trilliant health

2026 Behavioral Health

SERVICE LINE INTELLIGENCE REPORT

INTRODUCTION

Analyzing Behavioral Health Trends

The ongoing behavioral health crisis – encompassing mental illness and substance use disorders – is one of the most pervasive and unresolved healthcare issues in the United States. Nearly one in four American adults lives with a mental illness, and more than 48,000 people die by suicide each year. Collectively, behavioral health conditions are a leading driver of disability, lost productivity and premature death across every demographic group.

The economic burden is equally staggering. The total cost of behavioral health conditions in the U.S., including healthcare utilization, lost wages, criminal justice encounters and premature death, exceeds $300B annually, with some estimates placing the true figure considerably higher.

Emerging trends – including rising rates of anxiety and depression among adolescents, growing social isolation and the lingering effects of the governmental and societal response to the COVID-19 pandemic – suggest that the behavioral health crisis will likely intensify and increasingly affect younger populations.

Importantly, many behavioral health conditions are treatable, and early intervention can significantly alter long-term outcomes. Yet access to care remains challenging: more than half of adults with a mental illness do not receive treatment, driven by provider shortages, cost, social stigma, fragmented care systems and coverage gaps.

For all these reasons, the behavioral health crisis is America's preeminent public health challenge. Meaningful advancements in prevention, early identification, access and adherence to evidence-based treatment would have an outsized impact on health outcomes, quality of life, healthcare spending and workforce productivity. Addressing the behavioral health crisis demands urgent, coordinated action from every health economy stakeholder – patients, providers, life sciences, payers and policymakers.

The purpose of this report is to identify the most important trends in behavioral health and to stimulate a data-driven discussion about the most important issues. In particular:

- **Where are the gaps in prevention and early intervention, and what will it take to close them?**
- **How can this data be used to expand access to evidence-based care for the populations with the highest need?**
- **What role does your organization play in addressing the structural barriers – cost, workforce shortages and coverage gaps – that prevent people from getting care?**
- **How will you measure and demonstrate "value for money" for the individuals and communities your organization serves?**

REPORT ROADMAP

Key Research Questions

The health economy creates more data than any other part of the U.S. economy, but policymakers and executives have been challenged to analyze and interpret the data thoroughly and quickly enough to adapt to constant rooted in flawed information that assumes the status quo. change. Stakeholders are satisfied with "anecdata" and surveys about what executives *think will happen* instead of demanding data that is objective and representative of what *is happening* in the market. As a result, myriad stakeholders continue to make decisions

This report provides nationally representative research and longitudinal insights to connect the dots across the health economy. **The first step in delivering value for money in the health economy requires data-driven strategies.**

Demand

- How are behavioral health prevalence and mortality changing?
- How does behavioral health impact different patient populations and how is this changing?
- How is behavioral health medication use changing?

Supply

- What are the trends in behavioral health provider supply?
- How are novel treatment paradigms and technologies influencing the behavioral health market?

Yield

- How does behavioral health impact overall healthcare costs?
- What is the policy landscape in behavioral health?
- How do prices compare for common behavioral health services?

INTRODUCTION

Behavioral Health Encompasses Several Conditions

A Framework for Understanding Behavioral Health

Mental Diseases & Disorders

Anxiety disorders
(e.g., generalized anxiety, obsessive compulsive disorder)

Mood disorders
(e.g., major depressive disorder, bipolar disorder)

Behavioral and emotional disorders
(e.g., ADHD, tic disorder)

Schizophrenia and other non-mood psychotic disorders

All other behavioral health disorders
(e.g., autism, eating disorders, sleep disorders)

Alcohol & Substance Use Disorders

Alcohol-related disorders

Opioid-related disorders

Nicotine dependence

Cannabis-related disorders

Hallucinogen-related disorders

Cocaine-related disorders

Inhalant-related disorders

Other psychoactive
substance-related disorders

INTRODUCTION

Factors That Will Impact the Future of Behavioral Health

Risk Factors

- **Psychological**
  (e.g., beliefs, coping skills, cognitive bias)
- **Environmental**
  (e.g., social media)
- **Social**
  (e.g., upbringing, family/peer relationships, media, culture, traumas)
- **Biological**
  (e.g., genetic, physical health)
- **Health literacy**
  (e.g., screening behavior)

Prevention

- **Screening**
- **Lifestyle modifications**
- **Exposures**

Behavioral Health

Treatment

- **Accessibility**
- **Change in cost**
- **Effectiveness**

Outcomes

- **Incidence rates**
- **Screening costs**
- **Treatment costs**
- **Resource needs**
- **Life expectancy**
- **Deaths**

Applying an Economic Framework to Study Behavioral Health Trends

For decades, the U.S. health economy has operated as if the fundamental rules of economics — demand, supply and yield — do not apply. However, the U.S. healthcare system is what game theorists call a “negative-sum game,” and the rules of that game are immutable. This reality impacts every health economy stakeholder.

This report uses the laws of economics as a framework by which to study emerging trends in behavioral health. To conduct this analysis, the Trilliant Health Provider Directory, national all-payer claims and health plan price transparency datasets were combined. These data components allow for the triangulation of what service was provided, where the service was provided, who provided the service and how much the service cost.

Demand

Refers to both the exogenous and endogenous factors that influence consumer preferences, need for and utilization of healthcare services.

Primary Data Source:
National all-payer claims dataset

Supply

Refers to the various providers of health services ranging from hospitals and physician practices to retail pharmacies, new entrants and virtual care platforms.

Primary Data Source:
Provider Directory

Yield

Refers to the intersection of demand and supply (i.e., negotiated rate) and is also influenced by market factors such as policy regulations and reimbursement incentives.

Primary Data Source:
Health plan price transparency dataset

METHODS

Understanding the Longitudinal Patient Journey

Trilliant Health's national all-payer claims database combines commercial, Medicare Advantage, Traditional Medicare and Medicaid claims, which provides a nationally representative sample. Trilliant Health's proprietary Provider Directory enables a unique view into providers and their practice patterns nationally. Trilliant Health's health plan price transparency data enables national and local analyses of commercial negotiated rates. Additional data were obtained from a variety of publicly available resources and are noted in respective source notes, including peer-reviewed journal publications, the Substance Abuse and Mental Health Services Administration and U.S. Centers for Disease Control and Prevention. Claims-based analyses were conducted through 2024.

Understanding the Patient Journey Via Claims Data

• In Network • Out of Network

Insurance and PCP Status

- Commercial PPO
- Established primary care relationship
- High socioeconomic status ZIP code

Health Status

- Generalized anxiety
- Major depression
- Insomnia

EXECUTIVE SUMMARY

Demand

Answering Key Research Questions

1

How are behavioral health prevalence and mortality changing?

Between 2008 and 2024, any mental illness prevalence increased 5.7 percentage points, affecting nearly one in four adults, while drug- and alcohol-induced mortality grew 176.1% since 1999.

Multiracial individuals have the highest prevalence of any mental illness (35.5%) and SUD (24.9%), Medicaid/CHIP beneficiaries lead across all major conditions and intentional self-harm mortality is highest in western states, ranging from 6.3 to 30.0 per 100,000.

Mortality trends reveal demographic divergence: drug- and alcohol-induced deaths among men have increased by over 100% across age cohorts since 2004, while intentional self-harm mortality declined among White individuals (-3.5%) but increased among Black (19.5%) and multiracial (18.3%) populations between 2018 and 2024.

2

How does behavioral health impact different patient populations and how is this changing?

Multiracial individuals (31.1%), women (28.2%) and adolescents (28.5%) have the highest rates of mental health treatment. However, mental health treatment exceeds SUD treatment by nearly 7x. Adults ages 26-49 have experienced increases in nearly all mental health and SUD conditions, with demand projected to grow most rapidly for ages 35-49.

Medicaid/CHIP beneficiaries have the highest treatment utilization (27.6% mental health; 7.4% SUD), while the uninsured have the lowest mental health treatment rates despite a 24.7% prevalence of any mental illness, compared to 23.4% for all adults.

Treatment gaps persist across populations: more than half of patients presenting to the ED for alcohol, SUD or anxiety did not receive specialized follow-up care within 30 days.

3

How is behavioral health medication use changing?

In 2024, 21.4% of women received prescription treatment for mental health, compared to 11.8% of men. By age group, the rate of medication treatment ranged from 12.7% among ages 12-17 to 17.4% among those ages 18-25. Additionally, medication treatment ranged from 6.0% among Asian Americans to 23.3% among multiracial individuals, followed closely behind at 21.3% among White individuals.

Between 2018 and 2024, stimulants had the fastest growth (53.3%), followed by antipsychotics (46.5%), with stimulant use particularly pronounced among women ages 18-44 (93.6%), while anxiolytics are the most commonly prescribed.

EXECUTIVE SUMMARY

Supply

Answering Key Research Questions

4

What are the trends in behavioral health provider supply?

By 2038, projected demand will exceed supply by 36,780 FTEs in adult psychiatry and 99,780 FTEs in mental health counseling, with only psychiatric NPs projected to exceed demand (108%). The percent adequacy of mental health professionals is 27.3% in the U.S., ranging from 5.7% in West Virginia to 52.3% in New Jersey.

The number of U.S. psychiatry-related residency positions has grown from 1,556 in 2018 to 2,388 in 2025. Despite this increase, residency positions have maintained a nearly 100% match rate, suggesting that supply is likely artificially constrained by the number of available positions.

In 2023, 83% of behavioral health providers reported burnout, with therapists citing the highest mental health fatigue of all specialties (77%) and low compensation as the leading driver.

5

How are novel treatment paradigms and technologies influencing the behavioral health market?

Allied health providers (NPs and PAs) surpassed psychiatrists to become the most common behavioral health prescriber type between 2018 and 2024, growing from 20.7% to 34.3% of prescription volume.

Direct-to-consumer online therapy platforms are expanding scalable access to care. There were 167 behavioral health M&A transactions in 2025, including Spring Health's planned acquisition of Alma and UHS's announced acquisition of Talkspace.

Emerging treatment modalities — including ketamine, psilocybin and MDMA for treatment-resistant depression and PTSD, and FDA-regulated prescription digital therapeutics for conditions including anxiety, depression and SUD — are expanding, though regulatory uncertainty and slow approval timelines constrain broad near-term adoption.

EXECUTIVE SUMMARY

Yield

Answering Key Research Questions

6

How does behavioral health impact overall healthcare costs?

In 2019, mental health and SUD accounted for 7.4% of total personal healthcare spending ($200B combined), with spending increasing by 30.8% and 87.5%, respectively, since 2010 and likely continuing to grow.

Untreated mental illness cost the U.S. economy an estimated $477.5B in 2024, projected to exceed $1.3T annually by 2040 — driven by premature death ($911.9B), workforce productivity losses ($252.3B) and emergency department overutilization ($17.5B).

Approximately 65% of adults cite cost as a barrier to treatment and nearly one in 10 Americans take on debt to access care.

7

What is the policy landscape in behavioral health?

The President's FY 2027 Budget Request calls to reduce NIH funding by $5B and proposes the creation of the Administration for a Health America, via a consolidation of HRSA, SAMHSA, CDC and OASH. This consolidation is intended to reduce the number of programs deemed duplicative or misaligned with administration priorities.

Separately, the Trump Administration has discontinued enforcement of the Mental Health Parity Rule, increasing financial and administrative barriers to mental health and substance use care independent of the budget process.

CMS is advancing the ACCESS and IBH models to shift toward outcome-driven, coordinated care for Medicare and Medicaid populations, with the ongoing Certified Community Behavioral Health Clinics demonstration showing tangible improvements in care coordination.

8

How do prices compare for common behavioral health procedures?

Commercial negotiated rates for psychotherapy vary substantially by procedure: CPT 90853 (group psychotherapy) has a median rate of $40 but can vary by $109 per session, while CPT 90837 (individual psychotherapy) has the widest absolute range at $464 and varies by 7x nationally.

Intensive outpatient program (IOP) rates have a median of $252 per day compared to $1,179 for a one-day inpatient psychiatric stay, though IOP rates can range by 15x and inpatient rates can range by 22x.

Applied to 200 seven-day inpatient stays, the range in commercial negotiated rates for a single inpatient psychiatric revenue code could produce a $7.9M spending difference between two hospitals within a single market.

Demand

Demand refers to both the exogenous and endogenous factors that influence consumer preferences, need for and utilization of healthcare services.

The U.S. behavioral health crisis did not subside with the end of the pandemic – it was further amplified.

Between 2008 and 2024, the prevalence of any mental illness among American adults increased by 5.7 percentage points, impacting nearly one in four adults. Substance use disorder (SUD) affected 18.1% of adults at its peak, and co-occurring mental illness and SUD remains an acute challenge, with 8.1% of adults affected in 2024. Despite recent declines, prevalence across conditions remains elevated relative to pre-pandemic levels – and the demand for services has followed.

That demand is not distributed evenly. Young adults ages 18-25 have the highest burden of mental illness (33.2%) and serious mental illness (9.4%), though those rates have begun to stabilize. Adults ages 26-49, by contrast, have seen prevalence increase across nearly all conditions. Women continue to experience higher rates of any mental illness, while men have seen faster growth since 2021 and bear a disproportionate burden of SUD. Multiracial individuals face the highest prevalence across virtually every behavioral health condition examined, including a 35.5% rate of any mental illness – a pattern that has remained consistent and, in some cases, worsened.

Medicaid and CHIP beneficiaries demonstrate the highest rates of both prevalence and treatment utilization, a dynamic that has significant implications for payers, health systems and policymakers alike.

The consequences of unmet behavioral health need are measurable in mortality. Drug- and alcohol-induced deaths have increased 176.1% since 1999, reaching 38.1 per 100,000 in 2024. Intentional self-harm accounted for 48,824 deaths in 2024 – the tenth leading cause of death in the country. Racial disparities in mortality are widening. While self-harm mortality among White individuals declined slightly between 2018 and 2024, it increased 19.5% among Black individuals and 18.3% among multiracial individuals.

Utilization data reveals a system under pressure. Behavioral health utilization increased 62.6% between 2018 and 2024, reaching 1,346 visits per 1,000 people – growth driven disproportionately by anxiety disorders, which also has the highest utilization rate of any behavioral health category. Telehealth has fundamentally restructured how behavioral health care is delivered. Behavioral health now accounts for 65.6% of all telehealth visits, up from 18.4% in 2018. Despite this expansion in access, critical gaps remain. More than half of patients who visit an emergency department for alcohol/SUD or anxiety did not receive specialized follow-up care within 30 days of discharge – a signal of both fragmentation and unmet need.

Looking ahead, it is projected that behavioral health demand will grow at a CAGR of 0.2% to 1.5% through 2030, reaching up to 56.9M visits. Growth is projected to be concentrated among adults ages 35–49 and in high-growth metros such as Austin, TX. Anxiety disorders alone are projected to account for 27.2M visits by 2030. The trajectory of that demand, however, will ultimately be shaped by the availability of providers, the uptake of pharmacotherapy, changes to screening guidelines and the evolution of direct-to-consumer behavioral health platforms.

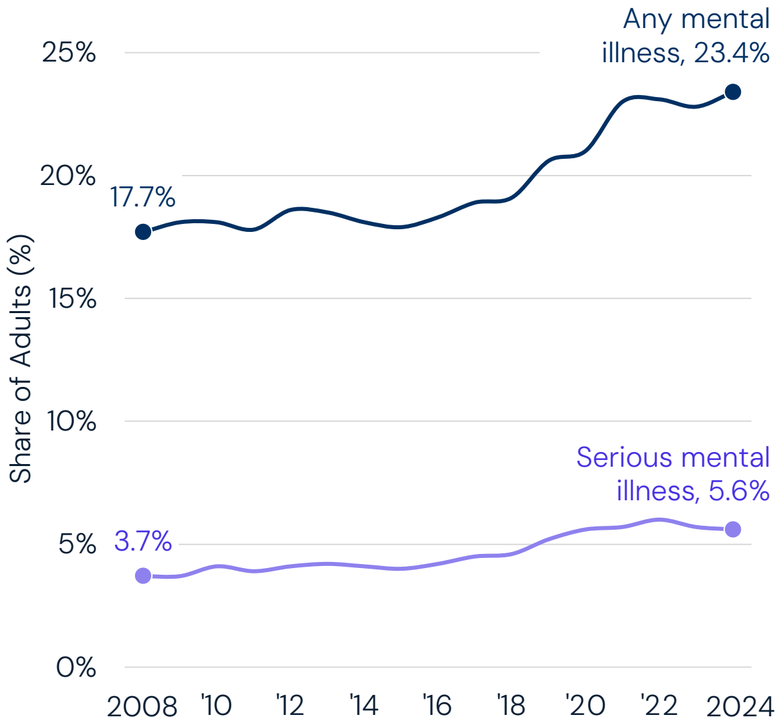
The data make it clear that behavioral health is no longer a peripheral concern for health economy stakeholders. It is a defining force shaping utilization, mortality and the financial performance of the health economy – and likely the economy at large.

DEMAND: PREVALENCE

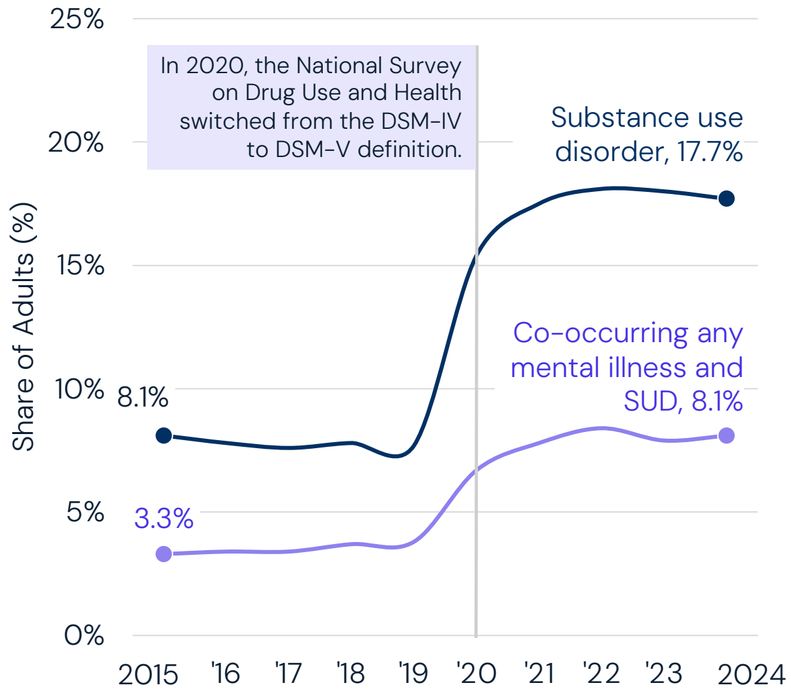
Behavioral Health Prevalence Increased Amid COVID-19 and Remains Elevated

Between 2008 and 2024, the prevalence of Americans with any mental illness increased by 5.7 PP, affecting nearly one in four adults. Serious mental illness grew more modestly, reaching 5.6% in 2024. While SUD peaked in 2022 at 18.1%, prevalence decreased to 17.7% of adults in 2024. Overall, prevalence across behavioral health conditions remains elevated relative to pre-pandemic levels.

Share of Adults With Any Mental Illness and Serious Mental Illness, 2008-2024



Share of Adults With Substance Use Disorder and Co-Occurring Any Mental Illness and Substance Use Disorder, 2015-2024



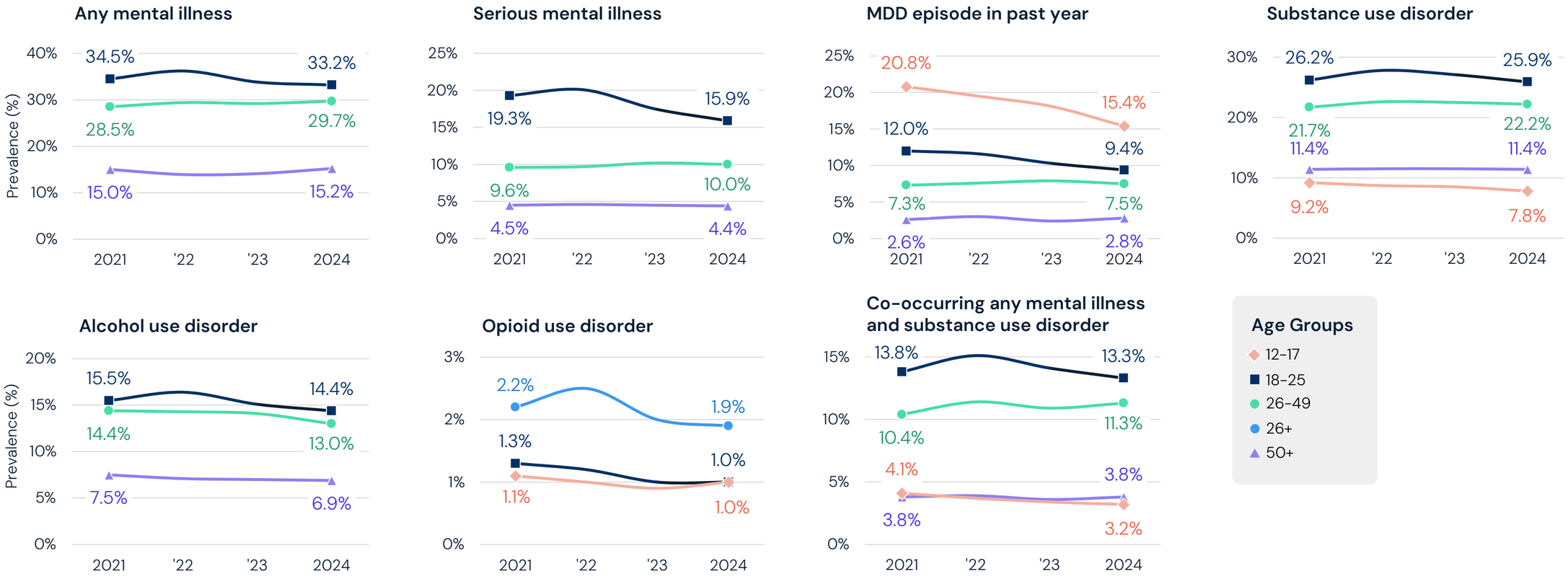
Note: PP denotes percentage points; DSM denotes Diagnostic and Statistical Manual of Mental Disorders; SUD denotes substance use disorder. SUD-related estimates are not comparable 2019 and earlier due to methodological changes since prior years were based on DSM-IV rather than DSM-V.
Source: National Survey on Drug Use and Health, Substance Use and Mental Health Services Administration, 2024.

DEMAND: PREVALENCE

Increasing Behavioral Health Prevalence Is Concentrated Among Young Adults

Adults ages 18–25 continue to exhibit the highest prevalence of any mental illness (33.2%) and serious mental illness (15.9%), though rates have declined since 2021. In contrast, adults ages 26-49 have experienced increases in nearly all mental health and substance use disorders, with the rate of any mental illness increasing by 1.2 PP and 0.9 PP for co-occurring any mental illness and SUD from 2021 to 2024.

Prevalence of Select Mental Health Conditions and Substance Use Disorders, by Age Group, 2021-2024



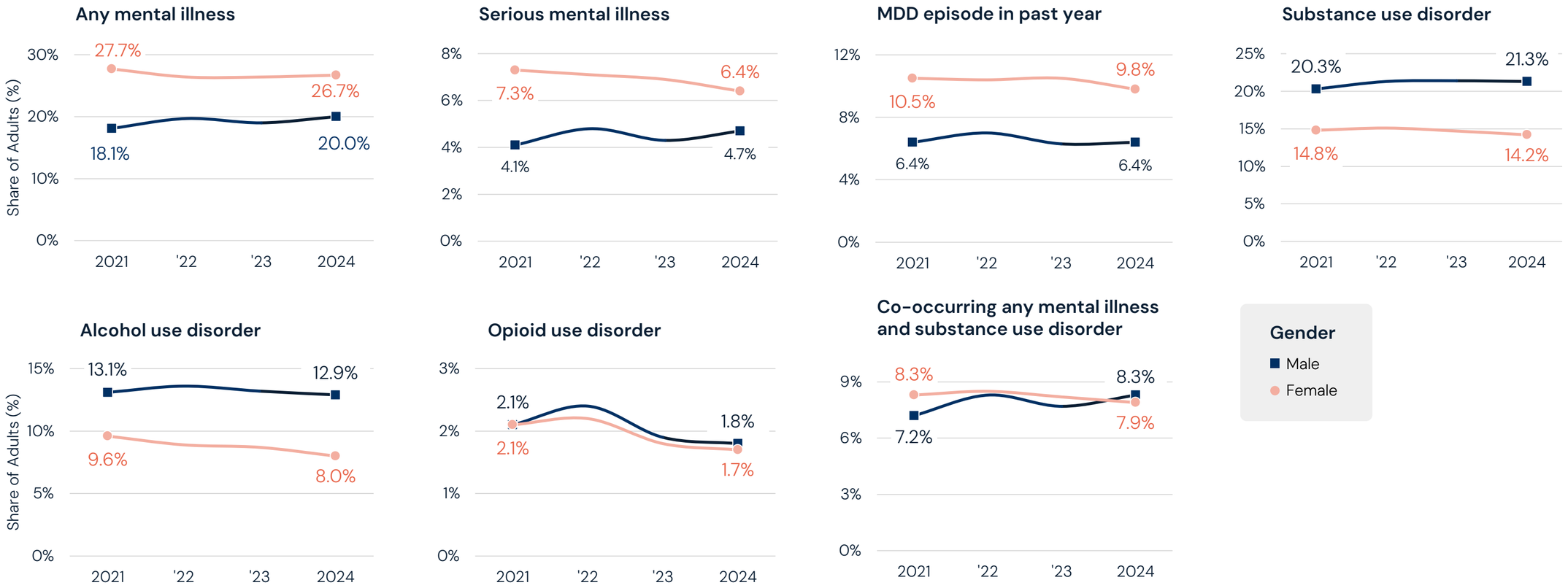
Note: PP denotes percentage point; SUD denotes substance use disorder; MDD denotes major depressive disorder. Opioid use disorder does not offer a further age breakdown.
Source: National Survey on Drug Use and Health, Substance Use and Mental Health Services Administration, 2021-2024.

DEMAND: PREVALENCE

Mental Illness Prevalence Is Higher in Women, But Increasing Among Men

Any mental illness prevalence is higher among women (26.7%) than men (20.0%), though since 2021, it has grown among men (1.9 PP) but decreased among women (1.0 PP). In contrast, SUD is more prevalent among men (21.3%) compared to women (14.2%). Co-occurring mental illness and SUD was more prevalent among women through 2023, but prevalence among men (8.3%) surpassed women (7.9%) in 2024.

Adult Prevalence of Select Mental Health Conditions and Substance Use Disorders, by Gender, 2021-2024



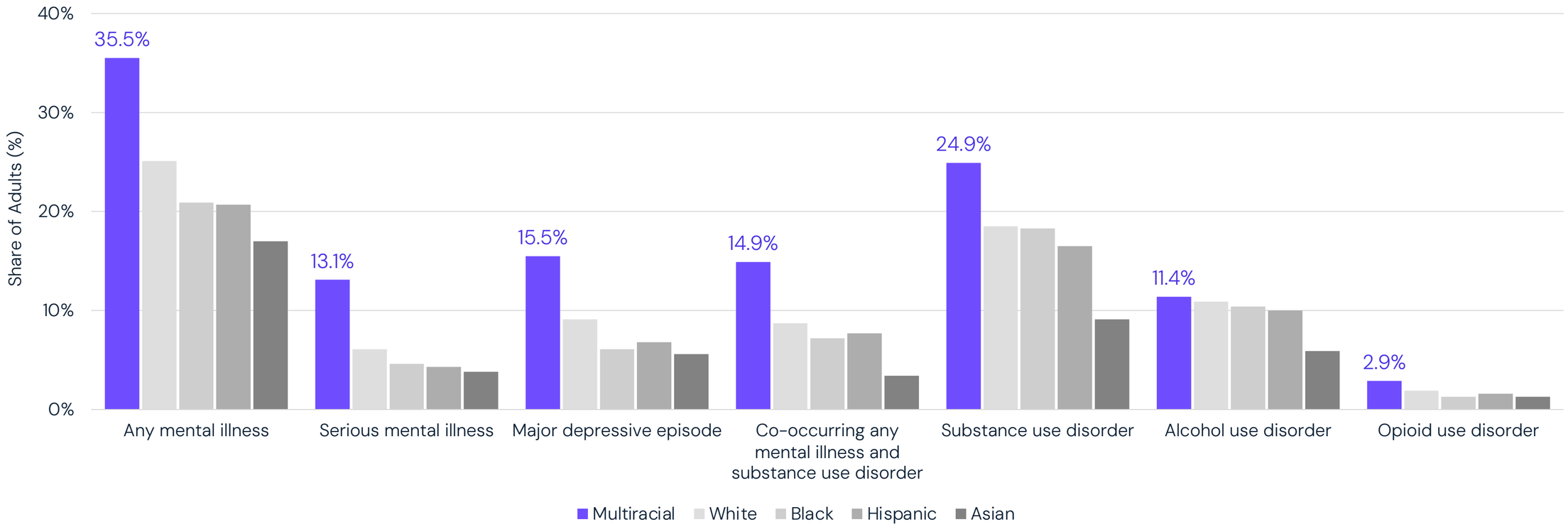
Note: SUD denotes substance use disorder; PP denotes percentage point; MDD denotes major depressive disorder.
Source: National Survey on Drug Use and Health, Substance Use and Mental Health Services Administration, 2021-2024.

DEMAND: PREVALENCE

Multiracial Individuals Demonstrate Most Intense Behavioral Health Need

Multiracial individuals have the highest prevalence across major behavioral health conditions, including any mental illness (35.5%), compared to 25.1% of White and 20.9% of Black individuals. Multiracial individuals also have the highest SUD prevalence (24.9%) compared to White (18.5%) and Black (18.3%) individuals. Since 2021. multiracial individuals have consistently had the highest prevalence across behavioral health conditions, with serious mental illness increasing by 4.6 PP and alcohol use disorder declining by 5.8 PP.

Adult Prevalence of Select Mental Health Conditions and Substance Use Disorders, by Race and Ethnicity, 2024

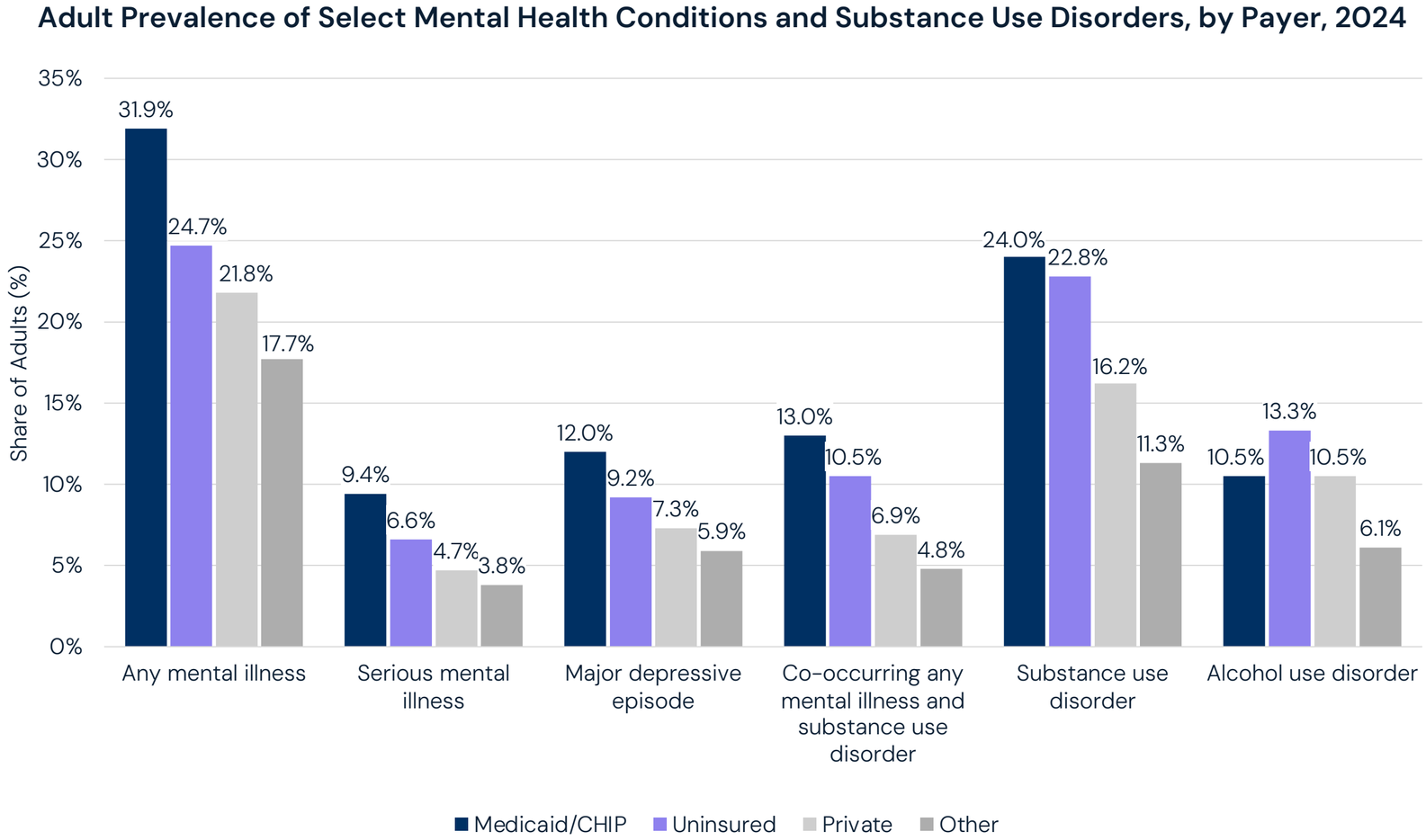


Note: SUD denotes substance use disorder; PP denotes percentage point.
Source: National Survey on Drug Use and Health, Substance Use and Mental Health Services Administration, 2024.

DEMAND: PREVALENCE

Behavioral Health Prevalence Is Highest Among Medicaid/CHIP Beneficiaries

Medicaid/CHIP beneficiaries have the highest prevalence of any mental illness (31.9%), followed by uninsured individuals (24.7%) and those with private coverage (21.8%). This pattern is consistent across serious mental illness, major depressive episodes, SUD and co-occurring mental illness and SUD. For example, in 2024, SUD prevalence was 24.0% among Medicaid/CHIP beneficiaries compared to 16.2% among privately insured individuals.



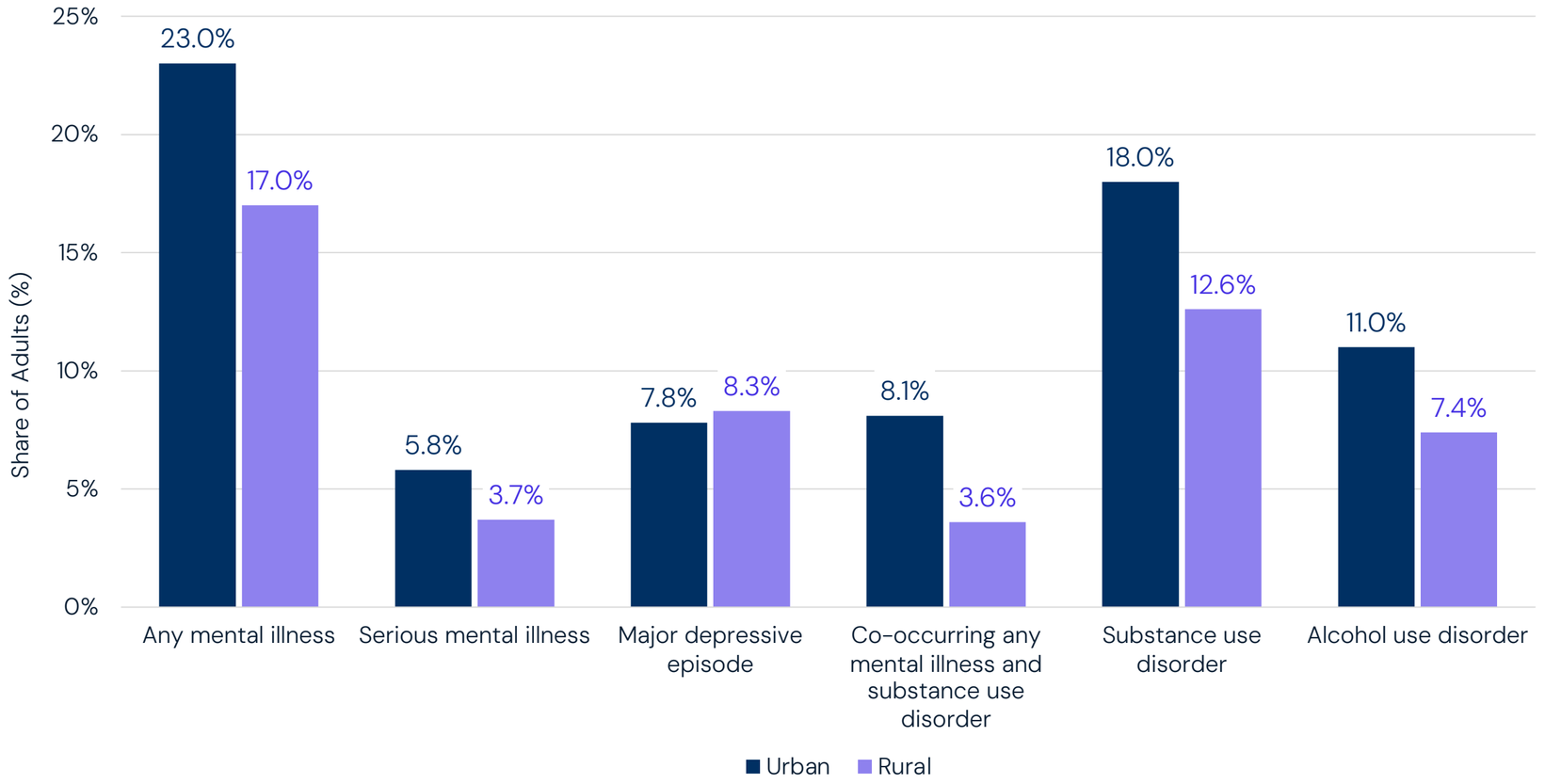
Note: SUD denotes substance use disorder; CHIP denotes Children's Health Insurance Program. Other payer type includes Medicare, military-related healthcare and other sources.
Source: National Survey on Drug Use and Health, Substance Use and Mental Health Services Administration, 2024.

DEMAND: PREVALENCE

Urban Areas Have Higher Levels of Behavioral Health Need

In 2024, any mental illness prevalence was higher among urban residents (23.0%) compared with rural residents (17.0%). SUD is also higher among urban residents (18.0%) compared to rural residents (12.6%). In general, urban areas exhibit higher prevalence across most other behavioral health conditions, with co-occurring mental illness and SUD more than twice as common in urban versus rural communities. With the majority of the U.S. population residing in urban areas, these trends also signal higher need by patient volume. Major depressive episodes are the only examined condition that is more common among rural individuals (8.3%), compared to urban individuals (7.8%).

Adult Prevalence of Select Mental Health Conditions and Substance Use Disorders, by Urbanicity, 2024



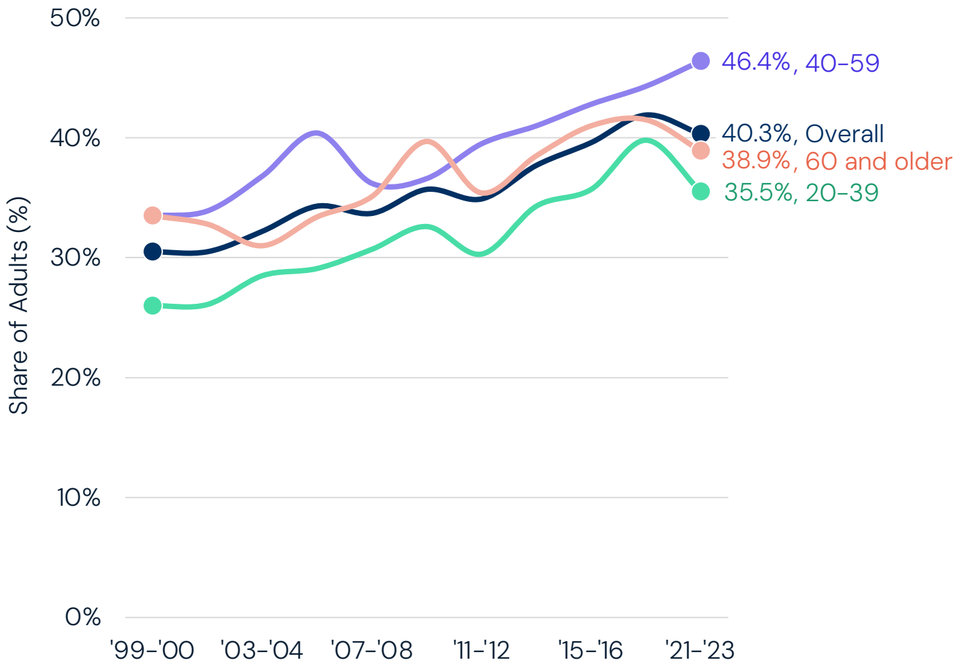
Note: SUD denotes substance use disorder.
Source: National Survey on Drug Use and Health, Substance Use and Mental Health Services Administration, 2024.

DEMAND: PREVALENCE

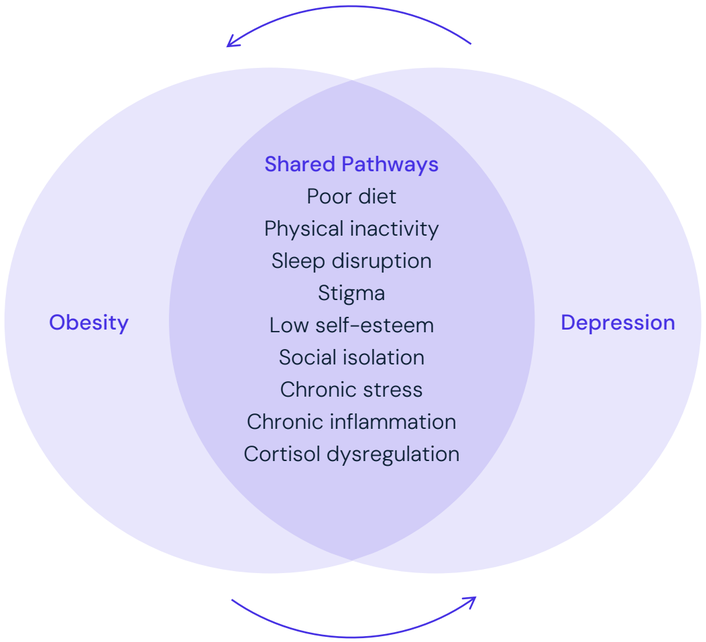
Poor Physical Health Contributes to Worsening Behavioral Health

Poor physical health and behavioral health are interconnected. Similar to rising mental health conditions, obesity prevalence has increased 9.8 PP from 1999 to 2023, now impacting 40.3% of adults. Obesity and depression share a bidirectional relationship, with each condition increasing the risk of the other over time. The relationship is driven by overlapping behavioral pathways – depression promotes poor diet, inactivity and sleep disruption, while obesity contributes to stigma, social isolation and chronic stress. At the same time, shared biological mechanisms, including systemic inflammation and disrupted metabolic signaling, affect brain function and mood regulation.

Prevalence of Obesity Among U.S. Adults, August 1999–August 2023



Relationship Between Obesity and Depression



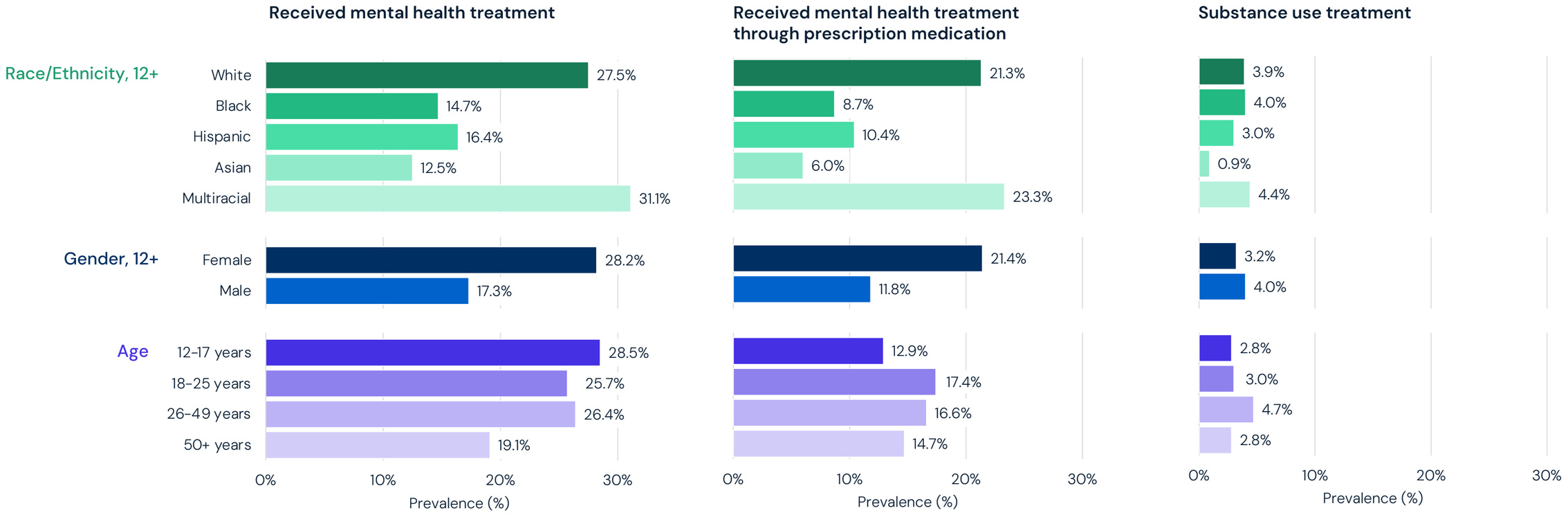
Note: PP denotes percentage point.
Source: U.S. Centers for Disease Control and Prevention; Luppino et al., Overweight, Obesity, and Depression: A Systematic Review and Meta-Analysis of Longitudinal Studies, *Archives of General Psychiatry*, 2010; Friedman, et al., Understanding the Bidirectional Association Between Obesity and Risk of Psychological Distress and Depression in Young Adults in the US: Available Evidence, Knowledge Gaps, and Future Directions, *Frontiers in Psychiatry*, 2025; Fu et al., Shared Biological Mechanisms of Depression and Obesity: Focus on Adipokines and Lipokines, *Aging*, 2023; Bannuru et al., Weight Stigma and Bias: Standards of Care in Overweight and Obesity—2025, *BMJ Journals*, 2025.

DEMAND: TREATMENT

Treatment Is More Common in Youth, Multiracial Individuals and Women

Between 2021 and 2024, the prevalence of mental health treatment among adults has increased from 18.8% to 22.9%. Notably, treatment for mental health exceeds treatment for SUD by nearly 7x. In general, multiracial individuals have the highest rate of mental health treatment (31.1%), followed by adolescents (28.5%), women (28.2%) and White individuals (27.5%). Mental health treatment through prescription medication shows a relatively similar pattern, albeit with a lower rate of utilization among adolescents.

Prevalence of Mental Health and Substance Use Treatments, by Demographics, 2024



Note: SUD denotes substance use disorder. Mental health treatment includes treatment for mental health, emotions, or behavior through inpatient treatment/counseling; outpatient treatment/counseling; use of prescription medication; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center. Substance use treatment includes treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medications for alcohol or opioid use disorder; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.
Source: National Survey on Drug Use and Health, Substance Use and Mental Health Services Administration, 2021-2024.

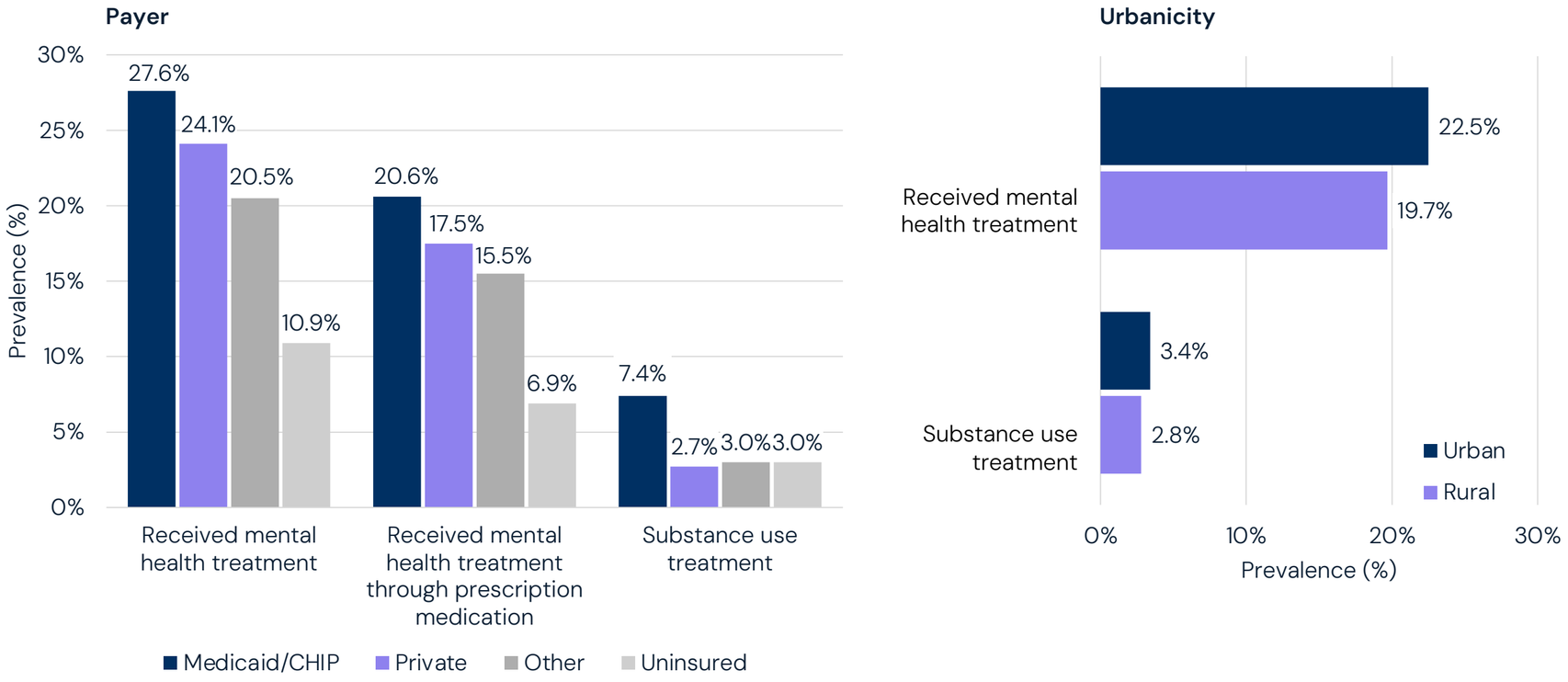
DEMAND: TREATMENT

Medicaid/CHIP And Urban Populations Have the Highest Rates of Treatment

Commensurate with the high prevalence rate, individuals covered by Medicaid/CHIP demonstrate the highest rates of behavioral health treatment, with 27.6% of beneficiaries receiving mental health services and 7.4% receiving SUD treatment. Individuals with private insurance have the second highest rate of mental health treatment (24.1%). Notably, the uninsured population has the lowest rate of mental health treatment.

Utilization is also higher in urban areas, where 22.5% of residents report receiving mental health treatment compared to 19.7% in rural communities. Similar geographic differences are observed for SUD treatment.

Prevalence of Mental Health and Substance Use Treatments, by Demographics, 2024

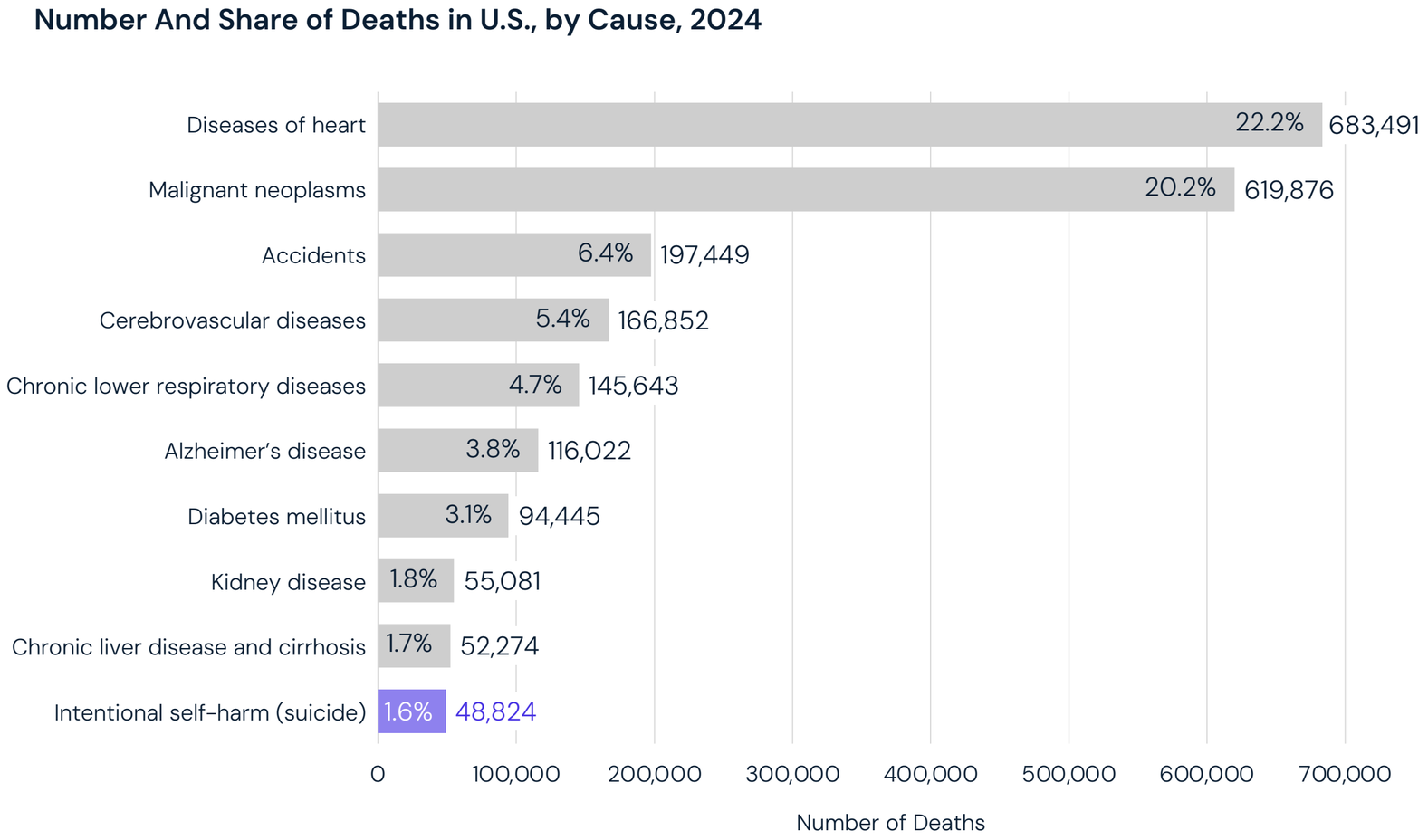


Note: SUD denotes substance use disorder. Other payer type includes Medicare, military-related healthcare or other sources. Mental health treatment measures include individuals 18 and older. Substance use treatment measures include individuals 12 years and older. Mental health treatment includes treatment for mental health, emotions, or behavior through inpatient treatment/counseling; outpatient treatment/counseling; use of prescription medication; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center. Substance use treatment includes treatment for drug or alcohol use through inpatient treatment/counseling; outpatient treatment/counseling; medications for alcohol or opioid use disorder; telehealth treatment; or treatment received in a prison, jail, or juvenile detention center.
Source: National Survey on Drug Use and Health, Substance Use and Mental Health Services Administration, 2021-2024.

DEMAND: MORTALITY

Intentional Self-Harm Is a Leading Cause of Death

In 2024, intentional self-harm accounted for 48,824 deaths. Equivalent to 1.6% of all deaths, this makes intentional self-harm the tenth most common cause of death in the U.S. Since 2008, intentional self-harm has consistently ranked among the top 10 causes of death, except between 2021 and 2023 when COVID-19 became a top cause of death and temporarily altered the rankings. Importantly, mental health and substance use disorders are not classified as a standalone cause of death but contribute to mortality across several other leading causes including accidents and chronic liver disease.



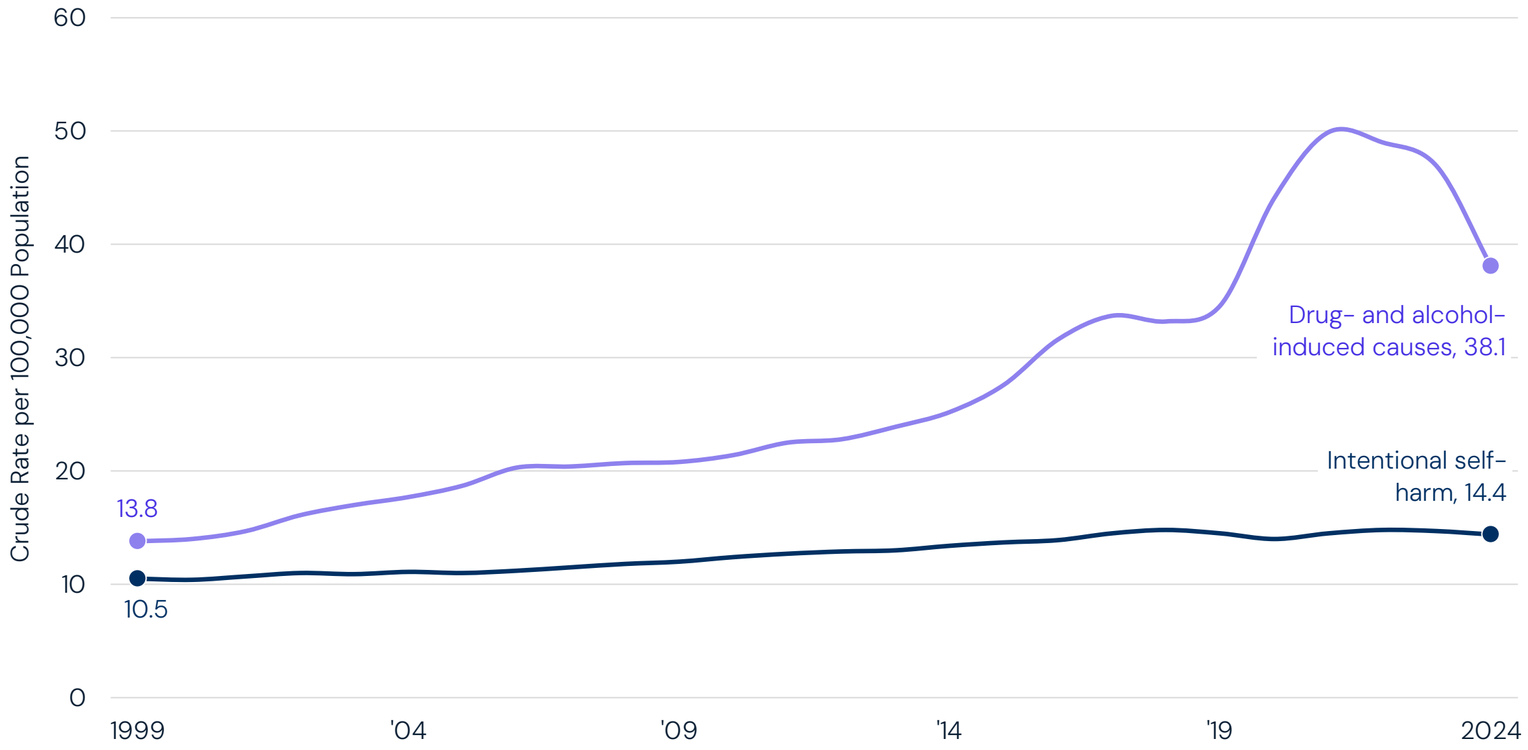
Note: ICD-10 codes comprising self-harm are U03,X60–X84,Y87.0.
Source: U.S. Centers for Disease Control and Prevention WONDER Database.

DEMAND: MORTALITY

Drug- and Alcohol-Induced Mortality Has Increased Nearly 3x, Peaking During COVID-19

From 1999 to 2024, drug- and alcohol-induced deaths increased from 13.8 to 38.1 per 100,000, a 176.1% increase. While the drug- and alcohol-induced death rate increased quickly during the COVID-19 pandemic, reaching 49.9 deaths per 100,000 in 2021, the 2024 death rate (38.1 deaths) is higher than pre-pandemic levels but commensurate with previous trends. In contrast, intentional self-harm deaths have increased more slowly and consistently, from 10.5 to 14.4 per 100,000, a 37.1% increase.

Rate of Intentional Self-Harm and Drug- and Alcohol-Induced Deaths per 100,000 Population, 1999-2024



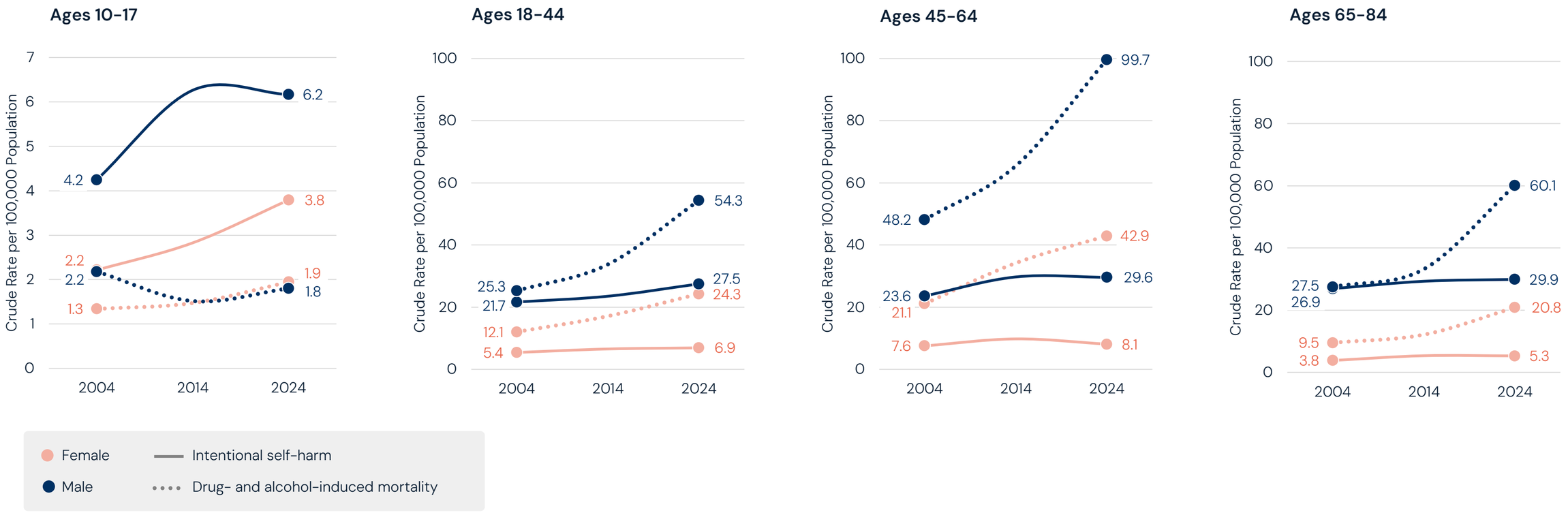
Note: ICD-10 codes comprising self-harm are U03,X60–X84,Y87.0. ICD-10 codes comprising alcohol- and drug-induced causes are X40-X44, X60-X64, X85, Y10-Y14, X45, X65, Y15.
Source: U.S. Centers for Disease Control and Prevention WONDER Database.

DEMAND: MORTALITY

Sharp Increase in Drug- and Alcohol-Induced Deaths Driven by Adult Men

Drug- and alcohol-related mortality is higher among men than women, ranging from 2.2x to 2.9x across age groups. Over the past two decades, the drug- and alcohol-induced mortality rate has increased substantially among men ages 18-44 (114.7%), 45-65 (106.9%) and 65-84 (118.7%). Among adolescents, males have the highest intentional self-harm mortality rate, increasing by 45.2% between 2004 and 2024.

Rate of Intentional Self-Harm and Drug- and Alcohol-Induced Deaths per 100,000 Population, by Age, 2004-2024

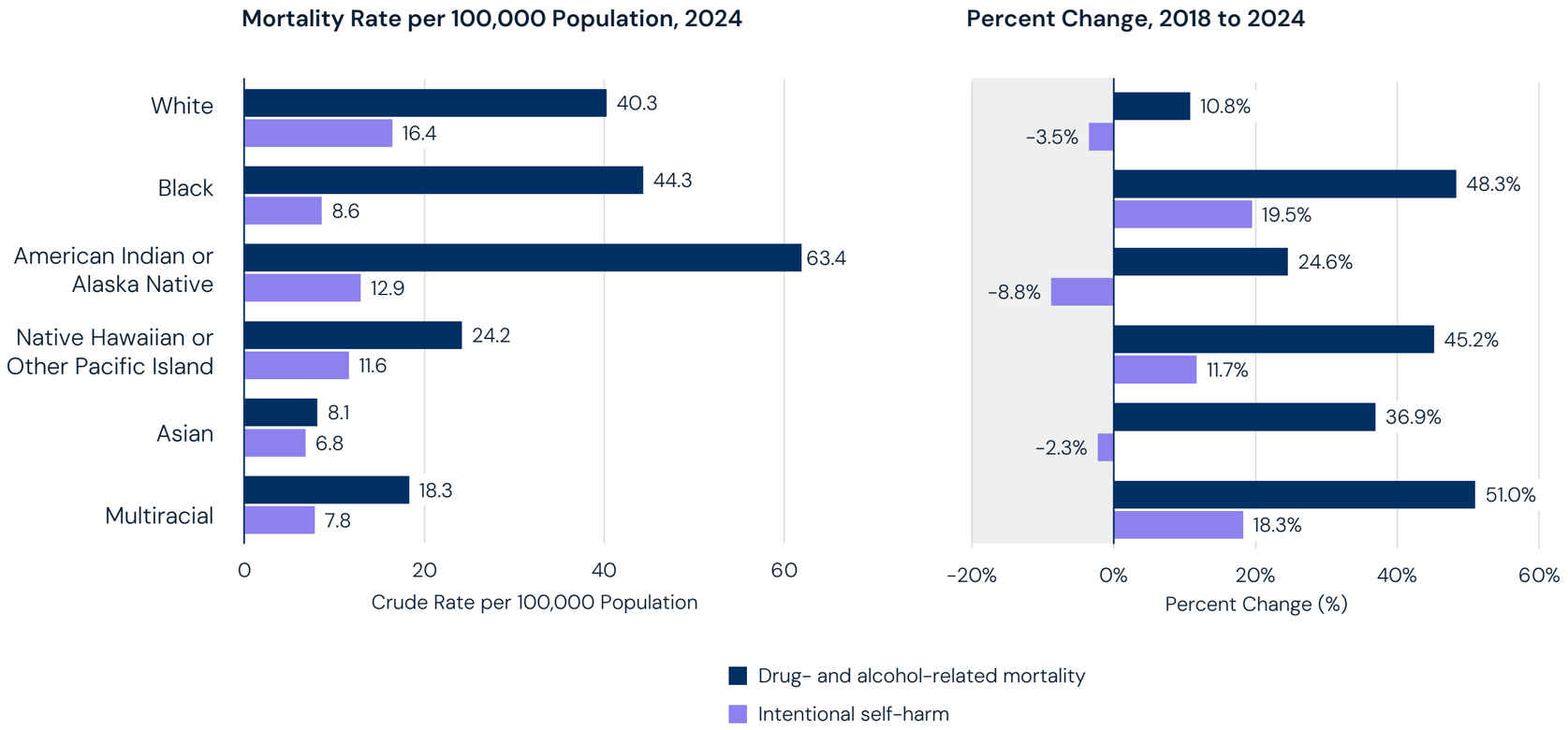


Note: ICD-10 codes comprising self-harm are U03,X60–X84,Y87.0. ICD-10 codes comprising alcohol- and drug-induced causes are X40-X44, X60-X64, X85, Y10-Y14, X45, X65, Y15.
Source: U.S. Centers for Disease Control and Prevention WONDER Database.

Intentional Self-Harm Mortality Has Increased Among Select Racial Minorities

Drug- and alcohol-induced deaths exceed deaths from intentional self-harm across all racial and ethnic groups. While White individuals continue to have the highest self-harm mortality rate (16.4 per 100,000), it declined by 3.5% between 2018 and 2024, compared with increases among Black (19.5%) and multiracial (18.3%) individuals. For drug- and alcohol-induced deaths, AIAN individuals have the highest mortality rate (63.4), followed by Black (44.3) and White (40.3) individuals. Although rates increased across all groups between 2018 and 2024, the increase was smallest among Whites (10.8%) and largest among multiracial (51.0%) and Black (48.3%) populations.

Rate of Intentional Self-Harm and Drug- and Alcohol-Induced Deaths per 100,000, by Race/Ethnicity, 2018 and 2024



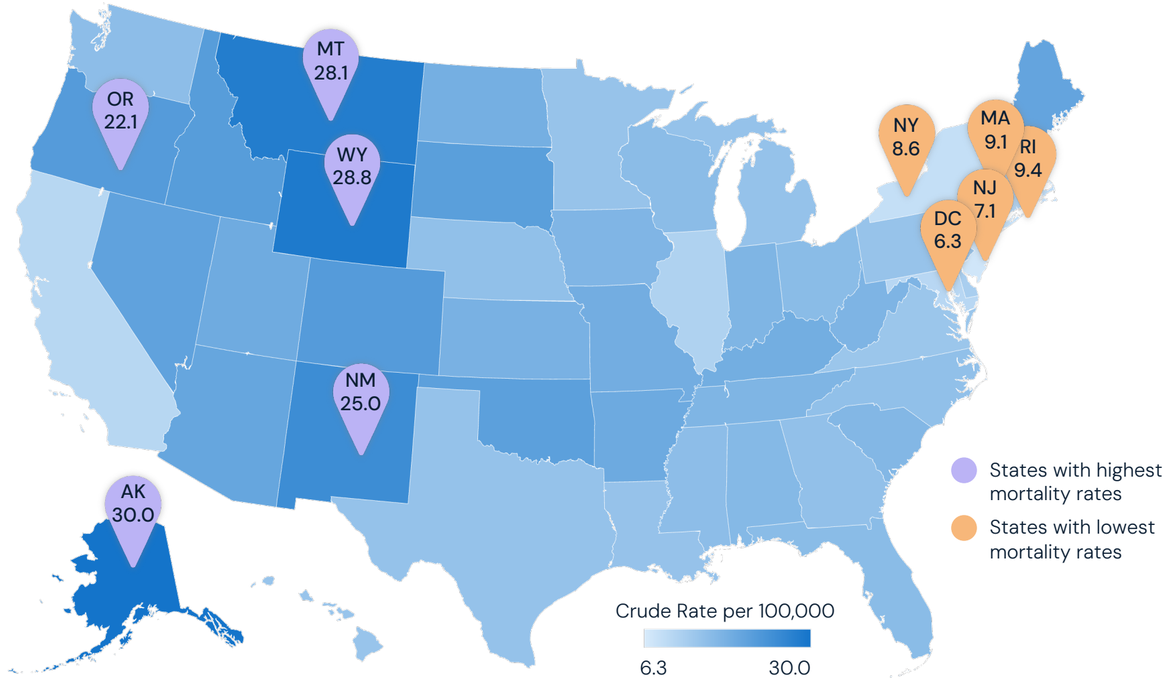
Note: AIAN denotes American Indian or Alaska Native. ICD-10 codes comprising self-harm are U03,X60–X84,Y87.0. ICD-10 codes comprising alcohol- and drug-induced causes are X40-X44, X60-X64, X85, Y10-Y14, X45, X65, Y15.
Source: U.S. Centers for Disease Control and Prevention WONDER Database.

DEMAND: MORTALITY

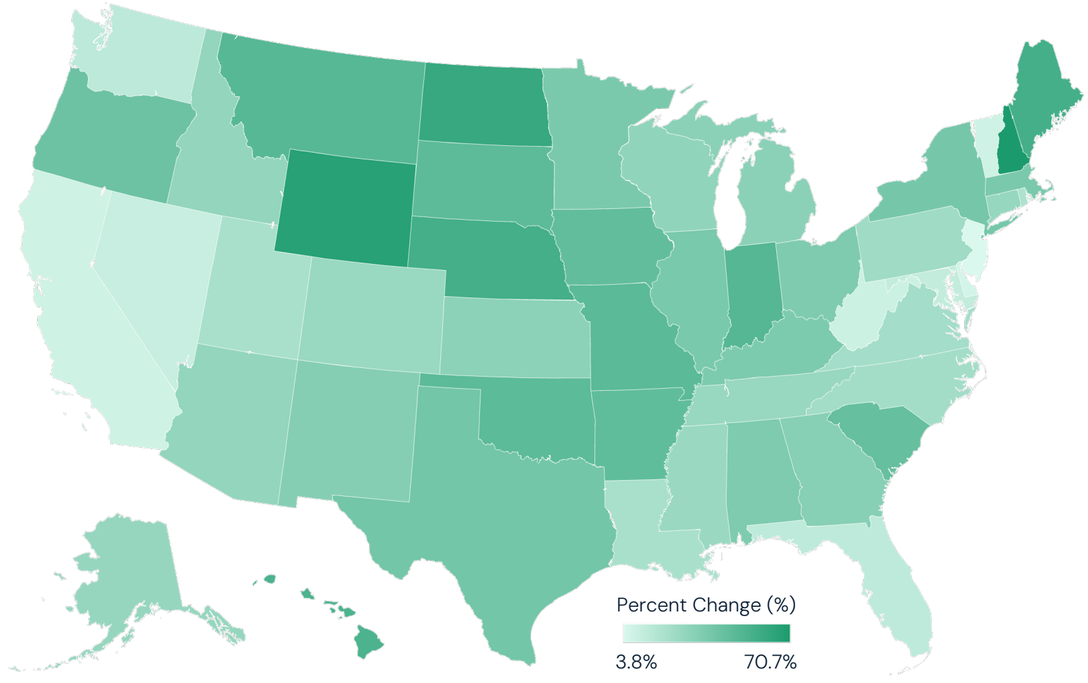
Western States Have Higher Self-Harm Mortality Rates

In 2024, the intentional self-harm mortality rate was 14.4 deaths per 100,000 nationally. The rate is highest in western states, led by Alaska (30 per 100,000), Wyoming (28.8), Montana (28.1), New Mexico (25.0) and Oregon (22.1). In contrast, mortality rates were lowest in the Northeast and Mid-Atlantic, including the District of Columbia (6.3), New Jersey (7.1), New York (8.6) and Massachusetts (9.1). From 2018 to 2024, state-level changes ranged from a 3.8% increase in New Jersey to 70.7% in New Hampshire.

Intentional Self-Harm Mortality Rate per 100,000, by State, 2024



Percent Change of Intentional Self-Harm Mortality Rate per 100,000, by State, 2018 to 2024



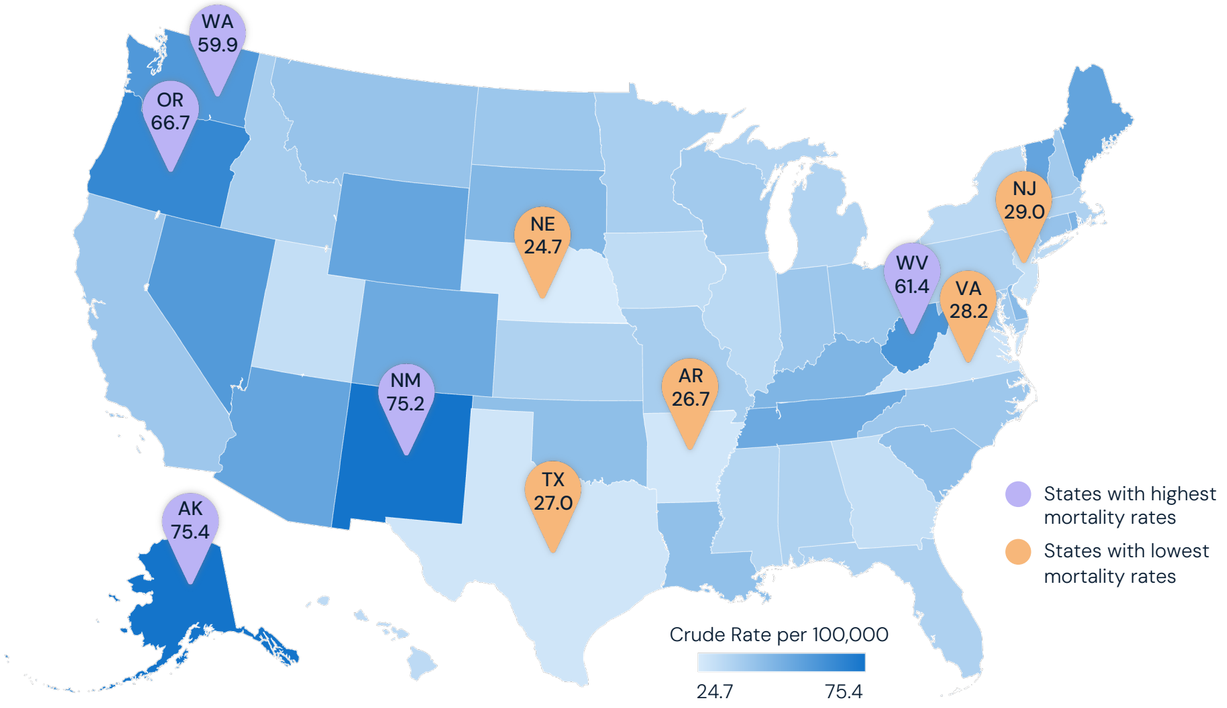
Note: ICD codes comprising self-harm are U03, X60–X84,Y87.0.
Source: Centers for Disease Control and Prevention Wonder Database.

DEMAND: MORTALITY

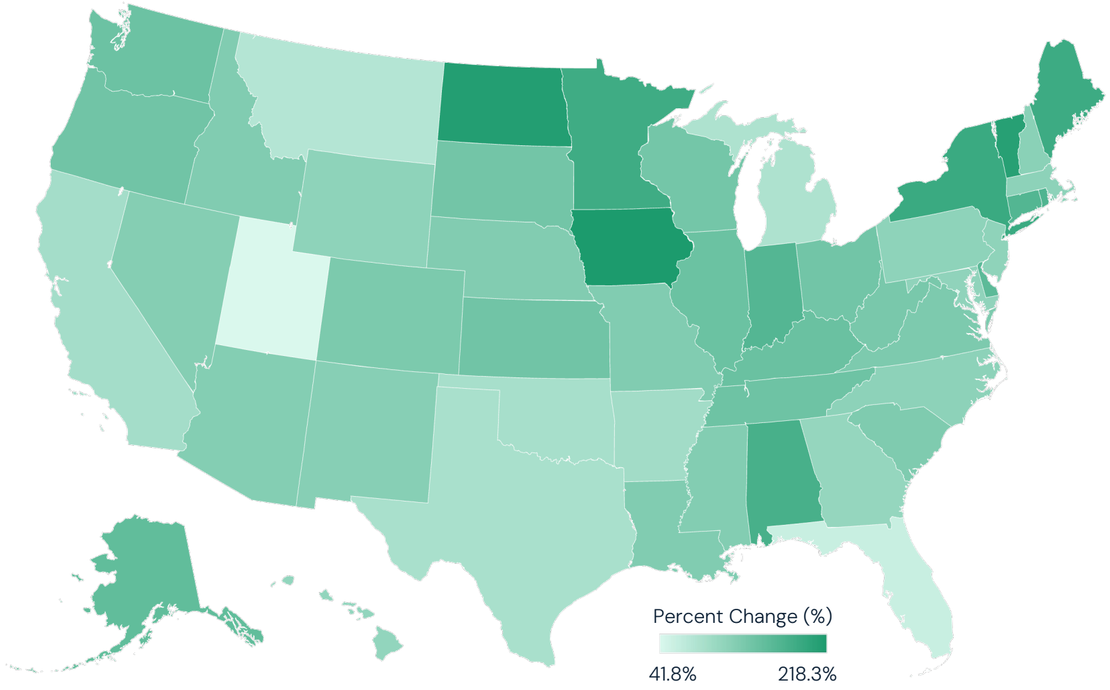
Drug- and Alcohol-Induced Mortality Rate Is Highest In Western States

In 2024, the drug- and alcohol-induced mortality rate was 38.1 deaths per 100,000 nationally. The mortality rate is highest in western states, led by Alaska (75.4 deaths per 100,000), New Mexico (75.2), Oregon (66.7), West Virginia (61.4) and Washington (59.9). In contrast, rates were lowest in the Northeast and Mid-Atlantic, including Nebraska (24.7), Arkansas (26.7), Texas (27.0) and Virginia (28.2). From 2018 to 2024, state-level changes ranged from a 41.8% increase to 218.3%, with the largest increases observed in Iowa and North Dakota.

Drug- and Alcohol-Induced Mortality Rate per 100,000, by State, 2024



Percent Change of Drug- and Alcohol-Induced Mortality Rate per 100,000, by State, 2018-2024

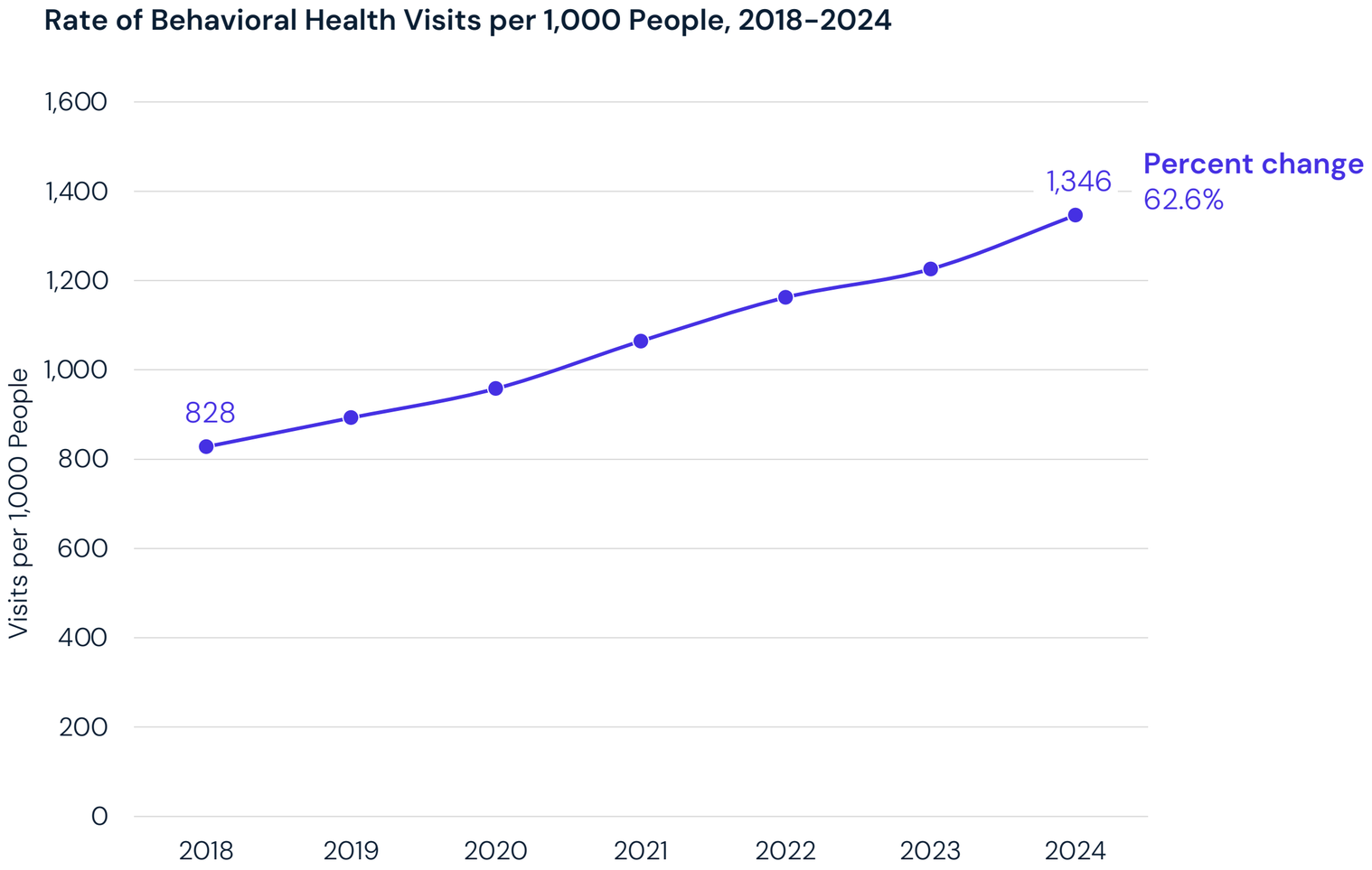


Note: ICD-10 codes comprising alcohol- and drug-induced causes are X40-X44, X60-X64, X85, Y10-Y14, X45, X65, Y15.
Source: Centers for Disease Control and Prevention Wonder Database.

DEMAND: UTILIZATION

Rate of Behavioral Health Visits Have Increased by Over 60% Since 2018

Between 2018 and 2024, the rate of behavioral health visits increased from 828 to 1,346 per 1,000 people, a 62.6% increase. Growth was relatively consistent, averaging 8.5% annually, with year-over-year increases ranging from 5.5% between 2022 and 2023 to 11.1% between 2020 and 2021.



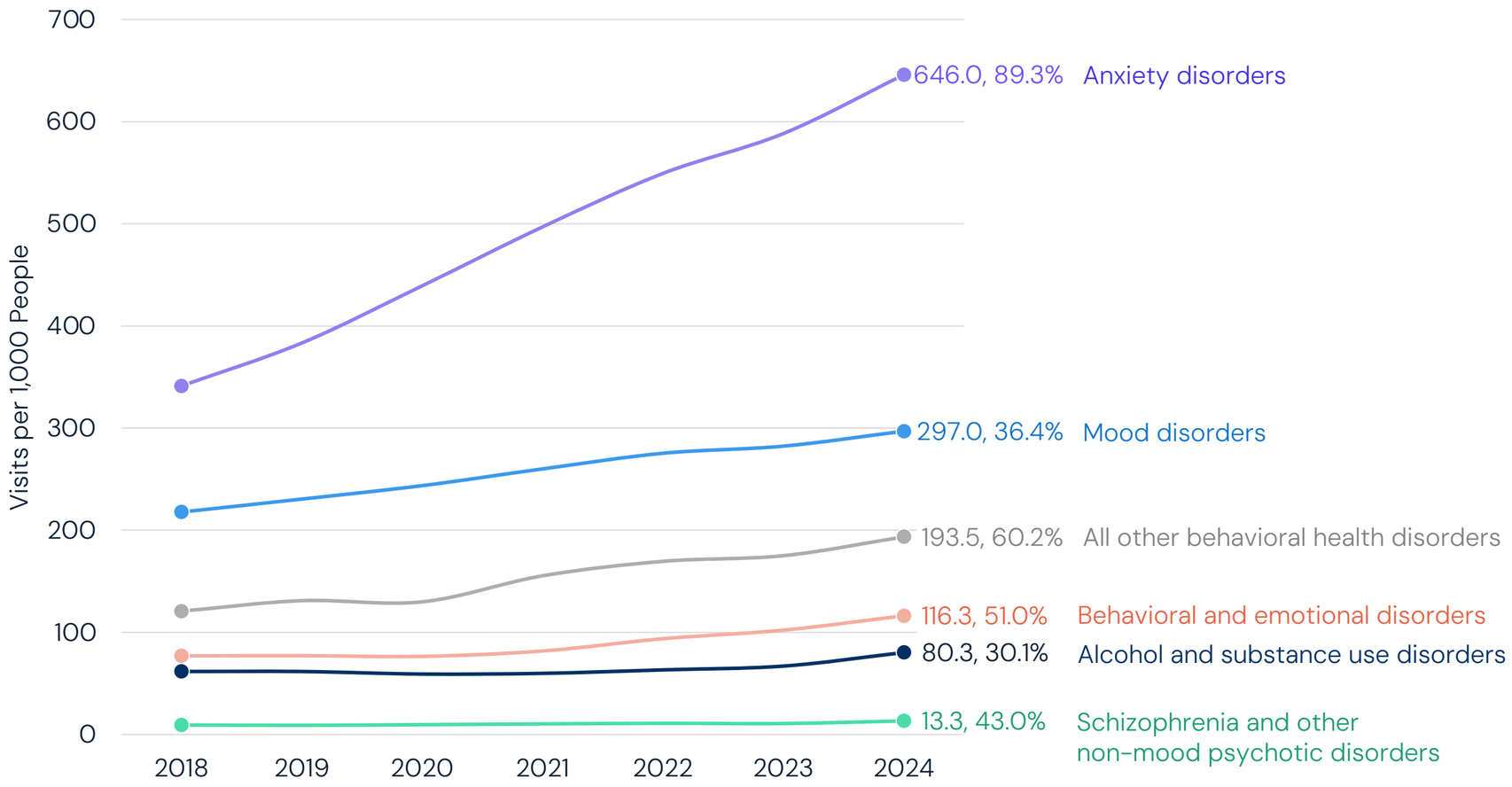
Note: Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

DEMAND: UTILIZATION

Anxiety Disorders Drive Growth in Behavioral Health Utilization Rate

From 2018 to 2024, anxiety disorders accounted for the highest behavioral health visit volume (646.0 visits per 1,000 people) and experienced the fastest growth (89.3%). Utilization increased across all studied conditions, including other behavioral health disorders (60.2%), which includes pervasive developmental disorders (e.g., autism) and speech and language developmental disorders, and behavioral and emotional disorders (51.0%), inclusive of ADHD and conduct disorders. Mood disorders remained the second-highest volume category (297.0 visits per 1,000), increasing 36.4% between 2018 and 2024.

Rate of Behavioral Health Visits per 1,000 People and Percent Change, by Condition Category, 2018–2024



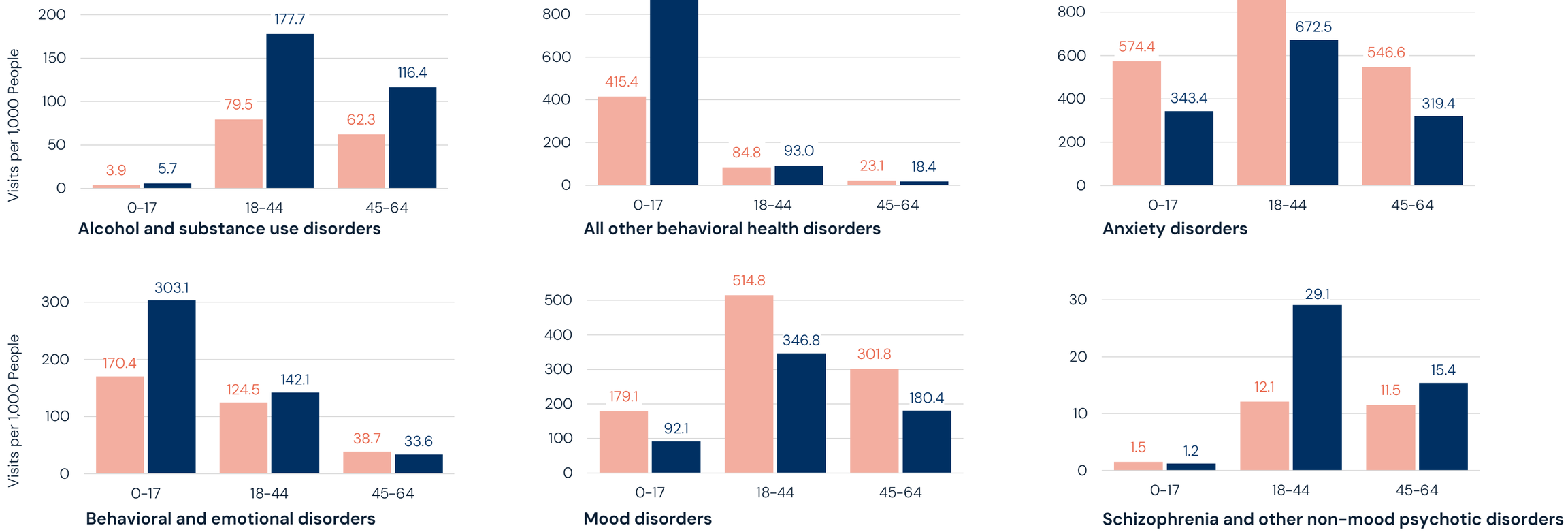
Note: ADHD denotes attention-deficit hyperactivity disorder. Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

DEMAND: UTILIZATION

Utilization Is Concentrated Among Young Adult Women and Male Youth

Anxiety disorders among women ages 18-44 represented the highest behavioral health utilization category (1,205.1 visits per 1,000 people). The second-highest utilization rate was observed among adolescent males ages 0-17 for other behavioral health disorders (951.1), which includes conditions like autism. Among mood disorders, utilization was highest among women ages 18-44 (514.8).

Rate of Behavioral Health Visits per 1,000 People, by Condition Category, by Age and Gender, 2024



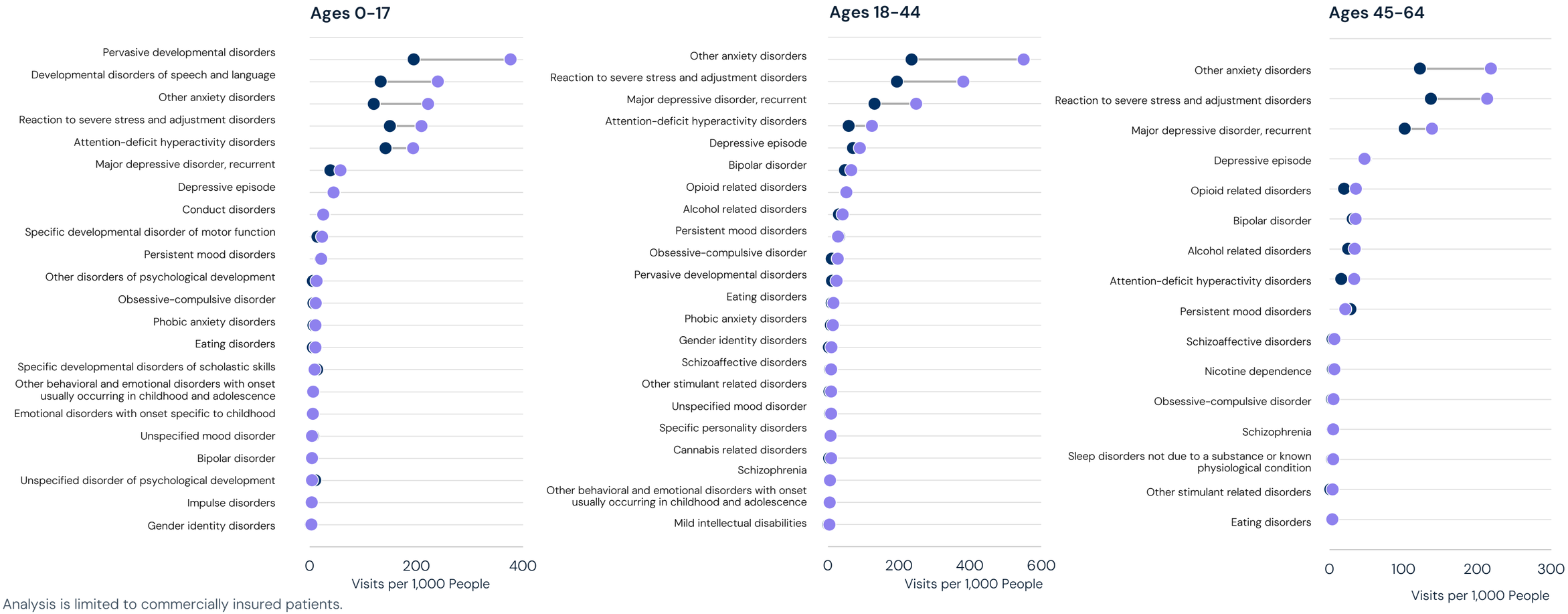
Note: Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

DEMAND: UTILIZATION

Developmental Disorders Dominate Pediatric Behavioral Health Visits

Among children, behavioral health utilization is highest for pervasive developmental disorders (e.g., autism) (376.8 visits per 1,000 people), which increased by 93.0% between 2018 and 2024. This is followed by speech and language disorders (240.3) and other anxiety disorders (209.8). In contrast, adult utilization is concentrated in anxiety disorders, reaction to severe stress and adjustment disorders and major depressive disorder.

Change in Rate of Visits per 1,000 for Select Behavioral Health Conditions, 2018 to 2024



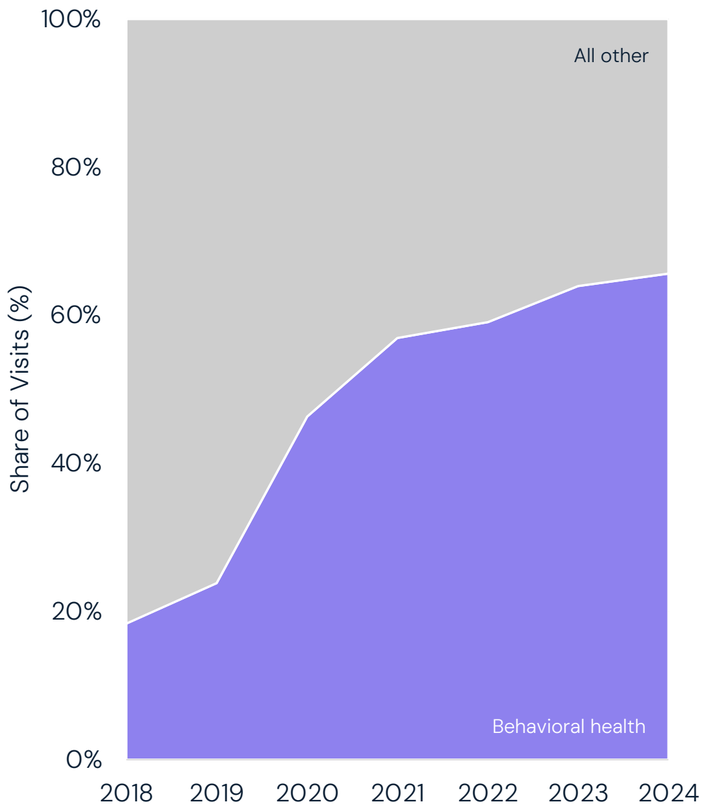
Note: Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

DEMAND: UTILIZATION

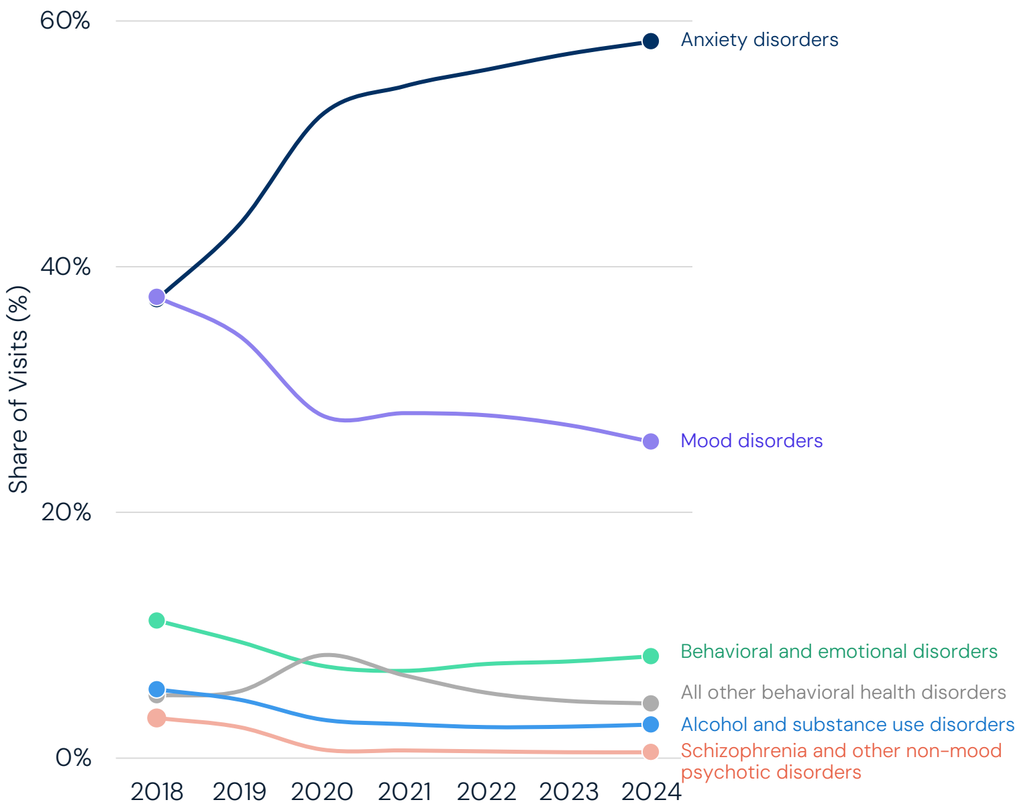
Behavioral Health Accounts for the Majority of Telehealth Use

Telehealth for the treatment and management of behavioral health conditions has emerged as a substitute for in-person care. Since 2018, the proportion of telehealth volume that is attributed to behavioral health has increased from 18.4% to 65.6%. In contrast, non-behavioral telehealth has decreased from 81.6% to 34.4% during the same period. An increasing share of behavioral health telehealth is for anxiety disorders, increasing from 37.3% in 2018 to 58.3% in 2024. Together, anxiety and mood disorders account for 84.0% of total behavioral health-related telehealth volume.

Share of Telehealth Visits, Behavioral Health and All Other, 2018-2024



Share of Behavioral Health Telehealth Visits, by Condition Category, 2018-2024



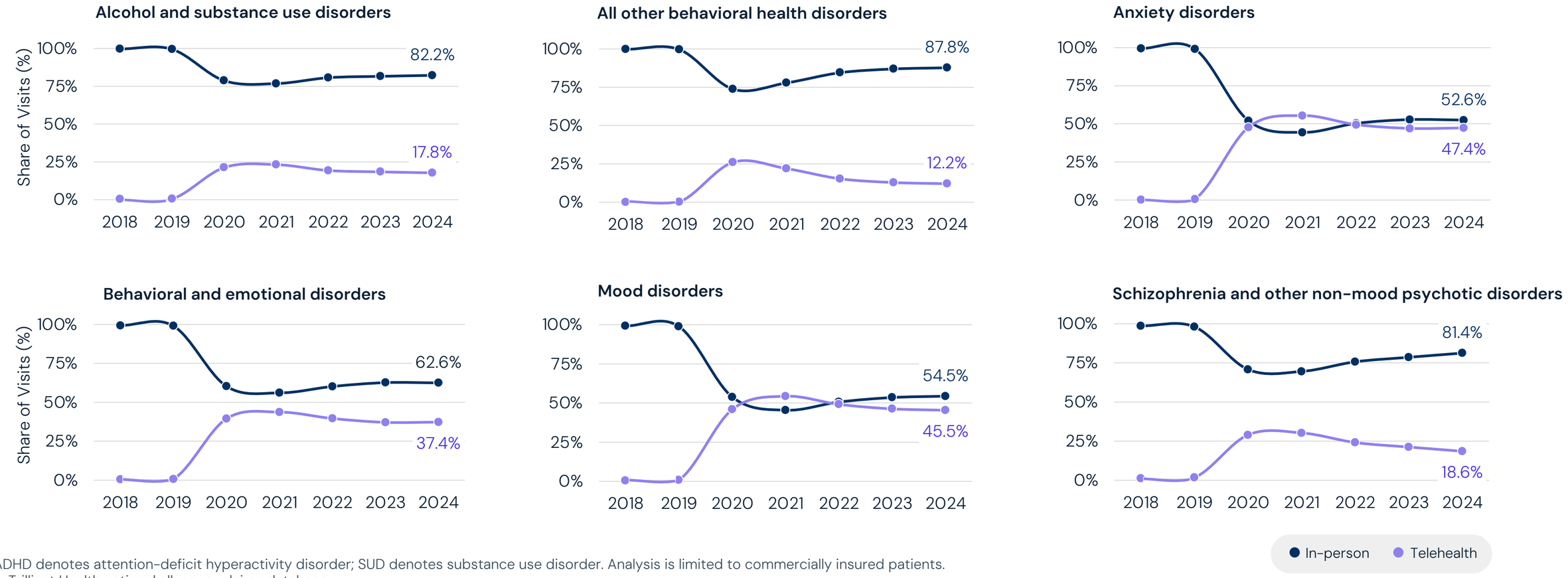
Note: Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

DEMAND: UTILIZATION

Following Pandemic Telehealth Surge, In-Person Care Remains Most Common

During the COVID-19 pandemic, telehealth became the primary care setting for anxiety and mood disorders and approached parity for behavioral health and emotional disorders (e.g., ADHD, conduct disorders). Since 2023, in-person visits have again become most common for all conditions, however there is meaningful variation. For example, 52.6% of visits for anxiety disorders take place in person compared to 82.2% of visits for alcohol and SUD.

Share of Behavioral Health Visits, by Condition Category, In-Person vs. Telehealth, 2018-2024



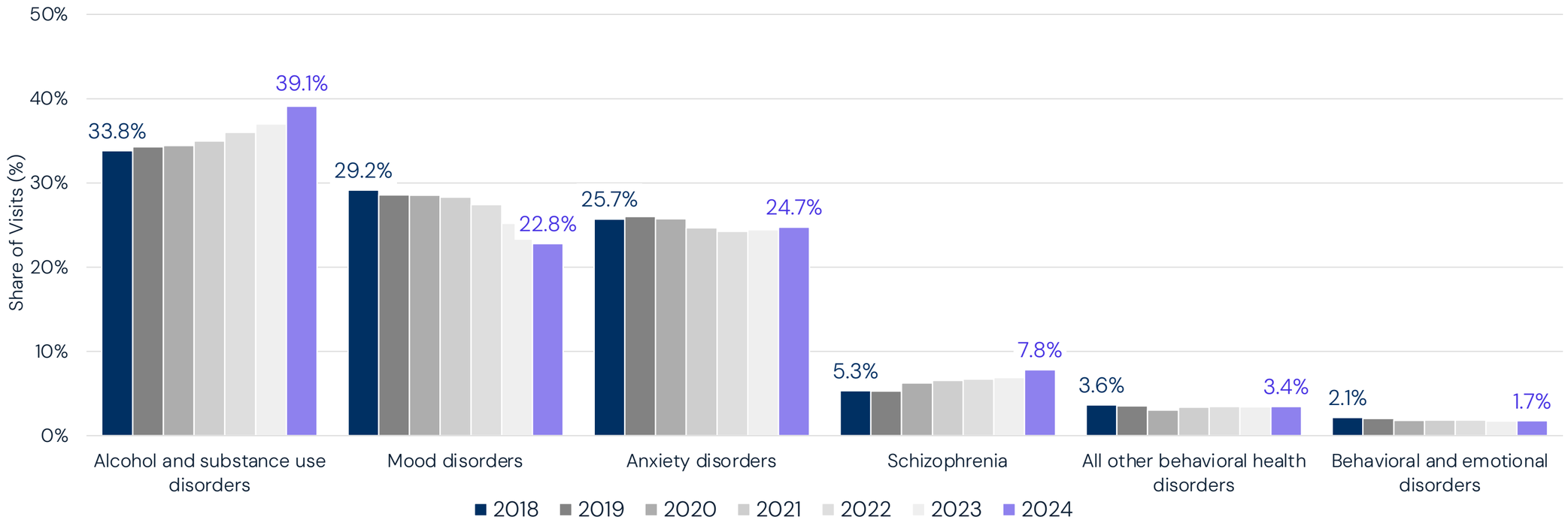
Note: ADHD denotes attention-deficit hyperactivity disorder; SUD denotes substance use disorder. Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

DEMAND: UTILIZATION

Alcohol and SUD Account for Largest Share of Emergency Department Visits

Between 2018 and 2024, alcohol and SUD consistently accounted for the largest share of emergency department behavioral health visits, increasing from 33.8% to 39.1%. Mood disorders declined from 29.2% to 22.8% of visits, while schizophrenia increased from 5.3% to 7.8%.

Share of Emergency Department Behavioral Health Visits, by Condition Category, 2018–2024



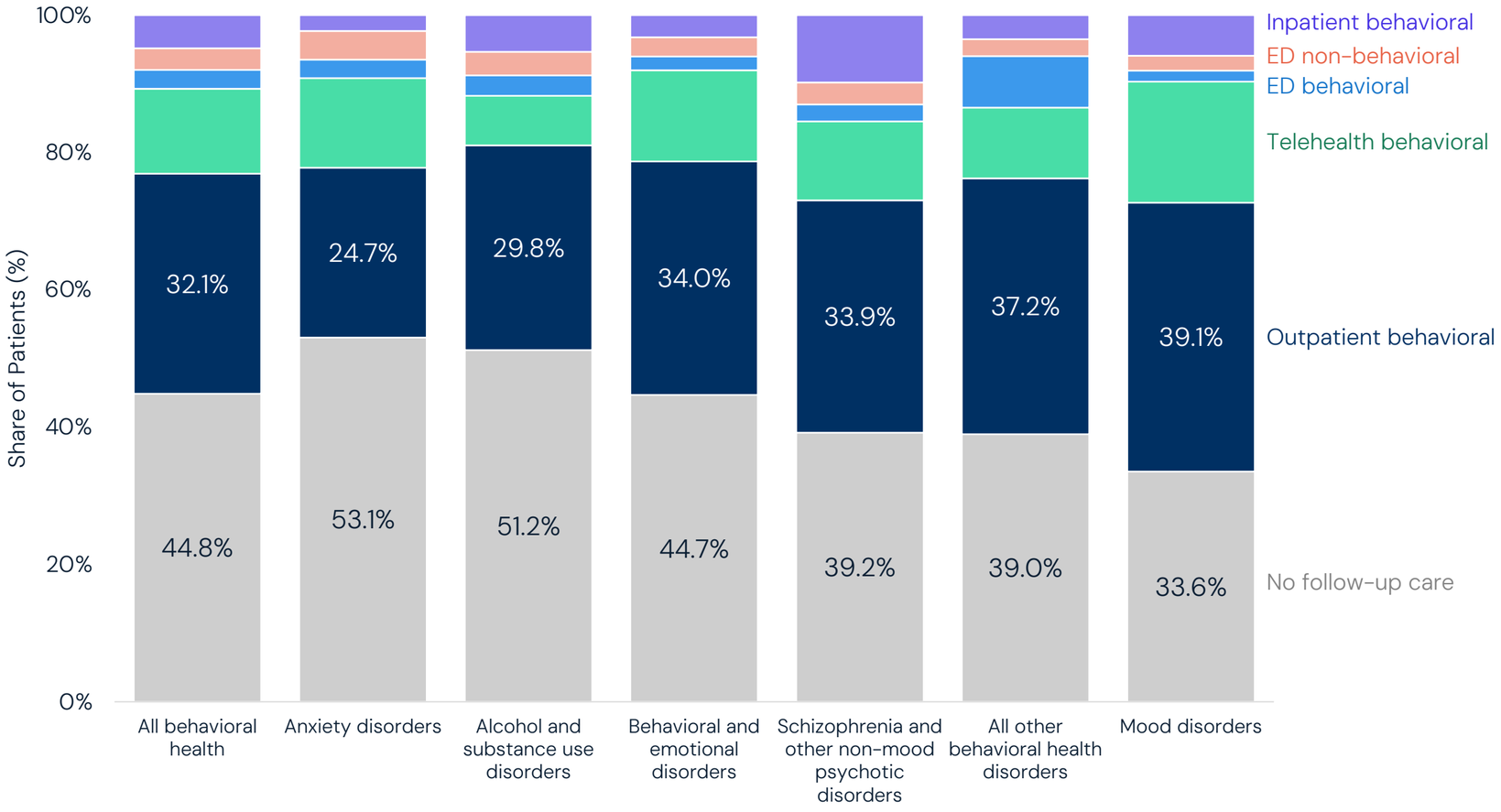
Note: SUD denotes substance use disorder. Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

DEMAND: UTILIZATION

Nearly Half of Behavioral Health ED Visits Do Not Result in Follow-Up Care

More than half of patients going to the ED for anxiety (53.1%) and alcohol and SUD (51.2%) did not receive any type of specialized follow-up care within 30 days of discharge. Most follow-up care occurred in outpatient behavioral settings (e.g., office-based counseling), accounting for 39.1% of follow-up visits within 30 days after an ED visit for mood disorders.

30-Day Follow-Up Care After Emergency Department Visit for Select Behavioral Health Conditions, 2024



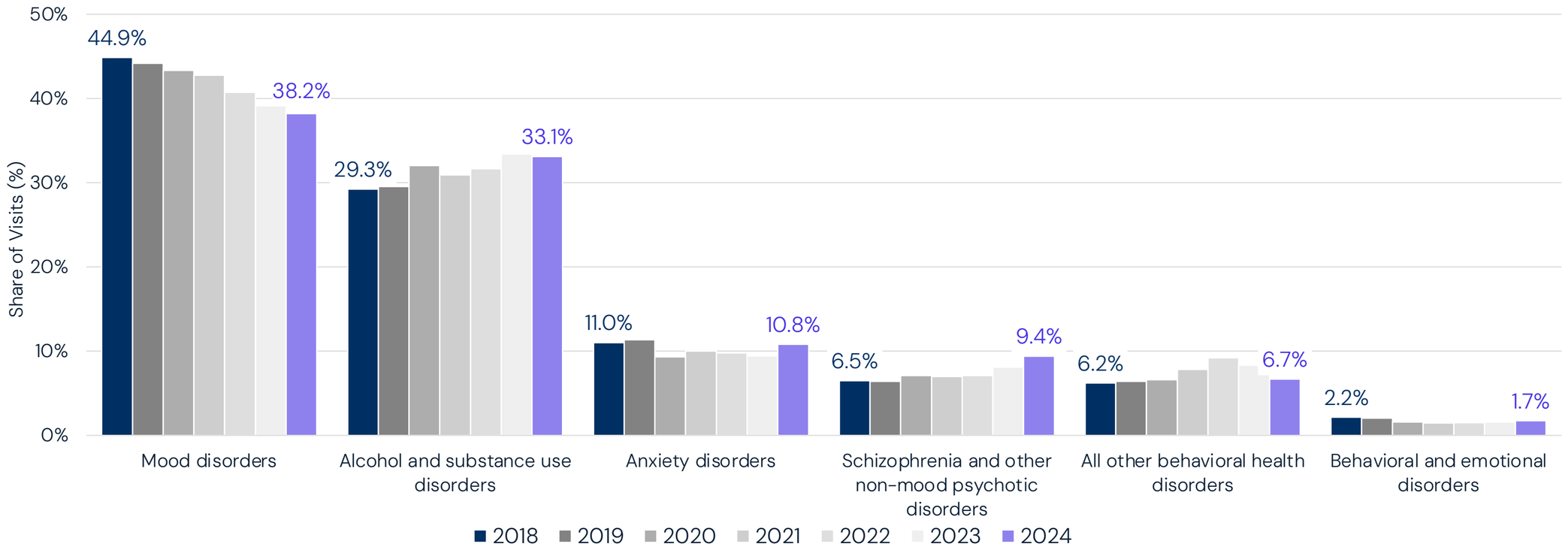
Note: ED denotes emergency department; SUD denotes substance use disorder.
Source: Trilliant Health national all-payer claims database.

DEMAND: UTILIZATION

Alcohol and SUD Account for a Growing Share of Inpatient Stays

Between 2018 and 2024, mood disorders consistently accounted for the largest share of inpatient behavioral health visits but decreased from 44.9% to 38.2%. Simultaneously, the proportion of alcohol and SUD visits, the second most common reason for a behavioral health-related inpatient stay, increased from 29.3% to 33.1% of visits.

Share of Inpatient Behavioral Health Visits, by Condition Category, 2018-2024



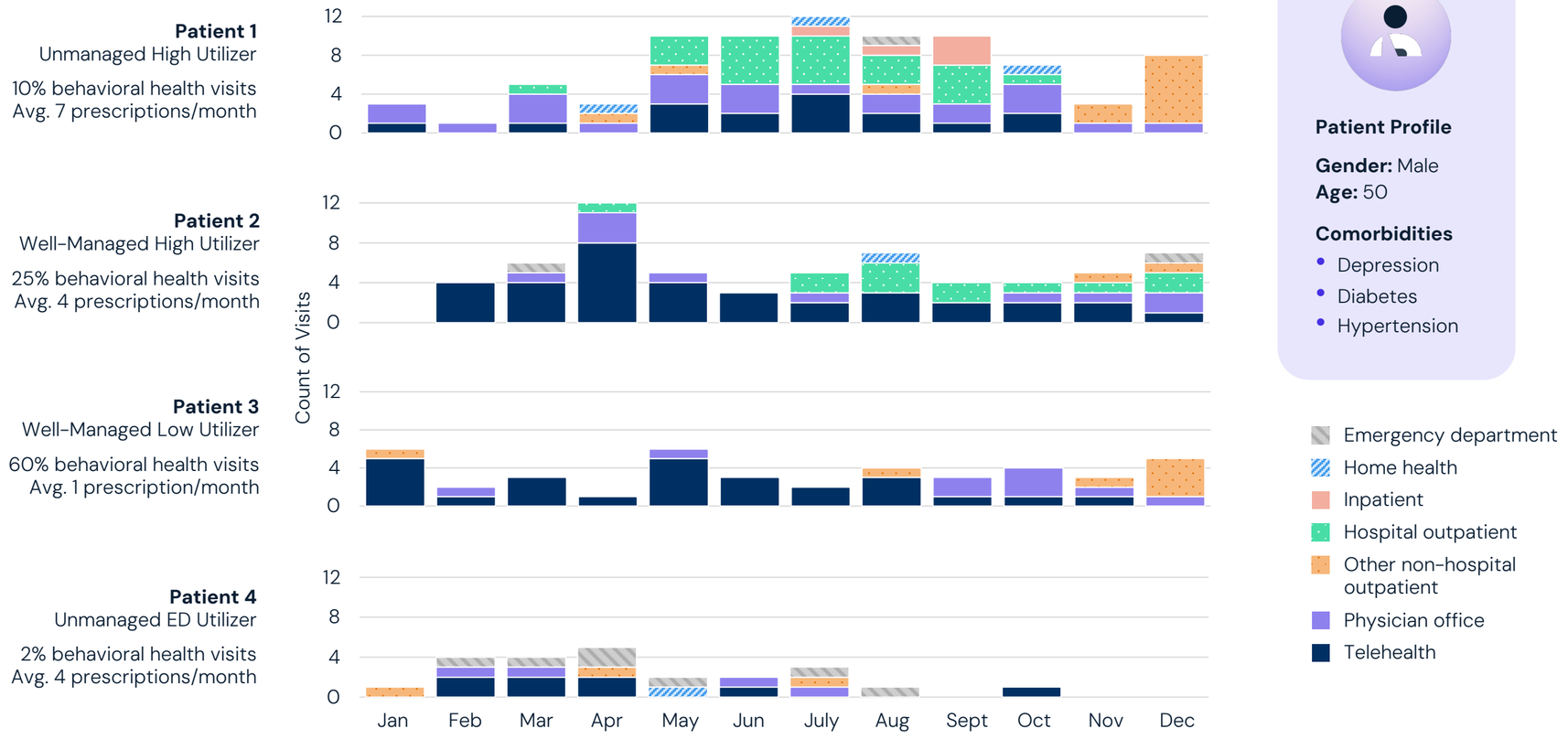
Note: SUD denotes substance use disorder. Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

DEMAND: UTILIZATION

Behavioral Health Engagement Shapes Divergent Utilization Patterns for Seemingly Similar Patients

The presence of a mental health diagnosis often corresponds with greater overall healthcare utilization and more complex care needs, though patterns can vary based on other patient characteristics and engagement with behavioral health services. Although clinically similar, these four patients have disparate care utilization patterns. Patients with higher behavioral health utilization (Patients 2 and 3) show more coordinated, outpatient-focused care, while those with minimal behavioral health care (Patients 1 and 4) rely more on emergency and acute settings.

Healthcare Utilization for Four Clinically Similar Patients, by Setting and Month, 2024



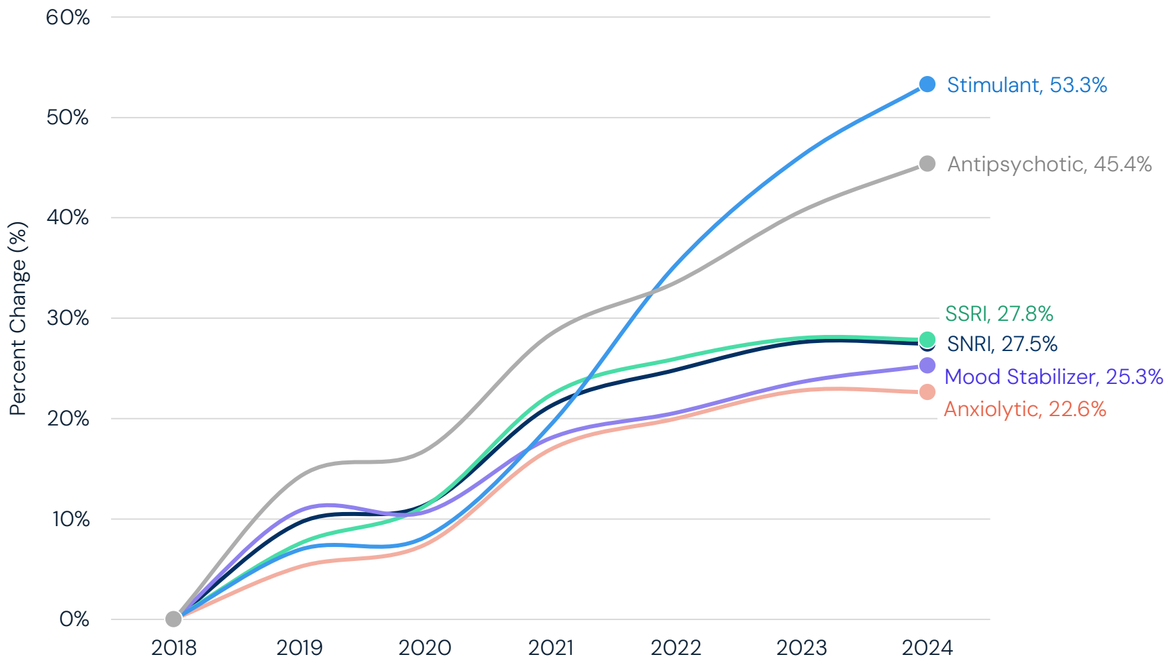
Note: ED denotes emergency department. Analysis is limited to commercially insured patients. Examples are illustrative but represent data from actual deidentified patients.
Source: Trilliant Health national all-payer claims database.

DEMAND: UTILIZATION

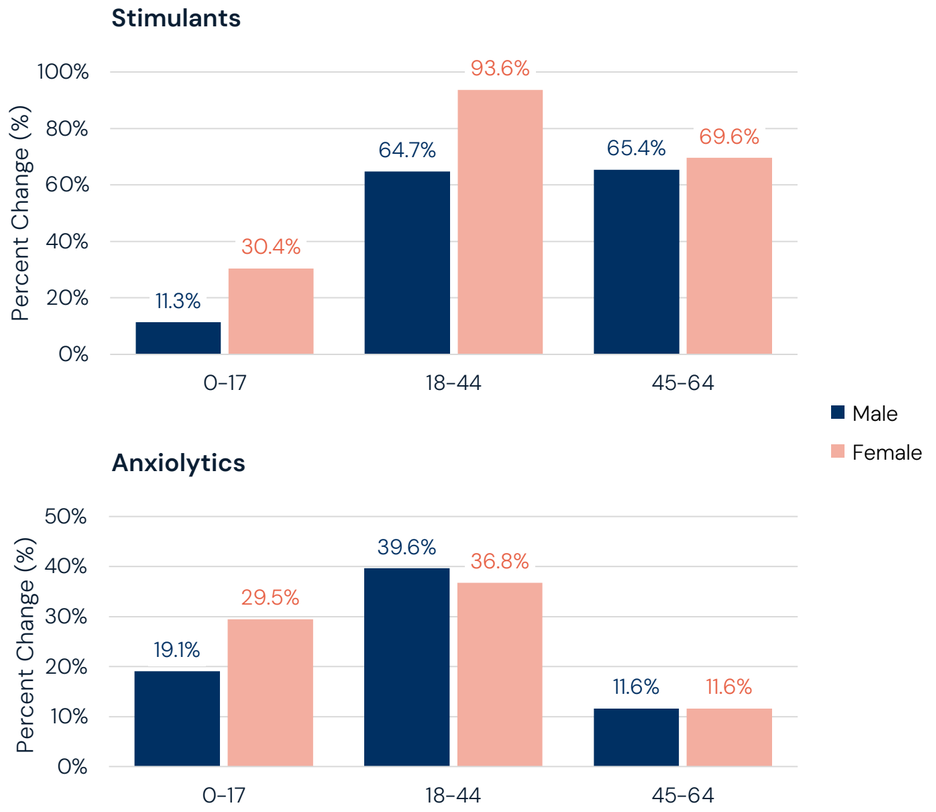
Stimulants Show Fastest Growth Among Behavioral Health Medications

Between 2018 and 2024, the share of patients taking stimulants increased the most (53.3%), followed by antipsychotics (45.4%). However, anxiolytics represent the medication class with the highest overall patient volume. Growth in stimulant use was particularly pronounced among women ages 18-44 (93.6%). For anxiolytics, percent increases ranged from 39.6% among men ages 18-44 to 11.6% among men and women ages 45-64.

Percent Change in Patients Since 2018, by Medication Class, 2018-2024



Percent Change in Patients, by Age and Gender, 2018 to 2024



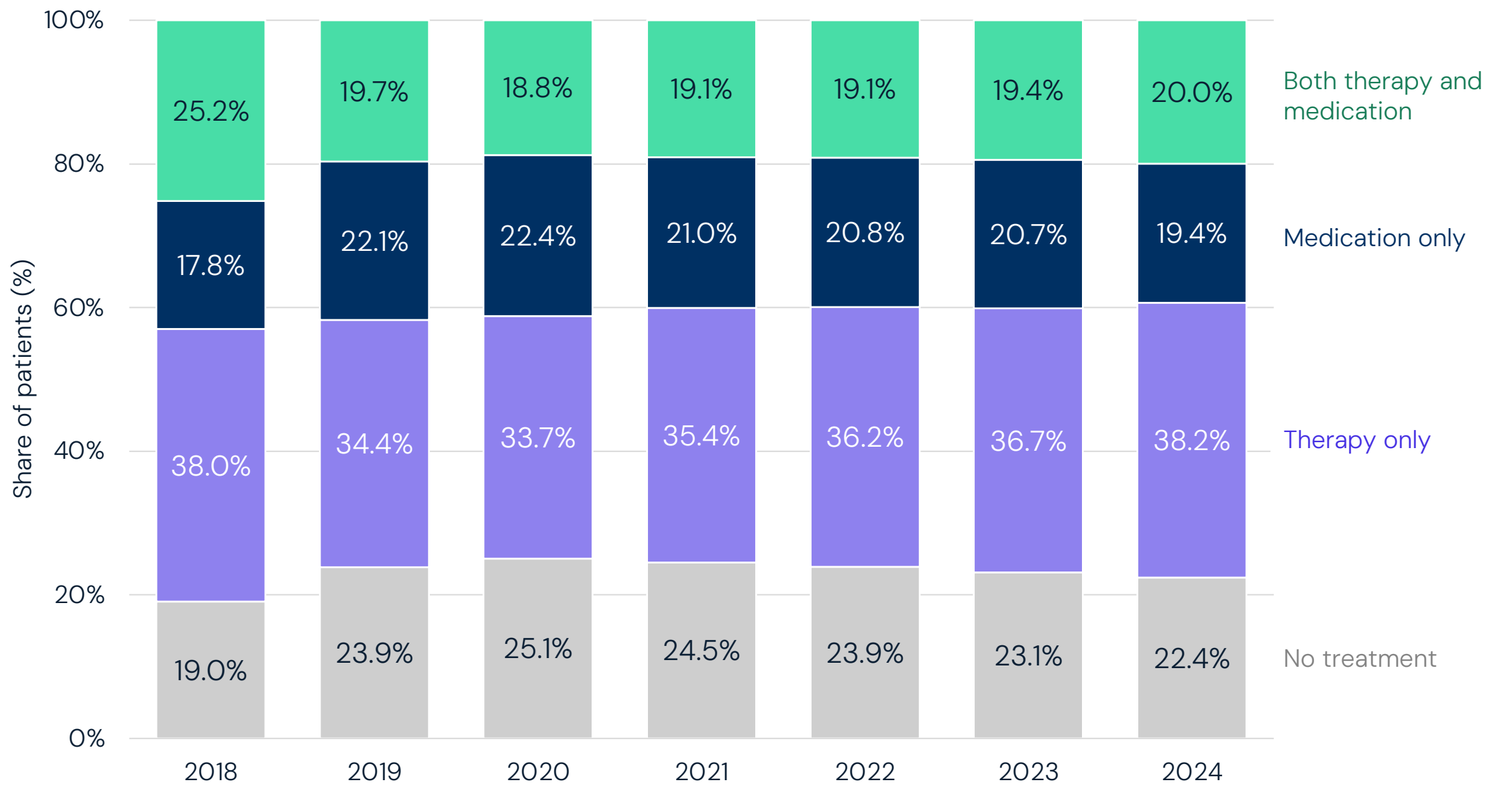
Note: SSRI denotes selective serotonin reuptake inhibitors; SNRI denotes serotonin and norepinephrine reuptake inhibitors.
Source: Trilliant Health national all-payer claims database.

DEMAND: UTILIZATION

Behavioral Health Treatment Patterns Remain Relatively Unchanged

From 2018 to 2024, treatment patterns for patients with anxiety and/or depression remained relatively stable. However, the share of patients not receiving treatment increased from 19.0% to 22.4%, peaking at 25.1% in 2020. During the same period, the share of patients receiving medication only increased from 17.8% to 19.4%.

Treatment Patterns for Patients with Anxiety and/or Depression, 2018–2024



Note: Analysis is limited to commercially insured patients.
Source: Trilliant Health national all-payer claims database.

DEMAND: UTILIZATION

USPSTF Guidelines Prioritize Screening and Early Detection

USPSTF recommendations emphasize routine screening and counseling for anxiety, depression, suicide risk, substance use and interpersonal violence across pediatric, adult and perinatal populations. These guidelines prioritize early detection and timely intervention to reduce long-term behavioral health morbidity and mortality. While there are clear benefits, broad screening recommendations for anxiety and depression can introduce the potential for overdiagnosis.

Summary of USPSTF Behavioral Health Recommendations, as of Q1 2026

Topic	Population	Grade	Recommendation	Date Last Updated
Intimate Partner Violence and Caregiver Abuse of Older or Vulnerable Adults: Screening	Women of reproductive age, including pregnant and postpartum women	B	Screening for intimate partner violence in women of reproductive age, including those who are pregnant and postpartum.	June 2025
Anxiety Disorders in Adults: Screening	Adults 64 years or younger, including pregnant and postpartum persons	B	Screening for anxiety disorders in adults, including pregnant and postpartum persons.	June 2023
Depression and Suicide Risk in Adults: Screening	Adults, including pregnant and postpartum persons, and older adults (65 years or older)	B	Screening for depression in the adult population, including pregnant and postpartum persons, as well as older adults.	June 2023
Anxiety in Children and Adolescents: Screening	Children and adolescents ages 8 to 18 years	B	Screening for anxiety in children and adolescents ages 8 to 18 years.	October 2022
Depression and Suicide Risk in Children and Adolescents: Screening	Adolescents ages 12 to 18 years	B	Screening for major depressive disorder (MDD) in adolescents ages 12 to 18 years.	October 2022
Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions	Nonpregnant adults; pregnant persons	A	Clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and FDA-approved pharmacotherapy for cessation to nonpregnant adults who use tobacco. USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco. **This recommendation is actively being reviewed and updated as of April 2026.**	January 2021
Unhealthy Drug Use: Screening	Adults age 18 years or older	B	Screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)	June 2020
Tobacco Use in Children and Adolescents: Primary Care Interventions	School-aged children and adolescents who have not started to use tobacco	B	Primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents. **This recommendation is actively being reviewed and updated as of April 2026.**	April 2020
Perinatal Depression: Preventive Interventions	Pregnant and postpartum persons	B	Clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions. **This recommendation is actively being reviewed and updated as of April 2026.**	February 2019
Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions	Adults 18 years or older, including pregnant women	B	Screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use. **This recommendation is actively being reviewed and updated as of April 2026.**	November 2018

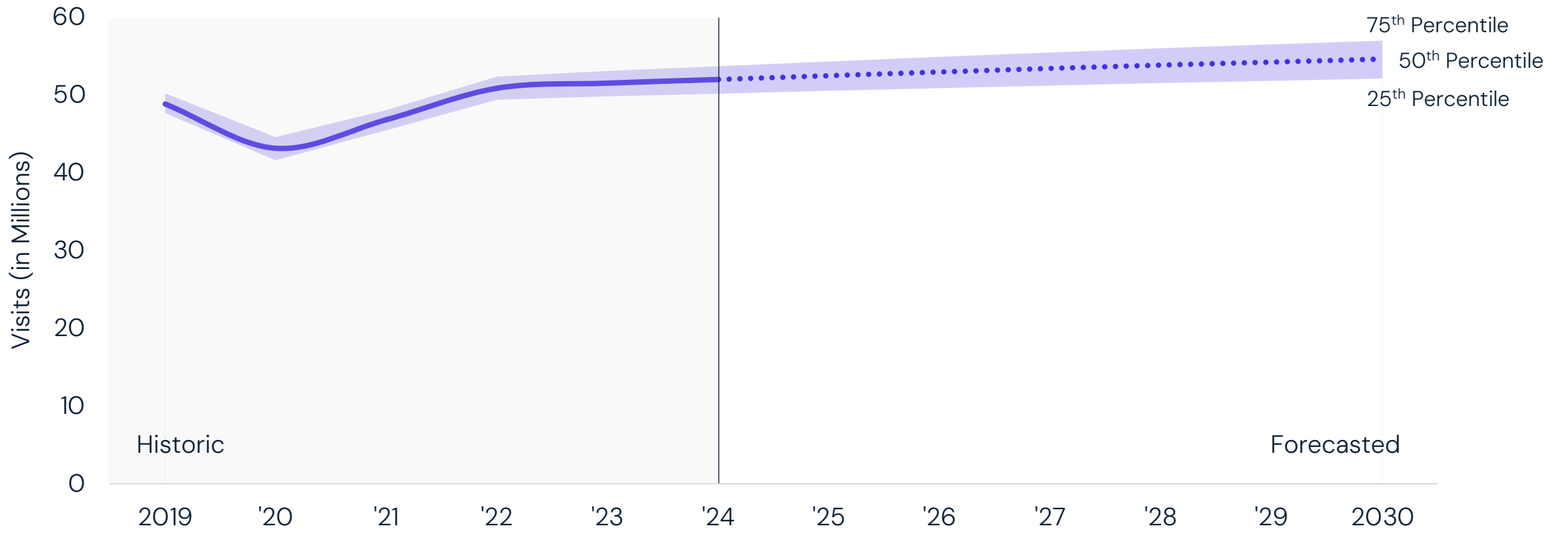
Note: FDA denotes U.S. Food and Drug Administration; USPSTF denotes United States Preventive Services Task Force. Only guidelines with a grade of B or above are displayed.
Source: United States Preventive Services Task Force.

DEMAND: UTILIZATION

Demand for Behavioral Health Services Could Reach 1.5% CAGR

The CAGR for behavioral health services is projected to range from 0.2% to 1.5% between 2025 and 2030. By 2030, there will be a projected 54.5M visits, with an upper bound of 56.9M.

National Historic and Projected Behavioral Health Demand, 2019–2030
CAGR = 0.8% (0.2%, 1.5%)



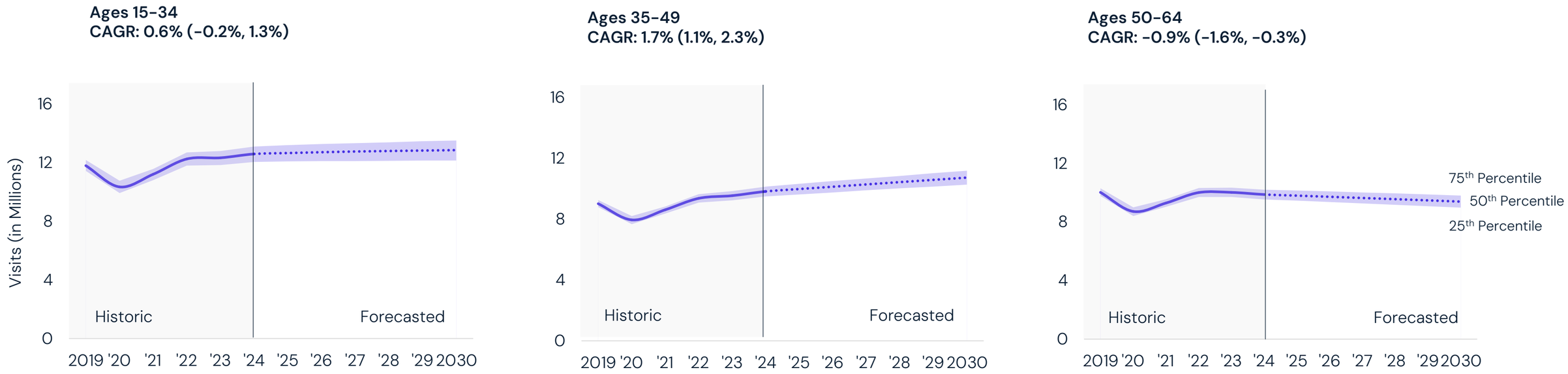
Note: CAGR denotes compound annual growth rate.
Source: Trilliant Health Demand Forecast.

DEMAND: UTILIZATION

Behavioral Health Demand Growth Is Highest Among Adults Ages 35-49

For patients ages 15-34 and 35-49, demand for behavioral health services is projected to grow between 2025 and 2030 but is projected to decline for patients ages 50-64. Demand is projected to increase most among adults ages 35-49, with the CAGR ranging from 1.1% to 2.3%.

National Historic and Projected Behavioral Health Demand, by Age Group, 2019-2030



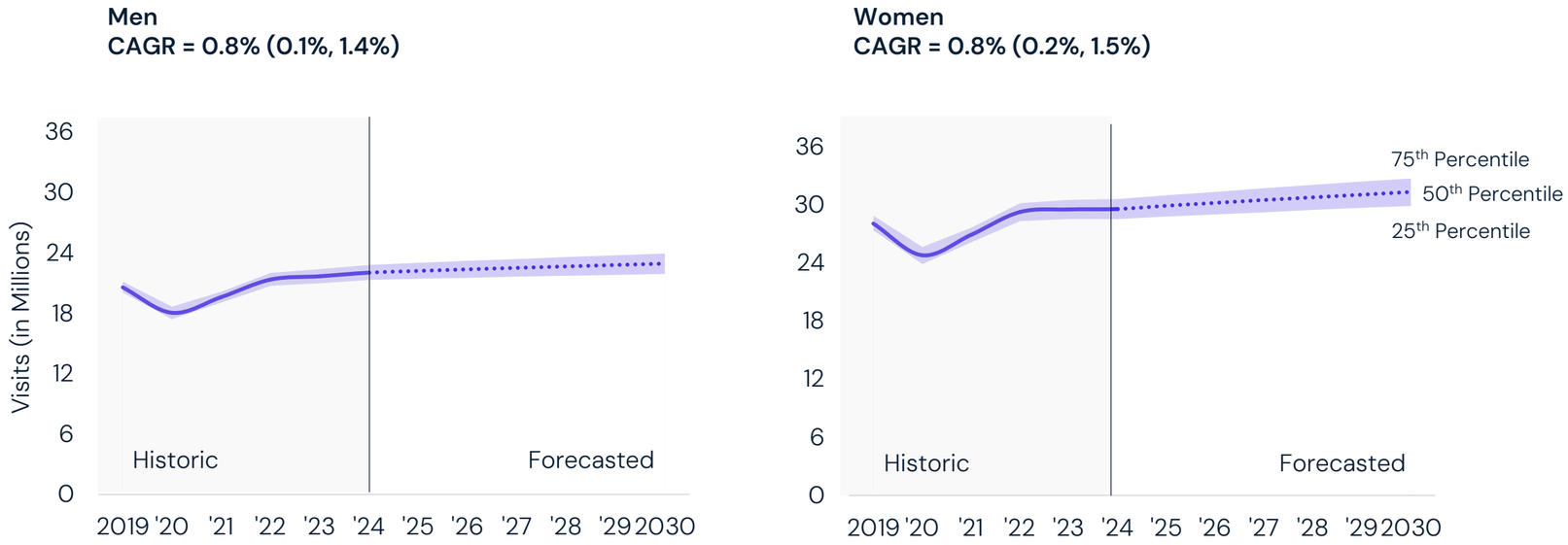
Note: CAGR denotes compound annual growth rate.
Source: Trilliant Health Demand Forecast.

DEMAND: UTILIZATION

Behavioral Health Demand Projections Are Similar for Men and Women

Between 2025 and 2030, the CAGR for behavioral health demand for men and women ranges from 0.1% to 1.4% and 0.2% to 1.5%, respectively. By volume, women are projected to continue to account for a larger proportion of all behavioral health visits.

National Historic and Projected Behavioral Health Demand, by Sex, 2019–2030



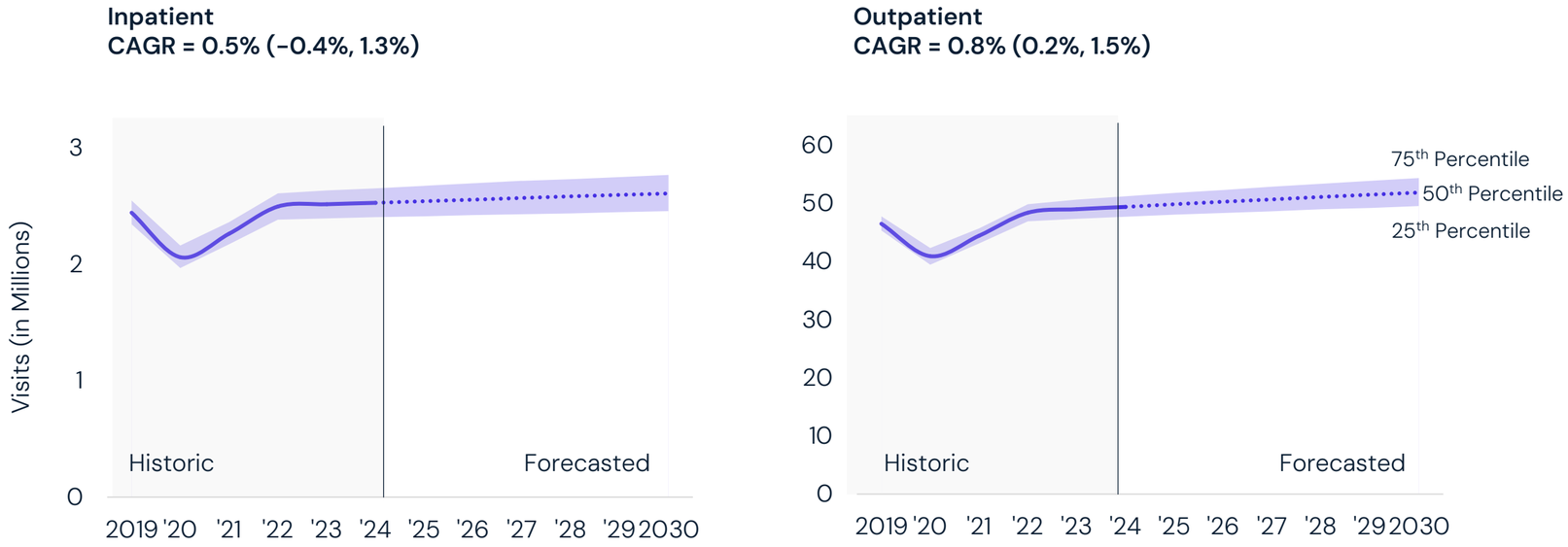
Note: CAGR denotes compound annual growth rate.
Source: Trilliant Health Demand Forecast.

DEMAND: UTILIZATION

Both IP and OP Behavioral Health Demand Projected to Grow

Between 2025 and 2030, the CAGR for inpatient and outpatient behavioral health demand ranges from -0.4% to 1.3% and 0.2% to 1.5%, respectively. By volume, outpatient behavioral health visits are projected to continue to account for the vast majority of all behavioral health demand.

National Historic and Projected Behavioral Health Demand, by Setting, 2019-2030



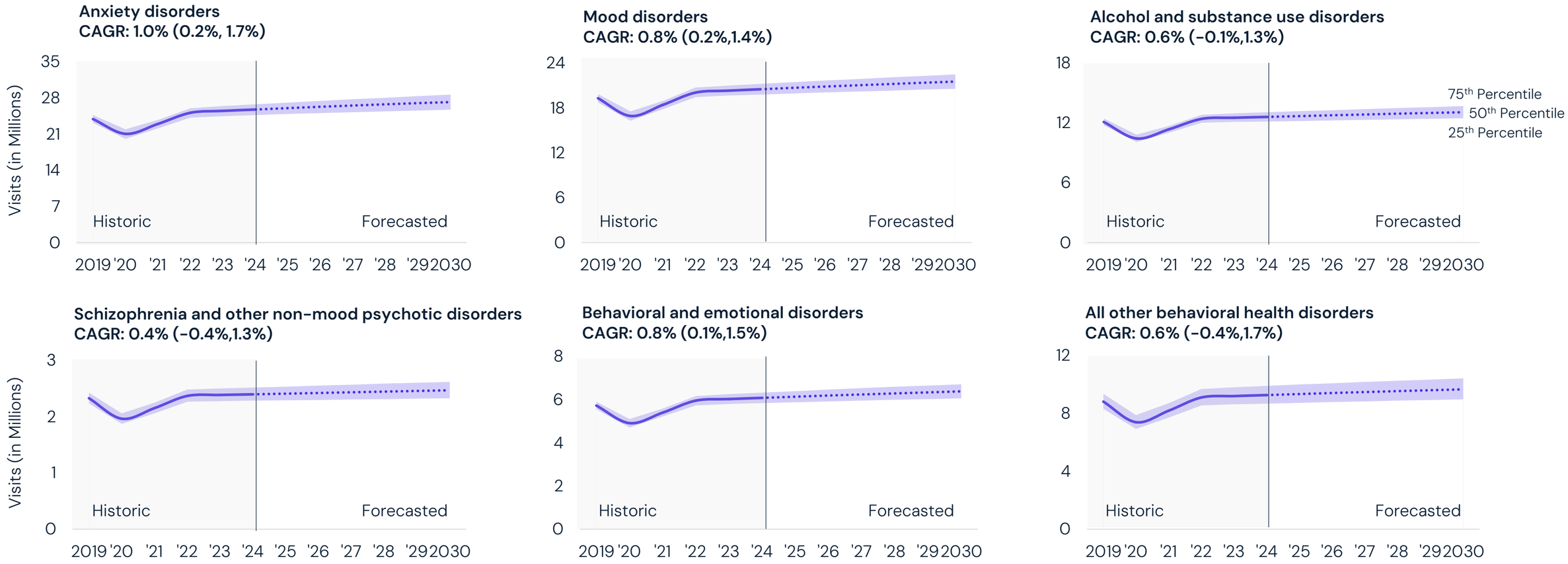
Note: CAGR denotes compound annual growth rate.
Source: Trilliant Health Demand Forecast.

DEMAND: UTILIZATION

Projected Behavioral Health Demand Is Highest for Anxiety Disorders

By 2030, there will be a projected 27.2M visits for anxiety disorders. This visit category could grow by as much as 1.7% CAGR between 2025 and 2030. However, the growth rate for behavioral services will inevitably be shaped by availability of treatment, uptake of medication therapy, screening recommendation changes and availability of alternative treatment options (e.g., direct to consumer platforms).

National Historic and Projected Behavioral Health Demand, by Condition Category, 2019-2030



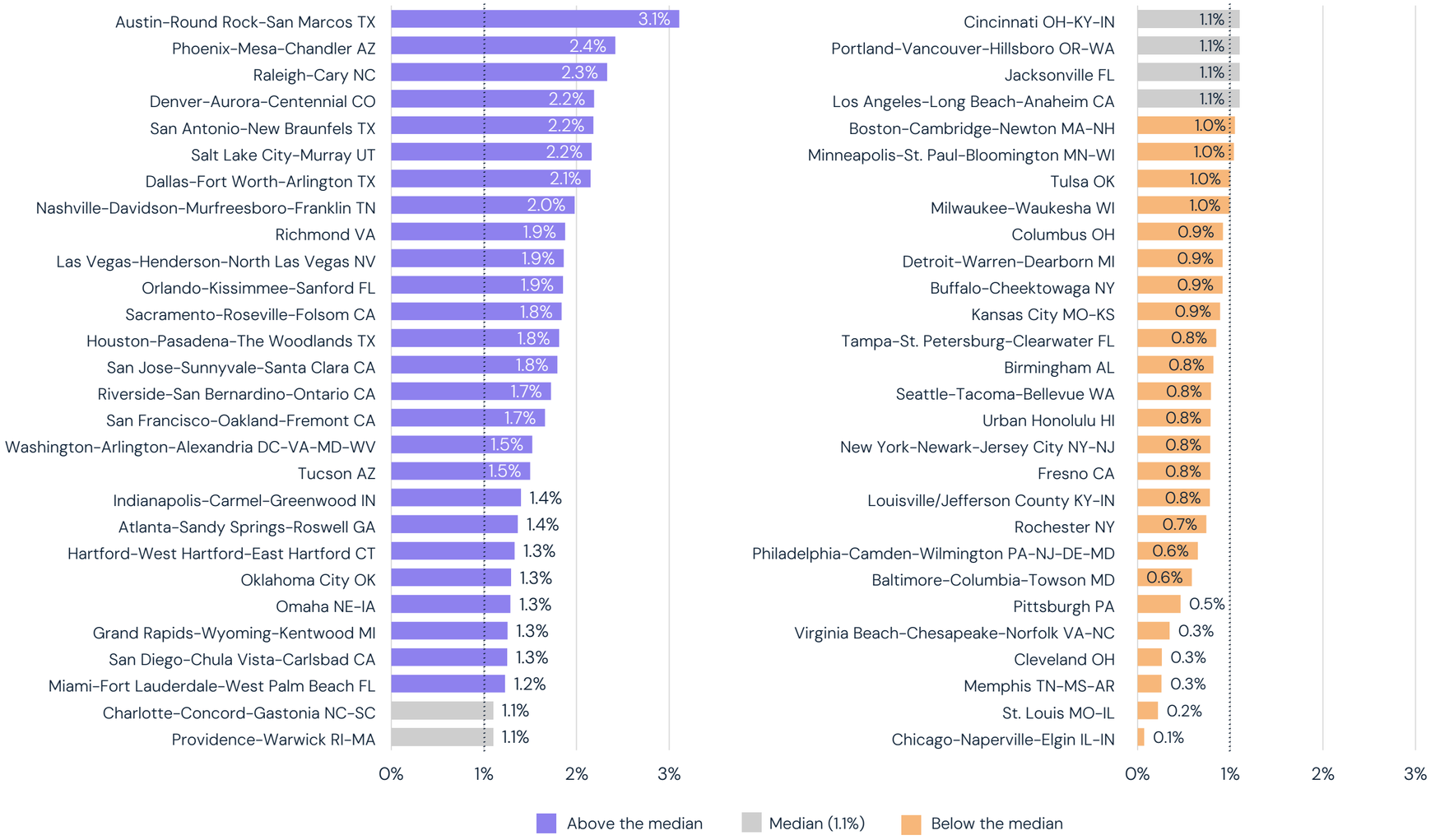
Note: CAGR denotes compound annual growth rate.
Source: Trilliant Health Demand Forecast.

DEMAND: UTILIZATION

Projected Behavioral Health Demand Is Variable But Increasing in Large Metro Areas

Among CBSAs with populations over 1M, 2025–2030 CAGR values range from 0.1% in Chicago, IL to 3.1% in Austin, TX. Geographic growth in demand for behavioral health services is collectively influenced by the combination of disease burden and population growth. Racial and ethnic composition, income levels and payer mix further shape this demand growth, as communities with higher proportions of Medicaid beneficiaries or uninsured populations are associated with higher behavioral health prevalence.

Behavioral Health Demand, by CBSA, Five-Year CAGR, 2025–2030



Note: CAGR denotes compound annual growth rate. CBSAs with populations over 1M are included.
Source: Trilliant Health Demand Forecast.

Supply

Supply refers to the various providers of health services ranging from hospitals and physician practices to retail pharmacies, new entrants and virtual care platforms.

The behavioral health workforce is not equipped to meet demand — and the gap is widening.

Fewer than 10% of behavioral health providers are MD or DO psychiatrists, with the majority of the workforce comprised of master's-level clinicians whose scope of practice limits their ability to prescribe medication or manage the full range of behavioral health conditions. By 2038, projected demand is expected to exceed supply by approximately 36,780 FTEs in adult psychiatry and 99,780 FTEs in mental health counseling. Only psychiatric nurse practitioners are on track to meet demand, while psychologists (48%) and adult psychiatrists (50%) face the largest projected shortfalls of any behavioral health profession. While the number of U.S. psychiatric residency positions has grown from 1,556 in 2018 to 2,388 in 2025, residency positions have maintained a nearly 100% match rate, suggesting that supply is artificially constrained by the number of available positions.

Geographic maldistribution compounds the shortage. Mental Health Professional Shortage Areas impact every U.S. state, with average adequacy of just 27.3% nationally – ranging from 5.7% in West Virginia to 52.3% in New Jersey. Across large metropolitan areas, 56.9% have a relative shortage of psychiatrists based on population benchmarks. However, even markets that appear adequately supplied based on population-based benchmarks may be strained by actual prevalence and need.

The composition of who is delivering behavioral health care is also shifting. Allied health professionals – nurse practitioners and physician assistants – now account for 34.3% of behavioral health prescription volume, up from 20.7% in 2018, surpassing psychiatrists to become the most common prescriber type. This reflects both the expansion of scope-of-practice laws and the growing specialization of NPs and PAs in behavioral health – a structural adaptation to a workforce that cannot otherwise keep pace with demand. At the same time, the workforce itself is under strain. Notably, 83% of behavioral health providers report burnout, with therapists reporting the highest rate of mental health fatigue of any specialty (77%) and most commonly citing low compensation as a driver. Burnout has well-documented consequences for care quality, including reduced empathy, impaired clinical effectiveness and increased care disruption.

The nature of care delivery is also evolving rapidly. Between 2020 and 2023, the share of psychologists offering hybrid care increased from 33% to 67%, reflecting a permanent restructuring of how and where behavioral health services are delivered. Direct-to-consumer online therapy platforms have proliferated, offering varying models of care, pricing and medication management. M&A activity likely reinforces these trends, with 167 behavioral health transactions recorded in 2025 – led by mental health deals including Spring Health's planned acquisition of Alma and Universal Health Services' announced acquisition of Talkspace. Innovation is also accelerating in treatment-resistant illness, with ketamine, psilocybin and MDMA under active study, though regulatory progress remains uncertain.

Applied behavior analysis (ABA) for autism offers a case study in the vulnerabilities of the behavioral health system. With new CPT codes introduced in 2019, ABA visits grew 309.2% by 2025. Due to existing incentive structures, these increases, particularly those in Medicaid, have drawn scrutiny from payers and policymakers who question whether the expansion reflects genuine unmet need or patterns of overutilization and, in some instances, fraud.

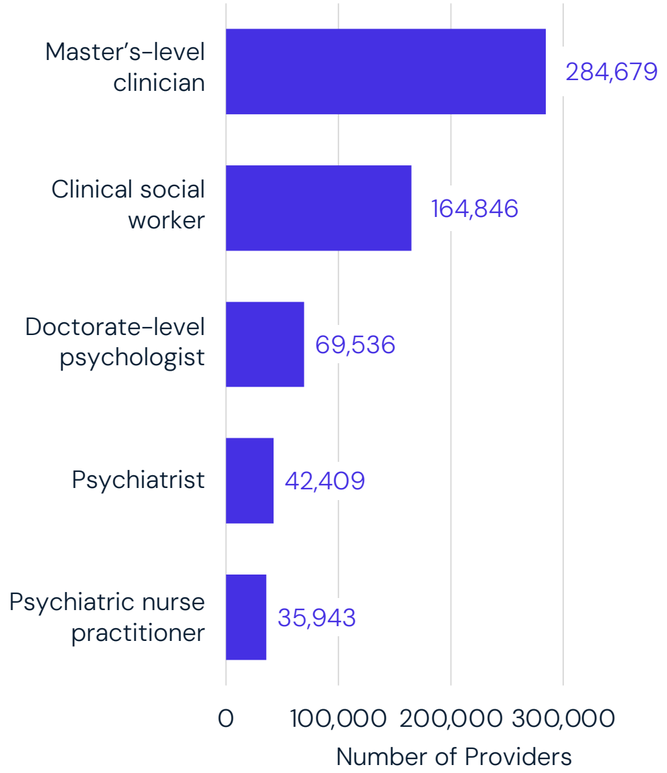
Across the behavioral health workforce, the data depicts a system stretched thin – one where structural reform, not incremental workforce growth, may be required to close the gap.

SUPPLY: PROVIDERS

Provider Supply Is Mostly Comprised of Master's-Level Clinicians

In the U.S., there are approximately 600,000 behavioral health providers, the majority of which are master's-level clinicians (e.g., psychotherapists, family therapists). Less than 10% of the behavioral health workforce is comprised of MD or DO psychiatrists. Notably, only MDs, DOs, NPs and PAs can prescribe medication to manage behavioral health conditions and not all provider types are equipped and trained to address all treatment needs across the range of behavioral health conditions.

Number of Billing Behavioral Health Providers, by Type, 2024



Note: PA denotes physician assistant; NP denotes nurse practitioner.
Source: Trilliant Health national all-payer claims database and Provider Directory.

Scope of Practice for Behavioral Health Providers

	Master's-Level Clinician	Clinical Social Worker	Doctorate-Level Psychologist	Psychiatrist	Psychiatric Nurse Practitioner
	Patient Assessment and Therapy			Prescribe and Monitor Medication and Patient Assessment and Therapy	
Degree Requirements	Master's degree (M.S. or M.A.) in a mental health-related field such as psychology, counseling psychology, marriage or family therapy	Master of Social Work	Doctor of Philosophy (Ph.D.) in a field of psychology or Doctor of Psychology (Psy.D.)	Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.), plus completion of residency training in psychiatry	Master of Science (M.S.) or Doctor of Philosophy (Ph.D.) in nursing with specialized focus on psychiatry
Typical Licenses and Credentials	Licensed Professional Counselor, Licensed Marriage and Family Therapist, Licensed Clinical Alcohol & Drug Abuse Counselor	Licensed Independent Social Workers, Licensed Clinical Social Workers, Academy of Certified Social Workers	Psychologists are licensed by licensure boards in each state	Licensed physician in the state where they are practicing; may also be designated as a Board-Certified Psychiatrist by the Board of Neurology and Psychiatry	National Council Licensure Examination, PMHNP-BC, board certification in psychiatric nursing
Clinical Scope of Work	These professionals are trained to evaluate a person's mental health and use therapeutic techniques based on specific training programs. They operate under a variety of job titles (e.g., counselor, clinician, therapist).	Clinical social workers are trained to evaluate a person's mental health and use therapeutic techniques based on specific training programs. They are also trained in case management and advocacy services.	Psychologists are trained to evaluate a person's mental health using clinical interviews, psychological evaluations and testing. They can make diagnoses and provide individual and group therapy. Some may have training in specific forms of therapy.	Psychiatrists are licensed medical doctors who have completed psychiatric training. They can diagnose mental health conditions, prescribe and monitor medications and provide therapy.	Psychiatric or mental health NPs can provide assessment, diagnosis and therapy for mental health conditions or substance use disorders. In some states, they are also qualified to prescribe and monitor medications.

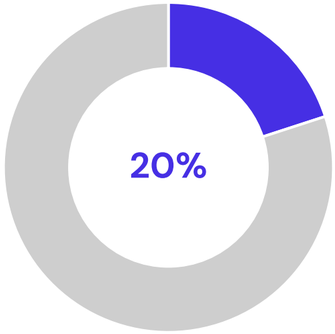
SUPPLY: PROVIDERS

Most Psychologists Deliver Care in Hybrid Settings

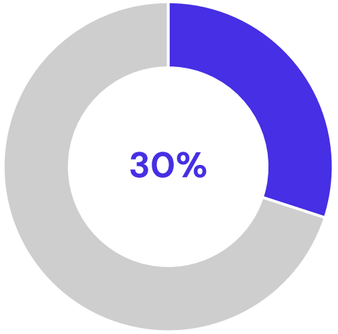
In 2025, only 20% of therapists worked in private practice and 30% worked in outpatient mental health centers. The nature of where psychologists are delivering care has shifted. Between 2020 and 2023, the share of psychologists offering hybrid care increased from 33% to 67%, while the proportion of fully remote psychologists declined from 64% to 21% and in-person-only psychologists increased from 3% to 13%. While behavioral healthcare was provided in hybrid and remote settings before the COVID-19 pandemic, it was not as common as it is now.

Share of Therapists, by Place of Employment, 2025

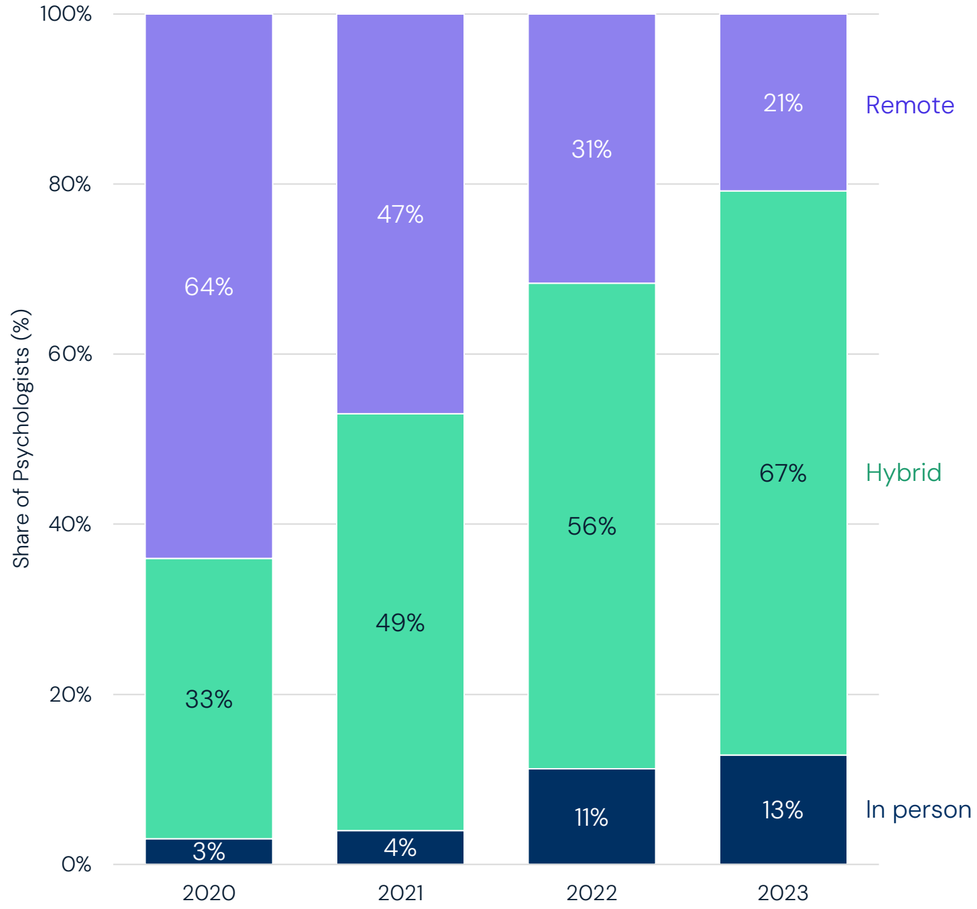
Share of therapists that work in a private practice



Share of therapists that work in an outpatient mental health center



Share of Psychologists, by Place of Work, 2020-2023



Note: Percentages may not add up to 100% due to rounding.
Source: Ambitions ABA; American Psychological Association.

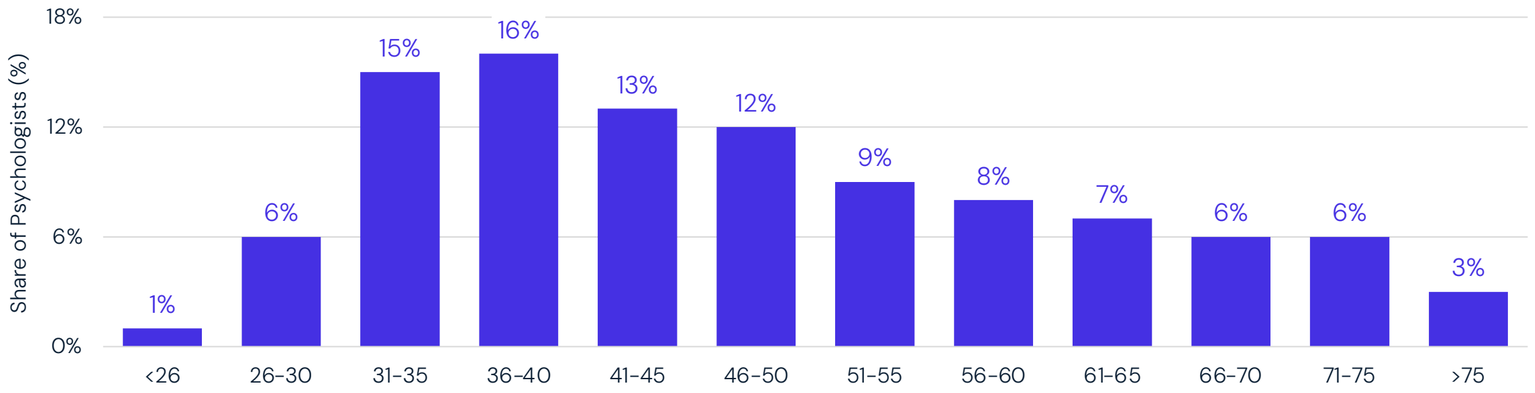
SUPPLY: PROVIDERS

Primarily White, Female Workforce Limits Patient-Provider Identity Concordance

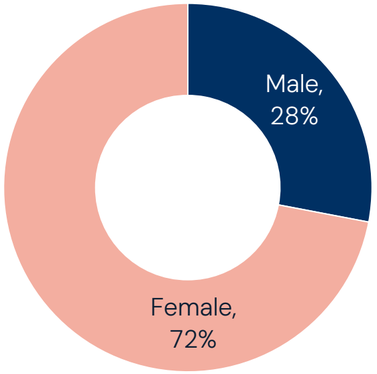
Most therapists are women (72%) and White (79%) and the majority (56%) are in their 30s or 40s. While some patients may prefer therapists who share their identity due to perceived trust or multicultural competence, a 2024 study found that patient-therapist demographic matching had a limited impact on treatment outcomes. That said, given the lack of diversity in the provider workforce, consumer desire for patient-provider identity concordance may create significant barriers to patients initiating care.

Psychologist Demographics, 2023

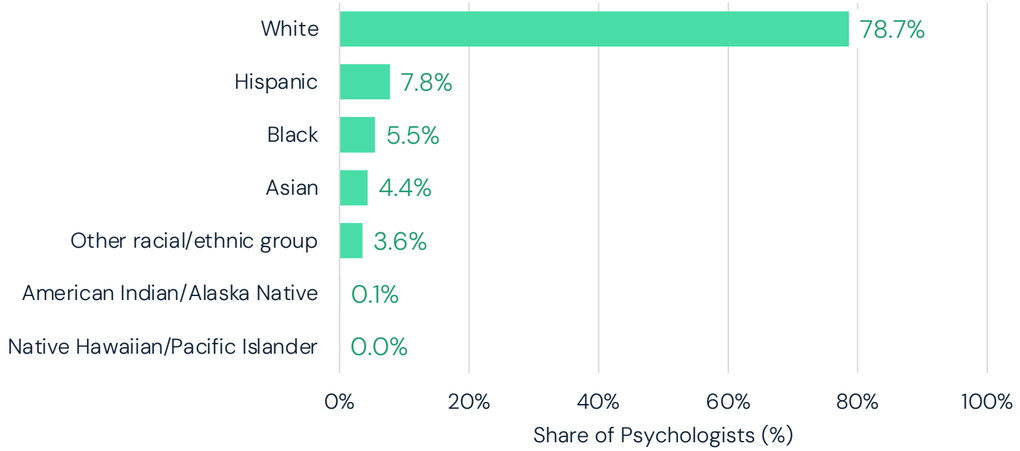
Age



Gender



Race/Ethnicity



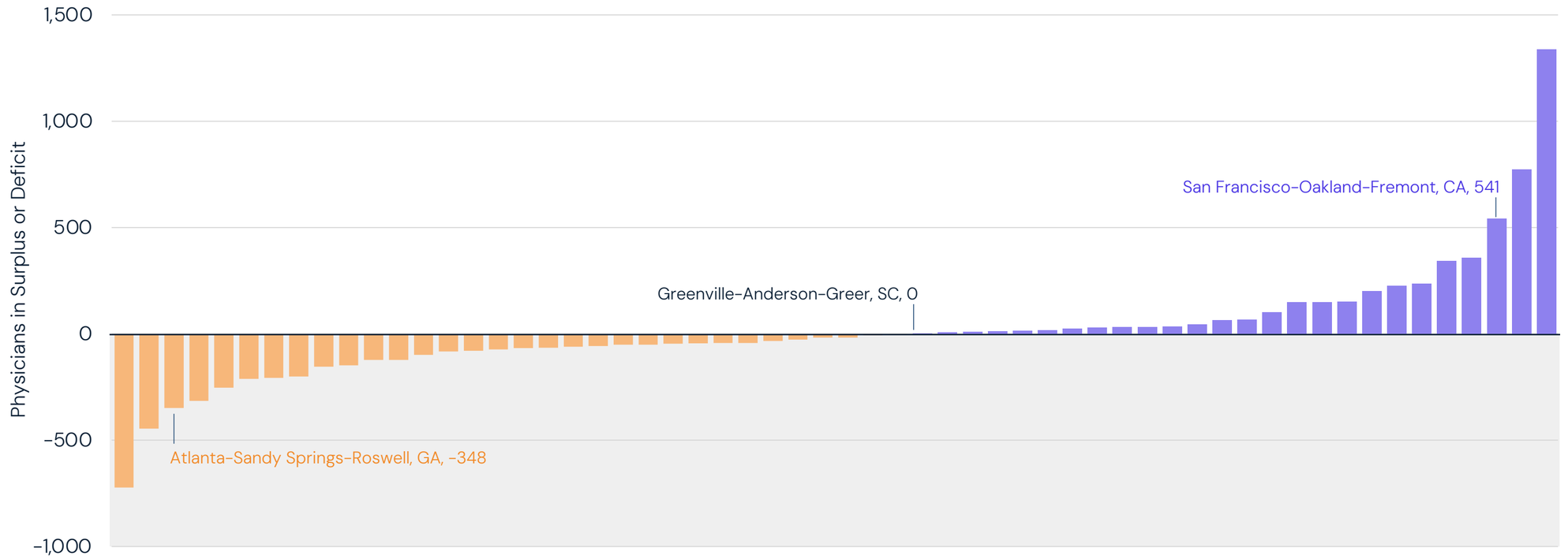
Note: Percentages may not add up to 100% due to rounding.
Source: American Psychological Association; Duong et al., Gender, Race/Ethnicity, and Patient-Therapist Matching on Gender and Race/Ethnicity: Predictors/Moderators of the Effectiveness of Trust/Respect Feedback, *Administration and Policy in Mental Health*, 2024.

SUPPLY: PROVIDERS

Over Half of Large Metros Have a Psychiatrist Shortage

Nationally, there are approximately 10,000 people per one psychiatrist. Across CBSAs with populations over 1M, 56.9% are in a shortage relative to this benchmark. For example, while San Francisco, CA has a relative surplus of 541 psychiatrists, Atlanta, GA has a deficit of 348 psychiatrists. Greenville, SC is relatively close to the population-based benchmark. Underlying demand for behavioral health services at the local level is a crucial factor influencing supply adequacy, as higher prevalence and utilization can strain even markets that appear to be in surplus based on population benchmarks.

Adequacy of Psychiatrists in Select Large Metropolitan CBSAs, 2024

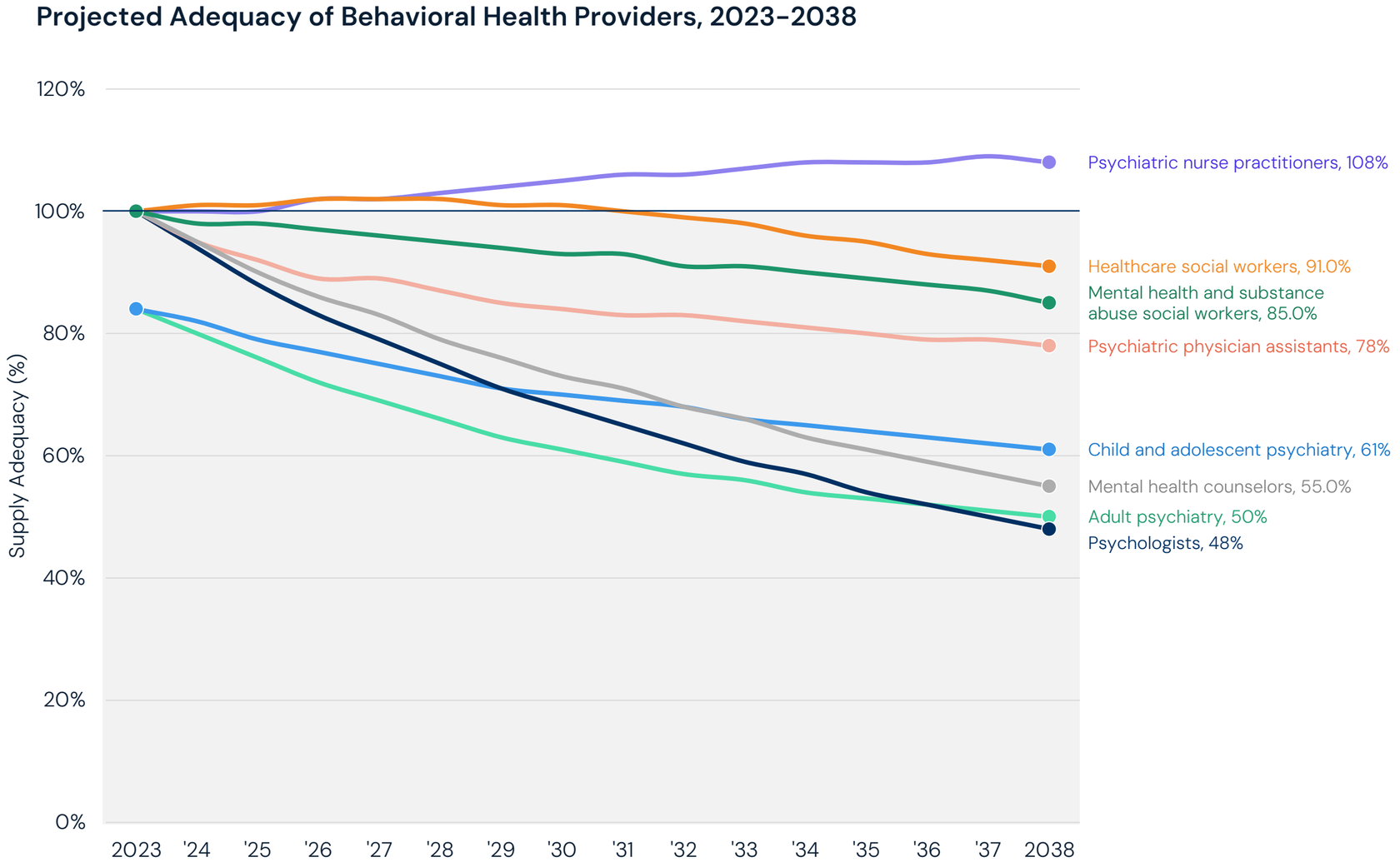


Note: FTE denotes full-time equivalent.
Source: Trilliant Health national all-payer claims database and Provider Directory.

SUPPLY: PROVIDERS

Projected Behavioral Health Provider Supply Is Not Expected to Meet Demand

By 2038, only psychiatric nurse practitioners are projected to exceed demand (108%), while all other behavioral health professions remain below full adequacy. Psychologists (48%) and adult psychiatrists (50%) face the largest projected shortages, worsening over time. Compared to adult psychiatrist supply, the projected child and adolescent psychiatrist supply is higher at 61%, though still inadequate. These gaps make clear that workforce growth is unlikely to keep pace with increasing behavioral health demand.



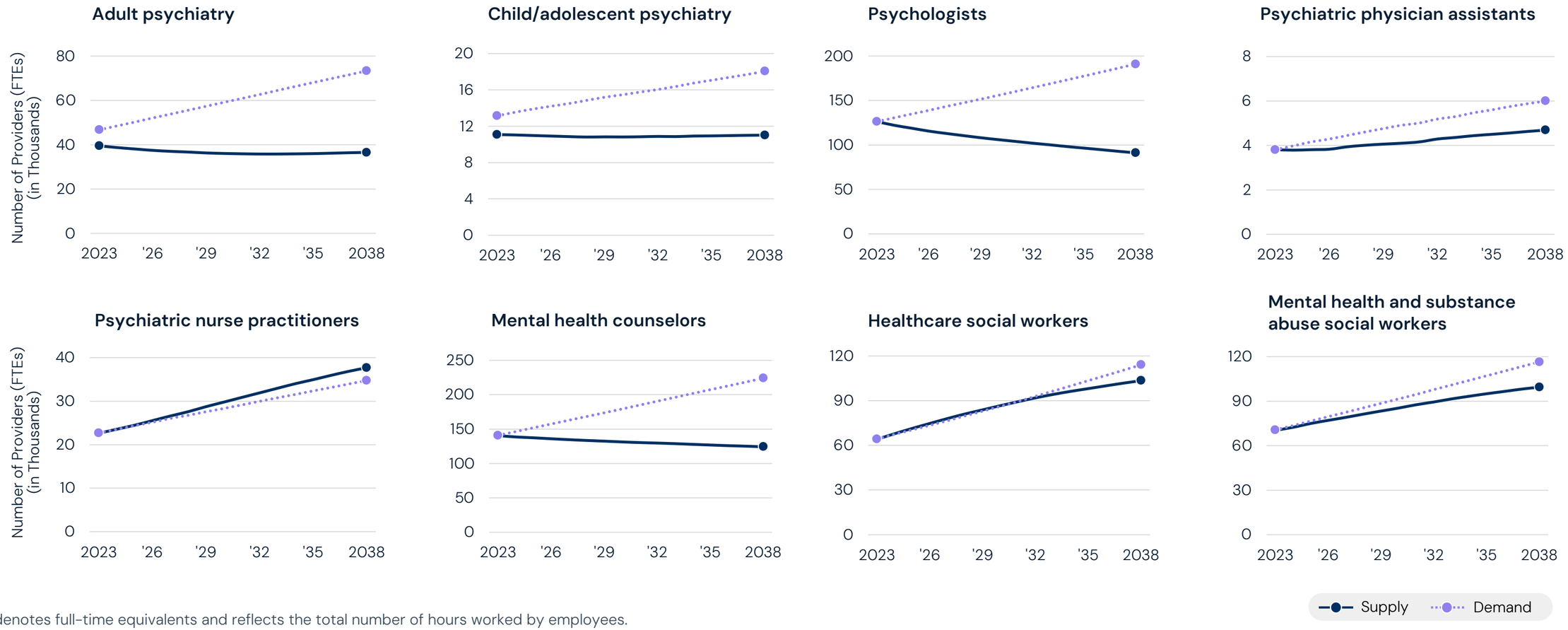
Source: U.S. Health Resources and Services Administration Workforce Projections.

SUPPLY: PROVIDERS

Behavioral Health Demand Outpaces Provider Supply

By 2038, projected demand is expected to exceed supply by approximately 36,780 FTEs in adult psychiatry and 99,780 FTEs in mental health counseling, reflecting some of the largest workforce gaps across all healthcare professions. Even with a modest surplus of psychiatric nurse practitioners, overall workforce growth is unlikely to meet rising population needs.

Supply and Demand of Behavioral Health Providers, 2023–2038



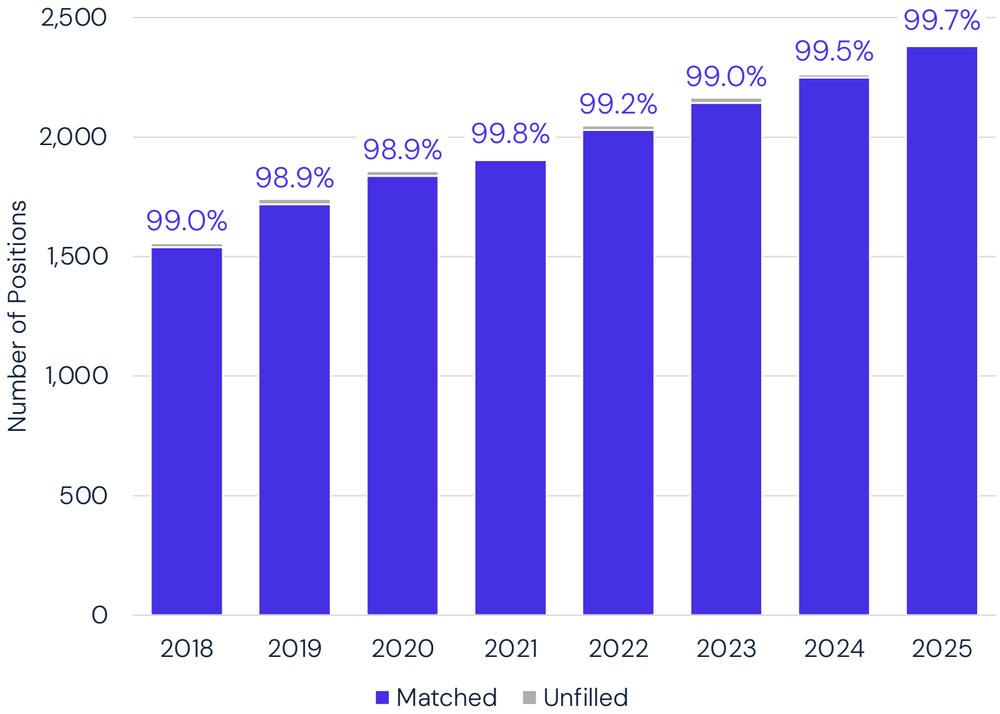
Note: FTE denotes full-time equivalents and reflects the total number of hours worked by employees.
Source: U.S. Health Resources and Services Administration Workforce Projections.

SUPPLY: PROVIDERS

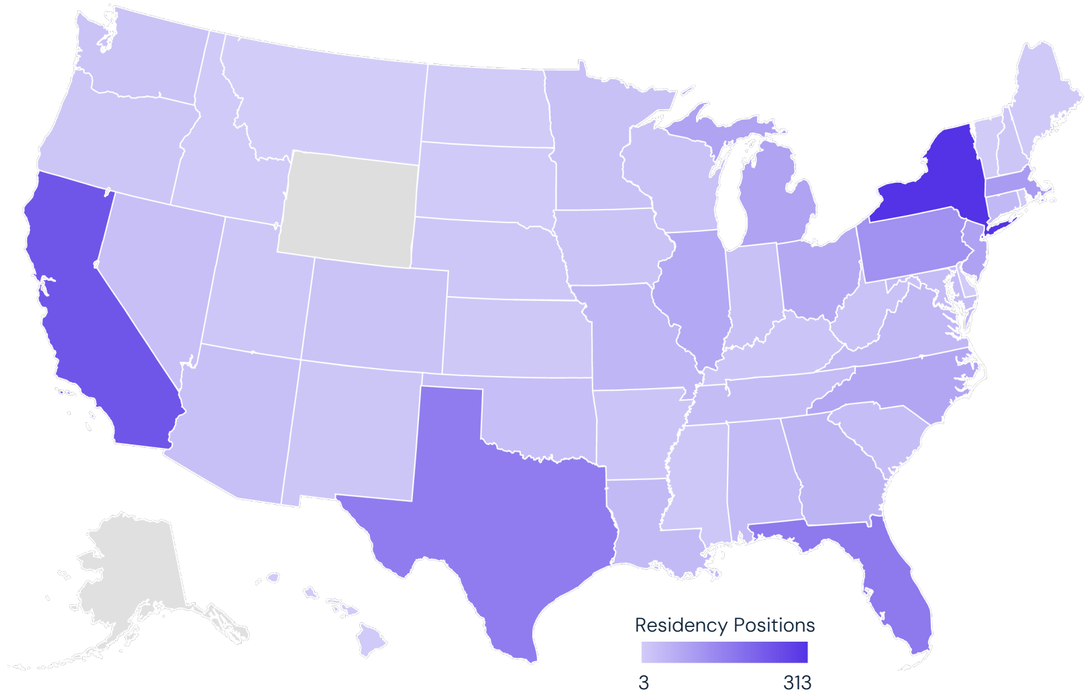
Psychiatrist Shortages Persist Despite 55% Growth in Residency Positions

The number of U.S. psychiatric residency positions has grown from 1,556 in 2018 to 2,388 in 2025. Despite this increase, residency positions have maintained a nearly 100% match rate, suggesting that supply is likely artificially constrained by the number of available positions. Notably, these positions are unevenly distributed across the country, with two states, Alaska and Wyoming, lacking a psychiatric residency program altogether.

Number of Psychiatric Residency Positions and Fill Rate, 2018–2025



Psychiatric Residency Positions, by State, 2025



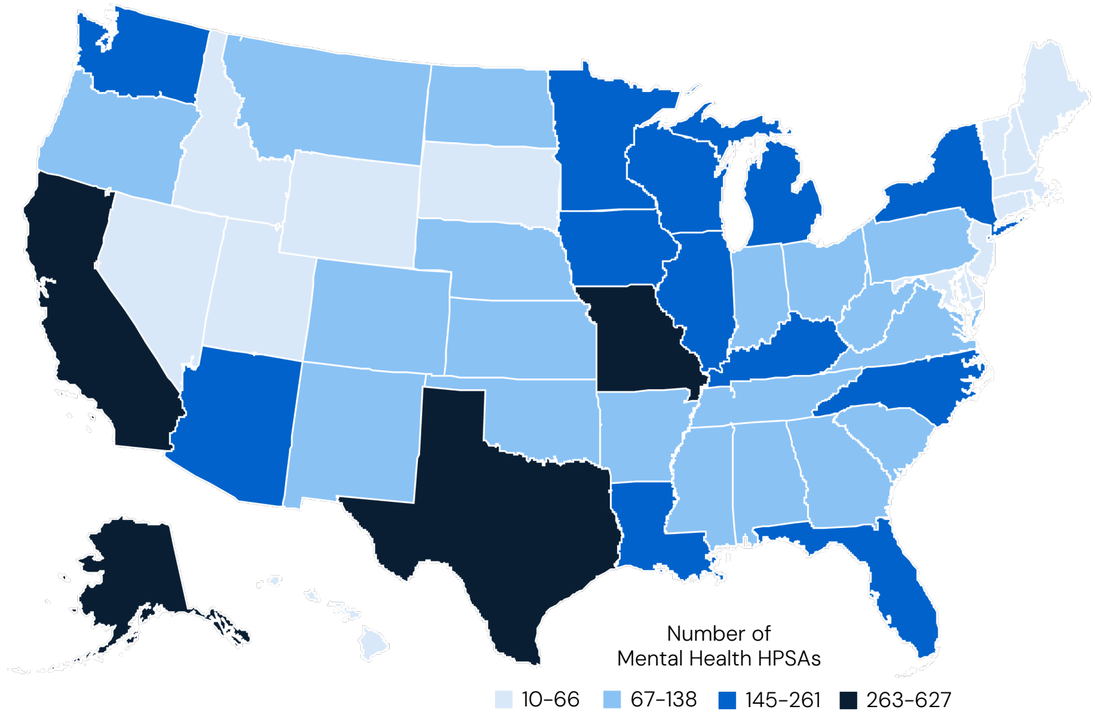
Note: States shaded with grey lack psychiatric residency programs.
Source: National Residency Match Program.

SUPPLY: PROVIDERS

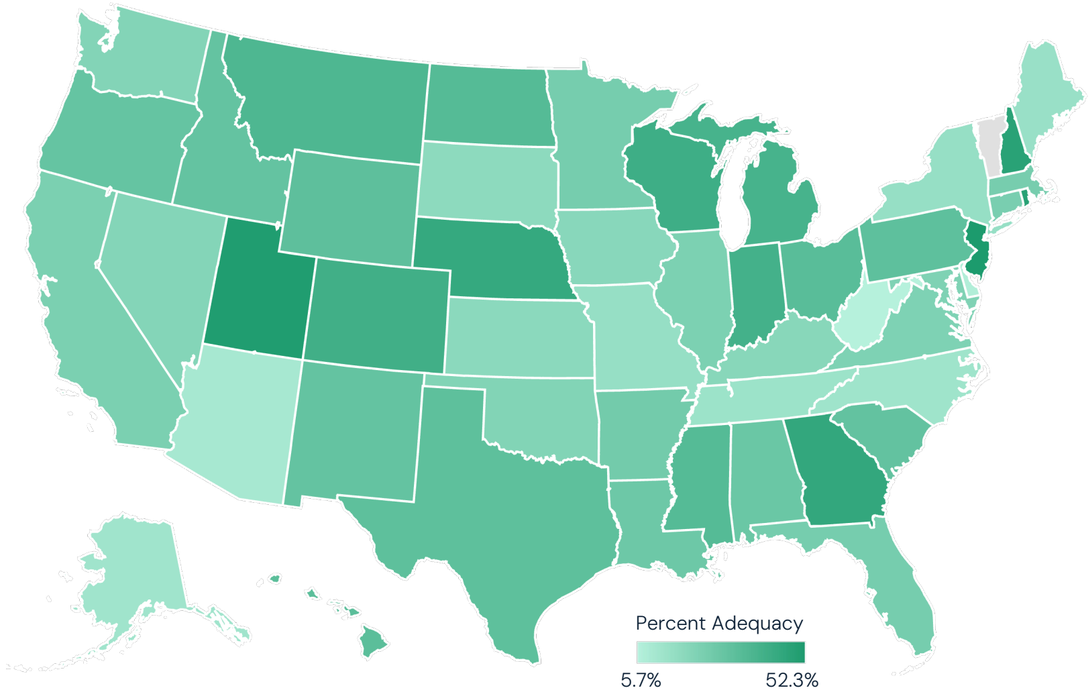
Mental Health Professional Shortage Areas Span Every U.S. State

The U.S. Health Resources and Services Administration (HRSA) designates mental health HPSAs as regions where the supply of psychiatrists, psychologists and other mental health providers is insufficient to meet population needs. On average, the U.S. has 131.5 HPSAs per state, ranging from 10 in Washington, D.C. to 627 in California. The percent adequacy of mental health professionals is 27.3% in the U.S., ranging from 5.7% in West Virginia to 52.3% in New Jersey.

Number of Mental Health HPSAs, by State, 2025



Percent Adequacy of Mental Health Professional Supply, by State, 2025



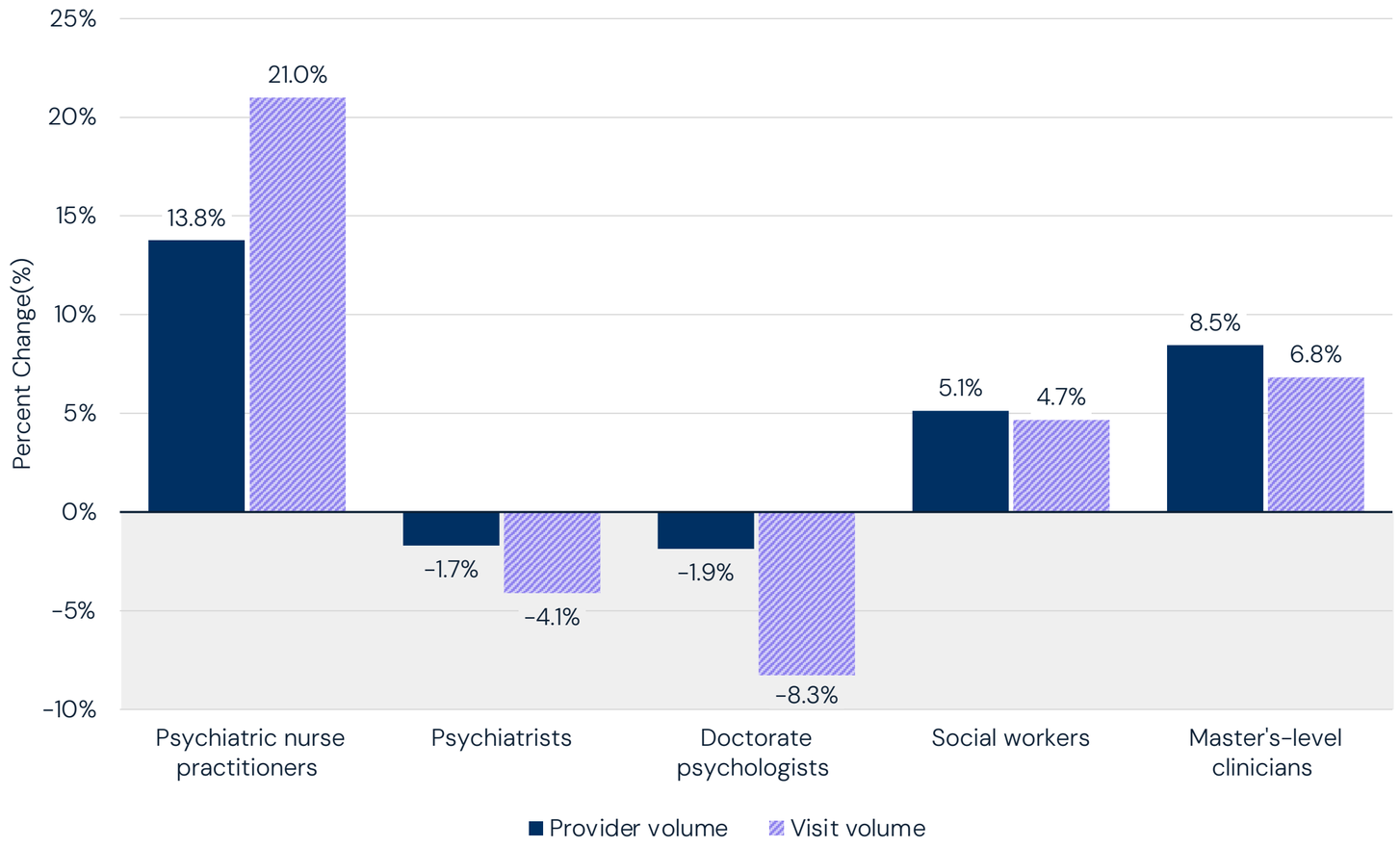
Note: HPSA denotes Health Professional Shortage Area. Percent adequacy is calculated by dividing the number of psychiatrists available to serve the population of the area, group or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA based on a ratio of 30,000 to 1 or 20,000 to 1 where high needs are indicated. Vermont does not have percent adequacy data available.
Source: U.S. Health Resources and Services Administration Workforce, Kaiser Family Foundation.

SUPPLY: PROVIDERS

Growth in Provider and Visit Volume Is Concentrated Among Nurse Practitioners

While the supply of most behavioral health providers is projected to be inadequate, supply and demand dynamics vary by provider type. For example, between 2023 and 2024, provider supply and visit volume increased among psychiatric NPs, social workers and master's-level clinicians. In contrast, both provider supply and utilization among psychiatrists and doctorate-level psychologists decreased, with declines in visit volume outpacing declines in supply. These trends likely reflect some amount of substitution between psychiatrists and psychiatric NPs, both of whom can prescribe medications. However, the extent to which this is driven by patient choice versus availability is unknown.

Percent Change in Number of Billing Behavioral Health Providers and Associated Visit Volume, 2023 to 2024



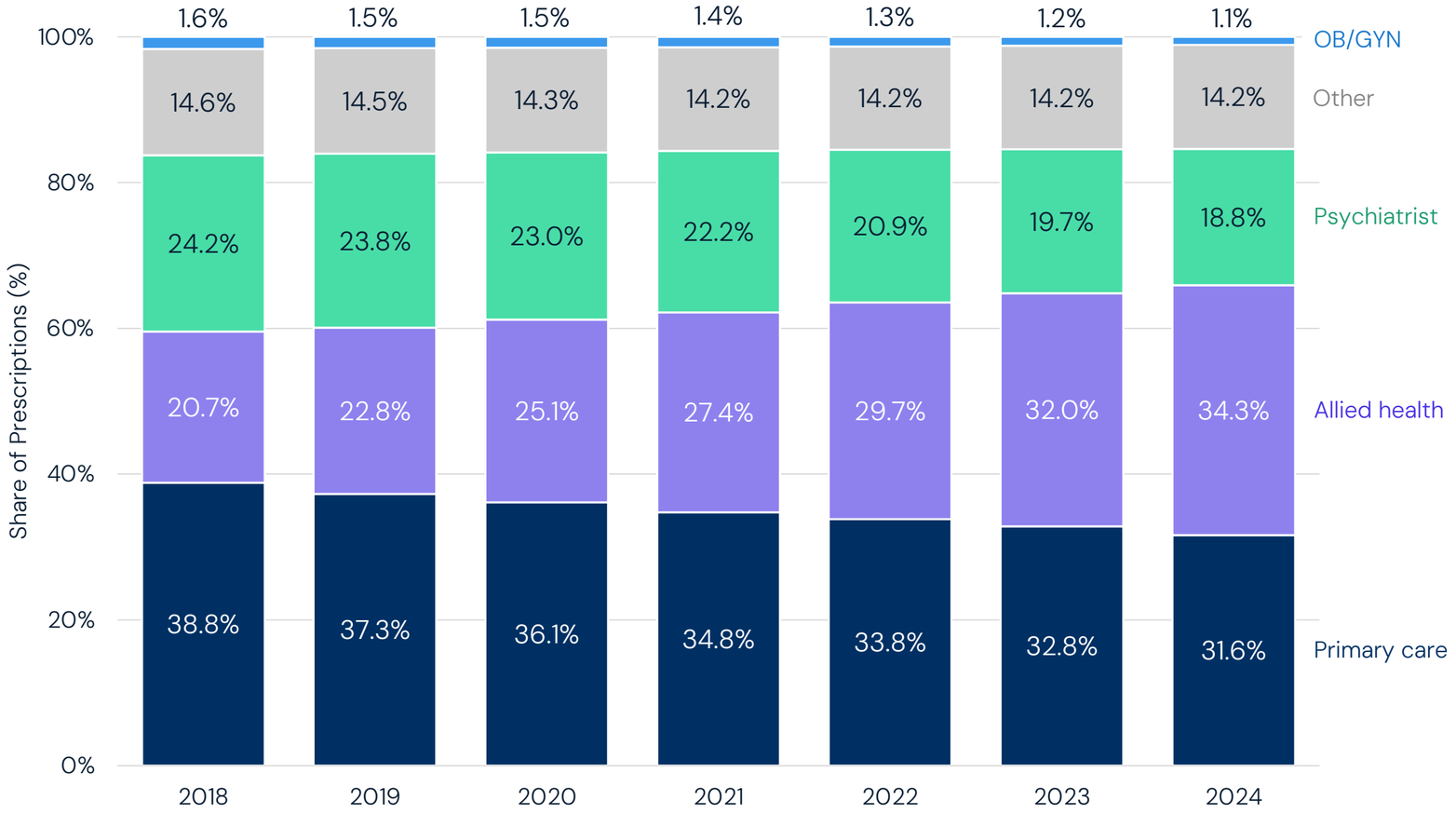
Note: NP denotes nurse practitioner.
Source: Trilliant Health national all-payer claims database and Provider Directory.

SUPPLY: PROVIDERS

Allied Health Professionals Are Managing a Growing Share of Behavioral Health Prescription Volume

Prescribing patterns for SSRIs, SNRIs, mood stabilizers and stimulants have shifted substantially in recent years. From 2018 to 2024, allied health providers (i.e., NPs and PAs) became the most common prescribing provider type, increasing from 20.7% to 34.3% of total prescription volume. Psychiatrists were the third highest prescriber in 2024, behind primary care providers. Together, allied health providers and primary care physicians accounted for 65.9% of prescription volume in 2024. The shift toward allied health likely reflects changing scope of practice laws and the growing number of NPs and PAs specializing in behavioral health.

Share of Behavioral Health Medication Prescribing, by Provider Type, 2018–2024



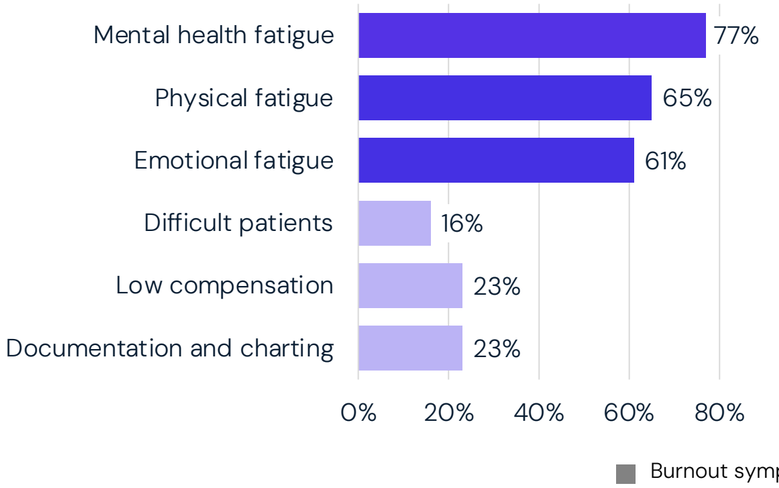
Note: NP denotes nurse practitioner; PA denotes physician assistant; SSRI denotes selective serotonin reuptake inhibitors; SNRI denotes serotonin and norepinephrine reuptake inhibitors.
Source: Trilliant Health national all-payer claims database and Provider Directory.

SUPPLY: PROVIDERS

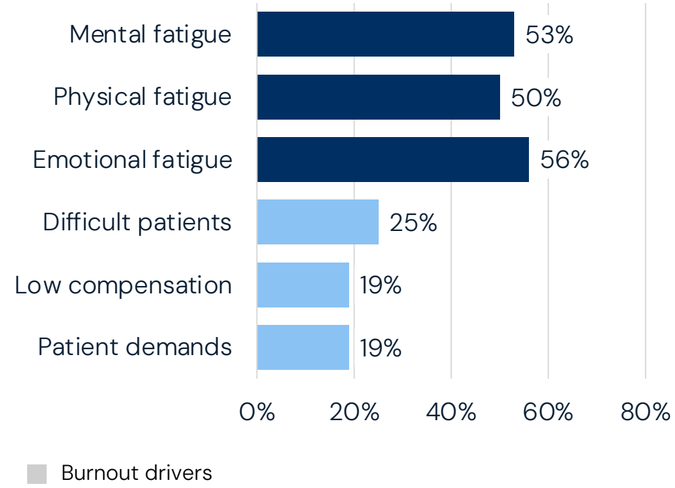
Low Compensation and High Patient Demand Contribute to Provider Burnout

Psychiatrists manage high daily patient volumes, averaging 10-20 patients per day, compared with five to seven for psychologists. A 2023 study found that 83% of behavioral health providers reported burnout. A 2025 study found that therapists reported the highest rate of mental health fatigue of all specialties (77%) and were most likely to report low compensation as a burnout driver (23%). Burnout is associated with lower quality of care, including reduced empathy, impaired clinical effectiveness and care disruptions driven by emotional exhaustion and internalization of patient experiences.

Burnout Drivers and Symptoms in Therapists, 2025



Burnout Drivers and Symptoms in Psychiatrists, 2025



Behavioral Health Professional Patient Panel

Provider Type	Average Sessions/ Day	Average Sessions/ Week
Psychiatrist	10-20	50-100
Psychologist/ therapist	5-7	20-30

Prevalence of Burnout Symptoms, by Provider Type 2025

Provider Type	Emotional Fatigue	Mental Fatigue	Physical Fatigue
Therapy	**61%**	**77%**	**65%**
Psychiatry	56%	53%	50%
Cardiology	N/A	38%	44%
Emergency medicine	68%	N/A	55%
Family medicine	45%	42%	39%
Pediatrics	45%	45%	42%
Primary care	55%	71%	55%

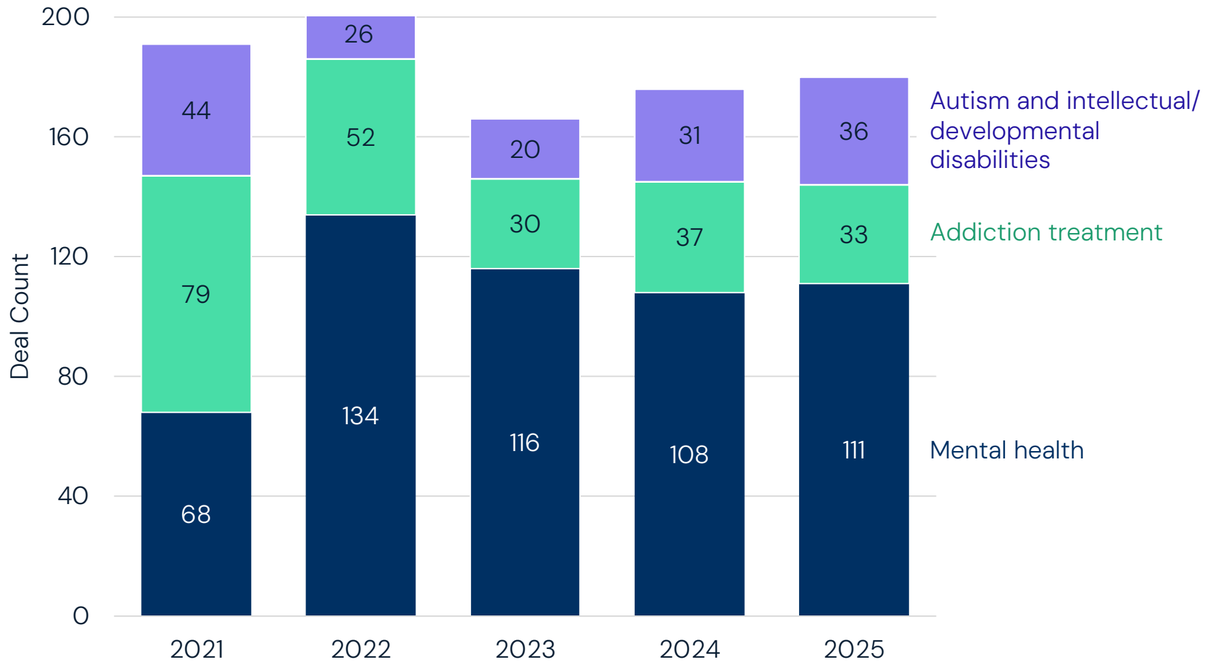
Source: Tebra; The National Council for Mental Wellbeing; Psychiatry Online; Talkspace; Headway; Tawfik et al., Evidence Relating Healthcare Provider Burnout and Quality of Care: A Systematic Review and Meta-analysis, Annals of Internal Medicine, 2019.

SUPPLY: INVESTMENT AND TECHNOLOGY

Behavioral Health M&A Activity Is Led by Mental Health Transactions

In 2025, there were 167 transactions in the behavioral health sector. Mental health drove the market, accounting for 111 deals, including Spring Health's planned acquisition of Alma. The transaction, expected to close in Q2 2026, reflects growing consolidation aimed at integrating digital tools, provider networks and payer relationships to expand access and improve continuity of care. Recent activity reinforces this trend, with UHS announcing its planned acquisition of Talkspace, an online therapy platform, in March 2026.

Behavioral Health Industry Transactions, 2021-2025



Spring Health Joins Forces with Alma, Expanding Access to Precision Mental Health Care

Our Next Chapter: Hazel Health and Little Otter Merge to Transform Care for Millions of Families

UHS to acquire Talkspace for $835M as hospital operator pursues behavioral health growth

DECEMBER 9, 2025

Handspring Health Announces the Acquisition of Joon Care

Note: M&A denotes mergers and acquisitions, UHS denotes Universal Health Services.
Source: Mertz Taggart Behavioral Health M&A Report: Q3 & Q4 2025; Fierce Healthcare; publicly available company information.

SUPPLY: INVESTMENT AND TECHNOLOGY

Online Therapy Platforms Vary Widely in Services, Pricing and Medication Management

Direct-to-consumer online therapy platforms offer varying care models, ranging from psychotherapy-only to integrated psychotherapy, psychiatric assessment and prescribing. Pricing structures differ, with many requiring monthly subscriptions. Notably, most providers accept insurance.

Overview of Select Online Therapy Platforms

	betterhelp	Talkspace	amwell	Brightside Health	CEREBRAL	Calmerry	growtherapy	SESAME	Thriveworks
Price Point	Monthly subscription costs **$70–100**/week Average **$23** co-pay per session	**$69**/week for messaging therapy **$99**/week for video + messaging therapy $109/week for video + messaging + workshops **$299** for initial psychiatry evaluation + **$175** per psychiatry session	**$99** or less per appointment **$199** for initial psychiatry evaluation + **$95** per psychiatry session	**$299**/month for four therapy video sessions and unlimited messaging **$95**/month + pharmacy copay for psychiatry **$349**/month for psychiatry + therapy	**$175**/session or **$795**/for three months for weekly video messaging therapy **$180**/every three months for psychiatry evaluation, messaging and medication **$365**/month for therapy + medication plan **$405**/session is maximum out-of-pocket	**$73**/week for four 30-minute live sessions a month, messaging **$66**/week for two 30-minute live sessions a month, messaging **$55**/week for four 30-minute live sessions a month **$50**/week for unlimited messaging	**$100–200**/session self-pay or **$0–50**/session copay with insurance	**$65–79**/session **$65**/month for mental health medication subscription	**$200–240** for initial therapy session + $160–195 for follow-ups (self-pay) **$0–55**/session copay with insurance **$300–375** for initial psychiatry evaluation + **$210–300** per psychiatry session
Included Services	Weekly live therapy session, optional group therapy, journaling, worksheets, goal setting and more Subsidiary of Teladoc Health	Therapy, psychiatry Text, audio messaging, live video sessions Partners with Amazon Pharmacy	Therapy, psychiatry Live video sessions Partners with CVS Health	Therapy, psychiatry Live video sessions, messaging, interactive lessons	Therapy, psychiatry Live video sessions, personalized care plan, monthly progress assessments In-house pharmacy CerebralRx	Therapy Live video sessions, unlimited text messaging	Therapy, psychiatry	Therapy, psychiatry Live video sessions, unlimited messaging	Therapy, psychiatry Live video sessions, messaging, treatment plans
Prescribing	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Accepts Insurance	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No, but accepts Costco Membership	Yes
Subscription or Membership Required	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No

Note: In March 2026, Universal Health Services announced its acquisition of Talkspace.
Source: Publicly available company information.

SUPPLY: INVESTMENT AND TECHNOLOGY

Novel Treatments Focus on Treatment-Resistant Illnesses

Treatments such as ketamine, psilocybin and MDMA are being studied for treatment-resistant depression and PTSD. Although HHS Secretary Kennedy publicly supported clinical psychedelic therapy in 2024, regulatory progress has remained slow, reinforcing uncertainty around large-scale adoption. Despite regulatory uncertainty for some treatments, clinical research and innovation in this space continue to grow.

Novel Treatments in Behavioral Health

Technology	Mechanism	Application
Psilocybin (COMP360) for treatment-resistant depression	Oral drug	Compass is in Phase III trials for a single dose psychedelic drug found in mushrooms for treatment-resistant depression. Phase II data has demonstrated statistically significant and clinically meaningful reduction symptom severity.
MDMA-assisted therapy for PTSD	Oral drug	Lykos Therapeutics is in Phase III of the study evaluating if MDMA-assisted therapy is safe and effective in people with at least moderate PTSD.
At-home brain stimulation device for depression	Brain stimulation device	The FDA approved the Flow Neuroscience at-home brain stimulation device for treating depression in December 2025. This is the first at-home non-invasive neuromodulation device. Utilization still requires physician monitoring.
Accelerated intermittent theta-burst stimulation (aiTBS) for treatment-resistant bipolar depression	Brain stimulation device	University of California San Diego conducted this clinical trial from 2022 through 2024 to test whether theta-burst stimulation was effective in treating patients with treatment-resistant bipolar disorder. Findings supported the clinical efficacy of reduced depressive symptoms.
Ketamine for major depressive disorder and treatment-resistant depression	Oral drug	Columbia University conducted this clinical trial from 2012 through 2019 to test whether ketamine could treat major depressive disorder. More recently, the University of Rochester launched a trial in January 2026 to test whether ketamine could effectively treat treatment-resistant depression.

Note: HHS denotes U.S. Department of Health and Human Services; PTSD denotes post-traumatic stress disorder.
Source: Clinicaltrials.gov, Politico.

SUPPLY: INVESTMENT AND TECHNOLOGY

Prescription Digital Therapeutics Target Mental Health Care

PDTs are FDA-regulated software-based treatments prescribed by clinicians to deliver evidence-based interventions for conditions such as depression, anxiety, PTSD and SUD. PDTs, which are regulated as software as a medical device (SaMD) and are clinically validated for safety and effectiveness, can be paired with traditional treatments or used independently. As demand for behavioral care continues to rise, PDTs have the potential to offer scalable, personalized solutions that expand access and support self-management.

Select FDA-Approved Prescription Digital Therapeutics for Behavioral Health Management

Disease State	Intervention	Manufacturer	Strategy	Mechanism
Generalized anxiety disorder	DaylightRx	Big Health, Inc	CBT – uses cognitive restructuring, relaxing and exposure to reduce anxiety symptoms	Smartphone application
Major depressive disorder	Rejoyn	Otsuka America Pharmaceutical, Inc	CBT – uses cognitive emotional training that includes personalized text messages as an adjunct to antidepressant medication therapy	Smartphone application
Postpartum depression	MamaLift Plus	Curio Digital Therapeutics, Inc	Neurobehavioral interventions - uses cognitive restructuring and delivers therapy by text, illustrations, video and interactive exercises	Smartphone application
Attention deficit-hyperactivity disorder	EndeavorRx	Akili Interactive Labs, Inc	Uses art, music, storytelling and reward cycles to target neural pathways associated with focus	Video game
Post-traumatic stress disorder	Freespira	Freespira, Inc	Stress reduction through guided and monitored breathing exercises	Breathing sensor and tablet with real-time breathing pattern feedback
	Prism	GrayMatters, Inc	Relaxation and stress reduction through EEG biofeedback	EEG headset and computer simulation
Substance use disorder	reSET	PursueCare	CBT – provides interactive lessons, quizzes and progress tracking to supplement individuals in outpatient treatment and on transmucosal buprenorphine.	Smartphone application
Opioid use disorder	reset-O			Smartphone application

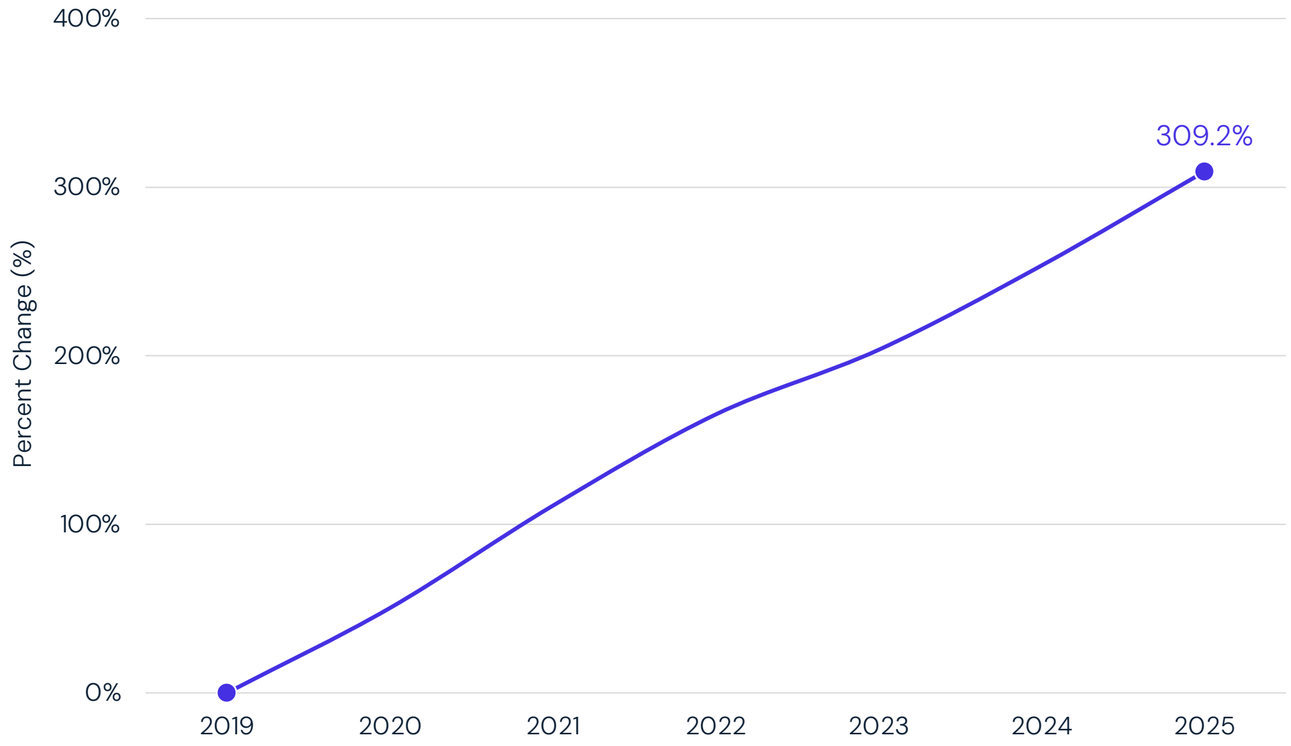
Note: PDT denotes prescription digital therapeutics; PTSD denotes post-traumatic stress disorder; SUD denotes substance use disorder; EEG denotes electroencephalogram; CBT denotes cognitive behavioral therapy.
Source: Transforming Psychiatry: The Rise of Prescription Digital Therapeutics, American Journal of Managed Care; publicly available company information.

SUPPLY: INVESTMENT AND TECHNOLOGY

Increase in ABA Therapy Highlights Behavioral Health Vulnerabilities

Since the introduction of new CPT codes in 2019, ABA visit volume has increased substantially, reaching a growth rate of 309.2% in 2025. These increases, have drawn scrutiny from payers and policymakers questioning whether the expansion reflects genuine unmet need or patterns of overutilization and, in some instances, fraud.

Percent Change in Applied Behavior Analyst Visits, 2019–2025



United States Attorney's Office
District of Minnesota

PRESS RELEASE

First Defendant Charged in Autism Fraud Scheme

STAT+ | POLITICS

Federal Medicaid audit finds massive overpayment for autism therapy in Colorado

The HHS OIG uncovered $285.2 million in improper and potentially improper payments

Note: ABA denotes applied behavior analysis, PP denotes percentage point.
Source: Trilliant Health national all-payer claims database.

Yield

Yield refers to the intersection of demand and supply (i.e., price) and is also influenced by market factors such as policy regulations and reimbursement incentives.

The nature of the U.S. healthcare system – spanning how care is priced, reimbursed and funded – is fundamentally misaligned with providing high-value care to behavioral health patients.

In 2019, mental health and substance use disorders (SUD) accounted for 7.4% – or roughly $200B – of personal healthcare spending. Due to increased utilization, that figure has undoubtedly grown in recent years. Yet the more consequential number may be what goes unspent. Untreated mental illness cost the U.S. economy an estimated $477.5B in 2024 and is projected to exceed $1.3T annually by 2040, with premature death and workforce productivity losses – through unemployment, absenteeism and presenteeism – accounting for the vast majority of projected costs. Emergency department overutilization alone is expected to grow 230.2% between 2024 and 2040. The economic case for treating behavioral health conditions is unambiguous. Unfortunately, the financial barriers preventing that are equally so.

Cost is a commonly cited barrier to accessing behavioral health care, reported by 65.2% of adults with unmet mental health needs and 45.3% of those with SUD. Nearly one in 10 Americans has taken on debt to pay for mental health treatment, and 60% of those individuals accumulate more than $1,000 in debt. The average individual spends $375 out-of-pocket monthly on mental health treatment – a figure that reflects not only the cost of care, but the inadequacy of coverage. Notably, 31% of Americans report that mental health treatment is financially out of reach.

Health plan price transparency data reveal why. Commercial negotiated rates for individual and group psychotherapy vary by up to 7x for the same CPT code – a disparity that cannot be explained by quality differentials or clinical complexity. Intensive outpatient therapy has a median rate of $252 per day, but ranges by 15x across providers. A single inpatient psychiatric revenue code has a median of $1,179 per day – and can range by 22x. In a single market, applying negotiated rates for one inpatient psychiatric code across 200 seven-day stays yields a spending difference of $7.9M depending solely on which hospital delivers the care.

Direct-to-consumer platforms (DTC) have introduced pricing transparency to a market historically defined by its absence, but transparency does not equate to affordability. A consumer navigating DTC therapy options may face annual costs of $3,000 to $5,000 – comparable with the cost of insurance-based options, but with meaningfully different out-of-pocket exposure depending on deductible status and benefit design. For many patients, the financially optimal path is not intuitive, and the friction of navigating these tradeoffs itself becomes a barrier to care.

The policy environment adds further uncertainty. Federal actions since 2025 have introduced new administrative and financial barriers to behavioral health access, including the FY 2027 Presidential Budget Request, which calls for a $5B reduction in NIH funding, and the Administration's refusal to enforce the Mental Health Parity Act. At the same time, CMS is piloting outcome-driven reimbursement models – including the ACCESS and IBH models – that signal a potential shift toward value-based care for Medicare and Medicaid populations. Whether these models scale meaningfully will depend on the combination of political durability and program effectiveness.

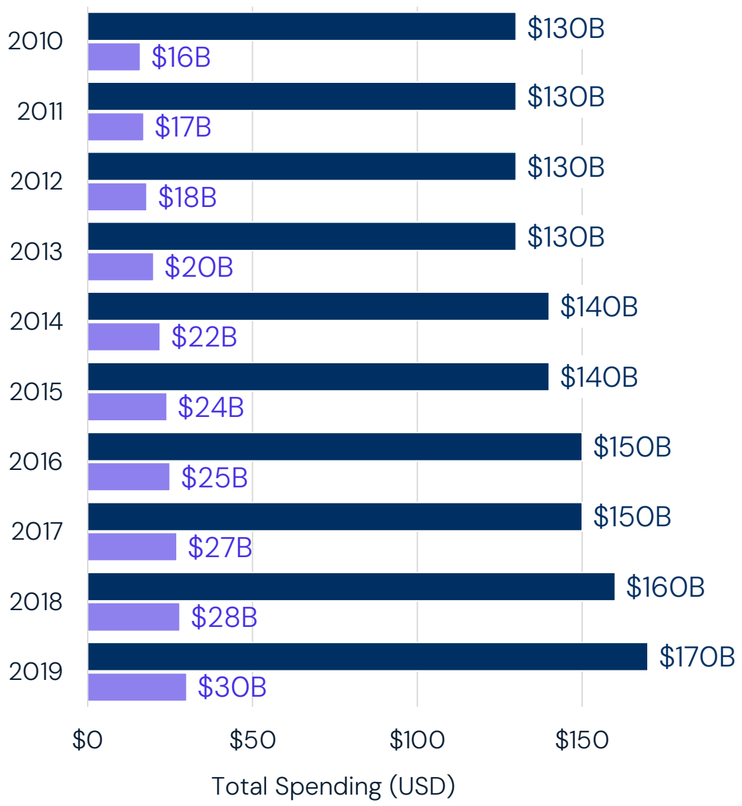
For health economy stakeholders, the question is no longer whether behavioral health requires structural change – it is who will drive it, and how quickly.

YIELD: SPENDING

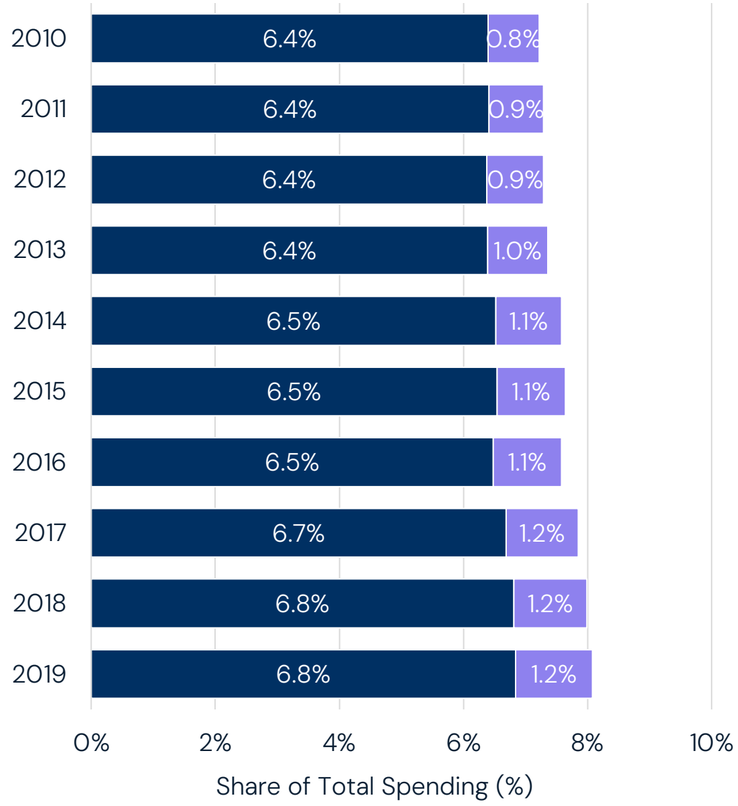
Behavioral Health Accounts for 7.4% of Healthcare Spending

Between 2010 and 2019, total personal healthcare spending for mental health and substance use disorders increased by 30.8% and 87.5%, respectively. In 2019, mental health accounted for 6.8% of total personal healthcare spending ($170B) while substance use disorders accounted for 1.2% ($30B), only increasing by 0.4 PP each since 2010. Spending has likely continued to grow following the COVID-19 pandemic, as behavioral health demand increased.

U.S. Personal Healthcare Spending for Mental Health and Substance Use Disorders, 2010-2019



Share of U.S. Personal Healthcare Spending for Mental Health and Substance Use Disorders, 2010-2019



Note: PP denotes percentage point. IHME Disease Expenditure Project (DEX) estimates U.S. personal healthcare spending based on insurance claims and facility data.
Source: Institute for Health Metrics (IHME) and Evaluation VizHub.

YIELD: SPENDING

Annual Economic Burden of Untreated Mental Illness Exceeds $477B

Untreated mental illness cost the U.S. economy an estimated $477.5B in 2024 and is projected to exceed $1.3T annually by 2040. Most projected costs are attributed to premature death ($911.9B) and workforce productivity losses ($252.3B) including unemployment, absenteeism and presenteeism. Additional projected spending is attributable to avoidable medical costs tied to chronic physical health conditions and emergency department utilization. Between 2024 and 2040, spending attributed to ED overutilization is expected to grow the most (230.2%).

Excess Costs of Untreated Mental Health, 2024 and 2040

	2024	2040
TOTAL EXPENDITURES	**$477.5B**	**$1.3T**
Chronic physical health conditions	**$23.9B**	**$76.0B**
Diabetes	$11.6B	$37.4B
Stroke	$2.9B	$9.2B
Hypertension	$3.9B	$12.6B
Ischemia	$3.2B	$9.1B
HIV	$2.4B	$7.8B
Emergency department overutilization	**$5.3B**	**$17.5B**
Productivity loss	**$116.0B**	**$252.3B**
Absenteeism	$7.4B	$11.4B
Presenteeism	$45.4B	$69.7B
Unemployment	$63.2B	$171.2B
Premature death	**$332.2B**	**$911.9B**

Note: ED denotes emergency department.
Source: Deloitte Center for Health Solutions.

YIELD: POLICY

Federal Policy Signals Reveal Misaligned Behavioral Health Priorities

Starting with not enforcing the Mental Health Parity Rule, many Federal actions under the second Trump Administration have increased the financial and administrative barriers to accessing behavioral health care. The FY 2027 President's Budget Request calls for a $5B cut to NIH funding and proposes the creation of the Administration for a Healthy America (AHA), which would consolidate programs within SAMHSA, while also defunding initiatives such as safe syringe programs for individuals with SUD and trans-sensitive behavioral health services.

Federal Policy Developments Related to Behavioral Health, 2024–2026

Sept. 2024 ›	The Biden Administration finalized the Mental Health Parity Rule, which furthered implementation of the Mental Health Parity and Addiction Equity Act, requiring private health insurers to cover mental health and addiction services at the same level of as other medical conditions. The rules restrict "nonquantitative treatment limitations" like prior authorization, network or provider shortages, that create higher barriers to mental health care.
Jan. 2025 ›	The Trump Administration stated that they would not enforce the Mental Health Parity Rule and considered rescinding it altogether. The ERISA Industry Committee filed a lawsuit claiming the Mental Health Parity Rule limits employers' ability to provide affordable health benefits to workers.
Feb. 2025 ›	President Trump issues an Executive Order establishing the Make America Healthy Again Commission, identifying chronic diseases and mental health as key priorities. The Department of Government Efficiency begins reduction in workforce, affecting SAMHSA.
May 2025 ›	The President's FY 2026 Budget Request calls for substantial mental health and SUD budget cuts. The HHS budget would fold SAMHSA into AHA and its funding would be reduced by over $1B. The budget request would consolidate three existing behavioral health block grants into a new Behavioral Health Innovation Block Grant (BHIBG) funded at $4B below the combined FY 2025 funding levels. The budget also requested overall NIH funding cuts of $18B (40%) and the merging NIDA, NIAAA, and NIMH into a new National Institute of Behavioral Health. HHS, DOL and Treasury issued a letter pausing the full enforcement of the 2024 Mental Health Parity Rule.
July 2025 ›	H.R. 1, 2025 reconciliation law, One Big Beautiful Bill Act (OBBBA) is signed into law, creating new indirect risks and potential opportunities for behavioral healthcare access. OBBBA is anticipated to reduce the projected growth of Federal Medicaid spending by $911B, through new work and reporting requirements that often lead to coverage losses. Because Medicaid is a primary payer for behavioral healthcare, covering around 25% of all mental health and SUD treatment nationally, such changes are expected to impact access to care. At the same time, this law exempts mental health and SUD services from new Medicaid cost-sharing requirements and allows behavioral health providers (e.g., CCBHCs, CMHCs, OTPs) to access funding through a $50B Rural Health Transformation Program.
Dec. 2025 ›	DEA/HHS extends telemedicine prescribing capabilities, affecting certain mental health and SUD medications. This is the fourth extension of the pandemic-era flexibility.
Feb. 2026 ›	H.R.7148, Consolidated Appropriations Act, 2026, is signed into law. Contrary to the President's FY 2026 Budget Request, the enacted budget generally maintained NIH (+$300M) and SAMHSA (-$700M) funding levels.
March 2026 ›	The President's FY 2027 Budget Request calls for a $5B cut to NIH. The budget request again proposes the creation of the AHA, via a consolidation of HRSA, SAMHSA, CDC and OASH with the goal of cutting $5B in programs deemed duplicative or misaligned with administration priorities. As part of this reorganization, several existing behavioral health funding streams would be replaced by a new $4.1B BHIBG, which the administration indicated would defund programs such as safe smoking and syringe kits, transgender health services and DEI initiatives.

Note: AHA denotes Administration for a Healthy America; CCBHC denotes Certified Community Behavioral Health Clinics; CDC denotes Centers for Disease Control and Prevention; CMHC denotes Community Mental Health Centers; OTP denotes Opioid Treatment Programs; DEA denotes Drug Enforcement Administration; DEI denotes diversity equity and inclusion; DOL denotes Department of Labor; ERISA denotes Employee Retirement Income Security Act; HHS denotes Department of Health and Human Services; NIDA denotes National Institute on Drug Abuse; NIAAA denotes National Institute on Alcohol Abuse and Alcoholism; NIMH denotes National Institute of Mental Health; OASH denotes Office of the Assistant Secretary for Health; SAMHSA denotes Substance Abuse and Mental Health Services Administration; SUD denotes substance use disorder.
Source: Kaiser Family Foundation; Reuters; Beckers.

YIELD: POLICY

New CMS Models Aim to Improve Behavioral Health Outcomes

Through the ACCESS and IBH models, CMS is shifting from volume-based reimbursement to outcome-driven, technology-enabled and coordinated care to strengthen behavioral health delivery for Medicare and Medicaid populations. Prior demonstrations of the CCBHC model show tangible improvements in behavioral health care coordination and follow-up.

CMS Behavioral Health Models

Certified Community Behavioral Health Clinic (CCBHC) Demonstration

- **Timeline:** 2016-2028
- **Problem:** Medicaid CCBHCs are underfunded with inconsistent care standards and fragmented care delivery across mental health, substance use and physical health services.
- **Solution:** To introduce prospective, cost-based payment, standardized service requirements and coordinated, open-access care to improve behavioral health access.
- **Result:** Evidence suggests CCBHCs improve care coordination, access and quality of behavioral health services, with stronger collaboration across providers. Follow-up within 30 days after an emergency department visit reached 68–71% for mental illness and 37–40% for substance use disorders, well above national benchmarks. Post-hospitalization outpatient follow-up was also higher than national averages, reaching 73–76% for adults and 77–80% for children.
- **Participants:** Over 500 select clinics serving Medicaid patients in 46 states plus Washington, D.C. and Puerto Rico.
- **Eligibility:** Accepted applications by April 1, 2026.

Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model

- **Timeline:** 2026-2036
- **Problem:** Traditional Medicare beneficiaries have limited access to technology-supported care services for managing chronic conditions due to Medicare payment barriers.
- **Solution:** A voluntary model focusing on four clinical tracks (including depression and anxiety) that ties reimbursement to patient outcomes rather than services delivered, allowing clinicians to use technology-enabled care tools to manage chronic conditions. Participating organizations manage all qualifying conditions and report condition-specific outcome measures (e.g., validated PROMs for pain, mood, and function).
- **Goal:** Measure whether technology-supported chronic care interventions improve condition-specific outcomes and assess clinician performance based on patients meeting predefined outcome targets.
- **Eligibility:** Participants must be Medicare Part B-enrolled organizations (excluding Durable Medical Equipment, Prosthetics, Orthotics, and Supplies and laboratory suppliers)
- **Participants:** Currently recruiting
- **Payment:** CMS will base payment on the overall share of an organization's patients who meet their outcome targets, allowing organizations to earn full payment through strong overall performance. There has been criticism that the maximum allowed amounts intended to cover the care management for the aligned condition are not high enough to encourage participation (e.g., $180 annually for behavioral healthcare).

Innovation in Behavioral Health (IBH) Model

- **Timeline:** 2025-2032
- **Problem:** Medicare and Medicaid populations face high rates of mental health conditions and substance use disorders, leaving them vulnerable to poor health outcomes (e.g., frequent emergency department visits, hospitalizations or premature death).
- **Solution:** Implement state-based, integrated behavioral health care teams that coordinate care across primary, specialty and behavioral health providers. The model tracks required care activities, ensures referrals are completed, and uses performance data to monitor outcomes.
- **Goal:** Measure whether integrated behavioral health teams improve clinical outcomes for beneficiaries with serious mental health or substance use disorders, with payment contingent on completion of required care activities and achievement of defined performance metrics.
- **Eligibility:** Participants must be licensed by the state to deliver outpatient behavioral services, either mental health or substance use disorders and serve at least 25 people enrolled in Medicaid per month with moderate to severe behavioral health conditions.
- **Participants:** Michigan, New York and South Carolina Medicaid agencies, with eight more states to be selected over the course of the model.
- **Payment:** CMS will ensure follow-through by tying payments to required care activities and performance outcomes, requiring coordinated referrals, aligning state oversight and supporting data systems that enable monitoring and accountability.

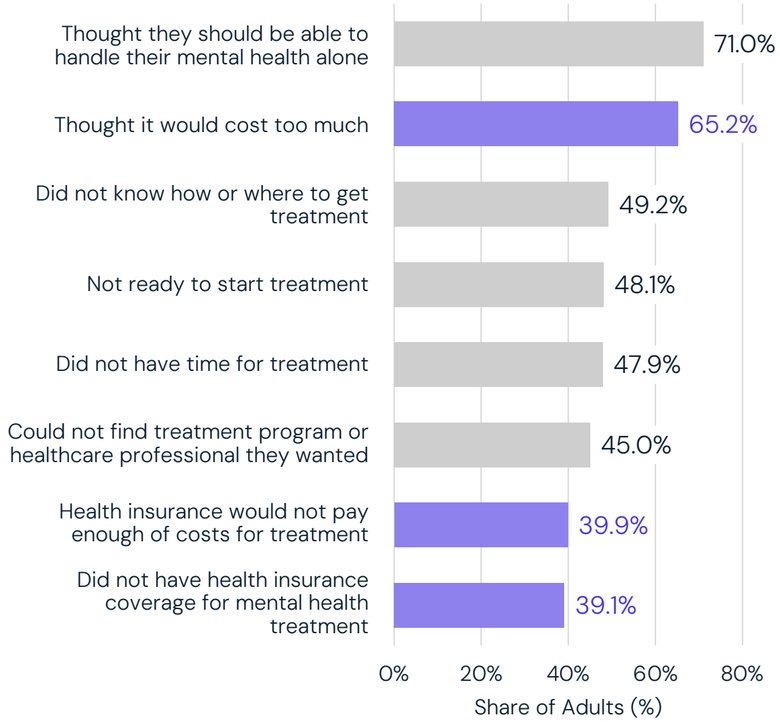
Note: CMS denotes Centers for Medicare and Medicaid Services; CCBHC denotes Certified Community Behavioral Health Clinic; ACCESS denotes Advancing Chronic Care with Effective, Scalable Solutions; IBH denotes Innovation in Behavioral Health.
Source: Centers for Medicare and Medicaid Services; ArentFox Schiff.

YIELD: PRICE

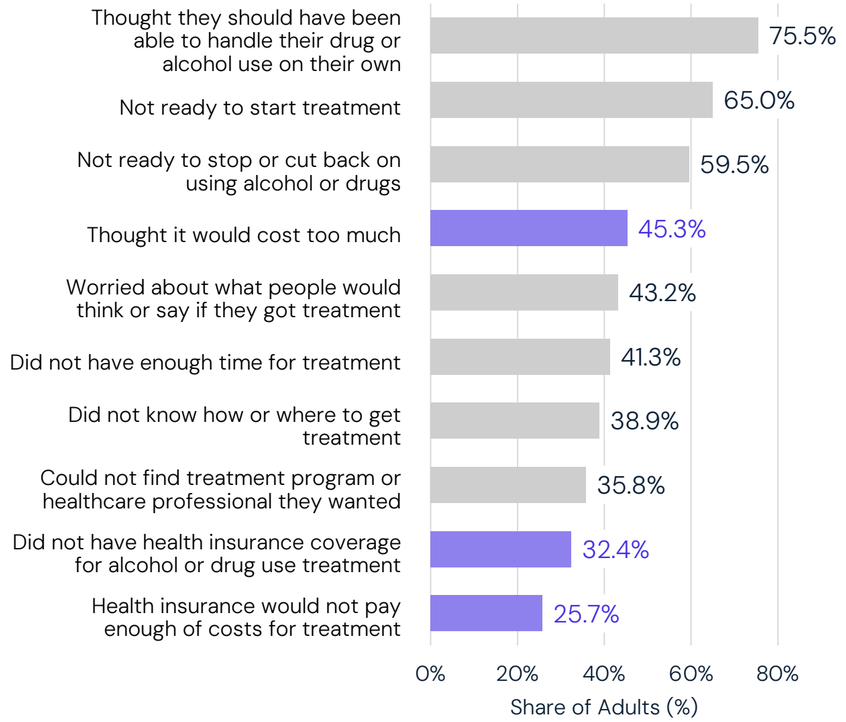
Cost Is a Primary Barrier to Accessing Behavioral Health Services

Cost remains a major barrier to behavioral health treatment, cited by 65.2% of adults with unmet mental health needs and 45.3% with substance use disorders. In addition, many also report insufficient insurance coverage.

Commonly Reported Reasons for Not Receiving Mental Health Treatment Among Adults with Any Mental Illness and Perceived Unmet Need for Treatment, 2024



Commonly Reported Reasons for Not Receiving SUD Treatment Among Adults with SUD and Perceived Unmet Need for SUD Treatment, 2024



Note: SUD denotes substance use disorder.
Source: National Survey on Drug Use and Health, Substance Use and Mental Health Services Administration, 2024.

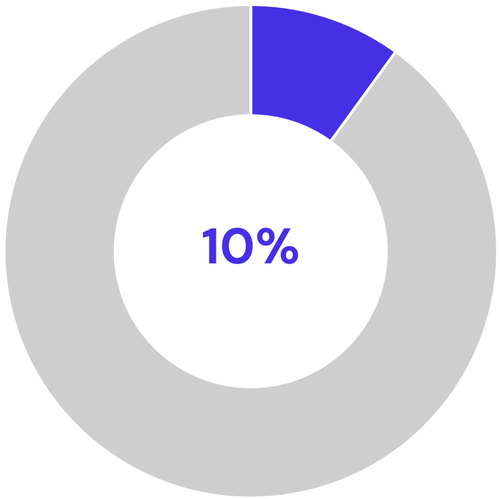
YIELD: PRICE

One in 10 Americans Assume Debt for Mental Health Treatment

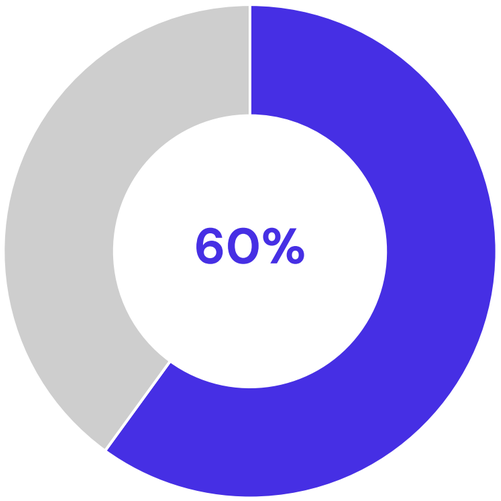
One in 10 Americans report taking on debt to pay for mental health treatment, and 60% of those individuals accumulate more than $1,000 in debt. Financial barriers remain widespread, with 31% of Americans reporting mental health treatment is financially out of reach. On average, individuals spend $375 out-of-pocket monthly on mental health treatment.

Financial Implications of Mental Health Treatment for Americans, 2025

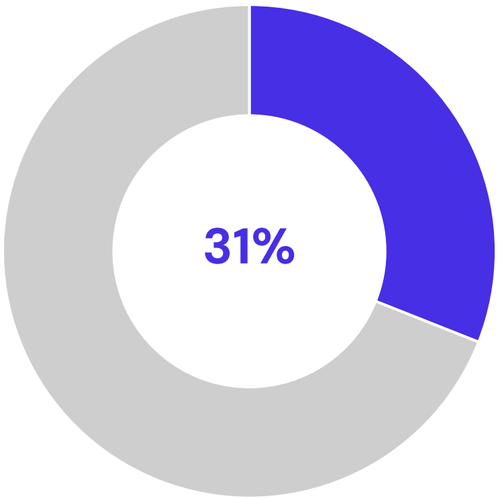
Americans reporting taking on debt for mental health treatment



Americans in mental health debt reporting debt of $1,000 or more



Americans reporting mental health treatment being financially out of reach



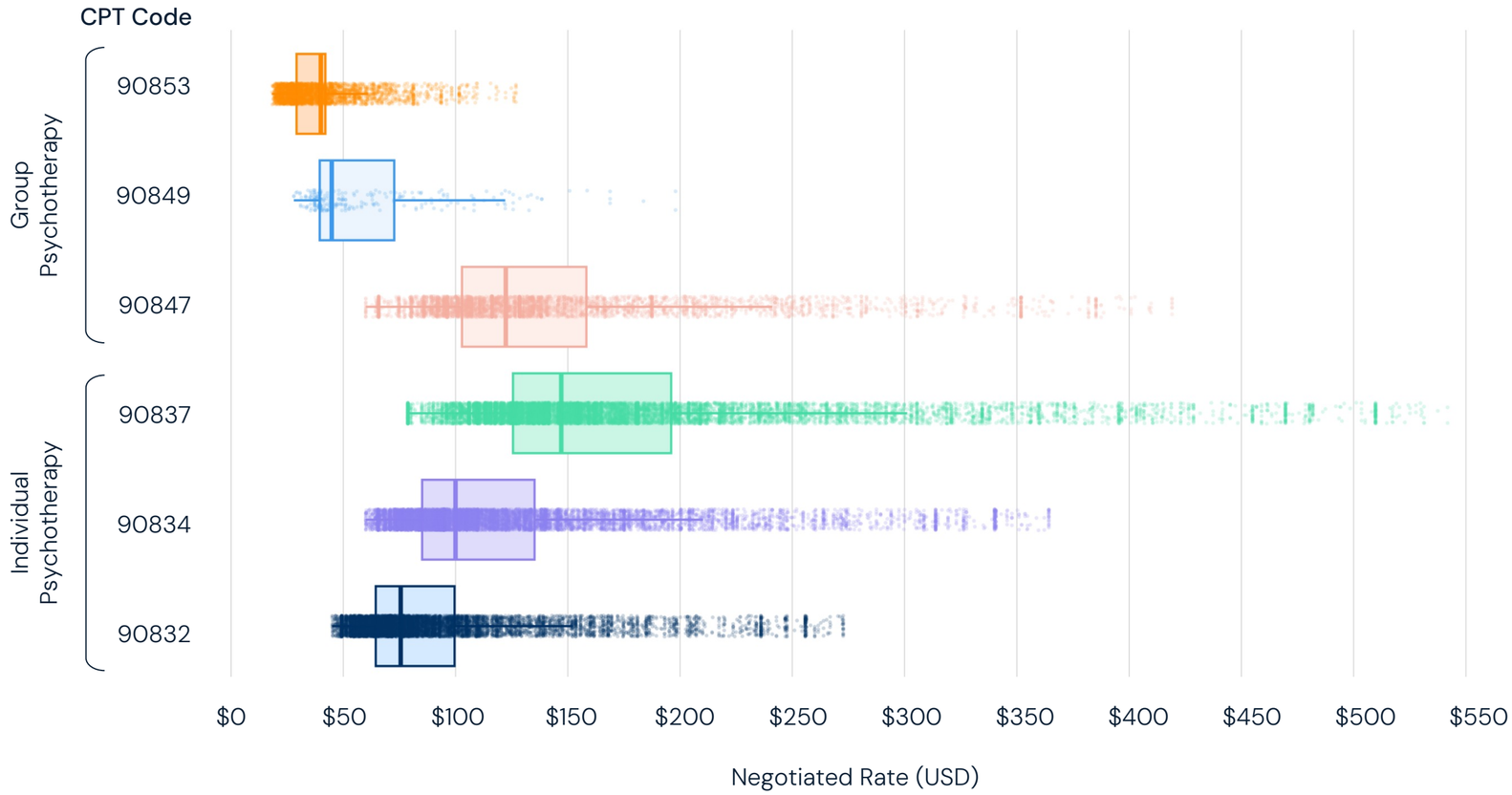
Source: Tebra; Self Financial, Inc.; Federal Reserve Bank of St. Louis.

YIELD: PRICE

Psychotherapy Negotiated Rates Vary Substantially

There is substantial variation in commercial UHC negotiated rates for individual and group psychotherapy codes. For example, the median negotiated rate for CPT 90853 (group psychotherapy) is $40, but negotiated rates can vary by up to $109 or 7x per session. For CPT 90837 (individual psychotherapy), the median rate is $147 but this ranges from $78 to $542, a potential difference of $464.

Commercial UHC Negotiated Rates for Individual and Group Psychotherapy, by CPT Code, 2025



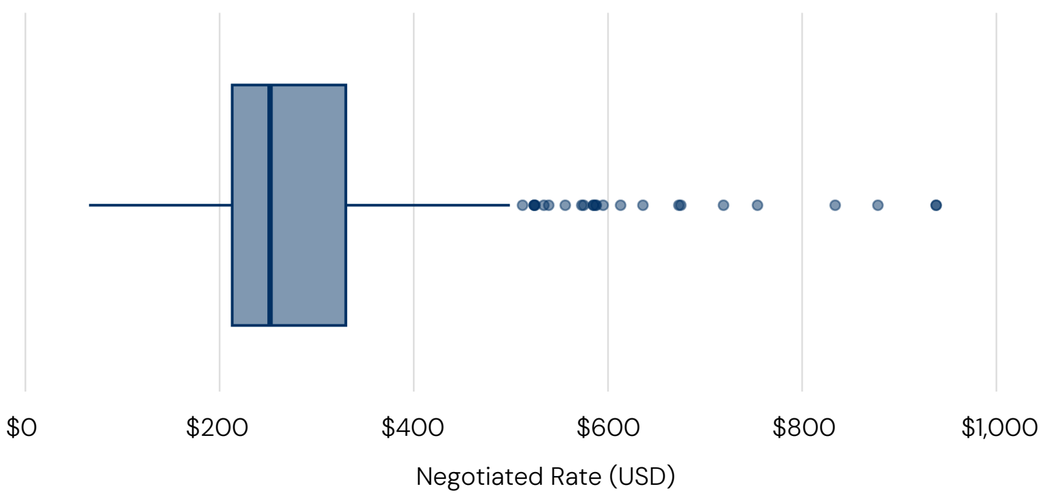
Note: CPT 90832 denotes 30 minutes of individual psychotherapy; CPT 90834 denotes 45 minutes of individual psychotherapy; CPT 90837 denotes 60 minutes of individual psychotherapy; CPT 90847 denotes family psychotherapy with the patient present; CPT 90849 denotes multiple-family group psychotherapy; CPT 90853 denotes group psychotherapy (other than of a multiple-family group). Commercial negotiated rates are shown for one national payer – UnitedHealthcare (UHC). Negotiated rates are winsorized between the 1st and 99th percentile. Included settings of care include clinics, physician group, behavioral health facilities and other outpatient settings.
Source: Trilliant Health health plan price transparency dataset.

YIELD: PRICE

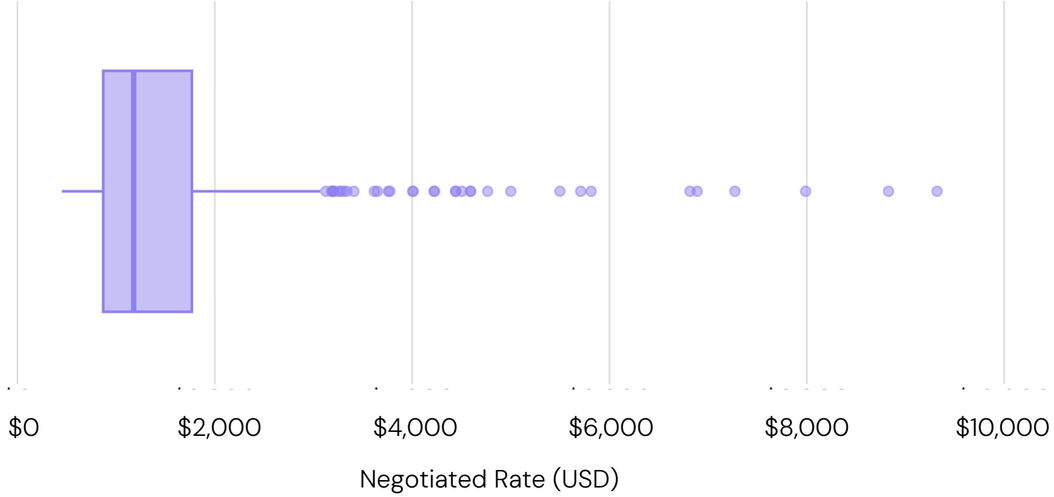
Intensive Outpatient Treatment Is Less Expensive Than Inpatient Treatment, With Substantial Variation

Commercial negotiated UHC rates for intensive outpatient therapy have a median of $252 per day, while a one-day inpatient psychiatric stay has a median of $1,179. Simultaneously, rates for intensive outpatient therapy range by 15x, while rates for inpatient treatment range by 22x.

Commercial UHC Negotiated Rates for Revenue Code 0905 (Intensive Outpatient Treatment), 2025



Commercial UHC Negotiated Rates for Revenue Code 0114 (Inpatient Psychiatric Treatment), 2025



Note: Revenue code 0905 denotes intensive outpatient psychiatric services furnished in a hospital outpatient department; revenue code 0114 denotes a private room within a psychiatric ward classification. Commercial negotiated rates are shown for one national payer – UnitedHealthcare (UHC) at short-term acute care hospitals. Negotiated rates are winsorized between the 1st and 99th percentile.
Source: Trilliant Health national price transparency dataset.

YIELD: VALUE

Spending Could Differ by $8M for One Psychiatric IP Code in One Market

In a scenario where the commercial UHC negotiated rate for revenue code 0114 is applied to 200 seven-day inpatient stays, spending on that single revenue code could range by $7.9M depending on whether that care was rendered at Hospital A or Hospital B in Atlanta, GA.

Spending Scenarios for Revenue Code 0114 (Inpatient Psychiatric Treatment) in Select Metropolitan CBSAs, 2025

LOCATION		HOSPITAL A	HOSPITAL B	SPENDING DIFFERENCE
Chicago-Naperville-Elgin IL-IN	1 day	$2,099	$997	$1.5M
	x 7 days & 200 visits	$2,938,600	$1,395,800	
Charlotte-Concord-Gastonia NC-SC	1 day	$1,817	$708	$1.6M
	x 7 days & 200 visits	$2,543,800	$991,200	
Asheville, NC	1 day	$2,700	$799	$2.7M
	x 7 days & 200 visits	$3,780,000	$1,118,600	
Atlanta-Sandy Springs-Roswell, GA	1 day	$6,816	$1,200	$7.9M
	x 7 days & 200 visits	$9,542,400	$1,680,000	

Note: IP denotes inpatient. Revenue code 0114 denotes a private room within a psychiatric ward classification. Commercial negotiated rates are shown for one national payer – UnitedHealthcare (UHC) at short-term acute care hospitals
Source: Trilliant Health national health plan price transparency dataset.

YIELD: VALUE

Transparency of DTC Treatment Options Does Not Equate to Reduced Costs

While DTC therapy options have the benefit of transparent pricing structures, this scenario shows that a patient would spend less out of pocket by receiving care through her employer-sponsored insurance benefits. While the annual cost of these four options ranges from $3,200 to $5,200, the patient would likely pay less in Scenarios 1 and 2 after meeting her $2,500 deductible. However, the patient would have access to more frequent therapy sessions in Scenario 4 with the subscription model.

Psychotherapy Spending Scenarios for Traditional and DTC Providers

Patient Profile

Gender: Female
Age: 37
Location: Dallas, TX

Insurance

- Commercially insured
- UnitedHealthcare
- $2,500 deductible
- 80% co-insurance

Health Status

- Anxiety
- Depression

	SCENARIO 1 Traditional Provider A w/ Insurance Benefits	SCENARIO 2 Traditional Provider B w/ Insurance Benefits	SCENARIO 3 Cerebral Self Pay	SCENARIO 4 Talkspace Self Pay
Access	2x 60-minute psychotherapy sessions/month (CPT 90837)	2x 60-minute psychotherapy sessions/month (CPT 90837)	2x psychotherapy sessions/month	Weekly subscription
Cost	$183/session	$124/session	$179/session	$99/week
Total Annual Spending	$4,758	$3,224	$4,654	$5,148
Patient Responsibility	**$4,306**	**$3,079**	**$4,654**	**$5,148**

Note: DTC denotes direct-to-consumer.
Source: Trilliant Health national health plan price transparency dataset; publicly available company information.

Conclusion

CONCLUSION

Answering Key Research Questions

1 How are behavioral health prevalence and mortality changing?

- Between 2008 and 2024, any mental illness prevalence increased 5.7 percentage points, affecting nearly one in four adults, while drug- and alcohol-induced mortality grew 176.1% since 1999.
- Multiracial individuals have the highest prevalence of any mental illness (35.5%) and SUD (24.9%), Medicaid/CHIP beneficiaries lead across all major conditions and intentional self-harm mortality is highest in western states, ranging from 6.3 to 30.0 per 100,000.
- Mortality trends reveal demographic divergence: drug- and alcohol-induced deaths among men have increased by over 100% across age cohorts since 2004, while intentional self-harm mortality declined among White individuals (-3.5%) but increased among Black (19.5%) and multiracial (18.3%) populations between 2018 and 2024.

2 How does behavioral health impact different patient populations and how is this changing?

- Multiracial individuals (31.1%), women (28.2%) and adolescents (28.5%) have the highest rates of mental health treatment. However, mental health treatment exceeds SUD treatment by nearly 7x. Adults ages 26-49 have experienced increases in nearly all mental health and SUD conditions, with demand projected to grow most rapidly for ages 35-49.
- Medicaid/CHIP beneficiaries have the highest treatment utilization (27.6% mental health; 7.4% SUD), while the uninsured have the lowest mental health treatment rates despite a 24.7% prevalence of any mental illness, compared to 23.4% for all adults.
- Treatment gaps persist across populations: more than half of patients presenting to the ED for alcohol, SUD or anxiety did not receive specialized follow-up care within 30 days.

3 How is behavioral health medication use changing?

- In 2024, 21.4% of women received prescription treatment for mental health, compared to 11.8% of men. By age group, the rate of medication treatment ranged from 12.7% among ages 12-17 to 17.4% among those ages 18-25. Additionally, medication treatment ranged from 6.0% among Asian Americans to 23.3% among multiracial individuals, followed closely behind at 21.3% among White individuals.
- Between 2018 and 2024, stimulants had the fastest growth (53.3%), followed by antipsychotics (46.5%), with stimulant use particularly pronounced among women ages 18-44 (93.6%), while anxiolytics are the most commonly prescribed.

CONCLUSION

Answering Key Research Questions

4 What are the trends in behavioral health provider supply?

- By 2038, projected demand will exceed supply by 36,780 FTEs in adult psychiatry and 99,780 FTEs in mental health counseling, with only psychiatric NPs projected to exceed demand (108%). The percent adequacy of mental health professionals is 27.3% in the U.S., ranging from 5.7% in West Virginia to 52.3% in New Jersey.
- The number of U.S. psychiatry-related residency positions has grown from 1,556 in 2018 to 2,388 in 2025. Despite this increase, residency positions have maintained a nearly 100% match rate, suggesting that supply is likely artificially constrained by the number of available positions.
- In 2023, 83% of behavioral health providers reported burnout, with therapists citing the highest mental health fatigue of all specialties (77%) and low compensation as the leading driver.

5 How are novel treatment paradigms and technologies influencing the behavioral health market?

- Allied health providers (NPs and PAs) surpassed psychiatrists to become the most common behavioral health prescriber type between 2018 and 2024, growing from 20.7% to 34.3% of prescription volume.
- Direct-to-consumer online therapy platforms are expanding scalable access to care. There were 167 behavioral health M&A transactions in 2025, including Spring Health's planned acquisition of Alma and UHS's announced acquisition of Talkspace.
- Emerging treatment modalities — including ketamine, psilocybin and MDMA for treatment-resistant depression and PTSD, and FDA-regulated prescription digital therapeutics for conditions including anxiety, depression and SUD — are expanding, though regulatory uncertainty and slow approval timelines constrain broad near-term adoption.

CONCLUSION

Answering Key Research Questions

6 How does behavioral health impact overall healthcare costs?

- In 2019, mental health and SUD accounted for 7.4% of total personal healthcare spending ($200B combined), with spending increasing by 30.8% and 87.5%, respectively, since 2010 and likely continuing to grow.
- Untreated mental illness cost the U.S. economy an estimated $477.5B in 2024, projected to exceed $1.3T annually by 2040 — driven by premature death ($911.9B), workforce productivity losses ($252.3B) and emergency department overutilization costs.
- Approximately 65% of adults cite cost as a barrier to treatment and nearly one in 10 Americans take on debt to access care.

7 What is the policy landscape in behavioral health?

- The President's FY 2027 Budget Request calls to reduce NIH funding by $5B and proposes the creation of the Administration for a Health America, via a consolidation of HRSA, SAMHSA, CDC and OASH with the intent to cut programs deemed duplicative or misaligned with administration priorities.
- Separately, the Trump Administration has discontinued enforcement of the Mental Health Parity Rule, increasing financial and administrative barriers to mental health and substance use care independent of the budget process.
- CMS is advancing the ACCESS and IBH models to shift toward outcome-driven, coordinated care for Medicare and Medicaid populations, with the ongoing Certified Community Behavioral Health Clinics demonstration showing tangible improvements in care coordination.

8 How do prices compare for common behavioral health services?

- Commercial negotiated rates for psychotherapy vary substantially by procedure: CPT 90853 (group psychotherapy) has a median rate of $40 but can vary by $109 per session, while CPT 90837 (individual psychotherapy) has the widest absolute range at $464 and varies by 7x nationally.
- Intensive outpatient program (IOP) rates have a median of $252 per day compared to $1,179 for a one-day inpatient psychiatric stay, though IOP rates can range by 15x and inpatient rates can range by 22x.
- Applied to 200 seven-day inpatient stays, the range in commercial negotiated rates for a single inpatient psychiatric revenue code could produce a $7.9M spending difference between two hospitals within a single market.

CONCLUSION

Stakeholder Imperatives

Providers

Engage in Continuous Care Relationships:
Establish and maintain a consistent relationship with behavioral health patients to support continuity of care, ongoing symptom monitoring and adherence to evidence-based treatment plans.

Recognize and Monitor Mental Health Needs:
Develop awareness of mental health risk factors (e.g., family history, trauma exposure, comorbid conditions) and proactively monitor for changes in mood or behavior.

Navigate Access and Treatment Options:
Understand high-value care pathways, including therapy modalities, medication options and digital/virtual supports, to ensure patients engage in timely and appropriate treatment.

Payers

Expand Access to Evidence-Based Behavioral Health Services:
Ensure broad coverage and network adequacy for behavioral health providers, including therapy, psychiatry and digital interventions, to support timely and guideline-concordant care.

Align Incentives to Outcomes and Quality:
Design reimbursement structures that incentivize measurement-based care and improved clinical outcomes rather than volume of services.

Address High-Cost and High-Need Populations:
Identify and proactively manage members with severe mental illness or substance use disorders through early intervention and longitudinal support.

Life Sciences

Invest in Innovative and Differentiated Therapies:
Advance development of novel pharmacologic treatments that address unmet needs in behavioral health, including treatment-resistant conditions and comorbid populations.

Support Appropriate Diagnosis and Treatment Initiation:
Partner with providers to improve screening, diagnosis and guideline-concordant treatment through education, tools and clinical support resources.

Generate Real-World and Outcomes Evidence:
Demonstrate clinical and economic value through real-world evidence, including impact on symptom control, adherence and total cost of care.

CONCLUSION

Stakeholder Imperatives

Patients

Engage in Ongoing Behavioral Health Care:
Establish and maintain a consistent relationship with a behavioral health provider to support continuity, trust and adherence.

Participate Actively in Treatment Decisions:
Engage in shared decision-making with providers to understand therapy options, medications and expected outcomes.

Understand Personal Risk Factors and Triggers:
Identify individual risk factors (e.g., family history, trauma, substance use) and recognize triggers that may worsen symptoms or lead to relapse.

Employers

Promote Access to Comprehensive Behavioral Health Benefits:
Offer and maintain benefits that include therapy, psychiatry, substance use treatment and digital/virtual care to ensure employees can access timely, evidence-based services.

Address Workplace Drivers of Mental Health:
Assess and mitigate organizational factors, such as workload, job strain and lack of flexibility, that contribute to stress and burnout.

Design and Incentivize a "Value for Money" Network:
Provide clear and understandable incentives for employees to avoid low-value providers, informed by health plan price transparency data.

Policymakers

Ensure Parity and Equitable Coverage:
Strengthen and enforce mental health parity requirements to align behavioral health coverage with physical health, reducing financial and administrative barriers to care.

Invest in Workforce Development:
Support training, loan repayment and scope-of-practice policies to grow and diversify the behavioral health workforce, including non-physician providers.

Integrate Behavioral and Physical Health Systems:
Promote care delivery and payment models that support integration of behavioral health into primary and specialty care to improve coordination and outcomes.

CONCLUSION

The data in this report tell a story that is difficult to ignore and impossible to dismiss. The behavioral health crisis is not a peripheral concern, a niche service line or a problem on the horizon. It is a defining force shaping the demand for care, the capacity of our workforce and the financial performance of every part of the health economy – today.

On the demand side, nearly one in four American adults is living with a mental illness, and substance use disorder affects more than one in six. Unfortunately, these post-pandemic statistics represent the new normal. Prevalence remains elevated, utilization has grown 62.6% since 2018 and the populations bearing the greatest burden – young adults, Medicaid beneficiaries, multiracial individuals and residents of urban communities – are precisely those for whom access remains most constrained. It is also worth acknowledging that demand for behavioral health services is not determined by the healthcare system alone. Personal health behaviors, social determinants and environmental factors – including the well-documented relationship between things like social media use and loneliness – contribute meaningfully to this problem. Addressing demand at its source, rather than solely at the point of care, will require engagement from sectors well beyond the health economy. That said, demand is unlikely the variable that needs to be solved for. Instead, it is the fixed condition against which everything else must be measured.

The supply of behavioral health services is structurally inadequate to meet that demand – and the gap is widening. By 2038, projected demand will exceed supply by nearly 37,000 FTEs in adult psychiatry and nearly 100,000 FTEs in mental health counseling. The psychiatric residency pipeline, while growing, is artificially constrained and the ultimate geographic distribution of those physicians fails to address shortages where they are most acute. The workforce is adapting – allied health professionals now lead behavioral health prescribing, hybrid care delivery has become the norm and M&A activity is accelerating across digital and traditional provider networks – but adaptation is not the same as what is truly needed. Burnout is endemic, with 83% of behavioral health providers reporting it, and the structural conditions driving it – high patient volumes, low compensation and sustained pressure on capacity – are not self-correcting.

Against this backdrop, the design of the U.S. healthcare system – spanning how care is priced, reimbursed and funded – is fundamentally misaligned with providing high-value care to behavioral health patients. Cost remains one of the most commonly cited barriers to treatment. At the same time, negotiated rates for the same psychotherapy code vary by 7x. The economic burden of untreated mental illness has already reached an estimated $477.5B annually and is projected to surpass $1.3T by 2040. Administrative priorities threaten the existence of SAMHSA and call to reduce NIH funding by $5B. At the same time, CMS is piloting outcome-driven reimbursement models that represent a meaningful, if nascent, shift toward value-based behavioral health care. The policy environment is pulling in two directions simultaneously, and the consequences of that tension will be felt most acutely by the patients with the least ability to absorb them.

What the data make clear is that incremental responses are insufficient. Expanding access requires confronting workforce shortages not just with more residency positions, but with deliberate geographic distribution strategies, expanded scope-of-practice frameworks and sustainable compensation models that reduce burnout and retain providers. Addressing affordability requires more than price transparency – it requires reimbursement structures that reflect the actual cost and value of behavioral health services, enforced parity and benefit designs that do not systematically deter utilization. And improving outcomes requires treating behavioral health not as a standalone service line, but as an integral component of whole-person care – one whose presence or absence shapes utilization, cost and outcomes across every other part of the health economy. Ultimately, every stakeholder will need to reorient around a common standard: value for money. In behavioral health, that means measuring success not by the volume of services delivered or premiums collected, but by whether the system is producing better outcomes at a cost the economy can sustain.

The U.S. health economy has long acknowledged the behavioral health crisis. Acknowledgment has not been sufficient. The demand exists, the workforce gaps are quantified, and the financial misalignments are measurable. For health system leaders, payers, policymakers and investors, the question is no longer whether to act – it is whether the actions taken will be commensurate with the scale of the problem.

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Every American is impacted by the health economy. We are committed to making it **exponentially better**.

Mission

To redefine how the healthcare industry **develops strategies, understands consumer healthcare decisions, and maximizes return on invested capital**.

Vision

To create **an algorithmic approach for every mission-critical decision** in the healthcare industry.

Goal

To be recognized as a **trusted advisor, dependable partner, and industry expert** for enterprise-wide decision-making across healthcare.

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