IssueBrief

MACPAC

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Access in Brief: Children's Use of Behavioral Health Services

Children enrolled in Medicaid or the State Children's Health Insurance Program (CHIP) are disproportionately affected by behavioral health conditions such as anxiety disorder, depression, autism spectrum disorder, attention deficit disorder, and attention-deficit/hyperactivity disorder (ADHD) compared to children who are privately insured (MACPAC 2016, 2015). Research indicates that youth mental health challenges have intensified over the past decade. Between 2016 and 2023, the prevalence of youth ages 12-17 having any mental health disorder, anxiety, and depression increased 35 percent, 61 percent and 45 percent respectively (HRSA 2024). The COVID-19 pandemic contributed to the decline in youth mental health by disrupting daily routines, schooling, and access to health care (HHS 2021). Additionally, social isolation; economic instability; and reduced access to social services, income, food, and housing may have contributed to unprecedented stresses for youth (HHS 2021). Recognizing these challenges, the U.S. Surgeon General issued an advisory in 2021 declaring youth mental health a national crisis (HHS 2021). Behavioral health spending as a share of total spending on children's medical care nearly doubled from 22.4 percent in 2011 to 40.2 percent in 2022 (Foster et al. 2026).

States are required to cover certain behavioral health benefits for children with Medicaid or CHIP coverage, and they have the flexibility to cover additional behavioral health benefits under optional state plan or waiver authorities (SSA § 2103(c)(5)). Further, under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement, children with Medicaid or CHIP coverage under age 21 enrolled through the categorically needy pathway are entitled to all medically necessary Medicaid-coverable services, including behavioral health services (CMS 2024a). Although states are not required to cover EPSDT in separate CHIP, 14 states have elected to do so (KFF 2026).[1]

Children can receive behavioral health services in a variety of settings, including office-based settings, schools, and behavioral health treatment facilities (e.g., inpatient and residential treatment settings). Access to behavioral health and other medically necessary services in schools has increased in recent years, as more states are covering school-based services outside of an individualized education plan.[2] Additionally, school-based health centers (SBHCs) have emerged as an important source of care for children and youth with Medicaid or CHIP coverage (CMS 2023a, SBHA 2023). The recent expansion of Certified Community Behavioral Health Clinics has also been shown to increase access to coordinated behavioral health services and improved early identification and treatment for children and youth by providing services in community locations and school settings (ASPE 2025).[3]

As part of MACPAC's ongoing work examining access to behavioral health care for children, we analyzed data from the 2022 National Survey on Drug Use and Health (NSDUH) to compare demographics, health status, and difficulties accessing care for non-institutionalized youth with Medicaid or CHIP coverage between ages 12-17 to those with private insurance and those who were uninsured. These analyses are descriptive and do not adjust for socioeconomic or other factors that may also be associated with the differences in need among children or potential differences in the quality of the services received. Although some children use more behavioral health services than others, rates of use do not necessarily correlate with need.

Findings indicate that across insurance types, 19.3 percent of youth ages 12-17 reported having a major depressive episode (MDE) and 14.0 percent of these youth reported having thoughts of suicide in the past year (Table 1). Among these youth, rates of receiving overnight mental health treatment were similar between youth with Medicaid or CHIP coverage and those who are privately insured (Table 3). However, a smaller percentage of privately insured youth reported receiving residential treatment in the past year compared to those who had

Medicaid or CHIP coverage (Table 3). Across insurance types, rates of MDE in the past year were similar within demographic groups, with one notable exception. Female youth with Medicaid coverage reported significantly higher rates of MDE in the past year (28.5 percent) compared to those who were uninsured (15.1 percent) (Table 2).

Prevalence of Mental Health Conditions

For youth respondents, the NSDUH measures prevalence of mental illness in two categories: MDE in the past year and MDE with severe role impairment. MDE in the past year is comprised of youth who reported feeling depressed or had lost interest or pleasure in daily activities in the same two-week period in the past 12 months. MDE with severe role impairment is comprised of youth who reported problems with their ability to do every day activities in the past 12 months (SAMHSA 2023).[4]

Among youth ages 12-17, neither the prevalence of having a MDE nor suicidal thoughts differed significantly across insurance types (Table 1). Overall, 19.3 percent of youth reported having a MDE in the past year. Additionally, 14.0 percent of youth reported having thoughts of suicide and 7.2 percent reported plans of suicide in the past year. There were no significant differences across insurance types.

TABLE 1. Major Depressive Episodes and Suicidal Thoughts and Behaviors among Non-Institutionalized Youth Ages 12-17, by Insurance Status, Calendar Year 2022

Type of condition	Percentage of youth age 12-17			
	Total	Medicaid or CHIP	Private coverage	Uninsured
Total (all youth 12-17)	**100.0%**	**37.5%**	**53.3%***	**3.9%***
Major depressive episode (MDE)				
Lifetime MDE	**26.3**	26.0	26.6	21.3
MDE in past year	**19.3**	19.0	19.6	13.8
MDE with severe role impairment in past year	**14.3**	14.7	14.1	11.5
Suicide				
Thoughts of suicide in past year	**14.0**	13.6	14.4	9.9
Plans of suicide in past year	**7.2**	8.1	6.8	–

Notes: CHIP is State Children's Health Insurance Program. MDE is major depressive episode. The 2022 National Survey on Drug Use and Health (NSDUH) used criteria from the Diagnostic and Statistical manual of Mental Disorders, 5th edition to identify major depressive episodes. The NSDUH did not exclude depressive symptoms that occurred exclusively in the context of bereavement. Questions from the Sheehan Disability Scale determined if a major depressive episode caused severe role impairment by creating major problems with the ability to do chores at home, do well at work or school, get along with family, or have a social life.
*Difference from Medicaid or CHIP is statistically significant at the 0.05 level.
– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC analysis of 2022 National Survey on Drug Use and Health.

Among youth ages 12-17, prevalence of MDE did not differ significantly between youth with Medicaid or CHIP coverage and those with private insurance, regardless of sex or race (Table 2). Overall, about 28.2 percent of female youth and 10.9 percent of male youth had an MDE in the past year. Comparing across insurance status,

the data indicate differences for females; specifically, female youth with Medicaid coverage were nearly twice as likely to report an MDE (28.5 percent) as those who were uninsured (15.1 percent).

TABLE 2. Selected Demographics of Non-Institutionalized Youth Age 12-17 with Major Depressive Episodes by Insurance Status, Calendar Year 2022

Demographic characteristics	Percentage of youth age 12-17 with reported MDE			
	Total	Medicaid or CHIP	Private coverage	Uninsured
Sex				
Male	**10.9%**	9.8%	11.7%	–
Female	**28.2**	28.5	28.0	15.1%*
Race and ethnicity				
White, non-Hispanic	**20.9**	23.1	20.1	–
Black, non-Hispanic	**16.8**	15.2	18.7	–
Hispanic	**18.8**	18.9	19.4	–
Asian, non-Hispanic	**15.7**	–	18.0	–
AIAN or NHPI, non-Hispanic	**13.5**	15.0	–	–
Two or more races	**18.6**	14.5	18.4	–

Notes: CHIP is State Children's Health Insurance Program. MDE is major depressive episode. AIAN is American Indian or Alaska Native. NHPI is Native Hawaiian or other Pacific Islander.
*Difference from Medicaid or CHIP is statistically significant at the 0.05 level.
– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC analysis of 2022 National Survey on Drug Use and Health.

Mental Health Treatment

Our findings indicate that 1.4 percent of all youth received mental health treatment in a residential mental health treatment center and 4.0 percent of those with an MDE in the past year stayed in a residential mental health treatment center. There were similarities in the reported treatment settings between those with Medicaid or CHIP coverage and those with private coverage. However, among all youth, those with Medicaid or CHIP coverage received residential mental health treatment at a higher rate (2.0 percent) than their peers with private coverage (1.1 percent) (Table 3). It should be noted that some estimates were too small to report, which limited our ability to analyze demographic information from the uninsured group for certain mental health treatment categories.

TABLE 3. Mental Health Treatment among Non-Institutionalized Youth Ages 12-17, by Insurance Status, Calendar Year 2022

Mental health treatment	Percentage of youth age 12-17		
	Total	Medicaid or CHIP	Private coverage
Treatment among all youth			
Received mental health treatment in a residential mental health treatment center	**1.4%**	2.0%	1.1%*
Received mental health treatment in some other place where you stayed overnight or longer	**0.9**	1.2	0.8
Seen in an emergency room or emergency department in the past 12 months	**2.8**	3.4	2.6
Treatment among youth with past year MDE			
Stayed in a residential mental health treatment center	**4.0**	4.9	3.7
Stayed in some other place overnight or longer	**1.9**	3.1	–
Seen in an emergency room or emergency department	**8.7**	9.9	8.4

Notes: CHIP is State Children's Health Insurance Program. MDE is major depressive episode. Response rates for uninsured youth were not included, as they were too small to provide a reliable estimate.
* Difference from Medicaid or CHIP is statistically significant at the 0.05 level.
– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC analysis of 2022 National Survey on Drug Use and Health.

Prevalence of Alcohol or Substance Use Disorders

Among youth with an alcohol use or substance use disorder in the past 12 months, there were some differences within demographic groups when comparing across insurance types (Table 4). A higher percentage of male youth with Medicaid or CHIP coverage (9.0 percent) had an alcohol or substance use disorder compared to those with private coverage (6.5 percent). Similarly, a higher percentage of female youth with Medicaid or CHIP coverage reported an alcohol use or substance use disorder (11.8 percent) compared to those with private insurance coverage (8.6 percent). This pattern continued across racial and ethnic groups. White youth with Medicaid or CHIP coverage had a higher prevalence of alcohol use or substance use disorder (11.0 percent), compared to those with private insurance (7.6 percent). Some demographic characteristics for the uninsured group could not be reported due to sample sizes being too small to provide reliable estimates.

TABLE 4. Selected Demographics of Non-Institutionalized Youth Age 12-17 with Past Year Alcohol Use or Substance Use Disorder, Calendar Year 2022

Alcohol use or substance use disorder	Percentage of youth age 12-17		
	Total	Medicaid or CHIP	Private coverage
Sex			
Male	**7.6%**	9.0%	6.5%*
Female	**10.0**	11.8	8.6*
Race and ethnicity			

Alcohol use or substance use disorder	Percentage of youth age 12-17		
	Total	Medicaid or CHIP	Private coverage
White, non-Hispanic	**8.2**	11.0	7.6*
Black, non-Hispanic	**9.1**	9.5	8.2
Hispanic	**10.7**	11.2	8.7
Two or more races	**9.7**	–	–

Notes: CHIP is State Children's Health Insurance Program. American Indian or Alaska Native and Native Hawaiian or other Pacific Islander were excluded from the table above due to high levels of statistical unreliability.
Uninsured category was removed in this table because the population size was too small to provide a reliable estimate.
*Difference from Medicaid or CHIP is statistically significant at the 0.05 level.
– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC analysis of 2022 National Survey on Drug Use and Health.

Substance Abuse Treatment

Our analysis measured and compared prevalence of substance abuse treatment among youth (ages 12-17) with a past year alcohol use or substance use disorder, comparing youth with Medicaid or CHIP coverage and those who were privately covered or uninsured (Table 5). Overall, 3.0 percent of these youth reported having ever received alcohol or drug treatment. Among youth with Medicaid or CHIP coverage, 5.6 percent reported staying in a residential mental health treatment center for alcohol or substance use treatment.

TABLE 5. Substance Abuse Treatment for Non-Institutionalized Youth age 12-17 with Past Year Alcohol Use or Substance Use Disorder, by Insurance Status, Calendar Year 2022

Treatment Characteristics	Percentage of Youth age 12-17	
	Total	Medicaid or CHIP
Ever received alcohol or drug treatment	**3.0%**	–
Stayed overnight or longer for treatment in past 12 months		
Stayed in hospital as an inpatient	**3.3**	4.1%
Stayed in a residential mental health treatment center	**4.6**	5.6
Seen in an emergency room or emergency department for alcohol or drug use	**3.9**	5.3

Notes: CHIP is State Children's Health Insurance Program.
Uninsured category was removed in this table because the population size was too small to provide a reliable estimate.
– Dash indicates that estimate is based on too small of a sample or is too unstable to present.

Source: SHADAC analysis of 2022 National Survey on Drug Use and Health.

Data and Methods

Data Sources

Data from this report come from the 2022 NSDUH, an annual, nationwide survey sponsored by the Substance Abuse and Mental Health Services Administration that conducts interviews with approximately 70,000 randomly

selected, civilian, non-institutionalized individuals age 12 and older in the United States. Respondents are residents of households (e.g., houses, apartments, and civilians living in military base housing) and individuals in non-institutional group quarters (e.g., shelters, rooming houses, college dorms, and halfway houses). Individuals with no fixed household addresses (e.g., people who are experiencing homelessness and not in shelters), active-duty military personnel, and residents of institutional group quarters (e.g., correctional facilities, nursing homes, and mental institutions) are excluded. The NSDUH is a primary source of national and state-level estimates on use of tobacco products, alcohol, illicit drugs (including non-medical use of prescription drugs), substance use disorders, mental health status, and related treatment (SAMHSA 2016a, SAMHSA 2016b). For more information on the NSDUH, see https://www.samhsa.gov/data/population-data-nsduh.

All differences discussed in the text of this brief are computed using t-tests and are significant at the 0.05 level.

Insurance coverage

Coverage source reflects the respondent's coverage status at the time of the survey interview. Because an individual may have multiple coverage sources and because sources of coverage may change over time, responses to survey questions may reflect characteristics or experiences associated with a coverage source other than the one assigned in this report.

The following hierarchy was used to assign individuals with multiple coverage sources to a primary source: Medicare, private, Medicaid or CHIP, other, uninsured. Private health insurance coverage excludes plans that cover only one type of service, such as accident or dental insurance. Other insurance includes TRICARE, CHAMPUS, Veterans' Affairs or military coverage in addition to any other type of health insurance not already defined. Individuals are defined as uninsured if at the time of the survey they did not have any of the coverage types mentioned above. Individuals were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accident or dental coverage only.

Data Limitations

It is important to note that because NSDUH data are self-reported, the survey may over- or underrepresent prevalence and need for treatment. However, it should be noted that some NSDUH variables are constructed using DSM-5 criteria rather than being directly self-reported. For example, the measured used to indicate use disorder is a derived DSM-5-based indicator that incorporates data from all past-year users of prescription drugs, rather than a simple self-report. Individual responses are subjective and not validated using psychiatric diagnostic information (SAMHSA 2019). They may be influenced by a variety of social and cultural factors, including beliefs and perceptions regarding mental health and substance use disorder (Ward et al. 2013). Stigma and fear of reporting drug use that involves criminalized behavior, for example, may lead to underreporting (Wogan and Restrepo 2020). Furthermore, NSDUH does not include residents of institutional group quarters, such as juvenile detention centers. Youth in these facilities tend to have high rates of mental health conditions and disproportionate numbers of underserved racial and ethnic minority youth (Alegria et al. 2010). Because the incidence of both disease and treatment is low among youth, estimates are more unstable. Estimates for rare events tend to be statistically unstable because only a small number of respondents experience the outcome. With so few cases, the estimate becomes highly sensitive to the inclusion or exclusion of individual respondents, which leads to a high relative standard error and reduced reliability.

This analysis relies on 2022 data and therefore does not reflect the effects of recent federal policy changes designed to improve coverage stability and access to care for children and youth with Medicaid or CHIP coverage. Recent policy changes include the following:

- 12-month continuous eligibility requirement: As of January 1, 2024, states must provide 12 months of continuous eligibility for children under age 19 enrolled in Medicaid and CHIP, which is estimated to provide 1.3 million children with at least one additional month of coverage (ASPE 2024a).

- Child core set reporting: Beginning in 2024, states are required to report behavioral health quality measures through the Child Core Set, enabling better monitoring of access, outcomes, and care comparisons (CMS 2023b).
- Pre- and post-release services for justice-involved youth: States must provide Medicaid-eligible incarcerated youth with screening and diagnostic services prior to release and targeted case management services before and after release, effective 2025 (The Consolidated Appropriations Act (CAA), 2023, P.L. 117-328).[5]

Endnotes

[1] CHIP gives states flexibility to create their programs as an expansion of Medicaid, as a program entirely separate from Medicaid, or as a combination of both approaches. Under separate CHIP, states offer health coverage to eligible children whose family's incomes are too high to qualify for Medicaid, but too low to afford private coverage (CMS n.d.). Federal rules provide states flexibility to design separate CHIP including covering benefit packages that look more like commercial insurance than Medicaid and to require out-of-pocket cost sharing. When states use a Medicaid-expansion CHIP program, federal Medicaid rules generally apply.

[2] An Individualized Education Program (IEP) is a written statement for a child with a disability that is in accordance with the Individuals with Disabilities Education Act (IDEA) requirements (CMS 2024b). Under federal law, state Medicaid programs may reimburse for covered services provided to Medicaid-enrolled children when those services are medically necessary and included in a child's IEP or, for infants and toddlers (children under age three), an Individualized Family Service Plan (IFSP). These school-based Medicaid services commonly include speech-language therapy, occupational and physical therapy, behavioral health services, nursing services, and specialized transportation (MACPAC 2026, 2024). As of October 2023, 25 states have amended their state plans or otherwise expanded coverage to include school-based services that are not part of an IEP or IFSP. Most states (18) expanded coverage for all services identified as medically necessary, while the remaining states cover a more limited set of services often including behavioral health care (HSC 2023, MACPAC 2023). Expanded coverage for school-based services was prompted by 2014 guidance from the Centers for Medicare & Medicaid Services clarifying that states can pay for medically necessary services for any Medicaid-eligible student, regardless of whether those services are identified in an IEP/IFSP or provided at no cost to other students (CMS 2014).

[3] Certified community behavioral health centers (CCBHCs) provide rapid response, individual assessment and crisis resolution by trained mental health and SUD treatment professionals and paraprofessionals, deployed to the location of the person in crisis (CMS 2021). CCBHCs can receive Medicaid payment for providing the following nine mandatory types of services to all people who seek care, regardless of coverage type or ability to pay: crisis mental health services; screening, assessment, and diagnosis; patient-centered treatment planning; outpatient mental health and substance use services; outpatient clinic primary care screening and monitoring; targeted case management; psychiatric rehabilitation services; peer supports, peer counselor services, and family/caregiver supports; and intensive, community-based mental health care for members of the armed forces and veterans (ASPE 2024b).

[4] In the 2022 NSDUH, respondents were classified as having a MDE in the past 12 months if (1) they had at least one period of 2 weeks or longer in the past year when, for most of the day nearly every day, they felt depressed or lost interest or pleasure in daily activities; and (2) they also had problems with sleeping, eating, energy, concentration, self-worth, or having recurrent thoughts of death or recurrent suicidal ideation. In the 2022 NSDUH, respondents were classified as having MDE with severe role impairment if their depression caused severe problems with their ability to (1) do chores at home, (2) do well at work or school, (3) get along with their family, or (4) have a social life. Adults age 18 or older were classified as having an MDE with severe impairment if their depression caused severe problems with their ability to (1) manage tasks at home, (2) manage tasks at work, (3) have relationships with others, or (4) have a social life (SAMHSA 2023).

[5] Under Section 5121 of the Consolidated Appropriations Act 2023, states can receive federal financial participation (FFP) for providing screening and diagnostic services and targeted case management (TCM) the 30 days prior to release and TCM for at least 30 days post release for post-adjudicated Medicaid-eligible youth under age 21 and youth formerly in foster care under age 26. The requirement for states to provide these services also generally applies to justice-involved youth under age 19 who are eligible for CHIP. As of January 1, 2025, states also have the option to receive FFP for Medicaid- and CHIP-covered services provided to eligible youth in public institutions during the initial period ending disposition of charges.

References

Alegria, M., M. Vallas, and P. Andres. 2010. Racial and ethnic disparities in pediatric mental health. Child and Adolescent Psychiatry Clinics of North America 19, no. 4: 759–774. https://doi.org/10.1016/j.chc.2010.07.001.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024a. Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements. State Health Official (SHO) Letter (# 24-005). Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024b. FAQ: How are SBS provided to Medicaid eligible children under IDEA? Baltimore, MD: CMS. https://www.medicaid.gov/faq/2024-06-25/166471.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. n.d. Children's Health Insurance Program (CHIP). Baltimore, MD: CMS. https://www.medicaid.gov/chip.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023a. Delivering services in school-based settings: A comprehensive guide to Medicaid services and administrative claiming. Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/2023-07/sbs-guide-medicaid-services-administrative-claiming-ud.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023b. Medicaid program and CHIP; mandatory Medicaid and children's health insurance program (CHIP) core set reporting. Baltimore, MD: CMS. https://www.govinfo.gov/content/pkg/FR-2023-08-31/pdf/2023-18669.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2021. Letter from Daniel Tsai to state health officials regarding "Medicaid guidance on the scope of and payments for qualifying community-based mobile crisis intervention services." December 28, 2021. Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. Letter from Cindy Mann to state Medicaid directors regarding "Medicaid payment for services provided without charge (free care)". December 15, 2014. Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf.

Foster, A., Cushing, A., Hoffmann, J., et al. 2026. Expenditures for pediatric behavioral health care over time and estimated family financial burden. *Journal of the American Medical Association Pediatrics*, no. 2: 194-201. https://doi.org/10.1001/jamapediatrics.2025.5181.

Health & Human Services (HHS). 2021. The U.S. Surgeon General's advisory: Protecting youth mental health. Washington, DC: HHS. https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.

Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau. 2024. Washington, DC: HRSA. https://mchb.hrsa.gov/sites/default/files/mchb/data-research/nsch-data-brief-youth-mental-behavioral-health-2023.pdf.

KFF. 2026. EPSDT in separate CHIP. Washington, DC: KFF. https://www.kff.org/state-health-policy-data/state-indicator/epsdt-in-separate-chip/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2026. *Access in brief: Students with individualized education plans in Medicaid*. Washington, DC: MACPAC https://www.macpac.gov/wp-content/uploads/2026/06/Access-in-Brief-Students-with-Individualized-Education-Plans-in-Medicaid.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2025. Issue brief: *School-based health centers and behavioral health care for students enrolled in Medicaid*. Washington, DC: MACPAC. https://www.macpac.gov/wp-

content/uploads/2025/03/School-based-Health-Centers-and-Behavioral-Health-Care-for-Students-Enrolled-in-Medicaid-Final.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2024. Issue brief: *School-based services for students enrolled in Medicaid*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2024/04/School-Based-Services-for-Students-Enrolled-in-Medicaid.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2021. Chapter 3: Access to Behavioral Health Services for Children and Adolescents Covered by Medicaid and CHIP. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-3-Access-to-Behavioral-Health-Services-for-Children-and-Adolescents-Covered-by-Medicaid-and-CHIP.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2016. *Medicaid access in brief: Children's use of behavioral health services*. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2016/06/Childrens-Use-of-Behavioral-Health-Services.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. Chapter 4: Behavioral health in the Medicaid program – people, use, and expenditures. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%94People-Use-and-Expenditures-1.pdf.

National School-Based Health Alliance (SBHA). 2023. Medicaid policies that work for SBHCs. Washington, DC: SBHA. https://www.sbh4all.org/federal-policy-and-advocacy/medicaid-policies-that-work-for-sbhcs/.

Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2025. The impact of Certified Community Behavioral Health Clinics on Children, youth, and their Families. Washington, DC: ASPE. https://aspe.hhs.gov/sites/default/files/documents/b7f9d3bcbaaa943ad6c521741c71ff1e/CCBHC-Child-Youth-Family.pdf.

Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2024a. New federal 12-month continuous eligibility expansion: over 17 million children could gain new protections from coverage disruptions. Washington, DC: ASPE. https://aspe.hhs.gov/sites/default/files/documents/0366907d43ad429094b60fb707ee9825/aspe-childrens-continuous-eligibility.pdf.

Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2024b. Certified Community Behavioral Health Clinics demonstration program: Report to Congress, 2024. August 2024. Washington, DC: ASPE. https://aspe.hhs.gov/sites/default/files/documents/6bd575319052622229d08148d6754b2a/CCBHC%20AnnualReport_2024%20Final%20Cleared%20Version%207%2030.pdf.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2023. Key substance use and mental health indicators in the United States: results from the 2022 national survey on drug use and health. Rockville, MD: SAMHSA. https://www.samhsa.gov/data/sites/default/files/reports/rpt42731/2022-nsduh-nnr.pdf.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2019. 2018 National Survey on Drug Use and Health: Methodological summary and definitions. Rockville, MD: SAMHSA. https://www.samhsa.gov/data/report/2018-methodological-summary-and-definitions.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2016a. Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health. Rockville, MD: SAMHSA. https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2015/NSDUH-FFR1-2015/NSDUH-FFR1-2015.pdf.

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services. 2016b. About population data / NSDUH. Rockville, MD: SAMHSA. https://www.samhsa.gov/data/population-data-nsduh/about.

Ward, E., J. Wiltshire, M. Detry, and R.L. Brown. 2013. African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors. Nursing Research 62, no. 3: 185–194. https://doi.org/10.1097/NNR.0b013e31827bf533.

Wogan, J. and M. Restrepo. 2020. Human rights, stigma, and substance use. Health and Human Rights Journal 22, no. 1: 51–60. https://pmc.ncbi.nlm.nih.gov/articles/PMC7348456/.