OLO Report 2025-9 June 17, 2025

Montgomery County Youth Behavioral Health

Part I: Background

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OLO Office of Legislative Oversight

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OLO Report 2025-9 **EXECUTIVE SUMMARY** **June 17, 2025**

At the County Council's request, the Office of Legislative Oversight (OLO) is writing a series of reports about the availability of youth behavioral health care in Montgomery County. This first report, *Part I: Background*, provides background information on behavioral health, describes issues facing behavioral health systems in the United States, and summarizes demographic data on youth and on the behavioral health workforce in the County.

Behavioral Health Overview

Behavioral health encompasses the study of mental health, substance use disorders, and other behaviors that impact overall well-being. "An individual's level of behavioral health can fall anywhere on the spectrum from illness to positive mental well-being, and it can vary over the course of a lifetime."

A positive state of behavioral health has benefits both for an individual and for the individual's community. Research shows that individuals in a good state of behavioral health often enjoy a better quality of life, better physical health, better management of mental illness, improved work performance, reduced stress levels, and enhanced resilience.

A poor state of behavioral health can negatively impact mood, thinking and behavior. Research show that adolescents with a mental health or behavioral health diagnosis are more likely to report being disengaged from school; to miss 11 or more days of school for health reasons; and to experience a lot of difficulty in making/keeping friends.

Research has shown that behavioral health care can have long lasting positive impacts. For youth it can:

- Reduce depression and anxiety;
- Reduce the risk of future behavioral health or mental health challenges in adulthood;
- Teach coping skills and resilience that can carry into adult life;
- Improve academic performance by improving concentration, organization, and resilience to stress;
- Foster better relationships with family, friends, and teachers; and
- Improve self-esteem and confidence.

Youth Behavioral Health Crisis

Based on the rate of adolescent brain development, current researchers argue that the definition of "youth" should be adjusted up from 18 years old to 24 or 25 years old. Research shows most people who will develop a mental health issue in their lifetime will do so by age 24. A 2005 research study found 50% of all lifetime mental health disorders begin by age 14 and 75% begin by age 24. Half of all young people will be affected by a mental health disorder by age 24.

Behavioral health researchers and policy makers around the world agree that today's youth are facing a mental/ behavioral health crisis. In the U.S., the proportion of youth experiencing mental health challenges had been increasing for a significant period before the COVID-19 pandemic:

> From 2009 to 2019, the proportion of high school students reporting persistent feelings of sadness or hopelessness increased by 40%; the share seriously considering attempting suicide increased by 36%; and the share creating a suicide plan increased by 44%. Between 2011 and 2015, youth psychiatric visits to emergency departments for depression, anxiety, and behavioral challenges increased by 28%. Between 2007 and 2018, suicide rates among youth ages 10-24 in the US increased by 57%.

The Behavioral Health Care System

Many stakeholders view the current behavioral health system in the U.S. as "fragmented" and "difficult to navigate" – because it is disconnected across health systems, providers, and funding streams. Many experts recommend developing a public health-based behavioral health system that applies public health principles – prevention, population-level strategies, equity, and data-informed decision-making – to mental health and substance use care. Implementing a public health-based care system requires partnerships among government agencies, school systems, service providers, and community organizations to bring together disjointed services into a more easily navigable and comprehensive system.

Key Features of a Public Health-Based Behavioral Health System

Feature	Description
Population-Based Approach	Focuses on the mental well-being of entire communities, not just individuals in clinical treatment. Efforts are tailored by geography, age, race/ethnicity, and risk level.
Prevention and Early Intervention	Prioritizes efforts to prevent mental illness and substance use, including programs in schools, workplaces, and communities (e.g., suicide prevention, anti-stigma campaigns, parenting programs).
Integrated Care	Coordinates behavioral health with primary care, social services, and public health to address whole-person needs. Models include behavioral health consultants embedded in other settings (e.g., medical offices, schools).
Social Determinants of Health (SDOH)	Addresses underlying factors like housing, employment, education, and trauma exposure that influence behavioral health outcomes.
Crisis Continuum	Offers a full range of crisis services: 24/7 call lines, mobile crisis teams, stabilization units, and follow-up care.
Data and Surveillance	Uses epidemiological methods to track behavioral health trends, disparities, risk factors, and service utilization for planning and accountability.
Community Engagement and Equity	Involves community members in designing culturally appropriate interventions and ensures underserved populations are prioritized.
Workforce Development	Expands and trains the workforce to deliver community-based, prevention-oriented behavioral health services, including peers and paraprofessionals.

Behavioral Health Workforce

Maryland's current behavioral health workforce is not large enough to provide needed services and care. Maryland's behavioral health workforce currently has approximately 34,600 professionals but needs an additional 32,800 professionals by 2028 – 18,200 to meet current demand and 14,600 to replace professionals leaving the field.

An October 2024 report on Maryland's behavioral health workforce identified the primary issues impacting the workforce as:

- Low pay;
- Lack of awareness of behavioral health careers;
- Cost of behavioral health education and training;
- Problems and delays with licensing and certifications processes; and
- Job burnout.

Montgomery County Data

Within the County's estimated 1.06 million residents, almost 321,000 (30.3%) are 24 years old or younger – the age by which 50% of all young people *will be affected* by a mental health disorder. Within Montgomery County Public Schools' (MCPS) 160K student enrollment, 70% of the students are 14 years or younger – the age by which 50% of lifetime mental health disorders will *begin*. The data below estimate rates of substance use and mental health issues experienced by County youth using data from the Substance Abuse and Mental Health Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH). These estimates show:

- 36% of County youth ages 18-25 (39,595) have experienced a mental illness.
- 14% of County youth ages 18-25 (15,110) had a co-occurring substance use disorder and any mental illness.
- 21% of County youth ages 12-25 (41,487) had a major depressive episode in the past year.
- 22% of MCPS students ages 12-18+ (16,769) had a major depressive episode in the past year.
- 14% of County youth ages 12-25 (26,195) had serious thoughts of suicide in the past year.
- 14% of MCPS students ages 12-18+ (10,930) had serious thoughts of suicide in the past year.
- 31% of County youth ages 12-25 (60,254) received mental health treatment.
- 33% of MCPS students aged 12-18+ (24,692) received mental health treatment.

Data show that the prevalence of substance use disorders increases dramatically from ages 12-17 to ages 18-25 years – from 9% to 27%. Among older youth, this impacts almost 30,000 County youth ages 18 to 25 and over 3,000 MCPS students 18 years or older. Other estimates on substance use disorder show:

- 21% of County youth ages 12-25 (41,362) needed substance use treatment.
- 15% of MCPS students aged 12-18+ (11,071) needed substance use treatment.
- 59% of youth ages 12-17 needing substance use treatment did not receive it.
- 86% of youth ages 18-25 needing substance use treatment did not receive it.
- 17% of County youth aged 12-25 who needed substance use disorder treatment did not receive it.

Upcoming Reports

The **second report** in this series on Montgomery County youth behavioral health will cover the availability of outpatient care available through Mongomery County Public Schools (MCPS). This report will describe services provided by MCPS staff, through Montgomery County Government-funded programs, and by community partners. The second report will be followed by reports that examine:

- Outpatient Behavioral Health Availability – County Government & Community Partners
- Outpatient Behavioral Health Availability – Private Providers
- Inpatient Behavioral Health Availability

For a complete copy of OLO Report 2025-9, go to OLO's *Reports Released from 2001 to Present*

OLO Report 2025-9

Montgomery County Youth Behavioral Health
Part I: Background

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Introduction

The County Council assigned the Office of Legislative Oversight (OLO) two projects asking OLO to assess the availability of both outpatient and inpatient behavioral health care for youth in the County. Originally envisioned as two separate reports, after conducting preliminary research and interviews, it became clear that the complexity of the issue requires a more nuanced and focused approach.

Given the critical nature of youth behavioral health and the urgency of addressing it, the Office of Legislative Oversight decided to divide the project into shorter reports, each with a specific focus. This approach will allow more focused discussions in each report on the various realms of behavioral health care in the County. OLO intends to release the following reports:

1. **Background of Youth Behavioral Health in Montgomery County**: This report will: 1) provide background information on behavioral health and its importance in overall health, 2) describe the behavioral health issues facing youth in the U.S., and 3) identify the major issues impacting behavioral health care for youth. The report will also provide demographic data on youth in Montgomery County, data on residents' insurance status that impacts access to behavioral health care, and data on the County's behavioral health workforce.

2. **Outpatient Behavioral Health Availability – Montgomery County Public Schools**: This report will describe the behavioral health services available through Montgomery County Public Schools (MCPS), which include services provided by MCPS staff, through County Government-funded programs, and by community partners.

3. **Outpatient Behavioral Health Availability – County Government & Community Partners**: This report will describe the availability of youth behavioral health outpatient services provided in County-run facilities and by County programs provided by community partners.

4. **Outpatient Behavioral Health Availability – Private Providers**: This report will describe outpatient behavioral health services for youth provided by private providers and private programs.

5. **Inpatient Behavioral Health Availability**: This report will describe the availability of inpatient behavioral health services for youth.

This first report in the series, *Montgomery County Youth Behavioral Health, Part I: Background*, is organized as follows:

- **Chapter 1 – Background on Behavioral Health and Youth** provides information on behavioral health, behavioral health care, the rates of behavioral health issues in youth, and the current themes discussed in recent literature and research on behavioral health.

- **Chapter 2 – Youth Behavioral Health-Related Data in Montgomery County** summarizes data related to youth and to the behavioral health workforce in Montgomery County;
- **Chapter 3 – Findings** summarizes the report's findings; and
- **Chapter 4 – Conclusion** wraps up the discussion in this report and highlights the next report in the series.

OLO staff members Leslie Rubin and Blaise DeFazio conducted this study with assistance from Natalia Carrizosa and Karen Pecoraro. OLO received a high level of cooperation from everyone involved in this study and appreciates the information and insights shared by all. In particular, OLO thanks:

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Fariba Kassiri, DCAO
Monisola Brobbey, County Exec. Office
James Bridgers, Health & Human Services*
Monica Martin, Health & Human Services
Sara Rose, Health & Human Services
Amanda Abbey, Health & Human Services
Arnecia Moody, Health & Human Services
Beka Urgessa, Health & Human Services
Ben Stevenson, Health & Human Services
Beth Tabachnick, Health & Human Services
Christopher Rogers, Health & Human Services
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Methodology. To prepare this report, OLO gathered information through document reviews, data analysis, and interviews with staff from the County Government, Montgomery County Public Schools (MCPS), and from community partners in the County.

Chapter 1. Background on Behavioral Health and Youth

This chapter provides background information on behavioral health, behavioral health care, behavioral health issues facing youth, and the major issues impacting behavioral health discussed in recent literature and research.

- **Part A** defines behavioral health and summarizes information and research on the importance of focusing on the behavioral health of the population;
- **Part B** describes the behavioral health crisis facing youth in the United States; and
- **Part C** describes the current focuses of literature and research on behavioral health.

Note: Behavioral health is a broad term that includes mental health plus additional issues such as substance use disorders, gambling addiction, and eating disorders. While "mental health" and "behavioral health" can have distinct meanings among researchers and health providers, they are often used interchangeably. OLO uses both terms in this report.[1] When describing data and research, OLO uses the terms used in the data source.

A. Behavioral Health

Behavioral health encompasses the study of mental health, substance use disorders, and other behaviors that impact overall well-being.[2] "It is an interdisciplinary field that encompasses psychology, psychiatry, public health, and social work. Its primary goal is to improve the overall health and well-being of individuals and communities."[3] "An individual's level of behavioral health can fall anywhere on the spectrum from illness to positive mental well-being, and it can vary over the course of a lifetime."[4]

A positive state of behavioral health has benefits both for an individual and for the individual's community. Research shows that individuals in a good state of behavioral health often enjoy a better quality of life, better physical health, better management of mental illness, improved work performance, reduced stress levels, and enhanced resilience.[5]

[1] David Rettew, "Behavioral Health or Mental Health? Which Is It?" Psychology Today (Nov. 15, 2023). See also, "What is behavioral health?" American Medical Association (AMA) (Aug. 22, 2022); "Mental and Behavioral Health," AMA.
[2] "What is behavioral health?," AMA.
[3] "*Behavioral Health: What Is it and Why Is It Important?*" Sierra Meadows Behavioral Health.
[4] "Behavioral Health Care in the United States: How It Works and Where It Falls Short," The Commonwealth Fund (Sept. 7, 2022).
[5] See, "Benefits of Good Mental Health," Canadian Mental Health Association. See also, "About Behavioral Health," U.S. Centers for Disease Control and Prevention (CDC), U.S. Dept. of Health and Human Services (HHS).

Background on Behavioral Health and Youth

Research at the community level shows that a community of individuals in a good state of behavioral health can experience improved well-being: strengthening social bonds, improving somatic health, spurring economic development, and fostering resilience to challenges. [6]

Mental health and substance use disorders can occur together – referred to as co-occurring disorders – and the occurrences may or may not be interrelated.[7] The National Institute of Mental Health notes that co-occurring disorders can arise in several circumstances:

- Common risk factors can contribute both to mental and behavioral health issues, including family occurrence or environmental factors such as stress and trauma;
- Mental health disorders can contribute to substance use and subsequent substance use disorders, such as use of alcohol or drugs in response to depression, anxiety, or post-traumatic stress disorder; and
- Substance use can alter brain functioning and structure, which may lead to mental health disorders.[8]

A person in a poor state of behavioral health may experience symptoms that can negatively impact mood, thinking and behavior.[9] Symptoms and signs can include:

- "Feeling sad or down
- Confused thinking or reduced ability to concentrate
- Excessive fears or worries, or extreme feelings of guilt
- Extreme mood changes of highs and lows
- Withdrawal from friends and activities
- Significant tiredness, low energy or problems sleeping
- Detachment from reality (delusions), paranoia or hallucinations
- Inability to cope with daily problems or stress
- Trouble understanding and relating to situations and to people
- Problems with alcohol or drug use
- Major changes in eating habits
- Sex drive changes
- Excessive anger, hostility or violence
- Suicidal thinking."[10]

[6] Stephanie Gilbert, "The Importance of Community and Mental Health," National Alliance on Mental Health (Nov. 18, 2019).
[7] "Substance Use and Co-Occurring Mental Disorders," National Institute of Mental Health (NIMH), U.S. HHS. Data show that youth who have experienced a depressive episode in the past year are more likely than their peers to have used illicit drugs and marijuana, misused opioids, and engaged in binge drinking. Nirmita Panchal, "Recent Trends in Mental Health and Substance Use Concerns Among Adolescents," KFF (Feb. 6, 2024).
[8] "Substance Use and Co-Occurring Mental Disorders," NIMH; "Co-Occurring Disorders and Health Conditions," National Institute on Drug Abuse.
[9] "Mental Illness," Mayo Clinic.
[10] Ibid.

Data show that for adolescents with a mental health or behavioral health diagnosis:

- They are three times as likely to report being disengaged from school;
- They are five times as likely to miss 11 or more days of school for health reasons; and
- They are ten times as likely to experience a lot of difficulty in making/keeping friends.[11]

"Behavioral health care" includes the prevention, diagnosis, and treatment of mental health conditions, substance use disorders (SUD), and other related issues. It also includes care for individuals recovering from behavioral health issues. The term encompasses a wide range of supports and services that include: teaching the knowledge, skills, and abilities to build healthy relationships and cope with adverse situations; group education and/or therapy; one-on-one therapy with a licensed behavioral health professional; crisis intervention; hospital-based services; and/or medication management.

Research has shown that behavioral health care can have long lasting positive impacts. For youth, in particular it can:

- Reduce depression and anxiety;
- Reduce the risk of future behavioral health or mental health challenges in adulthood;
- Teach coping skills and resilience that can carry into adult life;
- Improve academic performance by improving concentration, organization, and resilience to stress;
- Foster better relationships with family, friends, and teachers; and
- Improve self-esteem and confidence.[12]

Research also shows that early mental health treatment for young children and families produces beneficial outcomes and cost savings. Research shows that evidence-based treatment can lead to:

- "Fewer behavior problems, symptoms of PTSD, depression, and anxiety in children
- Less parental stress, anxiety, and depression
- Prevention of child abuse and neglect
- Long-term improved school success, physical and mental health, and financial stability."[13]

The next two subsections describe life factors that can impact a person's behavioral health.

[11] *National Survey of Children's Health: Adolescent Mental and Behavioral Health, 2023*, U.S. Census Bureau (Oct. 2024).
[12] *Promoting Mental Health and Well-Being in Schools: An Action Guide for School and District Leaders*, CDC Division of Adolescent and School Health (Dec. 2023). "Child and Adolescent Mental and Behavioral Health Resolution," APA (Feb. 2019).
[13] Jennifer Oppenheim, et al., "Cost-Effectiveness of Infant and Early Childhood Mental Health Treatment," Infant & Early Childhood Mental Health Technical Assistance Center, Georgetown University. See also, "WSIPP benefit-cost analysis," Washington State Institute for Public Policy.

Health Determinants. *Social determinants of health* (SDOH) "are the conditions in which people are born, grow, live, work and age. They include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care."[14] *Structural determinants of health* include broader forces that impact communities, such as economic policies, land development, social norms and policies, racism, climate change, and political structures.[15] Structural determinants of health frequently drive the distribution of social determinants of health.

SDOHs such as socioeconomic status have a fundamental impact on mental health outcomes.

> "[S]ocial stratification creates unequal access to resources – such as wealth and knowledge – that help individuals avoid exposure to harmful stressors. Higher levels of wealth and income enable access to key determinants of positive mental health, including adequate and safe housing, sufficient food security, and effective health care. Income losses appear to have a far greater impact on mental health than income gains, with further financial stressors such as income volatility, perceived job insecurity and moving into debt all linked to worsening mental health.[16]

Data show that SDOHs are unequally distributed in the U.S. by race and ethnicity, with Black, Indigenous, and People of Color (BIPOC) experiencing, on average, more adverse SDOH than White people. Research shows that the impacts of social determinants of health "are the single greatest contributor to individual health, exceeding the impact of genetics and personal behavior."[17]

The Anti-Drug Abuse Act of 1986 is an example of a structural determinant of health that continues to negatively impact social determinants of health in Black communities. The law mandated harsher sentences for the use of crack cocaine, more commonly used in Black communities, compared to sentences for use of the powder cocaine more commonly used in White communities. This resulted in mass incarceration in Black communities that in turn limited people's employment opportunities and led to housing and food insecurity as well as violence in those communities.[18]

Adverse Childhood Experiences (ACEs). Adverse childhood experiences (ACEs) are potentially traumatic events that occur in childhood (0-17 years) and can have long-term negative impacts on health, opportunity, and well-being. Examples include experiencing violence, abuse, or neglect,

[14] Samantha Artiga, et al., "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity," KFF (May 10, 2018).
[15] "Social Determinants of Health," Public Health Professionals Gateway, CDC; "Social Determinants of Health," Office of Disease Prevention and Health Promotion, U.S. HHS.
[16] James B. Kirkbride, et al., "The social determinants of mental health and disorder: evidence, prevention and recommendations," *World Psychiatry* (Feb. 2024).
[17] Iman Hassan, et al., "Structural and Social Determinants of Health," *Leading an Academic Medical Practice* (Feb. 29, 2024).
[18] "Ending Unequal Treatment: Strategies to Achieve Equitable Health Care and Optimal Health for All ," National Academies of Sciences, Engineering, and Medicine, at p. 51-52, 58 (2024).

witnessing violence, or growing up in a household with substance use problems, mental health issues, and/or familial or financial instability.

Research shows that ACEs can negatively impact individuals' physical and behavioral health and can contribute to lifelong health outcomes. For example:

> "Adults who had experienced four or more categories of ACE, compared to those who had experienced none, had the following increased risk for negative health behaviors:
>
> - 1.4- to 1.6-fold increase in physical inactivity and severe obesity;
> - 2- to 4-fold increase in smoking, poor self-rated health, multiple sexual partners (i.e., ≥50 sexual intercourse partners), and sexually transmitted disease; and
> - 4- to 12-fold increased risk for alcoholism, drug abuse, depression, and suicide attempt."[19]

B. Youth Behavioral Health Crisis

Research shows most people who will develop a mental health issue in their lifetime will do so by age 24. A 2005 research study found 50% of all lifetime mental health disorders begin by age 14 and 75% begin by age 24.[20] Data show half of all young people will be affected by a mental health disorder by age 24.[21]

Researchers and policy makers around the world in the field of behavioral health agree that today's youth are facing a mental/behavioral health crisis.[22] In 2021, the U.S. Surgeon General highlighted the proportion of youth experiencing mental health challenges had been increasing for a significant period of time before the COVID-19 pandemic and that rates increased significantly during the pandemic.[23] U.S. data show that one in six youth ages 6-17 experiences a mental health disorder *each year*.[24]

This section describes: (1) efforts to expand the definition of "youth" in the context of behavioral health and behavioral health care; (2) research findings on the prevalence of behavioral health/mental health issues among young people; and (3) the current lack of needed professionals in the behavioral health workforce and challenges faced in trying to expand the workforce.

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[19] *Findings from the Philadelphia Urban ACE Survey*, Public Health Management Corporation for Institute for Safe Families, at p. i, 1 (Sept. 18, 2013). See also, Maureen Sanderson, et al., "Adverse Childhood Experiences and Chronic Disease Risk in the Southern Community Cohort Study," *Journal of Health Care for the Poor and Underserved* (2021).

[20] Ronald C. Kessler, et al., "Lifetime prevalence of age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication, *Arch. Gen. Psychiatry*, Vol. 62 (Jun. 2005). See also, Patrick D. McGorry, et al., "Designing and scaling up integrated youth mental health care," *World Psychiatry* 21:1 (Feb. 2022); "Mental Health Conditions," National Alliance on Mental Illness.

[21] McGorry, et al., "Designing and scaling up integrated youth mental health care."

[22] Ibid.; *Protecting Youth Mental Health: The U.S. Surgeon General's Advisory*, U.S. Office of the Surgeon General, at p. 9 (2021).

[23] *Protecting Youth Mental Health: The U.S. Surgeon General's Advisory*, at p. 9.

[24] "Mental Health Conditions," National Alliance on Mental Illness; McGorry, et al., "Designing and scaling up integrated youth mental health care."

1. "Youth" Age Range

Historically, researchers exploring mental and behavioral health disorders have defined individuals under age 18 as "youth." Many current researchers and practitioners argue, however, that capping the definition of "youth" at 18 years in the context of behavioral health is based on legal definitions, not on the realities of youth development or the root causes of mental and behavioral health disorders.

Consequently, some researchers have begun looking at "transitional aged youth" (TAY) in the context of behavioral health, often defined as youth between the ages of 16 and 24 or 25.[25] One leading global researcher in the field who advocates for expanding the definition of youth to age 24 argues that "[m]ental ill-health represents the main threat to the health, survival and future potential of young people around the world."[26]

He highlights that "adolescents and young adults, despite having the greatest level of need, have the worst access to timely, quality specialized mental health care" at a time when they face "destabilizing social, technological and economic changes in society, including globalization, rising inequality and climate change."[27] The American Psychiatric Association (APA) agrees that transitional aged youth are "underserved in current mental health systems."[28] Data show, for example, 28% of youth ages 18-25 have a substance use disorder – the highest rate of any age group.[29]

2. Prevalence of Behavioral Health Issues in the Youth Population

Decades of research and data collection have documented the behavioral health crisis facing youth in the U.S. In a 2021 advisory on youth mental health, the U.S. Surgeon General highlighted that:

> From 2009 to 2019, the proportion of high school students reporting persistent feelings of sadness or hopelessness increased by 40%; the share seriously considering attempting suicide increased by 36%; and the share creating a suicide plan increased by 44%. Between 2011 and 2015, youth psychiatric visits to emergency departments for depression, anxiety, and behavioral challenges increased by 28%. Between 2007 and 2018, suicide rates among youth ages 10-24 in the US increased by 57%. Early estimates

[25] See Patrick Köck, et al., "Co-occurring Mental Disorders in Transitional Aged Youth With Substance Use Disorders – A Narrative Review," *Frontiers in Psychiatry* (2022); "Position Statement on Transitional Aged Youth," American Psychiatric Association (APA) (Dec. 2019).
[26] Patrick D. McGorry, et al., "Designing and scaling up integrated youth mental health care," *World Psychiatry* 21:1 (Feb. 2022).
[27] McGorry, "Designing and scaling up integrated youth mental health care;" Patrick D. McGorry, et al., "Early intervention in youth mental health: progress and future directions," *Evidence Based Mental Health* Vol. 21 No. 4 (Nov. 2018).
[28] "Position Statement on Transitional Aged Youth," APA.
[29] *Youth Mental Health and Substance Use Task Force: Redesigning the Health Care Delivery System to Better Meet the Needs of Youth*, Bipartisan Policy Center, at p. 8 (2025).

from the National Center for Health Statistics suggest there were tragically more than 6,600 deaths by suicide among the 10-24 age group in 2020.[30]

In 2023, 20% of adolescents aged 12-17 had a current mental or behavioral health diagnosis (a 35% increase from 2016) while 61% of those adolescents reported difficulty getting needed treatment.[31] Data show in 2022, half of youth ages 12-17 *in Maryland* with depression did not receive treatment.[32]

Data also show that rates of behavioral health issues differ significantly among groups, including differences by race and ethnicity, age, gender identities, disability status, and sexual orientations.[33] Among other statistics:

- Suicide rates among Black youth are increasing significantly and Black youth are more likely to die by suicide than White youth;
- During COVID, Hispanic youth experienced 1.5 times more major depressive episodes compared to Black youth;
- Girls are more likely to be diagnosed with depression, anxiety, and eating disorders;
- Boys are more likely to die by suicide;
- Youth from socioeconomically disadvantaged backgrounds are more likely to develop behavioral health issues compared to youth with higher socioeconomic status; and
- LGBTQ high school students attempt suicide approximately four times more than non-LGBTQ youth.[34]

Data on Indicators of Mental Health in Maryland. Established in 1909, Mental Health America (MHA) is a nonprofit "dedicated to the promotion of mental health, well-being, and illness prevention."[35] MHA publishes an annual report on *The State of Mental Health in America* that compiles national survey data to provide a snapshot of the mental health status of youth and adults in the U.S. The report ranks states

[30] *Protecting Youth Mental Health: The U.S. Surgeon General's Advisory*, at p. 8.
[31] *National Survey of Children's Health: Adolescent Mental and Behavioral Health*.
[32] Andy Hall, et al., *Investing in Maryland's Behavioral Health Talent*, Trailhead Strategies for the Maryland Health Care Commission, at p. 2, 11 (Oct. 2024).
[33] *How Medical Racism Exacerbates the Black Youth Mental Health Crisis*, Yale School of Medicine (Jan. 29, 2024); *Health Equity in Focus: 2023 Mental and Behavioral Health Data Brief*, America's Health Rankings, United Health Foundation (2023); Amanda Calhoun, "The Black Youth Mental Health Epidemic: A Crisis in Its Own Right," *Psychiatric Times* (Apr. 5, 2023); Isabella Backman, *2022 National Survey on LGBTQ Youth Mental Health*, The Trevor Project (2022); *Protecting Youth Mental Health: The U.S. Surgeon General's Advisory*; Alan Nelson, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," *Journal of the National Medical Assoc.* (Aug. 2002).
[34] See, *Protecting Youth Mental Health: The U.S. Surgeon General's Advisory*; *National Guidelines for Child and Youth Behavioral Health Crisis Care*; *Health Equity in Focus: 2023 Mental and Behavioral Health Data Brief*; *Ring the Alarm: The Crisis of Black Youth Suicide in America*, the Congressional Black Caucus Emergency Taskforce on Black Youth Suicide and Mental Health (2019).
[35] Maddy Reinert, et al., *The State of Mental Health in American: 2024 Ed.*, Mental Health America, at p. 4 (2024).

from 1-51 (including D.C.) for each measure. "States with positive outcomes ranked higher (closer to one) than states with poorer outcomes (closer to 51)."[36]

The data in the next table show Maryland's 2024 rankings for different adult and youth mental health indicators. Because the data come from different surveys, the wording of the questions differs somewhat between youth and adults. But some similar measures show a gap between the quality and availability of care in Maryland for youth and adults.

Table 1. Summary of Maryland Adult and Youth Rankings for Behavioral Health Indicators in *The State of Mental Health in America: 2024 Edition*
(States with positive rankings rate higher – closer to 1)

	Maryland Ranking
Adults – overall prevalence of mental illness and rates of access to care	6th
Youth – overall prevalence of mental illness and rates of access to care	31st
Adults with any mental illness (AMI)	14th
Youth with at least one major depressive episode (MDE) in the past year	45th
Adults with serious thoughts of suicide	5th
Youth with serious thoughts of suicide	22nd
Adults with AMI with Private Insurance That Did Not Cover Mental or Emotional Problems	5th
Youth with Private Insurance That Did Not Cover Mental or Emotional Problems	44th

Source: *The State of Mental Health in America: 2024 Edition*

The data presented in *The State of Mental Health in America* also show that attitudes around mental health can have a strong impact on whether a person receives care. Among youth ages 12-17 who had had a depressive episode in the past year, 87% reported the main reason they did not receive treatment was because they thought "they should have been able to handle their mental health, emotions, or behavior on their own."[37] (See discussion of stigma on page 22).

3. Behavioral Health Workforce

One significant cause of the current behavioral health crisis is that the U.S. faces a severe shortage of behavioral health professionals.[38] Behavioral health professionals include, among others:

[36] Ibid., at p. 6
[37] Ibid., at p. 33
[38] *Behavioral Health Workforce Shortages and State Resource Systems*, National Conference of State Legislatures (NCSL), at p. 1 (June 2024); Hall, et al., *Investing in Maryland's Behavioral Health Talent*, at p. 2, 11.

- Social and Human Services Assistants;
- Counselors and Therapists;
- Psychiatric Aides and Technicians;
- Social Workers in behavioral health settings;
- Psychologists (Clinical, Counseling, School);
- Psychiatrists;
- Nursing Assistants;
- Licensed Practical Nurses;
- Registered Nurses;
- Nurse Practitioners;
- Occupational Therapists;
- Rehabilitation Counselors;
- Community Health Workers; and
- Physician's Assistants.[39]

An October 2024 report on Maryland's behavioral health workforce identified issues that include:

- Low pay: 1) in many behavioral health professions; 2) between jobs in private settings vs. public behavioral health jobs; and 3) in some behavioral health job categories (e.g., community health workers such as peer recovery specialists, unlicensed professionals, certified alcohol and drug counselors);
- Lack of awareness of behavioral health careers;
- Cost of behavioral health education and training, including educational requirements that can include unpaid work to receive a license;
- Problems and delays with licensing and certifications processes; and
- Job burnout.[40]

Data in the report estimated that while Maryland has approximately 34,600 behavioral health professionals in the workforce, the state needs an additional 32,800 professionals by 2028 – 18,200 workers to meet current demand and 14,600 workers to replace those leaving the field by 2028.[41]

C. Current Focus Areas in Youth Behavioral Health Systems

As research progresses in understanding behavioral health and the impacts of behavioral health care, researchers and policy makers continually adjust recommendations for the systems that provide behavioral health care. This section describes current focus areas in behavioral health research and literature to improve the availability and effectiveness of behavioral health care for youth.

Current behavioral health systems and care models primarily focus on addressing behavioral health issues when they arise – with the emphasis on treatment of symptoms and recovery. Building on research that shows 75% of lifetime behavioral health issues develop by age 24 and the average time

[39] Hall, et al., *Investing in Maryland's Behavioral Health Talent*, at p. 8.
[40] Ibid., at p. 55-68. See also, *Behavioral Health Workforce Shortages and State Resource Systems*; "Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce," U.S. HHS (2022); *Youth Mental Health and Substance Use Task Force*.
[41] *Investing in Maryland's Behavioral Health Talent*, at p. 8.

between the onset of mental health conditions and accessing treatment is 11 years, stakeholders are increasingly focusing on prevention and early detection of behavioral health conditions, ways to expand youth access to behavioral health care, and identifying factors that today's youth want in behavioral health care to increase their willingness to engage with treatment.[42]

This section describes focus areas in current literature:

- A public health approach to breaking down silos in behavioral health care;
- Expanding the behavioral healthcare workforce;
- Understanding what today's youth want and need in behavioral health care;
- Addressing the stigma associated with needing/seeking behavioral health care;
- Preventative education and early intervention; and
- Providing trauma-informed care.

1. A Public Health Approach to Breaking Down Silos in Behavioral Health Care

Many stakeholders (e.g., researchers, providers, policy makers, patients) view the current behavioral health system in the U.S. as "fragmented" and "difficult to navigate" – because it is disconnected across health systems, providers, and funding streams.[43] Many experts recommend developing a public health-based behavioral health system that applies public health principles—prevention, population-level strategies, equity, and data-informed decision-making—to mental health and substance use care.

In general, public health refers to "what society does collectively to assure the conditions for people to be healthy."[44] Instead of focusing primarily on treating illness after it arises, this approach emphasizes early intervention, prevention, and systemic change to promote mental wellness across entire populations.

[42] *Youth Mental Health and Substance Use Task Force*; "Protecting the Nation's Mental Health," CDC (Aug. 8, 2024); Louise Lynch, et al., "'If you don't actually care for somebody, how can you help them?': Exploring Young People's Core Needs in Mental Healthcare—Directions for Improving Service Provision," *Community Mental Health Journal*, at p. 796 (2024); Jessica Stubbing, et al., "What Young People Want from Clinicians: Youth-Informed Clinical Practice in Mental Health Care," *Youth*, at p. 538 (2022); *Protecting Youth Mental Health: The U.S. Surgeon General's Advisory*; "Strategic Alignment: A Collective Vision for Behavioral Health in Montgomery County, Maryland," Montgomery County Dept. of Health and Human Services (2018); Beth A. Stroul, et al., "The Evolution of the System of Care Approach for Children, Youth, and Young Adults with Mental Health Conditions and Their Families," The Institute for Innovation and Implementation, Univ. of Maryland School of Social Work, at p. 1-14 (2021).

[43] *National Healthcare Quality and Disparities Report*, Agency for Healthcare Research and Quality, U.S. HHS (2022); "Strategic Alignment: A Collective Vision for Behavioral Health in Montgomery County, Maryland," Montgomery County Department of Health and Human Services.

[44] Stroul, et al., "The Evolution of the System of Care Approach," at p. 5.

Table 2. Key Features of a Public Health-Based Behavioral Health System

Feature	Description
Population-Based Approach	Focuses on the mental well-being of entire communities, not just individuals in clinical treatment. Efforts are tailored by geography, age, race/ethnicity, and risk level.
Prevention and Early Intervention	Prioritizes efforts to prevent mental illness and substance use, including programs in schools, workplaces, and communities (e.g., suicide prevention, anti-stigma campaigns, parenting programs).
Integrated Care	Coordinates behavioral health with primary care, social services, and public health to address whole-person needs. Models include behavioral health consultants embedded in other settings (e.g., medical offices, schools).
Social Determinants of Health (SDOH)	Addresses underlying factors like housing, employment, education, and trauma exposure that influence behavioral health outcomes.
Crisis Continuum	Offers a full range of crisis services: 24/7 call lines, mobile crisis teams, stabilization units, and follow-up care.
Data and Surveillance	Uses epidemiological methods to track behavioral health trends, disparities, risk factors, and service utilization for planning and accountability.
Community Engagement and Equity	Involves community members in designing culturally appropriate interventions and ensures underserved populations are prioritized.
Workforce Development	Expands and trains the workforce to deliver community-based, prevention-oriented behavioral health services, including peers and paraprofessionals.

Implementing a public health-based care system requires partnerships among government agencies, school systems, service providers, and community organizations to bring together disjointed services into a more easily navigable and comprehensive system.[45] Key considerations include:

- Multi-sector partnerships among government agencies, school systems, service providers, and community organizations;
- Social and institutional equity;
- Community-led solutions; and
- Data and research-informed actions.

The next subsections further describe key components of a public health-based care system.

[45] Ariene Rubin Stiffman, et al., "A Public Health Approach to Children's Mental Health Services: Possible Solutions to Current Service Inadequacies," *Administration and Policy in Mental Health* (2010); "Protecting the Nation's Mental Health," CDC (Aug. 8, 2024); *Framework for Public Health: A Closer Look*, Association of State and Territorial Health Officials, at p. 4 (2023).

a. Integrated Care

In the context of behavioral health care, "integrated care" typically refers to providing individuals access to behavioral health care in other types of settings, such as primary care settings and schools.[46] The U.S. Department of Health and Human Services (HHS) considers integrated care "critical to transforming care for individuals with [mental and substance use disorders] and is an HHS strategic priority."[47] HHS describes integrated care in this way:[48]

> Integrated care has been defined differently in different contexts, but it generally aims to treat the whole person's health care needs in a coordinated way that improves health outcomes. While integration often refers to inclusion of behavioral health services in primary care settings, HHS approaches it more broadly, to also include integration of physical health care into behavioral health settings, and integration of behavioral health care with other specialty areas such as OB/GYN care, as well as in social service and other settings. For example . . . services can be integrated into educational and early childhood care settings to reach youth, and integrated . . . services are often a component of evidence-based supportive housing models.[49]

Research shows that integrating behavioral health and other types of care can improve outcomes and enhance quality of care[50] and that integrated care results in increased access to and use of behavioral health services by patients.[51] Data show that in 2022, 94% of youth under age 18 had visited a doctor in the past year in a medical care setting.[52] Multiple types of behavioral health professionals can provide care in an integrated model, including psychologists, psychiatrists, social workers, nurses, and other licensed mental health professionals.[53]

Advocating for the expansion of integrated care, the American Psychological Association highlights research that shows that the approach:

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[46] "Understanding integrated behavioral health care and the Collaborative Care Model," Health Minds Policy Initiative (Oct. 3, 2024); "Issue Brief: HHS Roadmap for Behavioral Health Integration," Office of the Assistant Secretary for Planning and Evaluation, U.S. HHS, at p. 2 (Sept. 14, 2022); Sharon Hoover, et al., "Schools As a Vital Component of the Child and Adolescent Mental Health System," *Psychiatric Services* (Nov. 3, 2020); Aaron R. Lyon, et al., "Collaborative Care to Improve Access and Quality in School-Based Behavioral Health," *Journal of School Health* (2019).

[47] Ibid.

[48] *Framework for Public Health: A Closer Look*, at p. 5; "What is Integrated Behavioral Health?" Agency for Healthcare Research and Quality, U.S. HHS (on Mar. 7, 2025); "Behavioral Health Integration Fact Sheet," APA; Lyon, et al., "Collaborative Care to Improve Access and Quality in School-Based Behavioral Health."

[49] "Issue Brief: HHS Roadmap for Behavioral Health Integration," at p. 2.

[50] Michelle Dougherty, et al., *Health Information Technology Adoption and Utilization in Behavioral Health Settings: Final Report*, Office of the Assistant Secretary for Planning and Evaluation, U.S. HHS, at p. 4 (Dec. 2024).

[51] Kyle Possemato, et al., "Patient outcomes associated with primary care behavioral health services: A systematic review," *General Hospital Psychiatry* 58 (2018).

[52] *Youth Mental Health and Substance Use Task Force*, at p. 29.

[53] "Behavioral Health Integration Fact Sheet," American Psychological Association

- Improves satisfaction with care;
- Improves patient outcomes;
- Is cost-effective (reducing cost of care); and
- Improves provider experience of care (e.g., more job satisfaction, less burnout).[54]

b. Behavioral Health Equity

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) describes behavioral health equity as:

> [T]he right to access high-quality and affordable healthcare services and supports for all populations, including Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.[55]

Equity in behavioral health encompasses issues such as the impact of social and structural determinants of health, access to care and health insurance, and the development and structure of care and treatment. As noted in Section A, social determinants of health (SDOH) are non-medical factors that impact an individual's health outcomes and systemic determinants of health include broader forces that impact communities.[56] Structural determinants of health are the factors that drive the distribution of SDOH.

"Public health works to ensure that everyone has a fair and full opportunity to be as healthy as possible."[57] Historically, unjust practices and policies have "harmed, and continue to harm, the health of specific groups of people."[58]

> Current health disparities are rooted in these unfair social and institutional policies and practices that routinely advantage majority groups. Public health values working with groups of people in specific, sensitive ways to address unfair social and institutional policies and practices that affect their health.[59]

[54] Ibid. See also, Lyon, et al., "Collaborative Care to Improve Access and Quality in School-Based Behavioral Health." Note that a key factor negatively impacting the behavioral health workforce in the United States is provider burnout.
[55] *Practical Guide for Implementing a Trauma-Informed Approach*, SAMHSA, at p. iv (2023).
[56] "Social Determinants of Health," Public Health Professionals Gateway, CDC.
[57] *Framework for Public Health: A Closer Look*, at p. 3.
[58] Ibid.
[59] Ibid.

Data show that outside of non-Hispanic White individuals, members of other racial and ethnic groups are less likely to receive behavioral health care and less likely to have health insurance coverage.[60] Consequently, HHS has made access to equitable care for all a priority:

> [T]he HHS Roadmap [for Behavioral Health Integration] aims to provide care for underserved populations; people living in underserved areas; families with low incomes; American Indians and Alaska Natives; individuals with disabilities; individuals and families experiencing homelessness; individuals involved with the justice system; children, youth, and families involved with the child welfare system; and survivors of domestic violence, trafficking, and other forms of trauma. The HHS Roadmap has a particular emphasis on supporting providers who come from the communities they serve and are equipped to provide culturally and linguistically appropriate care. The HHS Roadmap aims to enable programs to customize care as appropriate to address diverse needs across sexual orientations, gender identities, races, and ethnicities.[61]

However, "[a] common refrain among child-serving health care professionals is that the health care system and its financing mechanisms are not designed to optimally serve youth and their families."[62] Experts recommend providing developmentally appropriate services and supports that are targeted toward youth, take into account the communities being served, and delivered by providers who are sensitive to cultural and linguistic variations in the community.[63]

> "Youth-serving organizations should think intentionally about how and to whom program services are offered. For example, actively recruit and engage populations who have historically been prevented from equal access to opportunities and may benefit the most from services. Engage with youth to understand what unique barriers prevent them from accessing mental health services. Recruit program staff directly from communities being served. Build program staff capacity to recognize personal biases, as well as structural challenges in these communities. For example, provide training on cultural and linguistic competence and related topics."[64]

[60] "Issue Brief: HHS Roadmap for Behavioral Health Integration," at p. 3.
[61] Ibid.
[62] *Youth Mental Health and Substance Use Task Force*, at p. 8.
[63] *National Guidelines for Child and Youth Behavioral Health Crisis Care*, at p. 7, 16; *Protecting Youth Mental Health: The U.S. Surgeon General's Advisor*, at p. 11, 29, 38; *Framework for Public Health: A Closer Look*; Santerrius J. Barlow, et al., "Suicide Prevention, Intervention, and Postvention for African Americans: An Equity-focused Review of Resources," African American Behavioral Health Center of Excellence (2024); "Black Masculinity (Re)Imagined: Program Overview," Black Emotional and Mental Health Collective (Mar. 2022).
[64] *Protecting Youth Mental Health: The U.S. Surgeon General's Advisor*, at p. 29.

c. Data and Health Information Technology

"Public health values collecting, analyzing, interpreting, and sharing data to inform decisions about programmatic and policy strategies. Public health also values contributing to research on mental health promotion and suicide prevention through evaluation and telling stories of success in communities."[65] Robust data collection and use can lead to improved outcomes for patients seeking behavioral health care.

Strategic and active use of data in behavioral health includes: (1) the provision of behavioral health services to patients using health information technology and electronic health records; and (2) the development, implementation, and evaluation of behavioral health programs.

Health Information Technology and Electronic Health Records. The U.S. Department of Health and Human Services (HHS) describes health information technology (HIT) as the use of computers and computer infrastructure to "to record, store, protect, and retrieve clinical, administrative, or financial information." Electronic health records (EHRs) are "'real-time, patient-centered records that make information available instantly and securely to authorized users.' Data from patient encounters are stored in a practice's EHR and can be accessed by patients and authorized providers or shared with other providers within a health system from whom a patient may receive care."[66]

HHS identifies HIT as an important tool in the department's vision of providing a 'full spectrum of integrated, equitable, evidence-based, culturally appropriate, and person-centered behavioral health care" in the U.S.[67] HHS has observed, however, that behavioral health lags behind other types of care settings (e.g., hospitals, physician practices) in adoption of health information technology and information exchange and use of EHRs.[68]

For example, in 2009 Congress passed a law providing financial incentives to hospitals and health professionals to implement use of certified EHRs. While psychiatrists were eligible for this funding, other behavioral health providers were not (e.g., psychologists, clinical social workers, community mental health centers, psychiatric hospitals/units, residential treatment centers). And while a 2018 federal law authorized the Centers for Medicare and Medicaid Services to initiate a program to promote adoption of EHRs in the behavioral health sector, the program was never implemented. Recent studies recommend the federal government take further steps to break down barriers that remain to the use of technology and data in behavioral health settings.[69]

Using Data for the Development, Implementation, and Evaluation of Behavioral Health Programs. In the context of establishing behavioral health systems and evidence-based programs, many models

[65] *Framework for Public Health: A Closer Look*, at p. 3.
[66] *Health Information Technology Adoption and Utilization in Behavioral Health Settings: Final Report*, at p. 4.
[67] Ibid., at p. 2.
[68] Ibid., at p. 3.
[69] Ibid., at p. 4-5, 26.

emphasize the collection, use, and interpretation of data for informed decision-making.[70] A report from The Council of State Governments describes various uses for data in developing, evaluating, and improving behavioral health care.

Table 3. "Determining How to Use Data" from *Choosing the Right Data Strategy for Behavioral Health and Criminal Justice Initiatives*

Types of Data Evaluation	What It Is	What It Tells You	Considerations
Implementation study	Data are used to address and improve health care implementation and delivery, including how to use research in practical application	Identifies factors influencing implementation processes and outcomes, including how to introduce potential solutions into a health system or scale them	Resources: Budget, staff, expertise level, existing secondary data or need to collect primary data Stakeholder engagement to capture all points in implementation process
Process evaluation	Data are used to report on the progress of a program or improve future program procedures	To what extent programs and policies have been implemented as intended and what the results have been	Scope: Evaluating one aspect of a program's activities or the program as a whole? Timing: Starting at the beginning of implementation or after it has already started? Resources (see above)
Outcome evaluation	Data are used to examine the effects or results of a program	How the program has impacted the target population and whether it has been effective in meeting objectives	Timing: Program must already be fully implemented Scope: Assessing long- or short-term impacts? Resources (see above)

[70] *Framework for Public Health: A Closer Look*, at p. 3; "A Public Health Approach to Children's Mental Health Services: Possible Solutions to Current Service Inadequacies."

Table 3. "Determining How to Use Data" from *Choosing the Right Data Strategy for Behavioral Health and Criminal Justice Initiatives* (cont.)

Continuous quality improvement	A multi-stakeholder quality management process uses data to focus on activities to improve community health needs Involves strategies to ensure that the innovation is being implemented and to address barriers to change	Measures consistency, success, and effectiveness of behavioral health services	Look at systems, not just people. Identify and engage multisystem stakeholders Sustainability: Ensure analysis and improvement is ongoing, not a one-off project
Cost benefit/ cost savings	Data provide a way to compare cost of program with its effects	The direct and indirect costs of program resources compared with outcomes	Ensuring accuracy of costs and benefit estimates. Some benefits may not be fully measurable.
Impact evaluation	Data assess how the program affected outcomes, including to what extent any effects were intentional and if effects would have happened in the program's absence	Helps determine whether the program is meeting objectives, including how and why it is working or not	Identifying a comparison group to determine the counterfactual (would effects have otherwise happened)
Developmental evaluation	Real-time data are used to inform ongoing decision-making incorporated into program development and implementation	What initial results say about expected progress and how data on changing circumstances can lead to program adaptations in real time	Often requires extensive field work as well as stakeholder collaboration
Effectiveness evaluation	Data help assess whether a program met its intended goals and objectives	How successful a program was in meeting its objectives, including assessing results vs. expectations and why a program may have failed or exceeded timelines. Focused on long-term systematic and aggregated impact.	Timing: Program must be fully implemented for a period of time Readiness: Jurisdiction must be willing and able to look at systems level Resources (see above)

Source: *Choosing the Right Data Strategy for Behavioral Health and Criminal Justice Initiatives*, Justice Center, The Council of State Governments, at p. 3 (Oct. 2021).

As stakeholders work to incorporate data into the development of behavioral health programs, researchers, including ones in the federal government, emphasize the need for collecting data that reflects individuals' lived experiences and traditions and communicating it in culturally responsive and linguistically inclusive ways.[71]

2. The Behavioral Health Workforce

As discussed above, the current behavioral health workforce is not large enough to provide the behavioral health care needed in Maryland or the U.S. Many recommendations to help build this workforce are regulated at the federal and state levels.

A report from the National Conference of State Legislatures recommends several policies to grow the behavioral health workforce, such as:

- Allowing practitioners licensed to practice in one state to practice in other states or to use a faster licensing process;
- Reviewing licensing requirements to increase the number of behavioral health providers, e.g., allowing individuals educated in other countries to practice, providing opportunities for people with lived experience to become licensed, reviewing requirements for types of degrees required to become licensed;
- Developing additional pathways to become a licensed behavioral health professional, such as apprenticeship and credential programs; and
- Expanding financial scholarship and loan repayment options for individuals seeking behavioral health careers.[72]

The State of Maryland has taken several steps in recent years to begin addressing the lack of needed behavioral health professionals. In 2023, Maryland adopted legislation to establish a Behavioral Health Workforce Investment Fund to provide funds to reimburse costs associated with educating, training, and expanding Maryland's behavioral health workforce.[73]

Interstate Licensing. In the past several years, the Maryland legislature has passed laws to join interstate licensing compacts, agreements that allow workers licensed in other states to practice in other member states. Maryland joined the Counseling Compact in 2021, which will allow interstate practice by professional counselors – in person and via telehealth. Currently, 37 states and the District

[71] *Framework for Public Health: A Closer Look*, at p. 3.
[72] *Behavioral Health Workforce Shortages and State Resource Systems*, at p. 5. See also, Lindsey Phillips, "A closer look at the mental health provider shortage," American Counseling Association (May 2023); Nastaran Far, "To Improve Mental Health Access, Remove Unnecessary Licensing Barriers for Internationally Trained Newcomers," Refugee Advocacy Lab.
[73] Maryland Senate Bill 283/House Bill 286 (2023 Legislative Session).

of Columbia have passed laws to join this compact.[74] Similarly, Maryland joined the Social Work Licensing Compact in 2025, which will allow multi-state licensing of social workers.[75]

The commissions responsible for enacting the compacts are in the process of establishing systems to operate the programs and begin interstate licensing. The Council of State Governments National Center for Interstate Compacts facilitates the adoption of these agreements in the U.S. An interstate license compact is also currently under development for school psychologists.

Peer Support Specialists. One recommendation for expanding the behavioral health workforce is to expand the role and number of behavioral health professionals that do not require an advanced degree, such as peer support specialists.[76]

> Peer support specialists are nonclinical health professionals who work in behavioral health settings with people diagnosed with mental health or substance use disorders. Also known as peer support workers or peer mentors, peer support specialists use their lived experience of recovery from mental illness or substance use disorders, along with formal training, to promote mind-body recovery and resiliency.[77]

Referred to in Maryland as certified peer recovery specialists (CPRS), individuals do not need a college degree (or an advanced degree) to be certified as a CPRS. Accordingly, the profession is open to significantly more individuals. To qualify to train as a CPRS in Maryland, individuals must:

- Be at least 18 years old;
- Be a resident or work in the State of Maryland at least 51% of the time;
- Have a high school diploma or GED; and
- Self-identify "as a person in long-term recovery from the effects of a behavioral health disorder (i.e. mental health and/or substance use disorder) for a period of two years or more."[78]

Note, however, peer support specialists in Maryland currently are among the lowest paid behavioral health professionals. The 2024 report analyzing Maryland's behavioral health workforce identified low pay as *the most important* issue impacting the state's behavioral health workforce.[79]

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[74] Counseling Compact. In 2021, Maryland was the second state to adopt legislation to join the Counseling Compact. "Maryland Enacts Counseling Compact!" Counseling Compact Commission. See also, Maryland Senate Bill 571/House Bill 736 (2021 Legislative Session).
[75] Maryland House Bill 345/Senate Bill 9 (2025 Legislative Session).
[76] *Behavioral Health Workforce Shortages and State Resource Systems*, at p. 4; Zoe Barnard, et al., "Behavioral Health Care By Youth, For Youth," Behavioral Health Tech (Apr. 29, 2025).
[77] "Peer Support Specialists; Connections to Mental Health Care," NCSL; see also, "Peer Support," SAMHSA.
[78] "Certified Peer Recovery Specialist (CPRS)," The Maryland Addiction & Behavioral-Health Professionals Certification Board.
[79] *Investing in Maryland's Behavioral Health Talent*, at p. 56.

Data in the report show that compensation for CPRSs is comparable to work in other, less stressful industries competing for employees (e.g., retail, food service, hospitality) and that 75% of social and human services assistants, which includes peer support specialists, earn less than a living wage ($24.74 an hour or $51,460 annually).[80] The data also show that in Maryland, Black and African American individuals are overrepresented in these lower-paying behavioral health professions.

Additionally, while Medicaid programs in most states in the U.S. offer providers reimbursement for both mental health and substance use peer support services (which can include government- and school-based providers), Maryland's Medicaid program is one of only a few that offers reimbursement only for substance use peer support services.[81]

Workforce Issues in Maryland. Stakeholder feedback in the 2024 report on Maryland's behavioral health workforce identified barriers in licensing processes to expanding the workforce. In particular, Maryland's behavioral health licensing processes are complicated and lengthy, inhibiting people from entering the profession in the state, and dissuading licensed professionals from other states coming to Maryland to practice.[82] Among other things, the report identifies the following problems:

- The Maryland Board of Professional Counselors and Therapists' license approval process for a variety of counselors and therapists is lengthy, sometimes taking up to two years. This impacts "alcohol and drug counselors, professional counselors, marriage and family therapists, behavioral analysts, and art therapists."
- There are few comprehensive training programs in Maryland to become a certified peer recovery specialist. Individuals must take courses from multiple institutions that do not coordinate class schedules or courses offered to streamline this process.[83]

Other feedback highlights issues in Maryland related to licensed school mental health providers, including process delays and the addition of more required coursework to obtain or maintain licensing. Stakeholders say that in addition to hindering Maryland professionals from obtaining licenses, these issues also make it difficult for licensed professionals from other states to become licensed in Maryland.

3. Shaping Outreach and Treatment Based on What Youth Want

While the topics in this section focus primarily on how to structure and improve behavioral health care systems (e.g., breaking down silos, expanding workforce) and how to shape care options to address the needs of youth (e.g., behavioral health equity, cultural and linguistic accessibility, trauma-informed

[80] Ibid., at p. 57.
[81] *Medicaid Reimbursement for Peer Support Services: A Detailed Analysis of Rates, Processes, and Procedures*, Peer Recovery Center of Excellence, at p. 14-27 (2024).
[82] *Investing in Maryland's Behavioral Health Talent*, at p. 63-65.
[83] Ibid.

care), these factors all need to be shaped with the goal of providing care options that youth will engage with. Research shows that "even after accessing mental health treatment young people have very high drop-out rates."[84] Research has also shown that a young person's relationship with their clinician is closely associated with their engagement in treatment.[85]

Two recent studies have sought to better understand the factors that impact a young client's relationship with their clinician. Both studies observed common characterizations in research literature of youth as "difficult," "immature," and "resistant," and unable to articulate their own reasons for not engaging with treatment (i.e., data typically gathered from parents and providers). Consequently, both studies gathered qualitative data directly from youth – information about their wants and needs with respect to behavioral health clinicians and services.

These studies draw on the lived experience of youth to identify factors that impact their engagement in their behavioral health care. Both studies have similar findings – that a clinician's approach to providing care is a significant factor in whether youth will engage in and continue their own care once they seek it out.[86] Youth identify several key factors that impact their relationship with a behavioral health provider, including trust and safety, empathy and understanding, accessibility and continuity, and youth participation in care decision-making.[87] One study identify five themes that emerged from research about what youth are looking for in a clinician:

- **A shared background**: someone like me;
- **Friendliness**: someone I connect with;
- **Professionalism**: someone who protects my space;
- **Respect**: someone who treats me as an equal;
- **Responds to the individual**: someone who works in the right way for me.[88]

The data from these studies suggest that "it is likely that respecting young people's priorities will aid the formation of a strong therapeutic relationship, in order to allow young people to truly engage in and become active participants in therapy."[89]

[84] Stubbing, et al., "What Young People Want from Clinicians," at p. 538; *Ring the Alarm: The Crisis of Black Youth Suicide in America*, at p. 5.
[85] Ibid., at p. 538-539.
[86] Lynch, et al., "Exploring Young People's Core Needs in Mental Healthcare," *Community Mental Health Journal*, at p. 796 (2024); Stubbing, et al., "What Young People Want from Clinicians."
[87] Lynch, et al. "Exploring Young People's Core Needs in Mental Healthcare," at p. 800-805.
[88] Stubbing, et al., "What Young People Want from Clinicians," at p. 543-547.
[89] Ibid., at p. 540.

4. Stigmas Associated with Behavioral Health Care

Although there is greater societal understanding and acceptance of behavioral health issues today more than ever – along with more available treatment options – stigmas can still hinder individuals seeking treatment.[90] The stigma surrounding behavioral health is often based on fear or a lack of understanding and on commonly misleading media representations that perpetuate stigmas associated with behavioral health issues.[91]

People often are faced with a "negative social attitude attached to a characteristic of an individual that may be regarded as a mental, physical or social deficiency."[92] Stigma can not only influence those experiencing behavioral health issues, but it also may interfere with the quality of care they receive in clinical settings.[93]

Mental health issues may be the most stigmatized conditions in the U.S., with patients labeled as "crazy" or "psycho," and assumptions that mental health issues lead to violence, incompetence, or unpredictability.[94] Research shows, however, that individuals with mental health conditions are no more violent than others and can be as productive as others, especially when their conditions are managed.[95]

A common stigma associated with substance use disorder is that it is a "personal choice reflecting a lack of willpower and moral failing."[96] Research shows, however, that addiction is a disease or chronic condition that does not stem simply from bad decisions or lack of willpower.[97]

Despite how common behavioral health conditions are for youth in the U.S.,[98] concerns about stigma, being treated differently, and/or losing employment and livelihood lead to people avoiding or delaying needed treatment.[99] A robust understanding of the stigmas associated with behavioral health disorders can assist with treatment.

The three primary types of stigmas associated with behavioral health are:

[90] Mental Health Stigma, CDC.
[91] Ibid.
[92] APA Dictionary of Psychology, APA.
[93] Reducing the Stigma of Addiction, Johns Hopkins Medicine; *Ring the Alarm: The Crisis of Black Youth Suicide in America*, at p. 2, 4-5.
[94] Gregory Fritz, Stigma and Mental Illness, Brown University (May 5, 2022).
[95] Mental Health: Get the Facts, SAMHSA, April 4, 2023.
[96] Ibid.
[97] Addiction, Cleveland Clinic (Mar. 16, 2023).
[98] Mental Health for Adolescents, Office of Population Affairs, U.S. HHS.
[99] Stigma, Prejudice, and Discrimination Against People with Mental Illness, APA.

- **Public Stigma** – involves the negative or discriminatory attitudes that others may have about behavioral health issues (e.g., negative stereotype that people with mental health issues are violent or dangerous).
- **Self-Stigma** – refers to the negative attitudes, including internalized shame that people with behavioral health issues may have about their own condition (e.g., an individual feeling like having a behavioral health disorder is their own fault and avoiding asking for help).
- **Structural Stigma** – involves policies of government and private organizations that intentionally or unintentionally limit opportunities for people with behavioral health issues (e.g., reduced funding for mental health services and research compared to physical health).[100]

Addressing Behavioral Health Stigmas. Multiple methods can help address and counter the stigmas associated with behavioral health issues, including:

- **Contact** – face-to-face contact with people living with a behavioral health condition who are in recovery can make a condition more relatable and manageable. An individual in a similar situation to a patient who shares their life experiences may offer empathy and compassion in a way that someone who has not had similar life experiences cannot.[101] Although virtual contact approaches are an option in treatment, research shows in-person contact has been found to have a larger effect on stigma-related behaviors.[102]
- **Open Conversations** – about 4 out of 10 teenagers say they are looking for someone else with similar health concerns.[103] Research shows that individuals publicly sharing their stories – in person and even through social media – can have a positive impact on youth mental health. Examples include celebrities who youth can relate to, such as Selena Gomez, Simone Biles, or Lady Gaga, who have publicly shared their stories of mental health challenges, bringing behavioral health into everyday conversations.
- **Understanding and Empathy –** showing compassion to those with behavioral health issues – as one would with a physical injury or illness – can build trust and encourage individuals to not hide a behavioral health condition, to talk about it, and get needed help.[104]
- **Education** – communicators, journalists, social marketers (social marketing campaign), and other types of media can help educate the public by portraying people with behavioral health

[100] Ibid.
[101] Katherine Ponte, Developing Effective Anti-Stigma Interventions, National Alliance on Mental Illness (Apr. 15, 2022).
[102] Marcelo A. Crockett, et al., Interventions to Reduce Mental Health Stigma in Young People: A Systematic Review and Meta Analysis, JAMA Network Open (Jan. 15, 2025).
[103] Stigma, Prejudice, and Discrimination Against People with Mental Illness.
[104] Ibid.; Addiction, Cleveland Clinic.

conditions correctly and avoiding the perpetuation of harmful and negative stereotypes (e.g., avoiding derogatory terms such as "psycho," "crazy," "junkie").[105]

- **Empowering Language** – using person-first language focused on a person and not their illness, with the understanding that behavioral health issues are treatable, can have positive impacts. When talking to those with behavioral health issues, it helps to use words that are not stigmatizing, such as using "a person with substance use disorder" instead of "addict," "user," or "junkie."[106]
- **Policies and Practices** – updating or changing policies and practices to support people with a behavioral health condition can reduce barriers and help those access quality health care services, secure safe housing, obtain quality education, and maintain employment.[107]
- **Targeted Outreach** – it is effective to target efforts toward groups where lack of help-seeking is the most established, such as youth, military communities, undocumented communities, etc.[108]
- **Peaceful Protest** – some groups target public statements, media reports, and advertising that include negative behavioral health stereotypes to encourage the speaker to rescind negative public statements.[109]

5. Prevention/Early Intervention

According to the National Alliance on Mental Illness (NAMI), the average time between the onset of mental health conditions and accessing treatment is 11 years.[110] This is concerning given the above statistic that show 50% of all lifetime mental health disorders begin by age 14 and 75% begin by age 24. Research shows that untreated symptoms can lead to negative impacts in various areas of life, including development, academic achievement, employment, and physical health.[111]

"It has been estimated that 75 to 80 percent of children, youth, and young adults with [serious emotional disturbances] or [serious mental illness] do not receive adequate treatment, largely due to structural, financial, or personal barriers to accessing high-quality mental health services."[112] Researchers and advocates stress the need for prevention and early intervention – for teaching youth

[105] Wulf Rossler, The Stigma of Mental Disorders: A Millennia-Long History of Social Exclusion and Prejudices, EMBO Reports (Jul. 28, 2016).
[106] Words Matter: Preferred Language for Talking About Addition, by the National Institute on Drug Abuse, June 23, 2021.
[107] Mental Health Stigma Reduction Campaign, Pan American Health Organization.
[108] Stigma, Prejudice, and Discrimination Against People with Mental Illness.
[109] Katherine Ponte, Developing Effective Anti-Stigma Interventions.
[110] Daniel H. Gillison, "Early Intervention Can Save Lives," National Alliance on Mental Health (NAMI) (Apr. 28, 2022). See also, "The Importance of Early Intervention for People Facing Mental Health Challenges," Mental Health First Aid from the National Council for Mental Wellbeing (Jun. 21, 2021).
[111] Stroul, et al., "The Evolution of the System of Care Approach," at p. 2.
[112] Ibid.

the skills needed to support their mental health and addressing issues that arise well before they reach a crisis level.[113]

Prevention programs include programs that teach youth about mental health, coping skills to address challenges that could lead to behavioral health issues, and how to make healthy life choices.[114] From the public health perspective, prevention can also include, among other things, the promotion of individual and community well-being to build resilience and connection.[115]

Early intervention focuses on reducing the risk of individuals encountering mental illness or substance misuse by having established resources and care in place to address the earliest signs and symptoms when a young person develops a behavioral health challenge.[116] Given the prevalence of onset of behavioral health challenges during adolescence, early intervention can give youth and surrounding adults the ability to recognize early signs and symptoms of various conditions and can provide the skills to cope with them if they do arise and connection to treatment and supports.

Researchers and practitioners highlight that:

- There is evidence that early intervention can prevent or delay the onset of disorders;
- Effective early management can prevent outcomes associated with mental health conditions, such as reduced educational and vocational productivity, social isolation, and premature death; and
- Delayed access to care can have lasting consequences, including limiting occupational opportunities and increasing risks of depression and substance use.[117]

6. Trauma-Informed Care

As described in Section A, exposure to trauma can lead to both physical health and behavioral health problems. "Individual trauma results from an event, series of events, or a set of circumstances that an individual experiences as physically or emotionally harmful or life threatening and that may have lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."[118] Trauma can exist on numerous levels, impacting individuals, families, groups, and communities.

[113] "Early Intervention Can Save Lives," NAMI.
[114] Amanda Cruz, "What is mental health prevention and early intervention?" Steinberg Institute (May 25, 2022).
[115] *Framework for Public Health: A Closer Look*, at p. 4.
[116] Amanda Cruz, "What is mental health prevention and early intervention?" Steinberg Institute (May 25, 2022); "Early Intervention Can Save Lives," NAMI.
[117] "The Importance of Early Intervention for People Facing Mental Health Challenges," Mental Health First Aid, National Council for Mental Wellbeing. McGorry, et al., "Early intervention in youth mental health: progress and future directions." See also, *Integrating Clinical and Mental Health: Challenges and Opportunities*, Bipartisan Policy Center, at p.5 (2019).
[118] *Practical Guide for Implementing a Trauma-Informed Approach*, at p. 2.

In particular, adverse childhood experiences (ACEs) are potentially traumatic events that occur in childhood (0-17 years) and can have long-term negative impacts on health, opportunity, and well-being. Individuals exposed to trauma are at higher risk for developing anxiety, depression, post-traumatic stress disorder, and some forms of psychosis. Research also shows a strong connection between trauma and development of alcohol and substance use, death by overdose, and suicide.[119] Trauma can result from both personal experiences and from witnessing events. Examples include:

- "Experiencing physical, sexual, or emotional abuse;
- Living with an individual with physical/mental health conditions or substance use disorders;
- Bullying;
- Occurrences of domestic violence or sexual assault;
- Living in foster care;
- Experiencing chronic poverty, racism, discrimination, or oppression;
- Violence in the community, war, or terrorism;
- Living through a natural disaster or other period of distress."[120]

A trauma-informed approach to care occurs when:

> A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.[121]

[119] *Practical Guide for Implementing a Trauma-Informed Approach*, at p. 4.
[120] Ibid. at p. 3. See also *Findings from the Philadelphia Urban ACE Survey*, at p. 14.
[121] *Practical Guide for Implementing a Trauma-Informed Approach*, at p. 1, 8. See also, *National Guidelines for Child and Youth Behavioral Health Crisis Care*, at p. 12.

Chapter 2. Youth Behavioral Health-Related Data in Montgomery County

This chapter summarizes data related to Montgomery County youth and behavioral health care, including youth demographic data, prevalence of behavioral health issues in County youth, data on County health insurance coverage, and data on the behavioral health workforce in Montgomery County. As noted in Chapter 1, data show that 50% of all lifetime mental health disorders begin by age 14 and 75% begin by age 24.[122] Consequently, many behavioral health experts currently advocate for expanding the definition of "youth" in the behavioral health context up to ages 24 or 25. Accordingly, the U.S. Census Bureau population estimates below include data on County residents up to age 24.

- **Part A** examines the youth population in Montgomery County based on the 2023 American Community Survey by the US Census Bureau;
- **Part B** reviews the youth population in Montgomery County Public Schools (MCPS);
- **Part C** estimates the number of County youth and MCPS students with behavioral health issues;
- **Part D** displays health insurance rates for Montgomery County residents, including youth; and
- **Part E** examines the Montgomery County behavioral health workforce.

A. Overall Youth Demographics

Of the County's estimated 1.06 million residents,[123] Census Bureau data show that almost 13% (135,471) are 14 years old or younger and just over 30% (320,799) are 24 years or younger.

Table 4. Estimated Montgomery County Youth Population, 2023

Age	Population	Percent
Under 5 years	59,366	5.6%
5 to 9 years	65,627	6.2%
10 to 14 years	69,844	6.6%
15 to 19 years	67,425	6.4%
20 to 24 years	58,537	5.5%
Youth Population	**320,799**	**30.3%**
25 years & older	737,675	69.7%
Total Population	**1,058,474**	**100.0%**

Source: 2023 American Community Survey, United States Census Bureau

[122] "Children and Young People: Statistics," Mental Health Foundation.
[123] "2023 American Community Survey," U.S. Census Bureau.

Of the approximately 321,000 individuals ages 24 and younger in Montgomery County, Census Bureau data show that almost 42% (134,181) are White, 19% (60,732) are Black or African American, 15% (48,055) are Asian, and 24% are two or more races (38,147) or some other race (37,236). In addition, 21% (67,683) identify as Hispanic.[124]

Table 5. Estimated Montgomery County Youth Population by Race & Ethnicity

Race	Population	Percent
White	134,181	41.8%
Black or African American	60,732	18.9%
Asian	48,055	15.0%
Two or More Races	38,147	11.9%
Some Other Race	37,236	11.6%
American Indian & Alaskan Native	2,315	0.7%
Native Hawaiian & Other Pacific Islander	132	0.0%
Total Youth Population	**320,799**	100%
Ethnicity		
Hispanic	67,683	21.1%
Not Hispanic	253,116	78.9%
Total Youth Population	**320,799**	100%

Note: Population estimates are based on the youth estimate from Table 1, multiplied by the racial percentage in the County.
Source: 2023 American Community Survey, United States Census Bureau

B. Montgomery County Public Schools Demographics

This section summarizes data on youth in Montgomery County Public Schools. In the 2024-2025 school year, there were 159,671 youth in MCPS ages 3-21.[125] As noted above, 50% of all lifetime mental health disorders begin by age 14.[126] In the 2024-2025 school year, just under 70% of MCPS students (107,364) fell into this age group.[127] The data in the next table show MCPS' 2024-2025 enrollment by grade and age group.

[124] According to the US Census Bureau, a person is considered Hispanic if the person is of Cuban, Mexican, Puerto Rican, South or Central America, or other Spanish origin or culture, regardless of race.
[125] Preliminary enrollment, "Superintendent's Recommended FY2026 Capital Budget and Amendments to the FY 2025-2030 Capital Improvements Plan," "Appendix A," MCPS Office of Facilities Management, Division of Planning, Design, and Construction.
[126] "Children and Young People: Statistics," Mental Health Foundation.
[127] Ages 3 to 21; "Age and Attendance Requirements 2025-26 School Year."

Table 6. 2024-2025 MCPS Enrollment by Grade

Grade	2024-2025 Enrollment	Typical Ages*
Prekindergarten	2,180	4-5
Head Start	700	3-5
Pre-K Special Ed.	1,745	3-5
Pre-K/Head Start Total	***4,625***	
Kindergarten	10,074	5-6
Grade 1	10,680	6-7
Grade 2	11,205	7-8
Grade 3	11,807	8-9
Grade 4	11,548	9-10
Grade 5	11,803	10-11
Grade 6	11,882	11-12
Grade 7	11,789	12-13
Grade 8	11,951	13-14
Grade 9	14,753	14-15
Grade 10	13,572	15-16
Grade 11	12,123	16-17
Grade 12	11,859	17-18
K-12 Total	***155,046***	
Grand Total	**159,671**	

Note: Students 14 years old and younger highlighted in grey.
*Typical ages: Age and Attendance Requirements 2025-26 School Year, Prekindergarten & Head Start, and Special Education
Source: Preliminary enrollment, Superintendent's Recommended FY2026 Capital Budget and Amendments to the FY 2025-2030 Capital Improvements Plan, Appendix A, MCPS Office of Facilities Management, Division of Planning, Design, and Construction

MCPS uses a different classification than the Census Bureau to identify students' race. Whereas the Census Bureau distinguishes race from ethnicity, MCPS includes "Hispanic" as a racial category as "all

Hispanic students, regardless of race."[128] With these designations, the largest percentage of MCPS students in the 2024-2025 school year were Hispanic (36%, 56,951 students), followed by White students (24%, 37,609 students) and Black or African American students (22%, 34,388 students).

Table 7. Estimated MCPS Youth Population by Race/Ethnic Group

Race/Ethnic Group	Students	Percent
Hispanic	56,951	35.7%
White	37,609	23.6%
Black or African American	34,388	21.5%
Asian	21,725	13.6%
Two or More Races	8,564	5.4%
American Indian & Alaskan Native	294	0.2%
Native Hawaiian & Other Pacific Islander	140	0.1%
Total	**159,671**	**100%***

Note: Percentage may not sum to 100% due to rounding.
Source: Preliminary enrollment, Superintendent's Recommended FY2026 Capital Budget and Amendments to the FY 2025-2030 Capital Improvements Plan, Appendix A, MCPS Office of Facilities Management, Division of Planning, Design, and Construction

C. Estimate of County Youth and MCPS Students with Behavioral Health Disorders

In this section, OLO estimates the number of County youth and the number of MCPS students with behavioral health disorders in the past year. The Substance Abuse and Mental Health Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH) captures data about individuals' patterns of drug and alcohol use, state of mental health, and use of substance use disorder treatment and mental health services. SAMHSA's estimates are based on statistical models that use NSDUH survey results to estimate levels of psychological distress and functional impairment for a particular population and provide a basis to estimate the number of individuals with behavioral health disorders or seeking behavioral health treatment.

In this section, OLO calculates estimates by applying estimated rates from the NSDUH survey to the census data on County's youth and to MCPS' data on students from ages 12-17 and ages 18+.[129]

[128] Preliminary enrollment, "Superintendent's Recommended FY2026 Capital Budget and Amendments to the FY 2025-2030 Capital Improvements Plan," "Appendix A," MCPS Office of Facilities Management, Division of Planning, Design, and Construction.
[129] Students eligible for enrollment in MCPS' cannot exceed 21 years old.

The NSDUH includes data for youth ages 12-17 and 18-25 years old, so OLO's estimates include only those age ranges (not younger youth). In addition, the NSDUH captures additional data related to mental illness and co-occurring disorders only for 18-25 age group, also included in the tables below.

The data in Table 8 show that:

- Almost 36% of County youth ages 18-25 (39,595) have experienced a mental illness. Within that age group, almost 14% (15,110) had a co-occurring substance use disorder and any mental illness.
- An estimated 21% of County youth ages 12-25 (41,487) and 22% of MCPS youth ages 12-18+ (16,769) had a major depressive episode in the past year.
- Approximately 14% of County youth ages 12-25 (26,195) and 14% of MCPS students ages 12-18+ (10,930) had serious thoughts of suicide in the past year.
- Approximately 31% of County youth ages 12-25 (60,254) and 33% of MCPS students aged 12-18+ (24,692) received mental health treatment.

Table 8. Estimated Mental Health Measures in County Youth and MCPS Students, 2023

	Prevalence Rates		County Youth Estimates			MCPS Student Estimates		
	Ages 12-17	Ages 18-25	Ages 12-17	Ages 18-25	Total County Youth Ages 12-25	Ages 12-17	Ages 18+[130]	Total MCPS Students Ages 12-18+
Estimated Census Population/MCPS Enrollment			83,659	110,293		64,188	11,859	
Mental Health Measures in the Past Year								
Received Mental Health Treatment[131]	33.0%	29.6%	27,607	32,647	60,254	21,182	3,510	24,692
Major Depressive Episode[132]	22.3%	20.7%	18,656	22,831	41,487	14,314	2,455	16,769
Had Serious Thoughts of Suicide	14.7%	12.6%	12,298	13,897	26,195	9,436	1,494	10,930
Made Any Suicide Plans	7.5%	4.4%	6,274	4,853	11,127	4,814	522	5,336
Attempted Suicide	4.4%	2.3%	3,681	2,537	6,218	2,824	273	3,097
Any Mental Illness[133]	--	35.9%	--	39,595	--	--	4,257	--
Serious Mental Illness[134]	--	9.8%	--	10,809	--	--	1,162	--
Co-Occurring Substance Use Disorder and Any Mental Illness	--	13.7%	--	15,110	--	--	1,625	--
Co-Occurring Substance Use Disorder and Serious Mental Illness	--	4.8%	--	5,294	--	--	569	--

Sources: 2023 American Community Survey Population Under 18 Years of Age & 2023 Data Tables for Male and Female Percentages by Age, US Census Bureau, 2023 National Survey on Drug Use and Health State Specific Tables (Maryland), Preliminary enrollment, Superintendent's Recommended FY2026 Capital Budget and Amendments to the FY 2025-2030 Capital Improvements Plan, Appendix A, MCPS Office of Facilities Management, Division of Planning, Design, and Construction

[130] Based on typical ages MCPS students by the end of their senior year. Students eligible for enrollment cannot exceed 21 years old.
[131] Mental health treatment includes treatment for mental health, emotions, or behavior through inpatient treatment/counseling; outpatient treatment/counseling; use of prescription medication; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.
[132] A major depressive episode (MDE) is a period of at least two weeks when an individual experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms.
[133] Mental illness aligns with Diagnostic and Statistical Manual of Mental Disorders (4th edition) criteria and is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. Estimates of serious mental illness (SMI) are a subset of estimates of any mental illness (AMI) because SMI refers to people with AMI that results in serious functional impairment. These estimates are based on indicators of AMI and SMI, rather than direct measures of diagnostic criteria.
[134] Ibid.

The data in Table 9 show that the prevalence of substance use disorders increases dramatically from ages 12-17 to ages 18-25 years – from 9% to 27%. Among older youth, this impacts almost 30,000 County youth ages 18 to 25 and over 3,000 MCPS students 18 years or older.

Table 9. Estimated Substance Use Disorder in County Youth and MCPS Students, 2023

	Prevalence Rates		County Youth Estimates			MCPS Student Estimates		
	Ages 12-17	Ages 18-25	Ages 12-17	Ages 18-25	Total County Youth Ages 12-25	Ages 12-17	Ages 18+[135]	Total MCPS Students Ages 12-18+
Estimated Census Population/MCPS Enrollment			83,659	110,293		64,188	11,859	
Substance Use Disorder in the Past Year								
Substance Use Disorder[136]	8.8%	27.0%	7,362	29,779	37,141	5,649	3,202	8,850
Alcohol Use Disorder	2.2%	14.3%	1,840	15,772	17,612	1,412	1,696	3,108
Drug Use Disorder[137]	7.7%	18.6%	6,442	20,514	26,956	4,942	2,206	7,148
Pain Reliever/Opioid Use Disorder	1.4%	1.1%	1,171	1,213	2,384	899	130	1,029

Sources: 2023 American Community Survey Population Under 18 Years of Age & 2023 Data Tables for Male and Female Percentages by Age, US Census Bureau, 2023 National Survey on Drug Use and Health State Specific Tables (Maryland), Preliminary enrollment, Superintendent's Recommended FY2026 Capital Budget and Amendments to the FY 2025-2030 Capital Improvements Plan, Appendix A, MCPS Office of Facilities Management, Division of Planning, Design, and Construction

Regarding substance use treatment, data show that:

- 21% of County youth ages 12-25 (41,362) and 15% of MCPS students aged 12-18+ (11,071) needed substance use treatment.
- Among youth needing substance use treatment, 59% of youth ages 12-17 and 86% of youth ages 18-25 did not receive it.
- 32,811 County youth aged 12-25 (17%) who needed substance use disorder treatment did not receive it.

[135] Based on typical ages MCPS students by the end of their senior year. Students eligible for enrollment cannot exceed 21 years old.
[136] Substance use disorder is defined as meeting the criteria for drug and alcohol use disorder.
[137] Drug use includes the use of marijuana (including vaping), cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine in the past year or any use (i.e., not necessarily misuse) of prescription pain relievers, tranquilizers, stimulants, or sedatives in the past year.

Table 10. Estimated Substance Use Treatment in County Youth and MCPS Students, 2023

	Prevalence Rates		County Youth Estimates			MCPS Student Estimates		
	Ages 12-17	Ages 18-25	Ages 12-17	Ages 18-25	Total County Youth Ages 12-25	Ages 12-17	Ages 18+[138]	Total MCPS Students Ages 12-18+
Estimated Census Population/MCPS Enrollment			83,659	110,293		64,188	11,859	
Substance Use Treatment in the Past Year								
Received Substance Use Treatment[139]	4.4%	4.3%	3,681	4,743	8,424	2,824	510	3,334
Classified as Needing Substance Use Treatment[140]	12.0%	28.4%	10,039	31,323	41,362	7,703	3,368	11,071
Not Receiving Substance Use Treatment among those Classified as Needing Substance Use Treatment	58.5%	86.0%	5,873	26,938	32,811	4,506	2,896	7,402

Sources: 2023 American Community Survey Population Under 18 Years of Age & 2023 Data Tables for Male and Female Percentages by Age, US Census Bureau, 2023 National Survey on Drug Use and Health State Specific Tables (Maryland), Preliminary enrollment, Superintendent's Recommended FY2026 Capital Budget and Amendments to the FY 2025-2030 Capital Improvements Plan, Appendix A, MCPS Office of Facilities Management, Division of Planning, Design, and Construction

[138] Based on typical ages MCPS students by the end of their senior year. Students eligible for enrollment cannot exceed 21 years old.

[139] Substance use treatment includes treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medication-assisted treatment; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center. Substance use treatment questions are asked of respondents who used alcohol or drugs in their lifetime. Substance use treatment measures include data from respondents who indicated that they received treatment but did not specify the substance(s) for which it was received.

[140] NSDUH respondents were classified as needing substance use treatment if they met Diagnostic and Statistical Manual of Mental Disorders (5th edition) criteria for a drug or alcohol use disorder or received treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medication-assisted treatment; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center. Substance use treatment questions are asked of respondents who used drugs or alcohol in their lifetime.

D. Health Insurance Coverage for Montgomery County Residents

In the U.S., access to behavioral health services often depends on an individual's health insurance coverage status – whether a person has private health insurance, has public coverage through programs such as Medicare or Medicaid, or is uninsured. The party that pays for services (e.g., the third-party insurance company or government entity that pays for services) is referred to as the "payer." The major types of payers for behavioral health services in the U.S. include:

- **Medicaid and CHIP Programs**: Medicaid and the Children's Health Insurance Program (CHIP) are the two primary public medical assistance programs for individuals with low-income and are operated by the states in partnership with the federal government.[141] CHIP applies if a family's income is too high to qualify for Medicaid and it covers medical and dental care for uninsured children and teens up to 19 years old.[142]
- **Medicare:** Medicare is a nationwide federally administered health insurance program that covers the cost of hospitalization, medical care and select other services for individuals aged 65 and older, individuals who have been receiving Social Security Disability cash benefits for at least 29 months, and individuals (including those under 65) with certain disabilities, permanent kidney failure (end-stage renal disease), or amyotrophic lateral sclerosis (ALS, aka Lou Gehrig's Disease).[143]
- **Private Insurance:** Individuals can obtain private health insurance coverage through their employer, by purchasing a plan directly from a health insurer, or through a health insurance exchange established as part of the Affordable Care Act.[144]
- **State Mental Health Authorities**: State Mental Health Authorities (SMHAs) are state agencies that historically functioned as centralized systems to administer state funding for mental health services but now provide some state-funded mental health services as part of a complex system of public funding that also includes Medicaid, Medicare, and federal grant funding.
- **Other Federal:** this category includes block grant programs[145] that supplement state-financed programs as well as additional federal programs that finance support services.

Individuals may also pay "out of pocket," in whole or in part for behavioral health services if they are uninsured or if their insurer does not cover the cost of services. In Montgomery County, the Medical Care for Uninsured Children or Care for Kids program administered by the Primary Care Coalition provides healthcare - including behavioral health needs - for uninsured children.[146]

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[141] "Medicaid & CHIP," Healthcare.gov
[142] "How to Apply for Medicaid and CHIP," USAGov.
[143] "Medicare," Social Security Administration, at p. 1 (2025).
[144] "How to Get Insurance through the ACA Health Insurance Marketplace," USAGov.
[145] *Medicaid and Block Grant Financing Compared*, Kaiser Commission on Medicaid and the Uninsured (Jan. 2004).
[146] "Medical Care for Uninsured Children (Care for Kids)," Montgomery County Dept. of Health and Human Services. Information about these services will be provided in a future report in this series.

The data in the next table show 2023 American Community Survey (ACS) data on the number and percentage of non-institutionalized Montgomery County residents and individuals under 25 holding different types of health insurance coverage. A higher percent of County residents have private health insurance compared to the U.S. population (76% vs. 67%). The data also show that:

- The percentage of individuals with *private insurance coverage* in Montgomery County is similar for individuals under 25 years old compared to all County residents (73% vs. 76% for all residents).
- Individuals under 25 years old in Montgomery County rely less on *public healthcare coverage* compared to all County residents (25% vs. 30% for all residents). Public healthcare coverage for those under 25 is almost entirely comprised of Medicaid.
- The percentage of *uninsured* County residents closely mirrors the uninsured U.S. population (7% vs. 8%).

Table 11. Health Insurance Coverage Status of Non-Institutionalized Montgomery County Residents: All Ages & Individuals Under 25 Years Old

	All Ages			Under 25 Years Old		
	Montgomery County		United States	Montgomery County		United States
Heath Coverage Type	**#**	**%***	**%***	**#**	**% ***	**%***
Private Health Insurance	**798,618**	**76%**	**67%**	**239,870**	**73%**	**63%**
Employer-Based Health Insurance	697,160	65%	55%	210,227	64%	54%
Direct-Purchase Health Insurance	136,963	13%	14%	28,908	9%	10%
TRICARE/Military Health Coverage	25,431	2%	3%	5,879	2%	2%
Public Coverage	**318,306**	**30%**	**37%**	**83,600**	**25%**	**34%**
Medicare Coverage	173,340	17%	19%	1,185	0.4%	0.7%
Medicaid/Means-Tested Public Coverage	167,106	16%	21%	82,388	25%	34%
Department of Veterans Affairs (VA) Health Care	11,902	1%	2%	559	0.2%	0.3%
Uninsured	**73,284**	**7%**	**8%**	**21,692**	**7%**	**8%**

*Percentages add up to more than 100% because an individual can hold more than one type of health insurance coverage.
Source: 2023 American Community Survey Tables for Montgomery County and the United States: S2703, S2704, S2702, B27004, B27005, B27006, B27007, B27008, and B27009.

E. Montgomery County Behavioral Health Workforce

As noted in Chapter 1, the 2024 report Investing in Maryland's Behavioral Health Talent assessed the behavioral health workforce in Maryland and in each county, broken down by profession. Data show Maryland currently has approximately 34,600 behavioral health professionals in its workforce. Data

also show the state needs an additional 32,800 professionals by 2028 – 18,200 to meet the demand for services as it exists today and 14,600 to replace professionals leaving the field.

Among other measures, the federal government uses the ratio of the number of health providers compared to the population of an area to designate Health Professional Shortage Areas (HPSA) in the U.S. For mental health, an area with less than one provider per 30,000 residents is designated as an HPSA.[147] The data in the next table show the County has slightly more behavioral health workers for every 30,000 residents compared to the state as a whole (167.9 vs. 167.4). While the County has fewer counselors and therapists per 30,000 residents than the state overall (34.2 vs. 42.2), it has more psychiatrists (10.3 vs. 5.8) and social and human service assistants (41.0 vs. 36.7).

Table 12. Number of Behavioral Health Workers Per 30,000 Residents, Montgomery County & Maryland

Category	Behavioral Health Employment Type	# Montgomery	# Per 30K Residents	# Maryland	# Per 30K Residents
Core Services	Social and Human Service Assistants	1,439	41.0	7,583	36.7
Core Services	Counselors and Therapists	1,201	34.2	8,732	42.2
Core Services	Social Workers - Behavioral Health	505	14.4	2,799	13.5
Core Services	Psychiatrists	361	10.3	1,196	5.8
Core Services	Clinical Psychologists	206	5.9	1,266	6.1
Core Services	Psychiatric Technicians	196	5.6	1,496	7.2
Nursing in BH	Registered Nurses	331	9.4	2,126	10.3
Nursing in BH	Nursing Assistants	227	6.5	1,094	5.3
Nursing in BH	Licensed Practical Nurses	62	1.8	339	1.6
Nursing in BH	Nurse Practitioners - Behavioral Health	38	1.1	313	1.5
BH Adjacent	Rehabilitation Counselors	453	12.9	2,105	10.2
BH Adjacent	Community Health Workers	417	11.9	2,548	12.3
BH Adjacent	Occupational Therapists	415	11.8	2,747	13.3
BH Adjacent	Physician Assistants	45	1.3	269	1.3
	Total	**5,896**	**167.9**	**34,613**	**167.4**

Source: 2024 Investing in Maryland's Behavioral Health Talent by the Maryland Health Care Commission and Trailhead Strategies

The data in the next table show Montgomery County ranks 9th in the state when comparing the number of behavioral health professions per 30,000 residents across Maryland counties. The jurisdictions ranked higher than Montgomery County have larger networks of providers and outpatient services. For example,

[147] "Mental Health Care Health Professional Shortage Areas (HPSAs)," KFF.

Baltimore City is the headquarters of Johns Hopkins Hospital, the state's largest hospital system. Baltimore City has a ratio of 363.4 behavioral health professionals per 30,000 residents.

Table 13. Number of Behavioral Health Professionals Per 30,000 Residents, by Maryland County

Jurisdictions	# of BH Professionals Per 30K Residents	Rank
Maryland	**167.4**	
Baltimore City	363.4	1
Talbot	292.1	2
Allegany	247.7	3
Dorchester	234.6	4
Kent	227.8	5
Wicomico	225.6	6
Washington	219.5	7
Baltimore County	193.0	8
Montgomery	**167.9**	**9**
Howard	158.6	10
Anne Arundel	148.4	11
St. Mary's	143.9	12
Somerset	140.6	13
Garrett	124.2	14
Cecil	119.2	15
Harford	110.8	16
Caroline	110.4	17
Frederick	110.3	18
Prince George's	104.8	19
Carroll	101.7	20
Worcester	96.3	21
Charles	85.4	22
Calvert	78.2	23
Queen Anne's	76.0	24

Source: 2024 Investing in Maryland's Behavioral Health Talent by the Maryland Health Care Commission and Trailhead Strategies

Data show that over three quarters of workers in Montgomery County's behavioral health workforce are Black or African American or White. Black or African American professionals are overrepresented in the workforce compared to their representation in the County (44% of behavioral health professionals vs. 19% of County population). Hispanic or Latino workers, by comparison, are underrepresented in the workforce compared to their representation in the County (10% vs. 21%). Data also show that Black or African American workers are overrepresented in lower paying jobs, such as nursing assistants (71%), and underrepresented in higher paying professions such as psychologists (17%) and psychiatrists (15%).

Conversely, Asian and White behavioral health care workers represent a larger share of workers in higher paying behavioral health professions. In the County, Asian residents make up 16% of the population and almost 37% of psychiatrists. White residents make up 41% of the County population and 60% of psychologists and 59% of occupational therapists.

Table 14. Demographic Estimates by Behavioral Health Occupation, Montgomery County

	Black	White	Hispanic	Asian	Other/2+ Races
% of Montgomery County Population, 2023	**19.4%**	**40.9%**	**20.5%**	**16.0%**	**3.2%**
Nursing Assistants	70.5%	13.6%	8.7%	5.4%	1.8%
Licensed Practical Nurses	61.9%	23.2%	7.3%	5.7%	2.0%
Rehabilitation Counselors	54.0%	30.5%	8.8%	4.2%	2.5%
Social and Human Service Assistants	52.4%	28.0%	12.0%	4.9%	2.7%
Community Health Workers	48.0%	31.3%	11.6%	6.2%	2.9%
Counselors and Therapists	45.4%	36.1%	10.5%	5.3%	2.8%
Social Workers - Behavioral Health	44.4%	37.9%	10.7%	4.4%	2.6%
Psychiatric Technicians	38.4%	27.6%	20.9%	9.3%	3.9%
Registered Nurses	35.6%	40.4%	7.0%	14.5%	2.5%
Nurse Practitioners - Behavioral Health	24.0%	53.6%	7.7%	12.1%	2.7%
Physician Assistants	20.7%	47.9%	13.8%	14.5%	2.5%
Occupational Therapists	19.0%	58.5%	6.3%	13.4%	2.7%
Clinical Psychologists	17.3%	59.7%	10.6%	10.1%	2.2%
Psychiatrists	15.3%	37.8%	8.0%	36.7%	2.2%
Total % of Behavioral Health Workforce	**44.4%**	**33.6%**	**10.3%**	**7.0%**	**4.7%**

Source: 2024 Investing in Maryland's Behavioral Health Talent by the Maryland Health Care Commission and Trailhead Strategies

Chapter 3. Findings

This first report in the Office of Legislative Oversight's series of reports on availability of youth behavioral health care in Montgomery County provides background information on behavioral health and describes the issues facing behavioral health systems in the U.S. It also summarizes County level data on youth, prevalence of behavioral health issues, insurance coverage, and the County's behavioral health workforce.

Note: Behavioral health is a broad term that includes mental health plus additional issues such as substance use disorder, gambling addiction, and eating disorders. While "mental health" and "behavioral health" can have distinct meanings among researchers and health providers, they are often used interchangeably. OLO uses both terms in this report. When describing data and research, OLO uses the terms used in the data source.

Finding #1. The field of behavioral health "focuses on understanding, preventing, and treating mental health and substance use disorders." Behavioral health care ranges from prevention efforts and education (e.g., teaching ability to cope with adverse situations) to treatment and recovery services (e.g., crisis intervention, therapy).

A positive state of behavioral health has benefits both for an individual and for the individual's community. Individuals in a good state of behavioral health often enjoy a better quality of life, better physical health, better management of mental health issues, improved work performance, reduced stress levels, and enhanced resilience. A good state of community behavioral health can strengthen social bonds, improve somatic health, and foster resilience to challenges.

Finding #2. A person in a poor state of behavioral health may experience symptoms that can negatively impact mood, thinking, and behavior. Research shows, however, that behavioral health education and care can have long lasting positive impacts.

Symptoms and signs of behavioral health issues can include:

- "Feeling sad or down
- Confused thinking or reduced ability to concentrate
- Excessive fears or worries, or extreme feelings of guilt
- Extreme mood changes of highs and lows
- Withdrawal from friends and activities
- Significant tiredness, low energy or problems sleeping
- Detachment from reality (delusions), paranoia or hallucinations
- Inability to cope with daily problems or stress
- Trouble understanding and relating to situations and to people
- Problems with alcohol or drug use

- Major changes in eating habits
- Sex drive changes
- Excessive anger, hostility or violence
- Suicidal thinking."

Data show that for adolescents with a mental health or behavioral health diagnosis:

- They are three times as likely to report being disengaged from school;
- They are five times as likely to miss 11 or more days of school for health reasons; and
- They are ten times as likely to experience a lot of difficulty in making/keeping friends.

Behavioral health care, however, can have long lasting positive impacts. For youth in particular, it can:

- Reduce depression and anxiety;
- Reduce the risk of future behavioral health or mental health challenges in adulthood;
- Teach coping skills and resilience that can carry into adult life;
- Improve academic performance by improving concentration, organization, and resilience to stress;
- Foster better relationships with family, friends, and teachers; and
- Improve self-esteem and confidence.

Research also shows that early mental health treatment for young children and families produces beneficial outcomes for families and cost savings. Evidence-based treatment can lead to:

- "Fewer behavior problems, symptoms of PTSD, depression, and anxiety in children
- Less parental stress, anxiety, and depression
- Prevention of child abuse and neglect
- Long-term improved school success, physical and mental health, and financial stability."

Finding #3. Today's youth are facing a mental/behavioral health crisis. Research shows that most people who will develop a mental health issue in their lifetime will do so by age 24. Data show that 50% of all lifetime mental health disorders begin by age 14 and 75% begin by age 24.

As research on the brain development of young people advances, many in the behavioral health field, including the American Psychiatric Association (APA), advocate extending the definition of youth from age 18 to age 24 or 25. One leading global researcher who supports this change asserts that "[m]ental ill-health represents the main threat to the health, survival and future potential of young people around the world."

In 2021, the U.S. Surgeon General issues an advisory on youth mental health. Data show that:

> From 2009 to 2019, the proportion of high school students reporting persistent feelings of sadness or hopelessness increased by 40%; the share seriously considering attempting suicide increased by 36%; and the share creating a suicide plan increased by 44%. Between 2011 and 2015, youth psychiatric visits to emergency departments for depression, anxiety, and behavioral challenges increased by 28%. Between 2007 and 2018, suicide rates among youth ages 10-24 in the US increased by 57%. Early estimates from the National Center for Health Statistics suggest there were tragically more than 6,600 deaths by suicide among the 10-24 age group in 2020.

In 2023, 20% of adolescents ages 12-17 had a current mental or behavioral health diagnosis (a 35% increase from 2016) while 61% of those adolescents reported difficulty getting needed treatment. In 2022, half of youth ages 12-17 *in Maryland* with depression did not receive treatment.

Finding #4. Social and structural determinants of health impact an individual's behavioral health and can have lasting health impacts. Understanding how these health determinants impact individuals and communities can help guide policies, reduce health inequities, and improve health outcomes.

Social determinants of health (SDOH) are non-medical factors that impact an individual's health outcomes, such as where people are born, grow, work, live, and age. Structural determinants of health include broader forces that impact communities, such as economic policies, land development, social norms and policies, racism, climate change, and political structures. Structural determinants of health frequently drive the distribution of social determinants of health.

SDOHs such as socioeconomic status have a fundamental impact on mental health outcomes.

> "[S]ocial stratification creates unequal access to resources – such as wealth and knowledge – that help individuals avoid exposure to harmful stressors. Higher levels of wealth and income enable access to key determinants of positive mental health, including adequate and safe housing, sufficient food security, and effective health care. Income losses appear to have a far greater impact on mental health than income gains, with further financial stressors such as income volatility, perceived job insecurity and moving into debt all linked to worsening mental health.

Research shows that the impacts of social determinants of health "are the single greatest contributor to individual health, exceeding the impact of genetics and personal behavior."

Finding #5. The unequal distribution of social determinants of health has resulted in differing rates of access to behavioral health care and differing rates of behavioral health issues among groups, including differences by race and ethnicity, age, gender identities, disability status, and sexual orientations.

Data show that social determinants of health are unequally distributed in the U.S. by race and ethnicity, with Black, Indigenous, and People of Color (BIPOC) experiencing, on average, more adverse SDOH than White people. Research shows that the impacts of social determinants of health "are the single greatest contributor to individual health, exceeding the impact of genetics and personal behavior."

For youth, data show, that:

- Suicide rates among Black youth are increasing significantly and Black youth are more likely to die by suicide than White youth;
- During COVID, Hispanic youth experienced 1.5 times more major depressive episodes compared to Black youth;
- Girls are more likely to be diagnosed with depression, anxiety, and eating disorders;
- LGBTQ high school students attempt suicide approximately four times more than non-LGBTQ youth.

Comparing youth and adults in Maryland:

- In an overall ranking among the 50 states and the District of Columbia that measured the prevalence of mental illness and rates of access to care, Maryland ranked the 6th "best" in the nation for *adults* and the 31st in the nation for *youth* ages 6-17.
- Looking at the percentage of individuals with serious thoughts of suicide, Maryland ranked 5th "best" for adults and 22nd for youth.

Finding #6. Maryland's current behavioral health workforce is not large enough to provide needed services and care. Maryland's behavioral health workforce currently has approximately 34,600 professionals but needs an additional 32,800 professionals by 2028 – 18,200 to meet current demand and 14,600 to replace professionals leaving the field.

An October 2024 report on Maryland's behavioral health workforce identified the primary issues impacting the workforce as:

- Low pay;
- Lack of awareness of behavioral health careers;
- Cost of behavioral health education and training;
- Problems and delays with licensing and certifications processes; and
- Job burnout.

Findings

A report from the National Conference of State Legislatures recommends several policies to grow the behavioral health workforce, such as:

- Allowing practitioners licensed to practice in one state to practice in other states or to use a faster licensing process;
- Reviewing licensing requirements to increase the number of behavioral health providers, e.g., allowing individuals educated in other countries to practice, providing opportunities for people with lived experience to become licensed, reviewing requirements for types of degrees required to become licensed;
- Allow additional pathways to become a licensed behavioral health professional, such as apprenticeship and credential programs; and
- Expand financial scholarship and loan repayment options for individuals seeking behavioral health careers.

The State of Maryland has taken several steps in recent years to begin addressing the lack of needed behavioral health professionals. In 2023, Maryland adopted legislation to establish a Behavioral Health Workforce Investment Fund to provide funds to reimburse costs associated with educating, training, and expanding Maryland's behavioral health workforce.

To assess the level of behavioral health care available in an area, the federal government uses the ratio of the number of health providers compared to the population of an area, measuring the number of providers per 30,000 residents. The data in the next table show that the County has slightly more behavioral health workers for every 30,000 residents compared to the state as a whole (167.9 vs. 167.4).

Number of Behavioral Health Workers Per 30,000 Residents, Montgomery County & Maryland

Category	Behavioral Health Employment Type	# Montgomery	# Per 30K Residents	# Maryland	# Per 30K Residents
Core Services	Social and Human Service Assistants	1,439	41.0	7,583	36.7
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BH Adjacent	Physician Assistants	45	1.3	269	1.3
	Total	**5,896**	**167.9**	**34,613**	**167.4**

Finding #7. Many stakeholders view the current behavioral health system in the U.S. as "fragmented" and "difficult to navigate" – because it is disconnected across health systems, providers, and funding streams.

Many experts recommend developing a public health-based behavioral health system that applies public health principles—prevention, population-level strategies, equity, and data-informed decision-making—to mental health and substance use care. In general, public health refers to "what society does collectively to assure the conditions for people to be healthy." Instead of focusing primarily on treating illness after it arises, this approach emphasizes early intervention, prevention, and systemic change to promote mental wellness across entire populations.

Key Features of a Public Health-Based Behavioral Health System

Feature	Description
Population-Based Approach	Focuses on the mental well-being of entire communities, not just individuals in clinical treatment. Efforts are tailored by geography, age, race/ethnicity, and risk level.
Prevention and Early Intervention	Prioritizes efforts to prevent mental illness and substance use, including programs in schools, workplaces, and communities (e.g., suicide prevention, anti-stigma campaigns, parenting programs).
Integrated Care	Coordinates behavioral health with primary care, social services, and public health to address whole-person needs. Models include behavioral health consultants embedded in clinics.
Social Determinants of Health (SDOH)	Addresses underlying factors like housing, employment, education, and trauma exposure that influence mental health outcomes.
Crisis Continuum	Offers a full range of crisis services: 24/7 call lines, mobile crisis teams, stabilization units, and follow-up care.
Data and Surveillance	Uses epidemiological methods to track behavioral health trends, disparities, risk factors, and service utilization for planning and accountability.
Community Engagement and Equity	Involves community members in designing culturally appropriate interventions and ensures underserved populations are prioritized.
Workforce Development	Expands and trains the workforce to deliver community-based, prevention-oriented behavioral health services, including peers and paraprofessionals.

Implementing a public health-based care system requires partnerships among government agencies, school systems, service providers, and community organizations to bring together disjointed services into a more easily navigable and comprehensive system.

Finding #8. To widely expand access to behavioral health care, many experts and stakeholders recommend developing "integrated care" systems where behavioral health services are offered and provided in a variety of other settings such as health care settings (e.g., primary care, OB/GYN, etc.) and schools.

The U.S. Department of Health and Human Services considers integrated care "critical to transforming care for individuals with [mental and substance use disorders] and is an HHS strategic priority." Research shows that integrating behavioral health and other types of care can improve outcomes and enhance quality of care and that integrated care results in increased access to and use of behavioral health services by patients.

The American Psychological Association notes that integrated care:

- Improves satisfaction with care;
- Improves patient outcomes;
- Is cost-effective (reducing cost of care); and
- Improves provider experience of care (e.g., more job satisfaction, less burnout).

Finding #9. Behavioral health care systems should be equitable, ensuring access to high-quality and accessible healthcare services and supports for all populations. Programs for youth specifically need to be structured around factors that will sustain youth engagement in behavioral health care.

Outside of non-Hispanic White individuals, members of other racial and ethnic groups are less likely to receive behavioral health care and less likely to have health insurance coverage. Historically, unjust practices and policies have "harmed, and continue to harm, the health of specific groups of people." In response, numerous federal agencies and behavioral health groups have made access to equitable behavioral health care for all a priority.

Behavioral health systems for youth need programs and solutions developed specifically to address the needs of youth and developed by and tailored to the specific needs of different communities. Research shows that young people have high drop-out rates in behavioral health care settings. Research also shows that a clinician's approach to providing care is a significant factor in whether youth will engage in and continue their own care once they seek it out. For youth, key factors that impact relationships with a behavioral health provider include trust and safety, empathy and understanding, accessibility and continuity, and youth participation in care decision-making

One study identify five themes that emerged from research about what youth are looking for in a clinician:

- **A shared background**: someone like me;
- **Friendliness**: someone I connect with;
- **Professionalism**: someone who protects my space;
- **Respect**: someone who treats me as an equal; and
- **Responds to the individual**: someone who works in the right way for me.

Additionally, comprehensive youth behavioral health programs should be based on a trauma-informed approach. Individuals exposed to trauma are at higher risk for developing anxiety, depression, post-traumatic stress disorder, and some forms of psychosis. Research also shows a strong connection between trauma and development of alcohol and substance use, death by overdose, and suicide. Trauma can result from both personal experiences and from witnessing events.

> A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.

Finding #10. Despite the increased understanding and acceptance of behavioral health issues, stigmas still significantly hinder individuals from seeking treatment. These stigmas, often based on fear or a lack of understanding, can negatively impact the quality of care received in clinical settings.

People with behavioral health issues often are faced with a "negative social attitude attached to a characteristic of an individual that may be regarded as a mental, physical or social deficiency." The stigma surrounding behavioral health is often based on fear or a lack of understanding and on commonly misleading media representations that perpetuate stigmas associated with behavioral health issues. A common stigma associated with substance use disorder, for example, is that it is a "personal choice reflecting a lack of willpower and moral failing." Research shows, however, that addiction is a disease or chronic condition that does not stem simply from bad decisions or lack of willpower.

Three types of stigma can impact individuals that have behavioral health issues.

- **Public Stigma** – involves the negative or discriminatory attitudes that others may have about behavioral health issues.
- **Self-Stigma** – refers to the negative attitudes, including internalized shame, that people with behavioral health issues may have about their own condition.
- **Structural Stigma** – involves policies of government and private organizations that intentionally or unintentionally limit opportunities for people with behavioral health issues.

Actions that can help counter the stigmas associated with behavioral health issues include:

- **Contact and Conversations** with people addressing similar behavioral health conditions.
- **Understanding and Empathy** to build trust and encourage individuals to seek help.
- **Education** that portrays people with behavioral health conditions correctly.
- **Policies and Practices** that eliminate barriers to care, housing, education, and job opportunities.
- **Targeted Outreach** to groups that may reject help, e.g., youth, military, undocumented individuals.
- **Peaceful Protest** objecting to public reports, advertising, etc. that include negative stereotypes.

Despite how common behavioral health conditions are for youth in the U.S., concerns about stigma being treated differently, and/or losing employment and livelihood lead to people avoiding or delaying needed treatment. A robust understanding of the stigmas associated with behavioral health disorders can assist with treatment.

Finding #11. Almost 13% (135,471) of Montgomery County's 1.1 million residents are youth 14 years old or younger and 30% (320,799) are youth 24 years old and under. Federal government estimates of prevalence rates of behavioral health issues provide insight into the number of youth in Montgomery County that may be impacted.

Within the County's youth population of 320,799, approximately 42% (134,181) of youth identify as White, 24% of youth (75,383) identify as some other race or two or more races, 19% (60,732) youth identify as Black or African American, and 15% (48,055) identify as Asian. Approximately 21% of these youth (67,683) identify as Hispanic and 79% identify as non-Hispanic.

In Montgomery County Public Schools, which categorizes race differently, based on state definitions. Of the 159,671 students ages 3-21 in the 2024-2025 school year, 36% (56,951) identify as Hispanic, 24% (37,609) identify as White, 22% (34,388) identify as Black or African American, 14% (21,725) identify as Asian, and 5% (8,564) identify as two or more races.

Estimates from the Substance Abuse and Mental Health Administration's (SAMSHA) National Survey on Drug Use and Health (NSDUH) provide insight into the number of County and MCPS youth affected by mental health and/or substance use disorder and youth receiving treatment for mental health and/or substance use disorder. Data on prevalence of mental illness show that:

- Almost 36% of County youth ages 18-25 (39,595) have experienced a mental illness. Within that age group, almost 14% (15,110) had a co-occurring substance use disorder and any mental illness.
- An estimated 21% of County youth ages 12-25 (41,487) and 22% of MCPS youth ages 12-18+ (16,769) had a major depressive episode in the past year.
- Approximately 14% of County youth ages 12-25 (26,195) and of MCPS students ages 12-18+ (10,930) had serious thoughts of suicide in the past year.
- Approximately 31% of County youth ages 12-25 (60,254) and 33% of MCPS students aged 12-18+ (24,692) received mental health treatment.

Data on the prevalence of substance use disorder show that:

- Substance use disorder increase dramatically from ages 12-17 to ages 18-25 – from 9% to 27%. Among older youth, this impacts almost 30,000 County youth ages 18 to 25 and over 3,000 MCPS students 18 years or older.

- 21% of County youth ages 12-25 (41,362) and 15% of MCPS students aged 12-18+ (11,071) needed substance use treatment.
- Among youth needing substance use treatment, 59% of youth ages 12-17 and 86% of youth ages 18-25 did not receive it.
- 32,811 County youth aged 12-25 (17%) who needed substance use treatment did not receive it.

Finding #12. More Montgomery County residents' (including youth) have private health care coverage compared to the United States as a whole. Fewer County residents have public health care coverage compared to the U.S. as a whole and slightly fewer County residents are uninsured compared to the U.S. as a whole.

	All Ages			Under 25 Years Old		
	Montgomery County		United States	Montgomery County		United States
Heath Coverage Type	**#**	**%***	**%***	**#**	**% ***	**%***
Private Health Insurance	**798,618**	**76%**	**67%**	**239,870**	**73%**	**63%**
Employer-Based Health Insurance	697,160	65%	55%	210,227	64%	54%
Direct-Purchase Health Insurance	136,963	13%	14%	28,908	9%	10%
TRICARE/Military Health Coverage	25,431	2%	3%	5,879	2%	2%
Public Coverage	**318,306**	**30%**	**37%**	**83,600**	**25%**	**34%**
Medicare Coverage	173,340	17%	19%	1,185	0.4%	0.7%
Medicaid/Means-Tested Public Coverage	167,106	16%	21%	82,388	25%	34%
Department of Veterans Affairs (VA) Health Care	11,902	1%	2%	559	0.2%	0.3%
Uninsured	**73,284**	**7%**	**8%**	**21,692**	**7%**	**8%**

Percentages add up to more than 100% because an individual can hold more than one type of health insurance coverage.

Finding #13. Montgomery County ranks 9th among counties in the state when comparing the overall number of behavioral health professionals per 30,000 residents.

To assess the level of behavioral health care available in an area, the federal government uses the ratio of the number of health providers compared to the population of an area, measuring the number of providers per 30,000 residents. The data in the table below show these numbers for each Maryland county.

The jurisdictions that ranked higher than Montgomery County when comparing the number of behavioral health professionals have larger networks of providers and outpatient services. For example, Baltimore City, the headquarters of the Johns Hopkins Hospital and the largest hospital system in the state, has a ratio of 363.4 behavioral health professionals per 30,000 residents. Montgomery County has a ratio of 167.9 behavioral health professionals per 30,000 residents.

Number of Behavioral Health Professionals Per 30,000 Residents, by Maryland County

Jurisdictions	# of BH Professionals Per 30K Residents	Rank
Maryland	**167.4**	
Baltimore City	363.4	1
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Wicomico	225.6	6
Washington	219.5	7
Baltimore County	193.0	8
Montgomery	**167.9**	**9**
Howard	158.6	10
Anne Arundel	148.4	11
St. Mary's	143.9	12
Somerset	140.6	13
Garrett	124.2	14
Cecil	119.2	15
Harford	110.8	16
Caroline	110.4	17
Frederick	110.3	18
Prince George's	104.8	19
Carroll	101.7	20
Worcester	96.3	21
Charles	85.4	22
Calvert	78.2	23
Queen Anne's	76.0	24

Finding #14. The racial distribution of behavioral health workers in Montgomery County does not mirror the racial distribution of County residents. Data also show racial disparities among professions, with Black or African American workers underrepresented in higher paying behavioral healthcare professions.

Data show that over three quarters of workers in Montgomery County's behavioral health workforce are Black or African American or White. Black or African American professionals are overrepresented in the workforce compared to their representation in the County (44% vs. 19%). Hispanic or Latino

workers, by comparison, are underrepresented in the workforce compared to their representation in the County (10% vs. 21%). Data also show that Black or African American workers are overrepresented in lower paying jobs, such as nursing assistants (71%), and underrepresented in higher paying professions such as psychologists (17%) and psychiatrists (15%).

Conversely, Asian and White behavioral health care workers represent a larger share of workers in higher paying behavioral health professions. In the County, Asian residents make up 16% of the population and almost 37% of psychiatrists. White residents make up 41% of the County population and 60% of psychologists and 59% of occupational therapists.

Demographic Estimates by Behavioral Health Occupation, Montgomery County

	Black	White	Hispanic	Asian	Other/2+ Races
% of Montgomery County Population, 2023	**19.4%**	**40.9%**	**20.5%**	**16.0%**	**3.2%**
Nursing Assistants	70.5%	13.6%	8.7%	5.4%	1.8%
Licensed Practical Nurses	61.9%	23.2%	7.3%	5.7%	2.0%
Rehabilitation Counselors	54.0%	30.5%	8.8%	4.2%	2.5%
Social and Human Service Assistants	52.4%	28.0%	12.0%	4.9%	2.7%
Community Health Workers	48.0%	31.3%	11.6%	6.2%	2.9%
Counselors and Therapists	45.4%	36.1%	10.5%	5.3%	2.8%
Social Workers - Behavioral Health	44.4%	37.9%	10.7%	4.4%	2.6%
Psychiatric Technicians	38.4%	27.6%	20.9%	9.3%	3.9%
Registered Nurses	35.6%	40.4%	7.0%	14.5%	2.5%
Nurse Practitioners - Behavioral Health	24.0%	53.6%	7.7%	12.1%	2.7%
Physician Assistants	20.7%	47.9%	13.8%	14.5%	2.5%
Occupational Therapists	19.0%	58.5%	6.3%	13.4%	2.7%
Clinical Psychologists	17.3%	59.7%	10.6%	10.1%	2.2%
Psychiatrists	15.3%	37.8%	8.0%	36.7%	2.2%
Total % of Behavioral Health Workforce	**44.4%**	**33.6%**	**10.3%**	**7.0%**	**4.7%**

Chapter 4. Conclusion

This first report in the Office of Legislative Oversight's upcoming series of reports on youth access to behavioral health care in Montgomery County provides a background on youth behavioral health and provides context for the following reports that will examine the availability of outpatient and inpatient care to youth in the County. This report identifies the driving factors behind and multifaceted nature of the youth behavioral health crisis in Montgomery County and the broader United States. The information highlights the importance of behavioral health as a cornerstone of overall health and well-being and describes the negative impacts associated with behavioral health conditions—ranging from academic disruption to increased risk of suicide and substance use.

Montgomery County, home to almost 320,000 individuals age 24 and under, is not immune to the challenges posed by youth experiencing behavioral health issues. While the County benefits from residents with higher rates of private insurance coverage compared to the U.S. and ranks relatively well in terms of the number of behavioral health professional compared to the County's population, disparities persist—particularly in equitable access to care, racial representation within the workforce, and adequate staffing to meet current and projected needs.

Next Report. The second report in this series will examine the availability of behavioral health care and services available to youth through Mongomery County Public Schools (MCPS), including services provided by MCPS staff, through County Government-funded programs, and by community partners.