status in America. And as both the Mental Health Parity and Addiction Equity Act and the Patient Protection and Affordable Care Act were implemented, we also saw a need to establish a baseline from which we could document the successes and failures of both federal and state initiatives aimed at improving mental health status.

This report is the result.

For the first time, Mental Health America has pulled together a number of indicators available across all fifty states and the District of Columbia. We have organized them into general categories relating to mental health status and access to mental health services. Some indicators are specific to children; others to adults.

Together, they do something that hasn't been done before – they paint a picture across the entire nation of both our mental health and how well we're caring for it.

As you'll see, disparity – more than parity – is the rule.

Some states fare better in the overall ranking and within each indicator, and some states fare worse. But I know from personal experience that policymakers and others want to know how their own state compares to others, and so they want to see these rankings. And keep in mind – who's on top and who's on the bottom can change dramatically depending on what indicators are most important to you.

Here's what's important to me. Taken as a whole, these indicators – and this report – encourage us to put a premium on earlier identification and earlier intervention on behalf of anyone with mental health concerns.

I wish that my own son Tim, who has battled schizophrenia for years, had been the beneficiary of what we at Mental Health America refer to as **B4Stage4** thinking. We have to stop waiting until mental illnesses reach Stage 4 to treat them. By Stage 4, problems are so far advanced that even with the best treatments available, recovery is often compromised. We have to treat mental illnesses just as we do other chronic conditions—aggressively and effectively before they reach Stage 4. This report shows us there is still much work to do.

And as much as stories like those told in *Losing Tim* put a face on these numbers, the numbers themselves help quantify just how many people like Tim are out there. Too many are heading for bad outcomes unless we change the way we think and act.

So, let's get the word out. Let's use this report as a starting point to change the conversation. Let's tell our stories, share these data, and help to advance our common cause of promoting mental health before Stage 4!

Paul Gionfriddo
President and CEO

Parity or Disparity: The State of Mental Health in America

Our Report is a Collection of Data Showing:

- How many people have a mental health need across all 50 states and the District of Columbia.
- How many people have access to insurance and access to mental health care in each state.
- How many people continue to face difficulty accessing care in each state.

Our Goals:

- To provide a snapshot of mental health status among children and adults for policy and program planning, analysis, and evaluation.
- To provide a baseline to track outcomes of state and federal legislation, including the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act (ACA).
- To increase dialogue and improve outcomes for individuals and families with mental health needs.

This Report:

- Includes national survey data that allow measurement of a community's needs, access to care, and outcomes regardless of the differences between the states and their varied mental health policies.
- Includes rankings that explore which states are more effective at addressing issues related to mental health.
- Shows similarities and differences among states in order to begin assessing how federal and state mental health policies result in more or less access to care.

Mental Health America 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 services, care and treatment for those who need it, and recovery as the goal.

As part of this report, MHA identified the following policy priorities related to insurance and access to care:

- **Enrollment.** All people should have insurance coverage. Insurance is especially important for people with mental health needs, who have historically been cut out of receiving insurance benefits for mental health and substance use treatment. *In 2012, 8.1 million American adults had a mental illness and were uninsured. In 2014, following the first ACA enrollment period, just over 8 million adults selected insurance through the marketplace. It is unclear how many individuals with mental illness accessed insurance through the marketplace.*

- **Medicaid Expansion.** All states should expand Medicaid if they are serious about meeting the needs of people with serious mental health concerns. The Medicaid coverage gap (the "Medicaid Gap") continues to leave a large number of people with behavioral health needs uninsured and untreated. States should expand Medicaid in a manner that results in access to care for people with behavioral health needs. *Due to the failure of many states to expand Medicaid, an estimated 3.5 million adults with mental illness or substance use remain uninsured and are currently part of the "Medicaid Gap."*

- **Access to Care.** All people should have access to the care they need, including the full range of medications and other therapeutic options (including but not limited to talk therapy, peer supports, work therapy, housing, and educational supports). MHA believes that long term services and supports are best provided in the community where people can maintain relationships that help them thrive. Hospital beds are important when needs are acute. Jails are never a good – or the right – place for recovery. *One out of five adults reports he/she did not receive needed mental health services. Additionally, two out of five children did not receive needed mental health services.*

- **Early Intervention.** Youth should get the treatment they need. Through screening and early intervention, we can significantly reduce the negative impact of mental illness on individuals and their families. This is particularly important in the school setting, as *10 times as many students need access to special education than receive it.*

- **Network Adequacy.** The mental health community depends on a strong workforce. To create a strong mental health workforce we need more clinical providers of all types, and we need to grow and train a vast network of peer support specialists. We believe that all insurance providers should include sufficiently broad networks of mental health professionals and we oppose "narrowing" networks as a cost savings measure. *In states with the smallest number of mental health providers per population, there are approximately 1,600 individuals for every one provider.*

- **Transparency in Insurance Coverage.** Consumers should know what services, limitations and costs they will face before they purchase their insurance plan. *The data shows that one out of three adults with a disability reports he/she cannot see a health care provider due to cost.*

- **Focus on Recovery.** What is determined to be "medically necessary" in coverage should be based on what is best for an individual in recovery. Focusing on recovery, community treatment, and early intervention will reduce utilization of expensive services and allow insurance companies to help more people. *The national 180-day state hospital readmission rate is 19.6 percent. The median length of stay in a state hospital is two months (63 days).*

- **Parity Compliance.** Insurance policies should be provided to consumers prior to purchasing a plan, especially for plans included on the health insurance marketplaces. Only fair and full disclosure of actual coverage will best promote meaningful consumer choice in health care. *MHA's analysis found fair and full disclosure of coverage outlines for Medicare Supplement Plans, but not for other commercial plans.*

- **More Mental Health Data.** There needs to be more collection of behavioral health data. Data should be specific to individuals with mental illness. Data should be open for public access. The best data are also clear and uniform across the states.

Following the first enrollment period of the ACA, administrative data collected included the number of individuals who chose a qualified health plan and how many individuals enrolled in Medicaid, but information on disability status was not collected. The lack of data on disability status during ACA enrollment means that for the mental health community, there is no way to know exactly how many people with mental illness gained access to insurance. This lack of data, coupled with the complexity of the mental health system as whole, results in more questions than answers. These challenges led MHA to investigate national survey data to answer questions about the impact of the ACA on individuals with mental health problems. A primer on the ACA and the complexity of mental health insurance can be found on page 43 in our section entitled "Insuring Individuals with Mental Illness."

Using national survey data, MHA wanted to answer the following questions:

- How many people with mental health needs will actually gain access to insurance under the ACA?
- Even after getting insurance, can people with mental health needs get access to care?
- Would barriers such as copays, coinsurances, denials of coverage, or lack of providers (both in insurance networks and in the community as a whole) reduce access to care?
- How will federal and state mental health policies affect access to mental health care?

Over time, MHA would like to explore additional questions, including:

- Do the national surveys and rankings reveal differences in how states are implementing and regulating federal legislation such as the ACA and MHPAEA?
- Will increased access to insurance result in increased access to behavioral health treatment?
- Will increased access to treatment result in better mental health outcomes?

This chart book presents a collection of data that provides a baseline for answering some questions about the ACA and MHPAEA. At this point, however, any analysis of why states have a particular ranking is beyond the scope of this report. Even so, MHA hopes that the state rankings reveal patterns that will lead to additional questions and future research that can further explain the "parity or disparity" MHA sees between the states.

Searching for Mental Health Data

Finding good mental health data is surprisingly difficult. This is especially true for youth data. While searching for mental health data, MHA found that national surveys define "mental health" differently. Some national surveys had definitions of disability that were relatively simple. The American Community Survey, for example, defines "Mental Disability" as: "Because of a physical, mental, or emotional condition lasting 6 months or more, the person has difficulty learning, remembering or concentrating." Other surveys took a broader approach. Among measures presented in the report, are indicators from SAMHSA's National Survey of Drug Use and Health (NSDUH). NSDUH's definition of mental illness is "having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder." The NSDUH measures of mental illness are collected and analyzed from a series of approximately thirty questions using the Mental Health Surveillance Study Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders. Also included in the report, the National Survey of Children's Health (NSCH) measures mental health among children as "emotional, behavioral or developmental issues" (EBD). Specifically, the NSCH defines a child with a mental health condition "as any child (age 0-17) with any kind of emotional, developmental, or behavioral problem that requires treatment or counseling."

The same complexities occur when exploring insurance access. For example, in the NSDUH, individuals are asked if they are insured by, e.g., private insurance, Medicare, Medicaid, CHIP, or TRICARE. Individuals are identified as "uninsured" if they are not covered by any private insurance or public insurance. The NSCH, similarly, asks if a child has any kind of health insurance coverage. In America, 94.5 percent of children had access to insurance at the time of the survey. The NSCH also explores "consistency of coverage", which identified any period in the past 12 months where a child was uninsured.

MHA Guidelines

Given the variability described above, MHA developed guidelines to identify measures that were most appropriate for inclusion in our ranking. Indicators were chosen that met the following guidelines:

- Data that were publicly available and as new as possible to provide up-to-date results.
- Data with definitions for mental illness that best represented individuals who have a mental health concern.
- Data that are available for all 50 states plus 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. For example, data from the Uniform Reporting System, which measures the public mental health system only, were assessed, but were not included in the ranking.
- Data that could be collected over time to allow for analysis of future changes and trends.

Our Final Measures

1. Adults with Any Mental Illness (AMI)
2. Adults with Dependence or Abuse of Illicit Drugs or Alcohol
3. Adults with Serious Thoughts of Suicide
4. Children with Emotional Behavioral Developmental Issues (EBD)
5. Youth Dependence or Abuse of Illicit Drugs or Alcohol
6. Youth with At Least One Major Depressive Episode
7. Youth Attempted Suicide (not included in the overall ranking)
8. Adults with AMI and Uninsured
9. Adults with AMI Who Received Treatment
10. Adults with AMI Reporting Unmet Need
11. Children with EBD Who Were Consistently Insured
12. Children Who Needed but Did Not Get Mental Health Services
13. Students Identified with Seriously Emotional Disturbance for an Individualized Education Plan
14. Children with Ongoing EBD Reporting Inadequate Insurance
15. Adults with Disability Who Could Not See a Doctor Due to Costs
16. Mental Health Workforce Availability
17. State Hospital 180-day Readmission Rate (not included in the overall ranking)
18. Improved Social Connectedness (not included in the overall ranking)

Survey Limitations

Each survey has its own strengths and limitations. Both the NSDUH and the NSCH have large sample sizes and utilized statistical modeling to provide weighted estimates of each state population. Of particular importance to the mental health community, 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.

A Complete Picture

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

Labels

The labels used in this report are provided as they appear in the original survey, which is why adult mental illness is labeled as "Any Mental Illness," while mental illness among children is labeled as "Emotional, Behavioral or Developmental Issues." The glossary provides both the full definition of the measure as well as the source of each measure.

Ranking

MHA calculated the report's rankings by giving a standardized score (Z score) for each measure and ranking the sum of the standardized scores. For measures where high scores are better outcomes, we calculated the standardized score by multiplying it by (-1), then used that figure in the sum. Measures that utilized reverse Z scores included: Adults with AMI Who Received Treatment, Children with EBD Who Were Consistently Insured, and Percent of Students Identified with Serious Emotional Disturbance for IEP. The ranking is based on the percentage or rate. All measures are important to us. MHA did not weight any measure in the rankings.

The Overall Ranking includes 15 measures. Youth Attempted Suicide, State Hospital 180 day Readmission Rate and Improved Social Connectedness were not included in any ranking. These measures were included in the report because we believe they highlight an important area of advocacy that MHA wants to track. Youth Attempted Suicide was not included in the overall ranking because it is missing data from a significant number of states. State Hospital Readmission and Improved Social Connectedness were not included in the overall ranking because they are outcome measures from only the public mental health system.

The Adult Ranking includes seven adult measures: Adult with Any Mental Illness (AMI), Adult Dependence or Abuse of Illicit Drugs or Alcohol, Adults with Serious Thoughts of Suicide, Adults with AMI and Uninsured, Adults with AMI who Received Treatment, Adults with AMI Reporting Unmet Need, and Adults with Disability who Could Not See a Doctor Due to Costs.

The Youth Ranking includes seven youth measures: Children with Emotional Behavioral Developmental Issues (EBD), Youth Dependence or Abuse of Illicit Drugs or Alcohol, Youth with At Least One Major Depressive Episode, Children with EBD who were Consistently Insured, Children Who Needed but Did Not Get Mental Health Services, Students Identified with Serious Emotional Disturbance for IEP, and Children with Ongoing EBD Reporting Inadequate Insurance.

The Need Ranking includes six prevalence of mental illness measures: Adult with Any Mental Illness (AMI), Adult Dependence or Abuse of Illicit Drugs or Alcohol, Adults with Serious Thoughts of Suicide, Children with Emotional Behavioral Developmental Issues (EBD), Youth Dependence or Abuse of Illicit Drugs or Alcohol, and Youth with At Least One Major Depressive Episode.

The Access Ranking includes nine measures of access and access quality: Adults with AMI and Uninsured, Adults with AMI who Received Treatment, Adults with AMI Reporting Unmet Need, Children with EBD who were Consistently Insured, Children who Needed but Did Not Get Mental Health Services, Students Identified with Serious Emotional Disturbance for IEP, Children with Ongoing EBD Reporting Inadequate Insurance, Adults with Disability who Could Not See a Doctor Due to Costs, and Mental Health Workforce Availability.

Individual Ranking includes each measure ranked individually with an accompanying chart. The chart provides the percentage and estimated population for each ranking. The estimated population number is weighted and calculated by the agency conducting the applicable federal survey. The ranking is based on the percentage or rate. Data are presented with 2 decimal places when available. The individual rankings were grouped into categories listed in the table of contents.

Mental Health America in Action

While the national and state data provide an overall picture of the mental health of a region, it is important to note these qualifications:

1. A higher ranking does not necessarily indicate that a state is "doing well" in an objective sense. Rather, a high ranking only means that the particular state is doing better *on that measure* than those states that rank lower on that specific measure. Fundamentally, the data and MHA's analysis reflect an immense amount of unmet need among all the states, even for the states that are, for the most part, doing "better" than other states.

2. Many of MHA affiliates advocate on a state level and see barriers experienced by individuals who have a mental illness. MHA included information from our affiliates throughout the report to highlight the complexity and ongoing unmet needs of the mental health community in specific states.

Ranking

Overall Ranking

The combined scores for 15 of our measures make up the overall ranking.

A high overall ranking indicates lower prevalence of mental illness and higher rates of access to care. A low overall ranking indicates higher prevalence of mental illness and lower rates of access to care.

Based on MHA's rankings, it appears that:

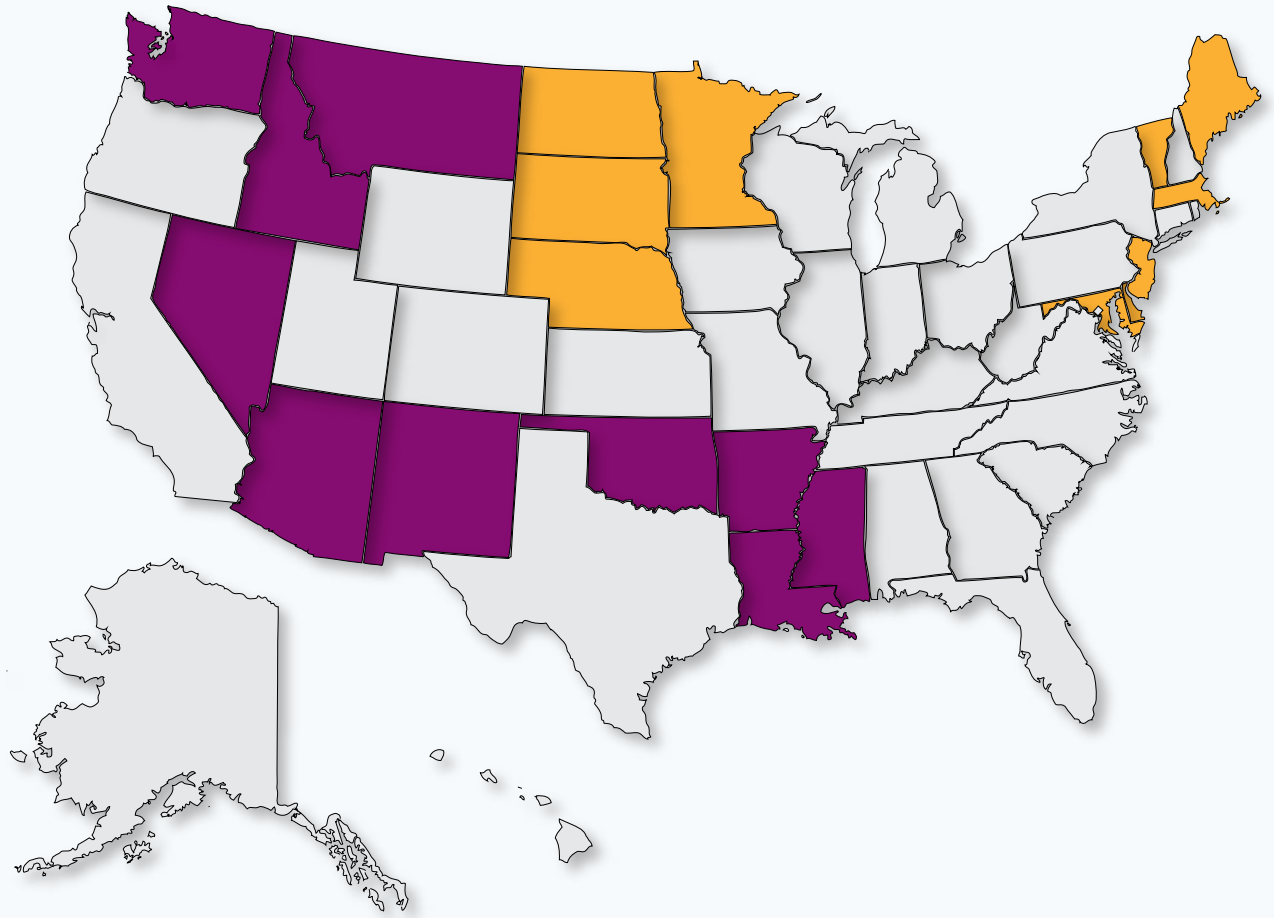
States with the lowest prevalence of mental illness and highest rates of access to care include:

- Massachusetts, Vermont, Maine, North Dakota, and Delaware.

States with the highest prevalence of mental illness and lowest rates of access to care include:

- Arizona, Mississippi, Nevada, Washington, and Louisiana.

States that rank in the top ten are in the Northeast and Midwest, while states that rank in the bottom ten are in the South and the West.



Rank	State
1	Massachusetts
2	Vermont
3	Maine
4	North Dakota
5	Delaware
6	Minnesota
7	Maryland
8	New Jersey
9	South Dakota
10	Nebraska
11	Connecticut
12	Iowa
13	Hawaii

Rank	State
14	Pennsylvania
15	Wisconsin
16	Illinois
17	New York
18	North Carolina
19	Kansas
20	Virginia
21	Ohio
22	Missouri
23	New Hampshire
24	Rhode Island
25	Tennessee
26	Florida

Rank	State
27	Kentucky
28	Colorado
29	California
30	District of Columbia
31	Alaska
32	Georgia
33	South Carolina
34	Indiana
35	West Virginia
36	Texas
37	Utah
38	Wyoming
39	Alabama

Rank	State
40	Oregon
41	Michigan
42	Idaho
43	Arkansas
44	Montana
45	Oklahoma
46	New Mexico
47	Louisiana
48	Washington
49	Nevada
50	Mississippi
51	Arizona

Adult vs. Youth

The scores for the seven adult and seven youth measures make up the Adult and Youth Ranking.

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

Based on MHA's rankings, it appears that:

States with the lowest prevalence of mental illness and highest rates of access to care:

For adults include:

- Massachusetts, New Jersey, Hawaii, Maryland, and Connecticut.

For youth include:

- Vermont, North Dakota, Wisconsin, Iowa and Maine.

States with the highest prevalence of mental illness and lowest rates of access to care:

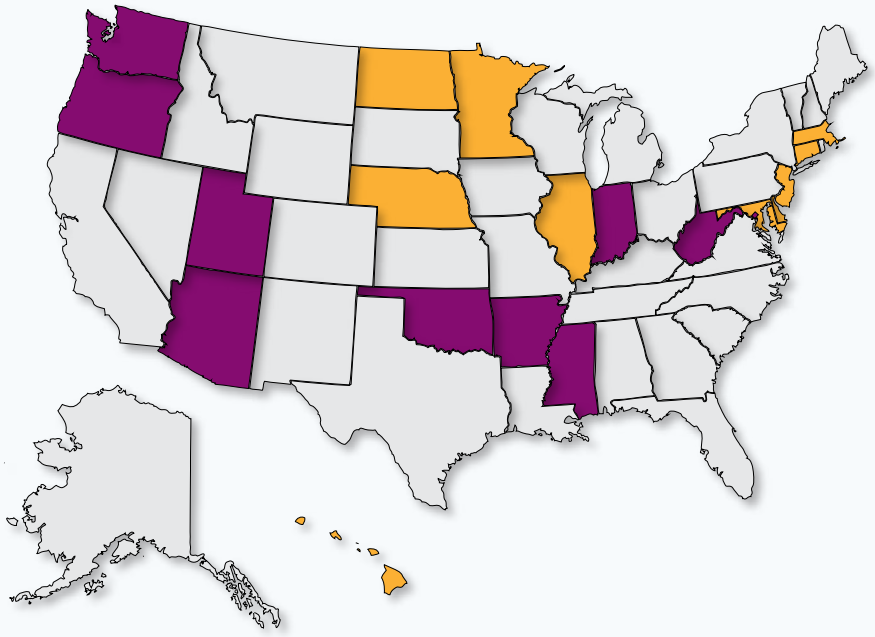
For adults include:

- Mississippi, Arizona, Oklahoma, Arkansas, and Washington.

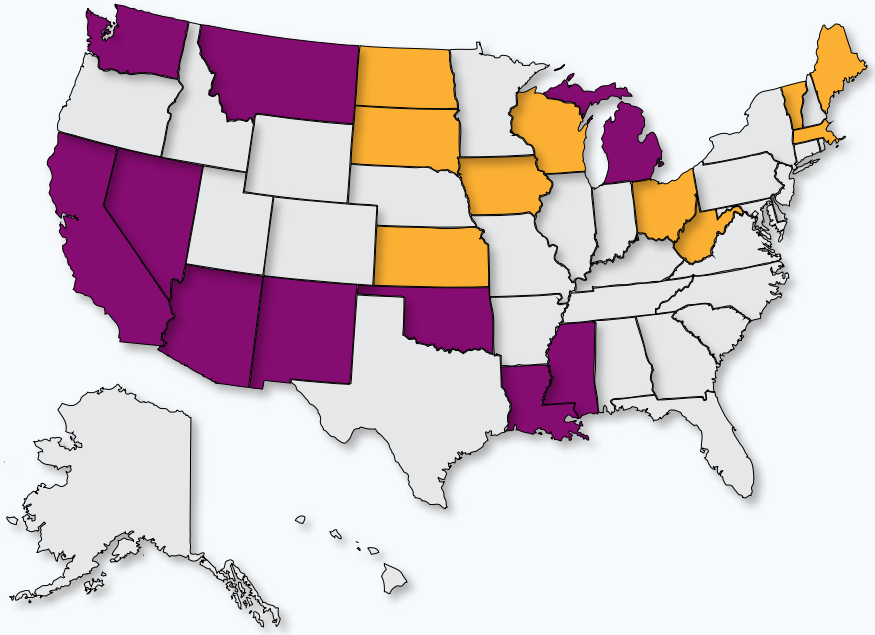
For youth include:

- Nevada, New Mexico, Montana, Louisiana, and Washington.

Adult Ranking



Youth Ranking



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

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

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

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

Comparing Overall, Adult, and Youth Ranking

Among the top quarter of ranked states (13 states for each ranking), four states are ranked high across Overall Ranking, Adult Ranking and Youth Ranking (In Orange):

- Massachusetts, Maine, North Dakota, and Minnesota.

In these states, both adults and youth have better mental health outcomes as compared to other states.

Among the bottom quarter of ranking states, five states consistently rank low across Overall Ranking, Adult Ranking and Youth Ranking (In Purple).

- Oklahoma, New Mexico, Washington, Mississippi, and Arizona.

In these states, both adults and youth have worse mental health outcomes as compared to other states.

How Adults Compare to Youth across States

Comparison across tables reveals both the states where adults are better cared for than youth and the states where youth are better cared for than adults.

Adults show better outcomes than youth where states rank higher in the Adult Ranking as compared to the Youth Ranking. These states include (In Red):

- New Jersey, Hawaii, Maryland, Connecticut, Illinois, North Carolina, Virginia, New Hampshire, California, Texas, Montana, Louisiana, and Nevada.

Similarly, youth show better outcomes than adults where states rank higher in Youth Ranking as compared to Adult Ranking. These states include (In Blue):

- Vermont, Wisconsin, Kansas, Ohio, District of Columbia, Indiana, Alaska, Utah and Arkansas.

Need vs. Access

The scores for the six prevalence and nine access measures make up the Need and Access Ranking.

A high ranking on the Need Ranking indicates a lower prevalence of behavioral health concerns. In other words, the lower a state ranks on the Need Ranking, the higher the "need" is for mental health services. The Need Ranking includes the number of adults and youth with mental, emotional, behavioral problems and substance use issues.

The Access Ranking indicates how much access to mental health care a state has. MHA's access measures include access to insurance, access to treatment, quality and cost of insurance, access to special education, and workforce availability. A high Access Ranking indicates that a state provides relatively more access to insurance and treatment.

Based on MHA's rankings, it appears that:

States with the lowest prevalence of behavioral health concerns (rank 1-5) are:

- New Jersey, Maryland, Florida, Alabama, and North Carolina.

States with the highest prevalence of behavioral health concerns (rank 47-51) are:

- New Mexico, District of Columbia, Washington, Michigan, and Oklahoma.

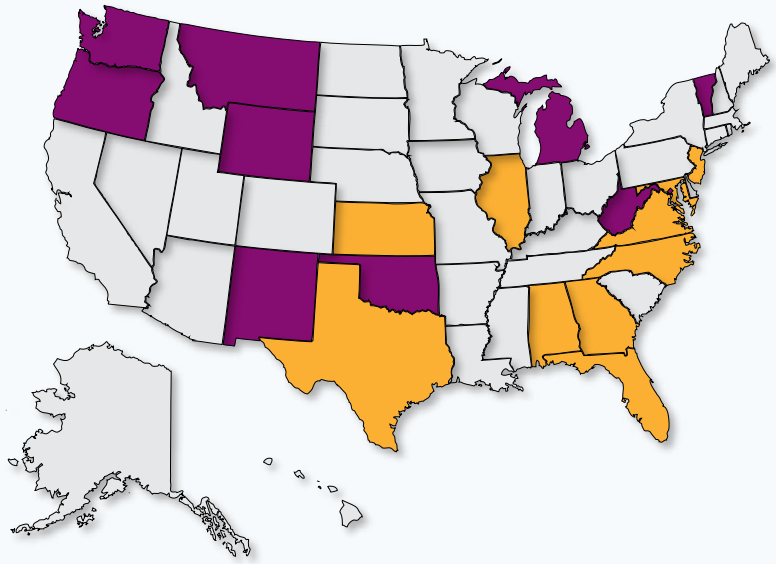
States with highest rates of access to mental health care (rank 1-5) are:

- Vermont, Massachusetts, Maine, Delaware and Iowa.

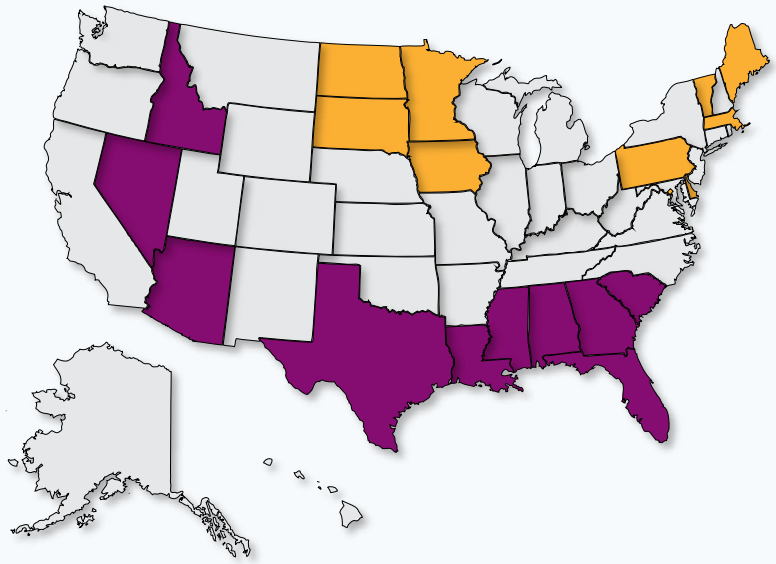
States with lowest rates of access to mental health care (rank 47-51) are:

- Nevada, Mississippi, Alabama, Louisiana, and Texas.

Need Ranking



Access Ranking



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

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

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

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

Comparing Overall, Need, and Access Ranking

Among the top and bottom quarter of ranked states, (13 states for each ranking):

- Florida, Alabama, Texas, and Georgia (In Purple) have the lowest rates of mental health need, but the lowest rates of access to care. Alabama, for example, has the lowest percentage of children with an emotional, behavioral, or developmental issue (EBD, ranked 1st, 6.87 percent of the population, on page 21), but among those children, access to treatment is relatively limited, as approximately a 13.7 percent lack consistent insurance and 46.3 percent did not receive needed treatment.

- Vermont and the District of Columbia (In Orange), on the other hand, have some of the highest rates of need but provide the best access to treatment. Vermont has a relatively high percentage of children with an EBD and is ranked 46th among children with an EBD (11.73 percent). However, in Vermont, only an estimated 3.3 percent of those children lack consistent insurance and only 22.1 percent did not receive needed treatment.

- Arizona and Arkansas (In Red) has both high rates of need and poor access to care, indicating that there are many in Arizona and Arkansas who might face significant barriers to recovery.

- On the other end, North Dakota (In Blue) stands out as having both low mental health prevalence and high access to treatment. People in North Dakota might face fewer barriers to recovery.

Implications on Overall Ranking

- Cases like Vermont and Maine show how a state can still have significantly high rates of mental health need, but move up in the overall ranking because of their strong access to treatment.

- Similarly, having lower rates of mental health need, but very poor access to treatment can result in lower positions in the overall ranking.

Adult Prevalence of Mental Illness

42.5 million
(18.19%) of adults in America suffer from any mental illness

19.7 million
(8.46%) have a substance use problem

8.8 million
(3.77%) report serious thoughts of suicide

Mental health, substance use, and suicidal thoughts are influenced by both biological and environmental factors. Environmental factors such as stress, poverty, housing, and lack of access to opportunities can increase rates of behavioral health problems. This is especially the case for substance use, where individuals often turn to illicit drugs and alcohol to cope with stress and symptoms. State policies, like Medicaid expansion or stronger jobs programs, can help to reduce stressors and thus potentially change the prevalence rates of behavioral health issues such as substance abuse and suicide.

Data Highlights

Size Matters

- New Jersey and Illinois have the lowest percentage of Adults with Any Mental Illness, but given the difference in population of each state, the aggregate population counts are quite different: 982,000 people in New Jersey and 1,524,000 in Illinois.

Southern States Come Out on Top

- Among Adult Dependence or Abuse of Illicit Drugs or Alcohol, nine of the top 10 states (i.e., those with the lowest rates of substance use) are located in in the South. It is unclear if the lower rates of substance use are due to cultural stigma related to drug use, the lack of availability of drugs, or a limitation in the survey.
- Among Adults with Serious Thoughts of Suicide, six of the 10 states with lowest rates of suicidal thoughts are also in the South.
- Again, explanation for these results is beyond the scope of this report, but these and other findings represent compelling examples of the need for additional research.

Mental Health America of Montana

In 2007, MHA Montana Initiated the Mental Health Policy Caucus to organize advocates, consumers, policy makers, providers and families around the issue of mental health. MHA Montana's efforts have resulted in a bi-annual legislative caucus that annually holds a Mental Health Policy Summit to address critical implementation issues like mental health parity, community-based service delivery, forensic mental health and the Medicaid medication formulary.

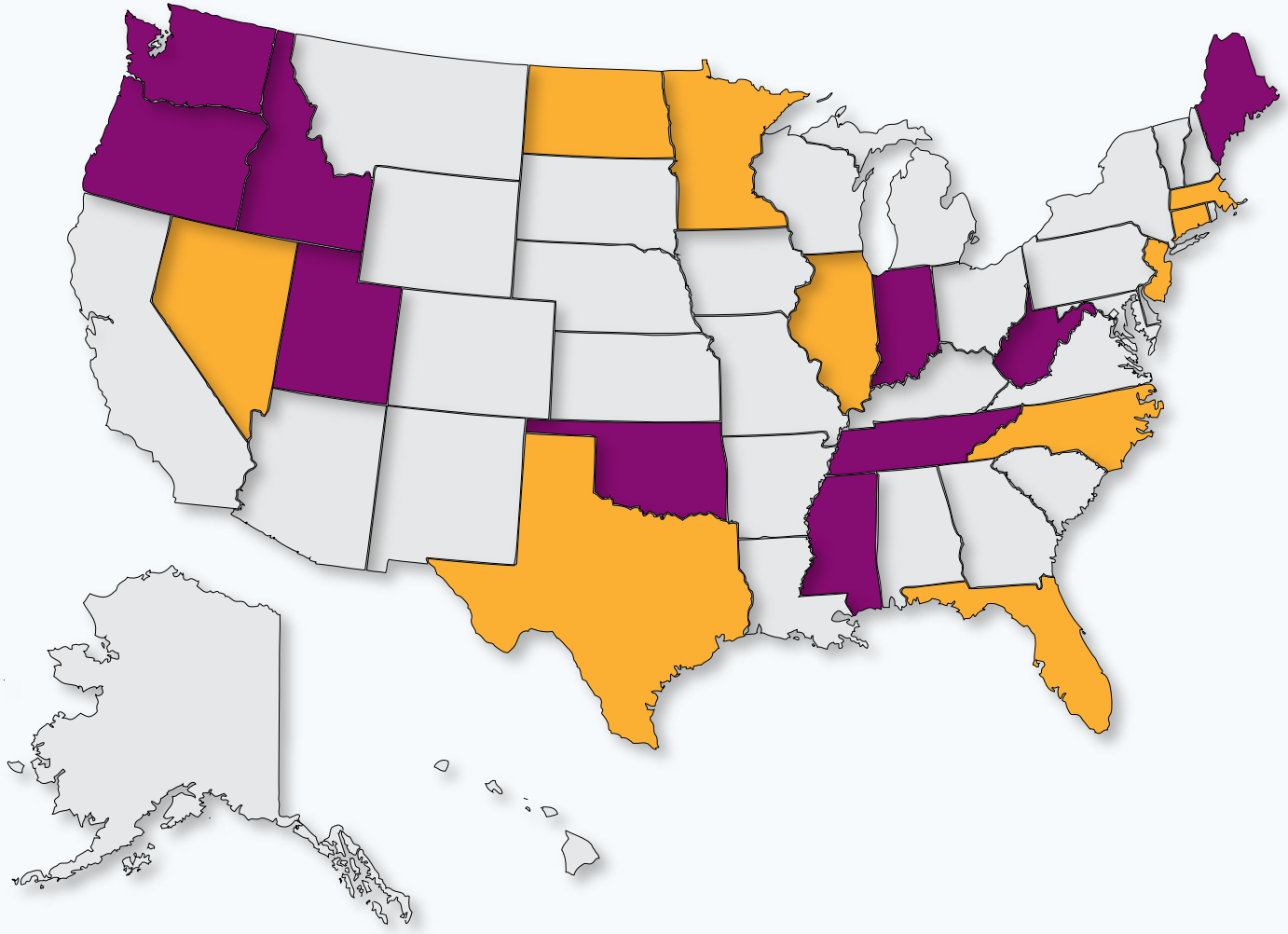
MHA Montana has worked with the Interim Legislative Committee on Children, Families, Health & Human Services to address the need for changes in the state Medicaid plan to include payment for Certified Peer Support services. The organization's advocacy efforts resulted in development of a Peer Support Task force to plan for implementation and training of Peer Support services with a commitment from the state Department of Public Health & Human Services to address the state Medicaid plan updates.

In 2011 MHA Montana started an initiative to develop a peer run organization with the benefit of funding from the Montana Mental Health Settlement Trust Fund. The organization mentored the new director and assisted with by-laws and Board of Director development. Montana's Peer Network receive its own 501(c)3 federal recognition in 2012 and are a strong peer advocacy and service organization in Montana, insuring a recovery oriented presence in the state.

Mental Health America of Georgia

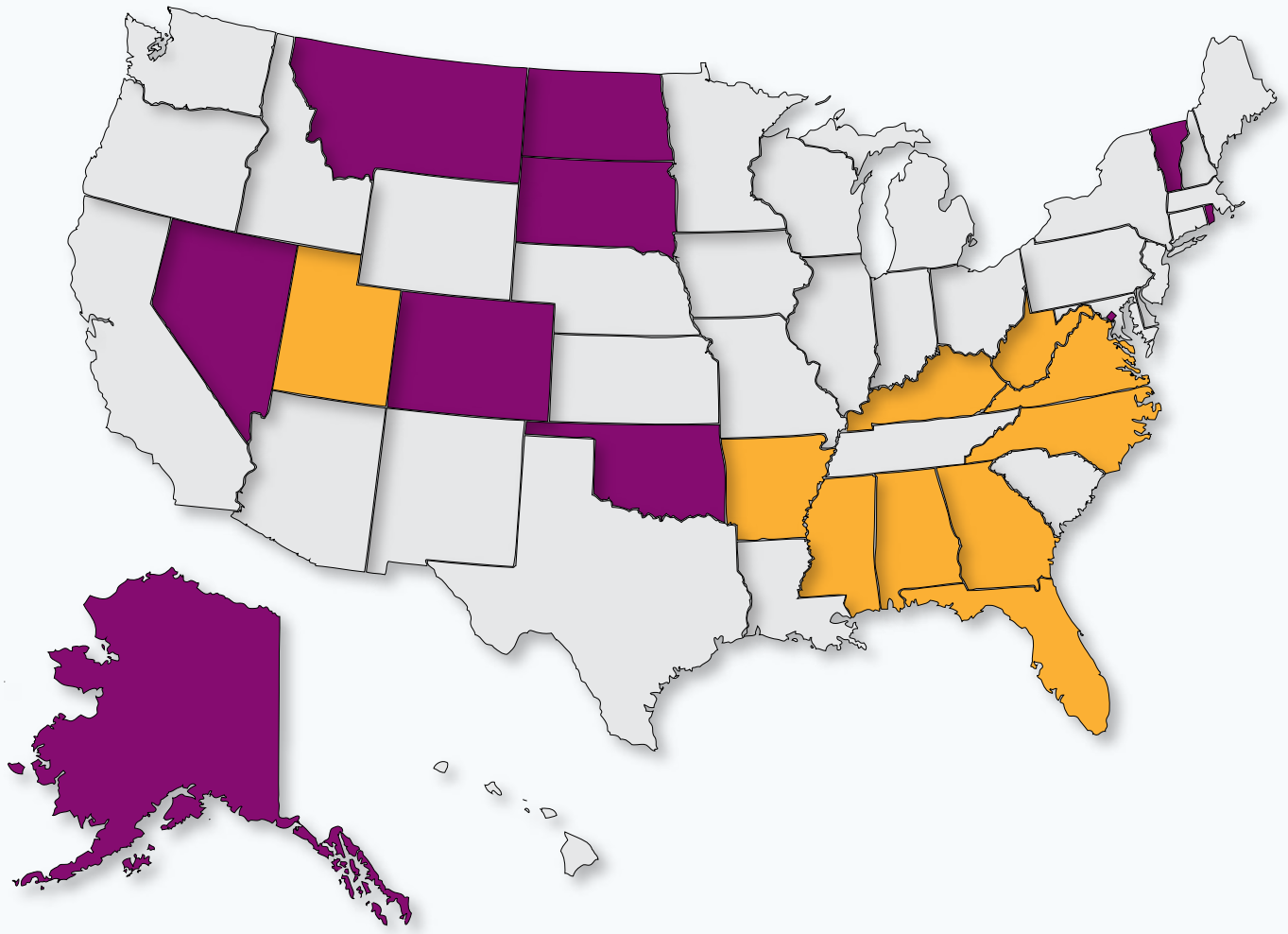
In 2012, MHA Georgia partnered with the state's Department of Behavioral Health and Developmental Disabilities and the Georgia Mental Health Consumer Network to bring the RESPECT Institute to Georgia. This program, which provides individuals with the skills and coaching necessary to transform their mental illness, treatment, and recovery experiences into educational and inspirational presentations, now has over 500 graduates who have spoken in front of over 33,000 individuals and state leaders throughout Georgia. MHA Georgia was able to educate and decrease stigma around people with mental illness through this program, by having the very individuals with lived experience advocate directly and in their own words.

Adults with Any Mental Illness



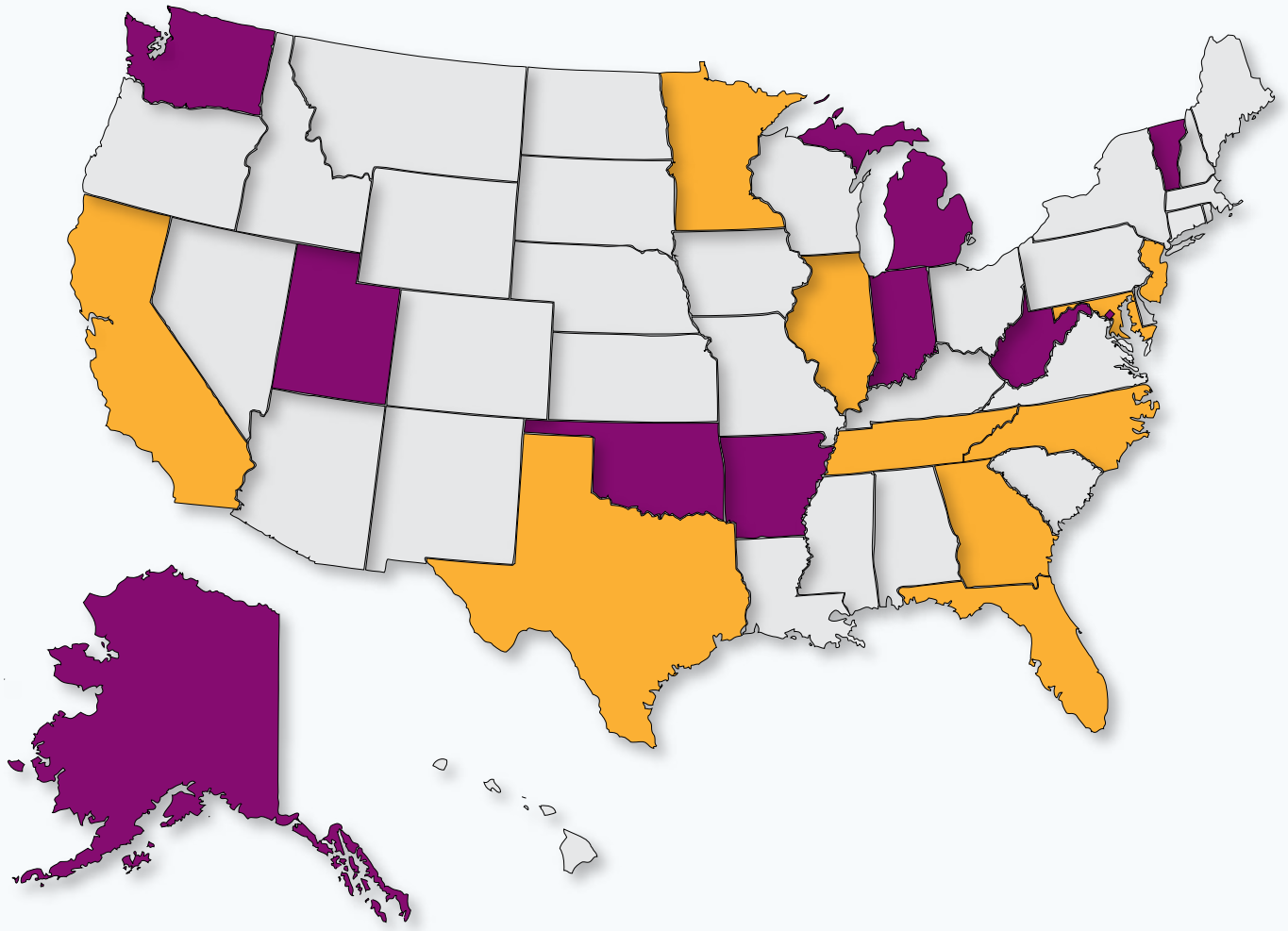
Rank	State	Percent	Number
1	New Jersey	14.66	982,000
2	Illinois	15.86	1,524,000
3	Nevada	16.05	327,000
4	Connecticut	16.71	457,000
5	North Carolina	16.84	1,213,000
6	Texas	16.86	3,104,000
7	Florida	16.87	2,509,000
8	Minnesota	17.18	692,000
9	North Dakota	17.21	90,000
10	Massachusetts	17.38	893,000
11	Hawaii	17.48	179,000
12	Virginia	17.50	1,063,000
13	California	17.68	4,964,000
14	South Dakota	17.77	108,000
15	Nebraska	17.89	243,000
16	Maryland	17.93	792,000
17	Wisconsin	17.98	778,000
18	Pennsylvania	17.99	1,765,000
19	Colorado	18.12	694,000
20	Kansas	18.20	381,000
21	Delaware	18.26	126,000
22	Iowa	18.40	424,000
23	New Hampshire	18.53	190,000
24	New York	18.61	2,792,000
25	Rhode Island	18.80	154,000
26	Arizona	18.83	901,000
27	Montana	18.92	145,000
28	Alaska	18.94	97,000
29	Georgia	18.99	1,360,000
29	Missouri	18.99	855,000
31	Louisiana	19.28	649,000
32	Alabama	19.34	698,000
33	Vermont	19.39	96,000
34	District of Columbia	19.44	99,000
35	Kentucky	19.47	635,000
36	South Carolina	19.56	688,000
37	New Mexico	19.59	300,000
38	Wyoming	19.60	84,000
39	Ohio	19.64	1,709,000
40	Arkansas	19.81	432,000
40	Michigan	19.81	1,484,000
42	Indiana	19.87	961,000
43	Maine	20.05	210,000
44	Tennessee	20.25	979,000
45	Mississippi	20.27	439,000
46	Idaho	20.58	235,000
47	Washington	20.77	1,074,000
48	Oregon	20.89	624,000
49	West Virginia	21.38	308,000
50	Oklahoma	21.88	609,000
51	Utah	22.35	431,000
	United States	18.19	42,546,000

Adult Dependence or Abuse of Illicit Drugs or Alcohol



Rank	State	Percent	Number
1	Alabama	6.58	238,000
2	Utah	6.79	131,000
3	Georgia	7.20	516,000
4	Mississippi	7.24	157,000
5	North Carolina	7.37	532,000
6	Kentucky	7.42	242,000
7	Virginia	7.56	459,000
8	Arkansas	7.64	167,000
9	Florida	7.71	1,146,000
10	West Virginia	7.85	113,000
11	Kansas	7.90	165,000
12	Maryland	7.92	350,000
13	Tennessee	7.95	384,000
14	Hawaii	7.96	82,000
15	New Jersey	8.03	538,000
16	Texas	8.07	1,484,000
17	Missouri	8.14	367,000
18	South Carolina	8.20	289,000
19	New York	8.36	1,255,000
20	Pennsylvania	8.40	824,000
21	Indiana	8.44	408,000
22	Idaho	8.45	97,000
23	Louisiana	8.48	285,000
24	Maine	8.52	89,000
25	New Hampshire	8.73	90,000
26	California	8.80	2,472,000
26	Illinois	8.80	845,000
28	Ohio	8.86	771,000
29	Michigan	8.92	668,000
30	Iowa	8.94	206,000
31	Nebraska	8.97	122,000
32	Wisconsin	9.08	393,000
33	Arizona	9.09	435,000
34	Delaware	9.10	63,000
35	Minnesota	9.22	372,000
36	Connecticut	9.29	254,000
37	Massachusetts	9.33	479,000
38	Wyoming	9.35	40,000
39	Oregon	9.49	283,000
40	Washington	9.50	491,000
41	New Mexico	9.54	146,000
42	Vermont	9.61	48,000
43	Oklahoma	9.94	276,000
44	Colorado	10.13	388,000
45	South Dakota	10.24	62,000
46	North Dakota	10.30	54,000
47	Nevada	10.31	210,000
48	Alaska	10.33	53,000
49	Montana	10.38	79,000
50	Rhode Island	10.91	89,000
51	District of Columbia	13.78	70,000
	United States	8.46	19,777,000

Adults with Serious Thoughts of Suicide



Rank	State	Percent	Number
1	Texas	3.34	614,000
2	New Jersey	3.37	226,000
3	Illinois	3.42	329,000
4	Maryland	3.43	152,000
5	Tennessee	3.52	170,000
6	Georgia	3.53	253,000
7	Florida	3.59	534,000
7	Minnesota	3.59	145,000
9	North Carolina	3.62	261,000
10	California	3.63	1,020,000
11	Colorado	3.65	140,000
12	Connecticut	3.66	100,000
13	Virginia	3.71	225,000
14	Alabama	3.76	136,000
14	Nevada	3.76	77,000
16	New York	3.77	566,000
17	Nebraska	3.78	52,000
18	Delaware	3.80	26,000
18	Hawaii	3.80	39,000
18	Montana	3.80	29,000
18	South Carolina	3.80	134,000
22	South Dakota	3.81	23,000
23	North Dakota	3.82	20,000
24	Kansas	3.83	80,000
25	Pennsylvania	3.88	380,000
26	Oregon	3.91	117,000
27	Massachusetts	3.92	202,000
28	Mississippi	3.92	85,000
29	Ohio	3.93	342,000
30	Iowa	3.94	91,000
31	Missouri	3.95	178,000
32	New Mexico	3.95	61,000
33	Louisiana	3.96	133,000
34	Arizona	4.02	193,000
34	New Hampshire	4.02	41,000
34	Wisconsin	4.02	174,000
37	Rhode Island	4.05	33,000
38	Idaho	4.08	47,000
39	Kentucky	4.11	134,000
40	Maine	4.12	43,000
41	Wyoming	4.17	18,000
42	District of Columbia	4.19	21,000
43	Indiana	4.25	206,000
44	Vermont	4.32	21,000
44	Washington	4.32	224,000
46	Arkansas	4.34	95,000
47	Oklahoma	4.37	122,000
48	Alaska	4.38	22,000
49	Michigan	4.43	332,000
50	Utah	4.55	88,000
51	West Virginia	4.69	68,000
	United States	3.77	8,818,000

Child/Youth Prevalence of Mental Illness

6.2 million
(8.5%) of children in America suffer from an Emotional, Behavioral, or Developmental (EBD) issue

1.6 million
(6.48%) have a substance use problem

2.1 million
(8.66%) report having at least one Major Depressive Episode in the year

8.01 percent
of youth report having attempted suicide once in the last year

2X more
Twice as many females attempt suicide (10.6%) as compared to males (5.4%)

Protecting youth against mental health problems cannot be understated. For most youth, symptoms start to present themselves at a young age. When services are provided early, youth are less likely to drop out of school, turn to substance use, or engage in risky self-injurious behaviors. Unfortunately, significantly less mental health data are available for youth populations. Without good data on the mental health status of America's youth, we will not be able to keep track of the impact of mental illness on their wellbeing or adequately support early intervention efforts.

Data Highlights

Along the Appalachian Mountains

- The highest rates of EBD among youth occur along states just to the west of the Appalachian Mountains. This area also has some of the highest rates of poverty and social inequality.
- This area also shows some of the lowest rates of substance use among youth.

The West

- Roughly five of the 10 states with the highest rates of both substance use and depression among youth are in the West.

Mental Health America of Hawaii

As a critical leader in mental health and mental illness awareness, MHA Hawaii is leading efforts to educate college students on how to recognize and get help for fellow students who may be experiencing mental health problems. Launched in 2014, the pilot program has already educated 1,500 community college students. Its success resulted in the creation of a full-time mental health counselor position on campus.

MHA Hawaii is also leading the advocacy charge by convening an essential monthly meeting between the ten community-based mental health agencies that provide all services for behavioral health for severely mentally ill individuals, the primary insurance provider which contracts out all the services, and the state's Medicaid office. These regular meetings have helped the agencies provide services for many individuals with mental illness in Hawaii.

Highest Highest-Ranked vs. Lowest-Ranked

- The range of prevalence of youth with EBD ranges from 6.87 percent in Alabama to almost double that at 13.95 percent in Kentucky.
- Similarly, the range of youth who attempted suicide also varies significantly among the states. Only 5.47 percent of youth in Massachusetts (ranked 1st) attempt suicide, while 14.34 percent of youth in Rhode Island (ranked 46th) attempt suicide.

Missing Data

- Five jurisdictions have chosen not to collect and report youth suicide attempt data to the CDC including California, the District of Columbia, Minnesota, Oregon, and Washington.
- Although states might collect their own data for rates of suicide attempts among youth, the lack of consistency in how responses are collected makes it more difficult to compare states with missing data to those who responded to the CDC survey.

Depression vs. Suicide Attempt

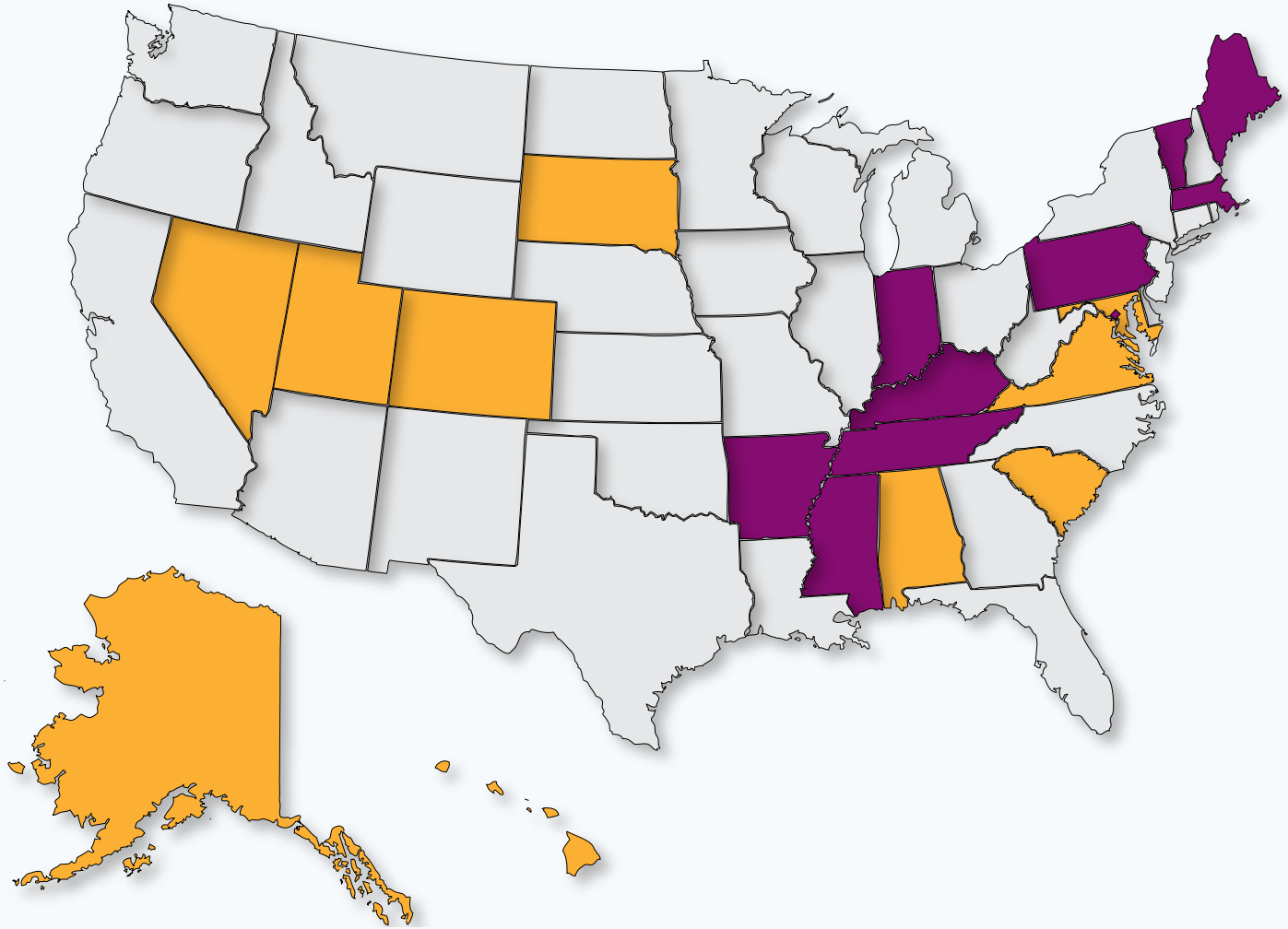
Most states have similar rates of reported depressive episodes and suicide attempts – but not all.

- Illinois, Indiana, North Dakota and Rhode Island have more youth reporting a suicide attempt than have a depressed episode (at least a 3 percent difference).
- Rhode Island has the largest percent difference with many more youth reporting suicide attempts than a depressed episode (a 5.34 percent difference).
- Iowa and New Hampshire have more youth reporting a depressed episode but lower rates of reported suicide attempts (at least a 3 percent difference).

Mental Health America of Georgia

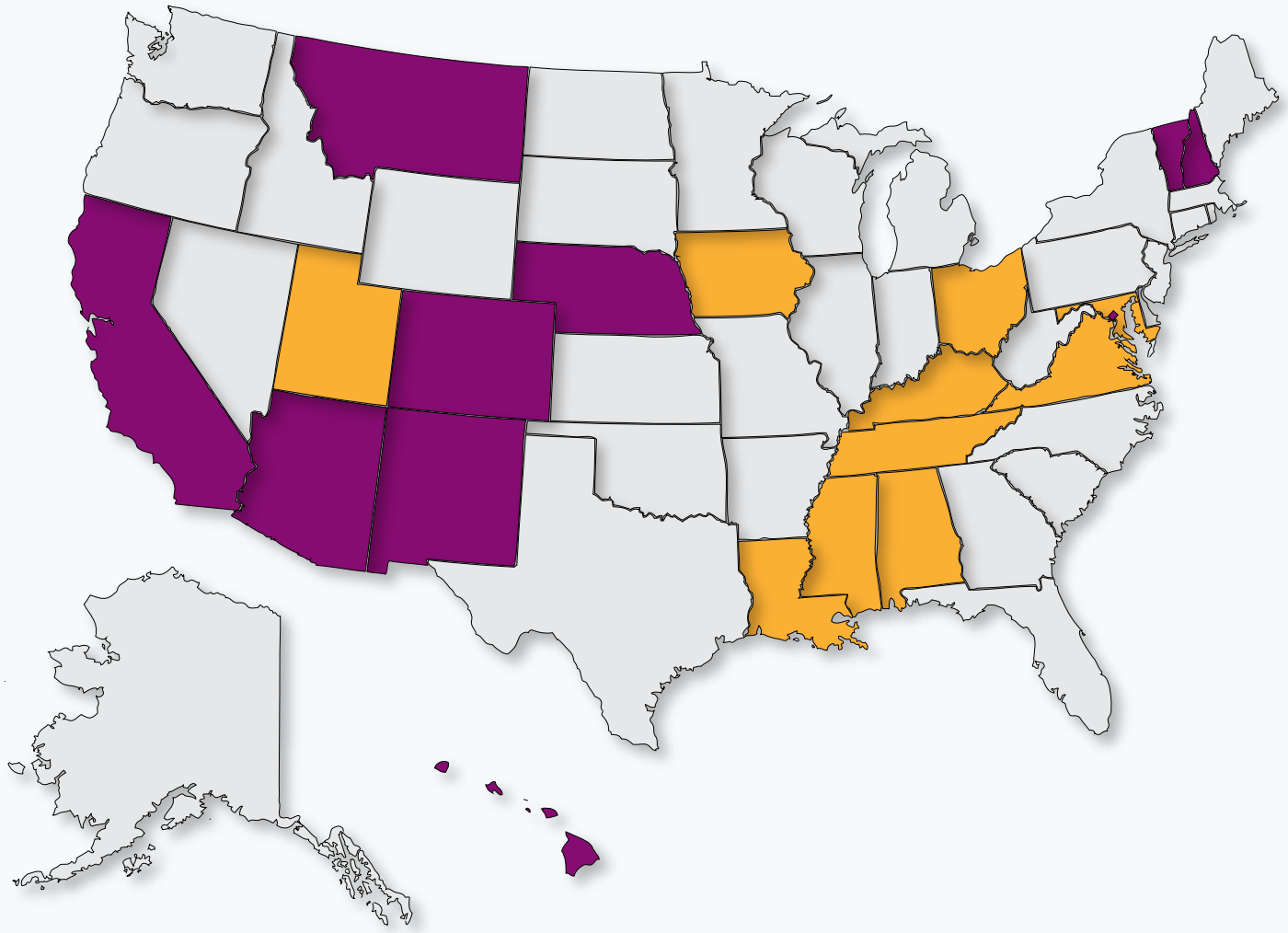
In 2008, an undertaking of MHA Georgia, Project Healthy Moms (PHM), has grown into a turn-key program for women and families struggling with maternal mental illness. The main objectives of PHM are to disseminate knowledge about maternal mental illnesses to providers and communities within Georgia, increase identification and treatment of maternal mental illness, support families and mothers living with these illnesses, and reducing the stigma associated with them. MHA Georgia achieves its objectives through a statewide resource list, online education and resources, a monthly newsletter, a bilingual warmline peer support, Maternal Mental Illness Screening and Identification trainings, and an annual 5K fundraising/awareness event called Move for Moms.

Children with Emotional Behavioral Developmental Issues



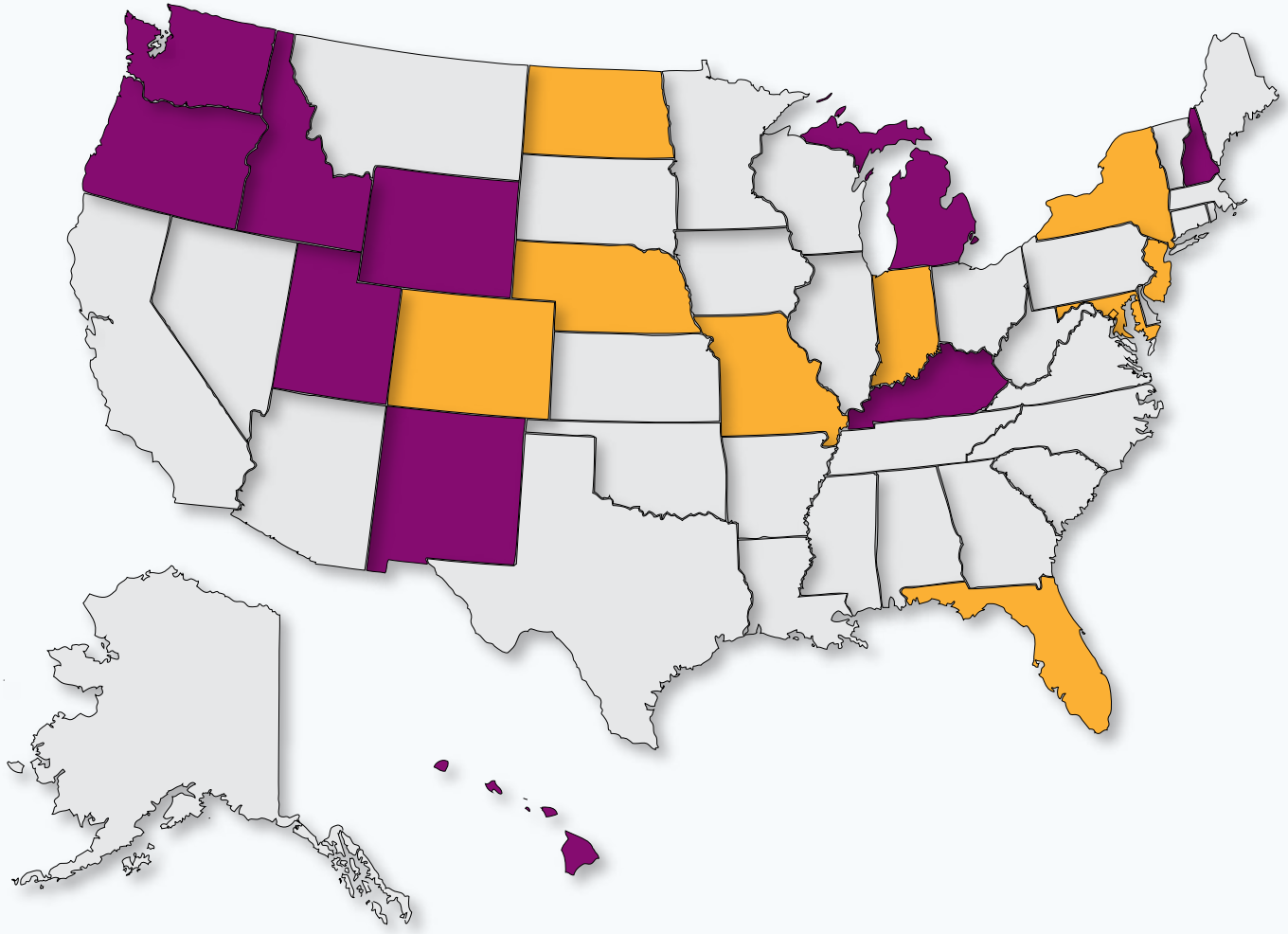
Rank	State	Percent	Number
1	Alabama	6.87	69,359
2	South Dakota	7.01	12,661
3	Colorado	7.25	78,535
4	Utah	7.28	55,507
5	Nevada	7.33	42,831
6	Hawaii	7.45	19,909
7	Maryland	7.62	91,563
8	Virginia	7.64	125,281
9	Alaska	7.65	12,529
10	South Carolina	7.81	75,373
11	New Jersey	8.01	145,568
12	New Mexico	8.15	37,525
13	California	8.23	677,498
14	Georgia	8.24	182,702
15	Kansas	8.27	53,084
16	Missouri	8.39	105,290
17	North Dakota	8.42	10,898
18	Texas	8.56	516,472
19	Nebraska	8.66	34,878
20	Wisconsin	8.77	104,141
21	Idaho	8.87	33,356
22	Florida	9.11	323,230
23	Louisiana	9.25	91,670
24	New Hampshire	9.44	23,543
25	Illinois	9.64	268,412
26	Connecticut	9.67	69,750
27	North Carolina	9.74	196,295
27	Rhode Island	9.74	18,929
29	West Virginia	9.95	34,113
30	Arizona	10.00	143,570
31	Washington	10.02	139,204
32	Minnesota	10.29	116,818
33	Montana	10.34	20,366
34	Oregon	10.42	78,838
35	Delaware	10.56	19,214
36	Wyoming	10.92	13,114
37	New York	10.97	410,383
38	Oklahoma	11.02	90,629
39	Michigan	11.07	226,090
40	Ohio	11.23	271,761
41	Iowa	11.27	73,173
42	Tennessee	11.29	150,311
43	Massachusetts	11.47	143,875
44	Pennsylvania	11.57	280,880
45	Indiana	11.61	164,911
46	Vermont	11.73	13,336
47	Mississippi	11.93	78,718
48	Maine	12.50	30,349
49	Arkansas	12.86	82,480
50	District of Columbia	13.56	12,039
51	Kentucky	13.95	125,602
	United States	8.50	6,250,020

Youth Dependence or Abuse of Illicit Drugs or Alcohol



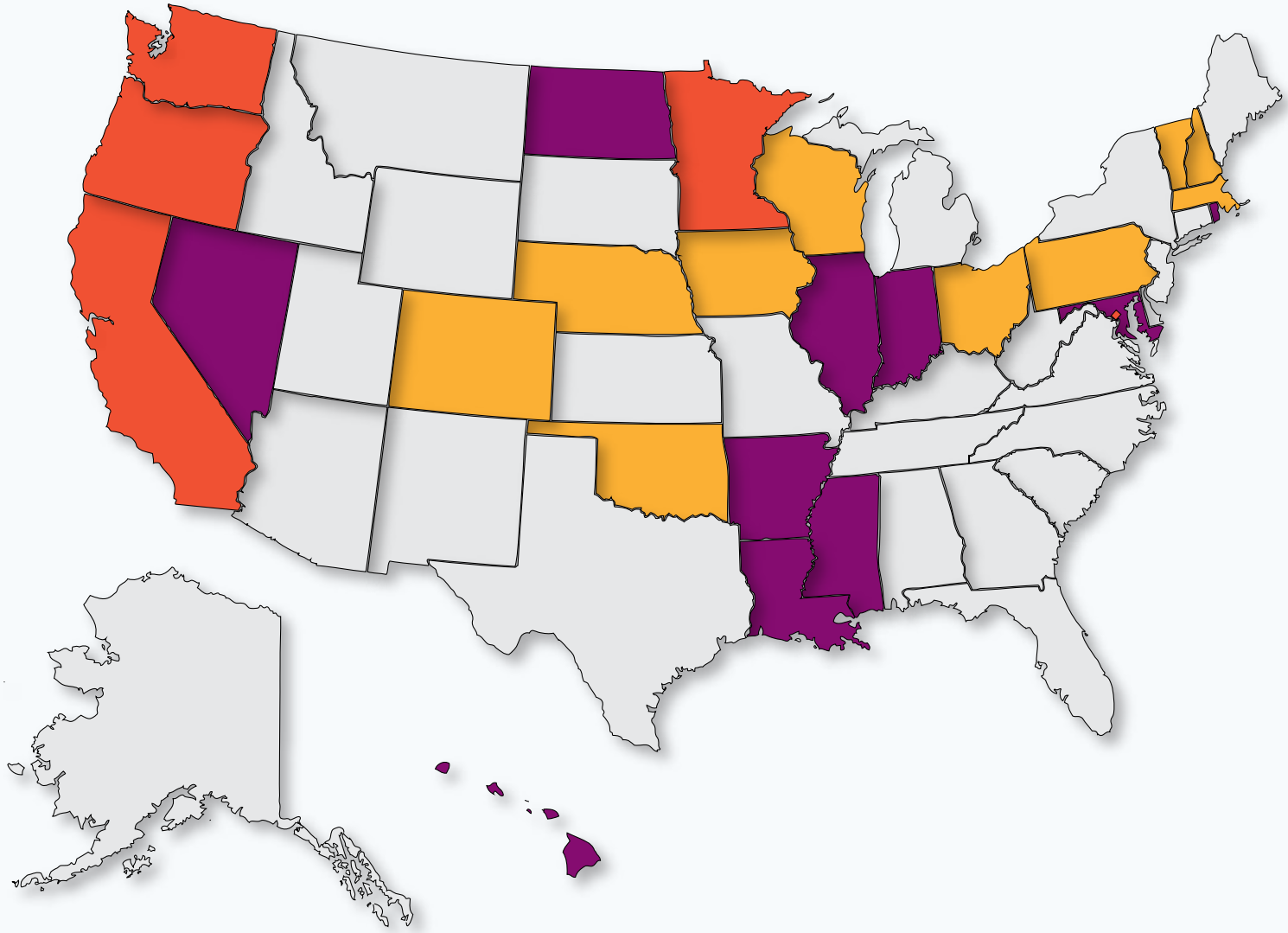
Rank	State	Percent	Number
1	Utah	4.65	12,000
2	Iowa	5.55	13,000
3	Alabama	5.60	22,000
4	Ohio	5.68	53,000
5	Virginia	5.71	35,000
6	Maryland	5.76	26,000
7	Kentucky	5.77	20,000
8	Tennessee	5.78	29,000
9	Louisiana	5.80	21,000
10	Mississippi	5.81	14,000
11	Illinois	5.83	62,000
12	Maine	5.84	6,000
13	Georgia	5.88	49,000
13	Kansas	5.88	14,000
15	Indiana	5.92	32,000
16	Arkansas	5.95	14,000
17	Florida	5.96	82,000
18	New York	5.99	88,000
19	North Carolina	6.11	46,000
20	Wisconsin	6.24	28,000
21	West Virginia	6.29	8,000
22	Missouri	6.31	30,000
23	Idaho	6.32	9,000
24	Delaware	6.33	4,000
25	North Dakota	6.38	3,000
26	Oklahoma	6.41	19,000
27	Alaska	6.53	4,000
28	South Carolina	6.63	24,000
29	Pennsylvania	6.64	64,000
30	Texas	6.68	151,000
31	Oregon	6.71	20,000
32	Minnesota	6.76	29,000
33	Connecticut	6.85	20,000
33	Nevada	6.85	15,000
35	Rhode Island	6.89	5,000
36	South Dakota	6.90	4,000
37	New Jersey	6.94	49,000
38	Washington	6.98	37,000
39	Wyoming	7.00	3,000
40	Michigan	7.01	57,000
41	Massachusetts	7.03	35,000
42	New Hampshire	7.11	7,000
43	Nebraska	7.12	10,000
44	Colorado	7.29	29,000
44	District of Columbia	7.29	2,000
46	California	7.50	237,000
47	Hawaii	7.52	7,000
48	Arizona	7.53	40,000
49	Vermont	7.76	4,000
50	Montana	8.51	6,000
51	New Mexico	9.21	16,000
	United States	6.48	1,618,000

Youth with At Least One Major Depressive Episode



Rank	State	Percent	Number
1	District of Columbia	7.23	2,000
2	North Dakota	7.27	4,000
3	New York	7.28	107,000
4	New Jersey	7.51	53,000
5	Indiana	7.58	41,000
6	Missouri	7.62	36,000
7	Colorado	7.74	31,000
8	Nebraska	7.97	12,000
9	Florida	8.05	111,000
10	Maryland	8.07	37,000
11	North Carolina	8.11	61,000
12	Mississippi	8.15	20,000
13	Vermont	8.21	4,000
14	Connecticut	8.26	24,000
14	Minnesota	8.26	35,000
16	Alaska	8.27	5,000
17	Kansas	8.28	20,000
17	Massachusetts	8.28	41,000
19	South Dakota	8.32	5,000
20	Georgia	8.43	70,000
21	Texas	8.45	191,000
22	Nevada	8.48	19,000
23	Delaware	8.49	6,000
24	Tennessee	8.57	43,000
24	Wisconsin	8.57	39,000
26	Alabama	8.69	33,000
26	Pennsylvania	8.69	84,000
28	Oklahoma	8.74	27,000
29	Illinois	8.86	94,000
30	Ohio	8.90	83,000
31	Maine	8.91	9,000
32	Louisiana	8.96	33,000
33	Rhode Island	9.00	7,000
34	Arkansas	9.01	21,000
35	South Carolina	9.03	32,000
36	Montana	9.04	7,000
37	West Virginia	9.13	12,000
38	Virginia	9.14	57,000
39	California	9.17	289,000
39	Iowa	9.17	22,000
41	Arizona	9.39	50,000
42	Wyoming	9.40	4,000
43	Idaho	9.47	13,000
44	Kentucky	9.52	32,000
45	Hawaii	9.79	10,000
45	New Hampshire	9.79	10,000
47	Michigan	10.06	82,000
48	Utah	10.17	27,000
49	Oregon	10.23	30,000
50	Washington	10.56	56,000
51	New Mexico	11.73	20,000
	United States	8.66	2,161,000

Youth Attempted Suicide



Rank	State	Percent
1	Massachusetts	5.47
2	Vermont	5.61
3	Pennsylvania	5.71
4	Iowa	5.98
5	Wisconsin	6.00
6	Nebraska	6.02
7	Colorado	6.13
8	Ohio	6.18
9	New Hampshire	6.70
10	Oklahoma	6.81
11	Missouri	6.91
12	Delaware	6.96
13	Idaho	7.01
14	New York	7.05
15	Utah	7.34
16	West Virginia	7.50
17	Kentucky	7.66
18	Florida	7.70
19	Montana	7.87
20	Connecticut	8.07
21	Maine	8.08
22	Alaska	8.36
23	Kansas	8.40
24	Wyoming	8.59
25	Georgia	8.81
26	Michigan	8.89
27	South Dakota	8.91
28	Tennessee	8.98
29	New Mexico	9.38
30	South Carolina	9.44
31	Virginia	9.83
32	New Jersey	9.86
33	North Carolina	9.89
34	Texas	10.08
35	Alabama	10.37
36	Arizona	10.60
37	Nevada	10.65
38	Hawaii	10.71
39	Arkansas	10.84
40	Maryland	10.88
41	Mississippi	10.90
42	Indiana	10.96
43	North Dakota	11.45
44	Illinois	12.41
45	Louisiana	13.11
46	Rhode Island	14.34
47	California	
48	District of Columbia	
49	Minnesota	
50	Oregon	
51	Washington	
	United States	8.01

Note: Colorado, Indiana, Iowa, Maryland data from 2011, North Carolina & Pennsylvania data from 2009, California, Oregon, Minnesota & Washington data are not available.

Adult Insurance and Access to Care

8.1 million

(3.9%) of adults in America have a mental illness and are uninsured

Only 41.4 percent

of individuals with any mental illness report receiving treatment

1 in 5

One out of five adults with AMI reported they did not get the mental health services they felt they needed

As noted earlier, the ACA has already decreased the number of uninsured Americans, but it is unclear how many individuals with mental illness gained insurance as a result of the law. This is especially the case in states that failed to expand Medicaid. Even when individuals are insured, it is clear that people continue to face barriers. Barriers include inability to pay for treatment, difficulty using or accessing the mental health benefits offered by insurance, and lack of available services. The most recent, publicly-available data for people with mental illness is from 2012. Thus, it will be several more years before we can fully evaluate the effects of the ACA on individuals with mental illness.

Data Highlights

The South and West vs. the Northeast and Midwest

- The highest percent of uninsured adults with mental illness are in the Southern and Western states.
- The lowest percent of uninsured adults with mental illness are generally in the Midwest and Northeast.

ACA Enrollment

- California enrolled the highest number of people in the first open enrollment (1,405,102), but also has roughly the same amount of people (1,111,000) who have a mental health problem and are uninsured.
- Hawaii is among those states with the lowest percent of uninsured individuals with AMI. During the first open enrollment, Hawaii enrolled the lowest number of individuals at 8,592, but has an estimated 15,000 uninsured individuals with AMI.

Mental Health Association in New Jersey

As a prominent mental health advocacy organization, MHANJ recently commissioned a study to analyze access to care and availability of appointments with psychiatrists in PPO Managed Care networks in the state. Through a survey sample of 525, MHANJ found that of the 1550 board certified psychiatrists in the state, only 702 were listed managed care networks. Additionally, 33 percent of the information on the plans' network lists was incorrect. Of those asked (62), 49 percent of psychiatrists were not taking new patients, and of those providers willing to see new individuals, 50 percent had a wait time of over a month. MHANJ is working throughout the state to share these findings with government officials, legislators, the media and the mental health community in an effort to raise awareness on access to care issues. MHANJ is actively educating consumers on how to access care, how the complaint and appeal process works, and what to do if an individual's needs are not met. They are also currently building a broad-based coalition to create significant change in insurance practices in behavioral health.

MHANJ has also established a statewide Call Center that integrates cutting-edge behavioral health information, referral and care management services with a Peer Recovery Warmline, a Suicide Prevention Life Line, and a Disaster response line to create a comprehensive access point for consumers, family members and the professional community. To date, the Call Center has attracted over 60,000 calls a year, and has expanded to include an Opiate/Heroin line focused on access to treatment and family peer support.

Highest-Ranked vs. Lowest-Ranked

- Even in the highest ranked state, Vermont, only 57 percent of individuals with a possibly diagnosable mental illness reported that they received treatment.
- In the ten lowest ranked states, only 30 percent of individuals who have a mental illness receive treatment.

Insurance Does Not Mean Access to Treatment

- In Massachusetts, only an estimated 1 percent of adults have AMI and are uninsured (48,000 individuals), but an estimated 20.4 percent of adults with AMI report having an unmet need (174,000 individuals). Thus, even though relatively many people in Massachusetts have access to insurance, there are a significant number of (presumably insured) people who nevertheless report barriers to treatment.

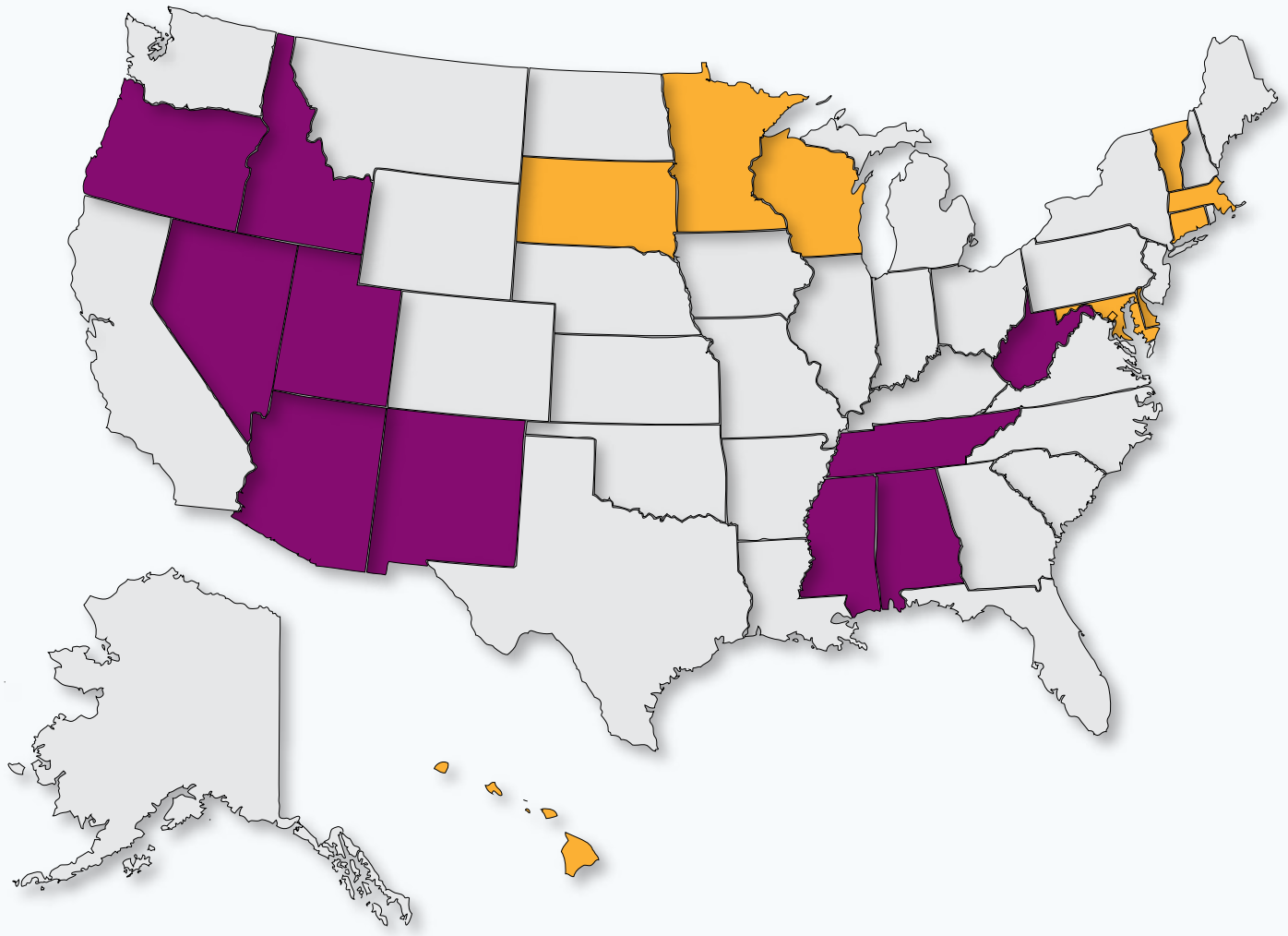
Mental Health Association of Southeastern Pennsylvania

As part of an MHA Navigator grant, MHASP assisted individuals in Philadelphia and the five county surrounding area of southeastern Pennsylvania during the first open enrollment of the Affordable Care Act (ACA) federal health insurance plans. While MHASP was able to assist individuals who needed insurance but could not afford it, due to the lack of Medicaid expansion in Pennsylvania, they could only refer them to low-cost or free health clinics, charity care, and the emergency room. While many were served during the open enrollment period and in fact obtained insurance, 33 percent of MHASP clients fell in the Medicaid Gap. MHASP is pleased Pennsylvania has decided to expand Medicaid for 2015.

Mental Health America of Georgia

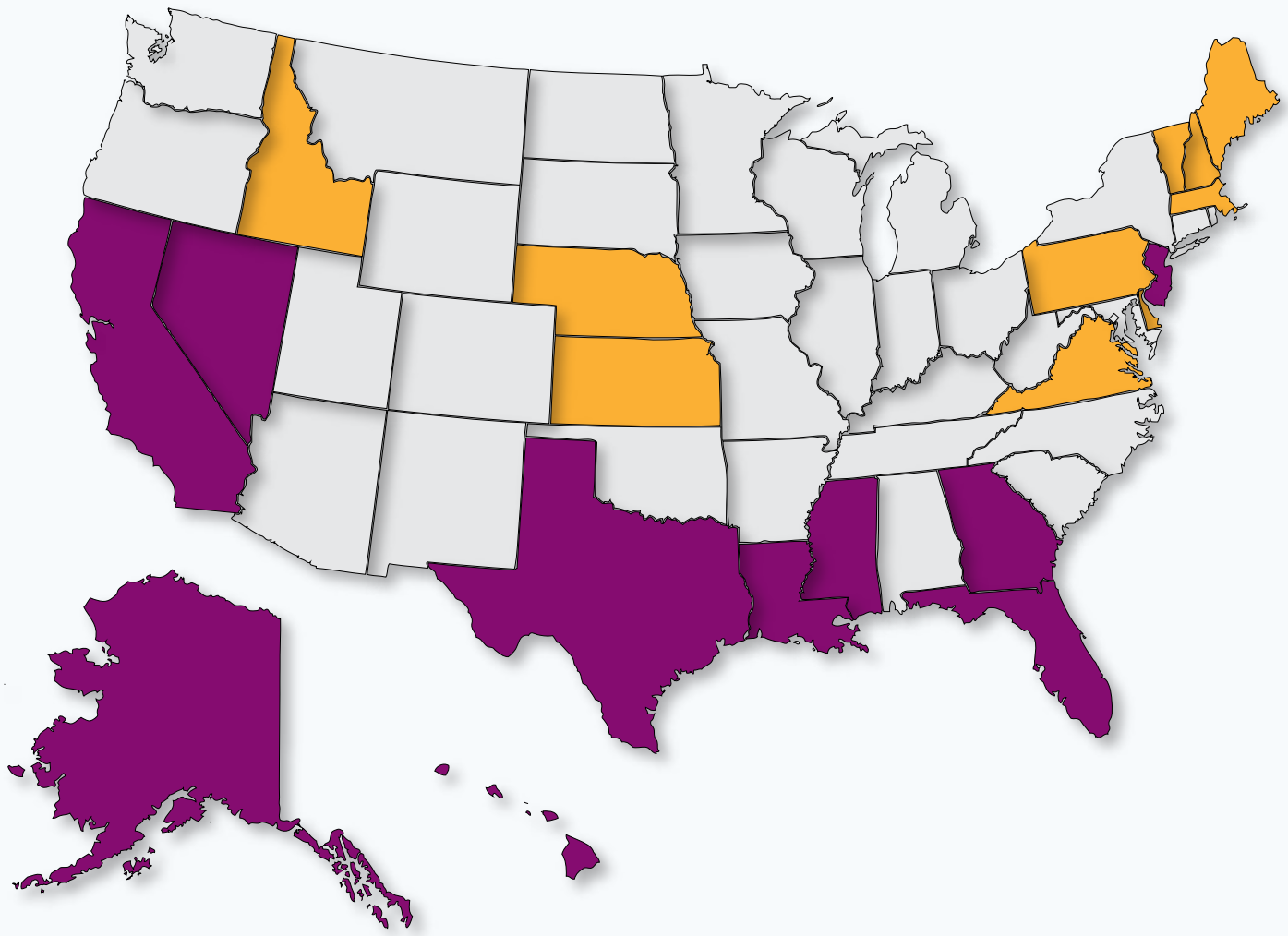
MHA Georgia is also actively involved in "Cover Georgia," a coalition focused on bringing Medicaid expansion to the state. While working with Cover Georgia, a coalition made up of twenty non-profit organizations, MHA Georgia has scripted media messages, collected stories from individuals with lived experience, and worked to secure community and legislative support.

Adults with Any Mental Illness and Uninsured



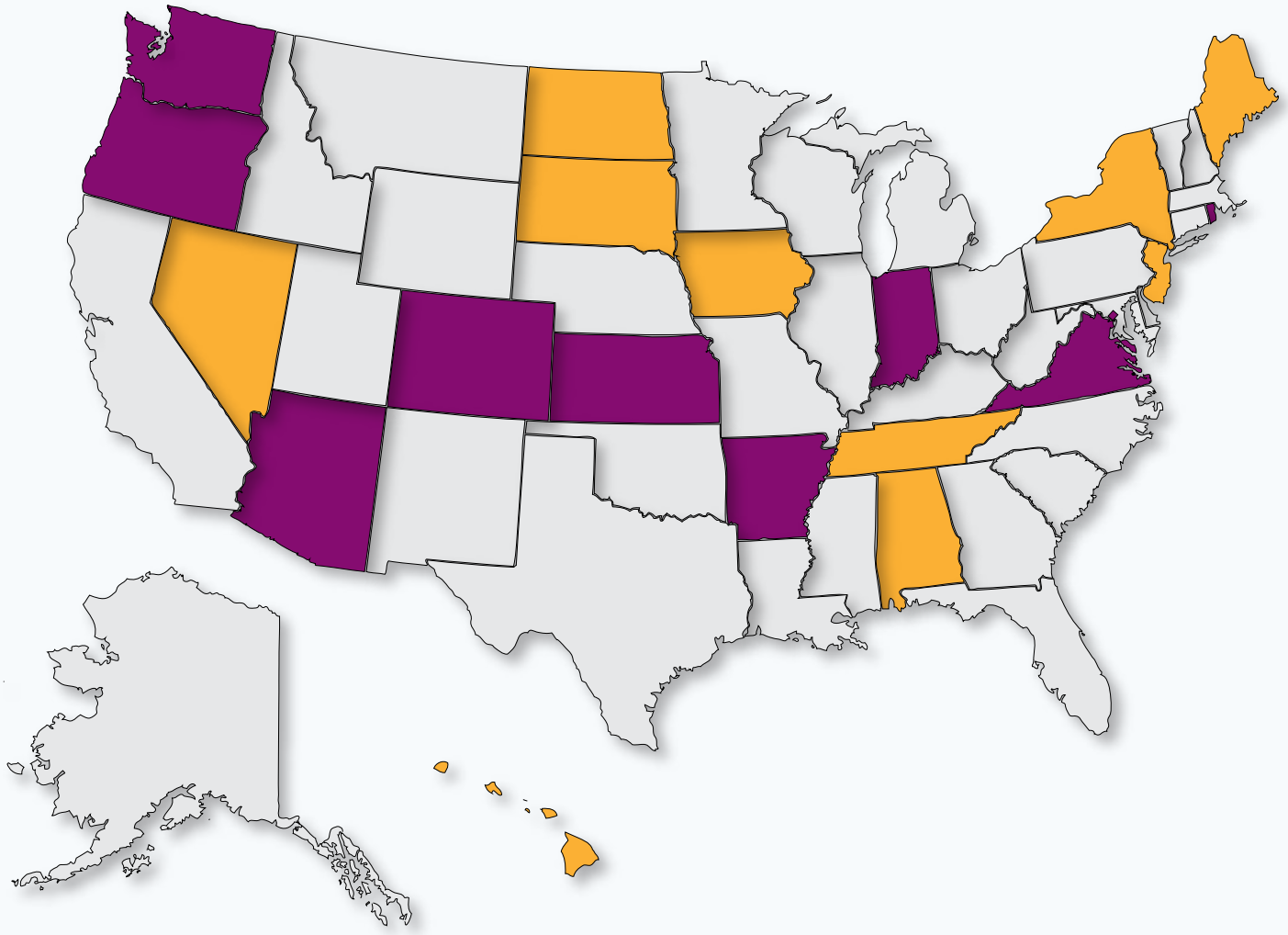
Rank	State	Percent	Number
1	Massachusetts	0.9	48,000
2	Connecticut	1.4	39,000
3	Hawaii	1.5	15,000
4	Vermont	1.5	7,000
5	District of Columbia	1.6	8,000
6	Delaware	1.7	12,000
7	South Dakota	1.8	11,000
8	Wisconsin	1.8	78,000
9	Maryland	2.0	86,000
9	Minnesota	2.0	78,000
11	North Dakota	2.0	10,000
12	New Jersey	2.2	146,000
12	Pennsylvania	2.2	219,000
14	Rhode Island	2.3	19,000
15	New York	2.4	354,000
16	Iowa	2.5	56,000
17	Maine	2.6	27,000
17	North Carolina	2.6	182,000
19	Kansas	2.7	55,000
20	Colorado	2.8	107,000
21	Missouri	2.9	129,000
21	Nebraska	2.9	39,000
21	New Hampshire	2.9	30,000
24	Illinois	3.0	287,000
24	Virginia	3.0	181,000
26	Kentucky	3.4	109,000
27	Michigan	3.6	266,000
28	Ohio	3.8	327,000
29	South Carolina	3.9	136,000
30	California	4.0	1,111,000
30	Montana	4.0	31,000
30	Oklahoma	4.0	111,000
30	Wyoming	4.0	17,000
34	Florida	4.1	599,000
35	Washington	4.2	216,000
36	Alaska	4.3	22,000
37	Georgia	4.4	313,000
37	Indiana	4.4	210,000
39	Texas	4.5	811,000
40	Arkansas	4.6	101,000
40	Louisiana	4.6	154,000
42	Oregon	4.6	137,000
43	New Mexico	4.9	75,000
43	Tennessee	4.9	234,000
45	Arizona	5.0	239,000
45	Nevada	5.0	100,000
45	West Virginia	5.0	72,000
48	Idaho	5.4	61,000
49	Utah	5.5	105,000
50	Mississippi	5.6	121,000
51	Alabama	6.3	225,000
	United States	3.5	8,127,000

Adults with Any Mental Illness Who Received Treatment



Rank	State	Percent	Number
1	Vermont	57.1	54,000
2	Massachusetts	52.7	457,000
3	Virginia	51.3	548,000
4	Nebraska	51.0	120,000
5	Maine	50.1	96,000
6	Kansas	49.9	172,000
7	New Hampshire	49.8	104,000
8	Pennsylvania	48.0	822,000
9	Idaho	47.9	127,000
10	Delaware	47.8	60,000
11	West Virginia	47.7	152,000
12	Ohio	47.4	828,000
13	South Dakota	47.0	47,000
14	South Carolina	46.8	300,000
15	Connecticut	46.5	210,000
16	Rhode Island	46.4	71,000
17	Arkansas	46.2	207,000
18	Montana	46.1	66,000
19	Kentucky	45.6	289,000
20	North Carolina	45.4	497,000
21	Minnesota	45.3	283,000
22	Missouri	44.8	390,000
23	Oregon	44.7	292,000
24	Washington	44.4	519,000
25	Iowa	44.3	194,000
26	New Mexico	43.9	127,000
27	Tennessee	43.4	455,000
28	Utah	43.2	201,000
29	Maryland	43.0	336,000
30	Illinois	42.7	653,000
31	Michigan	42.5	650,000
32	Colorado	41.5	267,000
32	Oklahoma	41.5	259,000
34	Wisconsin	41.3	296,000
35	Indiana	41.1	391,000
36	Alabama	40.3	320,000
37	Wyoming	40.0	32,000
38	District of Columbia	39.9	41,000
39	New York	38.9	1,113,000
40	North Dakota	38.7	30,000
41	Arizona	37.6	368,000
42	New Jersey	36.9	361,000
43	Alaska	36.2	37,000
44	Texas	36.1	1,083,000
45	Louisiana	35.9	225,000
46	California	35.7	1,680,000
47	Florida	35.4	860,000
48	Mississippi	34.9	147,000
49	Georgia	34.8	424,000
50	Nevada	30.9	100,000
51	Hawaii	26.5	48,000
	United States	41.4	17,410,000

Adults with Any Mental Illness Reporting Unmet Need



Rank	State	Percent	Number
1	Hawaii	11.1	20,000
2	Tennessee	15.2	160,000
3	North Dakota	15.7	12,000
4	Maine	16.8	32,000
5	Alabama	17.2	136,000
6	New York	17.9	513,000
7	Iowa	18.2	80,000
8	South Dakota	18.2	18,000
9	New Jersey	18.4	180,000
10	Nevada	18.5	60,000
11	Oklahoma	18.6	117,000
12	Georgia	18.9	232,000
13	Delaware	19.1	24,000
14	Texas	19.3	583,000
15	Nebraska	19.6	46,000
16	Louisiana	19.7	123,000
17	California	19.9	937,000
17	Kentucky	19.9	127,000
17	Pennsylvania	19.9	340,000
20	Wisconsin	20.0	144,000
21	Maryland	20.2	158,000
21	North Carolina	20.2	221,000
23	Florida	20.4	494,000
23	Massachusetts	20.4	174,000
25	Connecticut	20.6	93,000
26	Illinois	20.8	320,000
27	Alaska	20.9	21,000
28	Wyoming	21.1	17,000
29	West Virginia	21.2	68,000
30	South Carolina	21.5	138,000
31	Vermont	21.5	20,000
32	Ohio	21.7	378,000
33	Utah	22.4	104,000
34	New Hampshire	22.7	47,000
35	Michigan	22.9	351,000
36	Minnesota	23.0	145,000
37	Mississippi	23.2	99,000
37	Montana	23.2	33,000
39	New Mexico	23.4	67,000
40	Missouri	23.9	208,000
41	Idaho	24.4	64,000
42	Colorado	24.5	158,000
42	Oregon	24.5	159,000
44	District of Columbia	24.6	25,000
45	Rhode Island	25.2	39,000
46	Indiana	25.4	242,000
47	Arkansas	25.6	114,000
47	Virginia	25.6	269,000
49	Arizona	26.1	256,000
50	Washington	26.3	308,000
51	Kansas	28.1	97,000
	United States	20.8	8,771,000

Child/Youth Insurance and Access to Care

11.4 percent

of children with ongoing EBD were uninsured or had periods of no insurance

2:5

Two out of five children in America who needed mental health treatment did not receive it

Only .8%

of all students are identified as having a Serious Emotional Disturbance (SED) and are therefore likely as a matter of course to have their SED taken into consideration in planning for appropriate educational modifications and accommodations in their Individualized Education Plan

In general, children in America are more likely to have insurance coverage than adults. State Children's Health Insurance Program (CHIP) is an example of how government insurance can improve access for families who are too poor to pay for private insurance but not poor enough to qualify for Medicaid. For many of America's youth, however, having insurance coverage does not mean access to treatment. Without treatment, many of America's youth struggle to thrive. This treatment gap points to the increasing importance of access to school accommodations through an Individualized Education Plan (IEP). Unfortunately, the data show that many youth who need school accommodations through an IEP are not receiving them.

Data Highlights

The South and West vs. the Northeast and Midwest

- In all three indicators of insurance and access to treatment among youth, children did better in the Northeastern and Midwestern states than in the Southern or Western states.
- Seven of the lowest ranking 10 states where children were least likely to obtain needed treatment are in the South.
- Six of the lowest ranking 10 states where children were least likely to be consistently insured are in the West.

Mental Health America of Wisconsin

Through the Wisconsin Council on Mental Health, MHA Wisconsin is working alongside consumers, family members and other leaders to advocate for improvements in overall access to mental health services in the state. Numerous studies had highlighted the disparities in access to key services across the state, due in part to the requirement for counties to pay the "state" share of Medicaid for certain services.

The advocacy efforts of the Council is already seeing results—the work of MHA Wisconsin and others resulted in state funding for the "state" share of Medicaid for a Medicaid psycho-social rehabilitation programs serving both children and adults, which is expected to double the number of counties offering this service. The state is also expanding wrap-around programs for youth with serious mental illnesses to all counties and tribes, as well as piloting peer run respite programs in three areas of the state.

- Six of the lowest ranking 10 states where children are least likely identified as SED are in Southern states.
- Five states plus DC are among the top 10 highest-ranking in identifying youth with SED.
- Five of the top 10 highest ranking states where youth are most likely to obtain needed treatment are in the Midwest.

Highest-Ranked vs. Lowest-Ranked

- An estimated 98 percent of children with EBD are insured in the highest-ranked states, like Iowa and New Jersey. In lowest-ranked states, like Nevada and Georgia, only 80 percent of youth with EBD are insured, leaving an estimated 20 percent of youth with EBD uninsured.
- The difference between states providing the most and the least access to needed mental health for youth is significant. In North Dakota, only 13.7 percent of children reported they did not receive needed mental health services, while 59.6 percent of children Louisiana reported that they could not access needed mental health services.

Trouble in Schools

When identifying disability status for access to an IEP, the term "Serious Emotional Disturbance" (SED) is used to define youth with a mental illness. The number of students identified as having an SED for purposes of obtaining an IEP 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.

For example, in Vermont (ranked first), the rate is 24.65, but the actual percentage is 2.47 percent. That is, 2.47 percent of students in Vermont are identified as having SED as compared to only .17 percent of students in Arkansas.

In a 2010 study, the National Institute of Mental Health found that 8 percent of youth have an SED[1] . Only .8 percent of children, however, were identified by schools as having an SED for access to an IEP. This means that for every student who is in special education, up to 10 more who need accommodations appropriate to SED are not receiving them. This demonstrates the need for identifying (school-based) ways to increase the accuracy of identification of SED children, which is another important area for future research.

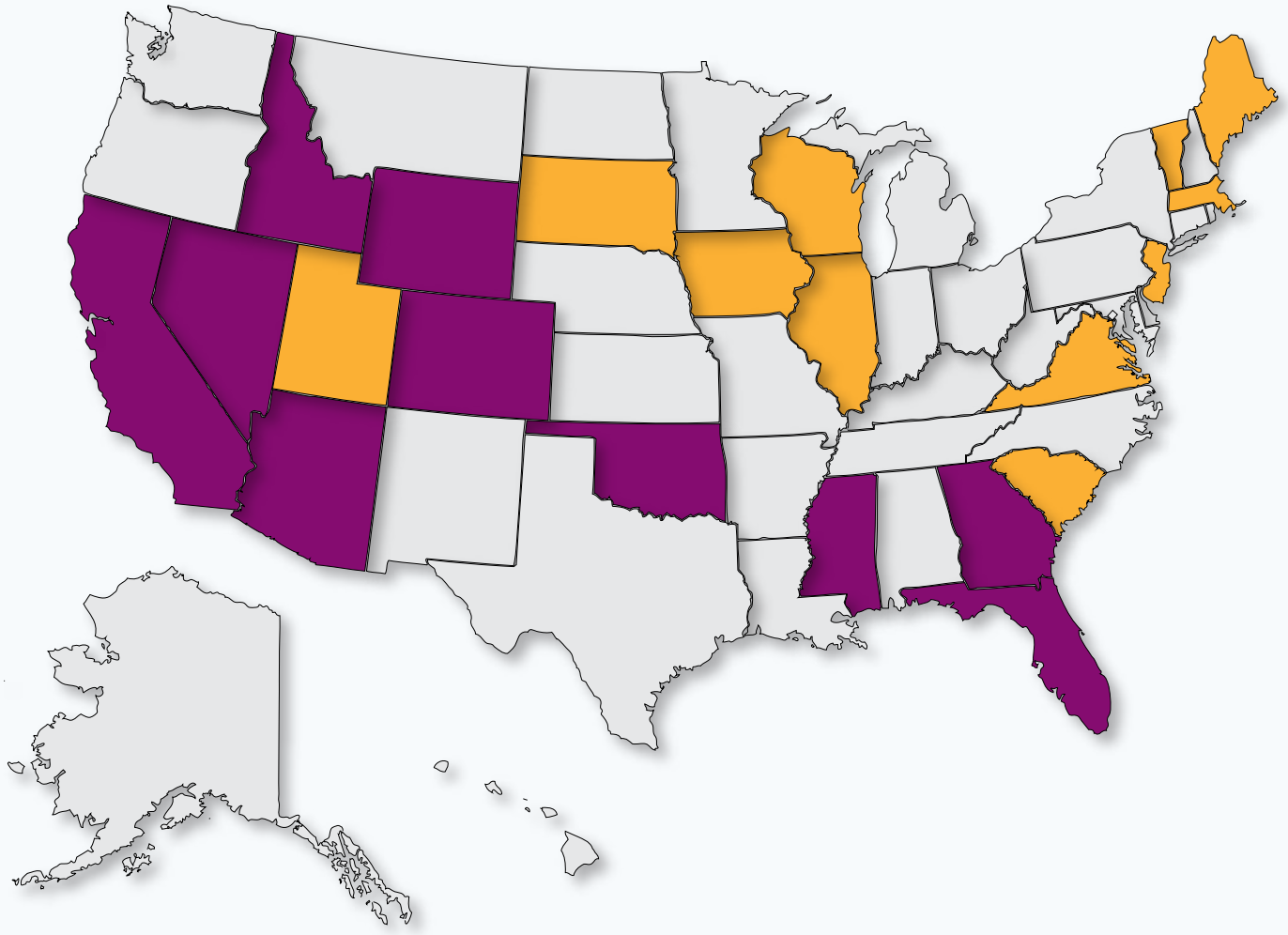
Mental Health Association in New Jersey

Additionally, MHANJ has trained a workforce of 30 Mental Health First Aid (MHFA) trainers with the goal of training 1,000 community gatekeepers to engage the public in understanding behavioral health and fight stigma around mental illness. MHANJ is marketing the training to the business community in an effort to generate revenue and address stigma in the workplace. MHANJ is linking those trained in MHFA with the MHANJ Call Center for ongoing support, access to services, and engagement with organization. MHANJ is also creating broad community partnerships with organizations such as the YWCAs, YMCAs, the Girl Scouts, and the New Jersey League of Municipalities.

[1] http://www.nimh.nih.gov/news/science-news/2012/survey-finds-more-evidence-that-mental-disorders-often-begin-in-youth.shtml

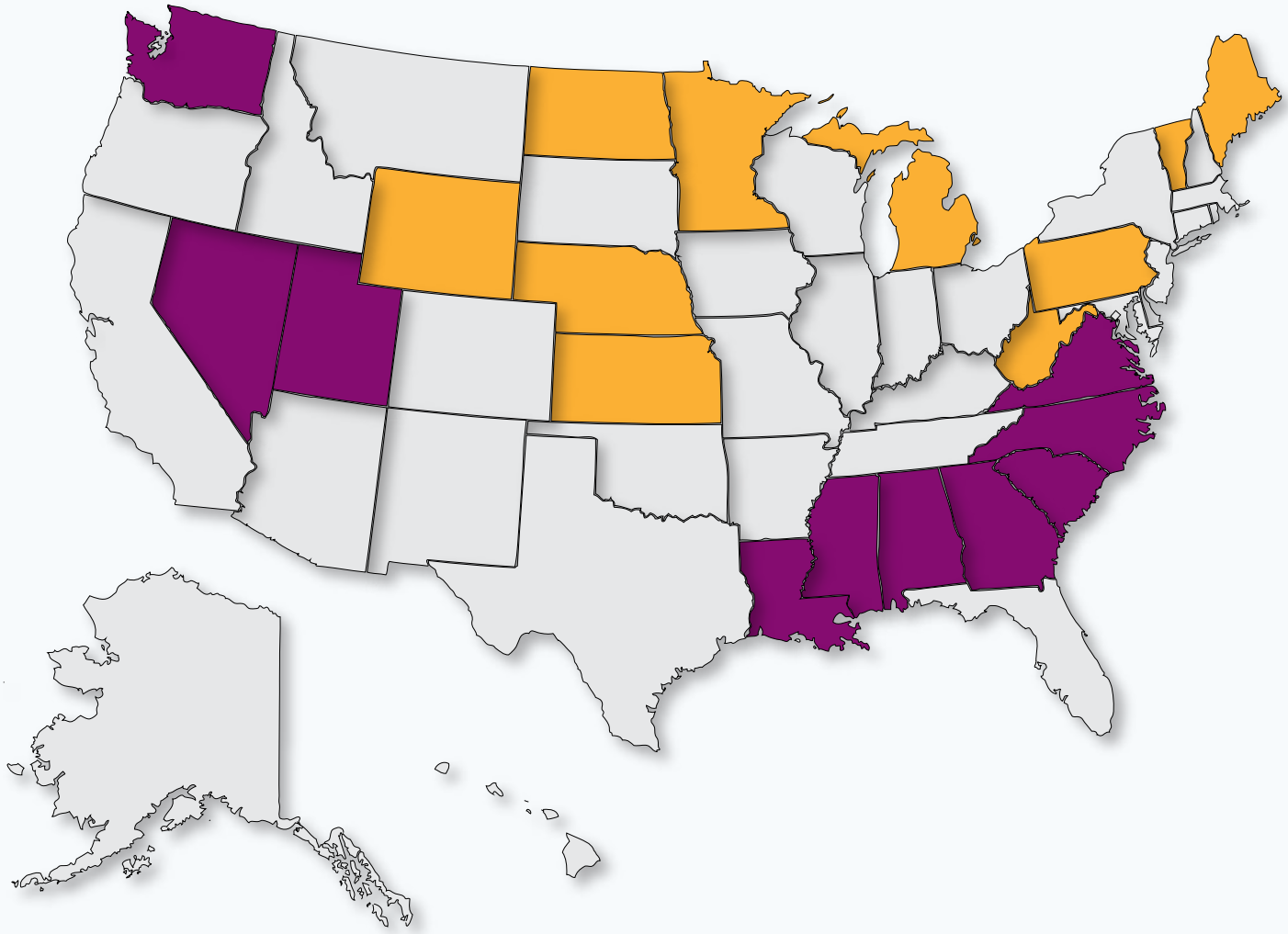
Children with Emotional Behavioral Developmental Issues who were Consistently Insured

Nationwide: 600,745 youth with EBD are uninsured or have periods of no insurance



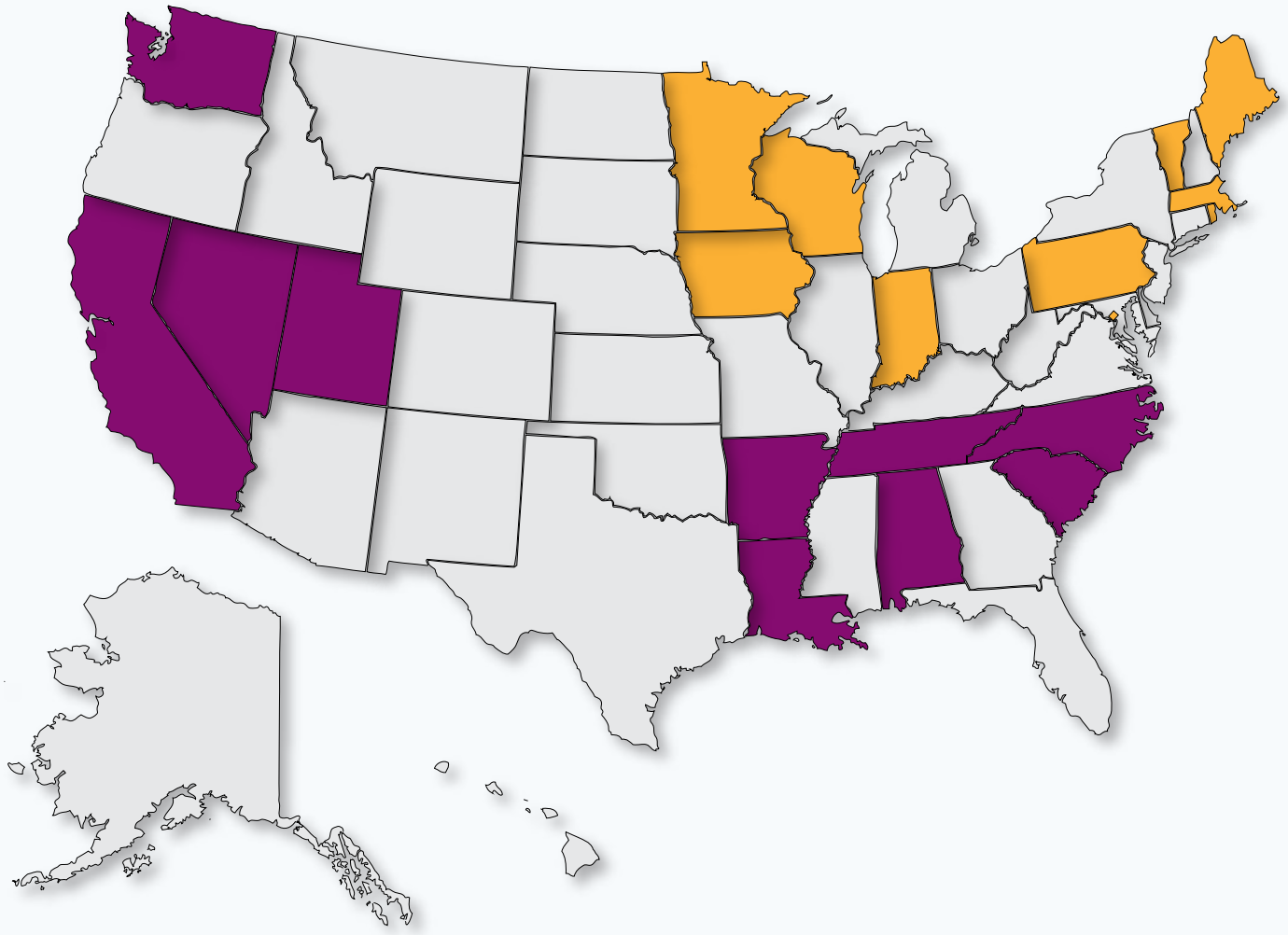
Rank	State	Percent	Number
1	Iowa	98.5	61,155
2	New Jersey	98.2	118,253
3	Massachusetts	97.5	126,127
4	Illinois	97.4	225,585
5	Vermont	96.7	10,594
5	Wisconsin	96.7	85,554
7	South Dakota	96.2	10,564
8	Maine	95.3	25,414
9	South Carolina	94.6	60,617
10	Utah	94.4	44,814
10	Virginia	94.4	113,194
12	District of Columbia	93.9	9,140
13	Ohio	93.7	222,918
14	New Mexico	93.5	26,103
15	Hawaii	92.8	15,211
15	Washington	92.8	104,442
17	Delaware	92.5	14,960
18	North Dakota	91.8	8,527
19	Connecticut	91.7	55,363
20	Louisiana	90.9	74,754
21	West Virginia	90.3	28,635
22	Indiana	90.0	128,502
23	Kentucky	89.7	101,259
24	Nebraska	89.2	26,370
25	Alaska	89.0	9,999
26	Arkansas	88.8	67,498
26	New Hampshire	88.8	18,528
28	Texas	88.7	425,355
29	Maryland	88.6	73,135
30	Pennsylvania	88.4	202,366
31	Missouri	88.1	84,243
31	Oregon	88.1	62,868
33	Tennessee	87.9	117,755
34	North Carolina	87.7	149,940
35	Minnesota	87.2	85,139
36	Kansas	87.1	40,042
37	Montana	86.8	15,239
37	New York	86.8	300,665
39	Rhode Island	86.7	12,813
40	Michigan	86.4	159,041
41	Alabama	86.3	53,883
42	Wyoming	85.7	9,851
43	Mississippi	85.1	52,512
44	Oklahoma	84.0	68,005
45	Florida	83.4	233,500
46	Arizona	83.3	97,860
47	Idaho	83.1	22,422
48	Colorado	82.7	59,313
49	California	80.9	382,838
50	Georgia	80.1	125,661
51	Nevada	78.1	27,691
	National	88.6	4,656,217

Children who Needed but Did Not Get Mental Health Services



Rank	State	Percent	Number
1	North Dakota	13.7	1,494
2	Vermont	22.1	2,942
3	Maine	22.2	6,723
4	West Virginia	26.4	8,979
5	Kansas	27.8	14,768
6	Minnesota	28.5	33,280
7	Nebraska	29.3	10,141
8	Pennsylvania	31.2	87,708
9	Michigan	32.5	73,478
10	Wyoming	32.7	4,290
11	Arkansas	33.2	27,226
12	Delaware	33.5	6,430
13	Iowa	33.7	24,652
13	New Hampshire	33.7	7,806
13	Ohio	33.7	91,602
16	Rhode Island	34.0	6,430
17	Oregon	34.2	26,941
18	Kentucky	34.3	43,031
19	Wisconsin	34.6	35,032
20	Connecticut	35.0	24,438
21	Colorado	35.1	27,589
21	Massachusetts	35.1	50,055
23	New York	35.6	146,198
24	South Dakota	36.4	4,607
25	Missouri	36.5	38,434
26	Alaska	36.8	4,612
27	California	37.3	253,018
28	Oklahoma	39.3	35,496
29	Tennessee	39.8	59,860
30	Montana	40.1	8,171
31	Arizona	40.3	57,861
32	Texas	40.5	209,212
33	Maryland	40.8	37,342
34	District of Columbia	41.1	4,947
35	Indiana	41.8	68,970
36	New Mexico	42.0	15,748
37	Florida	42.3	136,286
38	Hawaii	42.4	8,435
38	New Jersey	42.4	61,737
40	Idaho	43.7	14,257
41	Illinois	44.9	120,544
42	North Carolina	45.7	89,314
43	Washington	46.1	64,110
44	Alabama	46.3	32,125
45	Georgia	47.0	85,856
46	Mississippi	47.1	37,096
47	Virginia	47.4	59,351
48	South Carolina	49.9	37,474
49	Nevada	50.7	21,650
50	Utah	50.9	28,280
51	Louisiana	59.6	54,563
	United States	39.0	2,410,591

Students Identified with Serious Emotional Disturbance for IEP



Rank	State	Rate	Number
1	Vermont	24.65	1,930
2	District of Columbia	23.38	1,326
3	Minnesota	19.41	14,774
4	Massachusetts	16.51	14,154
5	Wisconsin	16.44	12,427
6	Rhode Island	15.48	2,024
7	Pennsylvania	14.03	22,858
8	Indiana	13.71	13,070
8	Maine	13.71	2,335
10	Iowa	13.35	5,725
11	New Hampshire	12.40	2,192
12	New York	11.22	27,566
13	Illinois	10.87	20,192
14	Connecticut	10.47	5,230
15	South Dakota	9.95	1,131
16	Ohio	9.88	15,601
17	Maryland	9.09	6,915
18	Georgia	9.05	13,629
19	North Dakota	8.98	788
20	Michigan	8.75	12,498
21	Oregon	8.71	4,524
22	Colorado	8.55	6,467
23	Virginia	8.34	9,432
24	Florida	8.13	19,584
25	Kentucky	7.87	4,734
26	Wyoming	7.85	641
27	Arizona	7.79	7,687
28	Missouri	7.63	6,231
29	Mississippi	7.52	3,354
30	Oklahoma	7.51	4,290
31	Nebraska	7.40	1,957
32	New Jersey	6.82	8,377
33	New Mexico	6.74	2,041
34	Hawaii	6.47	1,063
35	Delaware	6.34	745
36	West Virginia	6.00	1,479
37	Texas	5.84	25,510
38	Kansas	5.75	2,474
39	Alaska	5.69	671
40	Montana	5.51	712
41	Idaho	5.44	1,395
42	Washington	4.76	4,551
43	Nevada	4.68	1,881
44	South Carolina	4.55	2,946
45	California	4.36	24,981
45	North Carolina	4.36	5,911
47	Utah	4.21	2,263
48	Tennessee	3.69	3,295
49	Louisiana	2.84	1,756
50	Alabama	1.95	1,322
51	Arkansas	1.74	750
	United States	8.08	359,389

* Rate is Per 1,000 students.

Access Quality and Network Adequacy

1:3
One out of three children with ongoing EBD have insurance that is inadequate

1:3
One out of three adults with disability could not see a doctor because of costs

1:790
Nationally, there is only 1 mental health provider for every 790 individuals

19.6 percent
The national 180-day readmission rate (non-forensic) is 19.6%, which indicates a significant lack of available community-based services

70 percent
Seventy percent of those who receive mental health services report that they have improved social connectedness

For many, access to insurance does not mean access to care. Barriers such as high costs or a lack of available treatment providers mean that some people, even when they have access to insurance, cannot obtain treatment at all. Others may be able to access treatment only to find that treatment is limited and quality is poor. Furthermore, measuring basic access to treatment (Did you get treatment?) can hide the fact that for many people, even those with access to insurance, finding quality or appropriate treatment is another matter entirely.

The Importance of Measuring Outcomes

Quality indicators are becoming increasingly important as measures of efficacy and efficiency. While many outcome measures warrant highlighting, MHA included readmission rates and social connectedness because of their importance this year.

Readmission rates are increasingly used as a measure of outcomes. Short term readmission rates, like the 30-day readmission rate, are often used to measure quality of treatment during an inpatient stay. Longer readmission rates, like 90-day or 180-day readmission rates, are more likely indicators of the quality of both inpatient and outpatient care. Since psychiatric readmission rates are not collected or reported except among state hospitals, however, MHA presents the information reported even as we are aware of its limitations. MHA encourages the collection of psychiatric readmission rates for all hospitals (private and public) and will strive to identify and report on such measures.

Mental Health America of Colorado

MHA Colorado is an established advocate in the state, and is a founding member of the Colorado Mental Health Parity Coalition, which advocates for mental health and substance use equality. The Coalition—at the request of the Colorado Association of Health Plans—is actively working to develop a comprehensive business case and model on how to incorporate paid peers in the mental health and substance use treatment teams.

MHA Colorado is also an active member of the Steering Committee for the Chronic Care Collaborative, which is working with the Colorado Division of Insurance on monitoring mental health parity in private plans. Additionally, MHA Colorado is directly advocating to change the definition of narrow networks, which in its current characterization creates an artificial work force shortage for behavioral health, as well as unnecessarily long wait times (1-2 months) for mental health treatment.

For individuals with mental illness, isolation is a symptom and consequence of mental illness. One of the many important factors in recovery is community inclusion. For individuals with mental illness, being fully engaged in the community through work, school and relationships often results in long-term, positive outcomes. The measure of Improved Social Connectedness, while limited (measure of the public system only), is a good starting point, and we have included it in this report for that reason.

Data Highlights

The South

- Individuals and families that live in Southern states are much more likely to face barriers accessing treatment, especially when it comes to finding a mental health professional.
- Six of the 10 states with the lowest number of available mental health providers for their population are in the South. The South (as shown in previous charts) also has less access to treatment among both adults and youth as compared to other regions.
- Similarly, eight of the 10 states where more adults with a disability could not see a health care provider due to costs were Southern states.

Highest-Ranked vs. Lowest-Ranked

1 in 5 vs 1 in 2

In the highest-ranked states, West Virginia, Pennsylvania, and Vermont, around 20 percent of children have inadequate insurance. In the lowest-ranked states, Nevada, New Jersey, and Louisiana, 50 percent of children have inadequate insurance. In the NSCH, families had inadequate insurance when their insurance did not meet their child's needs, did not allow their child to see needed provider, or when out-of-pocket costs are unreasonable.

2x as Likely

In the highest-ranked states, Massachusetts, Hawaii, and Minnesota, around 20 percent of adults could not see a doctor due to costs. In the lowest-ranked states, Mississippi, Arkansas, and South Carolina, adults are two times as likely to not be able to see a doctor due to costs.

Mental Health Association of Maryland

Through the work of its Parity Project, MHA Maryland has partnered with other consumer organizations to ensure parity compliance and enforcement throughout the state. In 2013, this group secured passage of legislation to better enable consumers to enforce their parity rights, requiring plans sold in Maryland to provide notice to consumers about the Mental Health Parity and Addiction Equity Act (MHPAEA) and requiring private review agents to ensure that all medical necessity criteria comply with MHPAEA. We continue legislative efforts to require insurers to demonstrate parity compliance.

MHA Maryland is currently analyzing the networks of private insurance plans sold in 2014 through the Maryland Health Benefit Exchange, in order to understand consumers' experiences when attempting to access outpatient psychiatric care. MHA Maryland is concerned that while more individuals are insured through Medicaid expansion and state Health Insurance Exchanges, more insurers are narrowing their networks and providers are increasingly opting out of networks. MHA Maryland believe that states should consider formalizing network adequacy standards, and requiring insurers to allow out of network care at in-network cost sharing for consumers who are experiencing unreasonable delays.

300:1 vs 1600:1

- In states with the greatest number of available mental health providers, Massachusetts, Delaware and Vermont, there are approximately 300 individuals for every one mental health provider.
- In states with the lowest number of available mental health providers, Georgia, Texas, and Alabama, there are approximately 1,600 individuals for every one provider – 5x less access than the best states.
- Peer support specialists and workforce development programs are possible solutions to the significant mental health workforce gap in the states that have the lowest number of available mental health providers.

Length of Stay Matters

Although Arizona ranks first in State Hospital 180-day Readmission Rate, its median length of stay is 431 days, as compared to Nevada, which ranks last with an 88.99 percent 180-day readmission rate and 13 days as its Median Length of Stay.

States with the lowest rates of 180-day readmission show the highest median length of stay, while those with the highest readmission rates have very short median length of stay. Both ends of the ranking may indicate a lack of adequate community-based services. Individuals who transition in and out of the hospital or who are kept inpatient for long periods of time may do so because they lack evidence-based programs that support them in staying in their community.

Getting People Connected

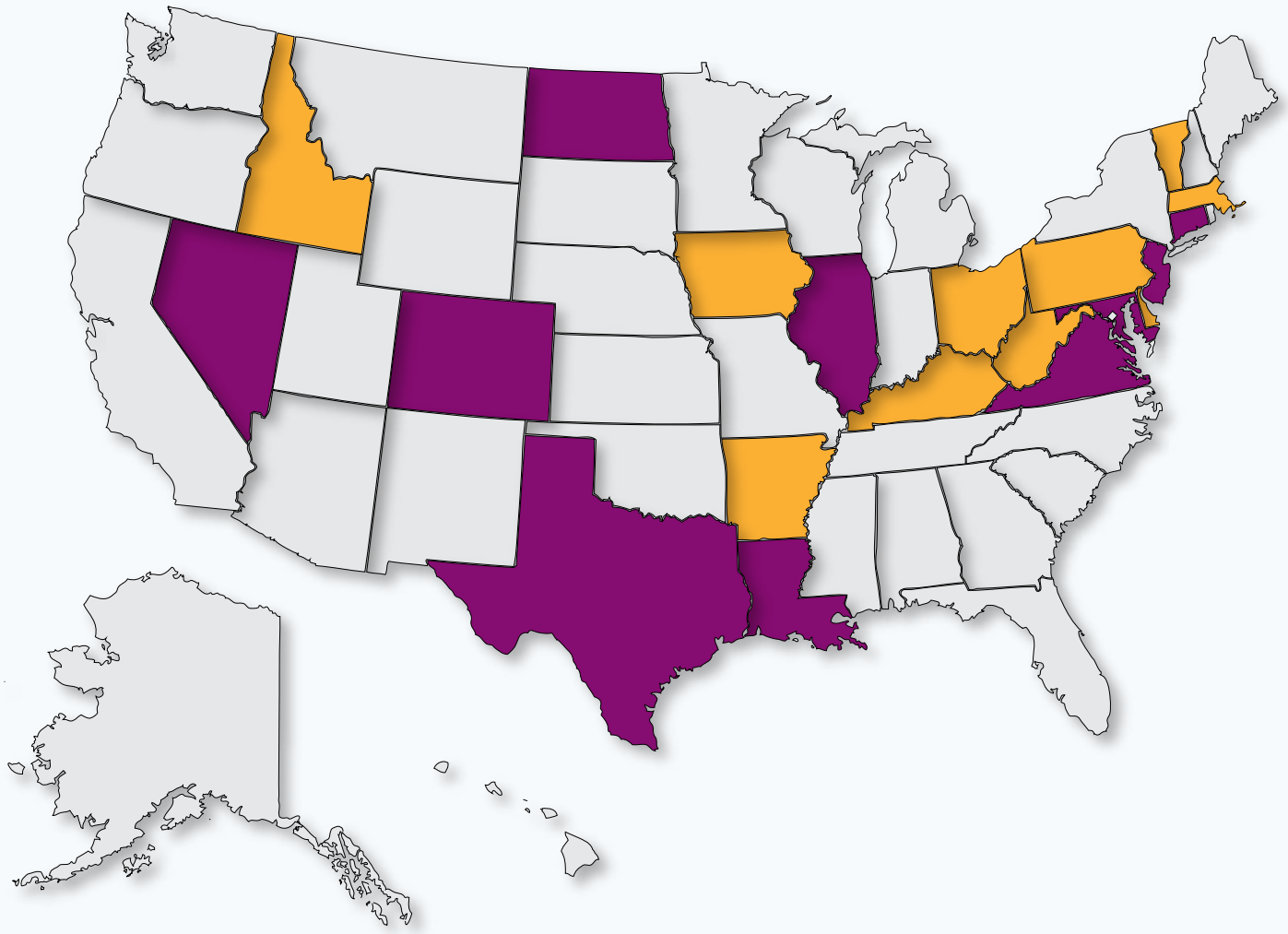
When people are given quality treatment, they report positive outcomes. This outcome measure demonstrates that providing quality treatment can improve quality of life and ultimately result in recovery.

- States like New Jersey, Florida and Mississippi have the highest rates of improved social connectedness (around 90 percent) as compared to states like Idaho, Oregon and Arkansas, where only 58 percent report improved social connection.

Mental Health America of Los Angeles

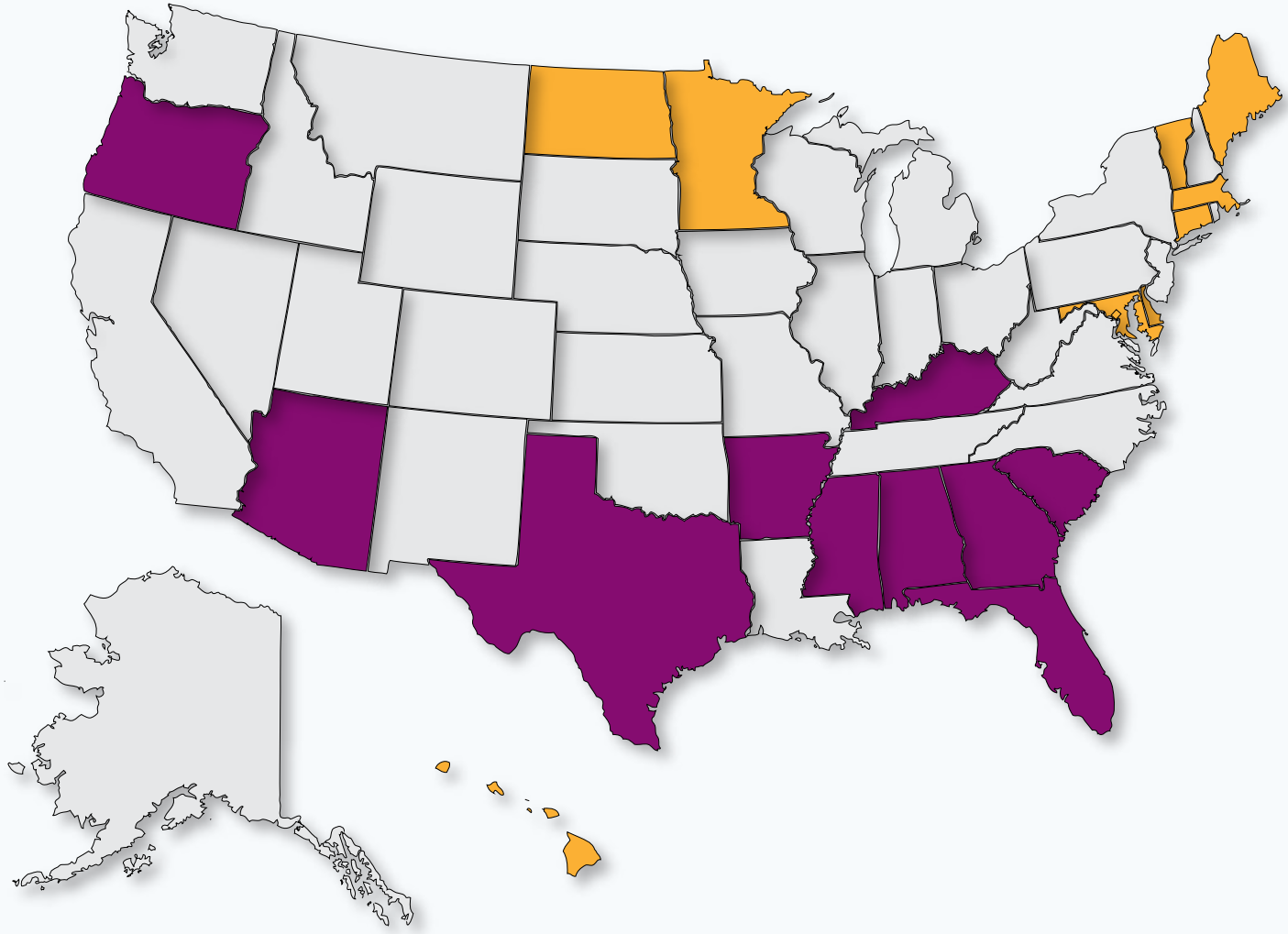
MHALA recognized the need to develop a strong mental health workforce in the most populous county in the U.S. MHALA's Training, Consultation and Workforce Development (TC&WD) team has trained more than 500 individuals through its Jump Start Fellowship program, 70% of whom have gone on to jobs in the mental health field. Of those who completed the program, 72% reporting having lived experience in mental health, having a close family member with lived experience or both. Since 2007, TC&WFD provided guest lectures on recovery-based approaches to more than 5,500 students and 300 faculty at local community colleges, four-year universities and graduate programs. The program developed an 18-unit fully accredited Mental Health Worker Program with Cerritos College that has had more than 100 students earn their certificate since 2010. Additionally, TC&WD has trained more than 200 peers through its three-level Peer Provider Training Program, which has been in operation since 2007.

Children with Ongoing EBD Reporting Inadequate Insurance



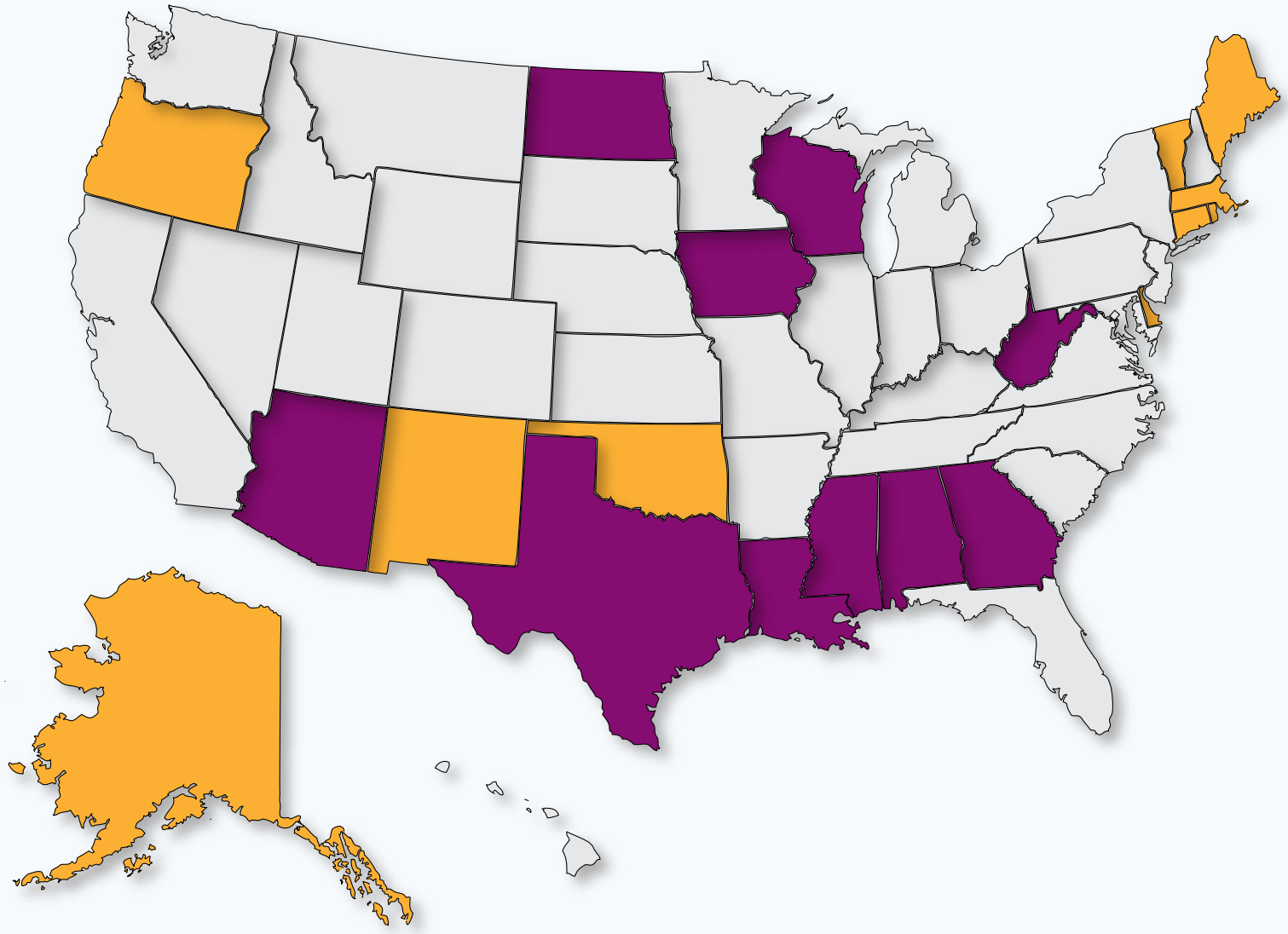
Rank	State	Percent	Number
1	West Virginia	17.9	5,654
2	Pennsylvania	20.2	44,713
3	Vermont	20.5	2,237
4	Kentucky	23.4	25,481
5	Delaware	23.5	3,767
6	Arkansas	24.1	17,741
6	Iowa	24.1	14,960
8	Ohio	24.8	60,767
9	Massachusetts	25.0	32,413
10	Idaho	25.2	6,488
11	Oregon	25.5	17,935
12	Maine	25.9	6,868
13	Georgia	26.4	38,172
13	Kansas	26.4	12,164
15	Wyoming	27.1	2,853
16	Nebraska	27.4	7,891
17	North Carolina	27.6	45,216
18	New Mexico	27.8	7,688
18	Tennessee	27.8	36,167
20	Hawaii	28.0	4,589
21	Indiana	28.5	39,641
22	Arizona	29.1	30,425
23	South Dakota	31.0	3,325
24	District of Columbia	31.3	2,962
24	Wisconsin	31.3	27,877
26	Alabama	31.8	20,073
27	California	32.0	146,713
27	Michigan	32.0	57,703
29	Missouri	32.9	30,813
30	Florida	33.3	84,718
31	Mississippi	33.4	19,819
31	South Carolina	33.4	20,859
33	Alaska	33.6	3,578
33	Rhode Island	33.6	4,712
35	Utah	33.8	15,745
36	Washington	34.0	37,141
37	Montana	34.1	5,848
38	Oklahoma	35.5	27,252
39	New York	35.6	120,733
40	Minnesota	36.1	34,826
40	New Hampshire	36.1	7,076
42	North Dakota	36.3	3,272
43	Illinois	36.4	82,513
44	Colorado	39.6	27,016
45	Connecticut	39.8	22,625
46	Texas	40.5	179,103
47	Maryland	40.6	31,319
48	Virginia	42.9	50,644
49	Louisiana	43.5	34,564
50	New Jersey	46.1	55,518
51	Nevada	52.0	16,086
	United States	32.3	1,638,262

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



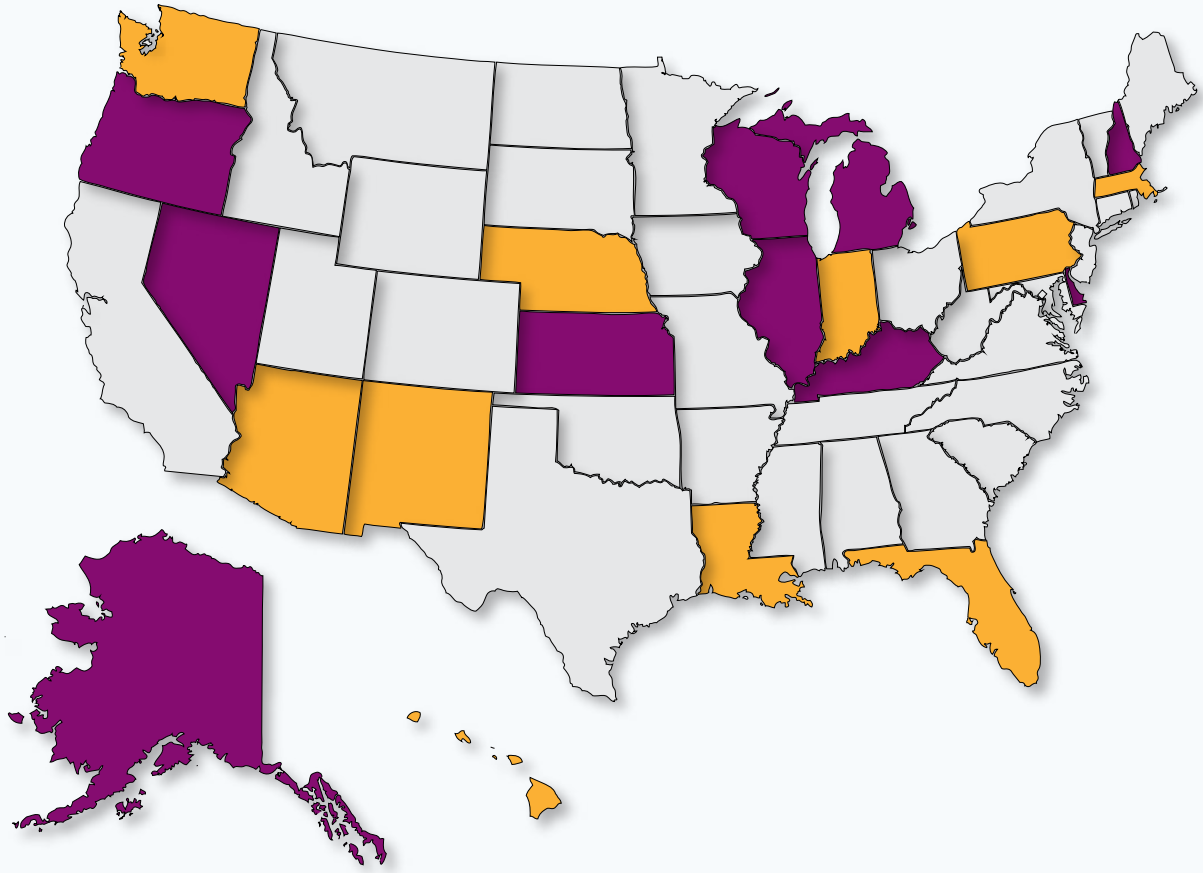
Rank	State	Percent	Number
1	Massachusetts	17.3	141,520
2	Hawaii	18.5	28,729
3	Minnesota	19.5	115,996
4	North Dakota	20.6	14,788
5	Maine	21.7	44,004
6	Vermont	21.8	16,644
7	District of Columbia	22.6	22,019
8	Connecticut	23.1	108,934
9	Delaware	23.6	27,651
10	Maryland	23.8	165,058
11	California	24.4	1,250,169
12	Alaska	24.9	28,240
13	Iowa	25.1	87,540
14	Michigan	25.4	400,904
15	South Dakota	25.9	26,235
16	Nebraska	26.0	52,875
16	New York	26.0	752,942
18	Rhode Island	26.9	41,199
18	Virginia	26.9	311,334
20	New Hampshire	27.1	51,968
21	New Jersey	27.8	245,671
22	Pennsylvania	28.0	492,844
23	Ohio	28.4	455,013
23	Washington	28.4	320,015
25	Illinois	28.7	461,415
26	Wisconsin	28.9	205,471
27	Idaho	29.4	75,106
27	Utah	29.4	102,162
29	Montana	29.6	46,663
30	Kansas	30.2	110,810
31	Missouri	31.0	287,242
32	Wyoming	31.2	22,125
33	Louisiana	31.5	238,510
34	New Mexico	32.0	98,202
35	West Virginia	32.4	112,364
36	Colorado	32.8	212,873
37	Indiana	33.0	297,872
38	Oklahoma	33.5	212,965
39	Tennessee	33.8	347,088
40	North Carolina	33.9	443,229
41	Nevada	34.5	120,460
42	Arizona	34.6	308,568
43	Oregon	34.8	235,105
44	Kentucky	35.2	269,328
45	Georgia	36.2	511,324
46	Texas	37.0	1,074,372
47	Florida	37.7	1,099,896
48	Alabama	37.9	335,497
48	South Carolina	37.9	275,583
50	Arkansas	39.5	185,746
51	Mississippi	43.7	203,972
	United States *	30.3	13,238,519

Mental Health Workforce Availability



Rank	State	Ratio
1	Massachusetts	248:1
2	Delaware	293:1
3	Vermont	329:1
4	Maine	342:1
5	Rhode Island	361:1
6	New Mexico	376:1
7	Oregon	410:1
8	Oklahoma	426:1
9	Alaska	450:1
10	Connecticut	455:1
11	New Hampshire	493:1
12	New York	510:1
12	Wyoming	510:1
14	Washington	533:1
15	Nebraska	560:1
16	Colorado	570:1
17	Utah	587:1
18	Hawaii	597:1
19	California	623:1
20	Michigan	661:1
21	Maryland	666:1
22	District of Columbia	675:1
23	Arkansas	696:1
23	North Carolina	696:1
25	Minnesota	748:1
26	Montana	752:1
27	New Jersey	809:1
28	Pennsylvania	837:1
29	Idaho	839:1
30	Illinois	844:1
31	Kentucky	852:1
32	Kansas	861:1
33	South Dakota	871:1
34	Florida	890:1
35	Indiana	890:1
36	Missouri	947:1
37	Tennessee	974:1
38	South Carolina	995:1
39	Virginia	998:1
40	Nevada	1,015:1
41	Ohio	1,023:1
42	Wisconsin	1,024:1
43	North Dakota	1,033:1
44	Iowa	1,144:1
45	Arizona	1,145:1
46	Mississippi	1,183:1
47	Louisiana	1,272:1
48	West Virginia	1,291:1
49	Georgia	1,440:1
50	Texas	1,757:1
51	Alabama	1,827:1

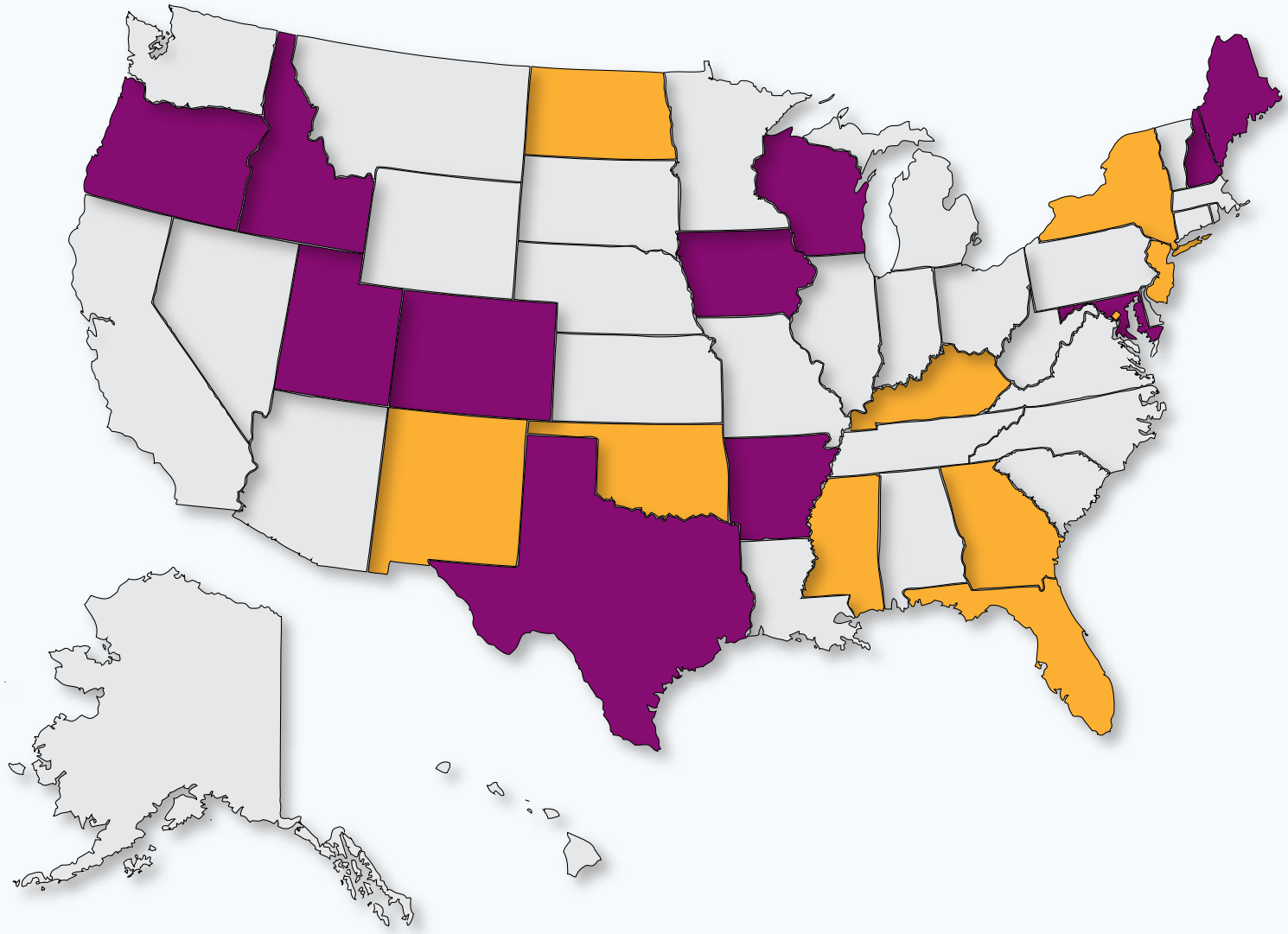
State Hospital 180-Day Readmission Rate



Note: Illinois and Kansis did not report LOS.

Rank	State	Percent	Median Length of Stay (Days)	# State Hospital Readmission
1	Arizona	0.00	431	0
1	Hawaii	0.00	97	0
3	Nebraska	5.05	205	5
4	Indiana	5.87	197	25
5	Florida	6.00	166	60
6	Pennsylvania	6.50	238	44
7	New Mexico	7.47	21	60
8	Massachusetts	8.47	77	48
9	Louisiana	8.51	14	163
10	Washington	8.60	71	115
11	Idaho	8.85	36	70
12	Connecticut	9.63	61	49
13	Utah	9.70	117	29
14	Montana	10.43	31	76
15	California	11.90	150	32
16	Virginia	12.05	30	401
17	South Carolina	13.40	18	254
18	Vermont	13.64	46	21
19	Alabama	13.65	44	336
20	Mississippi	13.94	25	457
21	Maine	14.20	50	74
22	Missouri	14.24	176	94
23	North Carolina	15.02	24	488
24	Texas	15.58	17	2,073
25	Arkansas	16.72	58	55
26	Oklahoma	16.79	48	704
27	District of Columbia	17.71	68	34
28	Rhode Island	17.85	5	204
29	New York	18.13	75	1,152
30	Iowa	18.50	28	217
31	West Virginia	19.26	18	203
32	Ohio	19.69	14	1,065
33	Tennessee	20.48	5	2,007
34	Colorado	21.14	31	256
35	Georgia	21.30	9	1,489
36	Minnesota	21.44	18	414
37	Wyoming	21.48	53	32
38	New Jersey	22.00	84	478
39	North Dakota	22.52	15	141
40	Maryland	23.10	105	64
41	South Dakota	23.39	10	442
42	Illinois	23.52		2,044
43	Oregon	24.15	109	92
44	Kentucky	25.21	8	2,111
45	Michigan	27.09	0	574
46	Kansas	27.98		1,081
47	Delaware	29.30	12	143
48	New Hampshire	30.47	7	728
49	Wisconsin	32.59	6	1,315
50	Alaska	32.93	6	521
51	Nevada	88.99	13	202
	United States	19.60	63	22,902

Adult Improved Social Connectedness



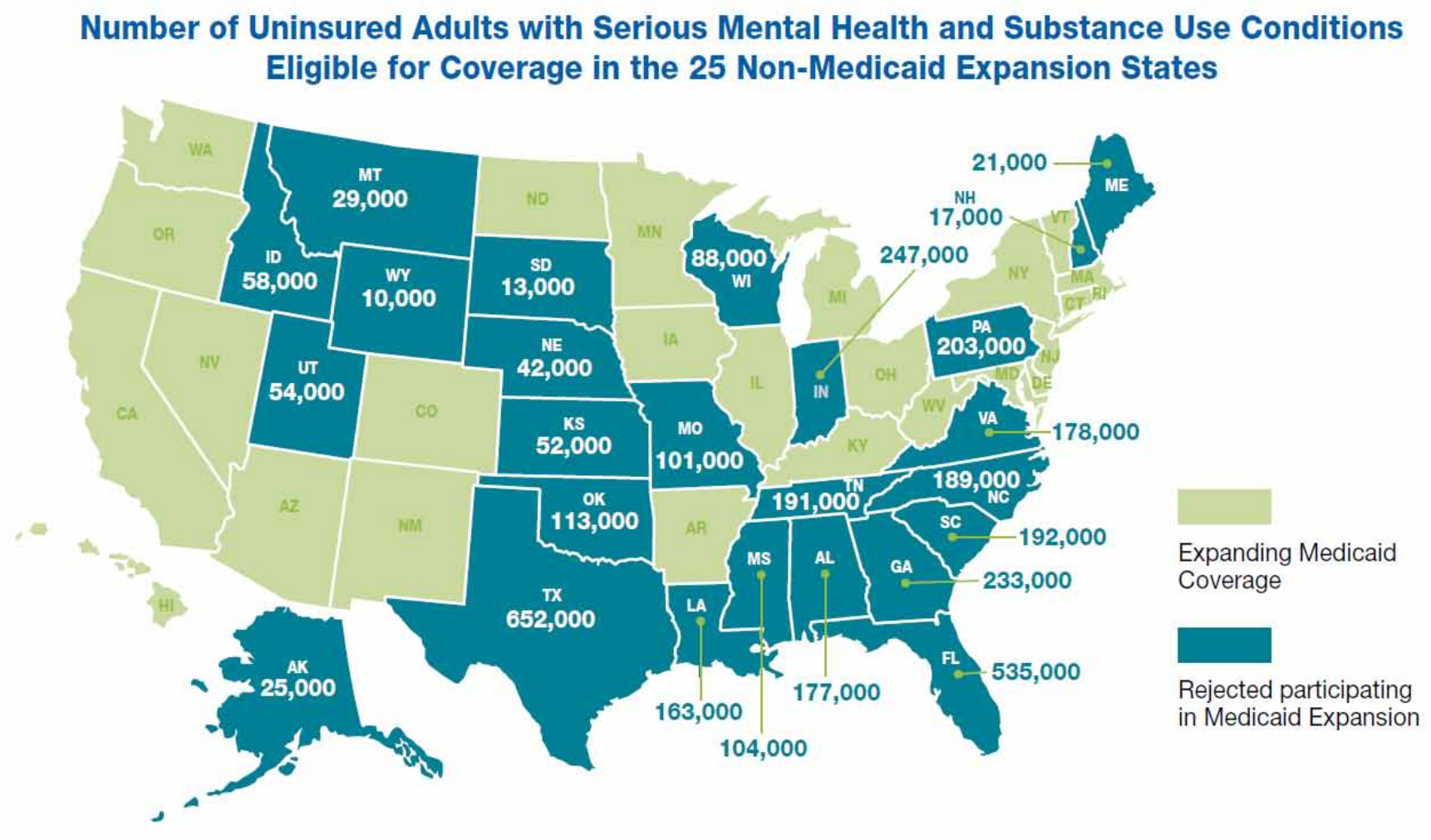
Rank	State	Percent
1	District of Columbia	95.4
2	New Jersey	94.4
3	Florida	86.7
4	Mississippi	84.4
5	Oklahoma	80.9
6	Kentucky	79.8
7	New York	77.8
8	Georgia	76.7
9	New Mexico	76.3
10	Kansas	75.4
11	North Dakota	75.4
12	Alabama	74.7
13	Delaware	73.8
14	Connecticut	73.7
15	Wyoming	73.7
16	Louisiana	73.5
17	North Carolina	73.0
18	West Virginia	72.9
19	Nevada	72.9
20	Arizona	72.1
21	Hawaii	72.0
22	Illinois	72.0
23	Nebraska	72.0
24	Michigan	71.0
25	Pennsylvania	70.6
26	Rhode Island	69.8
27	South Carolina	69.5
28	Minnesota	69.3
29	South Dakota	68.9
30	Missouri	67.6
31	California	67.5
32	Montana	66.5
33	Washington	66.5
34	Virginia	66.4
35	Indiana	66.0
36	Vermont	66.0
37	Alaska	65.9
38	Tennessee	65.8
39	Ohio	65.1
40	Massachusetts	64.5
41	Maryland	64.1
42	New Hampshire	64.1
43	Wisconsin	64.1
44	Utah	63.6
45	Colorado	63.4
46	Maine	63.1
47	Texas	62.9
48	Iowa	59.1
49	Arkansas	58.7
50	Oregon	58.5
51	Idaho	55.8
	United States	72.1

Note: Illinois, West Virginia data from 2011, Virginia data from 2010

Issue Spotlight: Insuring Individuals with Mental Illness

As part of the ACA, states were given the option of implementing their own state-run health exchange or using a federally-facilitated exchange. To date, 17 states have created their own State-Based Marketplaces, seven are in Partnership Marketplaces, and 27 states utilize the Federally-Facilitated Marketplace. In 2012, a Supreme Court ruling allowed states to choose whether or not they would expand Medicaid for individuals earning up to 138 percent of the federal poverty line. Today, 28 states (including the District of Columbia) have expanded Medicaid, 19 states have chosen not to expand Medicaid, and four states (Indiana, Utah, Tennessee, and Wyoming) may expand Medicaid within the next year.

In February 2014, the American Mental Health Counselors Association (AMHCA) assessed the impact, in the relevant states, of the decision to not expand Medicaid.[2] Since AMHCA's assessment, Pennsylvania and New Hampshire have expanded Medicaid, leaving an estimated 3.47 million uninsured adults with serious mental health and substance use conditions in the Medicaid Gap.



[2] American Mental Health Counselors Association. Dashed Hopes; Broken Promises; More Despair: How the Lack of State Participation in the Medicaid Expansion Will Punish Americans with Mental Illness. (2014). http://www.amhca.org/assets/content/AMHCA_DashedHopes_Report_2_21_14_final.pdf

Ranking Results from First Open Enrollment

Following the ACA's first open enrollment, the Assistant Secretary for Planning and Evaluation (ASPE) reported that 8,019,763 individuals (28 percent of potential marketplace enrollees) selected an insurance plan through the Health Insurance Marketplace. States that created their own marketplaces performed slightly better, insuring 32.5 percent of those potentially eligible, as compared to federally facilitated exchanges, which insured 26.3 percent.[3]

Rank	State	# Who Selected a Marketplace Plan	Estimated # Potential Marketplace Enrollees	% of Potential Population Enrolled
1	Vermont	38,048	45,000	85.17%
2	California	1,405,102	3,291,000	42.69%
3	Rhode Island	28,485	70,000	40.64%
4	Florida	983,775	2,545,000	38.66%
5	Idaho	76,061	202,000	37.74%
6	Michigan	272,539	725,000	37.57%
7	Connecticut	79,192	216,000	36.70%
8	Maine	44,258	122,000	36.27%
9	North Carolina	357,584	1,073,000	33.34%
10	Washington	163,207	507,000	32.17%
11	District of Columbia	10,714	36,000	29.77%
12	Georgia	316,543	1,063,000	29.77%
13	New Hampshire	40,262	137,000	29.33%
14	New York	370,451	1,264,000	29.32%
15	Delaware	14,087	48,000	29.06%
16	Wisconsin	139,815	482,000	29.00%
17	Kentucky	82,747	302,000	27.42%
18	Virginia	216,356	823,000	26.29%
19	New Jersey	161,775	628,000	25.74%
20	Utah	84,601	331,000	25.52%
21	Indiana	132,423	525,000	25.24%
22	Colorado	125,402	501,000	25.02%
23	Pennsylvania	318,077	1,276,000	24.93%
24	South Carolina	118,324	491,000	24.12%
25	Montana	36,584	152,000	24.10%
26	Tennessee	151,352	645,000	23.47%
27	Texas	733,757	3,143,000	23.35%
28	Illinois	217,492	937,000	23.21%
29	Missouri	152,335	657,000	23.18%
30	Arizona	120,071	551,000	21.79%
31	Alabama	97,870	464,000	21.08%
32	Louisiana	101,778	489,000	20.79%
33	Mississippi	61,494	298,000	20.62%
34	Oregon	68,308	337,000	20.27%
35	Arkansas	43,446	227,000	19.12%
36	Kansas	57,013	298,000	19.10%
37	Ohio	154,668	812,000	19.04%
38	Nevada	45,390	249,000	18.24%
39	Nebraska	42,975	239,000	17.99%
40	West Virginia	19,856	117,000	17.04%
41	New Mexico	32,062	193,000	16.61%
42	Alaska	12,890	78,000	16.50%
43	Minnesota	48,495	298,000	16.30%
44	Maryland	67,757	419,000	16.18%
45	Oklahoma	69,221	446,000	15.52%
46	Wyoming	11,970	80,000	14.92%
47	Hawaii	8,592	58,000	14.85%
48	North Dakota	10,597	77,000	13.83%
49	Massachusetts	31,695	259,000	12.24%
50	South Dakota	13,104	118,000	11.15%
51	Iowa	29,163	262,000	11.14%
	United States	8,019,763	28,605,000	28.04%

[3] The Henry J. Kaiser Family Foundation. Marketplace Enrollment as a Share of the Potential Marketplace Population. http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population

The Public or Private System: Parity or Disparity?

Because of state differences in Medicaid Expansion and Marketplace Types, whether or not one has access to insurance, whether insurance is affordable, and how complicated access can be depends largely on the state in which you reside. Along with state differences in exchanges and expansion, states vary considerably in how they choose to implement their public mental health system.

The federal and state governments share the responsibility of providing mental health care. In the most basic way, the Federal Government provides support to states mainly through federal regulation, mental health block grants, and insurance programs such as Medicaid, Medicare, CHIP, and TRICARE. States and counties have considerable choice in how and how much they use the available federal support for their constituents. For example, each state sets its own eligibility criteria for traditional Medicaid and CHIP. States also choose how much of the state budget will be spent on mental health treatment in the public system. Together, this collaboration of federal and state policies and funding streams, comprise the "public" mental health system.

Most low income individuals and families, and those with chronic mental health conditions, rely on the public system for their mental health care. Evidenced based practices such as supportive housing, supported employment, Assertive Community Treatment, Multi-systemic therapy, or Wraparound services, were developed in and made available only in the public mental health system. As seen in the following assessment of essential health benefits in the benchmark plans, many private insurance plans explicitly exclude specialized community based services.

The chart below demonstrates the differences across states in children's insurance coverage.[4] The difference in insurance coverage indicates in what system children are able to access their health and mental health care. Most states have larger percentages of children insured through the private market than the public system. In Arkansas, the District of Columbia, Louisiana, Mississippi, and New Mexico, more children are insured in the public system than the private market. If a state or jurisdiction invests in their public mental health system, individuals insured in that system are likely to have better access to care. For example, in 2012, the District of Columbia spent $305.37 per capita in their state mental health expenditures, while Louisiana spent $65.51 per capita.[5] This difference in mental health state budget expenditure might explain why individuals in DC have relatively higher access to care.

Furthermore, while looking for mental health data for our report, MHA found more publicly-available data from the public system as compared to the private system. Efforts to increase transparency in the government resulted in reports such as the Uniform Reporting System (URS). The URS is collected and reported by SAMHSA and provides robust mental health data that MHA hopes will be collected and analyzed into the future. However, for purposes of this report, reporting data from the URS suffers from a significant limitation, as it does not include outcomes for those who are obtaining services in the private system. Publicly-available data assessing the standards of mental health care in the private system are very limited.

Type of Insurance Coverage Among Children Age 0-17, 2011/2012

State	Public Insurance %	Private Insurance %	Currently Uninsured %
Alabama	45.2	50.7	4.1
Alaska	33.7	60.5	5.8
Arizona	35	53.2	11.8
Arkansas	51.7	43.6	4.7
California	39.5	54.1	6.4
Colorado	26.4	65.9	7.7
Connecticut	32.2	65.1	2.6
Delaware	35	61.3	3.7
District of Columbia	51.9	46.8	1.3
Florida	38.4	52	9.6
Georgia	39.3	53.4	7.2
Hawaii	31.3	67.4	1.2
Idaho	33.8	60.4	5.8
Illinois	41.9	56.5	1.6
Indiana	37.1	57.5	5.4
Iowa	31.7	65.5	2.8
Kansas	32.1	62.8	5.1
Kentucky	41.6	54.1	4.3
Louisiana	54.1	43.8	2.1
Maine	40.2	56	3.8
Maryland	28.8	66.7	4.5
Massachusetts	32.5	66.5	1
Michigan	41	56.3	2.7
Minnesota	26.3	69.2	4.5
Mississippi	51.5	41.1	7.4
Missouri	35.4	60.3	4.3
Montana	34.6	56.8	8.6
Nebraska	28	67	5
Nevada	30.7	55.8	13.5
New Hampshire	27.5	69.1	3.4
New Jersey	30.8	65.7	3.5
New Mexico	52	41.3	6.8
New York	38.5	58.7	2.9
North Carolina	40.9	52.9	6.2
North Dakota	21.4	72.1	6.6
Ohio	35.6	61.1	3.3
Oklahoma	44.5	48.2	7.3
Oregon	37.5	58.1	4.4
Pennsylvania	30.3	65.5	4.2
Rhode Island	36.1	59.9	3.9
South Carolina	44.8	48.8	6.4
South Dakota	29.6	67.1	3.3
Tennessee	40.2	54.4	5.4
Texas	38.6	51.9	9.5
Utah	16.6	74.7	8.7
Vermont	43.6	55	1.3
Virginia	25.6	69.1	5.3
Washington	31.4	64.8	3.8
West Virginia	42.8	53	4.2
Wisconsin	34.3	64	1.7
Wyoming	30.3	63.8	5.9
United States	37.1	57.4	5.6

[4] National Survey of Children's Health. Child and Adolescent Health Measurement Initiative, Data Resource Center on Child and Adolescent Health website. http://childhealthdata.org/browse/survey/results?q=2200&r=1
[5] NASMHPD Research Institute. SMHA Mental Health Per Capita Expenditures by Population Density, FY 2012. http://www.nri-incdata.org/RevExp2012/T21.pdf

From Public to Private Management

The increasing use of Medicaid Managed Care adds complexity to the public and private system. Over the last decade, states have progressively transitioned the management of their traditional Medicaid to Medicaid Managed Care (MMC). Under MMC, Medicaid is offered to people through a private insurance company that manages the provision and cost of a person's or family's care. During this transition, the mental health system has seen a rise in other types of managed care models, including Accountable Care Organizations and Coordinated Care Organizations, representing networks of providers who act together to provide managed care. For many states, MMC offered a way to extend care to individuals following enrollment in the ACA. One implication of the increased use of MMC is that for an increasing number of individuals and families, their access to mental health treatment will be managed by private for-profit companies.

The following chart shows the variation between states in what percentage of their Medicaid enrollees are in Managed Care vs. Traditional Medicaid.[6] States are ranked based on their percentage of State MCC. The ranking is not indicative of whether more or less managed care is better or worse for consumers. More research is needed on the impact of MMC on consumers. MHA supports more data collection and transparency in the private system. Such collection and transparency in the private system will allow the assessment of the impact of the MMC transition and analyze whether increased Medicaid Managed Care increases or decreases access to mental health treatment.

Percentage of State Medicaid Enrollment in Medicaid Managed Care 2011

Rank	State	% in State MMC	Rank	State	% in State MMC
1	Alaska	0.00%	27	New York	76.70%
2	New Hampshire	0.00%	28	New Jersey	77.70%
3	Wyoming	0.00%	29	Arkansas	78.40%
4	Maine	49.30%	30	Delaware	80.50%
5	West Virginia	51.00%	31	Pennsylvania	81.50%
6	Massachusetts	53.10%	32	North Carolina	83.20%
7	Virginia	58.20%	33	Nevada	83.60%
8	Vermont	58.50%	34	Nebraska	85.10%
9	California	60.10%	35	Oklahoma	86.50%
10	Alabama	61.10%	36	Mississippi	87.20%
11	North Dakota	63.60%	37	Kansas	87.40%
12	Wisconsin	63.70%	38	Washington	88.10%
13	Florida	63.80%	39	Michigan	88.40%
14	Louisiana	65.30%	40	Arizona	88.70%
15	Minnesota	65.70%	41	Kentucky	89.40%
16	District of Columbia	67.40%	42	Iowa	91.10%
17	Illinois	67.80%	43	Georgia	91.30%
18	Connecticut	68.60%	44	Colorado	94.60%
19	Rhode Island	68.60%	45	Missouri	97.70%
20	Indiana	70.30%	46	Oregon	98.20%
21	Texas	70.70%	47	Hawaii	98.70%
22	New Mexico	72.80%	48	Utah	99.80%
23	Maryland	74.60%	49	Idaho	100.00%
24	Ohio	75.40%	50	South Carolina	100.00%
25	South Dakota	75.80%	51	Tennessee	100.00%
26	Montana	76.10%		United States	74.2%

[6] The Henry J. Kaiser Family Foundation. Total Medicaid Managed Care Enrollment. http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/

Evaluating Insurance Plans

Limitations of Insurance Plan Summary of Benefits and Coverage

MHA evaluated mental health coverage among health exchange plans for comparison in the final *Parity and Disparity* report. We examined publicly-available information on the health plans that were included on marketplace exchanges. Through this process, MHA discovered that, more often than not, information about insurance plans was provided in the form of a "Summary of Benefits and Coverage." While such Summaries often appear at first glance to meet the requirements of MHPAEA and the ACA, they are often so limited in detail that it is very difficult to determine if that is actually the case. In order to identify what is actually covered or what exemption a person will face when trying to access his or her treatment, an observer must carefully analyze the plan's "Outline of Coverage," "Evidence of Coverage," or better yet, the full insurance policy. Unfortunately, outlines of coverage or insurance policies for plans on the health exchanges are not easily accessible. In most cases, a person would have to directly and individually request the policy from the insurance company or sign up and pay for insurance before receiving his or her policy by mail or email. In contrast, since 1995, the National Association of Insurance Commissioners has put out model regulations that moved states to require full and fair disclosure of Medicare supplement policies.[7] Full and fair disclosure of Medicare supplements included providing consumers with the outline of coverage at the time of application. For this reason, most Medicare Supplement Outline of Coverages can be found online. MHA encourages comparable protections and full disclosure for *all* insurance plans, especially plans found on the health insurance exchanges.

Because of the above limitations, MHA also examined the available State Benchmark Plans for analysis of their coverage of mental health and substance use treatments.

Essential Health Benefits and State Benchmark Plans

In 2010, the ACA introduced 10 Essential Health Benefits (EHBs) to form a baseline for what all plans on all exchanges must cover. The EHBs explicitly include both mental health and substance use disorder services. To determine specific details around all 10 EHBs, the Department of Health and Human Services (HHS) decided to use a benchmarking system. Each state chose a health plan from existing health plan as its "benchmark" plan. Once a benchmark was selected, that insurance plan became the standard of comparison for other Qualified Health Plans (QHP) within that state. Only plans that provide "substantially equal" coverage to the designated benchmark plan for each of the EHBs could be accredited as a QHP and included on that state's health insurance exchange. Thus, the state benchmark plans determine the minimum amount of coverage a QHP may offer for each of the EHBs.

Unfortunately, full policies for the state benchmark plans are not readily available. The HHS Center for Consumer Information & Insurance Oversight (CCIIO) has released some details of coverage for each benchmark plan.[8] The details of coverage allow for some analysis of what types of mental health and substance use coverage a consumer may have, and what kinds of limitations he or she might face. Analyzing the benchmark plans provides a starting point for evaluating QHPs for compliance with the rights and regulations set forth in the MHPAEA and the ACA. Finally, even though the benchmarks only provide the minimum guaranteed coverage for each of the EHBs, QHPs may exceed this coverage.

MHPAEA requires that health plans offering mental health services must not limit these services more than they limit comparable medical and surgical services. This protection applies to different kinds of quantitative limits, such as lifetime spending caps or annual visit limits, as well as non-quantitative limits, such as prior authorization requirements or exclusions.

Many of the benchmark plans do not yet comply with parity requirements, and CCIIO notes this on their website. The benchmark plans have visit limits and lifetime monetary limits for mental health that medical and surgical services do not have. There are exclusions in coverage for services such as residential treatment centers for mental health and cognitive rehabilitation without equivalent limitations in medical and surgical services. Under the parity law, there can only be exclusions in mental health coverage if it is the result of a neutral policy that applies to both medical/surgical and mental health, even if it affects mental health services more. This applies to formularies as well – any exclusion or "tiering" criteria cannot be applied disproportionately to mental health services.

In the updated, parity-compliant state benchmark plans, these unequal limitations and exclusions should disappear and be replaced with neutral utilization management guidelines. When the state benchmark plans are not parity-compliant, they provide less guidance to QHPs about their legal obligations. QHPs are working to meet parity requirements within their plans, but, until the state benchmark plans are updated to reflect parity requirements, the QHPs' obligations under the ACA will be less clear.

[7] National Association of Insurance Commissioners. Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act. http://www.naic.org/store/free/MDL-651.pdf
[8] The Center for Consumer Information & Insurance Oversight. Additional Information on Proposed State Essential Health Benefits Benchmark Plans. http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html

Comparing the State Benchmark Plans

Some plans are vague, while others are specific.

Some benchmark plans detail coverage with relative specificity, while others are notably vague. For example, Blue Cross Blue Shield of Alabama's 320 Plan states only that it covers mental health and substance use outpatient services, without further explanation or any language about exclusions. Other plans offer more information. Tennessee's Blue Cross Blue Shield BCBST PPO lists the following in its explanation of excluded coverage for mental health:

> "a. Pastoral Counseling; b. Marriage and family counseling without a behavioral health diagnosis; c. Vocational and educational training and/or services; d. Custodial or domiciliary care; e. Conditions without recognizable ICD-9 diagnostic classification, such as adult child of alcoholics (ACOA), and co-dependency and self-help programs; f. Sleep disorders; g. Services related to mental retardation; h. Habilitative as opposed to rehabilitative services, i.e., services to achieve a level of functioning the individual has never attained; i. Court ordered examinations and treatment, unless Medically Necessary; j. Pain management; k. Hypnosis or regressive hypnotic techniques; l. Charges for telephone consultations, missed appointments, completion of forms, or other administrative services."

It is unclear if specificity is better or worse for the consumer. Plans can specifically exclude important services, which may undermine consumer services and access, but if plans are too vague, then individuals may not know what is covered until they receive a denial. Following an insurance denial, an individual's only recourse is to file an appeal through the insurance plan and then if necessary, through a state appeal process if one exists, or a state or federal court.

The lack of transparency in marketplace plans means that the responsibility is then placed on the consumer to identify the may or may not be covered after they have already purchased their plan.

Placing this burden on the consumer is problematic. Many people who receive a denial of coverage may not file appeal because the process is burdensome and opaque. Furthermore, even if one individual appeals a denial and it is reversed, unless he or she obtains a binding court opinion, this does not guarantee that the service will be covered for other similarly-situated individuals, who will then need to appeal as well.

By providing outlines of coverage or policies to consumers prior to purchasing a plan, individuals with known health care needs can identify those plans that work best for them and reduce the likelihood of needing to file an appeal and / or being unfairly denied services.

Some plans guarantee a lot more coverage than others.

Some plans guarantee more coverage than others. For example, Blue Cross Blue Shield of North Carolina's Blue Options plan offers a variety of services, including screening and intensive therapy, along with several kinds of rehabilitative services. This plan also has fewer exclusions than other plans. On the other hand, the BCBS Health Plan of Georgia POS plan explicitly excludes treatment of behavioral disorders and excludes cognitive rehabilitation, among a number of other excluded services. These two plans differ enormously from one another, and these differences will likely remain after the plans are made parity-compliant. Moreover, some benchmarks guarantee that QHPs in their state will cover at least a reasonable amount of mental health services, while others guarantee only the barest amount of late-stage services, such as inpatient treatment. While a QHP may cover more services regardless of what is contained in the state benchmark plan, guaranteed access to these services through the EHB portion of the state benchmark plan is an important protection for individual consumers. Ensuring that consumers have access to low-cost, early treatment such as quality community based outpatient care can reduce utilization of high cost services, such as emergency room visits and residential treatment.

There are many types of exclusions.

Among the 50 plans, 22 of the state benchmark plans had quantitative limits on mental health services. The limits ranged from eight visits (Utah) to many plans which offered up to 60 visits a year for outpatient treatment. Almost all quantitative treatment limits should have been removed from QHPs that were expected to start after July 1st, 2014.

Along with traditional non-quantitative treatment limitations such as preauthorization requirements or denials based on whether a treatment is deemed "medically necessary," below are the most common types of exclusions we found among the state benchmark plans. These exclusions may be indicative of the types of exclusions consumers will continue to see in their QHPs.

Limitations on types of services:

- Family or marital counseling
- Bereavement counseling
- Services by telephone
- Services in non-clinical settings; for example, services provided in-home, schools, domicile, and custodial care
- Psychological testing
- Residential treatment
- Community reintegration service.
- Services by practitioners that do not meet certain licensure guidelines, potentially excluding peer specialists
- Transportation for providers to get to clients or for clients to get to providers
- Cognitive therapy as a rehabilitative service
- Services that focus on vocational, educational, or parental counseling
- Services that teach self-help techniques like biofeedback
- Certain substance use treatments, including detoxification or methadone maintenance

Limitations based on type or severity of the condition:

- "Non-biologically based" conditions
- Certain types of disorders, such as oppositional disorders, learning disability, attention deficit disorder, attention deficit hyperactivity disorder, developmental disabilities or eating disorders
- Severity limitations, such as a "break with reality" before certain services may be accessed

Formularies may need to be revised.

Many benchmark plans exclude some branded medications from coverage, and almost all plans use tiered cost-sharing and utilization management such as step therapy or "fail-first" policies, making many of the medications prohibitively expensive or difficult to get. When new medications are covered, they are almost always on the highest cost-sharing tier. Parity requires that formularies treat mental health and general health medications equally, so while neutral policies may still limit access, formularies cannot unfairly limit access to psychotropic medications. For more information, see MHA's report with Breakaway Policy entitled: *Behavioral Prescription Drug and Services Coverage: A Snapshot of Exchange Plans.*

Rehabilitative services may need to be revised.

Blue Cross and Blue Shield of Kansas' Comprehensive Major Medical-Blue Choice excludes cognitive therapy for rehabilitation, while New Jersey's Horizon HMO specifically includes cognitive therapy. Currently, many state benchmark plans specify that rehabilitative services include physical, occupational, and speech therapy. Rehabilitative services are an EHB and are defined by the National Association of Insurance Commissioners as being "health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled," and these specifically include "psychiatric rehabilitative services in a variety of inpatient and or outpatient settings."[9] After the benchmark plans are made parity-compliant, the scope of rehabilitative services offered will need to expand dramatically for many plans and will need to include mental health rehabilitation services, unless excluded through neutral policies.

[9] National Association of Insurance Commissioners. http://www.naic.org/documents/committees_b_consumer_information_ppaca_glossary.pdf

The scope of preventive services is often unclear.

Hawaii Medical Service Association's Preferred Provider Plan 2010 specifies that it covers exactly what is required by the ACA, while Connecticare's HMO covers "preventive care/ screening/ immunization" generally. The ACA requires certain preventive services to be covered, including, for example, depression screenings and psychosocial/behavioral assessments. Some of the plans specify that they only cover the statutory minimum, while others state that they cover preventive services generally, so the scope of coverage is often unclear. For all plans, the scope of coverage for preventive services should be as broad as possible to best promote population health and lower downstream costs.

Going Forward

One key finding emerges from this report: whether one has parity or ongoing disparity in mental health care depends on where one lives. MHA believes all people should have parity in mental health care and recommends the following to increase parity and decrease disparity. First, expanding Medicaid and providing insurance to individuals with mental illness is a priority. Without insurance, individuals are more likely to wait until a mental health crisis and use costly services such as emergency hospital visits, and are less likely to have access to early intervention. Second, although access to insurance is an important first step, insurance coverage does not in itself guarantee meaningful access to treatment and supportive services. Health plan carriers should broaden coverage, particularly to include evidence-based community mental health services. Treatment provided, whether in the public or private system, should focus on prevention and early intervention services. Workforce development strategies should be developed and implemented in those states with the fewest available mental health providers. Health plan carriers should include sufficiently broad networks of mental health professional in their plans. Third, data on quality and performance measures of both the private and public mental health systems should be systematically collected and made publicly available. Collecting and making data publicly available will illuminate how various policies, such as transitioning to Medicaid Managed Care, are strengthening parity or increasing disparity across the states. Finally, transparency in insurance coverage will increase meaningful consumer choice and reduce unfair burden on the consumer. Government agencies should require updated state benchmark plans and post these plans online. Government agencies and health plan carriers should ensure that information about plans is fully disclosed to consumers and is as detailed and transparent as possible. Outlines of Coverage for all Qualified Health Plans should be available to consumers online before application. Only by taking these steps to increase transparency and comprehensive coverage can the country achieve the goal of strengthening parity and reducing disparity.

Glossary

Indicator	Description of Measure	Source
Adult Dependence or Abuse of Illicit Drugs or Alcohol	Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Illicit Drugs include marijuana/ hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically, including data from original methamphetamine questions but not including new methamphetamine items added in 2005 and 2006. Data survey year 2011-2012.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2011, and 2012
Adults with AMI (Any Mental Illness)	Any Mental Illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder, assessed by the Mental Health Surveillance Study (MHSS) Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Research Version—Axis I Disorders (MHSS-SCID) which is based on the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Three categories of mental illness severity are defined based on the level of functional impairment: mild mental illness, moderate mental illness, and serious mental illness. Any mental illness includes persons in any of the three categories. These mental illness estimates are based on a predictive model and are not direct measures of diagnostic status. Data survey year 2011-2012.	Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (February 28, 2014). The NSDUH Report: State Estimates of Adult Mental Illness from the 2011 and 2012 National Surveys on Drug Use and Health. Rockville, MD.
Adults with AMI and Uninsured	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). A respondent is classified as NOT having any health insurance (IRINSUR=2) if he/she met EVERY one of the following conditions. (1) Not covered by Private Health Insurance (PRVHLTIN=2) (2) Not covered by Medicare (MEDICARE=2) (3) Not covered by Medicaid (MEDICAID=2) (4) Not covered by Champus, Champva, Va, or Military (CHAMPUS=2) If the respondent is not classified as having or not having any health insurance according to PRVHLTIN, MEDICARE, MEDICAID, and CHAMPUS, then he/she is imputed to either of these two categories, where consistency is maintained between IRINSUR, IRINSUR2, and IRPINSUR. Annual estimated rate from data survey year 2010, 2011, 2012.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010, 2011, and 2012.
Adults with AMI reporting Unmet Need	Perceived Unmet Need for Mental Health Treatment/Counseling is defined as a perceived need for treatment/counseling that was not received. Perception of need was asked of all respondents regardless of disorder status. Respondents with unknown perception of unmet need information were excluded. Annual estimated rate from data survey year 2010, 2011, 2012.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010, 2011, and 2012.
Adults with AMI who Received Treatment	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. Annual estimated rate from data survey year 2010, 2011, 2012.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010, 2011, and 2012.

Indicator	Description of Measure	Source
Adults with Disability who Could Not See a Doctor Due to Costs	Disability questions were added to the Behavioral Risk Factor Surveillance System (BRFSS) core questionnaire in 2004. Consistent with Healthy People 2010, disability was determined using the following two BRFSS questions: "Are you limited in any way in any activities because of physical, mental or emotional problems?" and "Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?" Respondents were defined as having a disability if they answered "Yes" to either of these questions. Respondents were defined as not having a disability if they answered "No" to both questions. "Was there a time in the past 12 months when you needed to see a doctor but could not because of cost?" Responses were grouped into two categories: Yes and No. Data survey year 2012.	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, 2012 http://dhds.cdc.gov/dataviews/
Adults with Serious Thoughts of Suicide	Adults aged 18 or older were asked whether they had seriously thought about, made any plans, or attempted to kill themselves at any time during the past 12 months, or if they had received medical attention from a health professional or stayed overnight in a hospital in the past 12 months because of a suicide attempt. Data survey year 2011-2012.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2011, and 2012
Children who Needed but Did Not Get Mental Health Services	Children age 2-17 with an emotional, developmental, or behavioral problems for which they need treatment or counseling (K2Q22) who did not receive treatment from a mental health professional during the past 12 months (K4Q22). Data survey year 2011-2012.	National Survey of Children's Health. Child and Adolescent Health Measurement Initiative, Data Resource Center on Child and Adolescent Health website. Retrieved 09/17/14 from http://childhealthdata.org/browse/allstates?q=2220#
Children with EBD who were Consistently Insured	Children with Ongoing Emotional Behavioral or Developmental issues is defined as any child (age 0-17) with any kind of emotional, developmental, or behavioral problem that requires treatment or counseling (K2Q22 = Yes), and if so, whether the condition(s) have lasted or are expected to last for 12 months or longer (K2Q23). Consistently Insured combines responses to whether the child currently has health insurance coverage (K3Q01) and whether currently insured children have had periods with no insurance (K3Q03), to determine how many children have had continuous coverage for at least one year and how many were uninsured at the time of the survey or at some time within the previous 12 months. Data survey year 2011-2012.	National Survey of Children's Health. Child and Adolescent Health Measurement Initiative, Data Resource Center on Child and Adolescent Health website. Retrieved 09/17/14 from http://childhealthdata.org/browse/allstates?q=2199&g=463
Children with Emotional Behavioral Developmental Issues (EBD)	Children with Emotional Behavioral or Developmental Issues is defined as any child between age 2-17 with any kind of emotional, developmental, or behavioral problem for which he or she needs treatment or counseling. Data survey year 2011-2012.	Child and Adolescent Health Measurement Initiative. National Survey of Children's Health Enhanced Data File. Data Resource Center for Child and Adolescent Health. Retrieved 10/8/14 from http://childhealthdata.org/help/dataset.
Children with Ongoing EBD reporting Inadequate Insurance	Children with Ongoing Emotional Behavioral or Developmental Issues (any child (age 0-17) with any kind of emotional, developmental, or behavioral problem that requires treatment or counseling (K2Q22 = Yes), and if so, whether the condition(s) have lasted or are expected to last for 12 months or longer (K2Q23). Children with an ongoing EBD who have insurance coverage (Denominator), that report inadequate insurance (Numerator), defined as not meeting one or more of the following: 1) usually/always meets child's needs, 2) usually/always allow child to see needed provider, 3) out-of-pocket costs are usually/always reasonable or has no out-of-pocket costs. Data survey year 2011-2012.	National Survey of Children's Health. Child and Adolescent Health Measurement Initiative, Data Resource Center on Child and Adolescent Health website. Retrieved 09/17/14 from http://childhealthdata.org/browse/allstates?q=2201&g=463&a=4050

Indicator	Description of Measure	Source
Improved Social Connectedness	Adults served in the pubic system were asked to answer on a scale from Strongly Agree to Strongly Disagree answers to the following questions: 1) I am happy with the friendships I have. 2) I have people with whom I can do enjoyable things. 3) I feel I belong in my community. 4) In a crisis, I would have the support I need from family or friends. In the Uniform Reporting System, this measure is called "Improved Social Connectedness." Year 2012.	2012 Center for Mental Health Services, Uniform Reporting System Output Tables, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services. Retrieved 7/16/14 from /http://www.samhsa.gov/dataoutcomes/urs
Mental Health Workforce	This measure represents the ratio of the state population to the number of mental health providers including psychiatrists, psychologists, licensed clinical social workers, counselors, and advanced practice nurses specializing in mental health care. Survey data year 2013.	County Health Rankings & Roadmaps. http://www.countyhealthrankings.org/app/virginia/2014/measure/factors/62/map. 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.
State Hospital Readmission: 180 days Non-Forensic	Adults and Children served in the public system who had readmission within 180 days to state psychiatric Hospital: "Civil" (Non-Forensic) patients. Year 2012.	2012 Center for Mental Health Services, Uniform Reporting System Output Tables, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services. Retrieved 7/16/14 from /http://www.samhsa.gov/dataoutcomes/urs
Students Identified with Seriously Emotional Disturbance for IEP	Percent of Children Identified as having a Serious 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, Serious Emotional Disturbance is identified as a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: (A) An inability to learn that cannot be explained by intellectual, sensory, or health factors. (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers. (C) Inappropriate types of behavior or feelings under normal circumstances. (D) A general pervasive mood of unhappiness or depression. (E) A tendency to develop physical symptoms or fears associated with personal or school problems. Emotional disturbance includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance under paragraph (c)(4)(i) of this section. Year 2011-2012.	IDEA Data Center, 2012 IDEA Part B Child Count and Educational Environments, https://inventory.data.gov/dataset/8715a3e8-bf48-4eef-9deb-fd9bb76a196e/resource/a68a23f3-3981-47db-ac75-98a167b65259. US Department of Education, National Center for Education Statistics, Common Core of Data. http://nces.ed.gov/ccd/stnfis.asp

Indicator	Description of Measure	Source
Youth Attempted Suicide	Among youth grade 9 through 12th, percentage of Youth in High School who reported that during the past 12 months, they attempt suicide one or more times. Data survey year 2013.	Centers for Disease Control and Prevention. 2013. Youth Risk Behavior Survey. Available at: http://nccd.cdc.gov/youthonline
Youth Dependence or Abuse of Illicit Drugs or Alcohol	Among youth age 12-17, dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically, including data from original methamphetamine questions but not including new methamphetamine items added in 2005 and 2006. See Section B.4.8 in Appendix B of the Results from the 2008 National Survey on Drug Use and Health: National Findings. Data survey year 2011-2012	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010, 2011, and 2012 (2010 Data – Revised March 2012).
Youth with At Least One Major Depressive Episode	Among youth age 12-17, major depressive episode (MDE) is defined as in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), which specifies a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. For youth age 12-17. Survey Data 2011-2012.	SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010, 2011, and 2012 (2010 Data – Revised March 2012).