Children and Youth Behavioral Health Initiative Evaluation: Objectives Analysis Chartbook, 2013 to 2023

January 27, 2025

CYBHI
Children and Youth Behavioral Health Initiative

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Overview

California's Children and Youth Behavioral Health Initiative (CYBHI), a $4+ billion, multi-year effort established in July 2021, seeks to enhance, expand, and redesign the systems that support behavioral health for children and youth in the state. The initiative strives to reimagine the ecosystem that supports the behavioral health and well-being of all of California's children, youth, and young adults by delivering equitable, appropriate, timely, and accessible behavioral health services and supports.

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PURPOSE AND CONTEXT

- The purpose of this chartbook is to provide an overview of the recent trends in child and youth behavioral health to support the effective implementation of the CYBHI initiative.
- The CYBHI objectives cover the following three dimensions: (I) behavioral health and well-being, (II) access to and experience with services, and (III) system-level support and collaboration.
- CalHHS developed these objectives in collaboration with children, youth, families, subject matter experts, and other partners.
- The objectives measure progress toward the ultimate goal of creating a more integrated, youth-centered system for delivering behavioral health supports.

OVERVIEW

- CalHHS – along with key partners and interested parties – identified 15 key objectives across the three dimensions.
- This chartbook presents estimates of trends from 2013 to 2023 for children (ages 0 to 11) and youth (ages 12 to 25) living in California from secondary data sources that can monitor progress toward the objectives.
- To show how objectives differ across subgroups, the chartbook presents estimates by age/grade, gender/sex at birth, race, ethnicity, sexual orientation, language spoken, and geographic region (see **Appendix A** for more information on subgroups).
- Tables with numbers for all the metrics featured in the chartbook figures (including by subgroup) can be found in an accompanying file.

OBJECTIVES INCLUDED IN CHARTBOOK

	Behavioral health and well-being	Metrics status
1	Increase in (a) overall social, emotional, and mental well-being and (b) children and youth's strengths and skills to address behavioral health challenges	Included
2	Decrease in behavioral health challenges	Included
3	Decrease in rates of suicidal ideation among children and youth	Included
4	Decrease in emergency department visits (ED) and hospitalizations for children and youth with behavioral health-related conditions	Included
5	Increase in school engagement, as measured by reducing absenteeism	Included
6	Decrease in stigmatizing attitudes toward behavioral health	Included
	Access and experience with services	
7	Improvement in the experience of (a) accessing and (b) receiving behavioral health services and supports	Included
8	Increase in (a) knowledge of available behavioral health supports and services and (b) confidence that children, youth, and families can get supports and services when they self-identify a need	Included
9	Increase in behavioral health services and supports received by children and youth	Included
10	Increase in representativeness of behavioral health professionals' demographic characteristics, especially in underserved communities	Planned for future
11	Increase in preventive services and family supports for children and youth of all ages	Planned for future
12	Substance use prevention strategies specifically for younger children and adolescents	Included
	System-level support and collaboration	
13	Decrease in system-level barriers to behavioral health care for children and youth, especially in underserved communities	Planned for future
14	Increase in cross-sector collaboration within the behavioral health ecosystem (measured using qualitative data)	Not included
15	Increase in use of the school-linked statewide fee schedule (led by the California Department of Health Care Services)	Not included

DATA AVAILABILITY AND LIMITATIONS

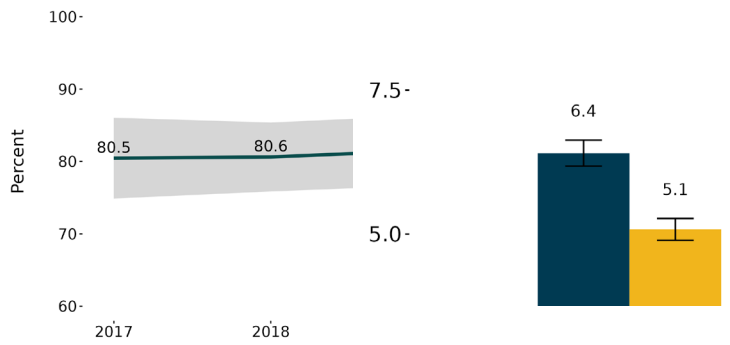
- Data availability varies across the CYBHI system and performance measures.
  - For each objective, we list the planned metrics and data sources in this chartbook. For some, data are not available for all years and all subgroups of interest.
  - For some metrics, data development is still under way and requires partnering with external organizations to adjust how data are collected to support California with long-term measurement (see prior slide).
  - Where possible, we show comparisons to national estimates.
- Many data sources have unique limitations (see **Appendix B** for more information).
  - Sample sizes for some metrics were insufficient to support precise estimates for the overall population or subgroup estimates, and some were not representative of the state. We note the limitations of specific metrics in the following sections.

A NOTE ON SUPPRESSION

- There is an ethical obligation to protect identifying information when presenting analytical results.
- When sample sizes for a particular group are small (for example, fewer than 10 members), researchers typically should not report the results—also called *suppression*.
- This is a particular issue with rare health issues and under-represented groups, which already have small numbers compared with other groups—hindering our ability to investigate health equity for some groups.
  - Group size for a particular metric is dependent on the survey and the associated sample.
  - It is also important to note that many surveys were not designed to adequately assess subgroup differences, which limits our ability to assess health equity outcomes.

INTERPRETING THE METRICS

Example figure. On the left, the solid line denotes the mean survey response, and gray shading denotes the 95% confidence interval. On the right, the bar height represents the mean survey response, and the whiskers (black lines shaped like a letter "I") represent the 95% confidence interval.



- For metrics developed from survey responses, we used gray shading for line graphs or whiskers for bar graphs to show the 95% confidence intervals around the estimates (see example figure).
- In some instances, such as with the California Healthy Kids Survey (CHKS), the confidence intervals are tiny and barely visible.

COMMON ACRONYMS AND DEFINITIONS

Acronyms

- **CYBHI:** Children and Youth Behavioral Health Initiative
- **ED**: Emergency department
- **MH:** Mental health
- **SUD:** Substance use disorder
- **AI/AN:** American Indian/Alaska Native
- **NH/PI:** Native Hawaiian/Pacific Islander
- **CA:** California
- **U.S.:** United States

Definitions

- **Behavioral health:** Mental health and substance use disorders
- **Objectives:** 15 outcome measures that capture the goals of CYBHI
- **Metrics:** Specific measurements that operationalize the objectives
- **Child:** Person ages 0 to 11
- **Youth:** Person ages 12 to 25
- **Disparity:** Differences between groups that are likely due to inequities
- **Race and ethnicity:** We consider race and ethnicity as separate dimensions of identity where possible, but in many cases, we include them as a single dimension due to methodological issues (for example, suppression or survey design)

Highlights from analysis

Note that these findings are descriptive and should be interpreted with caution.

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HIGHLIGHTS

- This series of slides presents high-level key findings or highlights before showing the objective-by-objective findings.
- For each objective, we present:
  - Observed strengths that might indicate CYBHI is helping to achieve the objective
  - Opportunities for improvement that might indicate where CYBHI activities could intervene
  - Specific opportunities to reduce health disparities among important subgroups

Strengths and opportunities for objectives related to behavioral health and well-being

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STRENGTHS AND OPPORTUNITIES BY OBJECTIVE

Objective #1

Increase in (a) overall social, emotional, and mental well-being and (b) children and youth's strengths and skills to address behavioral health challenges

- Strengths:
  - Most students felt protected and safe in their homes.
  - Many students reported being close to people at school, having support from family and friends, and understanding their own moods and feelings.
- Opportunities:
  - There are small decreases rates of flourishing behaviors (for example, feeling close to people at school) among students.
  - Half of students reported a lack of engagement in school activities.
  - Less than one-third reported that they do not feel they can make a difference at school.
  - About half of youth reported that (1) at least two nonparent adults took genuine interest in them and (2) they are able to talk to their families about issues.

Opportunities to reduce disparities

- Those identifying as AI/AN had lower rates of flourishing behaviors compared with students identifying as White.
- Those identifying as Asian had low levels of perceived social support.
- Those identifying as Hispanic/Latino had low levels of perceived social support.
- Those identifying as transgender were less likely to feel close to people and almost half as likely to report understanding their moods and feelings compared with those who are not transgender.
- Those identifying as nonbinary had lower rates of flourishing behaviors and understanding of moods and feelings compared with cisgender students.
- Those identifying as gay, bisexual, or another sexuality were almost half as likely to understand their moods and feelings compared with students who identify as heterosexual.
- Those identifying as female had lower levels of perceived social support compared with those identifying as male.
- Those living in the Central Coast region had lower levels of perceived social support compared with those in other regions.

STRENGTHS AND OPPORTUNITIES BY OBJECTIVE

Objectives #2 and #3

2. **Decrease in behavioral health challenges**
   - Strengths:
     - There was a small decrease in alcohol disorders and binge drinking for youth in California.
     - Heavy drug use was infrequent.
   - Opportunities:
     - Rates of MH diagnoses (for example, depression and anxiety) increased.
     - Rates of cannabis use and diagnoses of cannabis, nicotine, and opioid use disorders increased.
3. **Decrease in rates of suicidal ideation among children and youth**
   - Strengths:
     - California has a lower suicide rate than the rest of the United States.
   - Opportunities:
     - Rates of suicidal ideation and suicides did not decrease but remained stable.

Opportunities to reduce disparities

- Those identifying as AI/AN were more likely to have a behavioral health diagnosis or symptoms and had the highest rate of death by suicide compared with all other groups.
- Those identifying as NH/PI had the second highest rate of death by suicide compared with all other groups.
- Those identifying as transgender had a rate of suicidal ideation nearly three times higher than those not identifying as transgender.
- Those identifying as male had a rate of death by suicide three times higher than that of females.
- Those identifying as gay or bisexual had rates of suicidal ideation nearly three times higher than that of heterosexuals.
- Those living in the Central Coast and the Northern and Sierra regions had the highest rates of behavioral health diagnoses or symptoms.

STRENGTHS AND OPPORTUNITIES BY OBJECTIVE

Objectives #4 and #5

4. **Decrease in ED visits and hospitalizations for children and youth with behavioral health-related conditions**
   - Strengths:
     - There was a small decrease in ED and inpatient visits for behavioral health reasons.
     - The rate of ED use for behavioral health reasons was lower in California than in the rest of the United States.
   - Opportunities:
     - Rates of ED and inpatient visits for self-harm increased.
     - Rates of ED use for nonfatal overdoses increased.
     - Inpatient hospitalizations for MH were slightly higher in California compared with the United States.
5. **Increase in school engagement, as measured by reducing absenteeism**
   - Strengths:
     - Chronic absenteeism rose dramatically—in the 2021–22 school year but there was a small decrease in 2022–23.
     - Absenteeism due to MH challenges was 9.5 percent, on average (see opportunities for information on disparities).
     - Absences due to alcohol or drug use were infrequent and declining.
   - Opportunities:
     - Opportunities related to health disparities (see other column)

Opportunities to reduce disparities

- Those identifying as AI/AN had (1) the highest ED visit rate for nonfatal opioid overdoses, increasing 72% from 2021 to 2022, and (2) higher rates of chronic absenteeism compared with White youth.
- Those identifying as NH/PI had higher rates of chronic absenteeism compared with White students.
- Among all groups, those identifying as Black had (1) the highest ED visit and inpatient hospitalization rates with any behavioral health diagnosis and (2) the highest ED visit and inpatient hospitalization rates for self-harm and nonfatal overdoses. Black students also had higher rates of chronic absenteeism compared with White students.
- Those identifying as transgender were more likely to miss school due to MH issues and alcohol or drug use compared with those who did not identify as transgender.
- Those identifying as nonbinary had higher rates of chronic absenteeism compared with cisgender students.
- Those identifying as female (1) had high rates of ED use for MH, (2) had nearly double the rate of inpatient and ED visits and stays for self-harm, and (3) were more likely to miss school due to MH issues than those who identify as male.
- Those identifying as male had higher rates of ED visits related to substance use than those identifying as female.
- Those living in the Northern and Sierra regions had (1) the highest ED visit and inpatient hospitalization rates with behavioral health diagnoses and (2) the highest rates of chronic absenteeism.

Strengths and opportunities for objectives related to access and experience with services

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STRENGTHS AND OPPORTUNITIES BY OBJECTIVE

Objectives #6 and #7

6. **Decrease in stigmatizing attitudes toward behavioral health**
   - Strengths:
     - The rate of students reporting stigma toward seeking professional help has decreased since 2016–17.
   - Opportunities:
     - Just under half of students were concerned about what would happen if they engaged with behavioral health services.
     - About half of the students were not comfortable seeking services from behavioral health professionals.
7. **Improvement in experience of (a) accessing and (b) receiving behavioral health services and supports**
   - Strengths:
     - None identified in this analysis for the overall population.
   - Opportunities:
     - Over half of youth reported difficulty in receiving behavioral health care.

Opportunities to reduce disparities

- Those identifying as Asian had the highest levels of stigma around MH issues compared with all other groups.
- Those identifying as transgender were nearly twice as likely to report MH stigma compared with those not identifying as transgender.
- Almost two-thirds of those identifying as nonbinary reported MH stigma.
- Half of those identifying as female reported MH stigma.
- Those identifying as gay or bisexual were twice as likely to report MH stigma compared with youth identifying as heterosexual.

STRENGTHS AND OPPORTUNITIES BY OBJECTIVE

Objectives #8 and #9

8. **Increase in (a) knowledge of available behavioral health supports and services and (b) confidence that children, youth, and families can get supports and services when they self-identify a need**
   - Strengths:
     - About two-thirds of 6th to 12th graders knew where to go for help.
     - There was an increase in the percentage of students who knew where to find help at school.
   - Opportunities:
     - About half of the students felt confident about finding help.
9. **Increase in behavioral health services and supports received by children and youth**
   - Strengths:
     - There was a small increase in the number of Medi-Cal enrollees receiving behavioral health services.
   - Opportunities:
     - Most Medi-Cal enrollees with behavioral health needs were not receiving services.

Opportunities to reduce disparities

- Those identifying as NH/PI had the lowest rates of accessing behavioral health services compared with all other groups.
- Those identifying as transgender (1) were less likely to report confidence in finding support at school for substance use issues, (2) had slightly less knowledge of where to go for help, and (3) had higher rates of seeking behavioral health treatment compared with those not identifying as transgender.
- Those identifying as gay or bisexual (1) had slightly less knowledge about and confidence in finding help at school and (2) reported higher rates of seeking behavioral health services compared with heterosexual students.
- Those living in the San Joaquin Valley region had the lowest use of behavioral health services compared to those living in other regions.

STRENGTHS AND OPPORTUNITIES BY OBJECTIVE

- **Objective #10: Increase in representativeness of behavioral health professionals' demographic characteristics, especially in underserved communities**
  - Not included in this chartbook but planned for future versions.

- **Objective #11: Increase in preventive services and family supports for children and youth of all ages**
  - Not included in this chartbook but planned for future versions.

STRENGTHS AND OPPORTUNITIES BY OBJECTIVE

Objective #12

12. **Substance use prevention strategies specifically for younger children and adolescents**
    - Strengths:
      - About two-thirds of students reported seeing or hearing substance use prevention messages.
      - Over half of students reported high perceived risk from cocaine and heroin.
      - Students identifying as AI/AN reported more confidence with finding substance use support at school, reducing the gap with other groups.
    - Opportunities:
      - Less than one-quarter of school staff reported that their school provided extensive substance use prevention instruction.
      - About half of the students reported talking to a parent or guardian about substance use prevention messages heard at school.
      - About half of the students reported perceiving great harm from alcohol use.

Opportunities to reduce disparities

- Those identifying as AI/AN, Black, or Hispanic/Latino reported lower rates of seeing substance use prevention messages compared with White students.

Objective-level findings

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1. Increase in (a) overall social, emotional, and mental well-being and (b) children and youth's strengths and skills to address behavioral health challenges

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METRICS FOR OUTCOME 1

Metric (data sources; ages/grades)
Percentage of students displaying aspects of flourishing (they felt they were doing things that made a difference, felt they were doing interesting activities at school, and felt close to people at school) (CHKS Core Module; 7th, 9th, and 11th graders)
Percentage of students who understood their moods and feelings (CHKS Core Module; 7th, 9th, and 11th graders)
Percentage of youth who felt able to talk to family about feelings (California Health Interview Survey [CHIS]; ages 12–17)
Percentage of youth who felt that family stood by them during difficult times (CHIS; ages 12–17)
Percentage of youth who felt safe and protected by an adult in their home (CHIS; ages 12–17)
Percentage of youth who had at least two nonparent adults who take genuine interest (CHIS; ages 12–17)
Percentage of youth who felt supported by friends (CHIS; ages 12–17)

1. KEY TAKEAWAYS: OVERALL POPULATION

Overall well-being

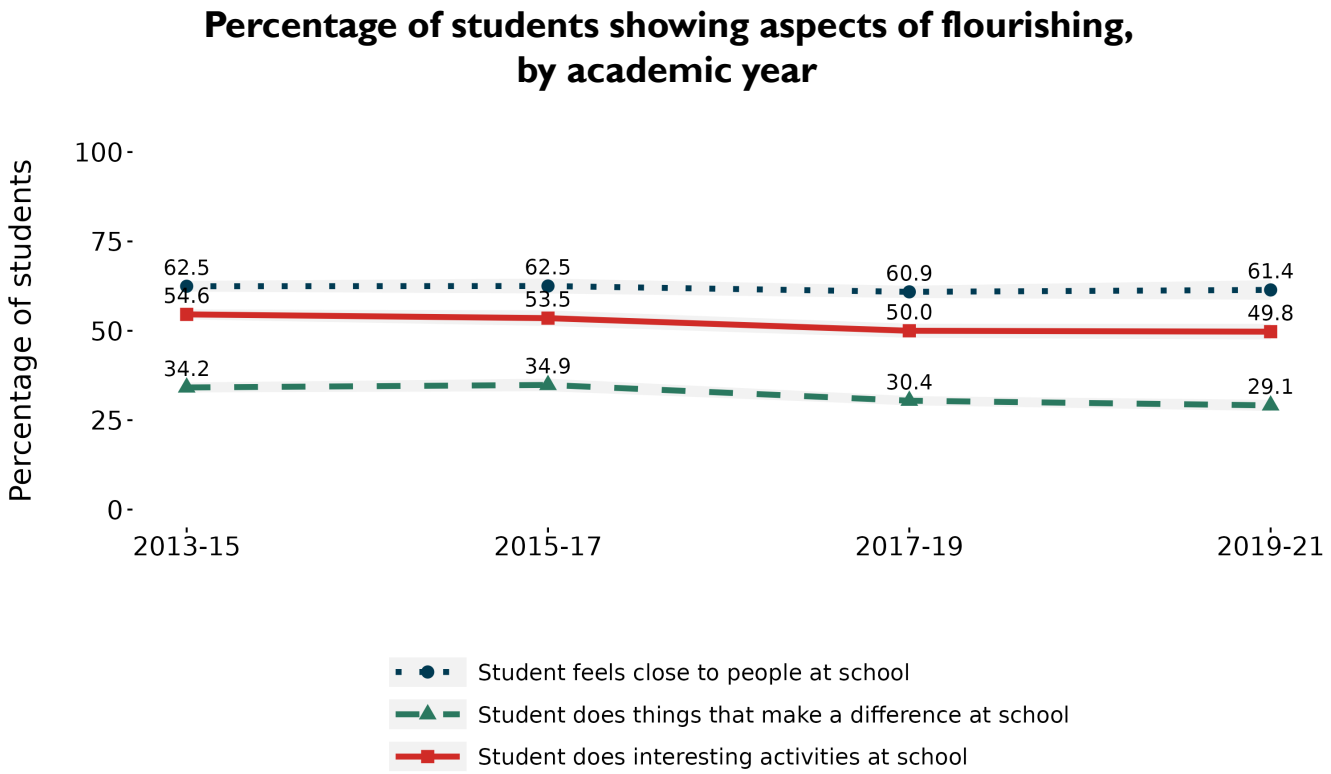
- From 2013–15 to 2019–21, a slightly smaller percentage of students have shown aspects of child flourishing, defined as closeness to others and engagement in interesting or meaningful activities.
- Although almost two-thirds of 7th, 9th, and 11th graders felt close to people in their school, only about half of these students felt they do interesting activities at school, and less than one-third of these students felt they do things that make a difference at school.
- During 2021–22,* among youth ages 12–17, about half felt able to talk to family about their feelings, slightly more than half had at least two nonparent adults who took genuine interest, about 70% felt their family stood by them during difficult times or felt supported by friends, and 90% felt safe and protected by an adult at home.

Strengths and skills to address behavioral health challenges

- In 2019–21, over half of students reported being able to understand their moods and feelings.

*Survey questions were available in the CHIS starting in 2021.

STUDENT FLOURISHING SLIGHTLY DECREASED FROM 2013–15 TO 2019–21



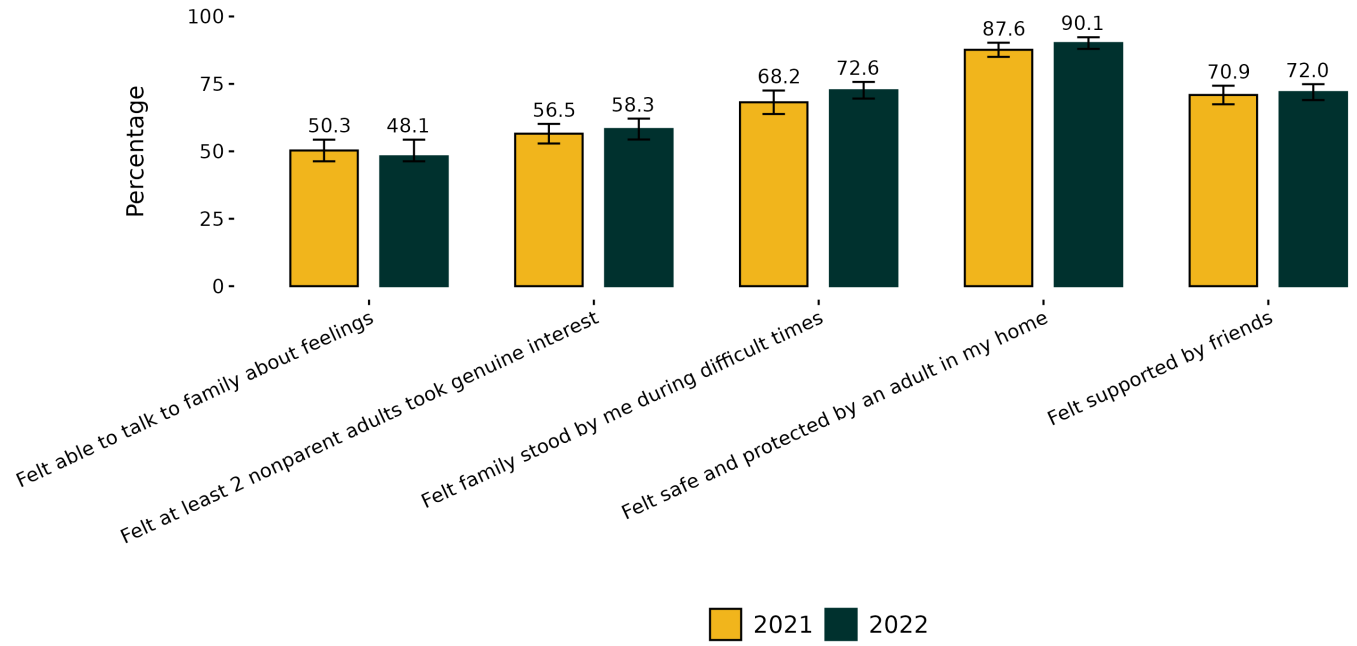
The CYBHI evaluation team selected these metrics from the CHKS as strengths-based items aligned with the Child Wellness Checklist.

Source: CHKS, core module of biennial survey, 2019-2021

Notes: The 7th-, 9th-, and 11th-grade student responses come from items in the CHKS biennial survey, which is weighted to be representative of the California student population. These items correspond to the Student Wellness Checklist: https://bestrong.global/outreach/BeStrong-Student_Wellness-Checklist.pdf. Students responded "pretty much true" or "very much true" to the following survey statements: "I feel close to people at school," "At school, I do interesting activities," and "At school, I do things that make a difference."

MOST YOUTH FELT SAFE AND PROTECTED AT HOME, BUT FEWER REPORTED SUPPORT FROM ADULTS

Percentage of youth ages 12 to 17 years old reporting aspects of social support, by year



Although most youth reported feeling safe and protected at home, about one-third fewer reported being able to talk to their family about their feelings and felt at least two nonparental adults showed genuine interest in them.

Source: CHIS, 2021-2022.

Notes: Youth ages 12 to 17 years old were asked whether they have seen or been present when the following experiences happened in their lifetime: (a) felt able to talk to family about feelings, (b) felt family stood by them during difficult times, (c) felt safe and protected by an adult at home, (d) had at least two nonparent adults who took genuine interest in them, and (e) felt supported by friends. This figure shows the percentages of youth who responded "all of the time" or "most of the time" for each item.

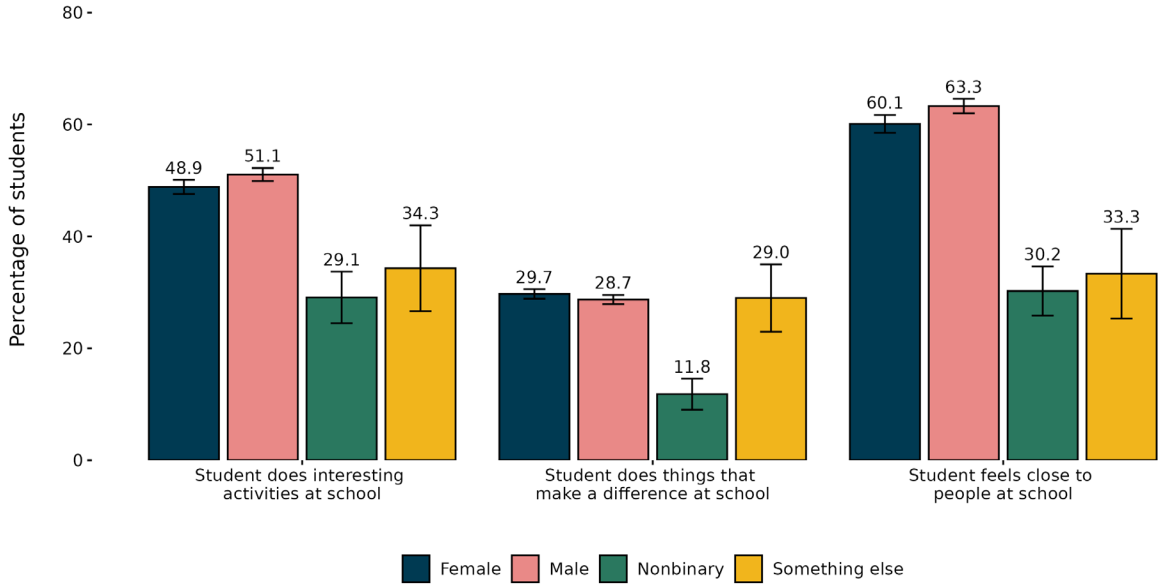
1. KEY TAKEAWAYS: DISPARITIES AND SUBGROUP DIFFERENCES

- **Gender/sex at birth:**
  - Students identifying as transgender were less likely to feel close to people and almost half as likely to report understanding their moods and feelings compared to those who did not identify as transgender.
  - Students identifying as nonbinary had lower rates of flourishing than their peers identifying as male or female.
  - Students identifying as male reported the highest rates of understanding their moods and feelings, whereas students identifying as nonbinary reported the lowest.
  - Youth identifying as female generally reported less social support compared to males.
- **Sexual orientation:** Students identifying as bisexual or gay were slightly less likely to report signs of flourishing but much less likely to report understanding their moods and feelings.
- **Race and ethnicity:**
  - Students identifying as AI/AN had lower rates of flourishing than their peers identifying as other races or ethnicities.
  - Differences in understanding moods and feelings by race and ethnicity were small.
  - Youth identifying as Hispanic or Asian generally reported less social support than their peers identifying as other race and ethnicity.*
- **Region:** Youth in the Central Coast region generally reported less social support compared with youth in other regions.

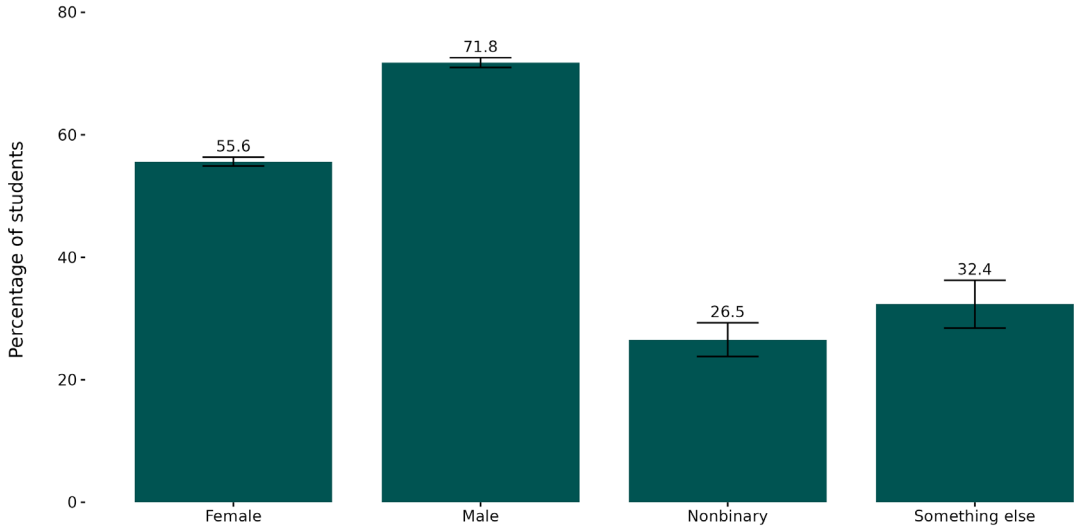
* Data on social support for youth who identify as Black, AI/AN, or NH/PI were not available due to suppression.

STUDENTS IDENTIFYING AS NONBINARY WERE LESS LIKELY TO REPORT FLOURISHING OR UNDERSTANDING MOODS AND FEELINGS

Percentage of students showing aspects of flourishing, by gender in 2019–21



Percentage of students who reported understanding their moods and feelings, by gender in 2019–21

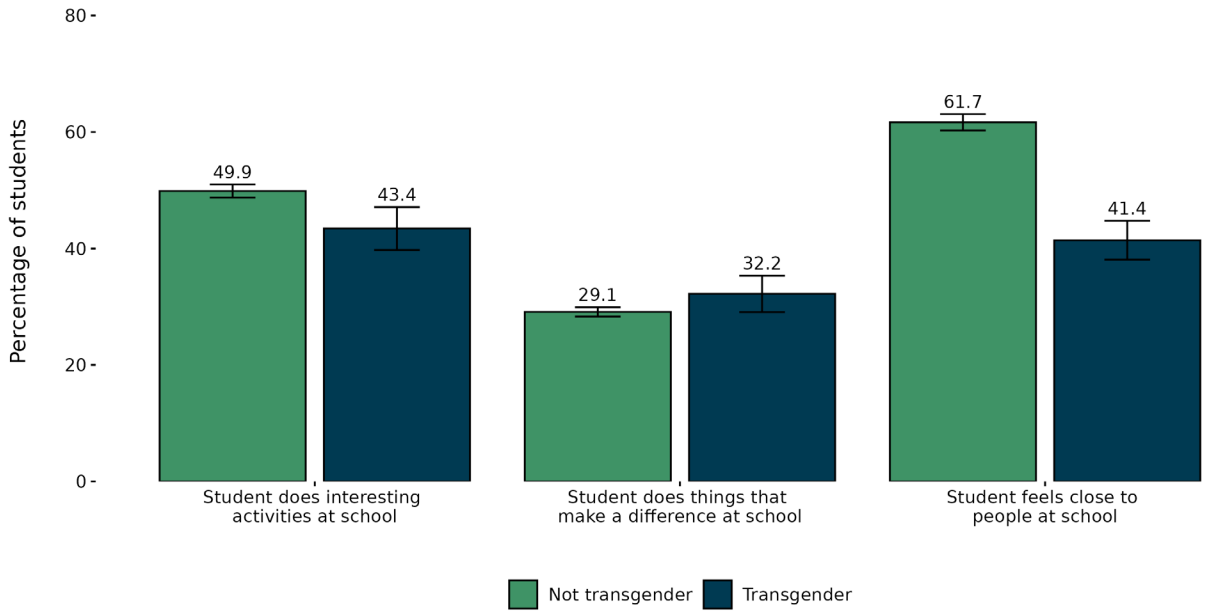


Source: CHKS, core module of biennial survey, 2019–21.

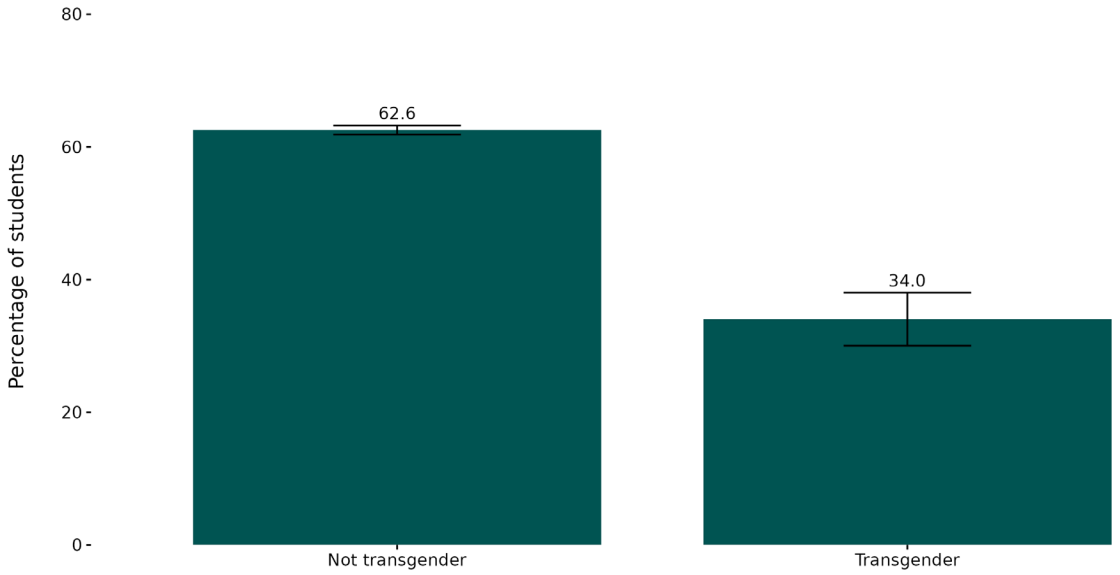
Notes: The 7th-, 9th-, and 11th-grade student responses come from items in the CHKS biennial survey, which is weighted to be representative of the California student population. The flourishing items correspond to the Student Wellness Checklist: https://bestrong.global/outreach/BeStrong-Student_Wellness-Checklist.pdf. Students responded "pretty much true" or "very much true" to the following survey statements: "I feel close to people at school," "At school, I do interesting activities," and "At school, I do things that make a difference." Students responded "pretty much true" or "very much true" to the following survey statement: "I understand my moods and feelings."

STUDENTS IDENTIFYING AS TRANSGENDER WERE LESS LIKELY TO REPORT FEELING CLOSE TO PEOPLE AT SCHOOL AND UNDERSTANDING MOODS AND FEELINGS AS STUDENTS NOT IDENTIFYING AS TRANSGENDER

Percentage of students showing aspects of flourishing, by transgender identity in 2019–21



Percentage of students who reported understanding their moods and feelings, by transgender identity in 2019–21



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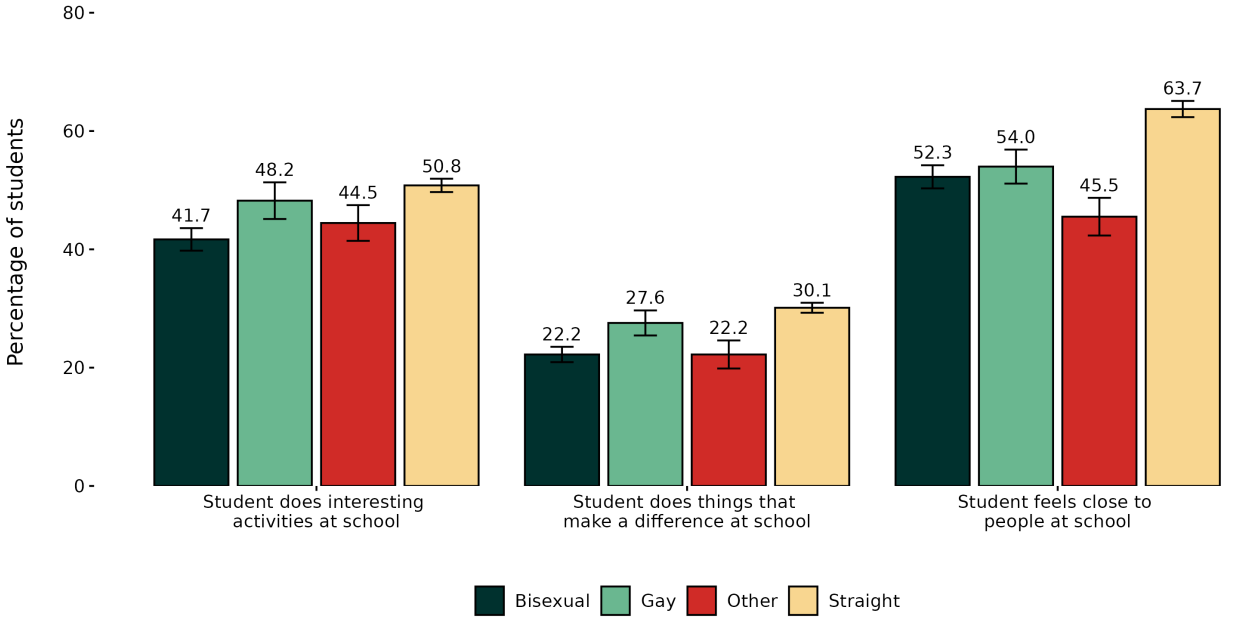
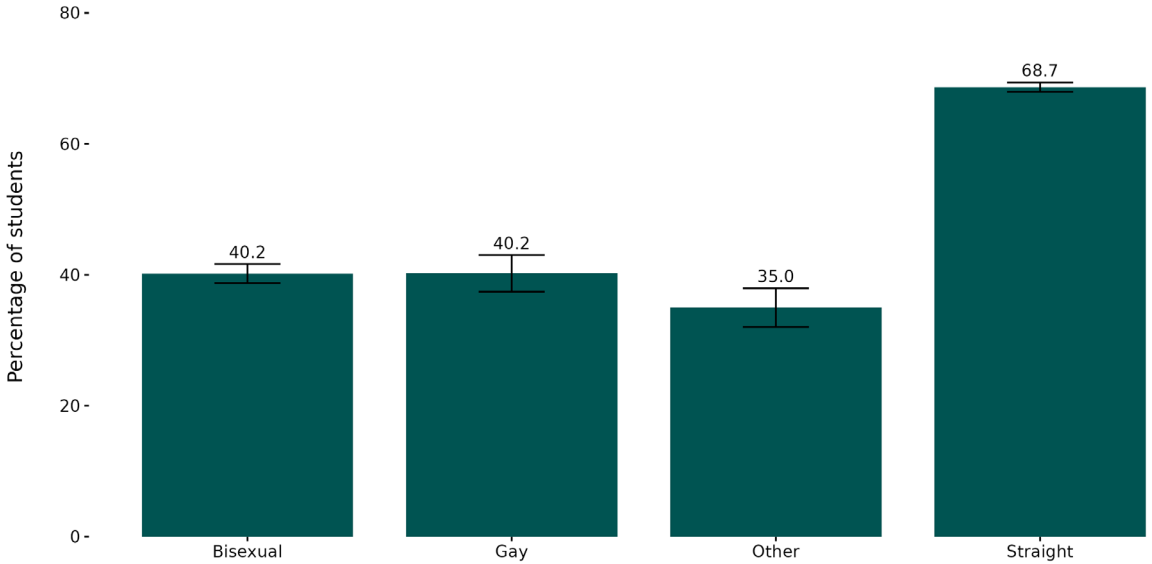
STUDENTS IDENTIFYING AS *NOT* HETEROSEXUAL OR "STRAIGHT" WERE LESS LIKELY AS TO REPORT FEELING CLOSE TO PEOPLE AT SCHOOL AND UNDERSTANDING MOODS AND FEELINGS AS THOSE WHO DID IDENTIFY AS STRAIGHT

Percentage of students showing aspects of flourishing, by sexual orientation in 2019–21



Percentage of students who reported understanding their moods and feelings, by sexual orientation in 2019–21

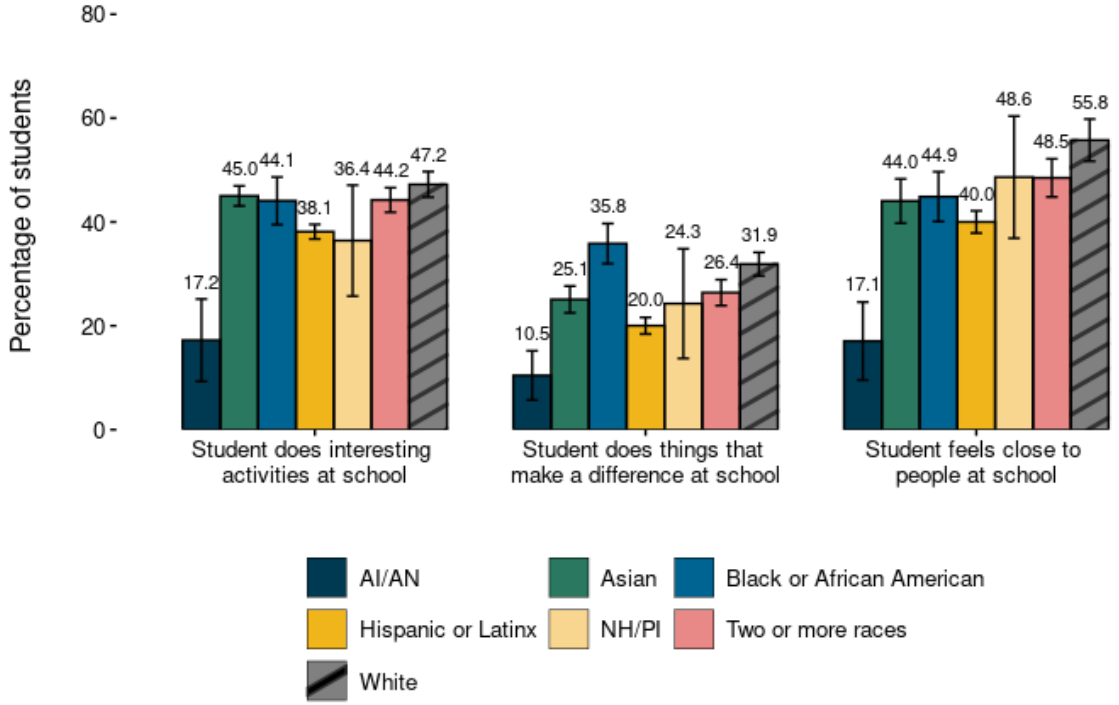


Source: CHKS, core module of biennial survey, 2019–21.

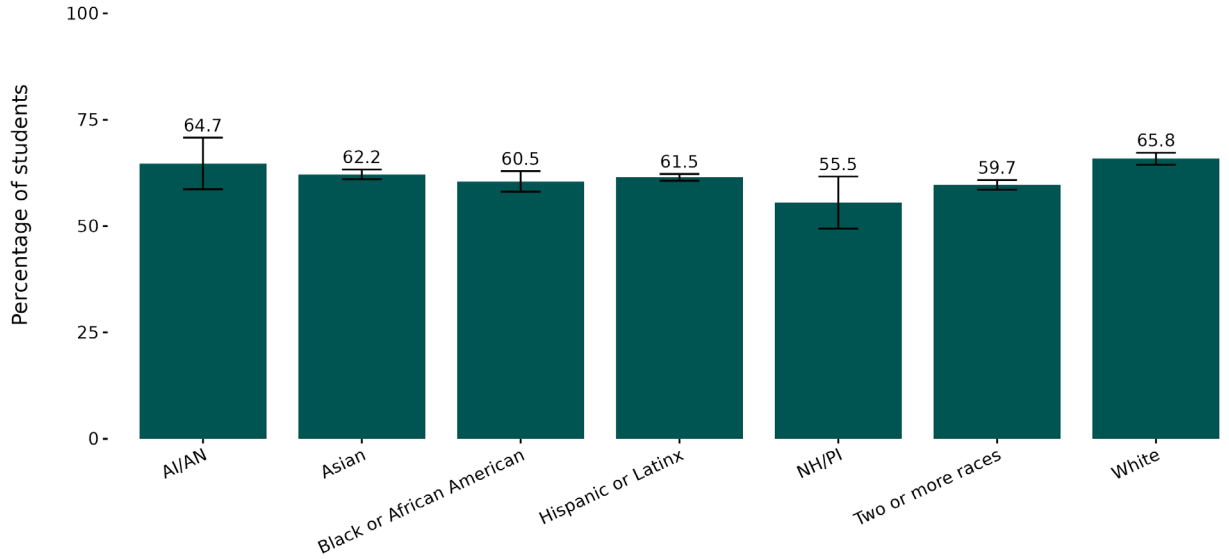
Notes: The 7th-, 9th-, and 11th-grade student responses come from items in the CHKS biennial survey, which is weighted to be representative of the California student population. The flourishing items correspond to the Student Wellness Checklist: https://bestrong.global/outreach/BeStrong-Student_Wellness-Checklist.pdf. Students responded "pretty much true" or "very much true" to the following survey statements: "I feel close to people at school," "At school, I do interesting activities," and "At school, I do things that make a difference." Students responded "pretty much true" or "very much true" to the following survey statement: "I understand my moods and feelings."

FLOURISHING WAS LOWEST FOR STUDENTS IDENTIFYING AS AI/AN

Percentage of students showing aspects of flourishing, by race



Percentage of students who reported understanding their moods and feelings, by race and ethnicity in 2019–21



Source: CHKS, core module of biennial survey, 2019–21.

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2. Decrease in behavioral health challenges

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METRICS FOR OUTCOME 2

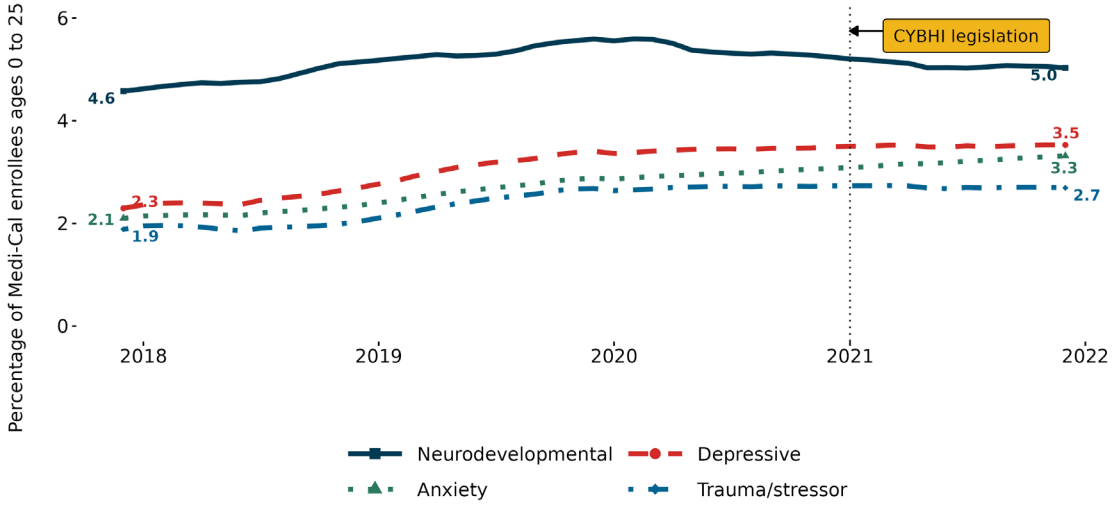
Metric (data sources; ages/grades)
Percentage of children and youth with an MH diagnosis or emotional symptoms (Transformed Medicaid Statistical Information System [T-MSIS] Analytic File [TAF]; ages 0–25)
Percentage of children and youth with a substance use disorder (SUD) diagnosis (TAF; ages 0–25)

2. KEY TAKEAWAYS: OVERALL POPULATION

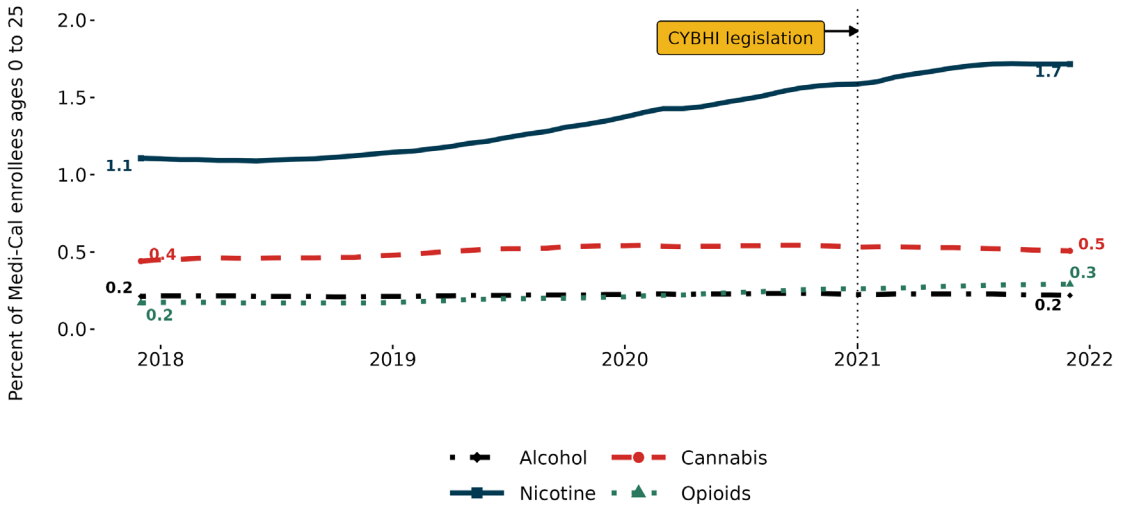
- **MH challenges:** From 2018 to 2021, rates of anxiety, depression, and trauma or stressor disorders among the Medi-Cal-enrolled population increased.
- **Substance use:** Trends varied depending on the substance.
  - Rates of alcohol disorders and binge drinking decreased, and heavy drug use was infrequent.
  - Rates of cannabis use and diagnoses of cannabis, nicotine, and opioid use disorders increased.

AMONG MEDI-CAL ENROLLEES, RATES OF THE MOST COMMON MH DIAGNOSIS INCREASED FROM 2018 TO 2022; RATES OF NICOTINE, OPIOID, AND CANNABIS DISORDERS ALSO INCREASED

Percentage of Medi-Cal enrollees ages 0 to 25 who had MH diagnoses in the four most common categories



Number of Medi-Cal enrollees ages 0 to 25 who had SUD diagnoses in the four most common categories



In contrast to rates of depression, anxiety, and trauma/stressor-related disorders, which increased, the percentage of children and youth with neurodevelopmental disorders such as autism and attention-deficit/hyperactivity disorder declined during the COVID-19 public health emergency. This may be due to reduced in-person interaction with educators and social services and medical professionals.[a]

On November 30, 2016, California's Department of Health Care Services released an All-Plan Letter clarifying requirements for comprehensive tobacco cessation services to include annual assessment, provision of counseling and Food and Drug Administration-approved medications, and tracking.[b] This may have affected rates of identified nicotine dependence.

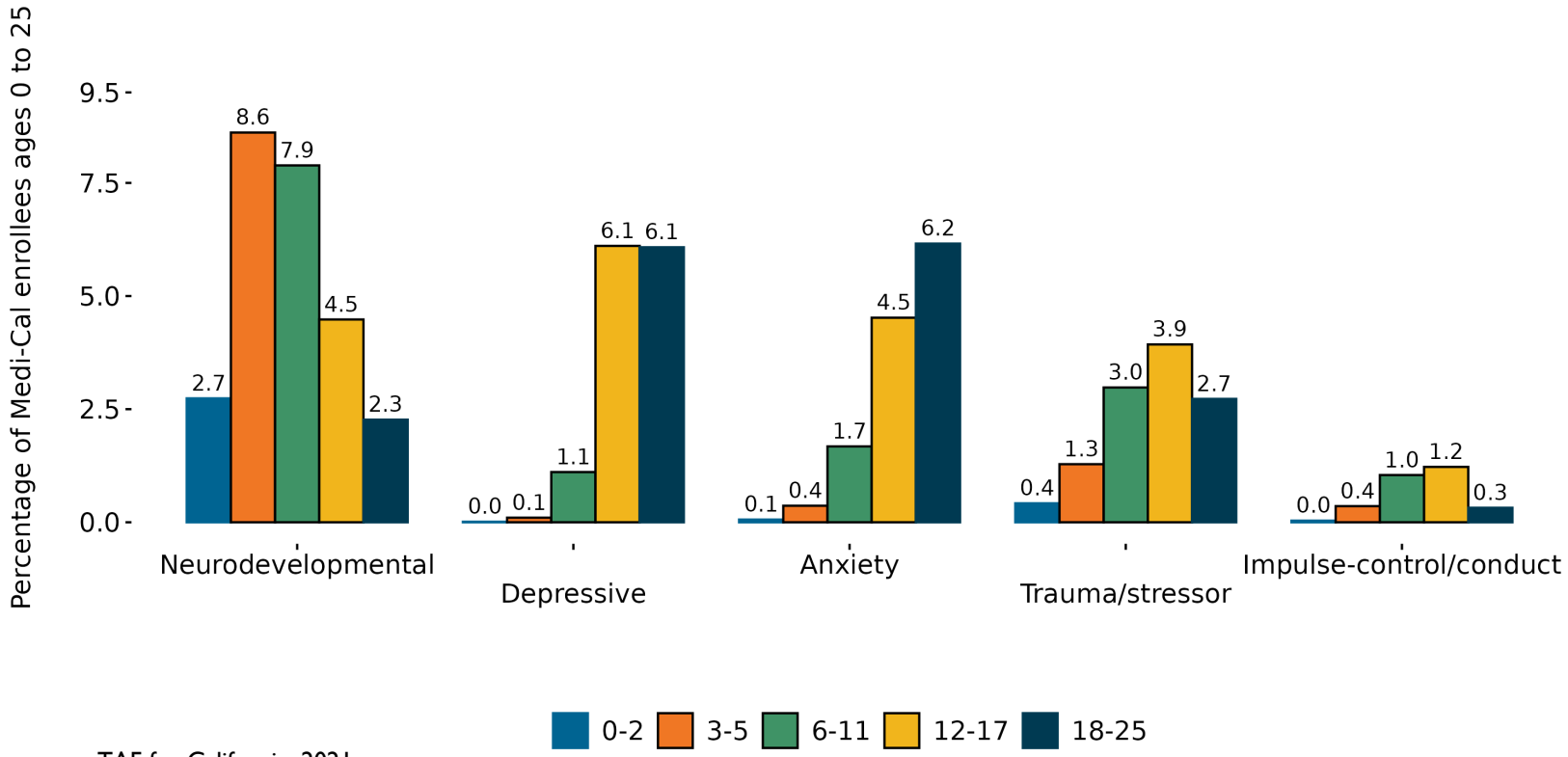
Source: TAF for California

2. KEY TAKEAWAYS: DISPARITIES AND SUBGROUP DIFFERENCES

- **Age/grade:**
  - Children ages 3 to 11 were more likely to be diagnosed with neurodevelopmental disorders, whereas youth (ages 12–25) were more likely to be diagnosed with anxiety and depression. However, this is confounded with age when a diagnosis is typically made. For example, older youth will already have been diagnosed with neurodevelopmental disorders earlier in their lives and would no longer show up in active diagnoses.
- **Gender/sex at birth:**
  - Among Medi-Cal enrollees, males were more likely to be diagnosed with neurodevelopmental disorders and externalizing disorders (such as impulse control or conduct disorders), whereas females were more likely to be diagnosed with internalizing disorders (such as depression). This finding is consistent with the literature on gender differences in MH diagnoses.
- **Race and ethnicity:** Among Medi-Cal enrollees, children and youth who identify as AI/AN were most likely to have a behavioral health diagnosis or behavioral health symptoms.
- **Region:** The Northern and Sierra region and the Central Coast region had the highest rates of behavioral health diagnoses or symptoms.

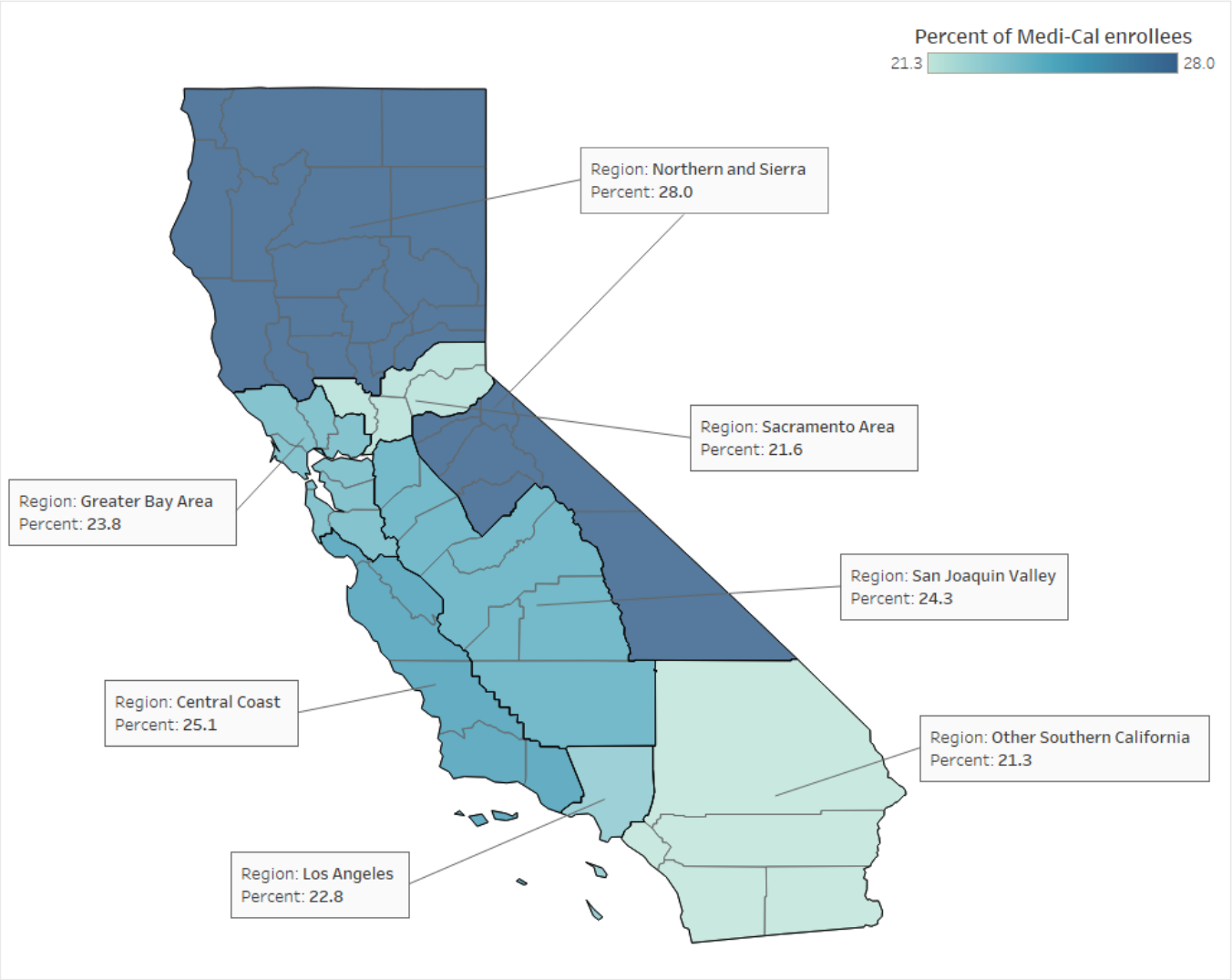
AMONG MEDI-CAL ENROLLEES, YOUNGER CHILDREN HAD HIGHER RATES OF NEURODEVELOPMENTAL DISORDERS, AND ADOLESCENTS AND YOUNG ADULTS HAD HIGHER RATES OF ANXIETY AND DEPRESSION

Percentage of Medi-Cal enrollees who had an MH condition in the most common diagnostic categories, by age group, 2021



Source: TAF for California, 2021.
Note: Neurodevelopmental diagnoses are likely confounded by age, meaning that youth are typically diagnosed with these as they reach developmental milestones.

Percentage of Medi-Cal enrollees with behavioral health diagnoses or symptoms (ages 0 to 25)



MEDI-CAL ENROLLEES IN THE NORTHERN AND SIERRA REGION AND THE CENTRAL COAST REGION HAD THE HIGHEST RATES OF BEHAVIORAL HEALTH DIAGNOSES OR SYMPTOMS IN 2021

Source: TAF for California.

3. Decrease in rates of suicidal ideation among children and youth

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METRICS FOR OUTCOME 3

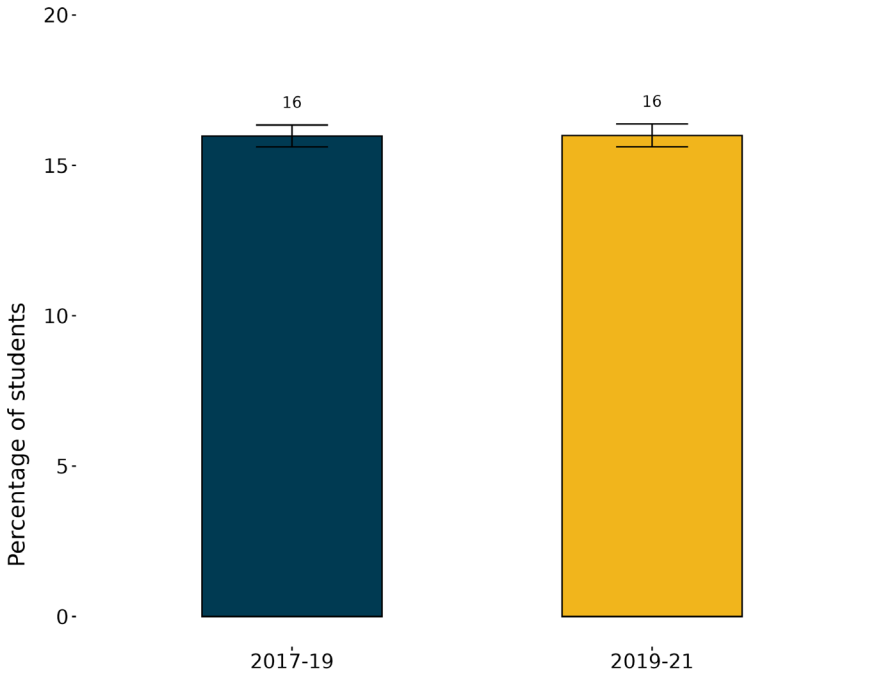
Metric (data sources; ages/grades)
Deaths by suicide per 100,000 children and youth (CDC Wonder; ages 0–25)
Percentage of students who reported seriously considering attempting suicide in the past 12 months (CHKS Core; 9th and 11th graders)

3. KEY TAKEAWAYS: OVERALL POPULATION

- **Suicidal ideation:** About 15% of 9th and 11th graders seriously considered suicide—a number that did not change much over time.
- **Deaths by suicide:** There was a generally stable trend from 2018 to 2023 with a slight increase in 2021. Compared with the United States, California's rates were 50% lower in 2023 with a difference of 2.3 deaths per 100,000 children and youth ages 0–25.

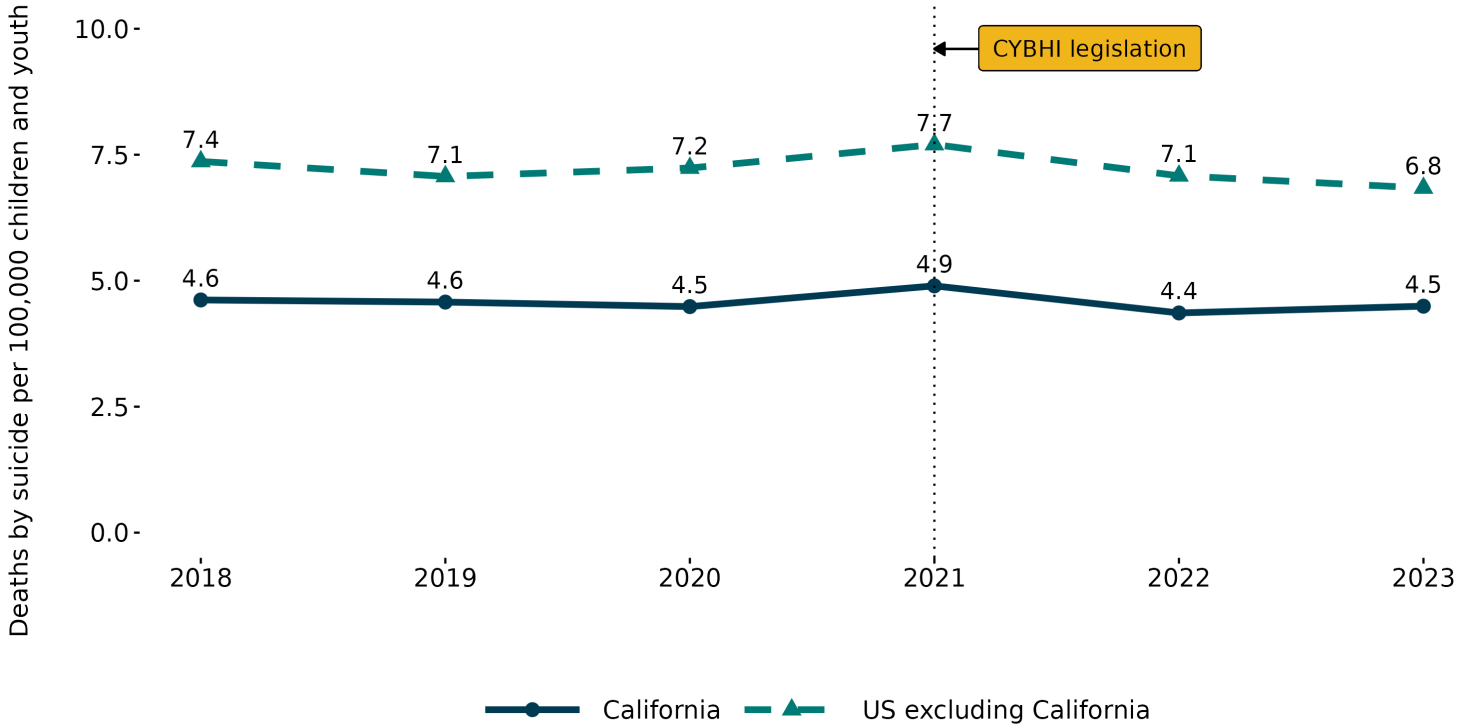
THE PERCENTAGE OF YOUTH WHO SERIOUSLY CONSIDERED SUICIDE WAS STABLE THROUGH 2021; THE RATE OF DEATH BY SUICIDE IS LOWER IN CA COMPARED WITH THE U.S.

Percentage of 9th- and 11th-graders who seriously considered suicide during past 12 months



Source: CHKS, core module of biennial surveys, 2017–19 and 2019–21.
Notes: Data come from 9th- and 11th-grade student responses that are weighted to be representative of the state.

Deaths by suicide per 100,000 children and youth ages 0 to 25



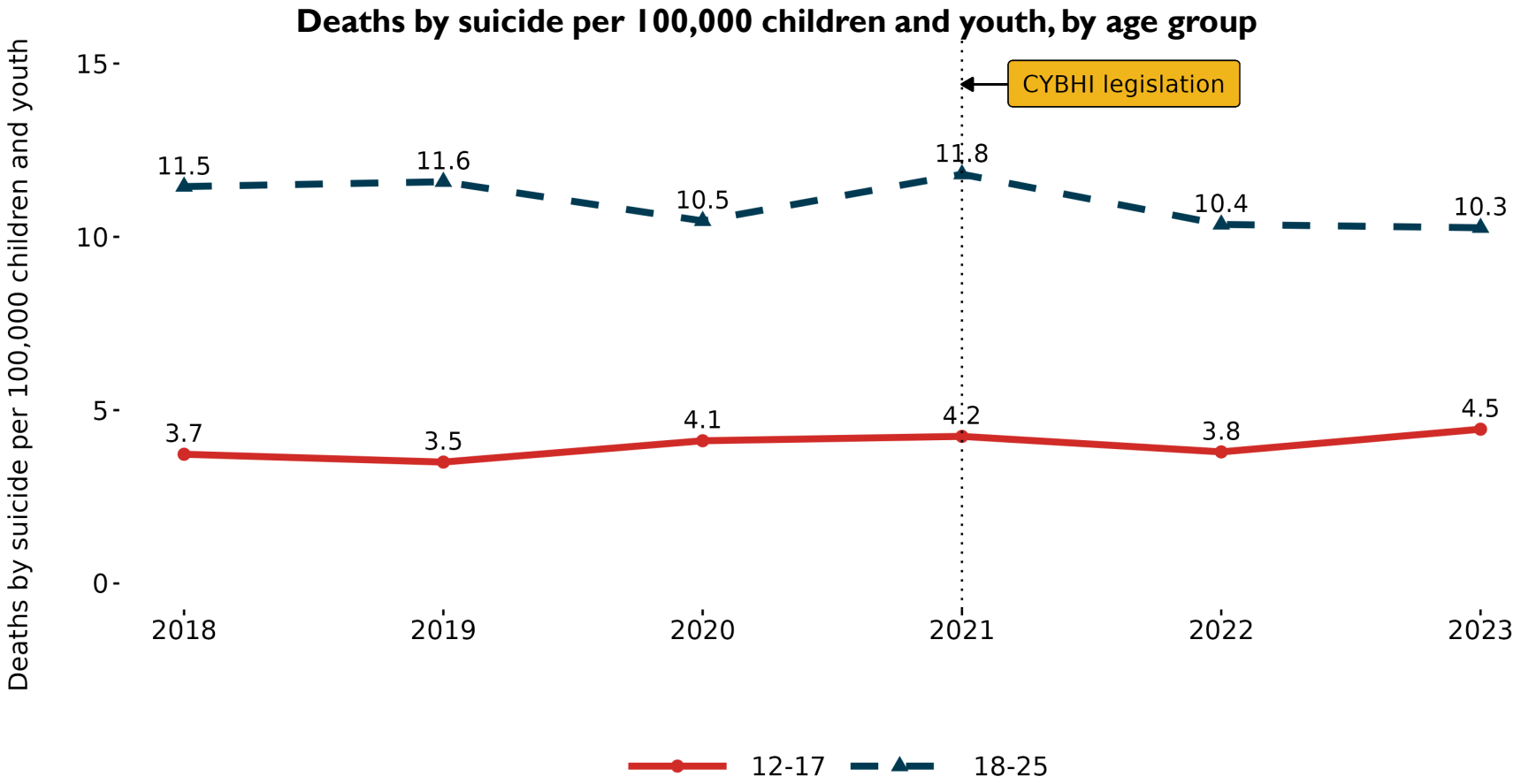
Source: CDC Wonder.

In California and nationally, suicide is one of the leading causes of death (top three) for children and youth ages 15–24.[c]

3. KEY TAKEAWAYS: DISPARITIES AND SUBGROUP DIFFERENCES

- **Age:**
  - 18- to 25-year-olds had the highest rate of death by suicide, and it declined slightly from 2021 to 2023.
  - 12- to 17-year-olds had a lower rate than 18- to 25-year-olds, but it slightly increased from 2021 to 2023.
  - Children under age 12 rarely died by suicide (typically fewer than 11 deaths annually, statewide).
- **Gender/Sex at birth:** Females had higher rates of suicidal ideation than males in 2017–19, while males had a rate of death by suicide three times higher than females in 2023.
- **Transgender:** Youth who identify as transgender had a rate of suicidal ideation nearly three times higher than those who do not identify as transgender.
- **Sexual orientation:** Youth who identify as bisexual, gay, or lesbian had rates of suicidal ideation nearly three times higher than those who identify as heterosexual.
- **Race and ethnicity:**
  - There were no differences in suicidal ideation by race and ethnicity from 2017 to 2019.
  - Youth who identify as AI/AN had the highest rate of death by suicide in 2022–23 followed by NH/PI in 2021–23.
  - Youth who identify as Hispanic had the lowest rate of death by suicide in 2023.
- **Region:** Youth living in the Northern and Sierra region in 2023 had the highest rates of death by suicide (more than 72% higher than in Los Angeles, the region with the lowest rates).

THE RATE OF DEATH BY SUICIDE WAS MORE THAN TWO TIMES HIGHER FOR 18- TO 25-YEAR-OLDS THAN FOR 12- TO 17-YEAR-OLDS

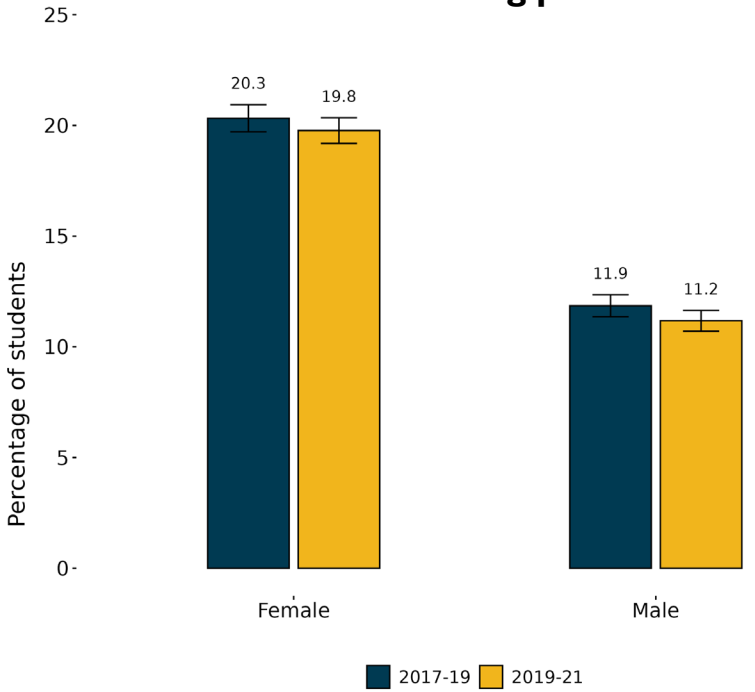


The age group difference in deaths by suicide was smaller in California than in the rest of the United States. In 2023, the age group disparity in California was 5.8 deaths per 100,000 compared with a U.S. disparity of 10.0 per 100,000.

Source: CDC Wonder
Notes: Data include youth ages 12 to 25. Suicides by children under age 12 are rare and not reported separately in the data.

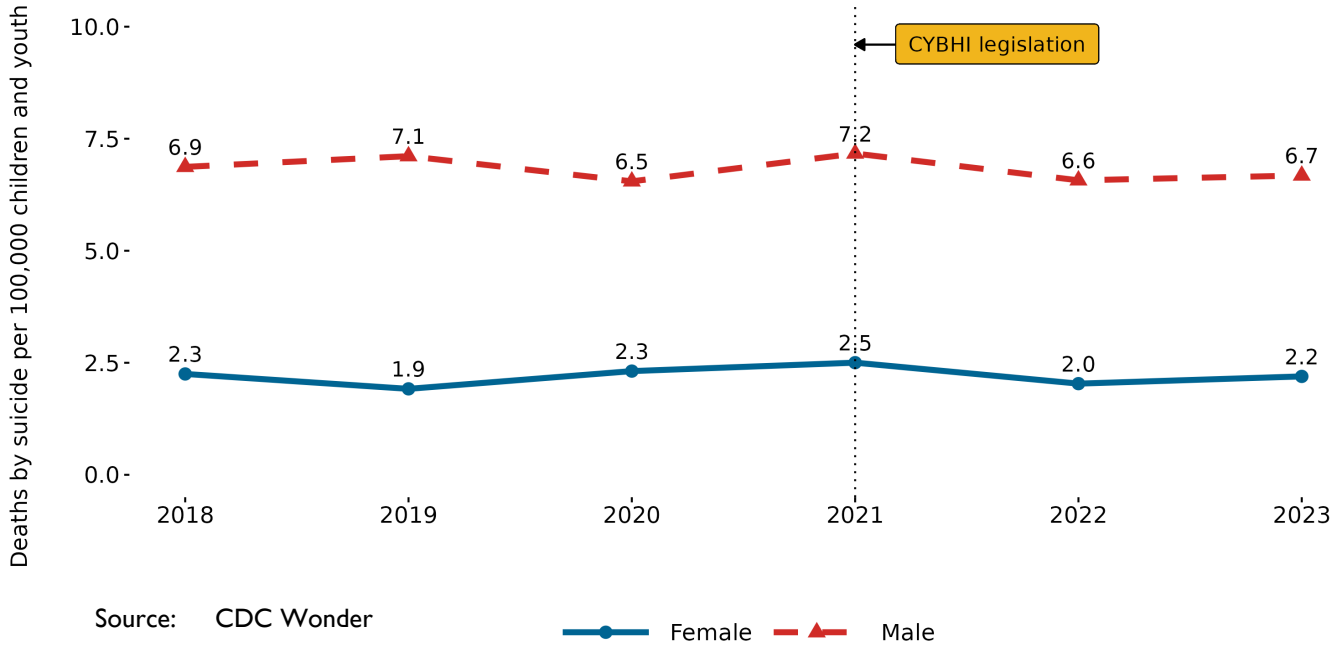
FEMALES WERE ALMOST TWO TIMES MORE LIKELY TO CONSIDER SUICIDE, BUT MALES HAD A HIGHER DEATH BY SUICIDE RATE: THREE TIMES THE RATE OF FEMALE DEATH BY SUICIDE IN 2023

Percentage of 9th- and 11th-grade students who seriously considered suicide during past 12 months, by gender



Source: CHKS, core module of biennial surveys, 2017–19 and 2019–21.
Notes: Data come from 9th- and 11th-grade student responses that are weighted to be representative of the state.

Deaths by suicide per 100,000 children and youth ages 0 to 25, by sex



Source: CDC Wonder

The difference by sex in deaths by suicide was smaller in California than in the rest of the United States. In 2023, the sex-related disparity in California was 4.5 deaths per 100,000 compared with the U.S. sex-related disparity of 7.6 per 100,000.

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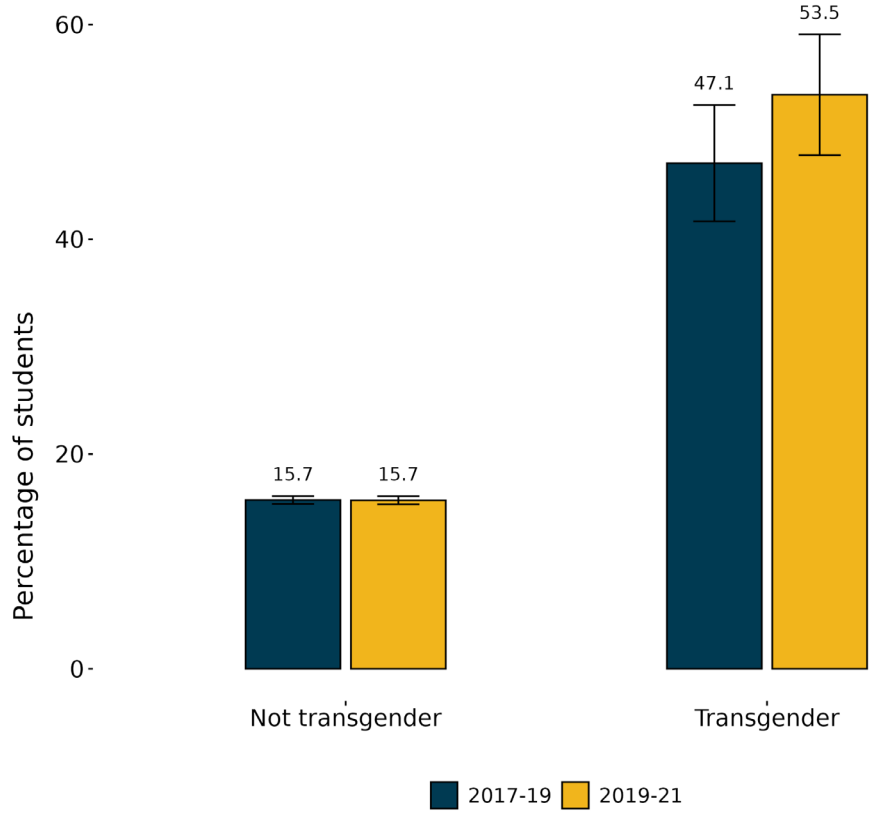
STUDENTS WHO IDENTIFY AS TRANSGENDER WERE ABOUT THREE TIMES MORE LIKELY TO SERIOUSLY CONSIDER SUICIDE THAN PEERS WHO DO NOT IDENTIFY AS TRANSGENDER

Percentage of 9th- and 11th-grade students who seriously considered suicide during the past 12 months, by transgender identity



Source: CHKS, core module of biennial surveys, 2017–19 and 2019–21.
Notes: Data come from 9th- and 11th-grade student responses that are weighted to be representative of the state.

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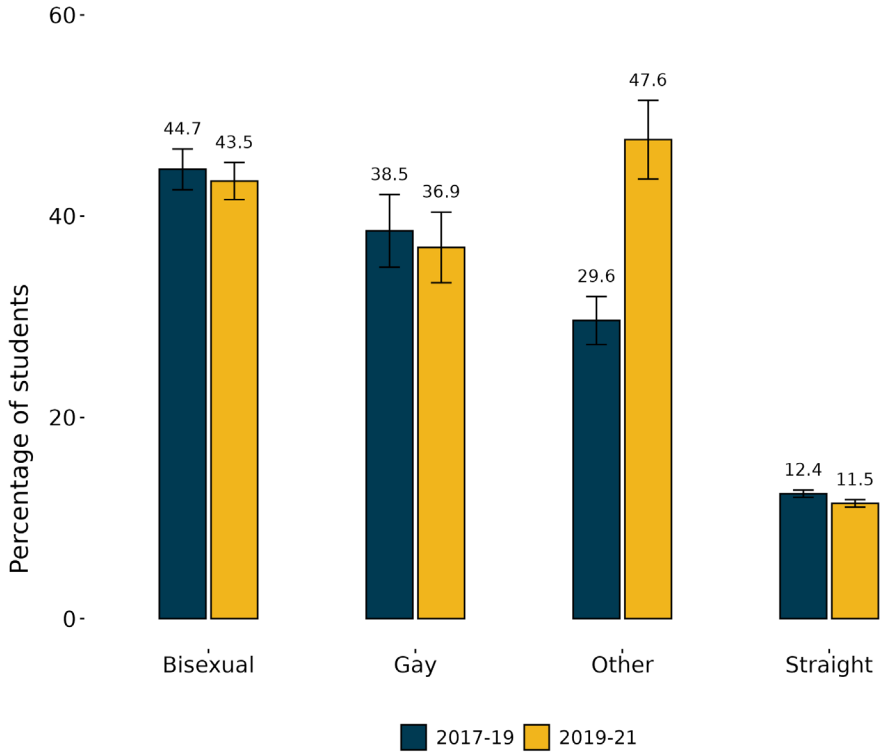
STUDENTS WHO IDENTIFY AS BISEXUAL OR GAY WERE MORE THAN THREE TIMES MORE LIKELY TO SERIOUSLY CONSIDER SUICIDE THAN THEIR PEERS WHO IDENTIFY AS STRAIGHT

Percentage of 9th- and 11th-grade students who seriously considered suicide during past 12 months, by sexual orientation

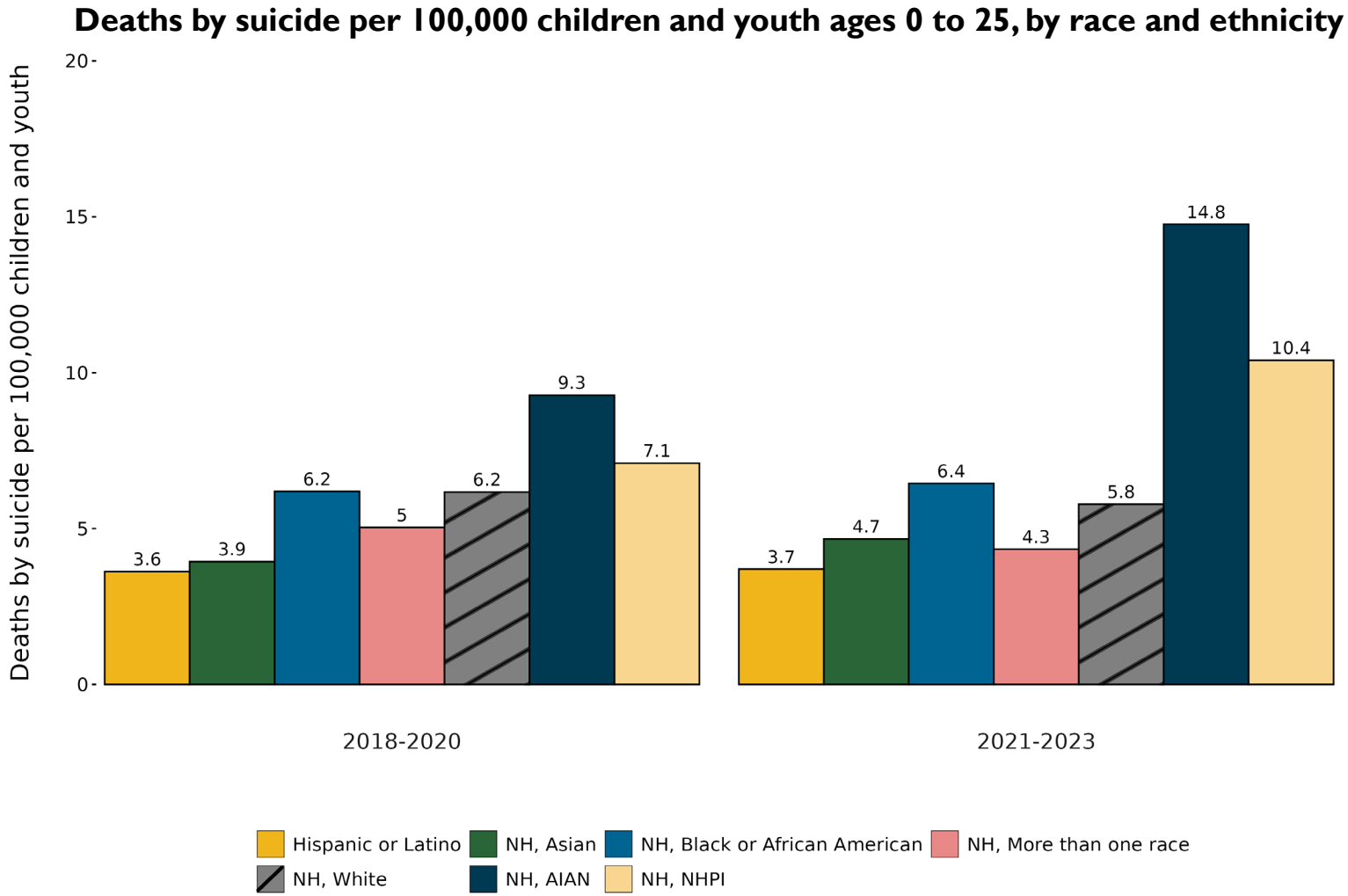
Students had the option of answering "other" when reporting their sexual orientation starting in 2016–2017. This category may include youth who identify as an orientation not listed in the survey, such as asexual. "Other" may also include youth who are unsure or feel their identity is fluid. LGBTQ+ youth who do not neatly fit into categories of straight or gay, including bisexual youth, often feel misunderstood and excluded from both LGBTQ+ and non-LGBTQ+ spaces.[d] In addition, women were much more likely to identify as bisexual than men were.[e] These factors may be considered when noting the rates of suicidal ideation for bisexual students, as well as the rates for students reporting "other."



Source: CHKS, core module of biennial surveys, 2017–19 and 2019–21.
Notes: Data come from 9th- and 11th-grade student responses that are weighted to be representative of the state. Sexual orientation of "other" was not an option before 2016–2017.

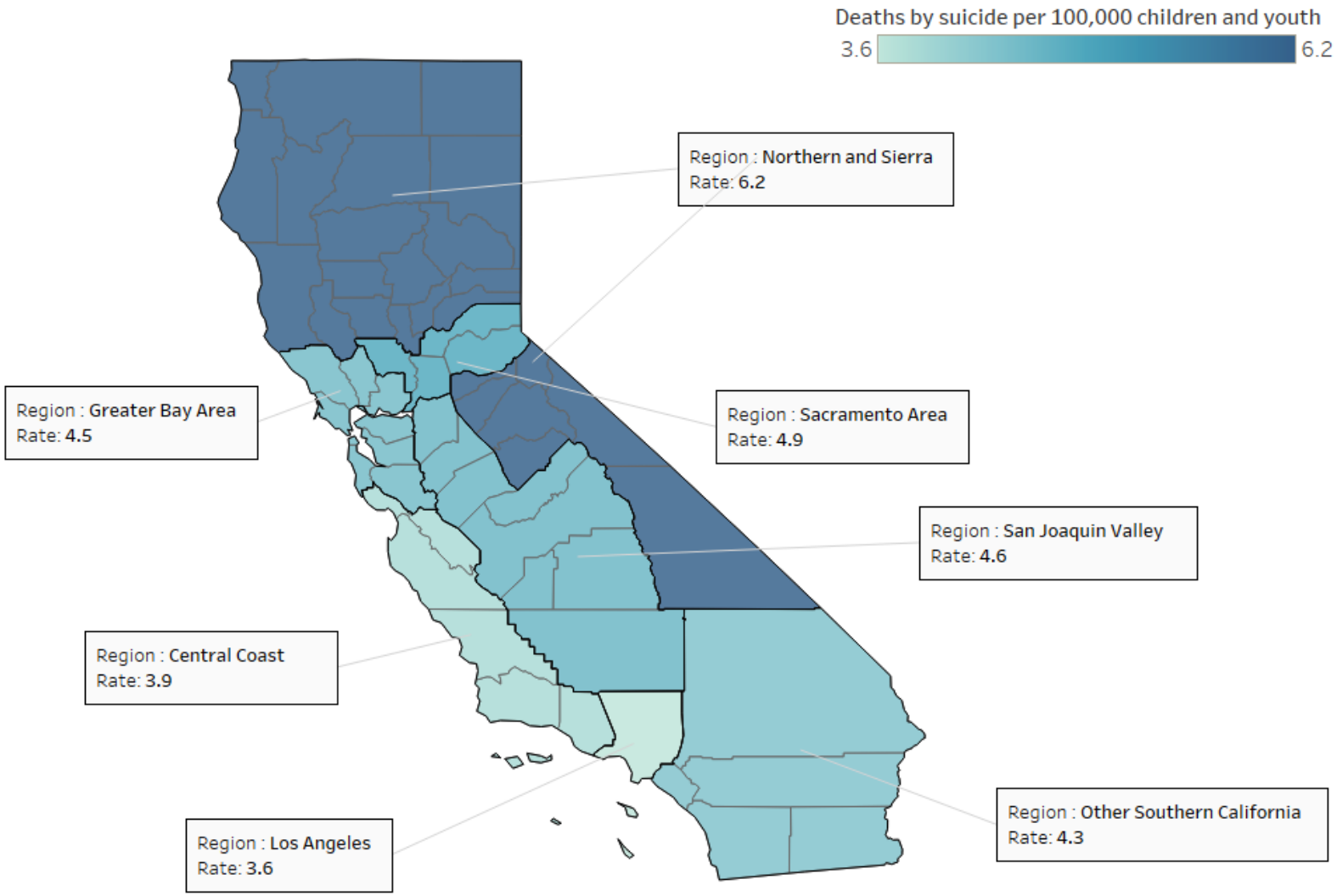
CHILDREN AND YOUTH WHO IDENTIFY AS AI/AN HAD THE HIGHEST RATES OF DEATH BY SUICIDE FOLLOWED BY NH/PI; THOSE WHO IDENTIFY AS HISPANIC HAD THE LOWEST RATES

Due to the lower overall population size of AI/AN and NH/PI children, the number of deaths is lower and suppressed in annual data to preserve anonymity. Thus, we aggregated death rates over three years.



Source: CDC Wonder.

Deaths by suicide per 100,000 children and youth ages 0 to 25, by region



YOUTH IN THE NORTHERN AND SIERRA REGION HAD THE HIGHEST RATE OF DEATH BY SUICIDE IN 2023

Source: CDC Wonder.

4. Decrease in ED visits and hospitalizations for children and youth with behavioral health-related conditions

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METRICS FOR OUTCOME 4

Metric (Health Care Access and Information [HCAI] ED and inpatient data; ages 0 to 25)*
Emergency department visits per 1,000 children and youth for any behavioral health diagnosis
Emergency department visits per 1,000 children and youth for nonfatal overdose overall
Emergency department visits per 1,000 children and youth for self harm
Inpatient hospitalization stays per 1,000 children and youth for any behavioral health diagnosis
Inpatient hospitalization stays per 1,000 children and youth for nonfatal overdose overall
Inpatient hospitalization stays per 1,000 children and youth for self harm

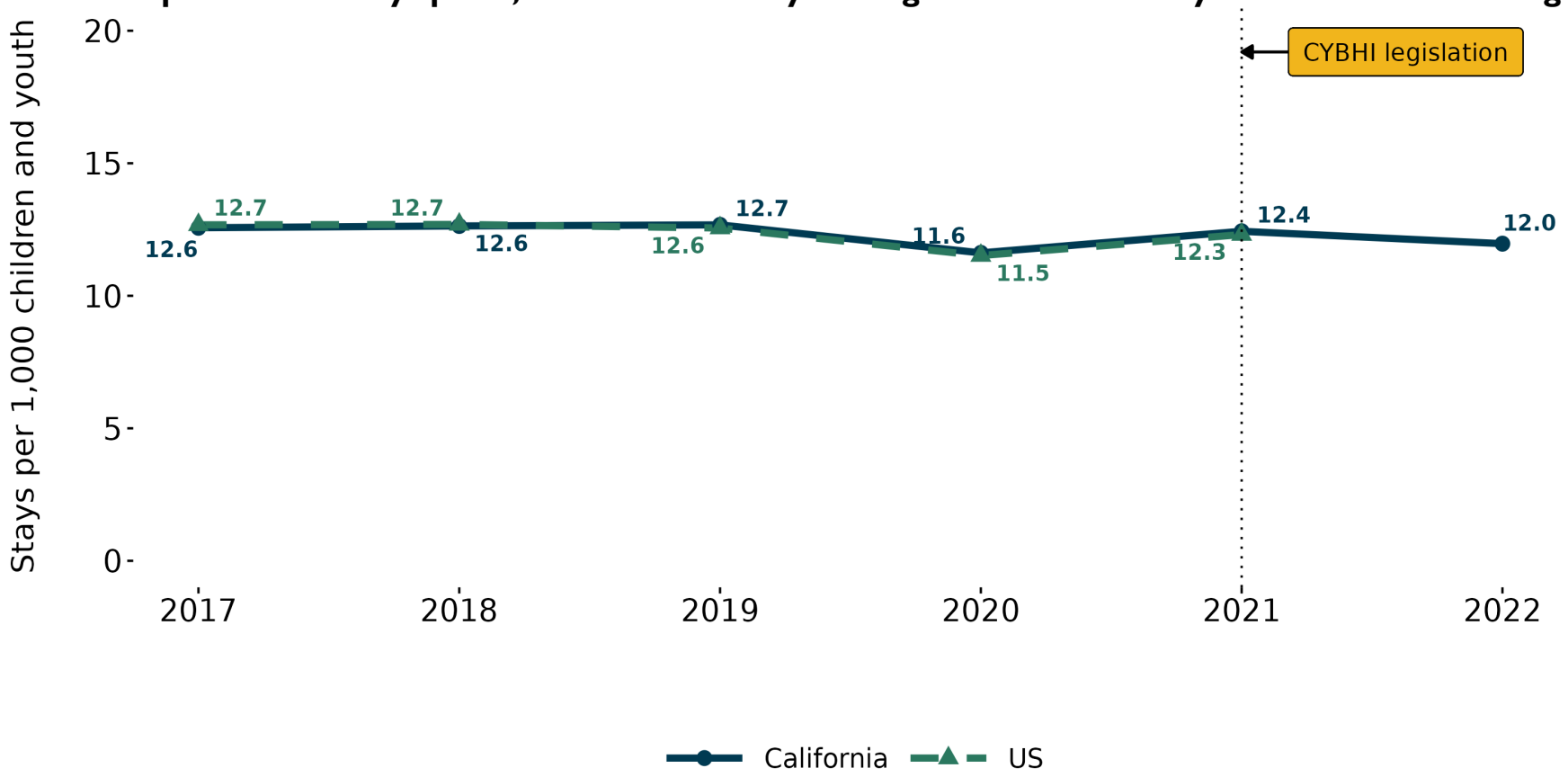
* See Appendix C for more information on metrics definitions.

4. KEY TAKEAWAYS: OVERALL POPULATION

- **Any behavioral health condition:** ED visit and inpatient hospitalization rates decreased slightly from 2021 to 2022. Inpatient hospitalizations in California are very similar to the United States, while ED rates in California are lower than in the United States.
  - Inpatient hospitalizations for MH were slightly higher in California compared with the United States, while ED visits for MH were lower than in United States. In California for both acute care setting, rates slightly declined from 2021 to 2022.
  - Inpatient hospitalizations and ED visits for SUD in California are lower than in the United States and slowly decreasing over time.
- **Self-harm:** ED visit and inpatient hospitalization rates increased. Inpatient hospitalization rates were higher in California compared with the United States, while ED visits rates were lower.
- **Nonfatal overdoses (overall)**: ED visit rates increased, and inpatient hospitalization increased slightly.
  - **Nonfatal overdoses (opioids):** ED visit rates increased substantially, whereas inpatient hospitalization rates remained unchanged.

RATES OF INPATIENT HOSPITALIZATIONS FOR ANY BEHAVIORAL HEALTH CONDITION WERE VERY SIMILAR BETWEEN CA AND THE U.S.

Inpatient hospitalization stays per 1,000 children and youth ages 0 to 25 with any behavioral health diagnosis



Source: California Department of HCAI and the Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) National Inpatient Sample (NIS), 2017-2021.

Note: Data from the AHRQ HUCP NIS is used as the national comparison include California. The national files do not have the information necessary to remove the state of California for comparison. National data are not available for 2022 at present.

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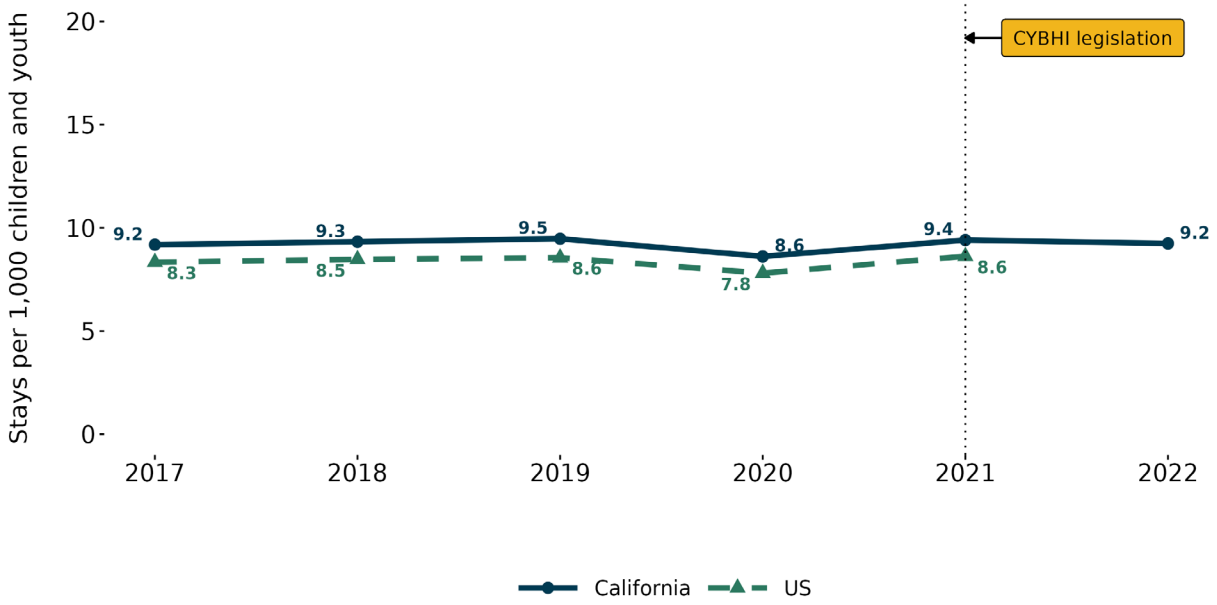
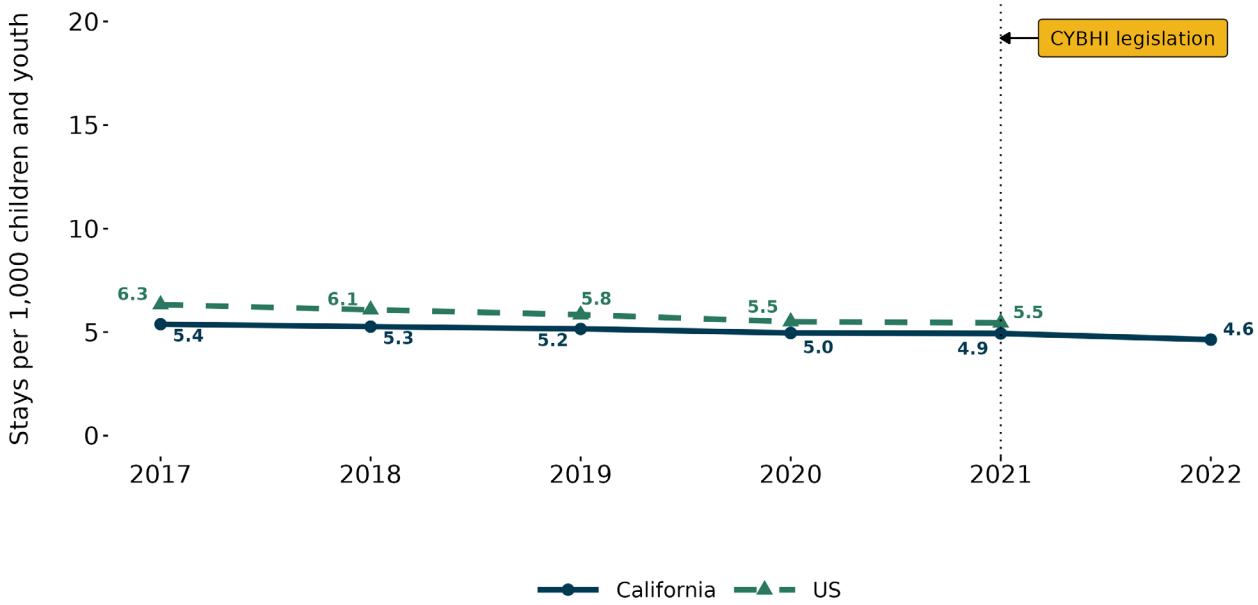
RATES OF INPATIENT HOSPITALIZATIONS FOR MH WERE SLIGHTLY HIGHER IN CA COMPARED WITH THE U.S., WHILE RATES OF SUD WERE SLIGHTLY LOWER

Inpatient hospitalization stays per 1,000 children and youth ages 0 to 25 with any MH diagnosis



Inpatient hospitalization stays per 1,000 children and youth ages 0 to 25 with any SUD diagnosis



Source: California Department of HCAI and the Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) National Inpatient Sample (NIS), 2017-2021.

Note: Data from the AHRQ HUCP NIS is used as the national comparison include California. The national files do not have the information necessary to remove the state of California for comparison. National data are not available for 2022 at present.

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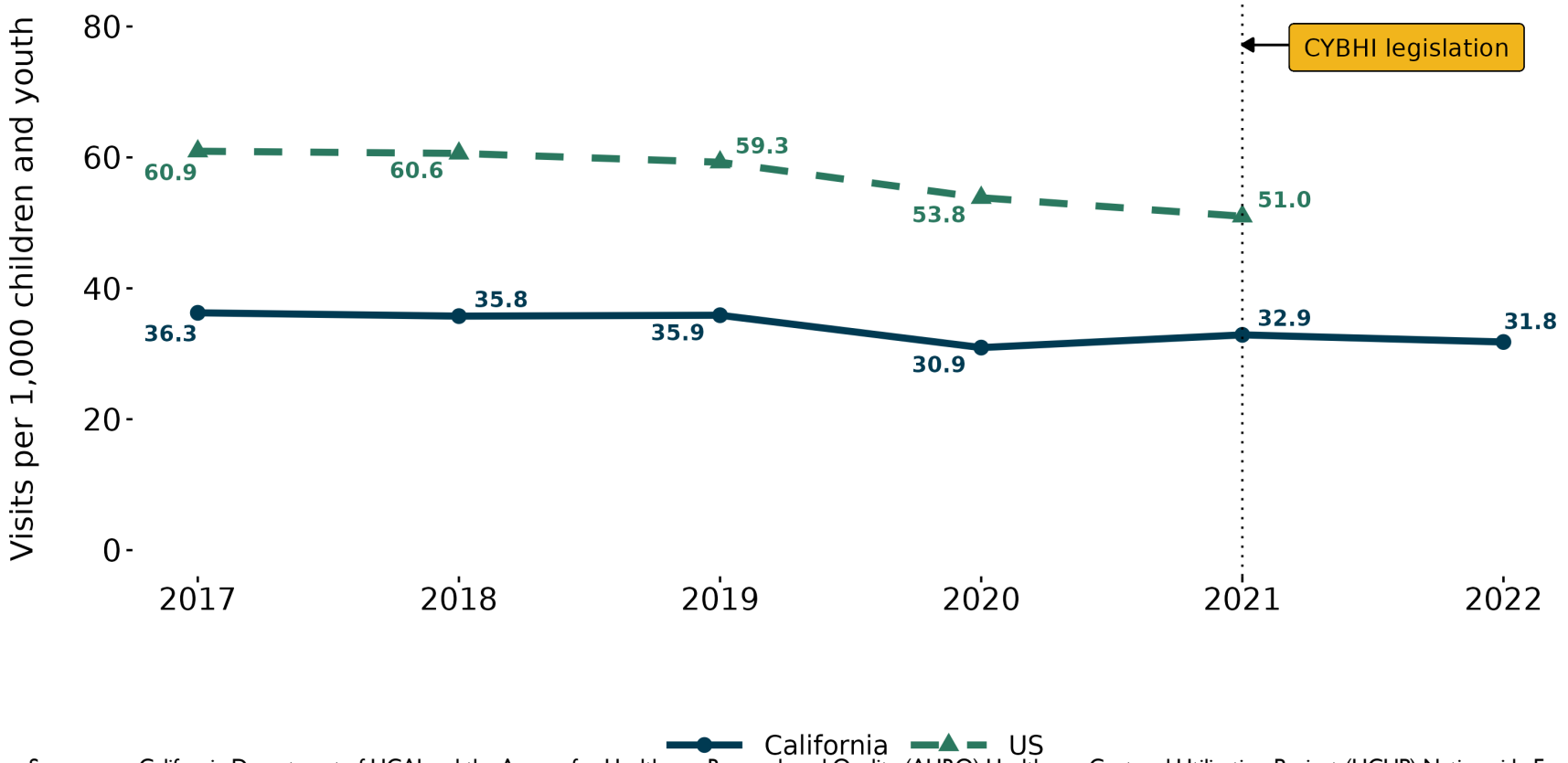
RATES OF ED VISITS FOR ANY BEHAVIORAL HEALTH CONDITION WERE DECREASING, AND RATES IN CA WERE LOWER COMPARED WITH THE U.S. IN 2021

ED visits per 1,000 children and youth ages 0 to 25 with any behavioral health diagnosis



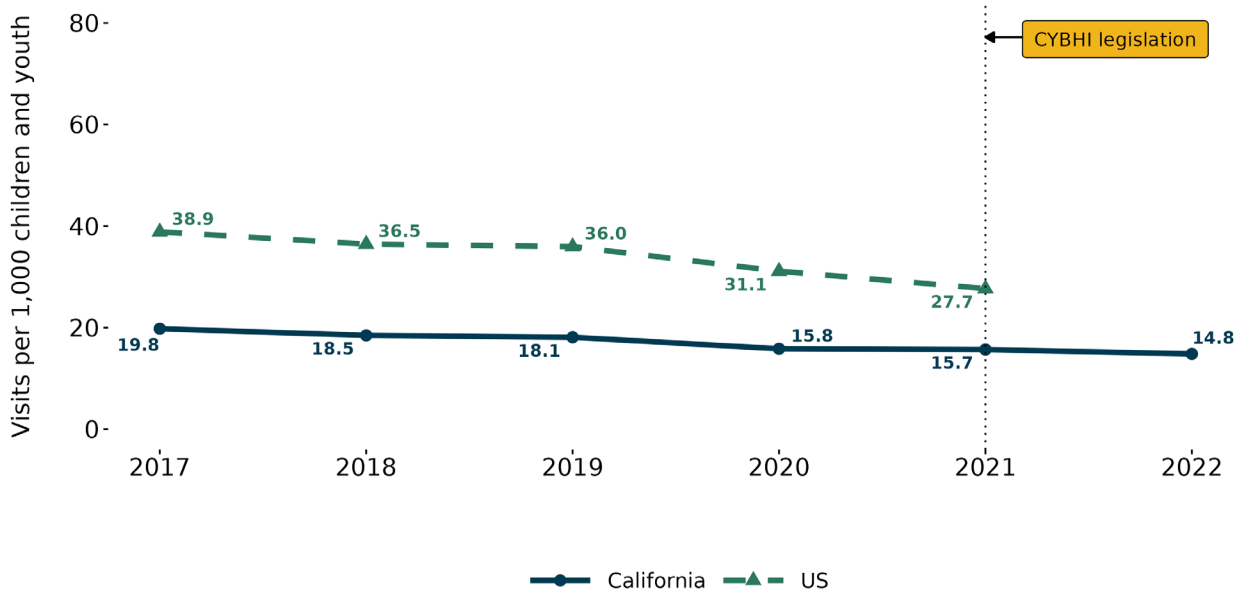
Source: California Department of HCAI and the Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) Nationwide Emergency Department Sample (NEDS), 2017-2021.

Note: Data from the AHRQ HCUP NEDS is used as the national comparison include California. The national files do not have the information necessary to remove the state of California for comparison. National data are not available for 2022 at present.

RATES OF ED VISITS FOR MH AND SUD WERE LOWER IN CA COMPARED WITH THE U.S. AND DECREASED SLIGHTLY FROM 2017 TO 2022

ED visits per 1,000 children and youth ages 0 to 25 old with any MH diagnosis

ED visits per 1,000 children and youth ages 0 to 25 with any SUD diagnosis



Source: California Department of HCAI and the Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) Nationwide Emergency Department Sample (NEDS), 2017-2021.

Note: Data from the AHRQ HCUP NEDS is used as the national comparison include California. The national files do not have the information necessary to remove the state of California for comparison. National data are not available for 2022 at present.

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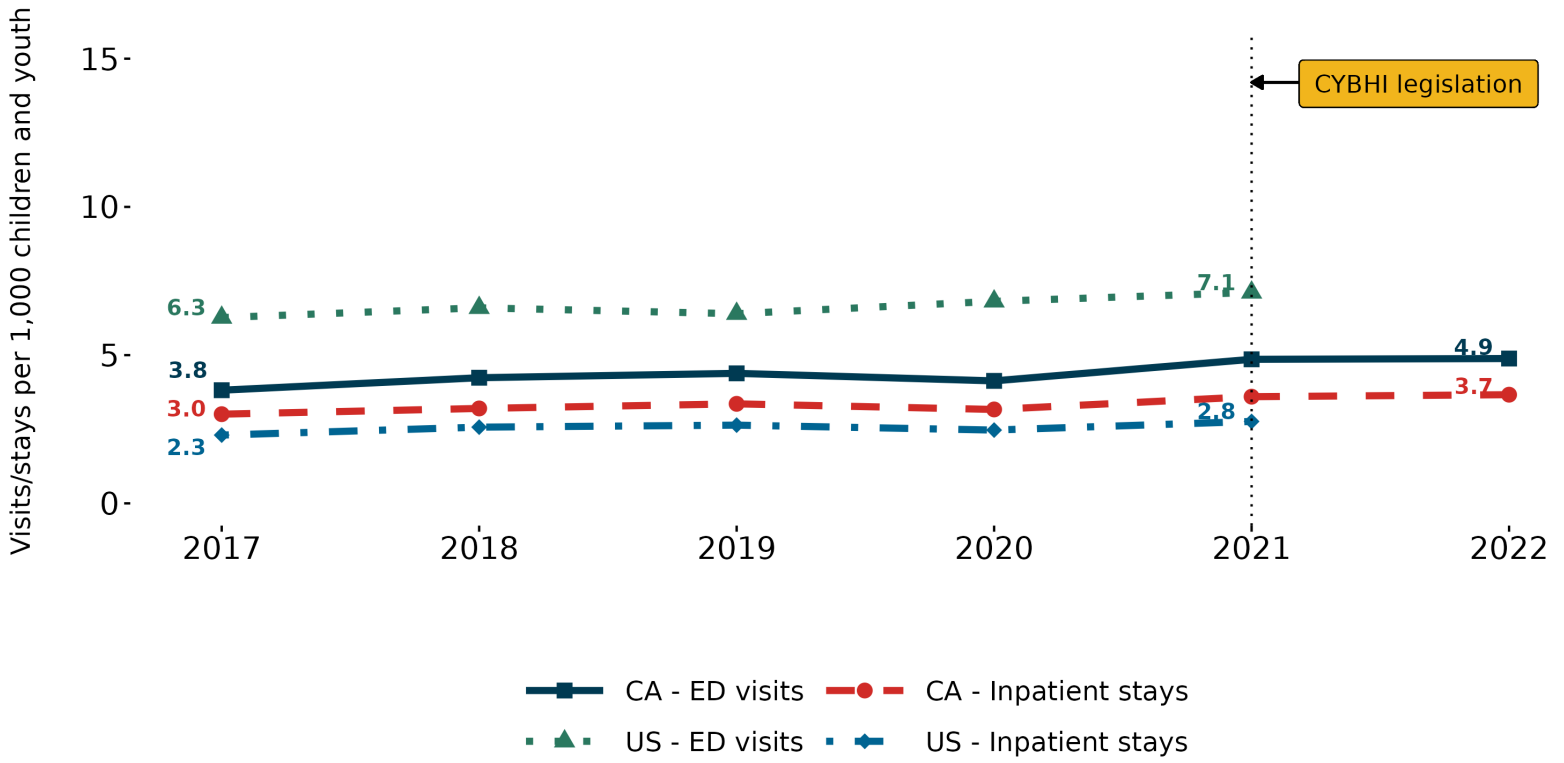
COMPARED TO THE U.S., RATES OF HOSPITALIZATIONS FOR SELF-HARM WERE HIGHER IN CA, WHILE RATES OF ED VISITS FOR SELF-HARM WERE LOWER; BOTH HOSPITALIZATIONS AND ED VISITS FOR SELF-HARM WERE INCREASING

Acute-care stays/visits per 1,000 children and youth ages 0 to 25 for self-harm, by acute-care setting

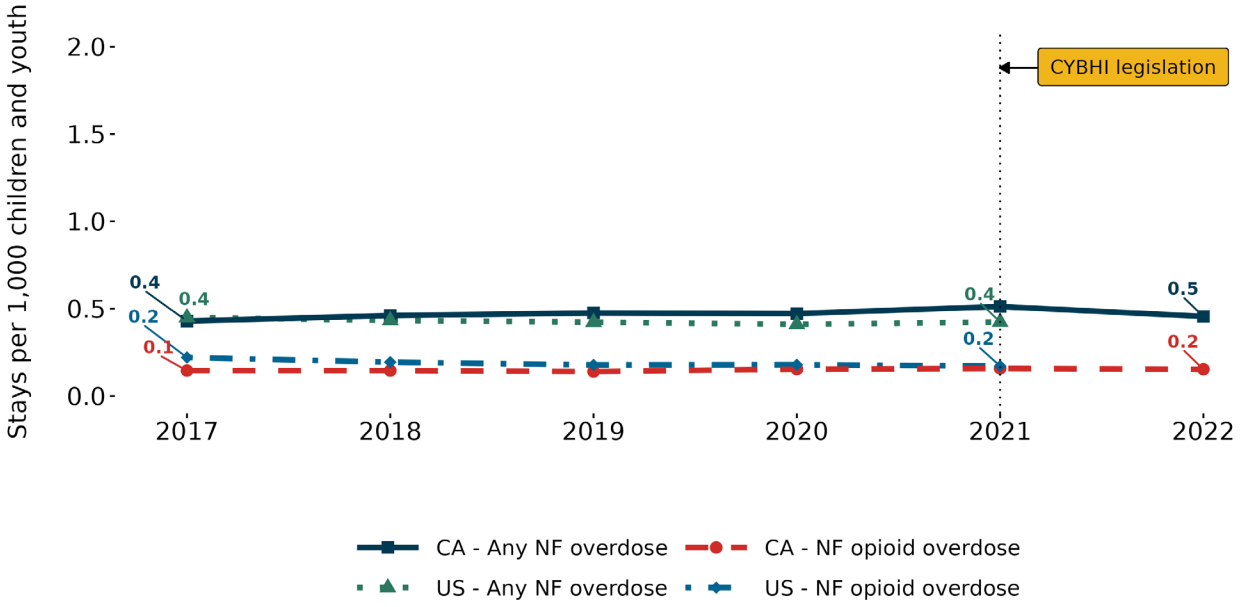


Source: California Department of HCAI and the Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) Nationwide Emergency Department Sample (NEDS), 2017-2021 and National Inpatient Sample (NIS), 2017-2021.

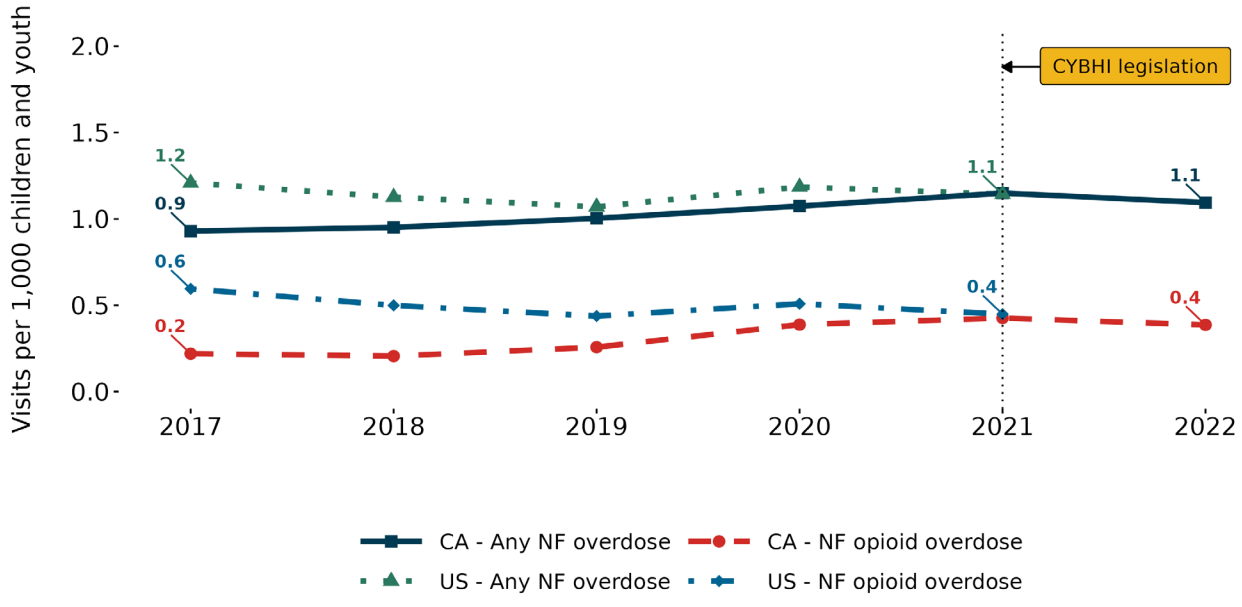
Note: The self-harm measure definition we used comes from the California Department of Public Health and is based on a definition from the Council of State and Territorial Epidemiologists used to identify "nonfatal intentional self-harm emergency department visits," including suicide attempts and suicidal ideation. Data from the Healthcare Cost and Utilization Project used as the national comparison include California. The national files do not have the information necessary to remove the state of California for comparison. National data are not available for 2022 at present.

INPATIENT HOSPITALIZATIONS FOR NONFATAL OVERDOSES WERE SIMILAR BETWEEN CA AND THE U.S.

Inpatient hospitalization stays per 1,000 children and youth ages 0 to 25 for nonfatal overdose and nonfatal opioid overdose



ED visits per 1,000 children and youth ages 0 to 25 for nonfatal overdose and nonfatal opioid overdose



Source: California Department of HCAI and the Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) Nationwide Emergency Department Sample (NEDS), 2017-2021 and National Inpatient Sample (NIS), 2017-2021.

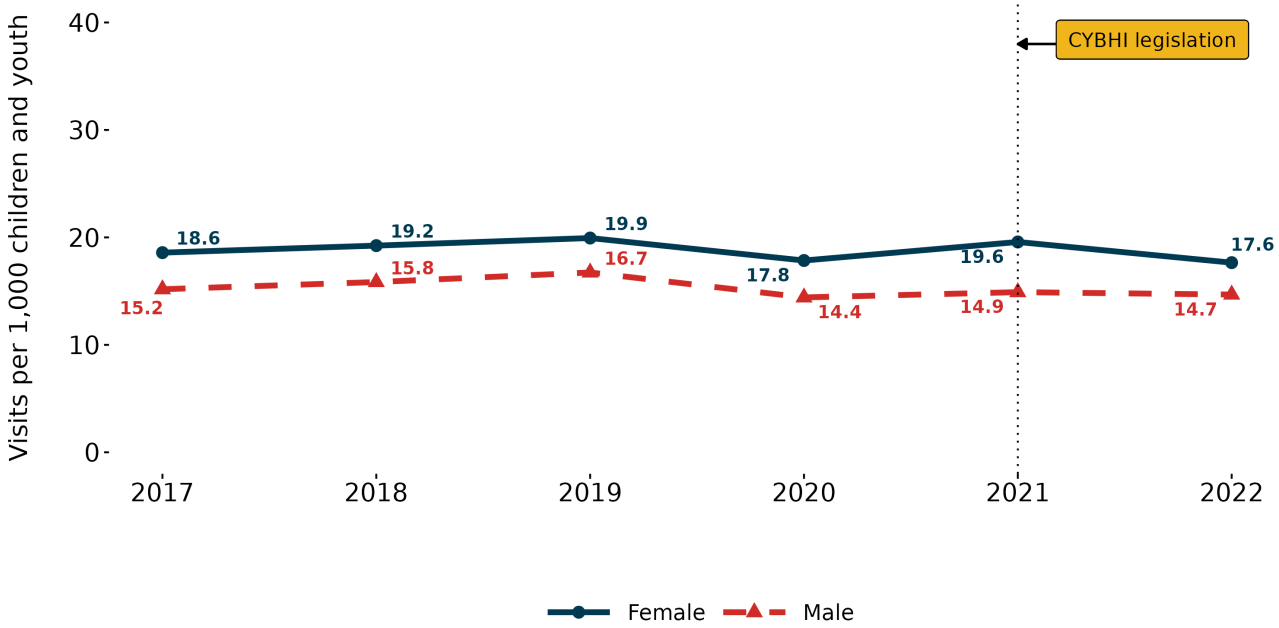
Note: NF = nonfatal. Data from the AHRQ HCUP NEDS and NIS are used as the national comparison include California. The national files do not have the information necessary to remove the state of California for comparison. National data are not available for 2022 at present.

4. KEY TAKEAWAYS: DISPARITIES AND SUBGROUP DIFFERENCES

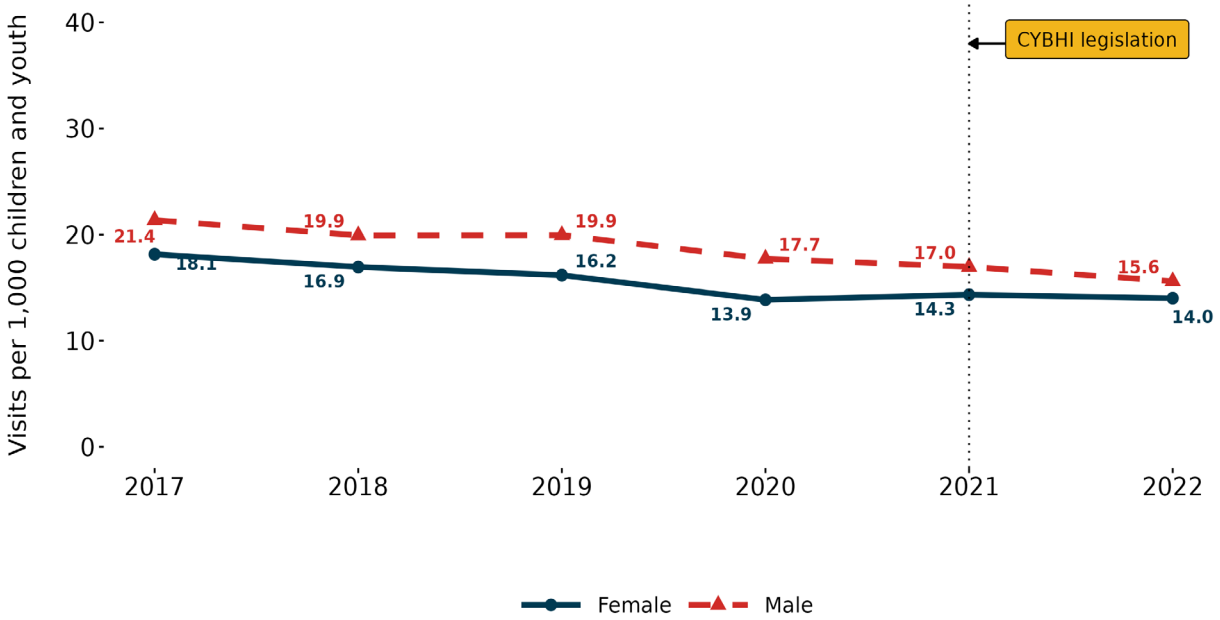
- **Age**
  - ED visits for any behavioral health diagnosis were highest for 18- to 25-year-olds. Rates decreased slightly from 2021 to 2022 for 18- to 25-year-olds but slightly increased for 12- to 17-year-olds.
  - ED visits for self harm were highest among 12- to 17-year-olds and increased from 2021 to 2022, and rates for 18- to 25-year-olds slightly declined.
- **Race and ethnicity:**
  - Children and youth who identify as Black had the highest ED visit and inpatient hospitalization rates with any behavioral health diagnosis, nearly double the rate of the next highest group.
  - Children and youth who identify as Black also had the highest ED visit and inpatient hospitalization rates for self-harm and nonfatal overdoses (overall).
  - Children and youth who identify as AI/AN had the highest ED visit rate for nonfatal opioid overdoses, increasing 72% from 2021 to 2022.
- **Region:** Northern and Sierra counties had the highest ED visit and inpatient hospitalization rates with behavioral health diagnoses in 2022—about double that of Los Angeles, the region with the lowest rates.

ED VISITS FOR MH WERE HIGHER AMONG FEMALES, AND ED VISITS FOR SUD WERE HIGHER AMONG MALES

ED visits per 1,000 children and youth ages 0 to 25 for MH diagnoses, by sex



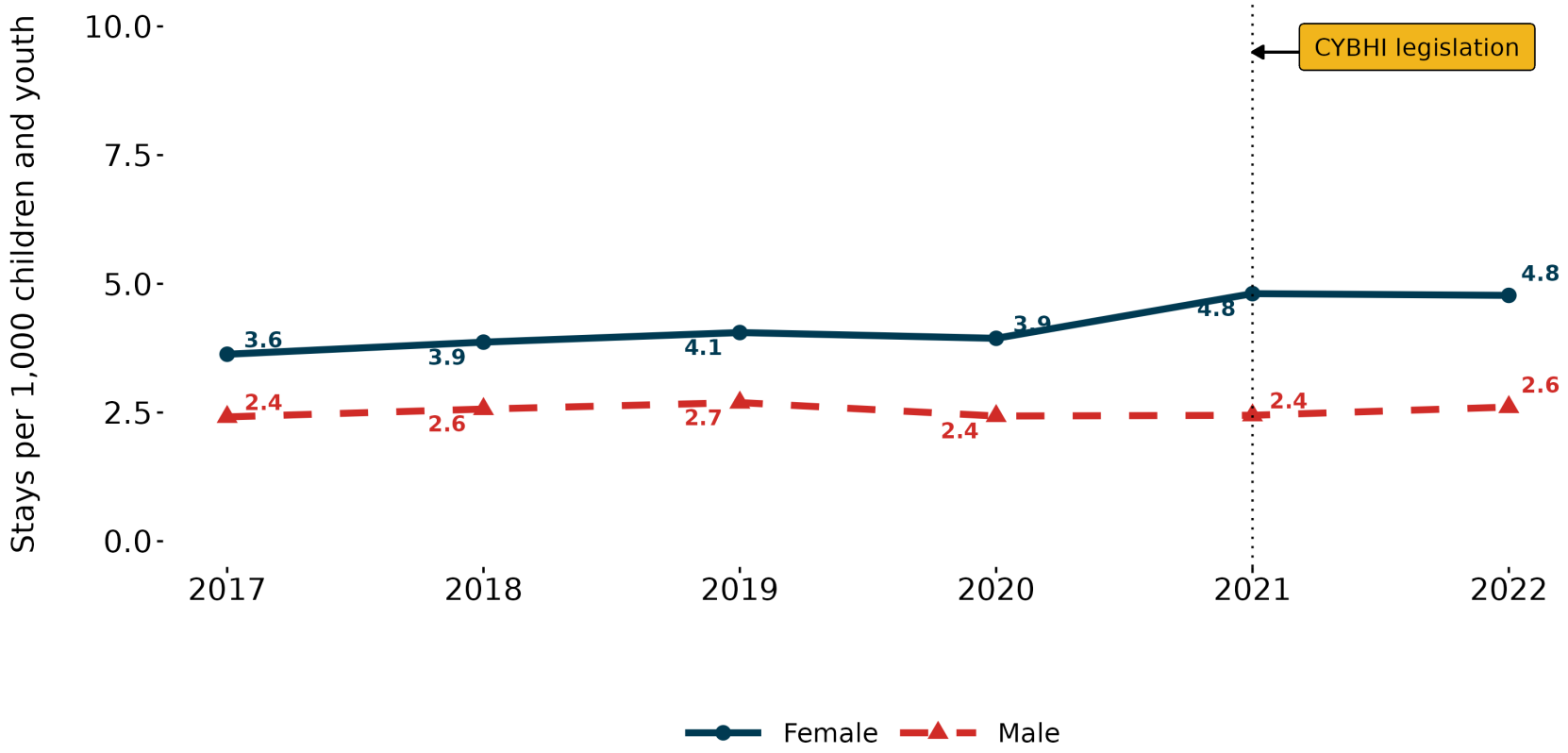
ED visits per 1,000 children and youth ages 0 to 25 for SUD diagnoses, by sex



Source: California Department of HCAI.

HOSPITALIZATIONS FOR SELF-HARM ARE HIGHER AMONG FEMALES AND INCREASED FROM 2020 TO 2022, BUT THEY WERE RELATIVELY UNCHANGED FOR MALES

Inpatient hospitalization stays per 1,000 children and youth ages 0 to 25 for self-harm, by sex

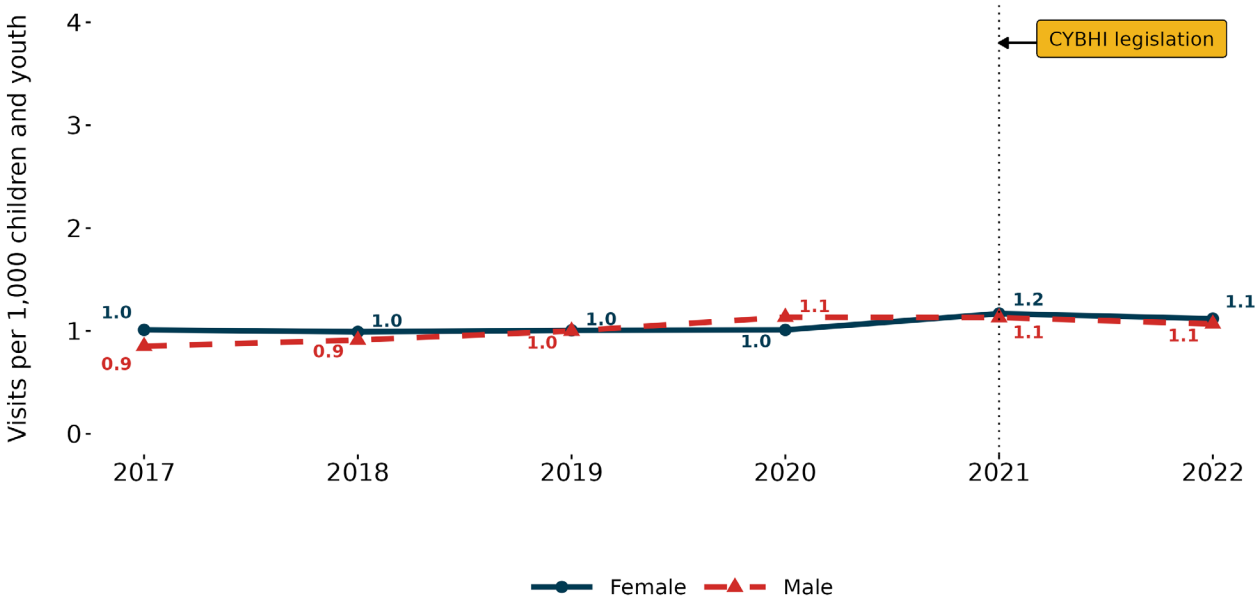


Trends in ED visits by sex were similar.

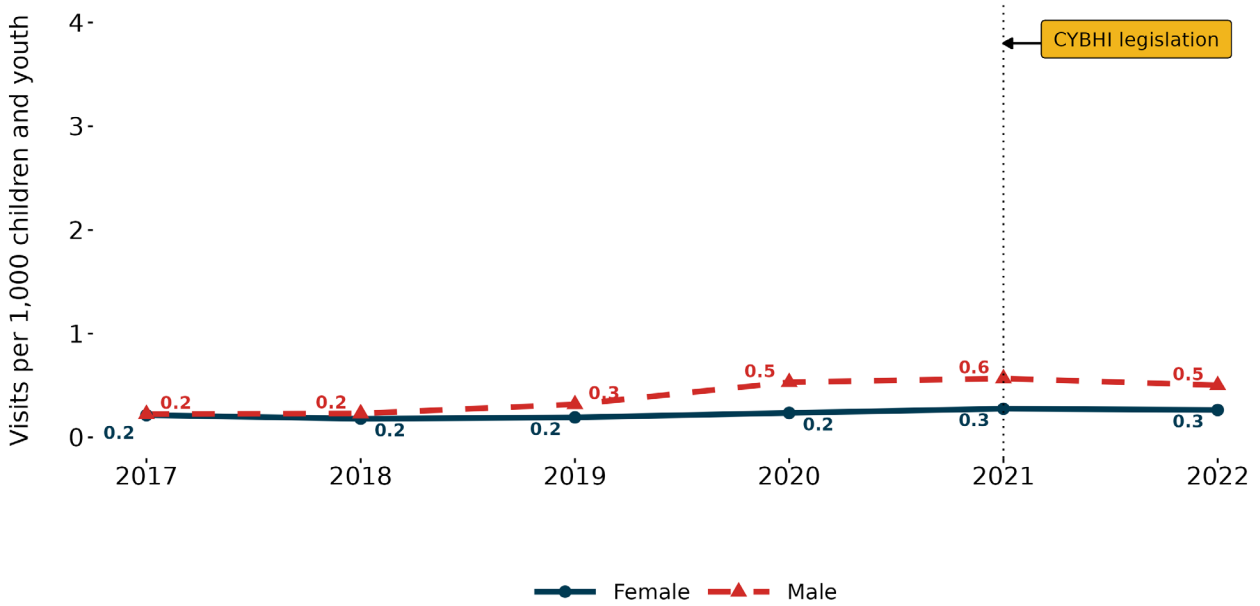
Source: California Department of HCAI.
Note: The self-harm measure definition we used comes from the California Department of Public Health and is based on a definition from the Council of State and Territorial Epidemiologists used to identify "nonfatal intentional self-harm emergency department visits," including suicide attempts and suicidal ideation.

ED VISITS FOR NONFATAL OVERDOSES WERE SIMILAR FOR MALES AND FEMALES, AND ED VISITS FOR NONFATAL OPIOID OVERDOSES INCREASED FOR MALES AND FEMALES

ED visits per 1,000 children and youth ages 0 to 25 for nonfatal overdose, by sex



ED visits per 1,000 children and youth ages 0 to 25 for nonfatal opioid overdose, by sex

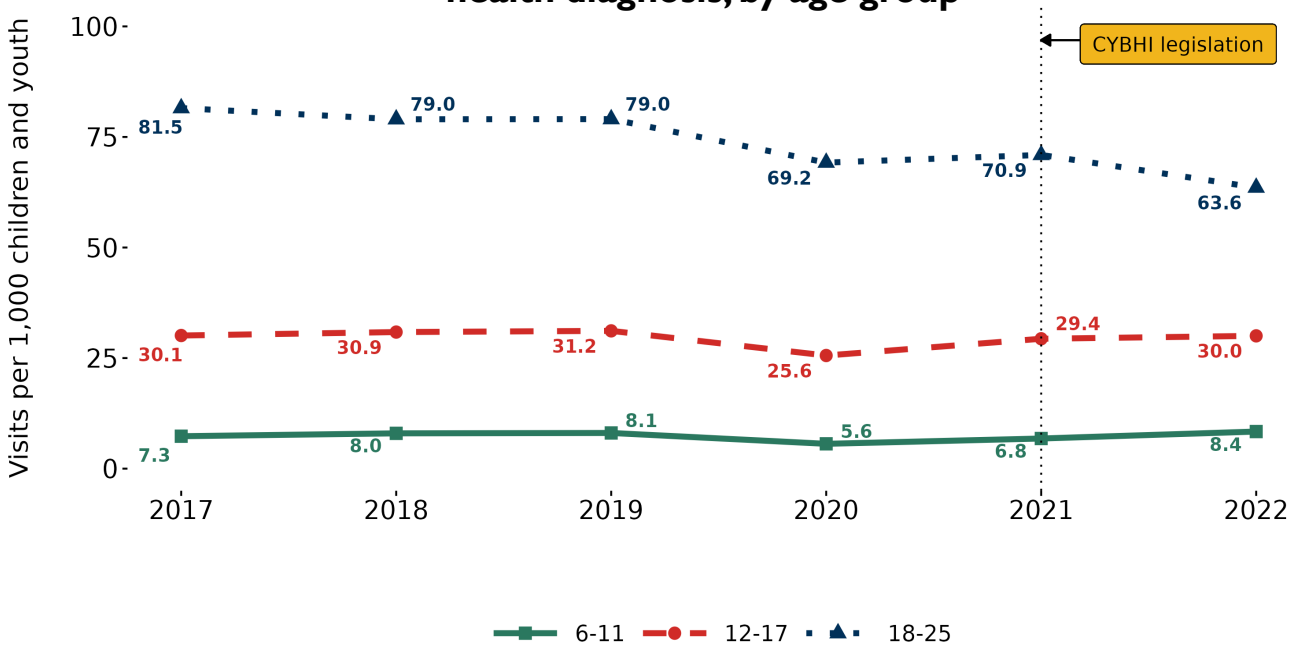


Trends in inpatient stays by sex were similar.

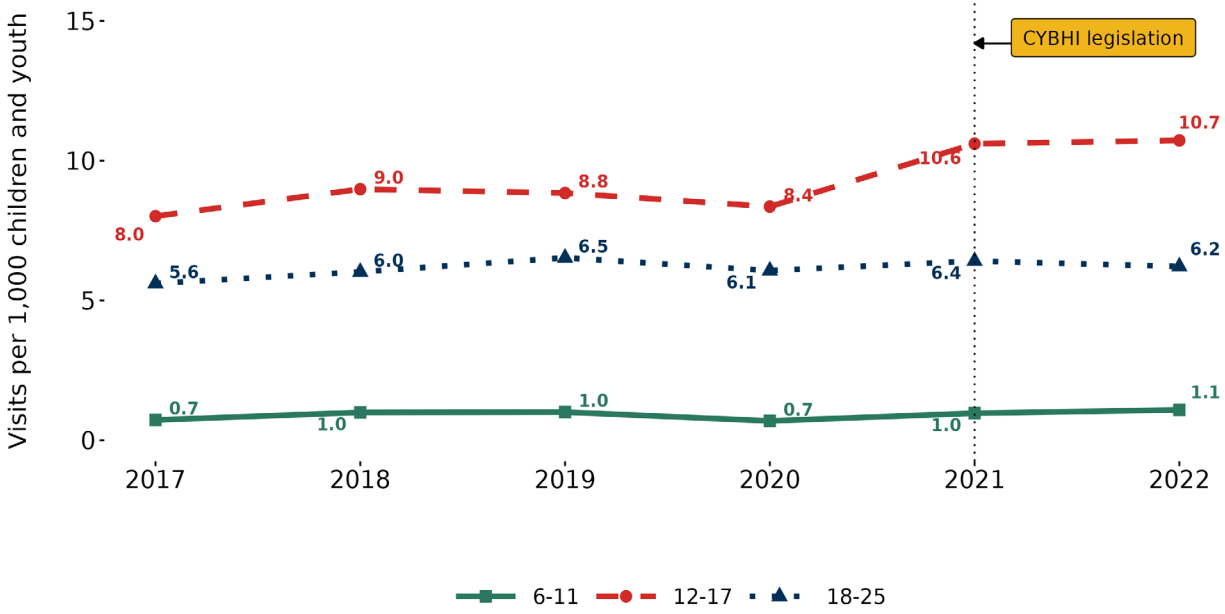
Source: California Department of HCAI.

ED VISITS FOR ANY BEHAVIORAL HEALTH DIAGNOSIS WERE HIGHEST FOR 18- TO 25-YEAR-OLDS, AND ED VISITS FOR SELF-HARM WERE HIGHEST FOR 12- TO 17-YEAR-OLDS

ED visits per 1,000 children and youth for any behavioral health diagnosis, by age group



ED visits per 1,000 children and youth for self-harm, by age group



Source: California Department of HCAI.

Note: The self-harm measure definition we used comes from the California Department of Public Health and is based on a definition from the Council of State and Territorial Epidemiologists used to identify "nonfatal intentional self-harm emergency department visits," including suicide attempts and suicidal ideation. Children ages 0 to 5 are not shown because their rates for self-harm rounded to 0. They are included in all other figures to encompass the entire 0-to-25 children and youth population but not as a separate age group in this figure for these measures.

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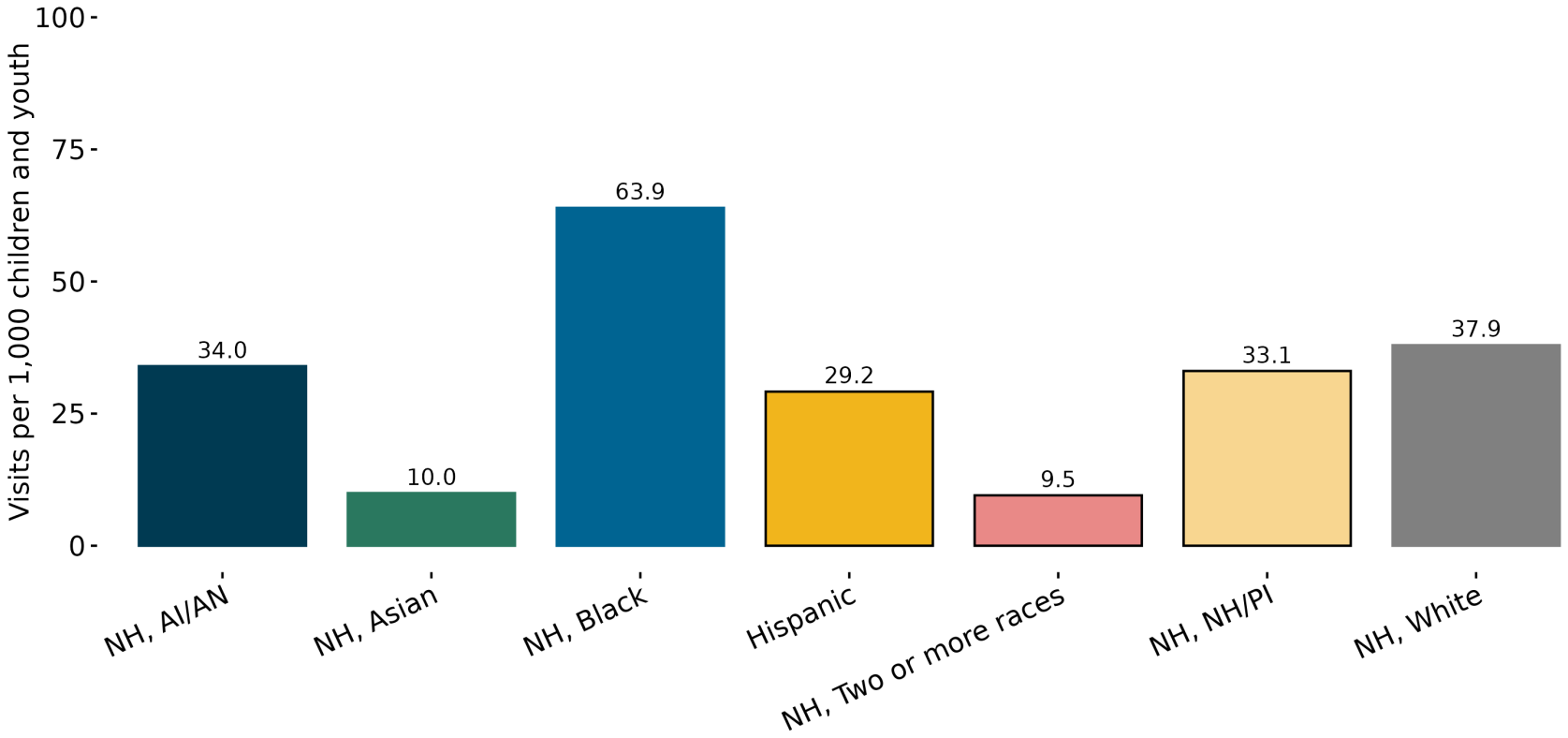
ED VISITS WITH ANY BEHAVIORAL HEALTH DIAGNOSIS WERE HIGHEST AMONG CHILDREN AND YOUTH WHO IDENTIFY AS BLACK

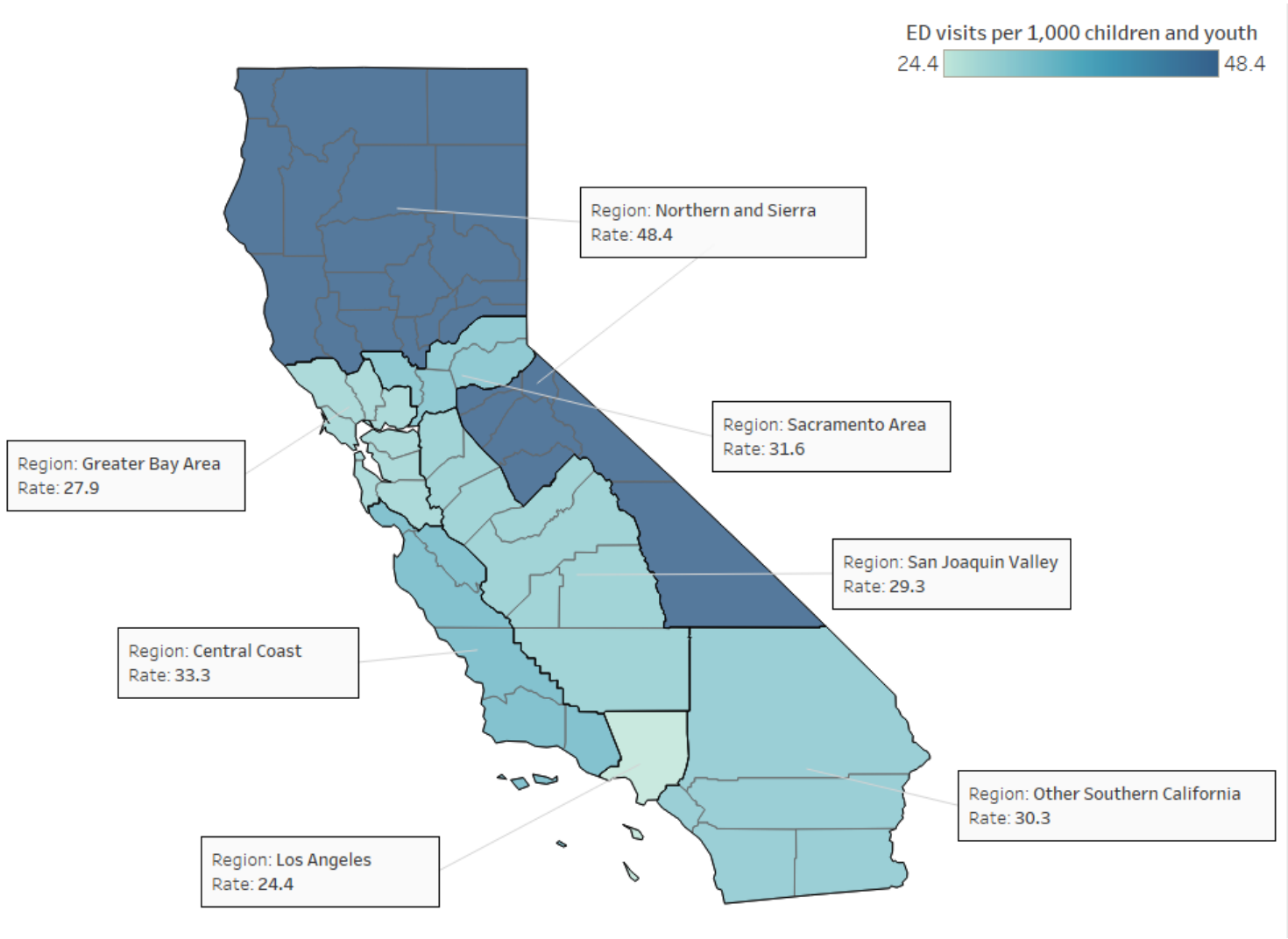
ED visits per 1,000 children and youth ages 0 to 25 with any behavioral health diagnosis, by race and ethnicity



A conceptual model for child MH and MH disparities posits four mechanisms as possible reasons for racial disparities in behavioral health diagnoses:[f] (1) socioeconomic status (e.g., low education and income), (2) childhood adversities (e.g., maltreatment, family violence), (3) family structure across development (e.g., single motherhood, early child-bearing, divorce, paternal involvement), and (4) neighborhood-level factors (e.g., residential composition, stability, segregation). Exposure to these factors vary by race and ethnicity as well as in their effect on children and youth.

Source: California Department of HCAI, 2021.
Note: NH = non-Hispanic.

ED visits per 1,000 children and youth ages 0 to 25 with any behavioral health diagnosis, by region



CHILDREN AND YOUTH IN THE NORTHERN AND SIERRA REGION HAD THE HIGHEST RATE OF ED VISITS WITH ANY BEHAVIORAL HEALTH DIAGNOSES IN 2022

Source: California Department of HCAI, 2021.

5. Increase in school engagement, as measured by reducing absenteeism

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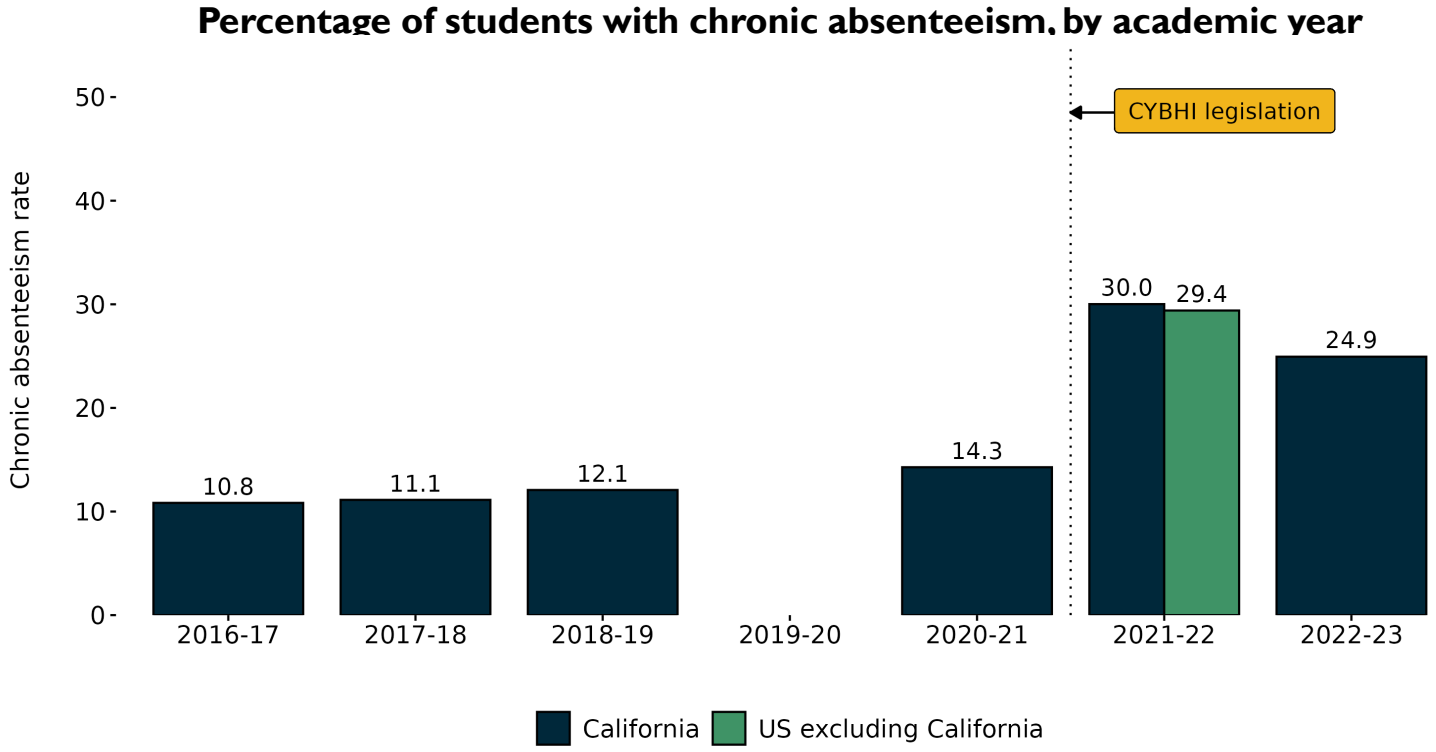
METRICS FOR OUTCOME 5

Metric (data sources; ages/grades)
Percentage of students who were chronically absent (California Department of Education; grades K–12)
Percentage of students with school absences due to mental health issues (CHKS Core; 7th, 9th, and 11th graders)
Percentage of students with school absences due to alcohol or drug use (CHKS Core; 7th, 9th, and 11th graders)

5. KEY TAKEAWAYS: OVERALL POPULATION

- **Chronic absenteeism rates:** Increased rates from academic year 2016–17 through a post-COVID-19 surge (2021–22) that has slightly decreased in 2022–23.
- **Absenteeism due to MH or substance use challenges:**
  - Absenteeism due to MH challenges was low (just under 10 percent) and declined from 2015–17 to 2017–19.
  - Absences due to alcohol or drug use were infrequent and slightly declined over this period.

CHRONIC ABSENTEEISM ROSE DRAMATICALLY—TO 30.0%—IN THE 2021–22 SCHOOL YEAR BUT DECREASED IN 2022–23



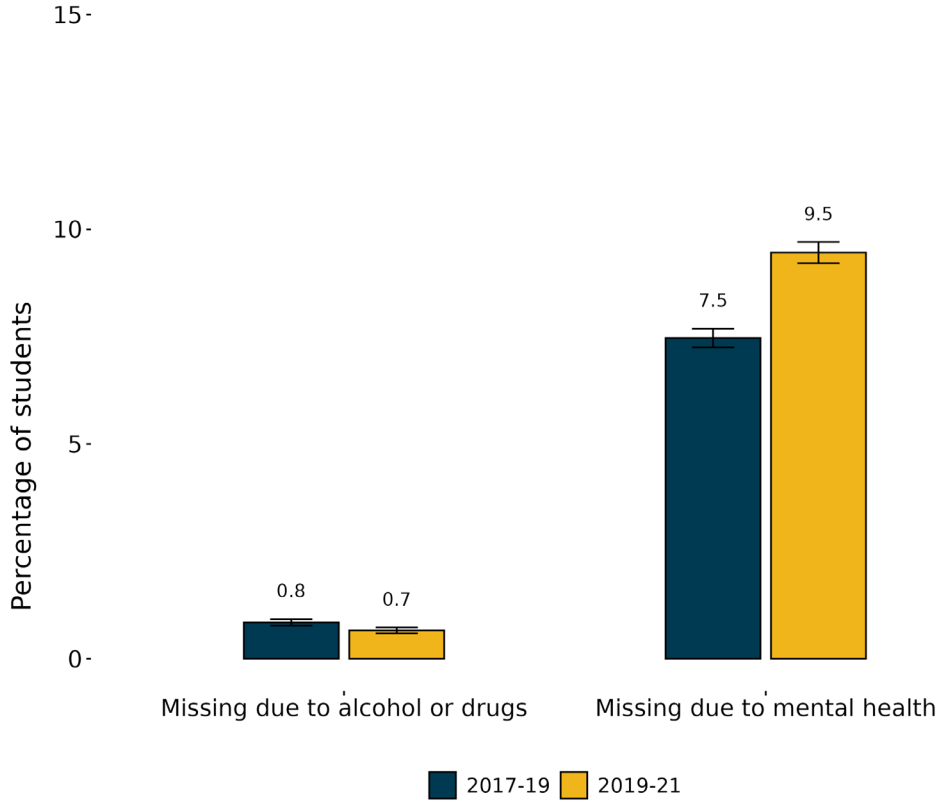
"Students who are chronically absent are missing critical instruction time and are at the greatest risk of falling behind and dropping out of school."[g]

Source: California Department of Education, U.S. Department of Education.

Notes: Chronic absenteeism is defined as having missed at least 10% of the school days in which the student was enrolled. Absenteeism data were not reliable for the 2019–20 school year because of the COVID-19 pandemic, and absenteeism data from the 2020–21 school year should be interpreted with caution because of distance learning. National comparison data were collected in the same way by the U.S. Department of Education. The data point here includes all states except California and includes the Bureau of Indian Education and Puerto Rico.

STUDENT ABSENCES DUE TO ALCOHOL OR DRUG USE WERE INFREQUENT; ABSENCES RELATED TO MH CHALLENGES DECREASED FROM 2016–17 TO 2018–19

Percentage of students who reported school absences due to MH issues or alcohol/drug use



Source: CHKS, core module of biennial surveys, 2017–19 and 2019–21.

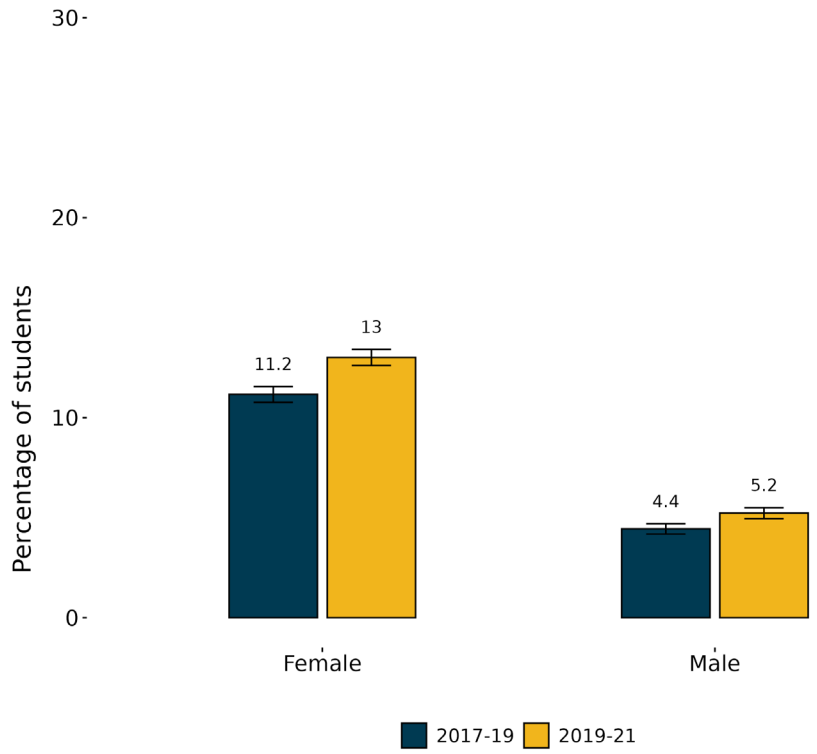
Notes: Data come from 7th-, 9th-, and 11th-grade student responses to the CHKS, which are weighted to be representative of the state. Students were asked if in the past 30 days they missed a day of school for any of the following reasons: (a) feeling very sad, hopeless, anxious, stressed, or angry and (b) used alcohol or drugs.

5. KEY TAKEAWAYS: DISPARITIES AND SUBGROUP DIFFERENCES

- **Gender:**
  - Students who identify as transgender were more likely to miss school because of MH issues and alcohol or drug use than those who do not identify as transgender.
  - Students who identify as nonbinary had higher chronic absenteeism rates than their peers who identify as male or female.
  - Students who identify as female were much more likely to miss school because of MH issues than those who identify as male.
- **Sexual orientation:** Students who identify as bisexual or gay were more likely to miss school because of MH issues and alcohol or drug use than those who identify as heterosexual.
- **Race and ethnicity:**
  - Students who identify as Black, AI/AN, or NH/PI had higher chronic absenteeism rates than their peers who identify as other races or ethnicities.
  - Students who identify as White missed school because of MH issues at double the rates of students who identify as Asian.
  - Differences in the rate of absences because of alcohol or drug use by race and ethnicity were small.
- **Region:** Youth in the Northern and Sierra region and San Joaquin Valley region had the highest chronic absenteeism rates. (We could not compare reasons for absences by region because of data limitations.)

STUDENTS WHO IDENTIFY AS FEMALE WERE MORE THAN TWICE AS LIKELY AS THOSE WHO IDENTIFY AS MALE TO MISS SCHOOL DUE TO MH ISSUES

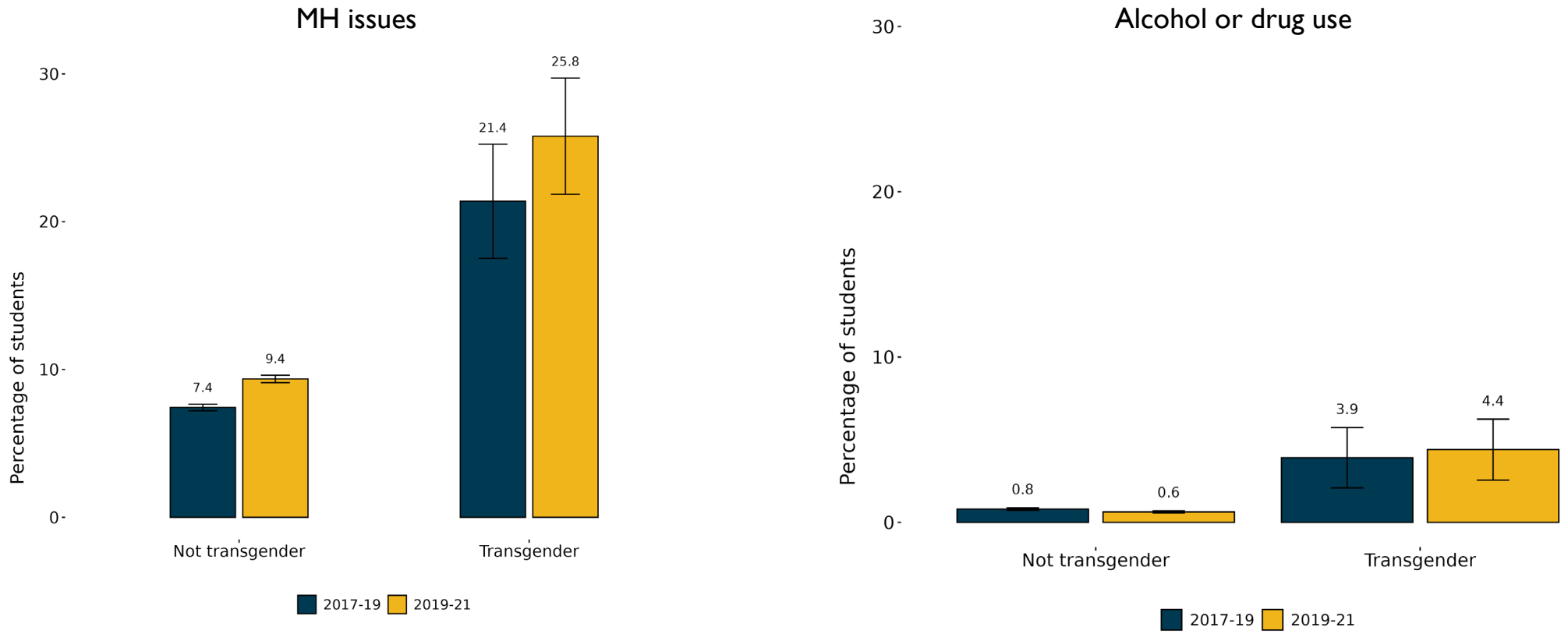
Percentage of students who reported school absences due to MH issues, by gender and school year



Source: CHKS, core module of biennial surveys, 2017–19 and 2019–21.
Notes: Data come from 7th-, 9th-, and 11th-grade student responses to the CHKS, which are weighted to be representative of the state. Students were asked if in the past 30 days they missed a day of school because they were feeling very sad, hopeless, anxious, stressed, or angry.

STUDENTS IDENTIFYING AS TRANSGENDER WERE MORE THAN TWICE AS LIKELY TO MISS SCHOOL DUE TO MH ISSUES AND MORE THAN FOUR TIMES AS LIKELY TO MISS SCHOOL DUE TO ALCOHOL OR DRUG USE THAN STUDENTS NOT IDENTIFYING AS TRANSGENDER

Percentage of students who reported school absences due to MH issues or alcohol or drug use, by transgender identity and school year



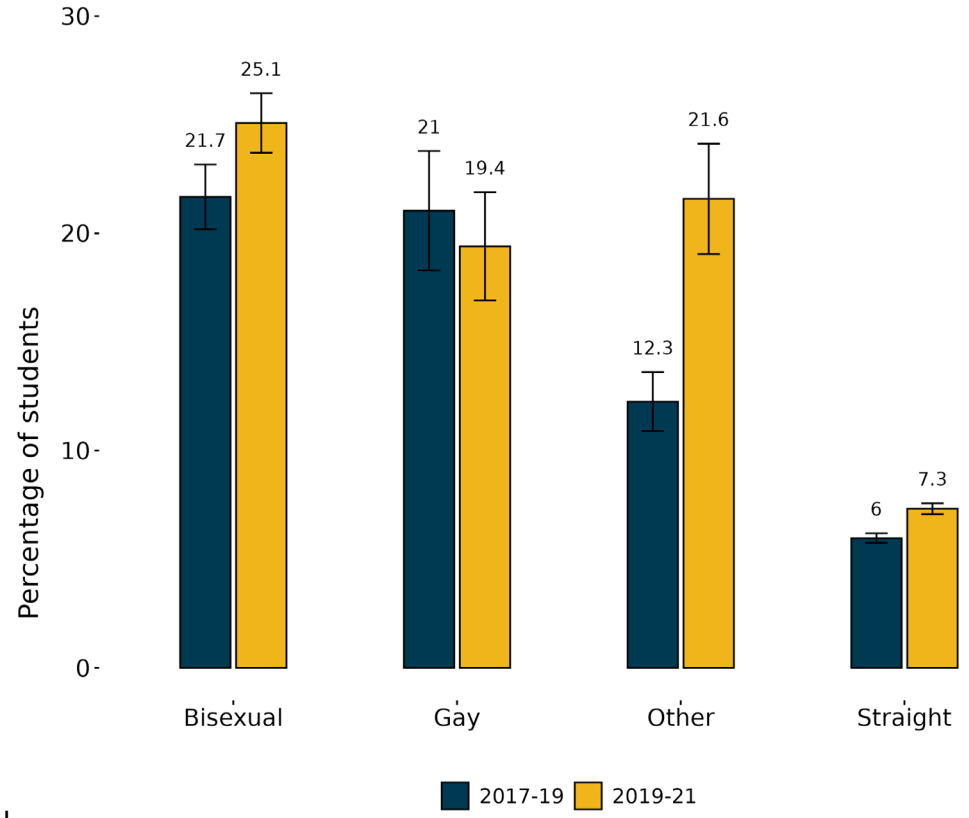
Source: CHKS, core module of biennial surveys, 2017–19 and 2019–21.

Notes: Data come from 7th-, 9th-, and 11th-grade student responses to the CHKS, which are weighted to be representative of the state. Students were asked if in the past 30 days they missed a day of school for any of the following reasons: (a) feeling very sad, hopeless, anxious, stressed, or angry and (b) used alcohol or drugs.

STUDENTS WHO IDENTIFY AS BISEXUAL OR GAY WERE MORE THAN THREE TIMES AS LIKELY TO MISS SCHOOL DUE TO MH ISSUES THAN THOSE WHO IDENTIFY AS HETEROSEXUAL ("STRAIGHT")

Percentage of students who reported school absences due to MH issues, by sexual orientation and school year

Students had the option of answering "other" when reporting their sexual orientation starting in 2016–2017. This category may include youth who identify as an orientation not listed in the survey, such as asexual. "Other" may also include youth who are unsure or feel their identity is fluid. LGBTQ+ youth who do not neatly fit into categories of straight or gay, including bisexual youth, often feel misunderstood and excluded from both LGBTQ+ and non-LGBTQ+ spaces.[d] In addition, women were much more likely to identify as bisexual than men were.[e] These factors may be considered when noting the rates of school absences for bisexual students, as well as the rates for students reporting "other."



Source: CHKS, core module of biennial surveys, 2017–19 and 2019–21.

Notes: Data come from 7th-, 9th-, and 11th-grade student responses to the CHKS, which are weighted to be representative of the state. Students were asked if in the past 30 days they missed a day of school because they were feeling very sad, hopeless, anxious, stressed, or angry. Sexual orientation of "other" was not an option before 2016–2017.

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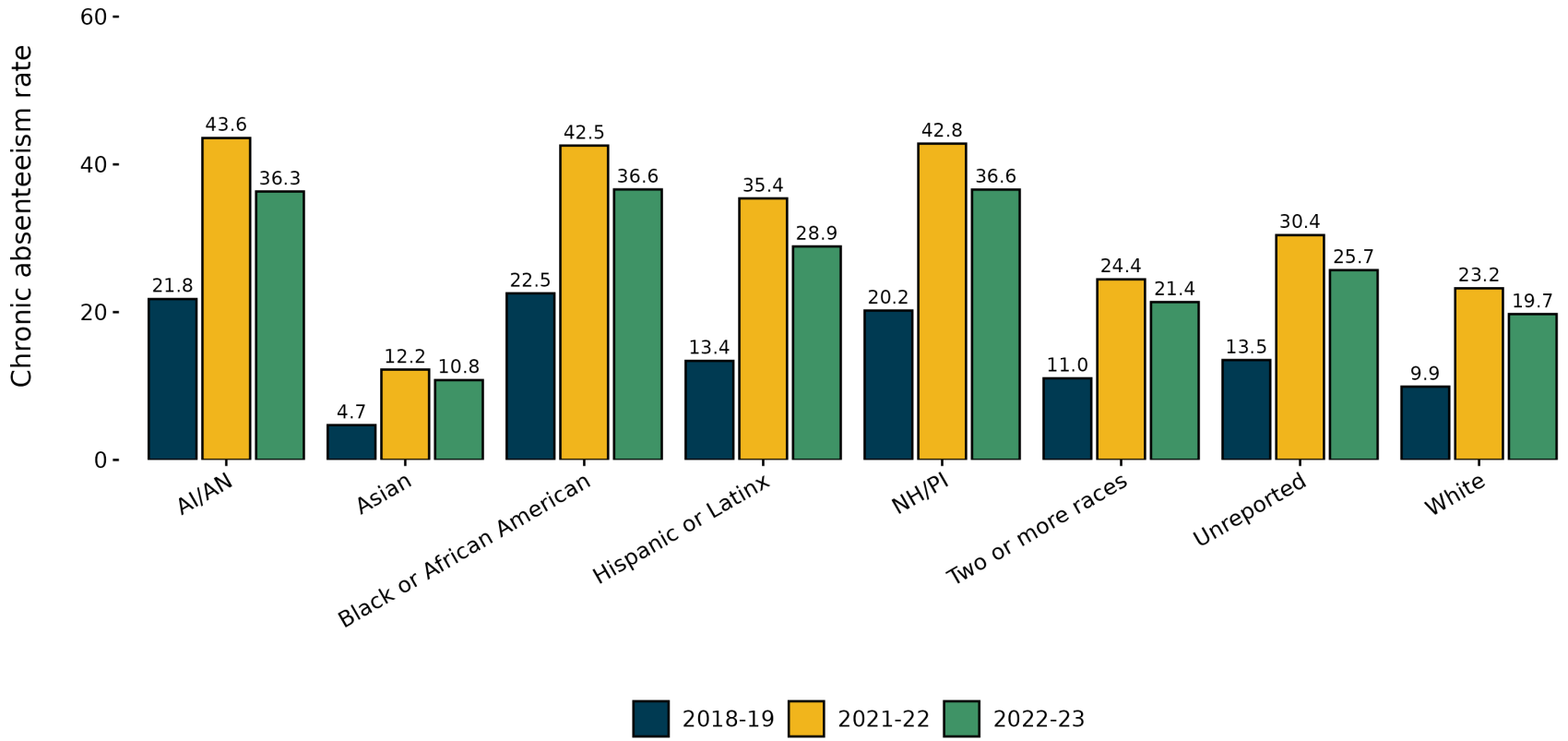
CHRONIC ABSENTEEISM WAS HIGHEST FOR STUDENTS WHO IDENTIFY AS AI/AN, BLACK, AND NH/PI

Percentage of students with chronic absenteeism, by race and ethnicity and school year



Source: California Department of Education.

Notes: Chronic absenteeism is defined as having missed at least 10% of the school days in which the student was enrolled. Absenteeism data were not reliable for the 2019–20 school year because of the COVID-19 pandemic, and absenteeism data from the 2020–2021 school year should be interpreted with caution because of distance learning.

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6. Decrease in stigmatizing attitudes toward behavioral health

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METRICS FOR OUTCOME 6

Metric (data sources; ages/grades)
Percentage of students who had concerns about receiving help for MH if needed (CHKS Mental Health Supports Module; grades 6–12)
Percentage of youth who did not seek needed MH or SUD help because they did not feel comfortable talking to a professional about personal problems (CHIS; ages 18–25)
Percentage of youth who did not seek needed MH or SUD help because they were concerned about what would happen if someone found out they had a problem (CHIS; ages 18–25)

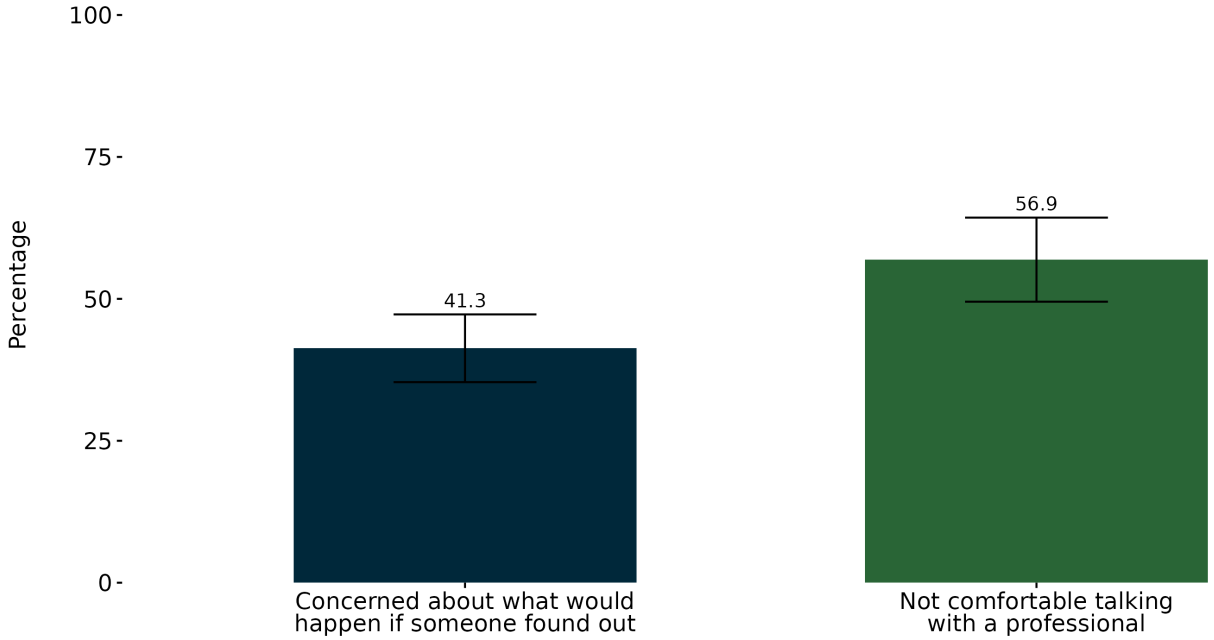
6. KEY TAKEAWAYS: OVERALL POPULATION

- Among youth ages 18–25 who needed but did not seek help for MH and SUD in 2022:
  - 41% were concerned about what would happen if someone found out.
  - Slightly more than half did not feel comfortable talking with a professional about personal problems.
- Among students in grades 6–12 in 2022–23, less than half would be stopped from talking to a counselor or therapist because of stigma.
  - The rate of students reporting stigma for MH has decreased since 2016–17.

We urge caution in interpreting these findings because only those who identified a need but did not receive help were asked these questions. Thus, the population responding to this question changed over time as the share of youth who received help changed. There is evidence in the literature that show increasing numbers of youth may be receiving help. For example, one study shows that stigma surrounding MH treatment decreased from 2007 to 2017 among U.S. college students.[h]

AMONG THOSE WHO WERE NOT RECEIVING SERVICES, ABOUT HALF SAID IT WAS BECAUSE OF STIGMA

Percentage of those who perceived needs but did not receive treatment due to stigma, ages 18 to 25

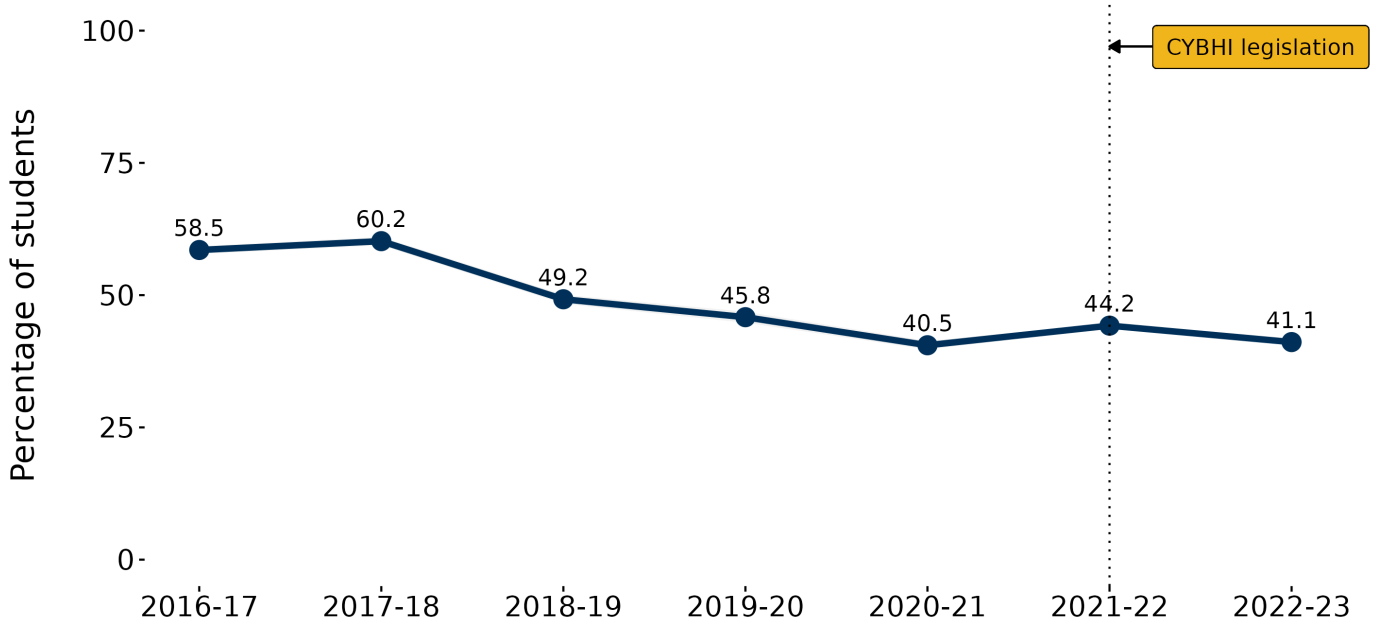


These questions are independent: a respondent can answer yes to one, both, or neither question.

Source: CHIS, 2022.
Notes: The survey question was asked of those who reported needing but not receiving treatment.

AROUND 40% OF STUDENTS REPORTED STIGMA RELATED TO SEEKING PROFESSIONAL HELP

Percentage of students who would be stopped from talking to a counselor or therapist because of stigma, by school year



Source: CHKS, Mental Health Supports Module of secondary surveys.

Notes: Data come from a question on the Mental Health Supports Module of the CHKS secondary surveys, which are not weighted to be representative of the California student population. Students responded to the question, "If you were very sad, stressed, lonely, or depressed, would any of these things stop you from talking to a counselor or therapist?" with one or more of the following responses: "People would think there's something wrong with you," the counselor or therapist "wouldn't understand," "Your parents might find out," or "Other students might find out."

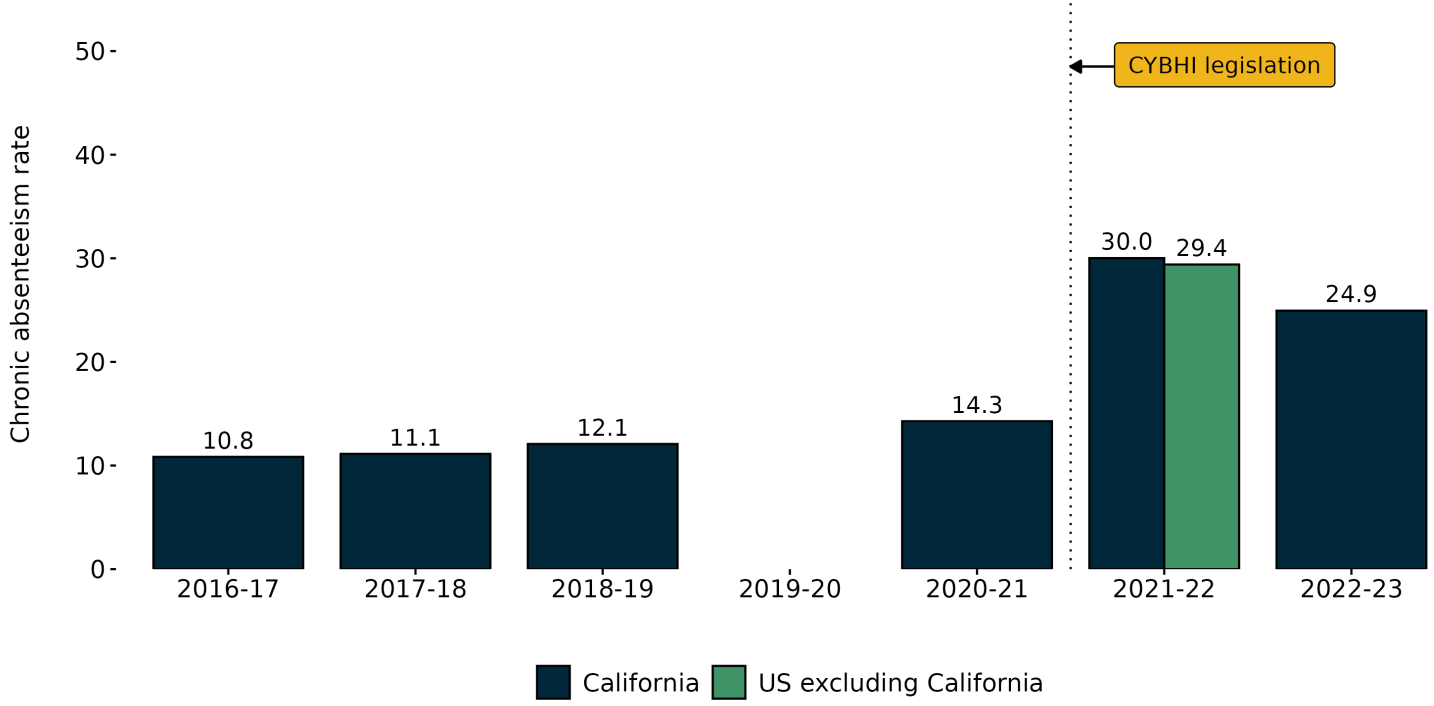
6. KEY TAKEAWAYS: DISPARITIES AND SUBGROUP DIFFERENCES

- **Gender:**
  - Students who identify as transgender were almost twice as likely as non-transgender students to report MH stigma, with almost three-quarters reporting they would be stopped from seeking help compared to those who did not identify as transgender.
  - More than two-thirds of non-binary students report MH stigma.
  - Roughly half of female students and one-third of male students report MH stigma.
- **Sexual orientation:** Students who identify as bisexual or gay were twice as likely to report MH stigma than students identifying as straight.
- **Race and ethnicity:**
  - Students who identify as Black reported the lowest amount of MH stigma.
  - Students who identify as Asian reported the highest amount of MH stigma.

We urge caution in interpreting these findings because they were drawn from a non-representative survey with low item-level response rates. Rather than produce population estimates, we highlighted only the race and ethnicity subgroup in figures to display trends with more clarity.

CHRONIC ABSENTEEISM ROSE DRAMATICALLY—TO 30.0%—IN THE 2021–22 SCHOOL YEAR BUT DECREASED IN 2022–23

Percentage of students with chronic absenteeism, by academic year



"Students who are chronically absent are missing critical instruction time and are at the greatest risk of falling behind and dropping out of school."[g]

Source: California Department of Education, U.S. Department of Education.

Notes: Chronic absenteeism is defined as having missed at least 10% of the school days in which the student was enrolled. Absenteeism data were not reliable for the 2019–20 school year because of the COVID-19 pandemic, and absenteeism data from the 2020–21 school year should be interpreted with caution because of distance learning. National comparison data were collected in the same way by the U.S. Department of Education. The data point here includes all states except California and includes the Bureau of Indian Education and Puerto Rico.

7. Improvement in experience of (a) accessing and (b) receiving behavioral health services and supports

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METRICS FOR OUTCOME 7

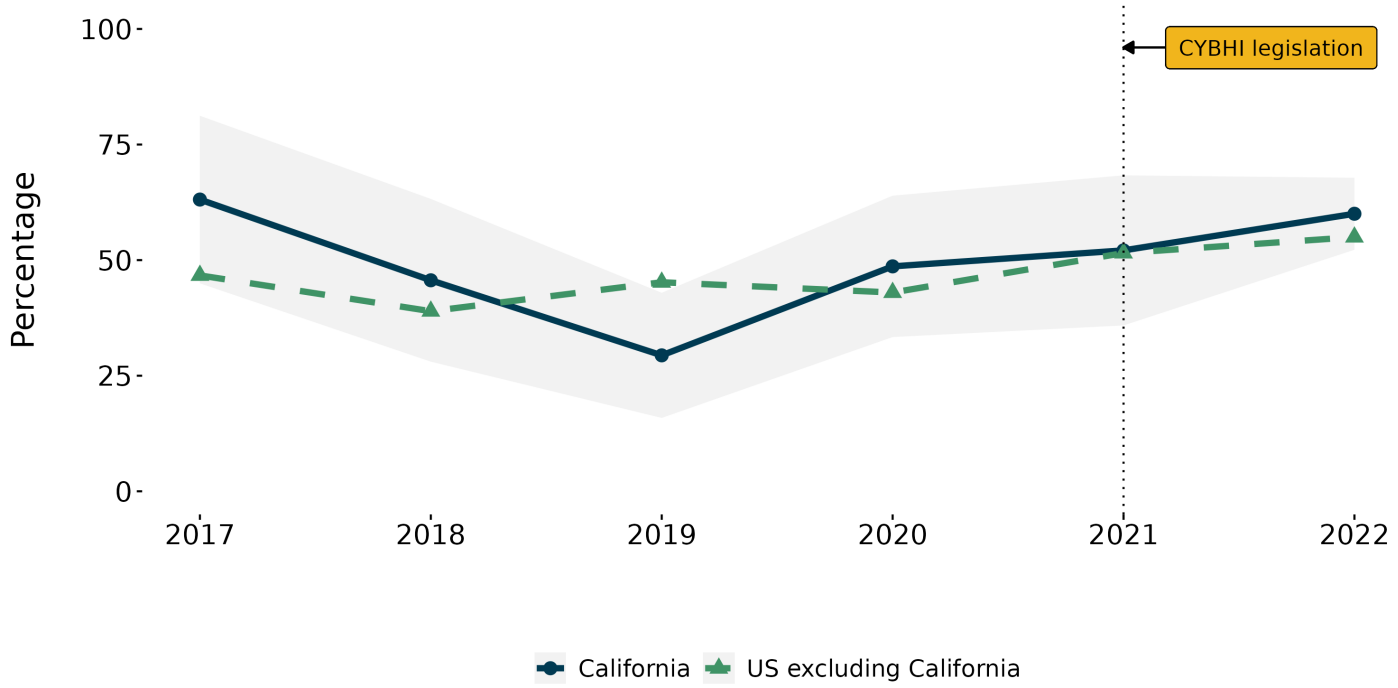
Metric (data sources; ages/grades)
Percentage of parents who felt it was difficult to obtain MH care for their child (National Survey of Children's Health; ages 0–17)
Percentage of youth satisfied with the care they received (CHIS; ages 18–25)

7. KEY TAKEAWAYS: OVERALL POPULATION

- **Difficulty receiving services:**
  - Among those ages 0 to 17 who received care or those who needed care but did not receive it, the percentage who had difficulty receiving care increased to 60% in 2022.
  - The level of difficulty receiving services was similar between California and the rest of the United States from 2017 to 2022.

DIFFICULTY RECEIVING MH CARE REMAINED A SIGNIFICANT CHALLENGE FOR CHILDREN AND YOUTH – WHICH WAS SIMILAR WITH THE U.S.

Percentage of parents of children and youth ages 0 to 17 who reported having difficulty receiving care



Source: National Survey of Children's Health.
Notes: This metric captures difficulty in receiving services for those who (1) received services or (2) needed but did not receive treatment or counseling from an MH professional.

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7. KEY TAKEAWAYS: DISPARITIES AND SUBGROUP DIFFERENCES

- The percentage who had difficulty receiving care was similar between (a) males and females, (b) those who identify as Hispanic or Latino and those who do not, and (c) age groups (ages 0 to 5, 6 to 11, and 12 to 17).

8. Increase in (a) knowledge of available behavioral health supports and services and (b) confidence that children, youth, and families can get supports and services when they self-identify a need

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METRICS FOR OUTCOME 8

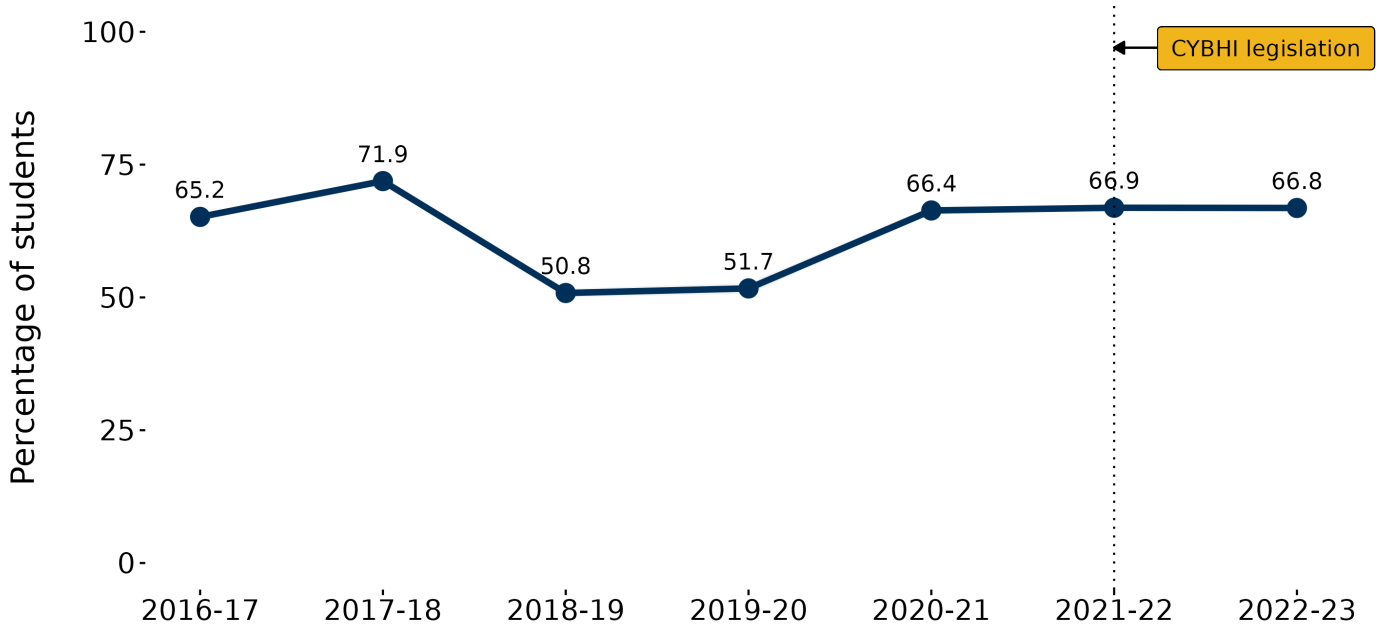
Metric (data sources; ages/grades)
Percentage of students who knew whom to contact at school for help (CHKS MH Module; grades 6–12)
Percentage of students who felt that their school helps with alcohol or other drug issues (CHKS AOD Module; 7th, 9th, and 11th graders)

8. KEY TAKEAWAYS: OVERALL POPULATION

- Roughly two-thirds of students in grades 6–12 reported knowing where to go for help when sad, stressed, lonely, or depressed.
- The percentage of 7th, 9th, and 11th graders who believed they could find help at school from a counselor, teacher, or other adult about substance use slightly increased from 2013–15, with more than half of students having reported confidence in finding help in 2019-21.

TWO-THIRDS OF STUDENTS REPORTED KNOWING WHERE TO GO FOR HELP AT SCHOOL

Percentage of students who knew where to go for help when sad, stressed, lonely, or depressed, by academic year



Source: CHKS, Mental Health Supports Module of secondary surveys

Notes: Data come from a question to 6th to 12th graders on the Mental Health Supports Module of the CHKS secondary surveys, which are not weighted to be representative of the California student population. Students responded "agree" or "strongly agree" to the question, "I know where to go or who to contact at school for help when I am very sad, stressed, lonely, or depressed."

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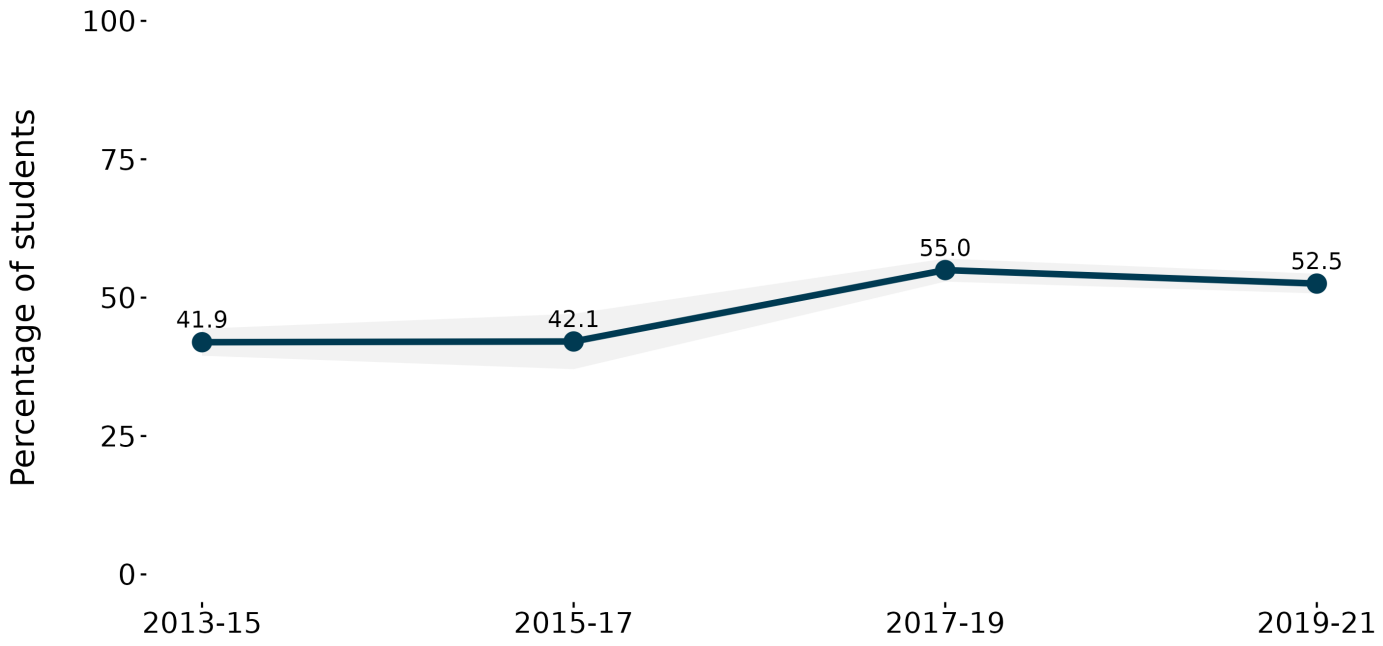
STUDENTS REPORTING CONFIDENCE IN FINDING HELP AT SCHOOL FOR SUBSTANCE USE ISSUES INCREASED SINCE 2013–15

Percentage of students who believe they could find help at school from a counselor, teacher, or other adult about substance use, by academic year



Source: CHKS, Alcohol and Other Drug module of biennial surveys.

Notes: The 7th-, 9th-, and 11th-grade student responses come from the Alcohol and Other Drug module of the CHKS biennial surveys, which are weighted to be representative of the California student population. Students responded "likely" or "very likely" to the following survey statement: "In your opinion, how likely is it that a student could find help at your school from a counselor, teacher, or other adult to stop or reduce using alcohol or other drugs?"

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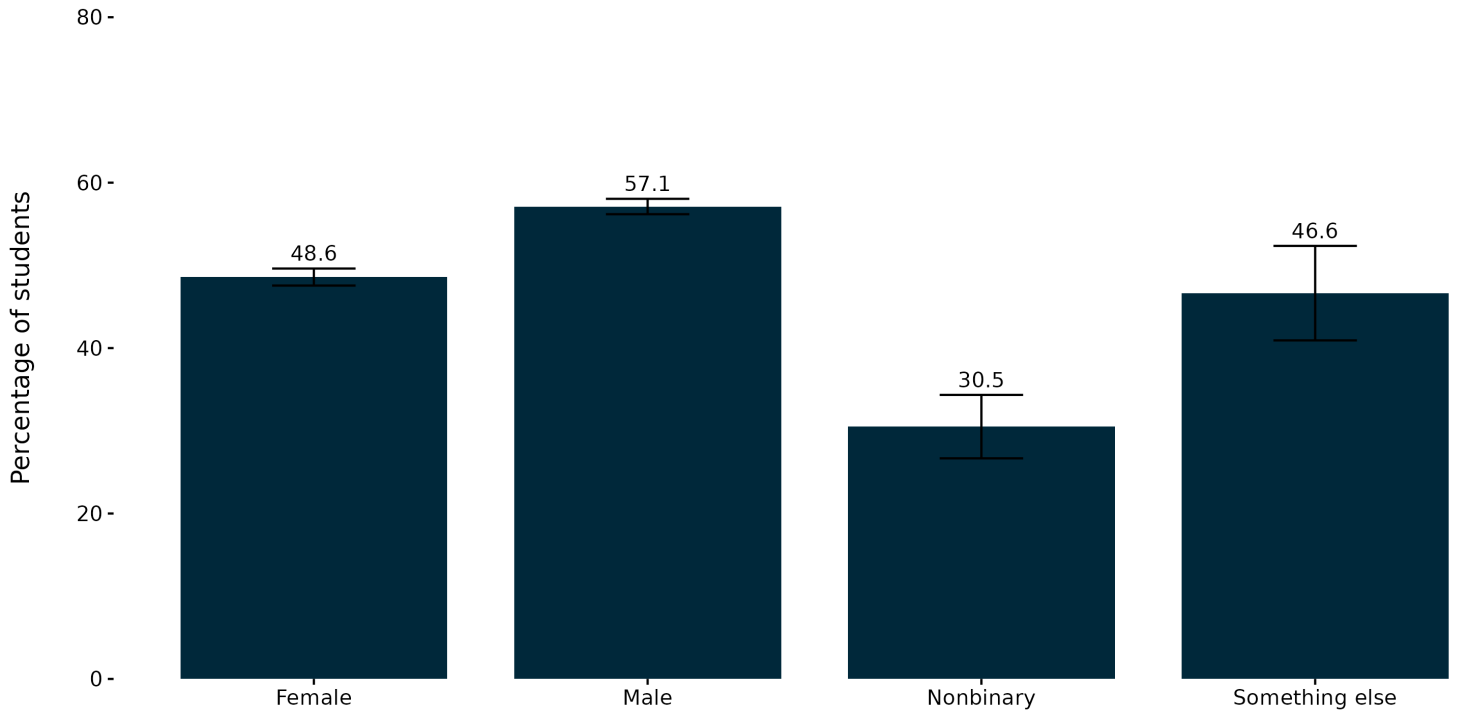
8. KEY TAKEAWAYS: DISPARITIES AND SUBGROUP DIFFERENCES

- **Gender:**
  - Students who identify as transgender were less likely to report confidence in finding support at school for substance use issues and slightly less knowledgeable of where to go for help.
  - Students of different genders reported similar rates of knowing where to go for help.
  - Male students reported higher levels of confidence of receiving substance use support at school than students of other genders.
- **Sexual orientation:** Students who identify as bisexual or gay reported slightly less knowledge and confidence in finding help at school than those who identify as heterosexual.
- **Race and ethnicity:**
  - From 2012–15 to 2019–21, a greater proportion of students who identify as AI/AN reported confidence with finding substance use support at school, reducing the gap with other groups.
  - By 2019–21, students across different race and ethnicity groups reported similar amounts of confidence in finding substance use support in school.

MALE STUDENTS REPORTED THE HIGHEST LEVELS OF CONFIDENCE OF RECEIVING SUBSTANCE USE SUPPORT AT SCHOOL

Percentage of students who believe they could find help at school from a counselor, teacher, or other adult about substance use, by gender in 2019-21

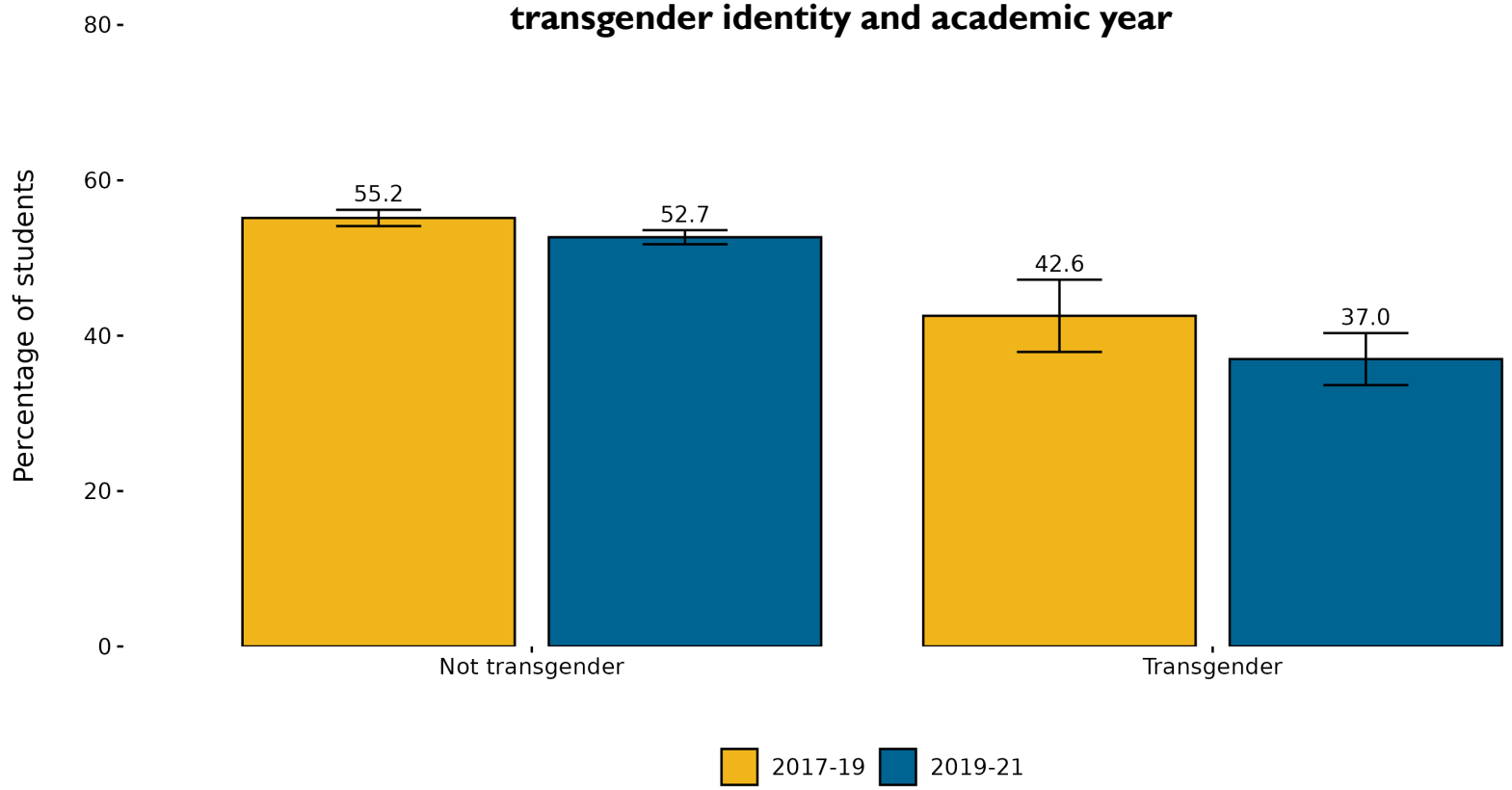


Source: CHKS, Alcohol and Other Drug module of biennial surveys, 2019-21.

Notes: The 7th-, 9th-, and 11th-grade student responses come from the Alcohol and Other Drug module of the CHKS biennial surveys, which are weighted to be representative of the California student population. Students responded "likely" or "very likely" to the following survey statement: "In your opinion, how likely is it that a student could find help at your school from a counselor, teacher, or other adult to stop or reduce using alcohol or other drugs?"

STUDENTS IDENTIFYING AS TRANSGENDER WERE LESS LIKELY THAN STUDENTS NOT IDENTIFYING AS TRANSGENDER TO BELIEVE THEY COULD FIND HELP AT SCHOOL

Percentage of students who believe they could find help at school from a counselor, teacher, or other adult about substance use, by transgender identity and academic year

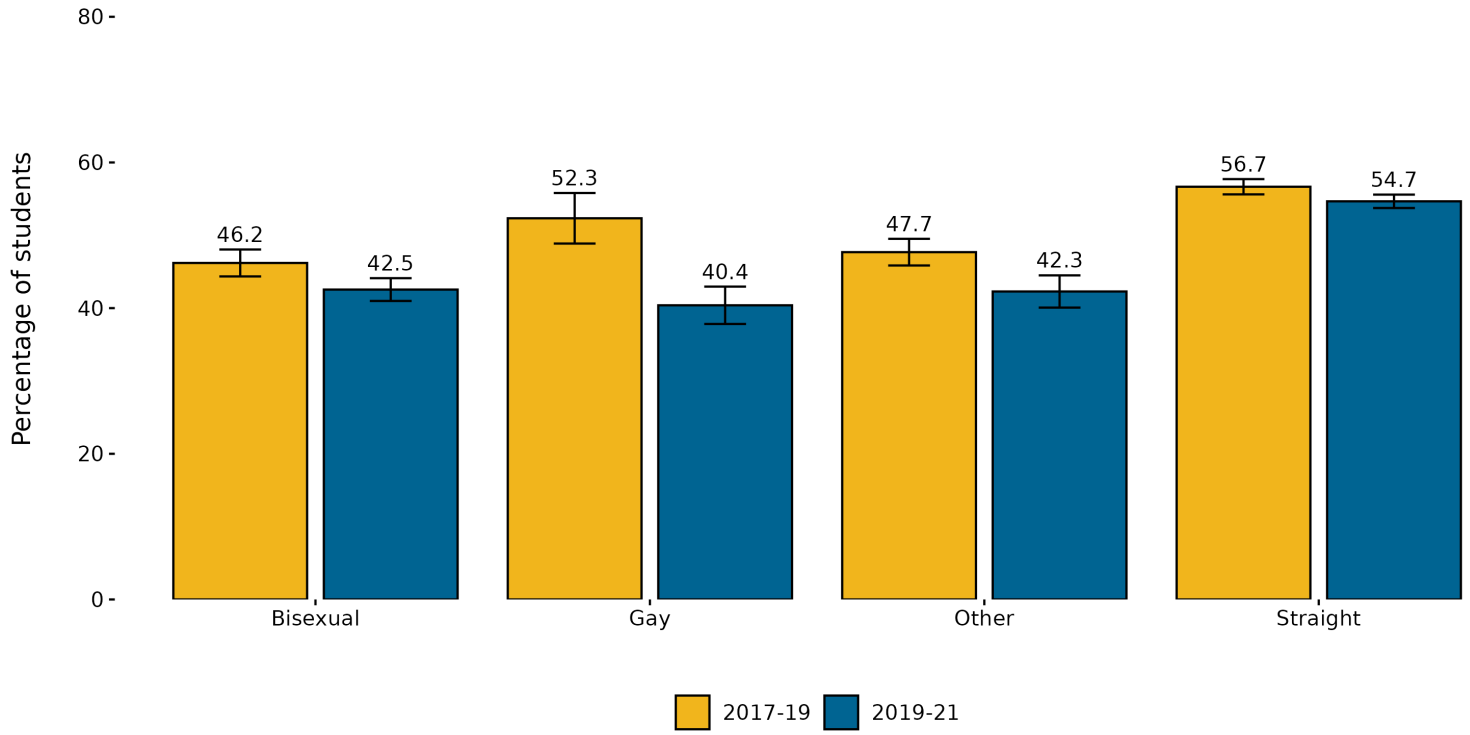


Source: CHKS, Alcohol and Other Drug module of biennial surveys.

Notes: The 7th-, 9th-, and 11th-grade student responses come from the Alcohol and Other Drug module of the CHKS biennial surveys, which are weighted to be representative of the California student population. Students responded "likely" or "very likely" to the following survey statement: "In your opinion, how likely is it that a student could find help at your school from a counselor, teacher, or other adult to stop or reduce using alcohol or other drugs?"

STUDENTS WHO IDENTIFY AS BISEXUAL, GAY, OR OTHER WERE LESS LIKELY TO BELIEVE THEY COULD FIND HELP AT SCHOOL THAN THOSE WHO IDENTIFY AS STRAIGHT

Percentage of students who believe they could find help at school from a counselor, teacher, or other adult about substance use, by sexual orientation and academic year



Source: CHKS, Alcohol and Other Drug module of biennial surveys.

Notes: The 7th-, 9th-, and 11th-grade student responses come from the Alcohol and Other Drug module of the CHKS biennial surveys, which are weighted to be representative of the California student population. Students responded "likely" or "very likely" to the following survey statement: "In your opinion, how likely is it that a student could find help at your school from a counselor, teacher, or other adult to stop or reduce using alcohol or other drugs?"

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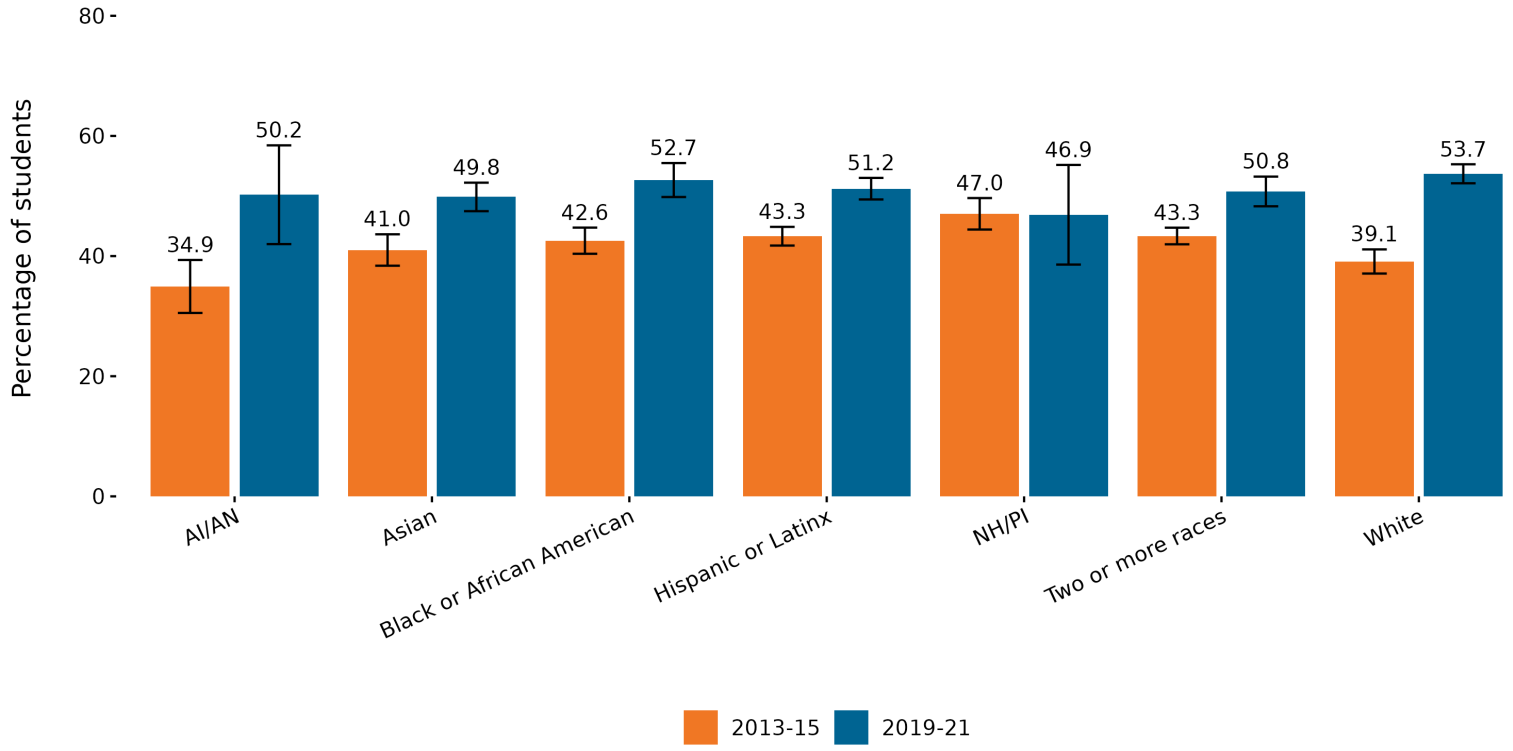
THE GAP BETWEEN AI/AN STUDENTS AND OTHER STUDENTS GREW SMALLER, WITH SLIGHT DIFFERENCES IN THEIR CONFIDENCE OF GETTING HELP AT SCHOOL IN 2019–21

Percentage of students who believe they could find help at school from a counselor, teacher, or other adult about substance use, by race and ethnicity and academic year



Source: CHKS, Alcohol and Other Drug module of biennial surveys.

Notes: The 7th-, 9th-, and 11th-grade student responses come from the Alcohol and Other Drug module of the CHKS biennial surveys, which are weighted to be representative of the California student population. Students responded "likely" or "very likely" to the following survey statement: "In your opinion, how likely is it that a student could find help at your school from a counselor, teacher, or other adult to stop or reduce using alcohol or other drugs?"

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9. Increase in behavioral health services and supports received by children and youth

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METRICS FOR OUTCOME 9

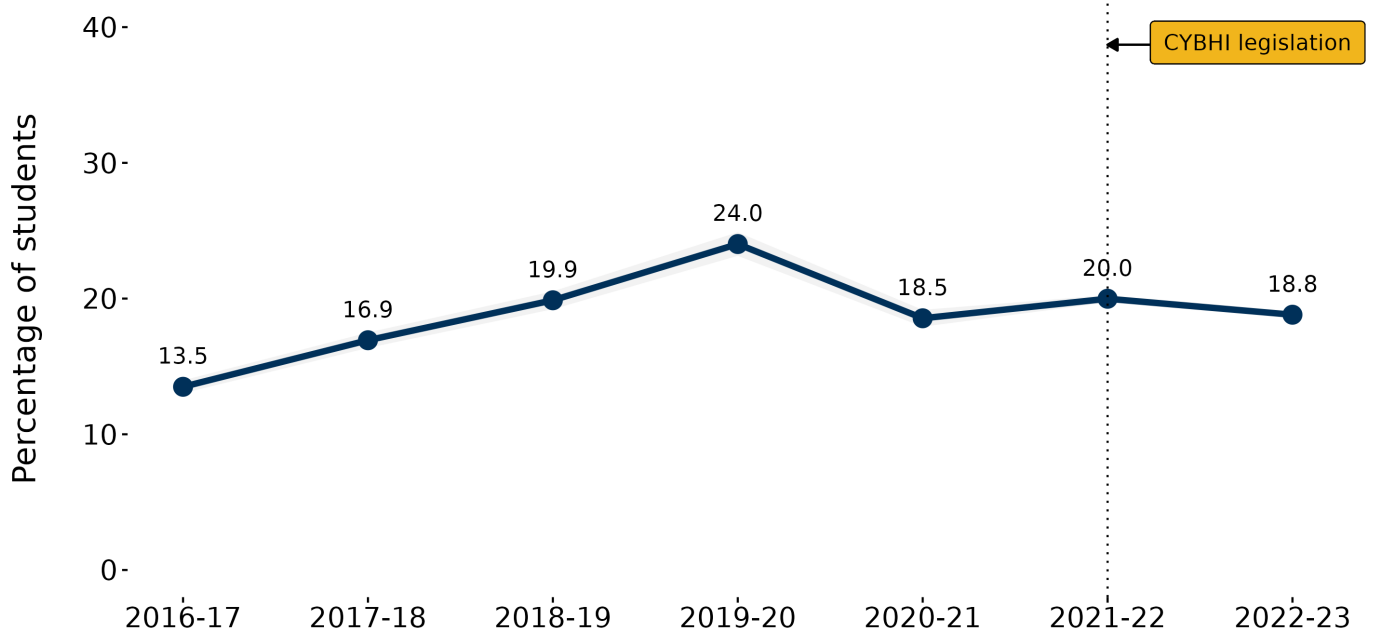
Metric (data sources; ages/grades)
Total children and youth receiving behavioral health services per 100,000 (TAF; ages 0–25)
Percentage of students who received care from a counselor or therapist (CHKS Mental Health Supports Module; grades 6–12)

9. KEY TAKEAWAYS: OVERALL POPULATION

- **Receipt of behavioral health services and supports:**
  - There was a small increase in the number of Medi-Cal enrollees receiving behavioral health services from 2018 to 2021, but many Medi-Cal enrollees with a behavioral health diagnosis did not receive services.
- **Percentage of students reporting they got help**
  - Just under 20% of students reported getting help when sad, stressed, lonely, or depressed, a trend that peaked in 2019–20 at 24% and has declined.

THE PERCENTAGE OF STUDENTS WHO WOULD LIKELY GET HELP IF NEEDED HAS REMAINED RELATIVELY STABLE OVER THE LAST THREE ACADEMIC YEARS

Percentage of students who would get help from a counselor or therapist if feeling sad, stressed, lonely, or depressed, by academic year



Source: CHKS, Mental Health Supports Module of secondary surveys.

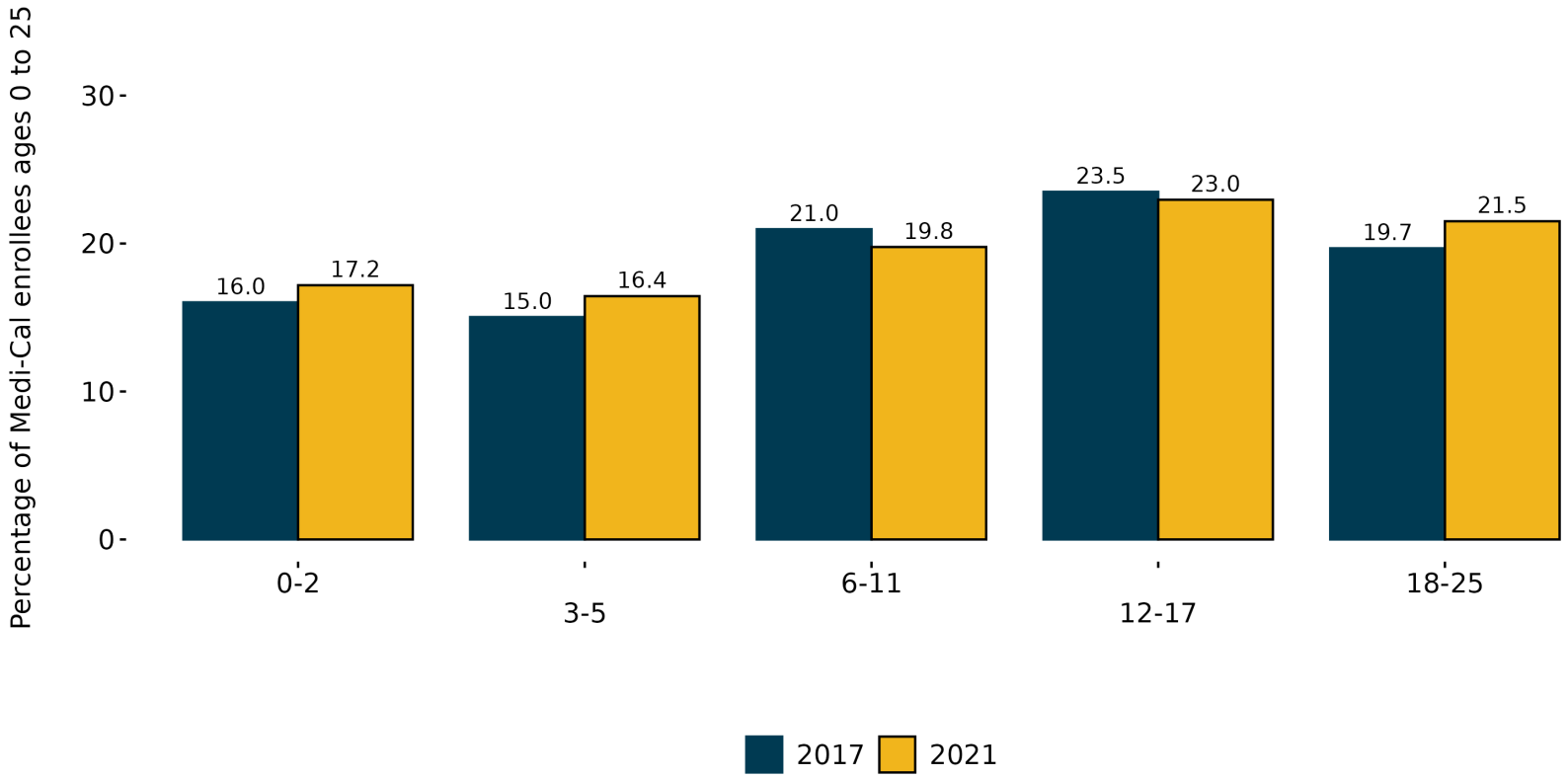
Notes: Data come from a question to 6th to 12th graders on the Mental Health Supports Module of the CHKS secondary surveys, which are not weighted to be representative of the California student population. The question asks, "If you were feeling very sad, stressed, lonely, or depressed, would you..." Students responded "get help from a counselor or therapist."

9. KEY TAKEAWAYS: DISPARITIES AND SUBGROUP DIFFERENCES

- **Age:** Medi-Cal-enrolled adolescents and youth (ages 6–25) had higher rates of behavioral health treatment use than younger children (ages 0–5).
- **Gender/sex at birth:**
  - Students identifying as transgender report higher rates of seeking behavioral health treatment than students not identifying as transgender.
  - Medi-Cal enrollees identifying as males and females had similar rates of behavioral health treatment use.
  - Students of all genders report similar rates of seeking behavioral health treatment.
- **Race and ethnicity:** Medi-Cal enrollees identifying as White had the highest rates of behavioral health treatment use, and enrollees identifying as NH/PI had the lowest rates among all racial and ethnic groups.
- **Region:** Medi-Cal enrollees in the Northern and Sierra region had the highest rates of behavioral health treatment use, and those in the San Joaquin Valley region had the lowest.
- **Sexual orientation:** Students identifying as gay or bisexual reported higher rates of seeking behavioral health treatment than students identifying as straight.

YOUTH AGES 6–25 HAD HIGHER RATES OF BEHAVIORAL HEALTH TREATMENT USE THAN PRE-SCHOOL-AGE YOUTH

Percentage of Medi-Cal enrollees with a behavioral health issue using any behavioral health services (ages 0 to 25)

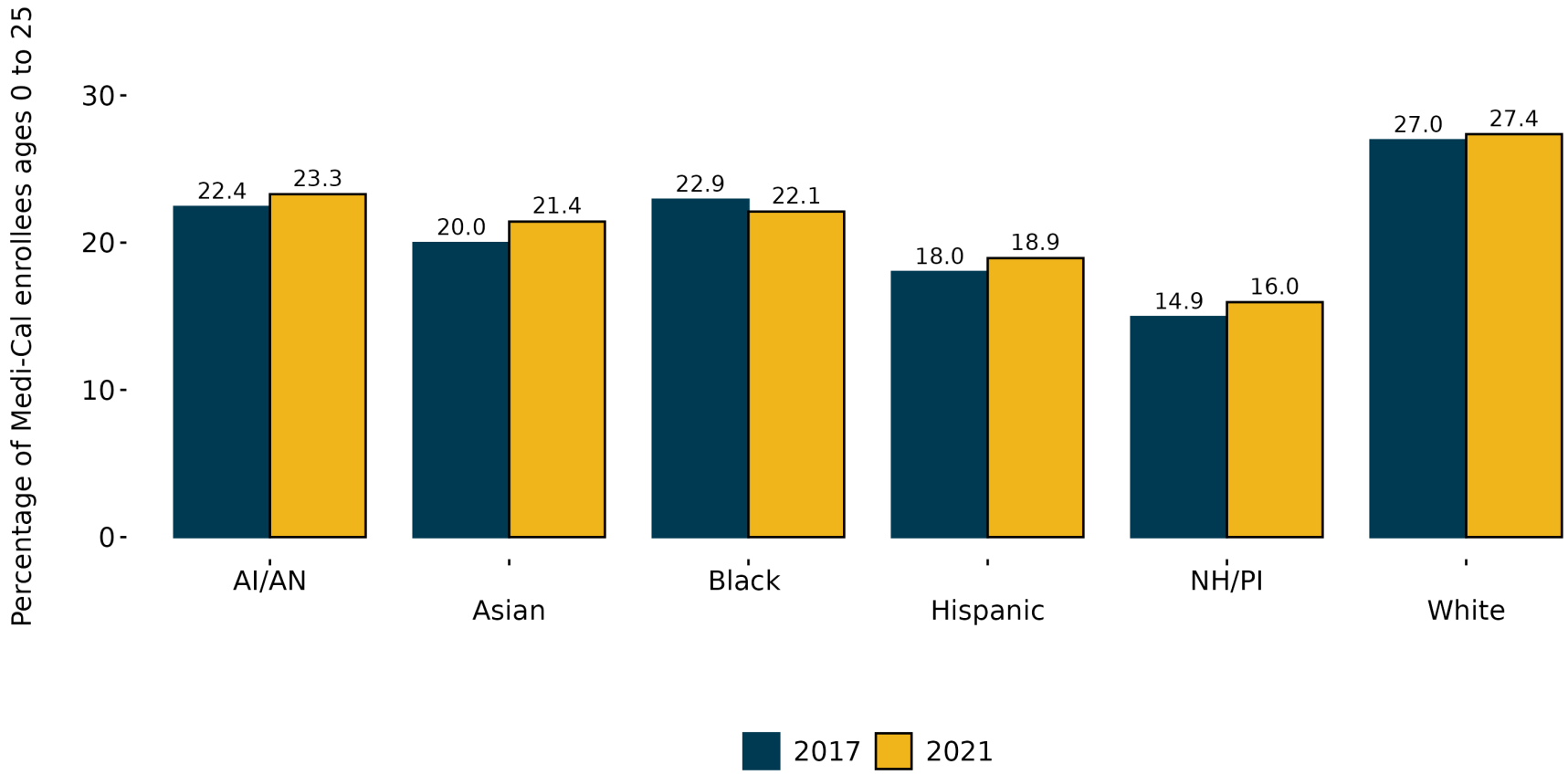


People with a "behavioral health issue" include everyone who used services in the current or 23 prior months billed with an MH or a SUD diagnosis or symptom (such as suicidal ideation) on the claim in any position. See Appendix D for symptoms included.

Source: TAF for California.
Notes: behavioral health treatment includes all services billed with an MH or a SUD diagnosis or symptom (such as suicidal ideation) on the claim in any position. See Appendix D for symptoms included.

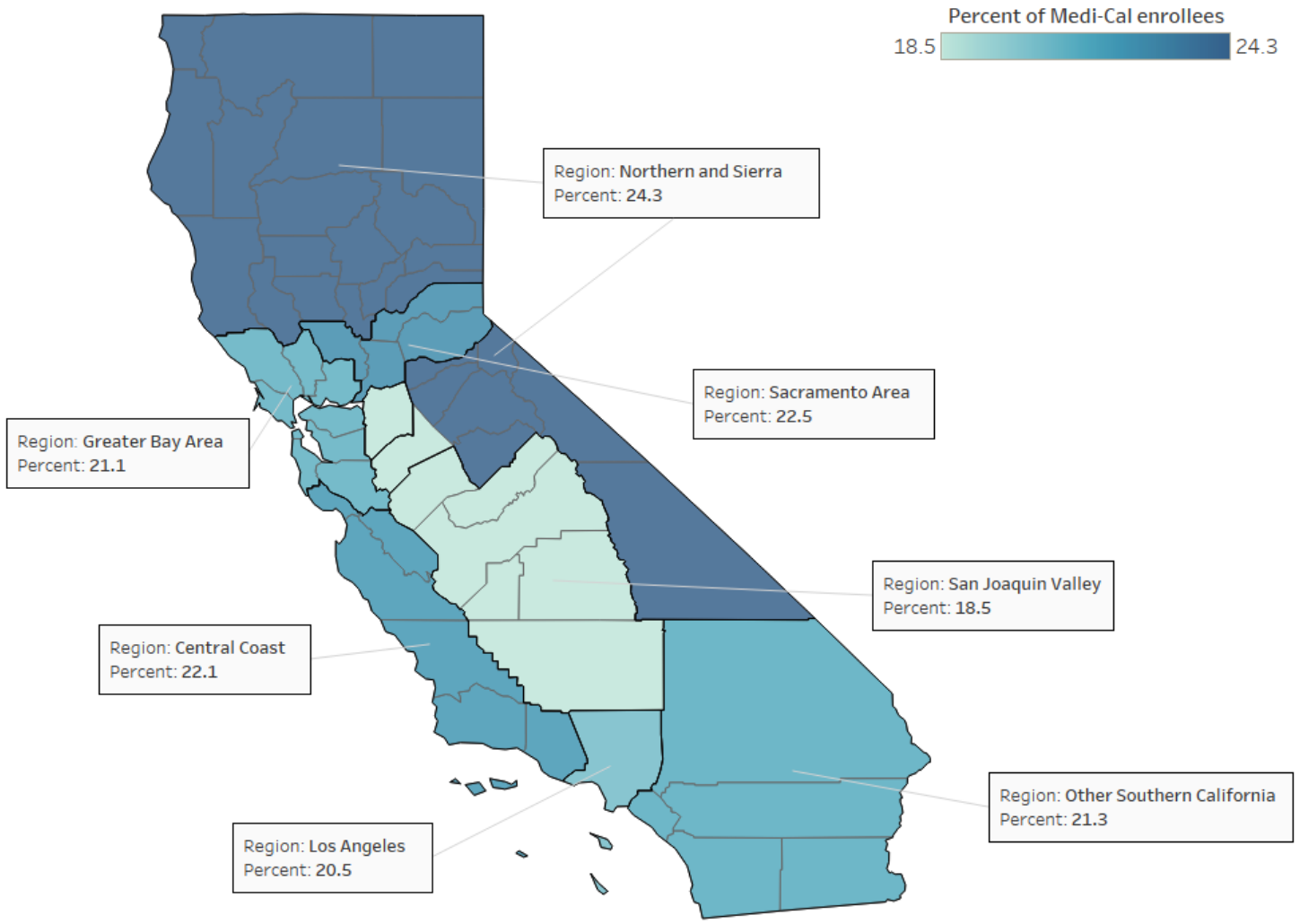
MEDI-CAL ENROLLEES IDENTIFYING AS WHITE HAD THE HIGHEST RATES OF BEHAVIORAL HEALTH TREATMENT, AND THOSE IDENTIFYING AS NH/PI HAD THE LOWEST RATES

Percentage of Medi-Cal enrollees with a behavioral health issue using any behavioral health services (ages 0 to 25)



Source: TAF for California.

Percentage of Medi-Cal enrollees receiving a behavioral health service (ages 0 to 25)

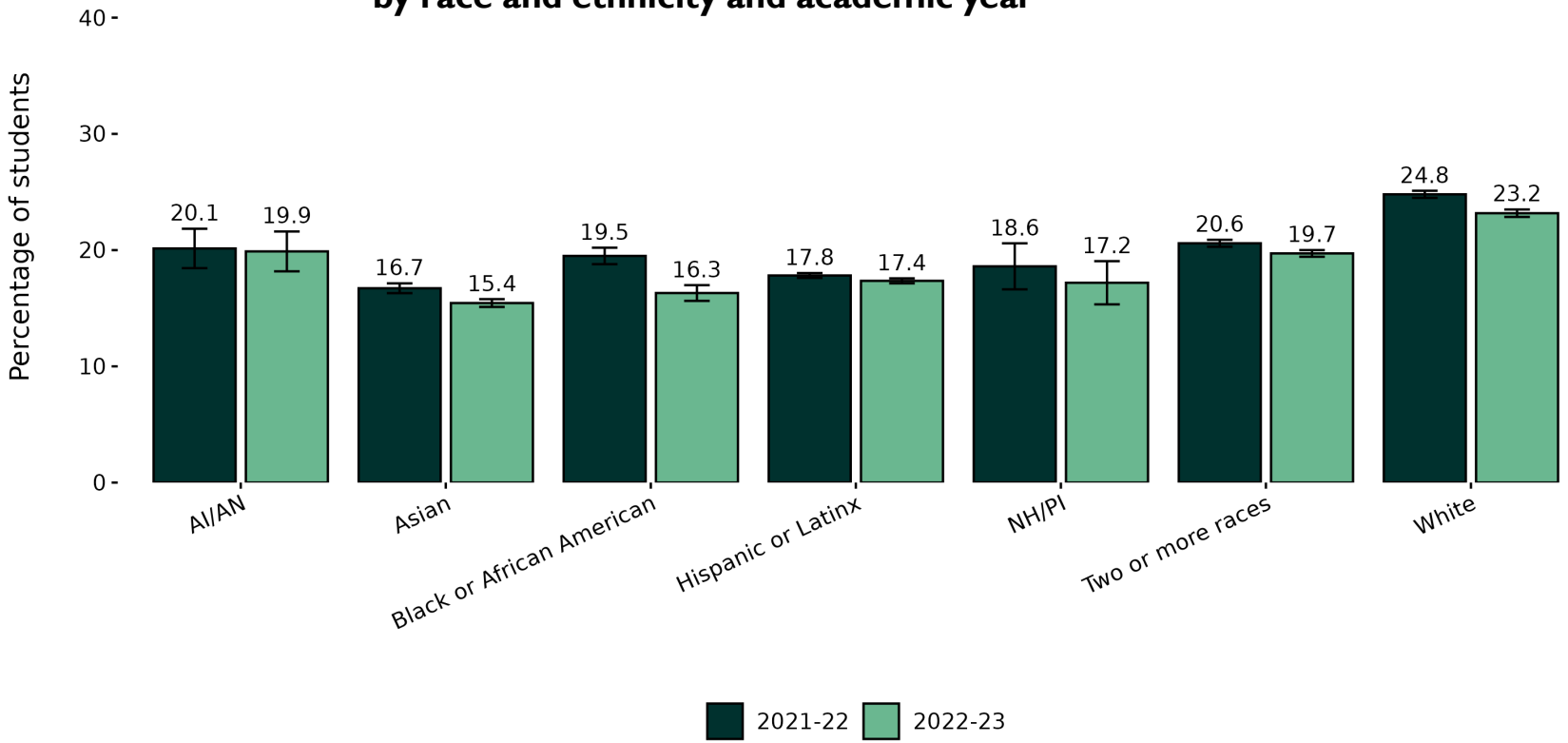


MEDI-CAL ENROLLEES IN THE NORTHERN AND SIERRA REGION HAD THE HIGHEST RATES OF BEHAVIORAL HEALTH TREATMENT, AND THOSE IN THE SAN JOAQUIN VALLEY REGION HAD THE LOWEST RATES

Source: TAF for California.

STUDENTS IDENTIFYING AS WHITE REPORTED THE HIGHEST RATES OF WILLINGNESS TO SEEK HELP, AND STUDENTS IDENTIFYING AS ASIAN REPORTED THE LOWEST

Percentage of students who believe they who would get help from a counselor or therapist if feeling sad, stressed, lonely, or depressed, by race and ethnicity and academic year



Source: CHKS, Mental Health Supports Module of secondary surveys.

Notes: Data come from a question to 6th to 12th graders on the Mental Health Supports Module of the CHKS secondary surveys, which are not weighted to be representative of the California student population. The question asks, "If you were feeling very sad, stressed, lonely, or depressed, would you..." Students responded "get help from a counselor or therapist."

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12. Substance use prevention strategies specifically for younger children and adolescents

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METRICS FOR OUTCOME 12

Metric (data sources; ages/grades)
Percentage of school staff who felt there is adequate substance use prevention instruction in school (CSSS; grades K–12)
Percentage of students who received messages about substance use prevention (CHKS AOD module; 7th, 9th, and 11th graders)
Percentage of students who had discussions with parent or guardian about substance use (CHKS AOD module; 7th, 9th, and 11th graders)
Percent of children and youth who initiated their first lifetime use of marijuana during the past year (National Survey on Drug Use and Health [NSDUH]; ages 12–17, 18–25)

METRICS FOR OUTCOME 12 (CONTINUED)

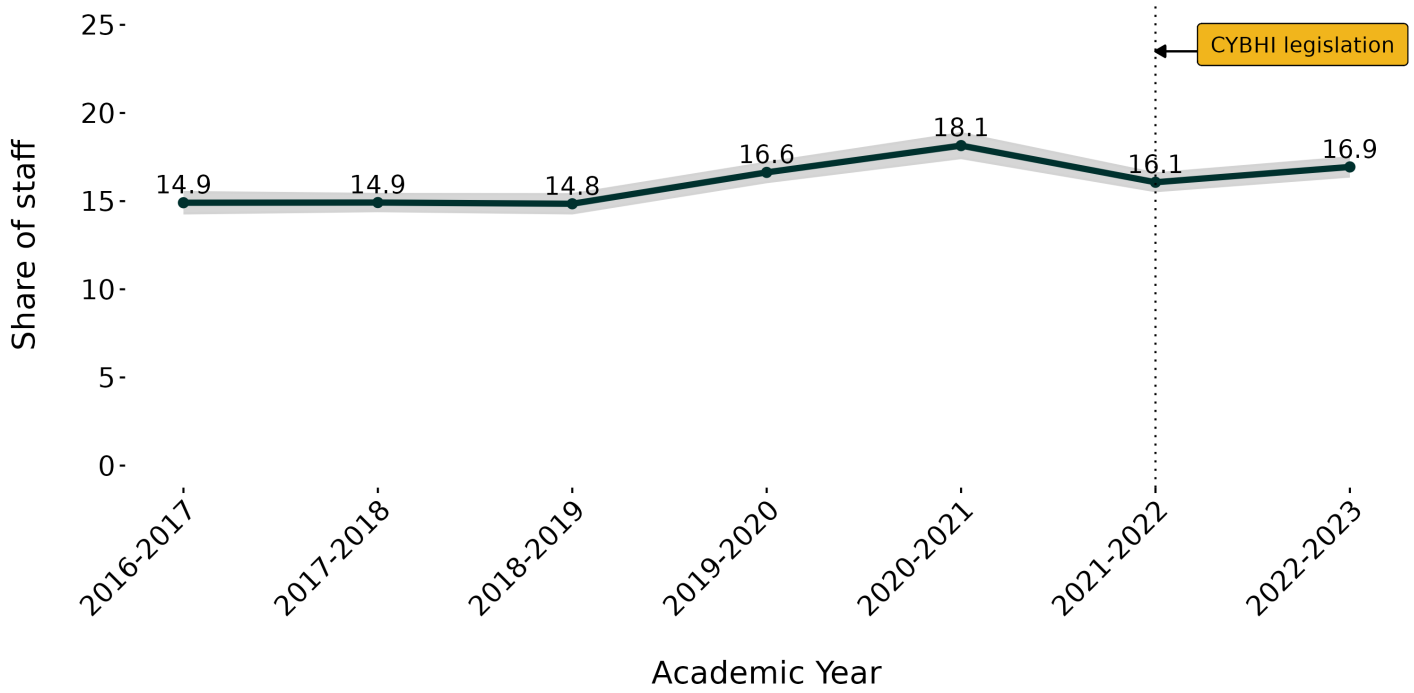
Metric (data sources; ages/grades)
Percentage of youth who perceived a risk of harm from smoking marijuana once a month (NSDUH; ages 12–17, 18–25)
Percentage of youth who perceived a risk of harm from smoking cocaine once a month (NSDUH; ages 12–17, 18–25)
Percentage of youth who perceived a risk of harm from trying heroin once or twice (NSDUH; ages 12–17, 18–25)
Percentage of youth who perceived a risk of harm from having five or more drinks of an alcoholic beverage once or twice a week (NSDUH; ages 12–17, 18–25)
Percentage of youth who perceived a risk of harm from smoking one or more packs of cigarettes per day (NSDUH; ages 12–17, 18–25)

12. KEY TAKEAWAYS: OVERALL POPULATION

- **School services:** Less than 20% of school staff reported that their school provides extensive substance use prevention instruction.
- **Messages and family discussions:** More than two-thirds of 7th, 9th, and 12th grade students reported seeing or hearing messages about substance use prevention, and almost half reported talking to a parent or guardian about it.
- **Marijuana initiation**: Less than 10% of the youth who had never tried marijuana reported their first use in the past year. California was similar to or had lower rates than the United States, depending on the age group.
- **Risk of harm:** Youth's perception of great risk of harm from marijuana, cigarettes, cocaine, and heroin have decreased, and their perception of great risk of harm from alcohol has remained similar in the past several years. For most metrics, California was similar to or had higher rates than the United States.

LESS THAN ONE-FIFTH OF SCHOOL STAFF REPORTED EXTENSIVE SUBSTANCE USE PREVENTION INSTRUCTION

Percentage of school staff who reported extensive substance use prevention instruction, by academic year

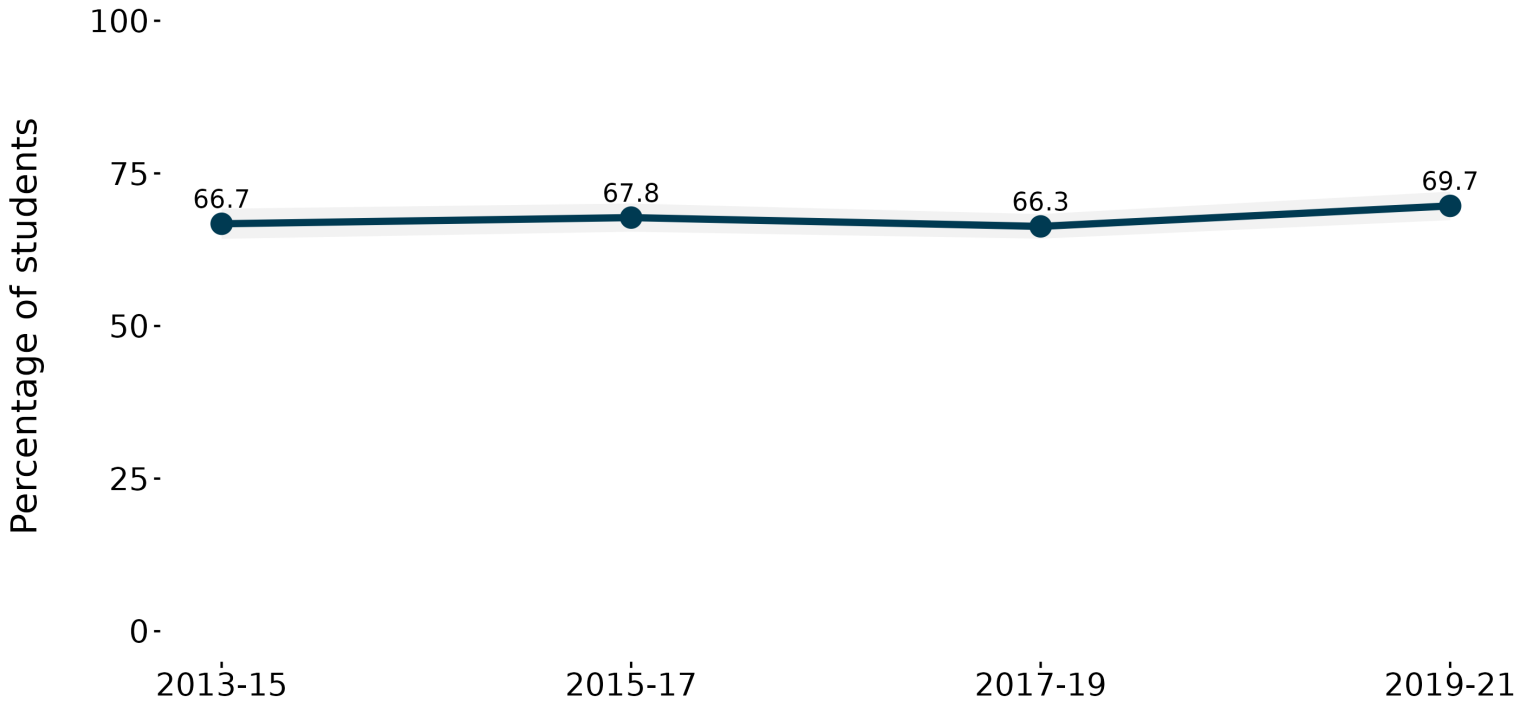


Source: California School Staff Survey.

Notes: The survey is a statewide optional survey to all school staff that is not weighted to be representative of the population. Staff responded "a lot" as an answer to "the extent that their school provides students alcohol or drug use prevention instruction." Possible answers are "a lot," "some," "not much," and "not at all."

A SLIGHTLY LARGER SHARE OF STUDENTS REPORTED SEEING OR HEARING MESSAGES ABOUT SUBSTANCE USE PREVENTION THAN IN PRIOR YEARS

Percentage of students who heard, read, or watched any messages about not using substances in the past 12 months, by academic year



Source: CHKS, Alcohol and Other Drug module of biennial surveys.

Notes: The 7th-, 9th-, and 11th-grade student responses come from the Alcohol and Other Drug module of the CHKS biennial surveys, which are weighted to be representative of the California student population. Students responded "yes" to the following question: "During the past 12 months, have you heard, read, or watched any messages about not using alcohol or drugs?"

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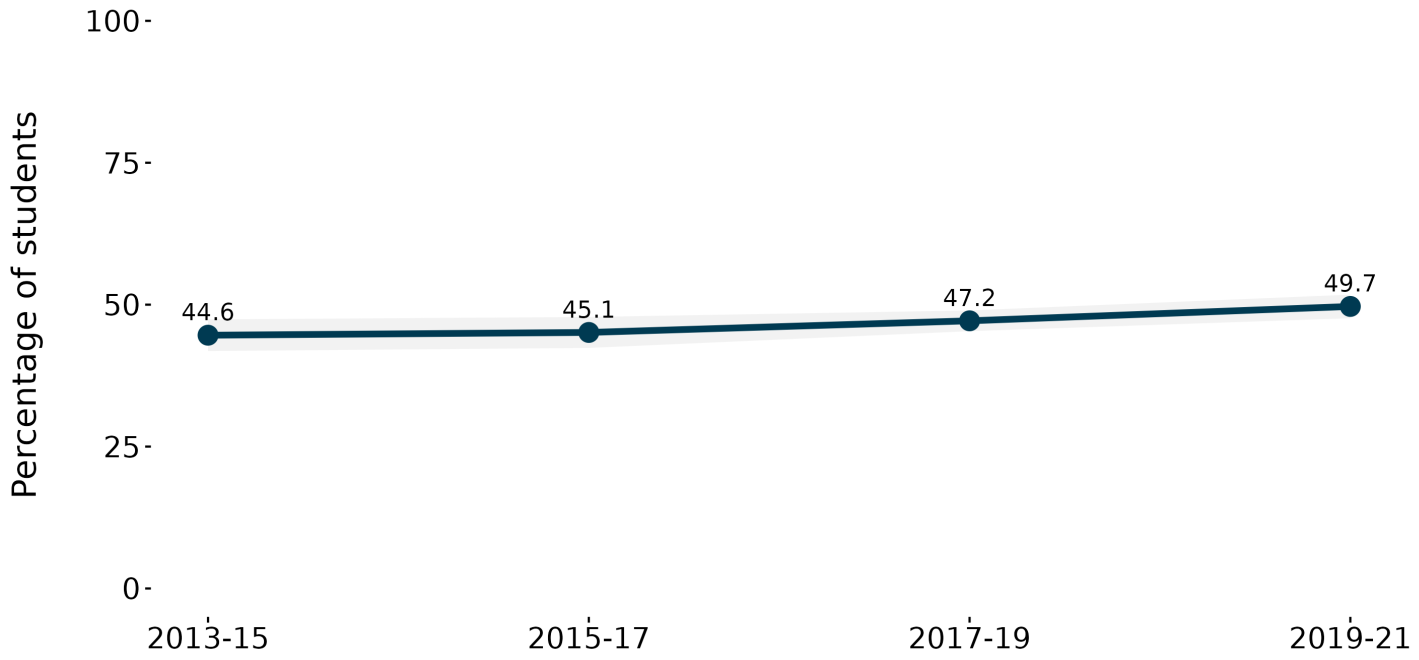
A SLIGHTLY LARGER SHARE OF STUDENTS REPORTED TALKING WITH A PARENT ABOUT SUBSTANCE USE PREVENTION THAN IN PRIOR YEARS

Percentage of students who talked with a parent or guardian about the dangers of substance use in the past 12 months, by academic year

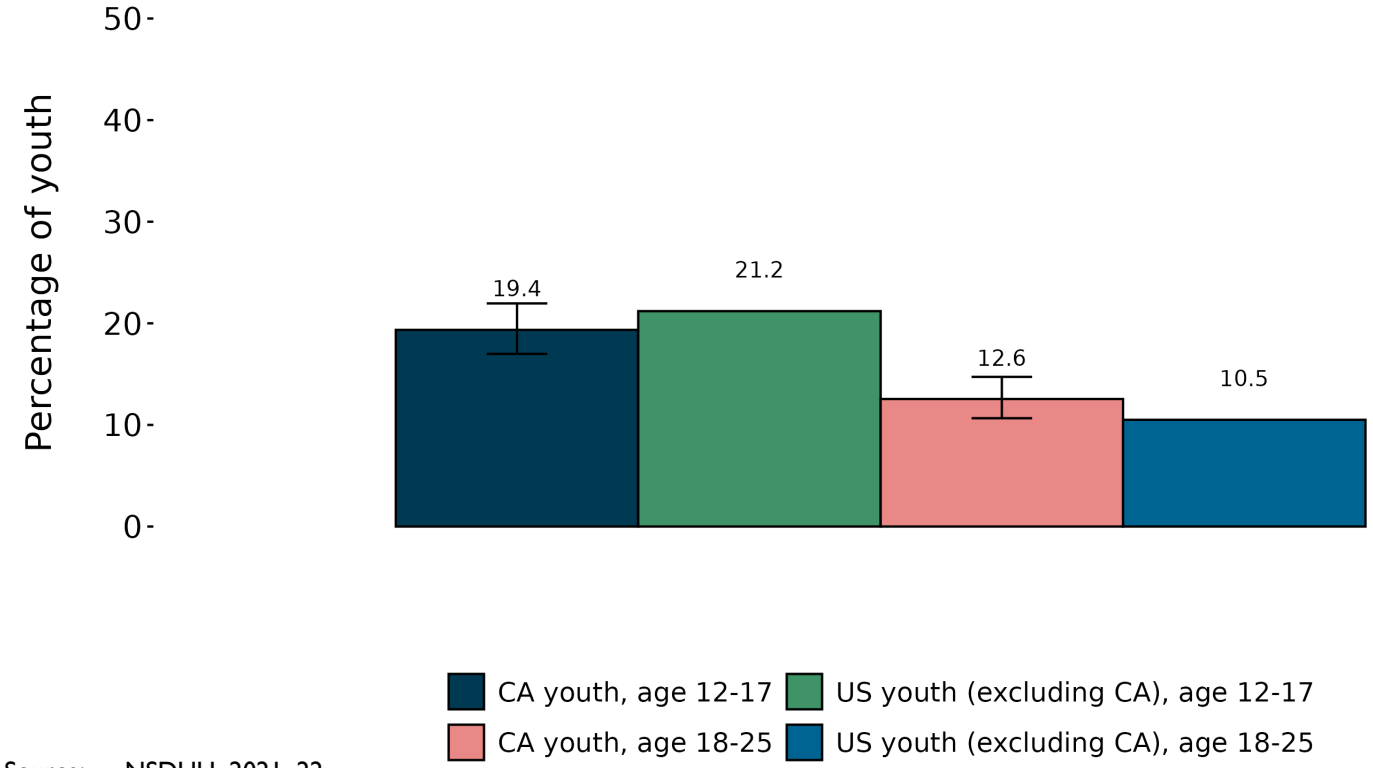


Source: CHKS, Alcohol and Other Drug module of biennial surveys

Notes: The 7th-, 9th-, and 11th-grade student responses come from the Alcohol and Other Drug module of the CHKS biennial surveys, which are weighted to be representative of the California student population. Students responded "yes" to the following question: "During the past 12 months, have you talked with at least one of your parents or guardians about the dangers of alcohol or drug use?"

A LARGER PROPORTION OF 18- TO 25-YEAR-OLDS INITIATED MARIJUANA USE THAN 12- TO 17-YEAR-OLDS

Percentage of youth who initiated marijuana use in the past year, 2021–2022



Source: NSDUH, 2021–22.

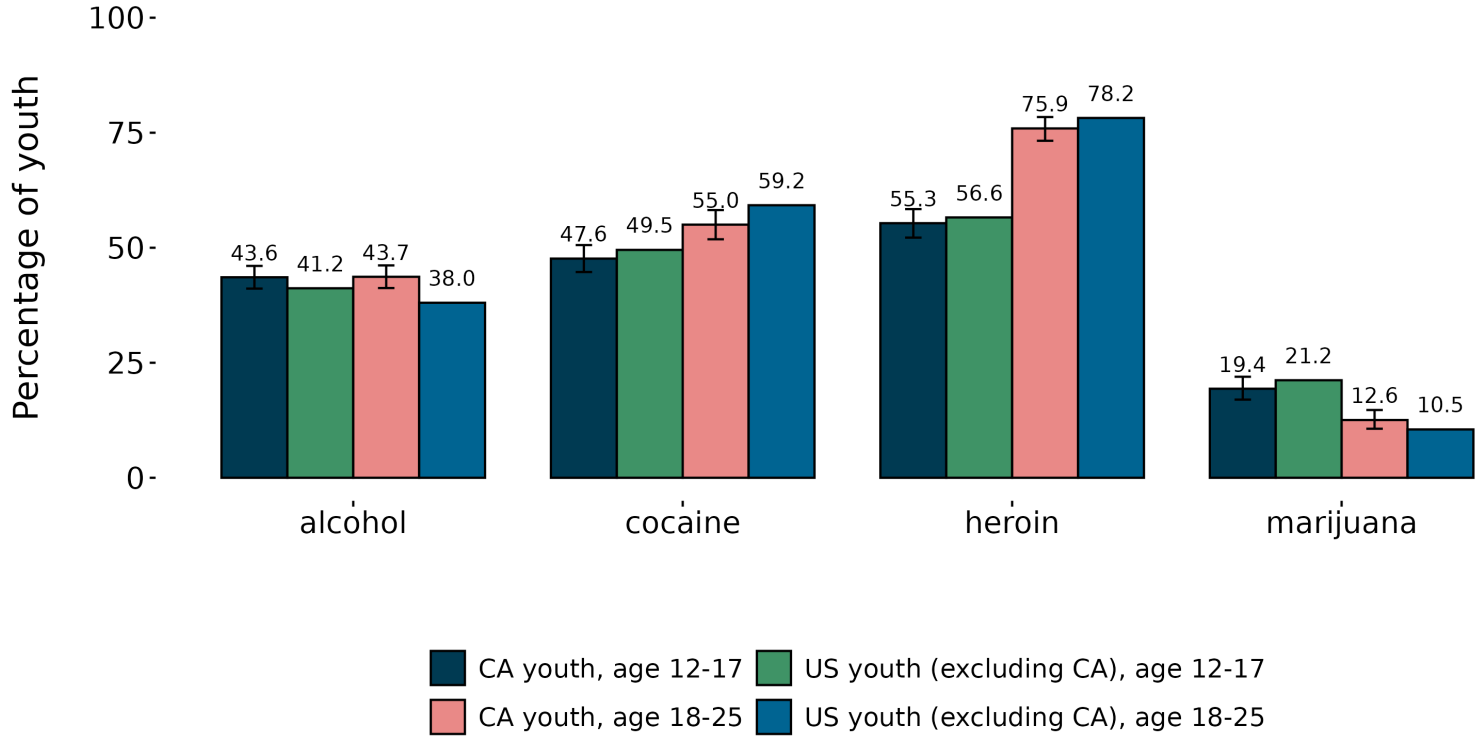
Notes: Data come from state summary tables of the NSDUH, conducted annually by the Substance Abuse and Mental Health Services Administration. Among respondents who had previously never used marijuana, the survey calculates the percentage who used marijuana for the first time in the past year. Estimates are based on a small area estimation methodology in which two years of NSDUH data combined with local data sources are weighted to be representative of the population. Data from 2019–20 and 2020–21 are not available due to methodology concerns arising from the COVID-19 pandemic. Estimates from 2021–22 should be treated with caution when compared with previous years because of changes in methodology.

12. KEY TAKEAWAYS: DISPARITIES AND SUBGROUP DIFFERENCES

- **Age:**
  - Youth ages 12–17 were more likely to perceive harm from marijuana and alcohol than youth ages 18–25
  - Youth ages 18–25 were more likely to perceive harm from cigarettes, cocaine, and heroin than youth ages 12–17
- **Race and ethnicity:**
  - Students who identify as Black, AI/AN, or Hispanic/Latino reported lower rates of seeing substance use prevention messages.
  - More than half of students who identify as White reported having a substance use prevention discussion with a parent, compared with less than half of students identifying as other racial groups.

ALTHOUGH 18- TO 25-YEAR-OLDS AND 12- TO 17-YEAR-OLDS PERCEIVED SIMILAR RATES OF HARM FROM ALCOHOL, YOUTH OF DIFFERENT AGES VARY IN PERCEPTION FOR OTHER SUBSTANCES, PARTICULARLY FOR HEROIN

Percentage of youth who perceived great risk of harm from alcohol, cocaine, heroin, and marijuana, 2021–2022

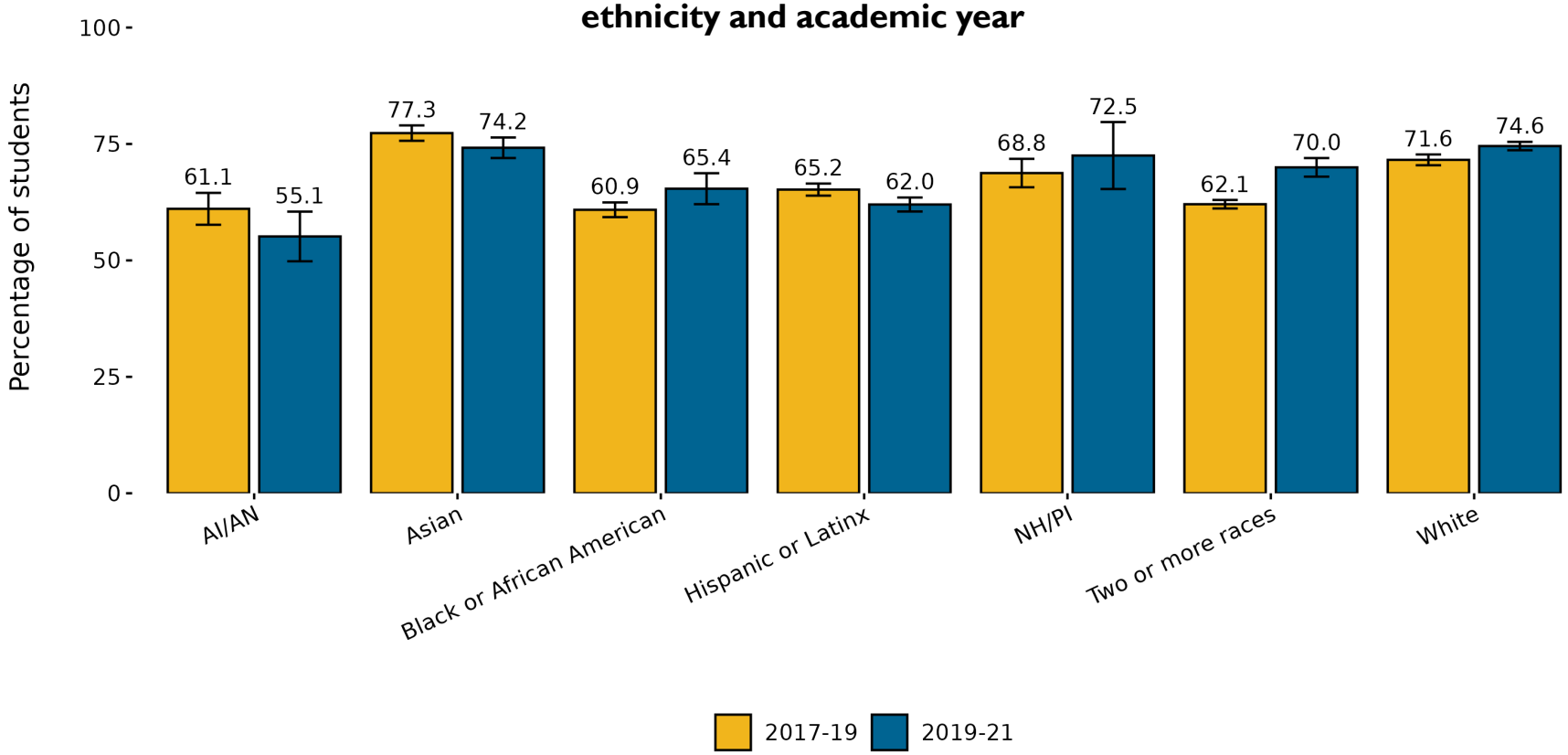


Source: NSDUH, 2021–22.

Notes: Data come from state summary tables of the NSDUH, conducted annually by the Substance Abuse and Mental Health Services Administration. Respondents replied "moderate risk" or "great risk" to the question, "How much do people risk harming themselves physically and in other ways when they smoke marijuana once a month?" Estimates are based on a small area estimation methodology in which two years of NSDUH data combined with local data sources are weighted to be representative of the population. Data from 2014–15 are not available in state summary tables. Data from 2019–20 and 2020–21 are not available due to methodology concerns arising from the COVID-19 pandemic. Estimates from 2021–22 should be treated with caution when compared with previous years because of changes in methodology.

AI/AN, BLACK, AND HISPANIC/LATINX STUDENTS REPORTED LOWER RATES OF SEEING SUBSTANCE USE PREVENTION MESSAGES

Percentage of students who heard, read, or watched any messages about not using substances in the past 12 months, by race and ethnicity and academic year



Source: CHKS, Alcohol and Other Drug module of biennial surveys.

Notes: The 7th-, 9th-, and 11th-grade student responses come from the Alcohol and Other Drug module of the CHKS biennial surveys, which are weighted to be representative of the California student population. Students responded "yes" to the following question: "During the past 12 months, have you heard, read, or watched any messages about not using alcohol or drugs?"

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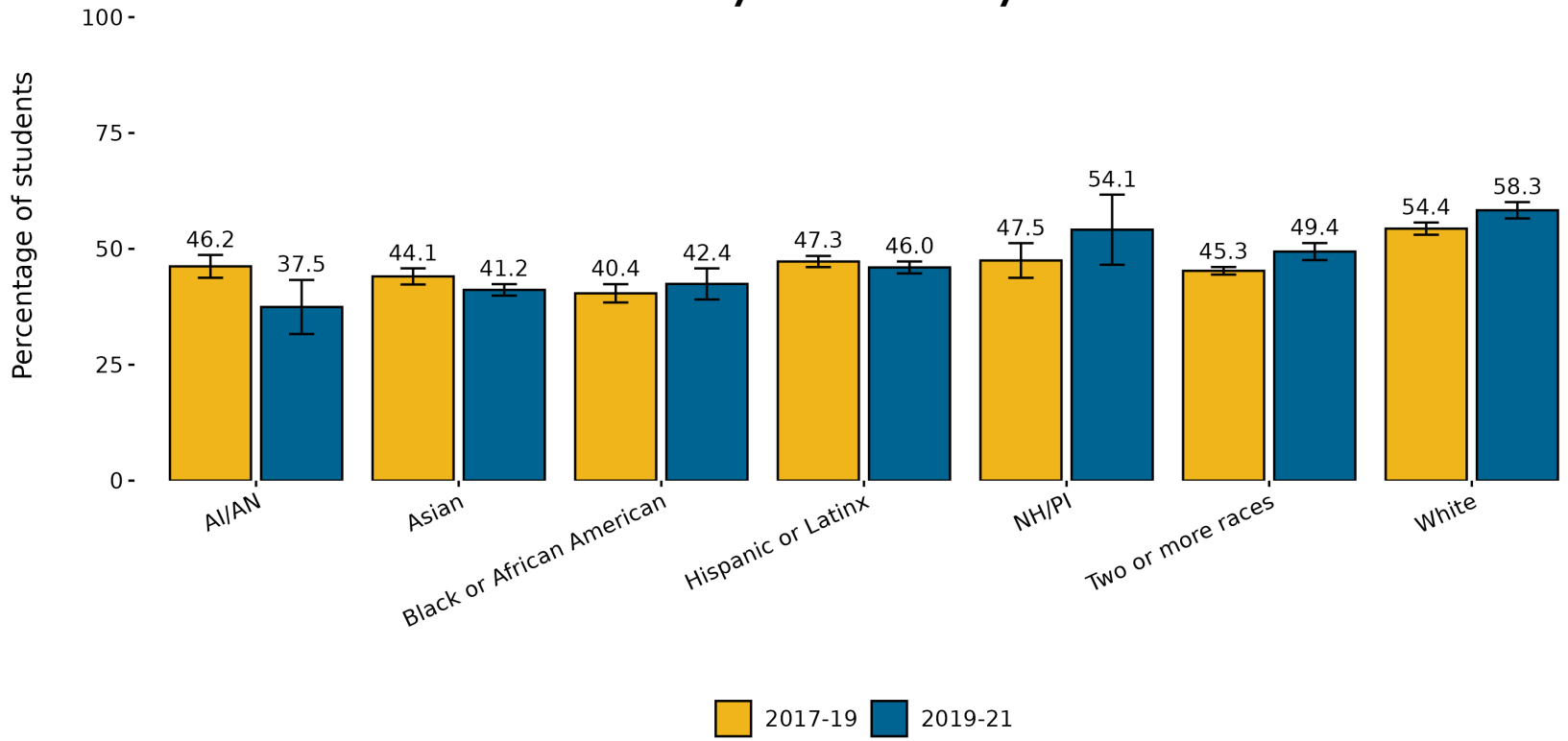
MORE THAN HALF OF WHITE STUDENTS REPORTED A SUBSTANCE USE PREVENTION DISCUSSION WITH A PARENT COMPARED WITH LESS THAN HALF OF STUDENTS IDENTIFYING AS OTHER RACIAL GROUPS

Percentage of students who talked with a parent or guardian about the dangers of substance use in the past 12 months, by race and ethnicity and academic year



Source: CHKS, Alcohol and Other Drug module of biennial surveys.

Notes: The 7th-, 9th-, and 11th-grade student responses come from the Alcohol and Other Drug module of the CHKS biennial surveys, which are weighted to be representative of the California student population. Students responded "yes" to the following question: "During the past 12 months, have you talked with at least one of your parents or guardians about the dangers of alcohol or drug use?"

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Endnotes

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ENDNOTES

Note	Source
a	Centers for Disease Control and Prevention. "Higher Autism Prevalence and COVID-19 Disruptions." 2024. https://www.cdc.gov/ncbddd/autism/features/new-autism-spectrum-disorder-report.html#:~:text=Autism%20spectrum%20disorder%20(ASD)%20continues,identification%20and%20initiation%20of%20services.
b	Kent, J. "Comprehensive Tobacco Prevention And Cessation Services For Medi-Cal Beneficiaries." November 30, 2016. https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-014.pdf.
c	KidsData. "Death Rate, by Age Group and Cause." n.d. https://www.kidsdata.org/topic/659/death-rate-age-cause/table#fmt=2318&loc=2&tf=122&ch=1307,1309,446,1308,530,531,533,532,975,534,529&sortColumnId=0&sortType=asc.
d	Human Rights Campaign Foundation. "Bi+ Youth Report." 2019. https://hrc-prod-requests.s3-us-west-2.amazonaws.com/files/images/resources/HRC-2019-Bi-Youth-_Report.pdf.
e	Gates, G.J. "How Many People Are Lesbian, Gay, Bisexual, and Transgender?" Williams Institute, UCLA School of Law, 2011. https://williamsinstitute.law.ucla.edu/publications/how-many-people-lgbt/.

ENDNOTES

Note	Source
f	Alegría, Margarita, and Jennifer Greif Green. "Disparities in Child and Adolescent Mental Health and Mental Health Services in the U.S." William T. Grant Foundation, 2015. https://wtgrantfoundation.org/wp-content/uploads/2015/09/Disparities-in-Child-and-Adolescent-Mental-Health.pdf.
g	Center for Research in Education and Social Policy. "Chronic Absenteeism and Its Impact on Achievement." CRESP Policy Brief Series, June 2018. https://www.cresp.udel.edu/wp-content/uploads/2018/07/P18-002.5_final.pdf.
h	Lipson, S.K., E.G. Lattie, and D. Eisenberg. "Increased Rates of Mental Health Service Utilization by U.S. College Students: 10-Year Population-Level Trends (2007–2017)." *Psychiatric Services,* vol. 70, no. 1, 2019, pp. 60–63.

Appendices

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APPENDIX A. SUBGROUPS

Subgroups included:

- Age/grade
- Gender/sex at birth
- Race
- Ethnicity
- Sexual orientation
- Region (defined as the CHIS regions)

Subgroup limitations:

- Not all data sources include data for all subgroups.
- Unable to report race and ethnicity separately for some data sources.

APPENDIX B. DATA SOURCES, METHODS, AND LIMITATIONS

Survey data source	Year(s) available	Data sample	Limitations
CA Health Interview Survey (CHIS)	2017–21	• Individual level • Ages: 1–11 (completed by an adult proxy), 12–17, and 18–25	• Switched from "phone" to "phone+web" modality in 2019. • Completed at home; adolescents may be reluctant to share sensitive information in presence of parents/caregivers. • Low response rate.
CA Healthy Kids Survey (CHKS)	Biennial survey, which includes the Core and Alcohol and Drug Modules: SY 2013–15 to 2019–21	• Individual level • Students in grades 7, 9, and 11	• Biennial survey weighted to be representative of all students in 7th, 9th, and 11th grades. • Significant data lag: data from the biennial survey is released every two years, more than one year after the end of the two-year survey period. • Survey from 2021–23 not yet available due to survey administration complications from COVID-19.
	Secondary survey, which includes the Mental Health Supports Module: 2016–17 to 2022–23	• Individual level • Students in grades 6–12.	• **Not** weighted to be representative of all students in 6th to 12th grades. • Optional modules administered inconsistently by schools; very low response rate.

APPENDIX B. DATA SOURCES, METHODS, AND LIMITATIONS (CONT'D.)

Survey data source	Year(s) available	Data sample	Limitations
California School Staff Survey (CSSS)	SY 2016–17 to 2022–23	• Individual level • K–12 teachers, administrators, and other school personnel	• Not weighted to be representative of all school personnel in state (biased toward actual survey respondents).
National Survey of Children's Health (NSCH)	2017 to 2021	• Household level • Households with children (ages 0–17)	• Small sample size for California (limited to respondents residing in California).
National Survey on Drug Use and Health (NSDUH)	2013–14 to 2021–22	• Individual level • Respondents age 12 and older	• Only some survey items are available in state summary tables, and not all items are available in all years. • No data available in 2019–20 and 2020–21 because of methodology concerns resulting from COVID-19. • Methodology changed in 2021–22, so caution should be used when comparing with earlier years.

APPENDIX B. DATA SOURCES, METHODS, AND LIMITATIONS (CONT'D.)

Administrative data source	Year(s) available	Data sample	Limitations
Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF)	2017–22	• Individual level • Limited to ages 0–25 for this analysis	• Limited to Medi-Cal and CHIP beneficiaries
Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) National Emergency Department Sample (NEDS) and National Inpatient Sample (NIS)	2017–21	• Inpatient admission/ED visit level • Limited to ages 0–25 for this analysis	
Department of Health Care Access and Information (HCAI) emergency department and inpatient data	2017–22	• Inpatient admission/ED visit level • Limited to ages 0–25 for this analysis	
Centers for Disease Control and Prevention (CDC) Wide-ranging Online Data for Epidemiologic Research (WONDER)	2018–23	• Individual level • Limited to ages 0–25 for this analysis	
California Department of Education: Chronic Absenteeism	SY 2016–17 to 2022–23	• State level • Grades K–12	• Data not available for SY 2019–20 and should be interpreted with caution for SY 2020–21
US Department of Education: Chronic Absenteeism	SY 2021–22	• National level • Grades K–12	• Only one year of data available

CHIP = Children's Health Insurance Program; ED = emergency department; SY = school year.

APPENDIX C. HCAI ED AND INPATIENT DATA NOTES

- The sample was composed of all ED visits or inpatient stays by California residents, ages 0–25, at any non-federal acute care hospital in California.
- An ED visit that results in hospitalization at the same acute-care facility was only counted once as an inpatient admission.
- Diagnosis codes for behavioral health, MH, SUD, nonfatal overdoes, and self-harm are available upon request. (ICD-10 CM codes are also available upon request.)
- Enrollees were assigned as having a behavioral health symptom or issue if the visit or admission had no other MH or SUD diagnoses and met criteria for symptom or issues. (ICD-10 CM codes are available upon request.)
- For more information on HCAI data, see https://hcai.ca.gov/data-and-reports/request-data/data-documentation/.

APPENDIX D. TAF ANALYSIS NOTES AND DEFINITIONS

- Analysis was limited to Medi-Cal and CHIP enrollees eligible for full benefits in the reference month.
- An enrollee was designated as having a behavioral health diagnosis generally if they have one inpatient or two outpatient claims with a diagnosis in the same MH or SUD diagnostic category in the current month or the prior 23 months,. The exception was for outpatient claims for services clearly indicative of a diagnosis, such as a tobacco cessation diagnosis or a pharmaceutical claims for medication-assisted treatment for opioid use disorder. In these circumstances, we required only one claim for classification.
- Enrollees were assigned as having a behavioral health symptom if they were not assigned to a diagnosis category but had at least one claim listing a behavioral health diagnosis, a suicidal or self-harm related diagnosis, or another indication of behavioral health need such as emotional state (R45), problems related to social environment (Z60), or a relational problems (Z62).
- Medi-Cal enrollment and policy references:
  - https://www.chcf.org/wp-content/uploads/2021/08/MediCalFactsFiguresAlmanac2021.pdf
  - https://www.chcf.org/blog/data-show-california-2019-health-insurance-enrollment-struck-balance/

APPENDIX D. TAF ANALYSIS NOTES AND DEFINITIONS (CONT'D.)

- **behavioral health issue:** A MH or SUD diagnosis or a behavioral health symptom as identified on the prior slide.
- **Non-diagnosed behavioral health issue:** A behavioral health symptom that does not meet the criteria for a MH or SUD diagnosis.
- **behavioral health treatment:** Services on a claim with an ICD-10 diagnosis code in any position indicating a MH or SUD diagnosis or symptom.
- **Acute care service:** Inpatient stays, ED visits, and crisis stabilization services.
- **Crisis stabilization:** Psychotherapy or other behavioral health treatment that addresses the immediate needs of a person experiencing a behavioral health crisis.
- **Practitioner service:** An evaluation and management service or a Federally Qualified Health Center visit.

APPENDIX D. TAF ANALYSIS NOTES AND DEFINITIONS (CONT'D.)

- **Psychotherapy/counseling/other psychiatric service:** Psychotherapy, counseling (including tobacco cessation and other substance use counseling) or other psychiatric service such as hypnotherapy, narcosynthesis, and activity therapy.
- **Screening/assessment/other diagnostic services:** Screening (including screening for adverse childhood events, depression, and SUDs), assessment (including cognitive, developmental, neurobehavioral, emotional, health, and behavioral assessments), or other diagnostic services (including psychological testing and evaluation) including administering, interpreting, and documenting these services.
- **Case management:** Services that support an enrollee's receipt of the physical, behavioral, and support services they need.
- **Community support services:** Services that help address health-related social needs.