Mercer

Government Human Services Consulting

Washington Thriving Quantitative Landscape and Gap Analysis Report

Washington State Health Care Authority

June 27, 2025

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Contents

Section 1

Executive Summary

In March 2024, the Washington State Health Care Authority (HCA) partnered with Mercer Government Human Services Consulting (Mercer) to contribute to Washington Thriving, an initiative to develop a statewide, prenatal through age 25 (P-25), Behavioral Health Strategic Plan. The plan involves a comprehensive analysis of the current Children and Youth Behavioral Health system in Washington, focusing on its strengths, resources, and needs. The initiative is guided by Second Substitute House Bill 1890, Chapter 76, Laws of 2022.[1] Mercer's work includes findings, identified gaps, and recommendations from an extensive quantitative analysis, along with a proposal for a data dashboard to enhance the understanding and management of the system. This report focuses solely on the quantitative analysis of the current system of care with the intent of being paired with further qualitative analysis, information from lived experience, and recommendations from the Advisory Group.

The priorities of the Children and Youth Behavioral Health Work Group (CYBHWG) and HCA included understanding the experiences of children, from P-25 and families who encounter gaps and barriers in accessing behavioral health services. To address these issues, Mercer collaborated with HCA and CYBHWG to organize an ideal continuum of care for children and families, centered around an envisioned System of Care and shared values. The envisioned System of Care framework was selected as the foundational model for the service system in Washington. This framework emphasizes community-based care including prevention, early identification, supportive care, treatment, aftercare, recovery, and resilience services offered in ambulatory, home, and school settings and offers a comprehensive range of services and support, including crisis, residential, and hospital care in more restrictive settings as needed.[2] For this report, the Legislation[3] proposed five data elements to consider based on the envisioned System of Care principles which are designed to provide valuable quantitative insights.

1. Estimated number of families in the perinatal phase, children, youth transitioning into adulthood, and the caregivers of those children and youth who need clinical behavioral health services or could benefit from preventive or early intervention services on an annual basis.
2. Estimated number of expectant parents and caregivers in need of behavioral health services.
3. A collection and analysis of disaggregated data to better understand regional, economic, linguistic, gender, and racial gaps in access to behavioral health services.

[1] Washington State Legislature. (2022). *Certification of enrollment: Second substitute house bill 1890, Chapter 76, Laws of 2022, 67th Legislature, 2022 Regular Session: Children and youth behavioral health work group—Modification*. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1890-S2.SL.pdf?q=20230524121245

[2] Washington Thriving. (2025, March 27). *System of care*. https://www.washingtonthriving.org/blog/rxsxvxmbf5a6sa14hholqf40vho9zb

[3] Washington State Legislature. (2022). *Certification of enrollment: Second substitute house bill 1890, Chapter 76, Laws of 2022, 67th Legislature, 2022 Regular Session: Children and youth behavioral health work group—Modification*. https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/House/1890-S2.SL.pdf?q=20230524121245

4. Estimated costs of providing services that include a range of behavioral health supports that will meet the projected needs of the population and address measured gaps.

5. Quantitative representations of the gaps and the recommended strategies directly related to the quantitative analysis to address the gaps.

These elements were vetted with a diverse group of data partners and stakeholders as described in Section 4 who contributed to finalizing a data collection plan with recommended data sources. The plan encompasses fifteen data metrics aimed at measuring reported gaps and access challenges within the behavioral health system. Data collection took place from January 2025 to April 2025, involving over a dozen different sources, with varying success in obtaining the requested information. The data requests did not include data containing protected health information due to the lengthy permission processes required for their use. Additional details regarding logistical challenges in data collection, as well as overall data quality and coding limitations, are provided in Section 6 of the report. These factors may affect the precise alignment of timeframes and age groupings outlined in the original data collection plan.

The analysis of the collected data revealed several quantifiable challenges related to behavioral health services access for the target populations of this report and highlighted the demand and prevalence of behavioral health services across various subpopulations. As noted by the Washington Thriving website, behavioral health includes the emotions and behaviors that affect our overall well-being, including mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms. People experiencing behavioral health challenges may struggle to navigate life, have positive relationships, and adapt to change. Behavioral health often intersects with other challenges, including homelessness, unemployment, and incarceration. Because Mercer utilized sources of data already collected, Mercer relied on each source's definition of behavioral health. Generally, each source of data defines behavioral health slightly differently. Mercer has included each sources definition of behavioral health as available throughout this report. Mercer especially recognizes the intersection of behavioral health and intellectual/ developmental disabilities (IDD). Unfortunately, there is very little data available in which quantitative conclusions can be drawn about how, specifically, the IDD or dually diagnosed population engages in mental health services.

Notable quantitative findings include a growing prevalence of postpartum depression among young mothers, with 54% of pregnant women diagnosed with substance use disorders not receiving treatment in 2024. There is an increasing need for behavioral health services among children in early childhood, affecting both low- and higher-income families. Over 50% of multi-system-involved children, including those in juvenile justice, child welfare, and foster care, require behavioral health treatment. One in 10 households require interpreter services to access the health care system in Washington.

While 7% of the State identifies as lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, and more, there is a lack of markers for sexual orientation or gender identity in the data collected to understand the demand for behavioral health services and service access concerns for these groups. Racial demographic data shows that although Whites have the highest prevalence of behavioral health conditions, African American and Latinos experience more severe episodes, and Native American and Alaskan Natives report the highest levels of suicide, post-traumatic stress disorder, and substance use disorders.

Youth needing intensive services doubled from 2018 to 2023, yet Washington has fewer pediatric inpatient psychiatric beds per capita than the national average. There has been a significant increase in telehealth usage among children and families seeking behavioral health services since the COVID-19 public health emergency, including using telehealth for the delivery of Evidence Based Practices (EBPs); however, the overall use of EBPs in Washington remains low compared to other states.

Many gaps were found, from gaps in prevention and education to gaps in both outpatient and crisis related services. For example, it was found that only 52% of children with mental health needs and 37% of children with substance use disorders are receiving services, with considerable variability in access across different regions of the State. Second, the highest unserved group for behavioral health services consists of children aged 0 years–4 years, while adolescents aged 13 years–18 years represent the highest unserved group for substance use disorder services. Third, there is a high variability in provider density across the State, with significantly scarce availability of inpatient intensive services for children; only two of Washington's 39 counties have youth detoxification facilities for substance use treatment and long-term residential care for behavioral health treatment. Access to ambulatory and outpatient services, such as assessments and counseling, also showed varying provider density by region across the State.

If half of the Medicaid children, youth, transition age youth, pregnant and postpartum women, and caregivers diagnosed with behavioral health needs, but not receiving treatment were to seek treatment, then the total costs to the State of Washington would be approximately $544,987,674. These are the annual expected costs for improving the behavioral health penetration rate among Medicaid eligible individuals on an on-going basis. $6.8 million is currently being spent annually for school districts to place children with behavioral health needs with Nonpublic Agencies out-of-state and out-of-district. Additional funding would be needed to serve children in local districts, as well as to improve promotion and prevention efforts and enhance EBP penetration. Finally, Mercer's research showed that there is an anticipated shortage in key personnel that provide behavioral health services between 2022–2037 defined as psychiatrists, psychologists, and addiction counselors.[4]

Final recommendations for the CYBHWG and HCA to consider include developing additional behavioral health services capacity for children under five years old, pregnant women with substance use disorder diagnoses, and children in foster care and the justice system. Additionally, there is a need to increase pediatric intensive service beds in areas identified as provider deserts. It is also recommended to evaluate coverage and develop incentives for the use of EBPs in the State Medicaid plan especially for children under the age of five years old and children in foster care and the justice system such as Parent Child Interaction Therapy, Incredible Years, Child Parent Psychotherapy, Multi-Systemic Therapy, and Functional Family Therapy. Aligning data collection practices with the goals of the CYBHWG and HCA is essential for efficient data reporting. Lastly, there should be an increase in the State's intensive service capacity to provide care for all 22 children who are currently being served out-of-state and the 66 children served out-of-district.

[4] Department of Health and Human Services, Health Resources and Services Administration. (n.d.). *Health workforce projections*. https://data.hrsa.gov/DataDownload/DD_Files/Workforce_Projections_FullData.xlsx

Mercer recommends designing a data dashboard that reflects the demand for services, the capacity of providers and networks, access and utilization trends, and outcomes categorized by age, subpopulations, and payer sources. However, it may be premature to undertake extensive work on developing this dashboard until the data collection challenges outlined in the report are addressed. Mercer's experience with HCA and involvement in strategic planning with the CYBHWG clearly shows that Washington is focused on incorporating the perspectives of children, youth and families supported by these systems and addressing disparities that enhance access to care, ensuring that children and youth in Washington can thrive and grow into healthy adults. In this report's recommendations, Mercer also outlines some concrete steps that can be taken to address some of the data limitations addressed in this report writing process that can bring the State closer to developing a comprehensive data dashboard.

Organization of Report

Following the Executive Summary, the quantitative landscape and gap analysis report is structured into the following sections:

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Section 5	Data Analysis
Section 6	Key Findings
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The remaining sections in the Appendices provide detailed information on Washington State's demographics, children in foster care, and the percentage of the population requiring behavioral health services. In addition, the report includes summaries of data partner meetings and a comprehensive list of all data sources.

The index on the following page offers a comprehensive list of tables, maps, and figures included in the report.

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Appendix D: Percentages of the Population Requiring Behavioral Health Services

Section 2

Introduction and Background

The Washington Legislature established the Children's Mental Health Work Group (renamed the Children and Youth Behavioral Health Work Group [CYBHWG]) in 2016 through Engrossed Second Substitute House Bill 2439, with the goal of identifying and addressing mental health access issues for children, youth, and families. The CYBHWG includes legislators, State agencies, health care providers, tribal governments, community behavioral health service providers, advocates, and other organizations, including youth and young people, as well as parents of children and youth who have received services.[5]

The Health Care Authority (HCA), along with the CYBHWG Workgroup and the Washington Thriving Advisory Group, contracted with Mercer Government Human Services Consulting (Mercer) to develop various products in alignment with the Work Order Manager, policy lead, CYBHWG staff, and Strategic Plan chairs and co-chairs, who provided guidance on key deliverables and ongoing community engagement for the larger project, particularly the Washington Thriving Strategic Plan. The Strategic Plan serves as a comprehensive statewide initiative aimed at enhancing the full continuum of behavioral health services for families in the prenatal and perinatal stages, children, youth transitioning to adulthood up to 25 years old, and their parents and caregivers.

The Landscape and Gap Analysis is described in the Second Substitute House Bill 1890, Chapter 76, Laws 2022 or as modified by 2024 legislation. HCA contracted with Mercer to develop the quantitative Landscape and Gap Analysis report that presents a collective assessment of Washington's Children's Behavioral Health system by:

- Outlining the strengths, resources, and needs within the State to improve its envisioned behavioral health System of Care, specifically for individuals from prenatal-through-age-25 (P-25) years old.
- Providing a framework for designing services that align with community needs, incorporating community-based participatory research or co-design process to ensure the analysis accurately reflects the values and needs of stakeholders and community members.
- Summarizing stakeholder input from data partner meetings and ongoing discussions with HCA and other engaged partners, including community stakeholders participating in the CYBHWG Workgroup.
- Identifying the Medicaid and non-Medicaid data sources and definitions through data partner meetings, as well as with HCA and CYBHWG stakeholders.
- Analyzing the quantitative measures. Systematically assessing the current behavioral health care system's ability to meet the needs of individuals requiring services, which includes a. A description of current systems; b. The identification of gaps in those

[5] Children and Youth Behavioral Health Work Group (CYBHWG). (n.d.). Washington State Health Care Authority. Available at: https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/children-and-youth-behavioral-health-work-group-cybhwg

systems, both public and private; and c. Recommended steps or strategies for addressing these gaps.

As part of the Washington Thriving Landscape and Gap Analysis report, Mercer developed a comprehensive overview of Washington State's P-25 population, which serves as the foundation for data collection and dashboard development. This framework encompasses the entire continuum of care, including community support, promotion, prevention and early intervention, outpatient and integrated care, intensive home and community-based services, comprehensive crisis care, inpatient psychiatric care, and residential treatment. It also incorporates available demographic and population characteristics such as race, ethnicity, sexual orientation, gender identity, income, and language. Due to unavailable or limited data, specific populations within the broader Washington Thriving demographic are not highlighted in the report, such as individuals with intellectual or developmental disabilities, unhoused youth, and as well as refugees and immigrants. As noted in the Executive Summary, this report focuses on the quantitative analysis of the current System of Care which should be read in context with the qualitative analysis including information from individuals with lived experience and recommendations from the Advisory Group. As a result, this analysis will not include other states' experiences or qualitative feedback from individuals with lived experience. In addition, because of timelines, Mercer did not gather and analyze raw data. Thus, data definitions will not match the Washington Thriving categories and will instead rely on existing reports and data collection.

A key component of this analysis involved identifying the primary subpopulations relevant to the project. The six primary subpopulations addressed in the quantitative report are:

- Families in the prenatal and perinatal phases, including pregnant individuals.
- Children age 0 years to 5 years old.
- Youth age 6 years to 12 years old.
- Youth age 13 years to 17 years old.
- Transition age youth age 18 years to 25 years old.
- Parents and caregivers of children and youth.

It is important to note that information regarding youth aged 6 years–17 years old may be analyzed as two distinct groups or as a single cohort, depending on the available data. While behavioral health services across this age range often share similarities, the age of consent plays a critical role. Most behavioral health services can be initiated by youth over the age of 13 years old without the need for parental consent. However, for those aged 13 years-17 years old, there is also the option of Family Initiated Treatment, allowing a parent or guardian to request an evaluation to determine the medical necessity of a behavioral health service without requiring the youth's consent.[6]

[6] Washington State Health Care Authority. (2022). *Family initiated treatment fact sheet.* Available at: https://www.hca.wa.gov/assets/program/family-initiated-treatment-fact-sheet-2022.pdf

The Data Dashboard Design proposes a set of relevant metrics to visually represent information regarding the processes and outcomes of system needs and changes in the children's Behavioral Health System over time. This design aims to identify and quantify gaps in the Behavioral Health System for the specified age groups and track progress in bridging those gaps. To achieve this, the State will need to address data sharing constraints, the quality of data, and prioritize Data Dashboard metrics from ongoing data sources that are most pertinent for describing the need, capacity, access/utilization, and outcomes of behavioral health care in Washington State.

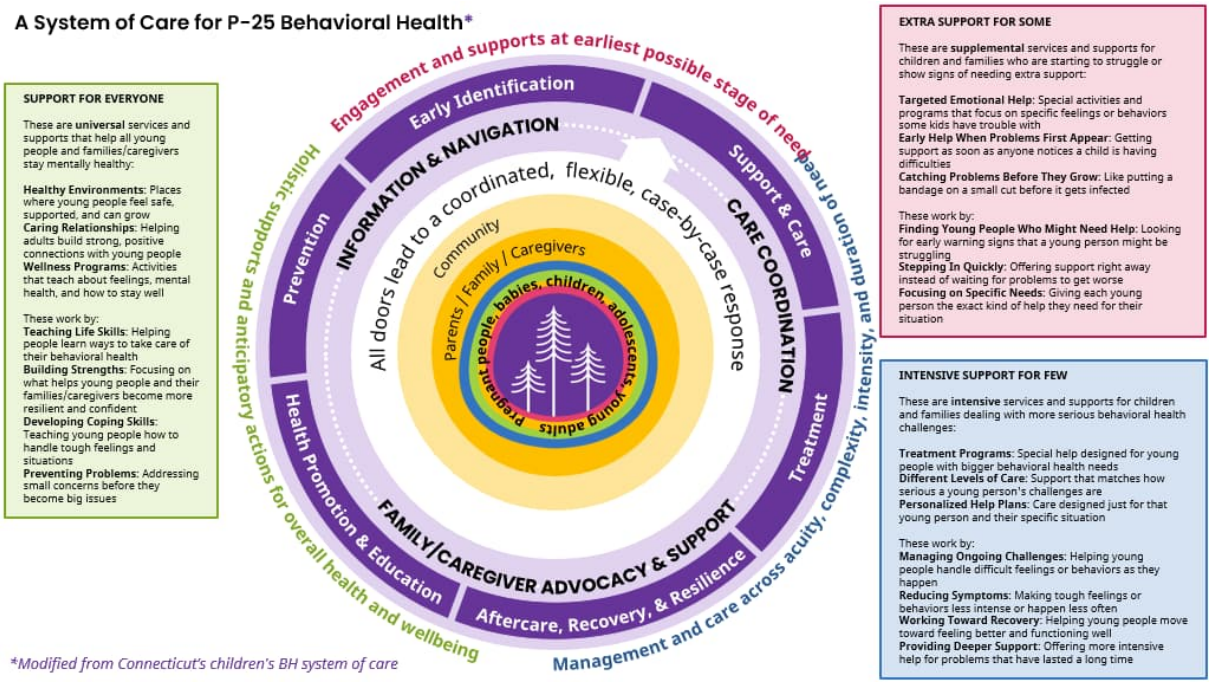
Envisioned System of Care

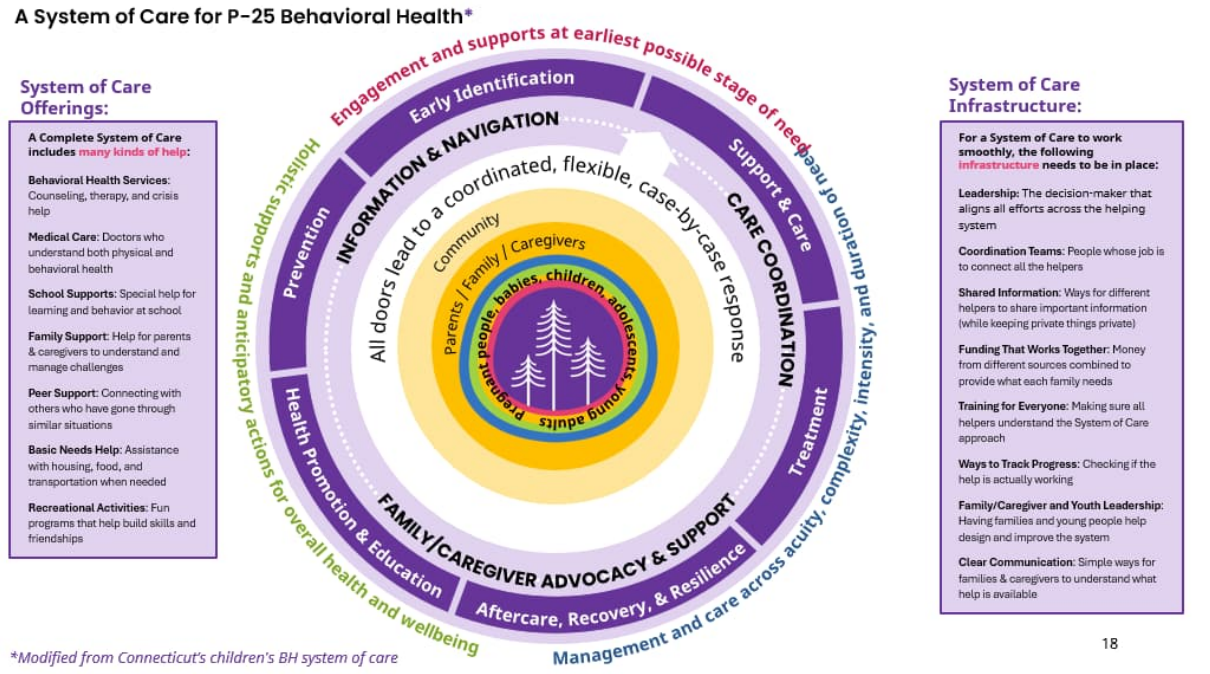
Fundamental to the development of the Landscape and Gap Analysis and Data Dashboard Design is the need for the State to describe and identify the envisioned System of Care that will inform, unify, and organize these analyses.

At the initial data partner meeting, Mercer outlined an envisioned System of Care as the framework for the continuum of care analysis of the State behavioral health landscape to determine what services are currently available for children, youth, young adults, and families in the prenatal stage up to the age of 25 years old.

The final framework for the envisioned System of Care (as seen in Figure 1 below) recognizes the important role that communities — such as schools, social services, and faith-based organizations — play in supporting and promoting behavioral health. Community-based organizations often address the unmet health-related social needs of high-risk populations. The Washington Thriving Advisory Group used examples of existing State comprehensive frameworks to build on, strengthen, and align the comprehensive service array with Washington's vision. The resulting model for P-25 behavioral health integrates an envisioned System of Care approach, further delineates and groups the core service components, adds recovery support services, and includes a comprehensive list of services for each component of the model.

Figure 1: An Envisioned System of Care for P-25 Behavioral Health





Source: Washington Thriving Advisory Group Meeting, February 11, 2025.

Integrating the Envisioned System of Care Approach

The overlay of the envisioned System of Care approach on the comprehensive service array ensures that the array includes a broad spectrum of effective community-based services and supports that are anchored in a set of core values. The core values of System of Care align with those of Washington Thriving — family and youth driven, community-based, and culturally and linguistically competent. Washington Thriving's envisioned System of Care *includes a full continuum of developmentally-and culturally-appropriate services and supports for pregnant people, babies, children, youth, young adults, and their parents and caregivers, accessible where they spend their time — community, school, and clinical settings.*[7] Because of this overlay, Mercer's analysis emphasizes the key service elements in a System of Care approach including: health education and promotion, prevention, and early intervention, evidence-based practices, school-based services, specialized services, and intensive treatment services including examining crisis, residential and institutional capacity.

Delineation and Grouping of Core Components

The Washington Thriving envisioned System of Care strengthens the comprehensive service array's focus on upstream services by separating the promotion, prevention, and early intervention components into three components — health education and promotion, prevention, and early identification. The education and promotion component includes information distribution, health and wellness promotion, school and community based social emotional learning, and behavioral health curriculums. It also includes an array of social interventions and community-based programming that span from wellness services to faith-based and grassroots programming. The prevention component includes behavioral health-specific prevention programs such as early childhood education, positive youth development services, and risk factors and basic needs prevention programming including basic needs support, early and after school care, supported housing, education, and employment and flexible funds. The early identification component includes services that range from universal screening to behavioral health consultation.

Prevention and early intervention are highlighted within the envisioned System of Care in hopes of reducing use of more intensive services, which have been on the rise in Washington. With the worsening pediatric mental health crisis, children increasingly have prolonged emergency department visits while awaiting definitive mental health care. This has been partially attributed to inadequate availability of pediatric inpatient psychiatric beds. A new study published in JAMA, August 2024,[8] found Washington had lower than the national average of 15 beds per 100,000 population.[9] Between 2008 and 2016, the percentage of statewide pediatric days decreased followed by a decrease in the number of pediatric inpatient unit beds in 2014 compared to its baseline. While a decrease in demand led to the

[7] Washington Thriving. (2025, March 27). *System of care*. https://www.washingtonthriving.org/blog/rxsxvxmbf5a6sa14hholqf40vho9zb

[8] Cushing, A. M., Nash, K. A., Foster, A. A., et al. (2024). Pediatric inpatient psychiatric capacity in the U.S., 2017 to 2020. *JAMA Pediatrics*, 178(10), 1080–1082. https://doi.org/10.1001/jamapediatrics.2024.2888

[9] The study looked at data from the 2017 to 2020 American Hospital Association Survey Database (AHASD), state-level demographics from 2015 to 2019 American Community Survey 5-year estimates, hospital and population from the 2010 Rural-Urban Commuting Area codes, and December 2020 state Medicaid expansion status from the Kaiser Family Foundation. The study found that Washington State was in the lowest tier of access with fewer than 15 pediatric Inpatient psychiatric beds per 100,000 Children in 2020.

decline in bed, by 2016 the number of pediatric inpatient unit beds available had fallen below the demand for pediatric inpatient unit beds resulting in greater demand than supply.[10]

Furthermore, the envisioned System of Care highlights the importance of supportive care within the service continuum by grouping supportive services identified across the comprehensive service array's core components into a stand-alone support and care component. This component includes tiered coordination as well as foundational community-assisted care and support, respite services, and trauma-informed and trauma-specific treatment methods. The service array also groups the outpatient and integrated care, intensive home and community-based services, comprehensive crisis care, inpatient, and residential treatment components into one core treatment component that contains four sub-components.

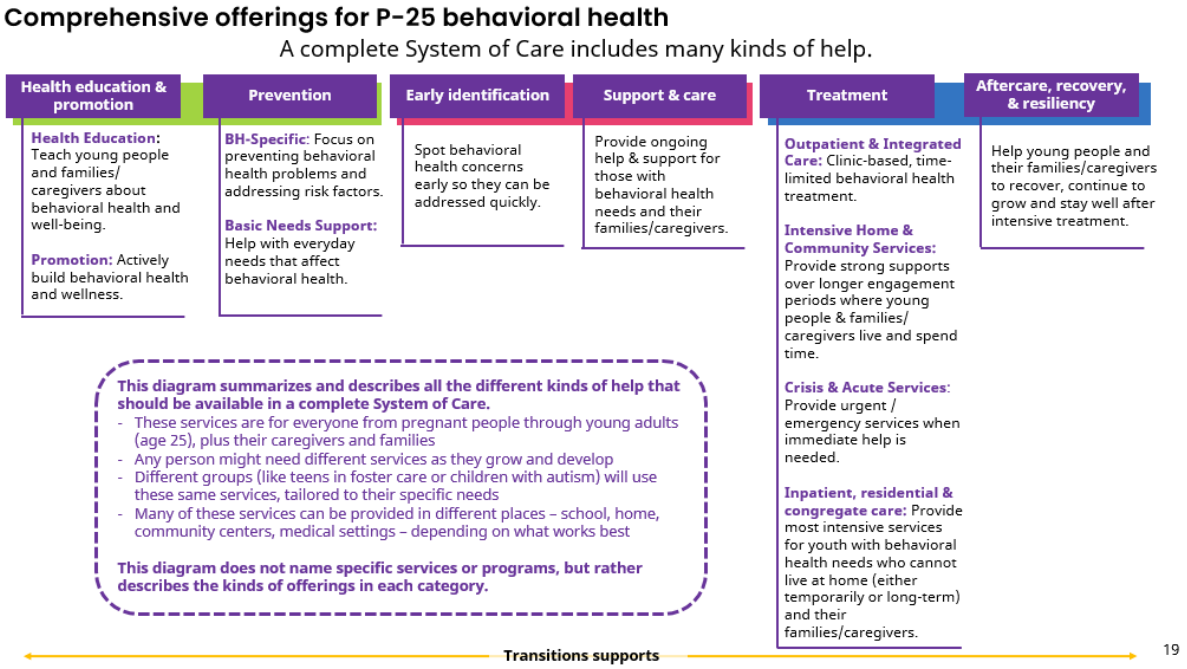
Stabilization and ongoing support to ensure families in the pre-natal and perinatal phases, children, youth, transition age youth, and caregivers have access to a full array of services and supports that support their recovery and aftercare, recovery, stabilization, and ongoing support component was added to the envisioned System of Care. This component includes life skills support, recovery-based transitions such as discharge, housing and supports, peer support, recovery navigator supports, adjunctive therapies (e.g., creative arts therapies, meditation), and recovery high schools.

Comprehensive List of Services

Each of the components of Washington Thriving's envisioned System of Care includes a comprehensive list of the services and support that the system should offer to meet the specific needs of the identified population. As can be seen in Figure 2 below, Home- and Community-Based Treatment and Support Services include a comprehensive array of identification, treatment, and support services. The array also includes residential interventions for children requiring intensive services and support. Promotion, Prevention, and Early Intervention include comprehensive services including early intervention and school-based services, which are important to prevent the need for treatment to the extent possible, especially crisis, inpatient, residential, and congregate care. Finally, there is a need for specialized services for youth and young adults of transition age and specialized services for young children and their families.

[10] Cushing, A. M., Bucholz, E. M., Chien, A. T., Rauch, D. A., & Michelson, K. A. (2021). Availability of pediatric inpatient services in the United States. *Pediatrics*, 148(1), e2020041723. https://doi.org/10.1542/peds.2020-041723

Figure 2: Array of Services and Supports



Source: Washington Thriving Advisory Group Meeting, February 11, 2025.

Array of Services and Supports

Array of Services and Supports	
Home- and Community-Based Treatment and Support Services	**Residential Interventions**
Screening	Treatment Family Homes
Assessment and Diagnosis	Therapeutic Group Homes
Outpatient Therapy – Individual, Family, and Group	Residential Treatment Services
Medication Therapies	Inpatient Hospital Services
Tiered Care Coordination	Residential Crisis and Stabilization Services
Intensive Care Coordination (e.g., Using Wraparound)	Inpatient Medical Detoxification
Intensive In-Home Mental Health Treatment	Residential Substance Use Interventions (Including Residential Services for Parents with Children)
Crisis Response Services – Non-Mobile (24 Hours, 7 Days)	**Promotion, Prevention, and Early Intervention**
Mobile Crisis Response and Stabilization	Mental Health Promotion Interventions
Parent Peer Support	Prevention Interventions
Youth Peer Support	Screening for Mental Health and Substance Use Conditions
Trauma-Specific Treatments	Early Intervention
Intensive Outpatient and Day Treatment	School-Based Promotion, Prevention, and Early Intervention
School-Based Mental Health Services	**Specialized Services for Youth and Young Adults of Transition Age**
Respite Services (Including Crisis Respite)	Supported Education and Employment
Outpatient Substance Use Disorder Services	Supported Housing
Medication Assisted Substance Use Treatment	Youth and Young Adult Peer Support
Integrated Mental Health and Substance Use Treatment	Specialized Care Coordination (Including Focus on Life and Self-Determination Skills)
Therapeutic Behavioral Aide Services	Wellness Services (e.g., Exercise, Meditation, Social Interaction)
Behavior Management Skills Training	**Specialized Services for Young Children and Their Families**
Youth and Family Education	Early Childhood Screening, Assessment, and Diagnosis
Mental Health Consultation (e.g., to Primary Care, Education)	Family Navigation
Therapeutic Mentoring	Home Visiting
Telehealth (Video and Audio)	Parent-Child Therapies
Adjunctive and Wellness Therapies (e.g., Creative Arts Therapies, Meditation)	Parenting Groups
Social and Recreational Services (e.g., After School Programs, Camps, Drop-In Centers)	Infant and Early Childhood Mental Health Consultation
Flex Funds	Therapeutic Nursery
Transportation	Therapeutic Day Care

Source: Institute for Innovation & Implementation. "The Evolution of the System of Care Approach for Children, Youth, and Young Adults with Mental Health Conditions and Their Families." 2021. https://www.cmhnetwork.org/wp-content/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf.

Section 3
Methodologies

Quantitative Gap Analysis Methodology

Mercer Government Health Services Consulting (Mercer) gathered extensive information from the Washington Thriving Advisory Group during the project's initial phase in 2024. After reviewing data sources and engaging with stakeholders involved in the Washington Thriving initiative, Mercer, in partnership with Health Care Authority (HCA), confirmed five key topics outlined in the Second Substitute Senate House Bill 1890, Chapter 76, Laws 2022 and modified by 2024 legislation for quantitative analysis. These topics serve as foundational data elements that support Mercer's quantitative analysis throughout the project. The five data elements are:

1. Estimated number of families in the perinatal phase, children, youth transitioning into adulthood, and the parents and caregivers of those children and youth who need clinical behavioral health services or could benefit from preventive or early intervention services on an annual basis.
2. Estimated number of expectant parents and caregivers in need of behavioral health services.
3. A collection and analysis of disaggregated data to better understand regional, economic, linguistic, gender, and racial gaps in access to behavioral health services.
4. Estimated costs of providing services that include a range of behavioral health supports that will meet the projected needs of the population and address measured gaps.
5. Quantitative representations of the gaps and the recommended strategies directly related to the quantitative analysis to address the gaps.

Mercer in collaboration with stakeholders selected metrics within each data element to research, identify trends, and support the Washington Thriving project. While a wealth of data is available, Mercer concentrated on metrics that could yield analytical insights into the Washington Thriving goals, specifically regarding the need for and provision of behavioral health services for children, youth, transition age youth, families in the perinatal phase, and caregivers of children and youth. By leveraging existing data, Mercer utilized and extrapolated information that was already well-established and generated findings and recommendations within this report.

Many of the identified metrics share similar data sources, and some may address the same need while focusing on different aspects of the population, depending on the specific information required for each element. For instance, certain metrics and data sources may encompass all six primary subpopulations within the Washington Thriving initiative, while others may concentrate solely on specific age ranges or individual subpopulations, such as postpartum depression or behavioral health needs in pre-kindergarten children.

When selecting the specific metrics for the quantitative analysis and report, Mercer considered the following criteria:

- The potential of the metric to inform the status of the Washington Thriving goals.
- The availability of data is necessary for calculating the metric, along with any relevant caveats.
- The construction of the formula to ensure it could provide insights into achieving the Washington Thriving goals.
- The ability of the metric's extraction and analysis leads to definitive conclusions.
- The presence of any significant data limitations.

In the data analysis section, Mercer has included all five of the data elements, the fifteen categories of metrics, and the corresponding data elements.

Landscape Analysis Methodology

During the first phase of the Washington Thriving project, Mercer engaged with the Strategic Plan chairs and the Advisory Group to review the overarching goals of the Children and Youth Behavioral Health Work Group Strategic Plan. During this meeting, participants discussed how the quantitative aspects of the behavioral health landscape intersect with and can be effectively coordinated alongside the Joint Legislative-Executive Committee on Behavioral Health.

Mercer also drew insights from a range of publicly available reports and data provided by HCA, as well as national databases, including:

- The National Survey on Drug Use and Health.
- The National Survey on Children’s Health.
- The Washington Healthy Youth Survey.
- The Centers for Disease Control and Prevention.
- The National Center for Injury Prevention and Control.
- Epidemiological surveys conducted by Ronald C. Kessler at Harvard Medical School's Department of Care Policy.

A comprehensive list of all data sources considered for the metrics can be found in Appendix F.

To enhance the sample dashboard design, HCA supplied Mercer with various publicly accessible data sources and reports, which were evaluated to establish a baseline for the landscape and gap analysis. These resources have been organized in Appendix F by description, ongoing status, age group of the population, and alignment with the envisioned System of Care outlined above.

Utilizing the current landscape of Washington's behavioral health System of Care, Mercer planned, facilitated, and documented multiple meetings with HCA and selected data partners from health and human services agencies to reach consensus on the overall quantitative data strategy. These meetings, which included a diverse array of data partners described in Section 4, focused on the following themes:

- **May 21, 2024:** Utilizing the Ideal Service Array to Identify Gaps in Service Provision for Ages Prenatal through age 25 years old.
- **May 29, 2024:** Exploring Available Data Sources to Understand Service Use and Identify Gaps in the Service Array.
- **July 1, 2024:** Gathering Input and Suggestions for a Recommended Data Dashboard Design to Inform Implementation of System Changes Derived from the Strategic Plan.
- **December 6, 2024:** Mercer formally submitted a data request to HCA and sister agencies.
- **March 2025–May 2025:** Mercer received data from HCA and sister agencies.

Section 4

Data Partner Engagement

Data Partners

A diverse array of data partners and stakeholders played a crucial role in the quantitative efforts of the Washington Thriving project. Health Care Authority (HCA) collaborated closely with Mercer to develop and support the creation of deliverables, while also engaging with data partners, the Children and Youth Behavioral Health Work Group (CYBHWG) Advisory Group, and the Joint Legislative Executive Committee (JLEC).

The following data partners actively participated in discussions facilitated by Mercer:

- Department of Children, Youth, and Families.
- Department of Commerce (housing).
- Department of Health (DOH).
- Department of Social and Health Services (DSHS) Research and Data Analysis Division.
- HCA Clinical Quality and Care Transformation Division.
- HCA Division of Behavioral Health and Recover.
- Health Management Associates.
- JLEC.
- Office of Financial Management (OFM).
- Office of the Insurance Commissioner (OIC).
- Office of the Superintendent of Public Instruction.
- Washington State Education Research and Data Center (ERDC).

Data Partner Meetings

Mercer conducted a comprehensive evaluation of potential data sources for quantitative metrics and a sample dashboard design, focusing on quality, consistency, accessibility, and potential biases. This assessment considered factors such as data linkage capabilities, quality control frequency, update regularity, and access constraints, including costs and required agreements. The aim was to ensure that the selected data sources accurately reflect the experiences of children, youth, young adults, and families, facilitating data-informed, person-centered decisions. Data partner engagement was integral to this process, with discussions emphasizing the availability of both quantitative and qualitative data on behavioral health services in Washington.

Key findings from the data partner meetings highlighted various service delivery systems, including community and school settings, outpatient and integrated care, intensive home and community-based services, comprehensive crisis care, and inpatient psychiatric care. Discussions revealed critical issues such as disparities in service access, the need for enhanced collaboration among service providers, and the importance of integrating data from multiple sources to improve service delivery and outcomes.

One-on-one discussions with specific data partners, including the DOH, DSHS, OIC, and OFM, further enriched Mercer's findings. The DOH emphasized the importance of ongoing data sources like the Healthy Youth Survey and the need for data sharing agreements. The DSHS highlighted the integration of various data streams to address the behavioral health needs of children in foster care. The OIC discussed challenges related to commercial insurance and the necessity for ongoing compliance work. Lastly, the OFM focused on the ERDC's role in analyzing student transitions and supporting policy decisions.

Overall, the insights gained from these meetings informed the quantitative analysis and dashboard design by highlighting the focus and concerns of the various data partners, as well as understanding what data is available. Furthermore, these meetings underscore the importance of a collaborative approach to data sharing and analysis, aimed at enhancing behavioral health services and outcomes for vulnerable populations in Washington.

A summary of the data partner discussions is available in Appendix E.

Section 5
Data Analysis

In this section, Mercer outlines the processes for data requests and collection, providing a comprehensive overview of each data element, associated metrics, definitions, and the identified data sources utilized in the quantitative Landscape and Gap Analysis. The section concludes with a summary of the data limitations. Key findings from the data analysis are presented in Section 6, while Section 7 highlights identified gaps and their quantification.

Data Elements

Each data element provides crucial insights into the behavioral health needs of families during the perinatal phase, as well as those of children and youth transitioning into adulthood, along with their parents and caregivers. Although the data received by Mercer Government Health Consulting Services (Mercer) varies in consistency, the primary six subpopulations analyzed include:

- Families in the perinatal phase including pregnant individuals.
- Children age 0 years to 5 years old.
- Youth age 6 years to 12 years old.
- Youth age 13 years to 17 years old.
- Transition age youth age 18 years to 25 years old.
- Parents and caregivers of children and youth.

Data Request and Collection of Data

After an extensive data partner process described in Section 4 and supporting research, Mercer developed a comprehensive data request for Health Care Authority (HCA) and non-HCA agencies (i.e., Department of Health [DOH], Office of the Superintendent of Public Instruction [OSPI], Education Research and Data Center [ERDC], etc.). The data requests identified each data element, specific data point, website link, data source including, but not limited to HCA, DOH, OSPI, ERDC, and publicly available data (i.e., Washington State Institute for Public Policy [WSIPP], Substance Abuse and Mental Health Services Administration [SAMHSA], U.S. Census, etc.) along with pertinent notes. Due to the multiple data sources, Mercer separated the comprehensive request to streamline the process. The request specified the minimum data timeframe (i.e., 2018–2024 or any data readily available), time unit (monthly), and requested output format (Excel). Many of the elements of the data requests are detailed in Table 1 and the subsequent tables below.

The data requests were issued to HCA in December 2024. Mercer and HCA participated in meetings to review the requests, identify potential barriers, and determine individuals who could support the requests within HCA and other agencies. In addition, Mercer and HCA discussed potential data use agreement requirements, necessary forms, the governance

structure, and processes for obtaining aggregated data. HCA coordinated with the non-HCA agencies and Mercer to strategize on collecting the requested data. Mercer was tasked with collecting the publicly available data specified in the data request.

As data became available, HCA and non-HCA agencies submitted the requested data to Mercer between March 2025 and May 2025. Data limitations are discussed in greater detail at the end of this section. However, it is important to note that despite multiple attempts, certain data sources remained inaccessible. Furthermore, the available data varied in terms of timeframes and age breakdowns for the identified subpopulations were not consistently provided. Additionally, some datasets were either partially complete or lacked essential components. Specifically, data for populations such as individuals with intellectual or developmental disabilities (IDD), unhoused youth, indigenous groups including Native youth and young adults, as well as refugees and immigrants, was either unavailable or severely limited.

Data Elements, Definitions, and Sources

Data Element A

Estimated number of families in the perinatal phase, children, youth transitioning into adulthood, and the parents and caregivers of those children and youth who need clinical behavioral health services or could benefit from early intervention services on an annual basis.

The metrics linked to Data Element A provide an estimate of the number of individuals and families within the specified subpopulation groups throughout Washington State, as well as the number of individuals in each subpopulation who may benefit from preventive or early intervention services or require behavioral health (BH) services. This element underscores the demand for BH services, and when integrated with the other elements, it will enhance the comprehensive analysis of capacity needs.

Table 1: Metrics, Definitions, and Data Sources for Data Element A

Data Metric	Metric Identifier	Definition	Data Source(s)
Percent of adult caregivers who could benefit from preventive or early intervention services	1a	Numerator: Number of adult caregivers who could benefit from preventive or early intervention services	Publicly Available Data: U.S. Census
	1b	Denominator: Number of adult caregivers	Publicly Available Data: SAMHSA, Center for Behavior Statistics and Quality, NSDUH

Data Metric	Metric Identifier	Definition	Data Source(s)
Percent of families in the perinatal phase who could benefit from preventive or early intervention services	2b	Numerator: Families who could benefit from preventive or early intervention in the perinatal phase	Publicly Available Data: US Census
	2a	Denominator: Estimated number of families in the perinatal phase	Washington DOH
Percent of Children/ Youth/Transition Age Youth 0–5; 6–17; 18–25 who have an individualized education plan (IEP) for an emotional/behavioral disability	3a	Numerator: The number of children and youth with an IEP for an emotional/behavioral disability in a given school year	Washington OSPI
	3b	Denominator: Children/ Youth/Transition Age Youth in a given school year Note: Under the Individuals with Disabilities Education Act and *N.D. v Reykdal*, eligible students may receive special education services through their 22nd birthday.	Publicly Available Data: U.S. Census — American Community Survey Data
Percent of Medicaid Children/Youth/Transition Age Youth 0–5; 6–17; 18–25 who have a BH diagnosis, have received a BH service and have received intensive services (i.e., hospital, residential, emergency department [ED])	3c	Numerator: The number of Medicaid children, youth, and transition age youth who had a BH diagnosis, received a BH service, and received intensive services in a given year	HCA
	3b	Denominator: Children/ Youth/Transition Age Youth in a given school year	Publicly Available Data: U.S. Census — American Community Survey Data

Data Metric	Metric Identifier	Definition	Data Source(s)
Percent of Pre-Kindergarten (4 years-5 years old) children with BH needs	3d	Pre-Kindergarten prevalence of BH needs including Social/ Emotional needs	ERDC
988 State Volume and Workload Estimate including demand for crisis services	4a	988 State Volume and Workload Estimate	Report to the Legislature, 988 Usage Report, November 2023, RCW 71.24.894
	4b	Number of calls to crisis line/warm line	988 Lifeline State-based monthly reports

In summary, Mercer leveraged data from the U.S. Census, the American Community Survey, and the National Survey on Drug Use and Health (NSDUH) — SAMHSA to calculate various metrics (Metric 1, Metric 2, and Metric 3) that estimate the demand for different subpopulation groups.

For Medicaid-related metrics, Mercer obtained data and information directly from HCA, which includes information on Medicaid children with mental health/substance use disorder (MH/SUD) diagnoses by age group. This data encompasses Medicaid children receiving MH/SUD services, including early intervention, ambulatory care, intensive outpatient services, medication-assisted treatment (MAT), and telehealth services, as well as those receiving ED services, hospitalizations, residential treatment, and withdrawal management, all categorized by age group.

While most of Data Element A focuses on potential demand, Metric 4 specifically measures the demand for BH services through 988 and crisis calls for any age individual with any insurance status. This metric captures the number of individuals actively seeking behavioral health support on 988 and crisis calls, addressing the limitation of previous data that only accounted for those with a mental health diagnosis or those already receiving services.

Data Element B

Estimated number of expectant parents and caregivers in need of Behavioral Health services.

Similarly, the metrics under Data Element B provide a count of Washington State parents and caregivers who may require BH services, as opposed to those focused on prevention and early intervention. Metric 5 leverages data from HCA and DOH to estimate the number of pregnant individuals in need of BH treatment. Mercer calculated the number of pregnant individuals who have received MH/SUD services, including ED visits, hospitalizations, residential treatment, or withdrawal management. Additionally, the analysis for Metric 5 includes Medicaid-eligible pregnant individuals who received MH/SUD early intervention services, ambulatory care, intensive outpatient treatment, MAT, or telehealth services.

Metric 6 assesses the number of Medicaid expectant caregivers with and without a BH diagnosis, while Metric 5b identifies the number of individuals experiencing postpartum

depression. Finally, Metric 6c quantifies the number of Medicaid parents and caregivers, both with and without BH diagnoses.

Table 2: Metrics, Definitions, and Data Sources for Data Element B

Data Metric	Metric Identifier	Definition	Data Source(s)
Number of total expectant caregivers identified as needing BH care	5a	Numerator: Total number of Medicaid pregnant individuals with and without BH diagnosis	HCA
	5	Denominator: The total number of caregivers in the perinatal phase in a given year	Washington DOH
Estimate for prenatal — postpartum depression	5b	The estimated rate of postpartum depression	Washington DOH
Number of caregivers with and without BH diagnosis (MAGI Households, Adults)	6a	Medicaid caregivers with BH and without BH diagnoses	HCA
	6b	Behavioral Risk Factor Surveillance including total number of Medicaid caregivers that received a MH/SUD early intervention, ambulatory, intensive outpatient, MAT, or telehealth service	Publicly Available NSDUH Data

Data Element C

A collection and analysis of disaggregated data to better understand regional, economic, linguistic, gender, and racial gaps in access to Behavioral Health services.

Metrics under Data Element C analyze the underlying demographics of the six primary subpopulations: families in the prenatal period, children and youth (ages 0 years–5 years, 6 years–12 years, 13 years–17 years, and 18 years–25 years old), and the parents and caregivers of these groups. Mercer calculated the demographic metrics by service category to provide insight into any demographic gaps in services.

The following demographic factors were examined using data from the DOH and Medicaid:

- Gender identification.
- Immigrants.

- In foster care (including transition age youth formerly in foster care).
- Income.
- American Indian and Alaskan Natives.
- Native Hawaiians or other Pacific Islanders.
- Language.
- Racial/ethnic groups.
- Sexual orientation.

Mercer calculated the demographic metrics by service category to identify potential demographic gaps in service provision. Unfortunately, sufficient data to analyze individuals with IDD and refugees were not available. However, anecdotal evidence suggests that a significant number of children served out-of-state and out-of-district may have co-occurring IDD and mental health conditions.

Furthermore, while Mercer did receive data on Native Hawaiians and other Pacific Islanders, the findings were not substantial enough to warrant detailed inclusion in the quantitative report.

Table 3: Metrics, Definitions, and Data Sources for Data Element C

Data Metric	Metric Identifier	Definition	Data Source(s)
Heatmap of BH provider clinics	7a	Names and addresses of BH providers (i.e., Youth Detoxification Beds, DBT, ABA Certified Providers, Youth Residential Beds, Counseling and Therapy, BH Outpatient Intervention, etc.)	Washington DOH
Demographics data	7b	Demographics of all populations and Medicaid population families in prenatal period; Children/Youth/Transition Age Youth 0-5; 6–17; 18–25; caregivers of children, youth, and transition age youth. Demographics include racial/ethnic groups, indigenous groups, sexual orientation, income, gender identification, language, children in foster care (including transition age youth formerly in foster care)	Washington DOH

Data Element D

Estimated costs of providing services that include a range of Behavioral Health supports that will meet the projected needs of the population and address measured gaps.

Data Element D provides an estimate of the costs associated with some of the most significant gaps in BH services and supports the five primary subpopulations. This element

emphasizes evidence-based practices (EBPs) and derives its calculations from unmet need analyses and cost estimates from the All Payer Claims Database.

As part of Element D, the following EBPs were analyzed:

- Acceptance and Commitment Therapy.
- Cognitive Behavioral Therapy.
- Dialectical Behavior Therapy (DBT).
- Eye Movement Desensitization and Reprocessing.
- Multisystemic Therapy.
- Parent-Child Interaction Therapy.
- Trauma Focused Cognitive Behavioral Therapy.
- Triple P (Positive Parenting Program).
- New Journeys Coordinated Specialty Care.
- Washington State's Wraparound with Intensive Servies.

Table 4: Metrics, Definitions, and Data Sources for Data Element D

Data Metric	Metric Identifier	Definition	Data Source(s)
Medicaid cost and utilization of EBPs by age group	8a	Analysis of current utilization and cost of EBPs for Medicaid children, youth, and young adults compared to the prevalence of target population, estimated population, and estimated cost per child per episode	HCA
	8b		All Payor Claims Database
Mental health service cost and use trends	9	Cost and Use trends for: 1. any mental illness and 2. any serious mental illness	Washington OIC
Cost benefit analysis of EBPs	9a	Cost benefit analysis of select children's EBPs (outpatient and intensive outpatient EBPs)	WSIPP SERI Guide Data
DCYF EBP Utilization Data	9b	EBP utilization data	Washington DCYF

Data Element E

Quantitative representations of the gaps and the recommended strategies directly related to the quantitative analysis to address the gaps.

Metrics under Data Element E aim to quantify the gaps in services and compare them to Washington's BH System of Care.

For Metric 10, Mercer leveraged utilization data from Metric 8, sourced from Medicaid and the All-Payer Claims Database, to estimate the costs associated with current BH service delivery. Mercer has calculated an estimate related to financial resources and capacity needed to address the identified gaps in care.

For Metric 11 and Metric 12, Mercer sought to obtain GeoAccess data from the ERDC regarding workforce demand and shortages to estimate gaps in service provision. Despite multiple attempts by HCA to secure this information through a formal data request, Mercer was ultimately unsuccessful in obtaining the data on workforce demand and shortages.

For Metric 13a, Mercer requested information on the current utilization of Medicaid services. For Metric 13b, Mercer employed the Health Management Associates service categories to help identify gaps within the System of Care.

For Metric 14, Mercer analyzed the number of children placed out-of-state to estimate the costs associated with developing in-state services that would facilitate their return.

For Metric 15, Mercer utilized the national Uniform Reporting System (URS) data from SAMHSA to compare outcomes, such as mental health hospital admission rates, against national averages. This analysis aims to identify potential improvements in care that could lead to a reduction in hospitalization rates.

Table 5: Metrics, Definitions, and Data Sources for Data Element E

Data Metric	Metric Identifier	Definition	Data Source(s)
Medicaid service utilization of EBPs by age group	10	Analysis of current utilization of EBPs for children, youth, and young adults compared to the prevalence of target population, estimated population	HCA, All Payor Claims Database
Utilization of services in Medicaid	13a	For identified Medicaid BH services	Washington HCA
Service array	13b	Qualitative listing of BH service array	Washington HCA
Gaps in access	14	Number of children placed out-of-state due to lack of services in the State	Washington OSPI
Washington to National rates	15	Hospital admission rates	SAMHSA, URS data

Data Limitations

In selecting the metrics, Mercer carefully considered the caveats, availability, and limitations of the data sources. The final analysis features metrics that include extrapolations estimating the demand and prevalence of BH needs among the targeted subpopulations. However, project timelines and Health Insurance Portability and Accountability Act (HIPAA) constraints rendered some data sources unavailable for the quantitative landscape report. Mercer utilized a diverse array of State and federal sources, each with varying restrictions and required permissions. Consequently, the quantitative landscape and gap analysis report excludes data sources containing protected health information due to the lengthy processes involved in obtaining permission for their use. It is anticipated that the proposed sample data dashboard described within Appendix A of this report will incorporate additional data sources in the future.

Beyond logistical challenges, there are inherent limitations within the data itself. Notably, quantitative data for many services is only accessible after an individual has received a diagnosis or attempted to engage in some form of service. Estimating perceived and unmet BH care needs is further complicated by the significant number of individuals who have not yet received a diagnosis and are not receiving any BH services.

Public data limitations include a lack of regional or substate-level data for BH prevalence estimates. For instance, NSDUH data were restricted to State-level rates, which were uniformly applied to counties and regions. Non-Medicaid perinatal BH data were primarily epidemiological and limited to national estimates based on existing literature. Additionally, the ability to track changes over multiple years is generally constrained, as many survey items and data elements have evolved over time. While Census data from the Population Estimates Program were prioritized for their higher accuracy, age data were provided in five-year groups that did not necessarily align with the specific age groups of interest, necessitating the assumption of equal variance to create appropriate breakouts.

Data coding limitations also exist for specific services, particularly EBPs. While it is feasible to estimate overall BH service utilization, states that do not mandate EBP-specific coding make it challenging to distinguish between generic psychotherapy or rehabilitative skill-building services and targeted EBPs. EBPs often require intensive interventions that incur costs related to coordination, oversight, training, supervision, and certification. These costs are frequently indirect, non-billable, and classified as overhead, making them ineligible for reimbursement under commercial and Medicaid insurance. As a result, many providers may opt not to train staff in EBPs, and those who are trained often lack compensation for reporting EBP delivery, leading to underreporting of these practices in Medicaid. Finally, since Mercer calculated metrics from multiple sources, the timeframes of the data in each metric may not align precisely.

Section 6

Key Findings

Mercer Government Health Consulting Services (Mercer) conducted an analysis of approximately fifteen (15) quantitative data metrics for the Gap and Landscape Analysis. This analysis yielded key findings regarding Washington's current service continuum. The data sources utilized to derive these findings are detailed in Section 5 of this report, while more comprehensive findings and specific data visualizations can be found in Appendix B, Appendix C, Appendix D, and Appendix F.

Although a substantial amount of data was examined, four main subsections can be highlighted to provide a high-level overview of the current landscape and needs of Washington's behavioral health system for prenatal through age 25 (P-25) years old population. These four primary subsections include:

- Demographic information to better understand the regional, economic, linguistic, gender, and racial gaps in access to behavioral health services for each of the age groups including children, youth, transition age youth, individuals in the perinatal period, families, and their parents and caregivers.
- Utilization of intensive services representing target populations who have been hospitalized, visited emergency departments, and accessed crisis services.
- Utilization of ambulatory services representing access to services such as assessment, counseling and therapy, behavioral health outpatient interventions, medication management, and Applied Behavioral Analysis.
- Utilization of preventive and evidence-based practices representing target populations who are being diverted from the intensive services or who are stepping down to a lower level of care.

Background

In the State of Washington, there are approximately 2.4 million children under the age of 26 years old, 1.5 million families and caregivers, and approximately 83,000 expectant caregivers. Notably, about 22% of this population lives below 200% of the Federal Poverty Line. Medicaid serves as a significant funding source, reimbursing 35.9% of services related to births and covering roughly 40% of children. Additionally, an estimated 8.6% of women of childbearing age and 3.1% of children are uninsured in Washington.[11]

Washington employs two geographical division systems for health and education. The Apple Health Integrated Managed Care Regions categorize the State into ten regions, each with varying population sizes. The largest of these regions, King County, is home to roughly one-fourth of the State's population. In parallel, the Washington State Educational Service

[11] U.S. Census Bureau, U.S. Department of Commerce. (2023). *Poverty status in the past 12 months of families* (Table S1702). American Community Survey, ACS 5-Year Estimates SubjectTables. https://data.census.gov/table/ACSST5Y2023.S1702?q=S1702:+Poverty+Status+in+the+Past+12+Months+of+Families&g=040XX00US53,53$0500000&moe=false.

Districts (ESD) divides the State into nine regions, with ESD 121 encompassing King County and serving as the largest ESD.

1. Demographic Information to Better Understand Gaps in Behavioral Health Services

Before examining the utilization of various service types within Washington's System of Care, it is essential to understand how behavioral health needs vary among children, youth, and transition age youth based on different characteristics. Individuals may enter the behavioral health system through multiple entry points, each representing children, youth, and transition age youth with diverse demographics, including race, language barriers, gender, socioeconomic status, and geographic location within the State. The following also explores how the prevalence of mental health and substance use issues differs among specific populations within the P-25 years old demographic.

Behavioral Health Needs in Children

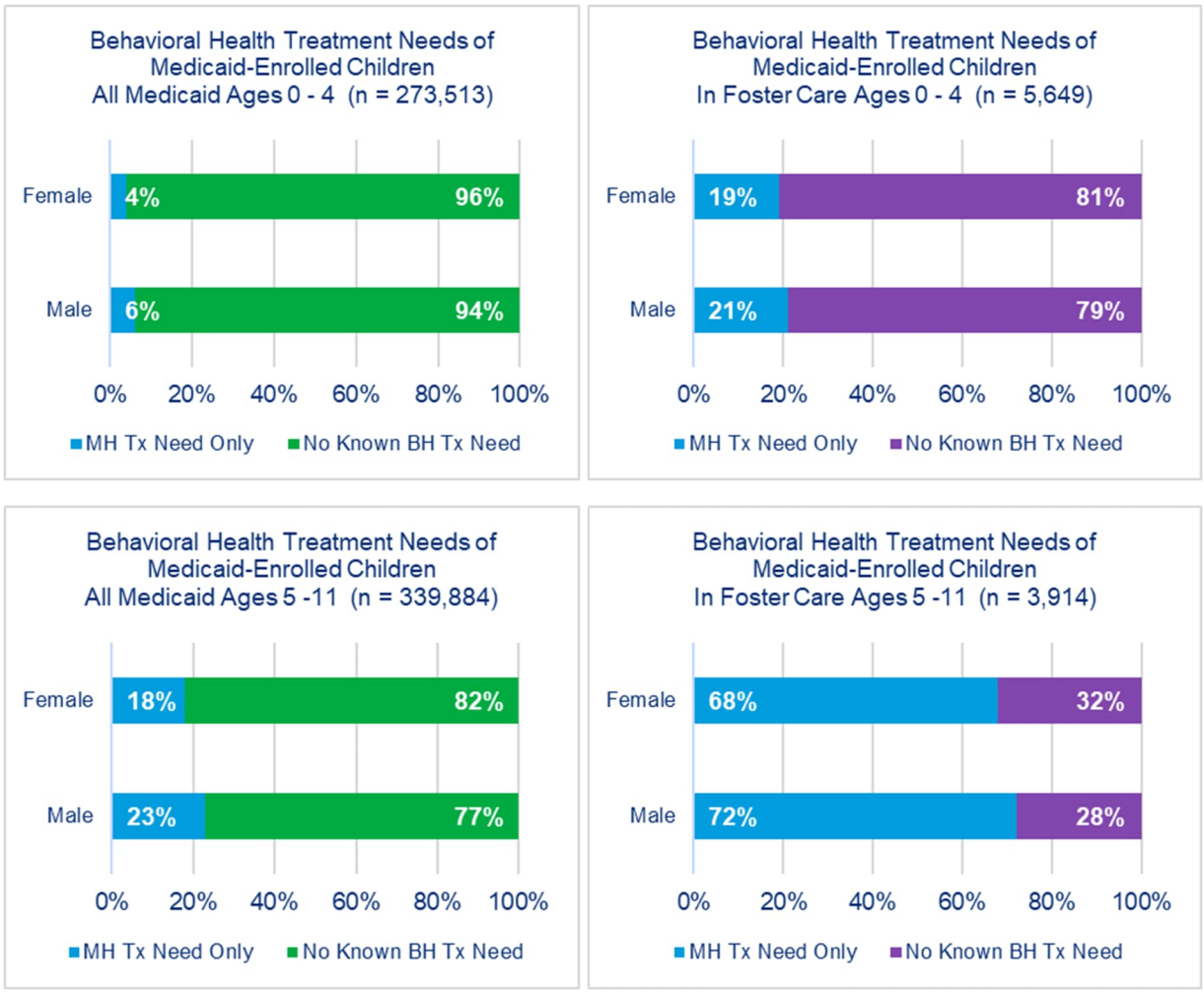
Washington evaluates children's health and well-being prior to entering kindergarten through the Washington Kindergarten Inventory of Developing Skills protocol. The data indicates that lower-income children and those enrolled in the Early Childhood Education and Assistance Program (ECEAP) are more likely to exhibit social and emotional needs during pre-kindergarten assessments. Over time, the prevalence of social and emotional needs among pre-kindergarten children has increased, revealing a higher percentage of children with behavioral health needs in the 2023–2024 cohort compared to a decade ago. Specifically, there has been a notable 13% increase in behavioral health needs among children enrolled in the ECEAP program, alongside a 6% rise among low-income children and a 4% increase among higher-income children. This data underscores the necessity for targeted behavioral health interventions for children in the ECEAP and low-income groups. *Note: the increase in behavioral health needs among children in ECEAP may be an indication that ECEAP is targeting the children most in need of services over time*. However, these increasing figures for low-income and higher-income children indicate a growing demand for behavioral health support among children under five years old, they also highlight the potential for early screening, diagnosis, and intervention services to address these needs before they escalate into more complex or intensive care requirements.

There has been a notable 13% increase in behavioral health needs among children enrolled in the ECEAP program.

In the figures below, children in foster care ages 0 years–4 years old were around four times more likely to require behavioral health treatment than non-foster care Medicaid children. For children in foster care ages 5 years–11 years old, the need for behavioral health treatment was about 3.5 times greater than in non-foster care Medicaid children.

Behavioral Health Treatment Needs of Medicaid-Enrolled Children, by Gender and Age Group, State Fiscal Year 2021

Figure 3: Behavioral Health Treatment Needs of Medicaid-Enrolled Children — Age 0–4 years old

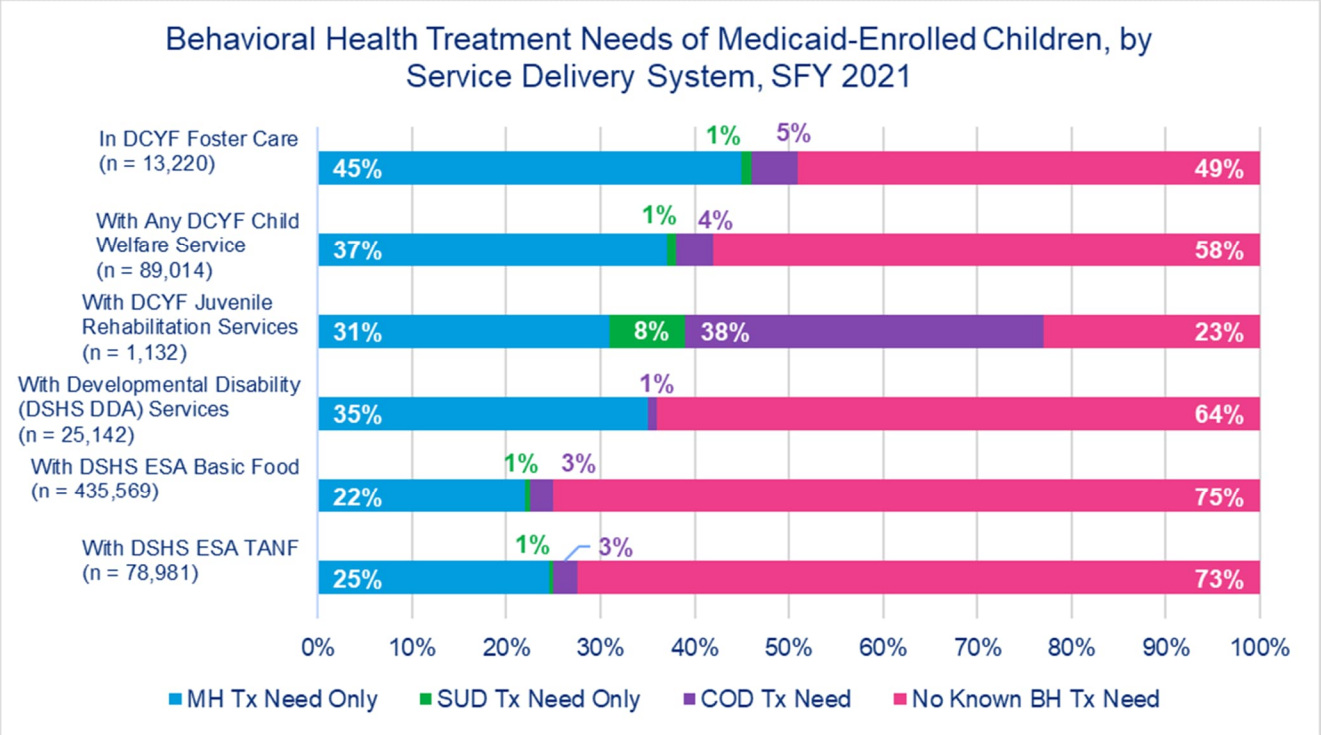


Multisystem-involved youth are those who receive services from multiple systems, including child welfare, juvenile justice, behavioral health, Medicaid, developmental disability services, Temporary Assistance for Needy Families (TANF), and other poverty-related programs. Many children requiring behavioral health treatment are involved in multiple systems and often face co-occurring conditions that exacerbate their behavioral health challenges, along with social determinants of health such as low income and food insecurity. For instance, children, youth, and transitional-age youth in foster care present unique behavioral health needs and complexities within the system. While these children are included in the overall utilization data, it is important to highlight the distinctions within the foster care population compared to the broader child and youth demographic in Washington.

The figure below illustrates that 51% of Medicaid children in the Department of Children, Youth, and Families (DCYF) foster care system require behavioral health treatment. Additionally, 42% of Medicaid children in DCYF child welfare services, 77% of those in DCYF juvenile rehabilitation services, 36% of Medicaid children receiving developmental disability services,

25% of Medicaid children with Department of Social and Health Services (DSHS) Economic Services Administration (ESA) basic food assistance, and 27% of Medicaid children receiving DSHS ESA TANF assistance also require behavioral health treatment.

Figure 4: Behavioral Health Treatment Needs of Medicaid-Enrolled Children, by Service Delivery System, SFY 2021 by Service Utilization for Total Population with Medicaid (Not Mutually Exclusive)



Source: Washington State Department of Social and Health Services. (2023, Nov.). Behavioral health treatment needs and outcomes among Medicaid enrolled children in Washington State. https://www.dshs.wa.gov/sites/default/files/rda/reports/CHILDRENS_BH_DASHBOARD_2023NOV.pdf

The data above indicates that Medicaid children who are involved in multiple systems frequently require behavioral health treatment, a need that is often exacerbated by complex socioeconomic backgrounds and co-occurring diagnostic conditions. While not always available in Washington, children, youth, and transition age youth who are multi-system involved, typically benefit from coordinated services and supports tailored to address their unique challenges. By implementing trauma-informed care, these coordinated efforts can significantly enhance outcomes for these vulnerable populations.

Behavioral Health Needs in Parents and Caregivers

Post-Partum and Pregnant Individuals

To estimate the number of postpartum parents and caregivers in need of clinical behavioral health services or those who could benefit from preventive or early intervention services annually, Mercer analyzed the percentage of individuals reporting postpartum depression based

on maternal age, Medicaid status, race/ethnicity, and region. The findings reveal that individuals receiving Medicaid are nearly twice as likely to report experiencing postpartum depression compared to their non-Medicaid counterparts (16.5% versus 8.8%). Additionally, younger individuals (ages 20 years–24 years old) are more than twice as likely to report postpartum depression compared to older individuals (19.9% for ages 20 years–24 years versus 8.7% for ages 35 years–39 years old). Furthermore, Native American or Alaska Native (16.4%) and Black individuals (20.2%) are more likely to report postpartum depression than White individuals (10.8%).

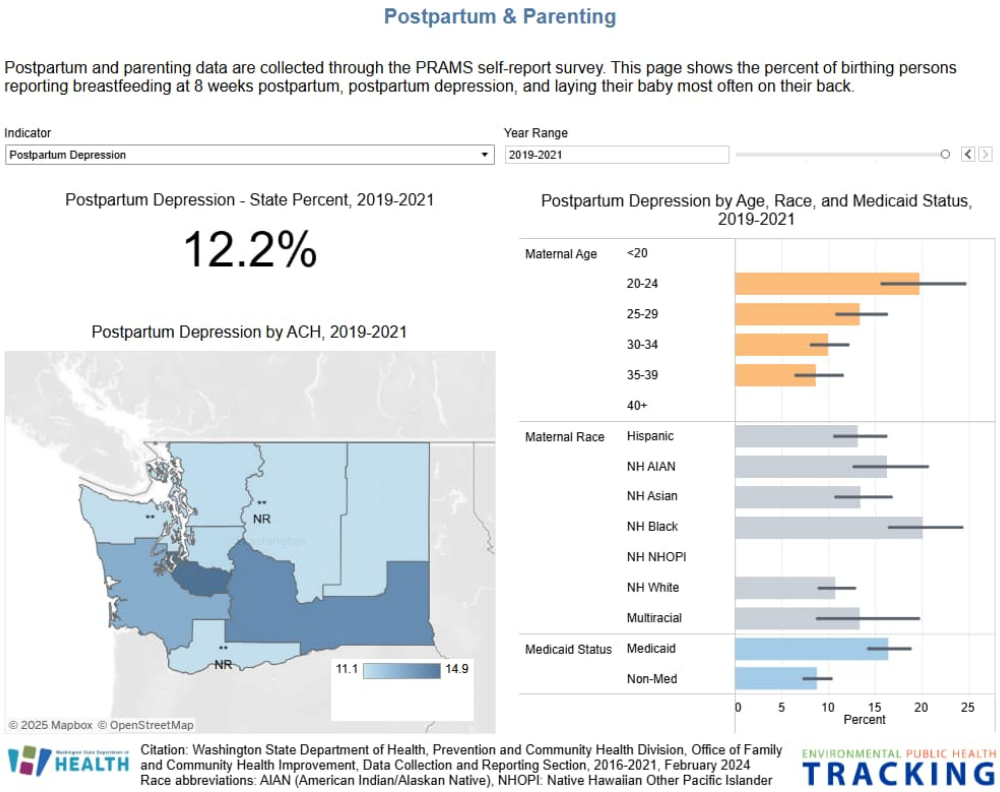
Postpartum Depression More Common in Younger Individuals: Rising Prevalence Across Racial and Ethnic Groups, Excluding Non-Hispanic Asians and Multiracial Populations.

The trend indicates a gradual increase in the percentage of individuals experiencing postpartum depression from 2016 to 2021, rising from 11.5% to 11.9% between 2016–2018 and 2017–2019, and continuing to 12.2% from 2018 to 2020. However, from 2019 to 2021, this percentage remained stable at 12.2%, showing no further increase during that period. The data highlights a higher incidence of postpartum depression among Medicaid recipients compared to non-Medicaid recipients. In terms of maternal age, younger individuals exhibit a higher incidence of postpartum depression than older age groups. The data also shows a gradual increase in the prevalence of postpartum depression across all racial and ethnic groups, except for non-Hispanic Asians and the multiracial group.

It is important to note that this data does not account for how many individuals suffering from postpartum depression received the necessary services and supports. It can be inferred that regions with a higher concentration of young mothers and/or mothers who are Native Alaskan/American Indian or Black will require additional resources to support postpartum individuals, including increased screening efforts.

Regarding substance use during pregnancy, Washington monitors alcohol, cannabis, and tobacco usage before and after pregnancy onset, as well as by race and region, utilizing self-reported data from the Pregnancy Risk Assessment Monitoring System (PRAMS). The most recent data available, covering the period from 2015 to 2021, indicates a decline in alcohol and tobacco use during pregnancy, while cannabis use has seen an increase over time.

Figure 5: Postpartum and Parenting Data PRAMS



Source: Washington State Department of Health, Prevention and Community Health Division, Office of Family and Community Health Improvement, Data Collection and Reporting Section, 2016–2021. (February 2024). Perinatal dashboard. https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/perinatal-data/dashboard

The reported use of alcohol during pregnancy is 6.5% and varies by race and region. White individuals (8.6%) and individuals in King County (9.6%) report higher alcohol consumption compared to other races and other region. Similarly, tobacco use during pregnancy stands at 4.2%, with Native American and Alaska Native individuals (16.4%) and those in King County (6.9%) exhibiting higher usage rates. As with postpartum depression data, it is important to note that this information does not indicate how many individuals using alcohol, tobacco, or cannabis during pregnancy received the necessary services and support.[12]

In 2023, approximately 254 Medicaid pregnant women were diagnosed with substance use disorders (SUD), with about 40% receiving treatment at any given time. Ongoing care is crucial for effective SUD treatment, as studies show that discontinuing care before 12 months significantly increases relapse rates.[13] In 2022, around 50% of pregnant women in Medicaid with an SUD diagnosis did not receive treatment during their pregnancy, and this figure rose to 54% in 2024. Additionally, women of color are three to four times more likely to experience pregnancy complications, resulting in higher rates of post-traumatic stress disorder (PTSD) within these

[12] Washington State Department of Health, Prevention and Community Health Division, Office of Family and Community Health Improvement, Data Collection and Reporting Section. (2024, February). *Perinatal dashboard (2016-2021).* https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/perinatal-data/dashboard

[13] McKay, J. R. (2021, January 21). Impact of continuing care on recovery from substance use disorder. *Alcohol Research Current Reviews*, 41(1), 01. https://doi.org/10.35946/arcr.v41.1.01

populations. Consequently, Washington can anticipate greater needs in counties with larger populations of women of color, indicating a need for enhanced case management and outreach for this demographic.[14] While case management is defined differently by each payor, it can be assumed that in this context case management may include outreach, education, and linkage to support services.

To effectively address the prevention of substance use during pregnancy, targeted strategies should be implemented:

- **Alcohol prevention** should focus on White individuals and those in the King County region.
- Cannabis **prevention** should target American Indian/Alaska Native and multiracial individuals, as well as those in the Spokane, Great Rivers, and Thurston-Mason regions.
- **Tobacco prevention** should specifically address Native American and Alaska Native individuals and those in the King County region.

Families, Parents, and Caregivers

An estimated 7% of female caregivers nationally experience anxiety, 4% suffer from obsessive-compulsive disorder, 14% struggle with depression and an additional 9% are affected by PTSD.[15] Alarmingly, 75% of individuals impacted by these maternal mental health conditions do not receive treatment. The economic burden of untreated perinatal mood and anxiety disorders can be assessed by examining the reduced productivity of mothers, the incidence of premature births, and the overall increase in maternal health costs.[16] In 2017, the estimated cost per mother-child pair from birth to five years postpartum was approximately $32,000, which inflates to about $41,000 in 2025 dollars for the same services. Seventy-five percent of individuals affected by these maternal mental health conditions do not receive the necessary treatment.

75% percent of individuals affected by these maternal mental health conditions do not receive the necessary treatment.

Mercer estimates that the percentage of Washington families with an adult caregiver in need of clinical behavioral health services or who could benefit from preventive or early intervention services ranges from 10.7% (for those experiencing a major depressive episode) to 28% (for those with any mental illness). Additionally, around 20.5% could benefit from SUD treatment. Notably, these rates for Washington are higher than the national averages of 8.6%, 22.9%, and 19.2%, respectively.[17]

[14] Maternal Mental Health Leadership Alliance. (2024, October 10). *Maternal mental health conditions statistics: An overview.* https://www.mmhla.org/articles/maternal-mental-health-conditions-and-statistics

[15] Maternal Mental Health Leadership Alliance. (2024, October 10). *Maternal mental health conditions statistics: An overview.* https://www.mmhla.org/articles/maternal-mental-health-conditions-and-statistics

[16] Luca, D. L., Margiotta, C., Staatz, C., Garlow, E., Christensen, A., & Zivin, K. (2020). *Financial toll of untreated perinatal mood and anxiety disorders among 2017 births in the United States. American Journal of Public Health, 110, 888–896.* https://doi.org/10.2105/AJPH.2020.305619

[17] SAMHSA, Center for Behavioral Health Statistics and Quality. (2022, 2023). *National surveys on drug use and health.*

Families Below Federal Poverty Line Decrease from 8% to 6.4% — A 20% Reduction from 2017 to 2023.

From 2017 to 2023, the estimated percentage of families with incomes below the Federal Poverty Line (FPL) in Washington decreased from 8% to 6.4%, representing a 20% reduction. Economic stress can significantly impact parental mental health, leading to less supportive and stable family environments that adversely affect children's emotional and behavioral development.[18] The estimated percentage of families with children under age 18 years old with incomes below the FPL also decreased from 2017 to 2023 from 12.8% of the population to 9.8% of the population. This represents a decrease of 23%. Children from low-socioeconomic status (SES) backgrounds may experience less access to quality health care, nutritious food, and safe living environments, all of which can contribute to various behavioral health needs. Studies also link lower SES to increased rates of substance abuse and other risky behaviors in adolescents.[19] Research links poverty to lower ratings on measures of well-being across the life span. Compared with children with higher SES, longitudinal research finds that children of low SES experience higher rates of parent-reported mental health problems and higher rates of unmet mental health needs. There is a strong gradient effect of social risk factors on child well-being; as social risk factors increase in number, so does the risk for poor mental health. Conversely, increases in family income are associated with a corresponding increase in child physical health, behavioral health, development, and health care access and utilization. Thus, children from families across the spectrum of lower income levels incur some risk for adverse health outcomes, with children from families facing the greatest poverty experiencing the greatest risk.[20] One study found that within a given location, those with the lowest incomes are typically 1.5 to 3 times more likely than the wealthy to experience depression or anxiety.[21]

Language Barriers Affecting Behavioral Health Needs

There is a growing number of families and children in the Washington Thriving target population with language barriers — defined as individuals who speak English less than *very well* and may need language services for themselves and/or their children in order to effectively access health care. In 2017, there were an estimated 6.9% of the population with language barriers, but by 2023, an estimated 7.4% of the Washington State population faced language barriers. Regionally, there are great variations in the percentage of the population with language barriers. Salish, Spokane, and Great Rivers have fewer than 3.2% of their populations having language barriers, while Greater Columbia, King County, and North Central have more than 10% of their populations that struggle with language barriers. Statewide, the most common language other than English is generally Spanish. In King County, however, the most common languages are Asian and Pacific Island languages (spoken by 12.8% of residents as opposed to 7% who speak

[18] U.S. Census Bureau, U.S. Department of Commerce. (2023). *Poverty status in the past 12 months of families* (Table S1702). American Community Survey, ACS 5-Year Estimates Subject Tables. https://data.census.gov/table/ACSST5Y2023.S1702?q=S1702:+Poverty+Status+in+the+Past+12+Months+of+Families&g=040XX00US53,53$0500000&moe=false

[19] Nong, J., Zhu, P., Li, X., Chai, P., Zhai, T., & Zhang, Y. (2022). Socioeconomic status and behavioral problems in children: The mediating effect of social relations in Mainland China. *Adolescents*, 2(4), 466-478. https://doi.org/10.3390/adolescents2040037

[20] Hodgkinson, S., Godoy, L., Beers, L. S., & Lewin, A. (2017). Improving Mental Health Access for Low-Income Children and Families in the Primary Care Setting. *Pediatrics*, *139*(1), e20151175. https://pmc.ncbi.nlm.nih.gov/articles/PMC5192088/#:~:text=Poverty%20has%20been%20consistently%20linked,persist%20across%20the%20life%20span.&text=Despite%20the%20mental%20health%20needs,high%2Dquality%20mental%20health%20services.

[21] Bennett, D. (2022). *Poverty, depression, and anxiety: A review of the literature*. MIT Department of Economics. https://economics.mit.edu/sites/default/files/2022-09/poverty-depression-anxiety-science.pdf

Spanish).[22] While this is not an isolated barrier for the prenatal through age 25 years old population, these observations suggest two key findings:

- That a larger proportion of the population is requiring assistance with language to access health care services.
- The needs of individuals vary greatly by region with at least one in 10 individuals in Greater Columbia, King County, and North Central needing assistance.

Table 6: Estimated Percent of the Population with Language Barriers[23]

Region	2017	2018	2019	2020	2021	2022	2023
Great Rivers	3.5%	3.2%	3.0%	2.8%	3.0%	2.9%	3.2%
Greater Columbia	11.4%	11.5%	11.6%	11.4%	11.6%	11.8%	11.6%
King	9.5%	9.6%	9.8%	10.0%	10.1%	10.0%	10.3%
North Central	10.2%	10.1%	10.0%	9.4%	9.3%	9.6%	10.0%
North Sound	5.9%	6.0%	5.9%	6.1%	6.4%	6.6%	6.9%
Pierce	4.9%	5.1%	5.0%	5.1%	5.3%	5.4%	5.5%
Salish	1.8%	1.9%	1.9%	2.0%	2.1%	2.2%	2.2%
Southwest	5.1%	5.1%	5.1%	5.2%	5.3%	5.4%	5.5%
Spokane	2.5%	2.9%	2.9%	2.8%	2.8%	2.8%	3.0%
Thurston-Mason	3.8%	3.7%	3.7%	3.6%	3.7%	3.9%	4.1%
Statewide	**6.9%**	**6.9%**	**6.9%**	**7.0%**	**7.1%**	**7.2%**	**7.4%**

Gender

Research and data continue to show how gender may affect mental health and how individuals may be more likely to experience specific mental health concerns based upon their gender. This includes both the trans and gender fluid community, but also the cis-gendered population. These differences can be seen in prevalence, symptomology, availability of certain treatments, and outcomes to their mental health conditions.

For example, cis females are more likely than cis males to experience depression and anxiety, without including post-partum anxiety. Even though women may experience these conditions at a higher prevalence, they often show signs of these mental health conditions that differ from males. This could include persistent sadness, withdrawal from social activities, and changes in eating or sleeping patterns. A further difference in males and females is often the causes of mental health concern. For women, this could include very specific things such as hormonal changes, higher rates of trauma and abuse, and societal pressures and stressors.[24] Similarly,

[22] U.S. Census Bureau, U.S. Department of Commerce. "Language spoken at home." *American Community Survey, ACS 5-Year Estimates Subject Tables*, (Table S1601). https://data.census.gov/table/ACSST5Y2023.S1601?q=s1601&g=040XX00US53,53$0500000&moe=false

[23] U.S. Census Bureau, U.S. Department of Commerce. "Language spoken at home." American Community Survey, ACS 5-Year Estimates Subject Tables, (Table S1601). https://data.census.gov/table/ACSST5Y2023.S1601?q=s1601&g=040XX00US53,53$0500000&moe=false

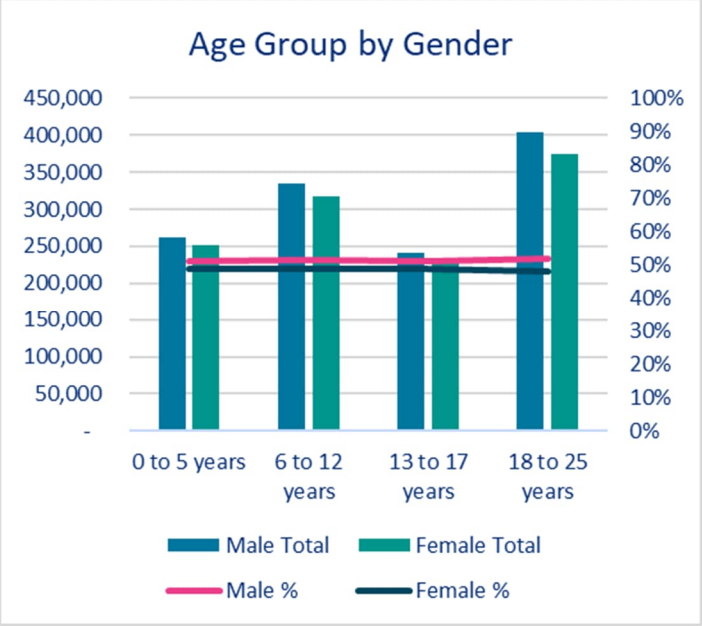
[24] Women & mental health: Why gender matters. (2024, July 15). *Behavioral Hospital of Bellaire*. https://bhbhospital.com/blog/women-mental-health-why-gender-matters/

the lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, and more (LGBTQIA+) community has been historically marginalized and are still expected to experience poorer mental health outcomes compared with heterosexual and cis-gendered counterparts due to facing additional barriers to access.

These barriers may include low practitioner knowledge of LGBTQIA+ issues, stereotyping of LGBTQIA+ behaviors, and ongoing stigma and marginalization.[25] Washington has one of the higher populations of lesbian, gay, bisexual, transgender (LGBT) adults in the United States, with about 6.9% of the population identifying as LGBT.[26] According to the annual Gallup poll, as many as 23% of young adults born between 1997–2006 now identify as LGBTQIA+.[27] Current data sources do not adequately represent diverse gender identities, including two-spirit individuals, when assessing BH needs. As a result, the data presented below reflects a gender binary perspective.

Understanding these gender differences is tantamount for providing effective and tailored mental health care.[24] There are gender differences at every age in the Washington population under 26 years. In all age groups, the gap between males and females varies slightly across age groups, but males maintain a higher count in each category.

Figure 6: Age Group by Gender in Washington



Source: Washington State Department of Health. (n.d.). Demographics data. Retrieved April 11, 2025, from https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/demographics

[25] Mental health challenges of lesbian, gay, bisexual and transgender individuals. (2021). *National Institutes of Health*. https://pmc.ncbi.nlm.nih.gov/articles/PMC7876969/

[26] Jones, Jeffrey M. Feb. 15, 2024. U.S. States Where the Highest and Lowest Shares of LGBT Adults Live. *Axios*. https://www.axios.com/2024/02/15/lgbt-american-communities-states-data

[27] Jones, Jeffrey M. Feb. 20, 2025. LGBTQ+ Identification in U.S. Rises to 9.3%. *Gallup*. https://news.gallup.com/poll/656708/lgbtq-identification-rises.aspx

Race and Ethnicity

Mercer found just over three-quarters of the Washington population (76%) is White. In 32 of the 39 counties, more than 82% of the population is White. The highest percentage of Black and African Americans live in Pierce and King counties. The highest percent of Asian Americans live in King and Snohomish counties. Six of the seven most racially diverse counties also have a 10% or higher Hispanic population. Across all age groups, the percentage of individuals identifying as White ranges from 69% to 74%. The representation of individuals identifying as Asian is between 9%–10%, while American Indian and Alaska Native, Black, and Native Hawaiian/Pacific Islander groups have smaller proportions of the population (3%, 5%, and 1%, respectively). The percentage of individuals identifying as two or more races is between 11% in the 0 years–5 years old age group and 8% in the 8 years–25 years age group. Seven counties have 5% or higher Native American population, compared to 2% statewide, though this number underrepresents the total population of Native Americans as Census data do not include individuals who identify as Native American in combination with any other racial group.

Nationally, research has shown that while racial and ethnic minorities often have higher rates of psychological distress and common behavioral health conditions than Whites, some studies also find that Whites have elevated levels of depressive and anxiety symptoms compared to their non-White peers. Data published in the 2022 Comparative and Regional Analysis Report[28] found that there are behavioral health inequities based on race and ethnicity in Washington State. In all behavioral health measures, the June 2023 Review of Findings: Behavioral Health Inequities & Disparities in Washington State from a Behavioral Health Community Perspective reported that in all behavioral health measures, individuals who identified as Black were statistically less likely to receive behavioral health-related care as compared to people who identified as White. This included follow up after a mental health-related hospitalization, substance use treatment rates, and use of medication for opioid use disorder.[29,30] African Americans tend to report higher levels of distress,[31] but also report higher levels of flourishing than Whites.[32] Here, flourishing is operationalized as the absence of mental disorders and the presence of high levels of psychological well-being. When considering psychiatric disorders, Hispanics (or Latinos), African Americans, and Asians all have lower rates of lifetime and past year psychiatric disorders than Whites.[33] However, when African Americans and Latinos experience mental illness, their episodes tend to be more severe, persist for longer periods of time, and are more debilitating than for any other race/ethnic group.[34]

The high rates of alcohol, substance use, and mental health disorders, suicide, violence, and behavior-related morbidity and mortality in American Indian and Alaska Native communities continue to be disproportionately higher than the rest of the U.S. population. Studies show

[28] Comagine Health. (2022). 2022 comparative and regional analysis report. Seattle, WA. https://bhinstitute.uw.edu/wp-content/uploads/2023/08/Behavioral-Health-Inequities-Dispartities-in-WA-report.pdf

[29] UW Medicine Behavioral Health Institute at Harborview Medical Center. (2023). Review of findings: Behavioral health inequities & disparities in Washington State from a behavioral health community perspective, 3. https://bhinstitute.uw.edu/wp-content/uploads/2023/08/Behavioral-Health-Inequities-Dispartities-in-WA-report.pdf

[30] Vega, W. A., & Rumbaut, R. G. (1991). Ethnic minorities and mental health. *Annual Review of Sociology*, 17, 351–83. https://www.researchgate.net/publication/228246892_Ethnic_Minorities_and_Mental_Health

[31] Hughes, M., & Thomas, M. E. (1998). The continuing significance of race revisited: A study of race, class, and quality of life in America, 1972 to 1996. *American Sociological Review*, 63, 785–95. https://www.researchgate.net/publication/313661984_The_Continuing_Significance_of_Race_Revisited

[32] Keyes, C. L. M. (2007). Promoting and protecting mental health as flourishing: A complementary strategy for improving national mental health. *American Psychologist*, 62(2), 95–108. https://doi.org/10.1037/0003-066X.62.2.95

[33] Miranda, J., McGuire, T. G., Williams, D. R., & Wang, P. (2008). Mental health in the context of health disparities. *American Journal of Psychiatry*, 165(9), 1102-1108. https://doi.org/10.1176/appi.ajp.2008.08030333

[34] Williams, D. R. (2018). Stress and the mental health of populations of color: Advancing our understanding of race-related stressors. *Journal of Health and Social Behavior*, 59(4), 466–485. https://doi.org/10.1177/0022146518814251

Indigenous people have disproportionately higher rates of mental health[35] problems such as suicide, PTSD, violence, and substance use disorders. These high rates result in American Indian and Alaska Native people reporting serious psychological distress, 2.5 times more[36] than the general population over a month's time.

Geographic Access in 1999, the Washington Legislature revised statutes to define rural counties as a county with a population density of less than 100 persons per square mile.[37] Subsequent legislation expanded the definition to include counties smaller than two hundred twenty-five square miles. In 2024, legislation[38] passed defining frontier one designations as a county with a population density of 21 persons per square mile or fewer and frontier two designations as a county with a population density of more than 21 persons per square mile, but fewer than 50 people per square mile.[39]

Rural access is a challenge. Much of the population is located in the urban counties with specialty providers not being evenly geographically dispersed throughout the State. A June 2023 behavioral health study found that 79% of Washington's residents live in counties categorized as urban.[40] The report went on to note that surveys and focus groups conducted throughout Washington in 2022 found that rural areas have unique behavioral health challenges including a lack of access to services and a lack of needed behavioral health services for specific communities.

In contrast, Mercer found that there are no Medicaid Children's Long-Term Inpatient Psychiatric Beds located in 33 of the 39 counties in Washington with only Pierce, Spokane, and Yakima having beds. In addition, Mercer found that four primary types of licensed facilities with specialty pediatric residential bed types including behavioral treatment and evaluation beds were consolidated in only eight counties. More information about this analysis is found in Section 7 Gaps in Services: Geographic Areas without Access as well as in Appendix B.

[35] Gone, J. P., & Trimble, J. E. (2012). American Indian and Alaska Native mental health: Diverse perspectives on enduring disparities. *Annual Review of Clinical Psychology*, 8, 131–160. https://doi.org/10.1146/annurev-clinpsy-032511-143127

[36] U.S. Department of Health and Human Services, Indian Health Service, Office of Public Health Support, Division of Program Statistics. (2014). *Trends in Indian health*. https://www.ihs.gov/sites/dps/themes/newihstheme/display_objects/documents/Trends2014Book508.pdf

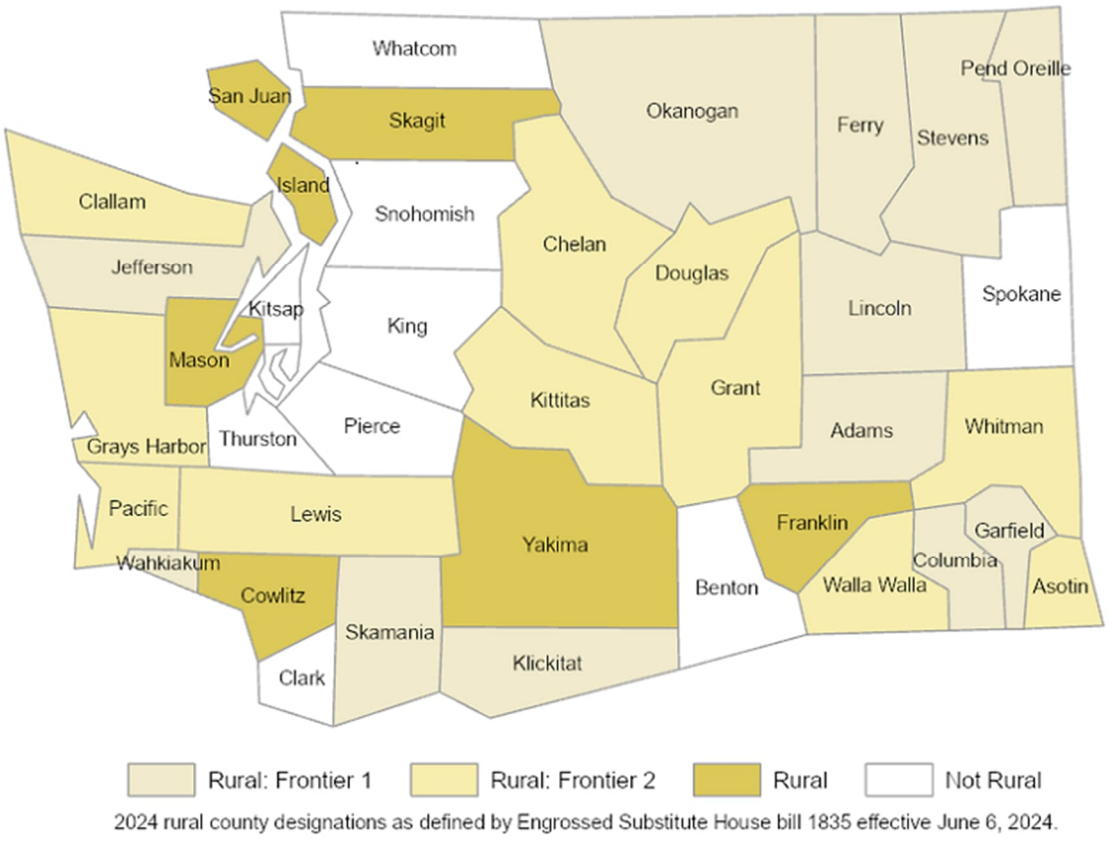
[37] Washington State Legislature. (n.d.). *RCW 82.14.379*.

[38] Washington State Legislature. (n.d.). *Engrossed Substitute House Bill 1835 for RCWs 43.160.020, 43.330.010, 82.02.010.*

[39] State of Washington, Office of Financial Management (2024, June 28). *Washington state tops 8 million residents in 2024.* https://ofm.wa.gov/sites/default/files/public/dataresearch/pop/april1/ofm_april1_press_release.pdf

[40] Review of Findings: Behavioral Health Inequities & Disparities in Washington State from a Behavioral Health Community Perspective, UW Medicine Behavioral Health Institute at Harborview Medical Center, June 2023, p. 3. https://bhinstitute.uw.edu/wp-content/uploads/2023/08/Behavioral-Health-Inequities-Dispartities-in-WA-report.pdf

Map 1: Population Density and Land Area Criteria[41]



The following table lists the types of counties by definition with the related density.

Table 7: Population Density and Land Area Criteria

Counties with a population density of less than 100 persons per square mile or counties smaller than 225 square miles as of April 1, 2024, by Frontier designation			
Rural: Frontier One	Rural: Frontier Two	Rural	Urban
Adams (11.16)	Asotin (35.73)	Cowlitz (99.81)	Benton (128.14)
Columbia (4.58)	Chelan (28.17)	Franklin (82.39)	Clark (853.31)
Ferry (3.34)	Clallam (45.18)	Island* (425.23)	King (1,124.28)
Garfield (3.27)	Douglas (24.82)	Mason (70.32)	Kitsap (724.12)
Jefferson (18.68)	Grant (39.3)	San Juan * (106.23)	Pierce (571.12)
Klickitat (12.53)	Grays Harbor (40.71)	Skagit (77.04)	Snohomish (415.57)
Lincoln (4.89)	Kittitas (21.16)	Yakima (61.29)	Spokane (317.08)

[41] State of Washington, Office of Financial Management (2024, June 28). *Population density and land area criteria used for rural area assistance and other programs*. Population density and land area criteria used for rural area assistance and other programs | Office of Financial Management

Counties with a population density of less than 100 persons per square mile or counties smaller than 225 square miles as of April 1, 2024, by Frontier designation			
Okanogan (8.2)	Lewis (35.35)		Thurston (424.92)
Pend Oreille (9.89)	Pacific (25.65)		Whatcom (112.91)
Skamania (7.28)	Walla Walla (49.9)		
Stevens (19.24)	Whitman (22.58)		
Wahkiakum (17.31)			

* Included due to a land area under 225 square miles.

2. Utilization of Intensive Services

As noted in the previous subsection, this section will discuss the utilization of intensive services as well as the characteristics and needs of the children, youth, and transition age youth requiring these *deep end* services. Deep end services are those services which require high intensity and often specialized providers. This may include hospitalizations, long-term residential treatment facilities, and crisis services. Though an individual may engage in these services for a number of reasons, it is often because the child, youth, or transition age youth could be a risk to themselves or others.

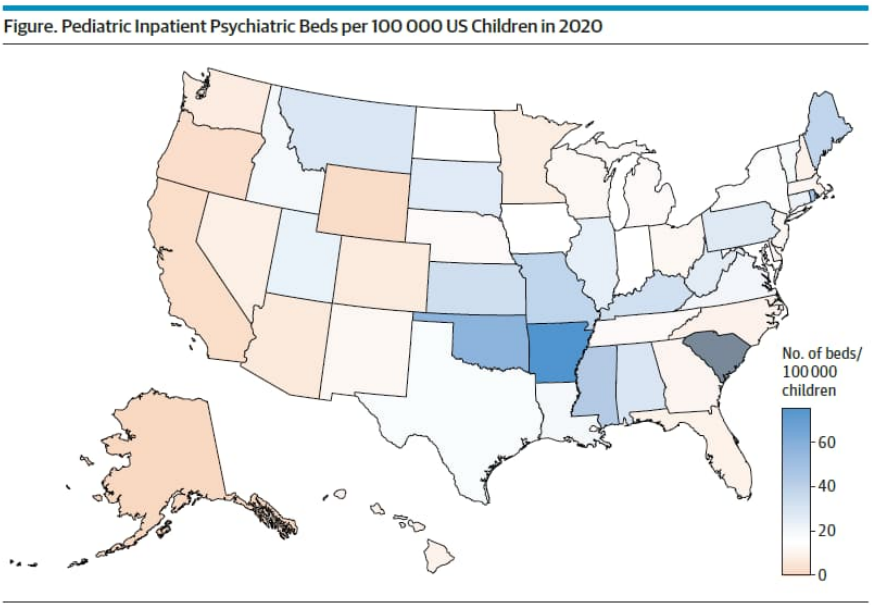
Utilization of intensive services can be a significant indicator of overall behavioral health needs of the community, as it calls out not only intensive services are needed but also shows the need for increased prevention and community-based services. Intensive services include hospitalizations, emergency department visits, and crisis services. It is assumed that the population requiring deep end services could have benefited from preventative or community-based services — if they did not already receive them.

Mercer found various trends that indicate an increase in deep-end services:

- The number of children served outside of their school district or the State due to lack of behavioral health resources has decreased 27.9% from 2021 to 2024. However, while emotional and behavioral disabilities were decreasing as a proportion of all disabilities, they were increasing as a proportion of all out-of-state placements.
- From 2018 to 2023, the number of children, youth, and transition aged youth monthly receiving inpatient mental health services doubled from 438 to 932. This occurred at a time when the number of children needing behavioral health services was dramatically increasing as well. Because of the two simultaneous increases, the proportion of children, youth, and transition age youth receiving inpatient mental health services grew from 6.5% to 9.2% of all young individuals receiving mental health services. There are only 311 specialized behavioral treatment and evaluation beds licensed in Washington in eight counties. Children requiring these services are either treated at different levels of care in their communities or must travel to these locations away from their families.

A new study published in JAMA, August 2024,[42] found Washington had lower than the national average of 15 pediatric beds per 100,000 population.[43] The figure below shows Washington's capacity compared to other states.

Figure 7: Pediatric Inpatient Psychiatric Beds per 100,000 U.S. Children in 2020



Source: Cushing, A. M., Nash, K. A., Foster, A. A., et al. (2024). Pediatric inpatient psychiatric capacity in the U.S., 2017 to 2020. JAMA Pediatrics, 178(10), 1080–1082. https://doi.org/10.1001/jamapediatrics.2024.2888

While it is not known what the ideal number of inpatient beds per 100,000 children are needed in a state, Washington is at the lowest end of the pediatric psychiatric bed inventory per 100,000 children. The same study also found that U.S. pediatric inpatient psychiatric bed capacity did not change from 2017 to 2020, despite the growing pediatric mental health crisis. The same author in a different study found that Washington's pediatric inpatient bed capacity and use decreased from 2008 and 2018. Despite increases in pediatric mental health emergency visits, bed availability has not increased. In addition, over 90% of pediatric inpatient psychiatric beds were in urban areas, raising concerns about access for rural children.[44] In some states, children increasingly have prolonged emergency department visits while awaiting stepdown care including pediatric inpatient psychiatric beds.[45]

[42] Cushing, A. M., Nash, K. A., Foster, A. A., et al. (2024). Pediatric inpatient psychiatric capacity in the U.S., 2017 to 2020. *JAMA Pediatrics*, 178(10), 1080–1082. https://doi.org/10.1001/jamapediatrics.2024.2888

[43] The study looked at data from the 2017 to 2020 American Hospital Association Survey Database (AHASD), state-level demographics from 2015 to 2019 American Community Survey 5-year estimates, hospital and population from the 2010 Rural-Urban Commuting Area codes, and December 2020 state Medicaid expansion status from the Kaiser Family Foundation. The study found that Washington State was in the lowest tier of access with fewer than 15 pediatric Inpatient psychiatric beds per 100,000 Children in 2020.

[44] Cushing, A. M., Bucholz, E. M., Chien, A. T., Rauch, D. A., & Michelson, K. A. (2021). Availability of pediatric inpatient services in the United States. *Pediatrics*, 148(1), e2020041723. https://doi.org/10.1542/peds.2020-041723

[45] Cutler, G. J., et al. (2022). Pediatric mental health emergency department visits and access to inpatient care: A crisis worsened by the COVID-19 pandemic. *Academic Pediatrics*, 22(6), 889–891. https://doi.org/10.1016/j.acap.2022.03.015

While specific prenatal through age 25 years old data is not available, 988 Suicide and Crisis Lifeline calls indicate an increasing need for intensive services. The call volume in Washington steadily increased from July 2021 to December 2024, with calls regularly exceeding 10,000 per month.[46] Overall, the data indicates a stable and high demand for crisis support services over the analyzed period, with the 988 Suicide and Crisis Lifeline being one of the most utilized services. As a positive, Washington reports call abandonment rates and time to answer within the acceptable industry standards, which are two indicators of appropriate use and capacity for individuals reaching out to 988.[47]

3. Utilization of Ambulatory Care

To prevent intensive behavioral health services described in subsection 2 above, it is crucial that Washington maintains adequate capacity in its system for ambulatory care. This subsection will describe the ambulatory utilization and characteristics of children, youth, and transition age youth in Washington receiving those services. Ambulatory services, or outpatient services, are those services that represent early intervention, prevention, diversion, and step-down care aimed at treating individuals in the least restrictive environment. Ambulatory services are paramount to any behavioral health system, as they provide opportunities for children, youth, and transition age youth to stay connected to their community while receiving ongoing care and management of symptoms.

Outpatient Services

From 2018 to 2023, Mercer found the number of children, youth, and transition age youth receiving outpatient services monthly continued to increase, growing from 6,555 to 7,921 (+20.8%). However, the proportion of children receiving outpatient services is a smaller percentage of children receiving any mental health services over time, decreasing from 97.2% of the population receiving outpatient services to just 78.3% receiving outpatient services.

Table 8: Utilization — Children Receiving Mental Health Services

Service Year	Children Receiving Mental Health Services Utilization — Any Services				% Receiving Outpatient Services	% Receiving Inpatient Services	% Receiving IMD Services	% Receiving Emergency Department Services
Age Range	0–5	6–17	18–25	Total	Percent of Total	Percent of Total	Percent of Total	Percent of Total
2018	53	38,511	36,075	74,639	97.2%	18.1%	0.6%	16.6%
2019	197	43,328	42,042	85,567	96.2%	11.3%	1.1%	9.9%
2020	240	47,557	51,258	99,055	75.7%	5.3%	27.5%	4.1%
2021	307	53,713	60,119	114,139	69.3%	4.4%	31.5%	3.0%
2022	308	53,996	56,037	110,341	76.5%	4.9%	23.8%	3.5%
2023	345	52,443	56,967	109,755	78.4%	5.7%	18.6%	4.2%

[46] 988Lifeline. State-based monthly reports. https://988lifeline.org/professionals/our-network/state-based-monthly-reports/

[47] SQM Group. (n.d.). Industry standards for the top 10 KPIs. https://www.sqmgroup.com/resources/library/blog/industry-standards-top-call-center-kpis

These trends show that over time:

- More Medicaid-eligible children, youth, and transition age youth need mental health services;
- More of these young individuals are being hospitalized and placed in institutions for mental disease;
- A growing number are seeking care in emergency departments again for mental health conditions; and
- A smaller percentage of children are receiving outpatient mental health services while residing with their families.

While there continues to be a growing number of individuals seeking mental health care, a growing proportion of children, youth, and transition age youth are not receiving outpatient or intensive outpatient/partial hospitalization, as can be seen in Table 9 below.

Table 9: Number of Washington Medicaid Beneficiaries Under Age 26 Years Old Receiving Outpatient Mental Health Services[48]

Mental Health Services Utilization — Outpatient Children, Youth, and Transition Aged Youth					
Service Year	**0–5 Years**	**6–17 Years**	**18–25 Years**	**Total**	**Proportion of Individuals Receiving Care**
2018	42	37,901	34,573	72,516	97.2%
2019	195	42,263	39,897	82,355	96.2%
2020	178	35,687	39,145	75,010	75.7%
2021	231	37,354	41,495	79,080	69.3%
2022	255	42,338	41,858	84,451	76.5%
2023	313	42,650	43,067	86,030	78.4%

Telehealth

One statistic that shows true promise is the number of children, youth, and transition age youth receiving mental health services in Washington via telehealth defined as online assessments, virtual services delivered and reported with a telehealth modifier or place of service, or a telephone visit. In 2018, the number of youth and transition age youth receiving mental health services via telehealth was just 64 per month or 0.9% of the population receiving care. However, by 2023, the number of individuals receiving mental health services via telehealth had increased to 1,935 or 19.1% of the population receiving care. While this number was less than the utilization rate at the height of the public health emergency, the growth in the use of telehealth represents a 2923% increase.

[48] Washington State Health Care Authority, (2018-2023).

SUD Services

On top of mental health needs, it is also important to acknowledge that children under 18 years old may also experience substance abuse and dependency. In 2023, there were 2,142 Medicaid individuals in Washington under the age of 18 years old with an SUD diagnosis on a monthly basis. There were also 68,527 Medicaid adults aged 18 years–26 years old with an SUD diagnosis, though the data does not provide these transition age youth breakouts. Of the children and youth under the age of 18 years old, only 868 or 40.5% received any SUD treatment. This included 29 individuals receiving Early Intervention, 762 receiving outpatient care (87.8%), 90 receiving medication-assisted therapy services, 50 receiving residential and inpatient services, and six receiving withdrawal management.

Treatment of youth in outpatient care is more likely to occur in SUD than in mental health, with fewer youth receiving residential and hospital care compared to the more preventative outpatient care. Separate withdrawal management treatment is not typically considered appropriate for youth and children, so it is expected that the utilization for children under 18 years old is low.

4. Evidence-Based Practices

An evolving area of behavioral health services that augments ambulatory care to prevent intensive services for children, youth, and transition age youth are evidence-based practices (EBPs). EBPs are those services that integrate research, clinical expertise, and patient values to optimize treatment outcomes specific to a certain population while keeping in mind current best practices and incorporating person-centered care. EBPs are often outpatient or intensive outpatient services that serve to divert from more deep end services; however, it should also be noted that EBP's can be incorporated into more intensive settings, such as therapeutic interventions in long-term residential placements.

Sustaining EBPs

Behavioral health EBPs are treatment approaches relying on the best available scientific evidence to guide treatment decisions. It involves using interventions and modalities that have been proven effective through rigorous research, clinical trials, and meta-analyses. Typically, EBPs are developed with specific populations in mind and are tailored to those populations. As such, not every EBP would be appropriate for every individual.

Washington State providers self-report several EBPs that they are trained to provide, and this information is collected by the Health Care Authority (HCA). The EBPs are categorized by their Therapeutic Family. Those EBPs with an asterisk are DCYF-Approved EBPs for the child welfare population.[49]

[49] DCYF Evidence-Based Practice Reporting Guide. (2022, June 2). *Washington State Department of Children, Youth, and Families*. https://www.dcyf.wa.gov/sites/default/files/pdf/EBPReportingGuide.pdf

Table 10: Evidence-Based Practices by Therapeutic Family

Therapeutic Family[50]	Training Program Name	
Cognitive Behavioral Therapy (CBT) for Anxiety and/or Depression	• Acceptance and Commitment Therapy (ACT) • Attachment-Based Family Therapy* • Blues Program* • Confident Kids • Cools Kids* • Coping Cat* • CBT for Psychosis* • Coping Cat/Koala Back* • Coping with Depression • Effective Child Therapy* • First Approach Skills Training for Anxiety (FAST-A) • FAST-D (Depression) • Get Lost Mr. Scary Programme* • Harborview CBT • Integrated Behaviour Therapy for Selective Mutism* • Managing and Adapting Practice*	• Modularized Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct* • Parent CBT* • Primary and Secondary Control Enhancement* • Take Action Program* • Taming Sneaky Fears* • The CALM Program • The Reach Institute • Timid Tiger* • Turtle Program* • Exposure Response Prevention for Obsessive-Compulsive Disorder (OCD) • Seattle Children's OCD-Intensive IOP
Eating Disorder Treatment	• Family-Based Treatment (FBT) for Eating Disorders	• Seattle Children's Eating Disorder Clinic
Infant Mental Health	• Attachment and Biobehavioural Catch-up (ABC) • Infant-Parent Psychotherapy (IPP) • National Child Traumatic Stress Network Learning Collaboratives	• Child-Parent Psychotherapy • Promoting First Relationships (PFR) • Theraplay
Interpersonal Psychotherapy	• Individual-based IPT (12 sessions)	• Interpersonal Psychotherapy-Adolescent Skills Training (IPT-AST)
Mood Disorder Treatment	• Collaborative Assessment and Management of Suicidality (CAMS)	• Dialectic Behavior Therapy (DBT) for adolescents with self-harming behavior
Parent Behavioral Therapy	• Adlerian Play Therapy • Brief PMTO • Brief Strategic Family Therapy (BSFT) • Child Behavioral Therapy (Individual)	• Multimodal Therapy (MMT) for Children with Disruptive Behavior • Oregon Social Learning Program (OSLO) • Parent Child Interaction Therapy (PCIT) for Children with Disruptive Behavior Problems

[50] 2023 reporting guide for research and evidence-based practices in children's mental health. (2023). *Washington State Health Care Authority*. https://www.hca.wa.gov/assets/program/ebp-reporting-guides.pdf

Therapeutic Family[50]	Training Program Name	
	• Child Parent Relationship Therapy • Communication Method Program (COMET) • Coping Power Program • Enhanced Behavioral Family Intervention • FAST-B (Child Behavior Problems) • FAST-E (Early Childhood) • FAST-P (Parenting Teens) • First Step to Success • Harborview CBT+ Learning Collaborative • Helping the Non-compliant Child • Incredible Years Parent Training • Incredible Years Parent Training + Child Training • Institute for Family Development, Homebuilders Core Curriculum and Implementing Cognitive Interventions Workshops • Managing and Adapting Practice (MAP) • Modularized Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems (MATCH-ADTC)	• Parent Management Training (PMT) • Parent Management Training Oregon (PMTO) • Problem Solving Skills Training • Research Units in Behavioral Intervention (RUBI) • Social Learning Parent Training (Hanf model) • STAY • Stop Now and Plan (SNAP) • The Reach Institute (CATIE trainings) • Triple P Precursor • Triple-P Level 4, Group • Triple-P Level 4, Individual • Tuning Into Kids

The Washington State Institution of Public Policy (WSIPP) maintains a cost-benefit analysis of EBPs for juvenile justice, child welfare, and children's mental health, as well as other target populations. As a requirement of the Washington State legislature since the 1990s, WSIPP identifies evidence-based mental health practices that can lead to better statewide outcomes coupled with a more efficient use of taxpayer dollars.[51]

Table 11: Cost-Benefit Analysis Results of Select Children's EBPs[52]

Service	Average Cost per Client for Services	Benefits Minus Cost per Participant (net present value)
General Outpatient EBPs		
By EBP	-$2,002 to $733	

[51] Washington State Institute for Public Policy. (n.d.). *Benefit-cost analysis*. https://www.wsipp.wa.gov/BenefitCost
[52] Washington State Institute for Public Policy. (n.d.). *Benefit-cost analysis*. https://www.wsipp.wa.gov/BenefitCost

Service	Average Cost per Client for Services	Benefits Minus Cost per Participant (net present value)
Group and individual cognitive behavioral therapy (CBT) for children and adolescents with Anxiety	-$ 538	$ 13,902
CBT-based models for Child Trauma	$ 131	$ 31,384
EMDR for Child Trauma	$ 733	$ 9,946
Incredible Years Parent Training	-$1,648	$ 8,698
PCIT for families in the Child Welfare System	-$2,002	$ 32,936
Triple P – Positive Parenting Program: Level 4, individual	-$ 928	$ 6,783
Cognitive behavioral therapy-based models for child trauma (TF-CBT)	$ 131	$ 31,384
Intensive Outpatient EBPs		
By EBP	-$9,849 to $424	
Acceptance and Commitment Therapy (ACT) for Children with anxiety	$ 424	$ 5,457
Child-Parent Psychotherapy	-$5,312	$ 77,733
Dialectical Behavior Therapy for youth in state institutions	-$1,761	$ 55,469
Functional Family Therapy for youth post release	-$9,196	$162,824
Multisystemic Therapy (MST) for court-involved/post-release youth ($20.90 per 15 m)	-$9,849	$ 19,768

***** *Amounts listed as negative indicate a cost, while positive amounts suggest that the cost is lower than the standard treatment.*

** WSIPP benefit-costs methods were updated December 2024.*

Barriers to EBPs

While there are a large number of mental health EBPs[53] provided to children in the State of Washington through DCYF and Medicaid, there are several challenges to funding EBPs in a financially sustainable manner. EBP programs need consistent and reliable reimbursement for sustainability, as these services often require intensive utilization and must be provided by qualified practitioners. The intensity of these services is often a key to a program's success since the risks are high that, without significant care management support in the community,

[53] Evidence-based practices are treatment approaches relying on the best available scientific evidence to guide treatment decisions. It involves using interventions and modalities that have been proven effective through rigorous research, clinical trials, and meta-analyses. EBPs integrate research, clinical expertise, and patient values to optimize treatment outcomes. EBPs are chosen based on evidence it is likely to help with the specific problems the person is reporting – not every EBP has been shown to be helpful with every problem.

some of these patients will not continue ongoing treatment and could relapse and need higher levels of more costly and less effective interventions such as hospitalization.

Most EBPs are intensive interventions that require higher staff-to-patient caseload ratios and incur costs associated with coordination, oversight of the team, training, supervision, and certification. EBPs also often have non-billable, indirect, and overhead costs that cannot be directly billed under some traditional reimbursement models, including costs for non-face-to-face professional services, collateral contacts, travel associated with community-based services, daily team meetings, outreach, telephone calls, and documentation.

Since these costs are often not compensated for by commercial and Medicaid insurance, which traditionally base behavioral health fee schedules on office-based licensed practitioners providing therapy, many providers do not undertake the investment to train staff in the EBPs. Even when there is training and delivery, there is often not an easy way for providers to report the delivery of EBPs because providers are not paid for reporting the EBPs, and/or the administrative claims data has not been set up to accept data associated with the costs of the care. This results in the underreporting of EBPs in Medicaid claims, even when they are provided.

In 2016, the University of Washington, Division of Public Behavioral Health and Justice Policy in collaboration with the School of Public Health Department of Global Health, conducted a study on *Preliminary Estimate of Costs Associated with Implementing Research and Evidence-based Practices for Children and Youth in Washington State*.[54] The study relied upon WSIPP cost-benefit analysis data and projected the cost of implementing children's EBPs in Washington State. The study's methodology looked at the actual costs of 28 providers implementing 11 distinct EBPs using state fiscal year 2014 costs. The study discussed the potential of paying for implementation of EBPs implementation stages and start-up costs versus recurrent costs.

There are specialized rates for four EBPs in Washington Medicaid — such as those for Washington State's Wraparound with Intensive Services (WISe), Assertive Community Treatment, multisystemic therapy (MST), and Coordinated Specialty Care for First Episode Psychosis under the New Journeys program — which allow for the implementation and provision of the services to be more widespread and reach a larger proportion of the target population needing the services. It should be noted that WISe is based on a full fidelity wraparound program but includes some difference which precludes it from being considered an EBP. However, for the purpose of this report, Mercer has included it with other EBPs due to its similar nature and use of EBP modalities within the model itself.

Medicaid has set a separate fee-schedule rate for MST (for H2033); however, that fee is very low compared to other State's MST rates. For example, MST in Washington has a rate of just $20.90 per 15 minutes on the January 1, 2025 fee schedule. However, Louisiana[55], Nebraska[56], and New Mexico[57] all have MST rates for 15 minutes that are from 44.6% to 282% higher than Washington State.

[54] Preliminary Estimate of Costs Associated With Implementing Research and Evidence-Based Practices for Children and Youth in Washington State. (2020). *Child Welfare Information Gateway*. https://cwlibrary.childwelfare.gov/discovery/fulldisplay/alma991001377422607651/01CWIG_INST:01CWIG

[55] Louisiana Medicaid. (n.d.). *Specialized Behavioral Health Fee Schedule*. https://www.lamedicaid.com/provweb1/fee_schedules/SBH_Fee.htm

[56] Nebraska Department of Health and Human Services. (n.d.). *Medicaid Provider Rates and Fee Schedules*. https://dhhs.ne.gov/Pages/Medicaid-Provider-Rates-and-Fee-Schedules.aspx

[57] New Mexico Human Services Department, Medical Assistance Division. (n.d.). *Fee-for-Service.* https://www.hca.nm.gov/providers/fee-for-service/

Table 12: Rate Comparisons by State for BH Practitioners[55,56,57]

State	Rate for Blended Qualifications (15 minutes)	Rate for Practitioners with Master's Degrees	Rate for Practitioners with Bachelor's Degrees
Washington	$20.90	-	-
Louisiana	-	$36.01	$30.23
Nebraska	$50.89	-	-
New Mexico	-	$66.10 (urban) $79.92 (rural)	$55.54 (urban) $65.80 (rural)

Without specialized rates to reimburse for the higher costs of children's EBPs, many providers will not engage in certain EBPs, reporting is not consistent, and utilization does not meet the need of the population. Many providers hesitate to invest in training staff in EBPs for children and youth because the associated costs are frequently not covered by commercial and Medicaid insurance. Even when there is training and delivery, there is often not an easy way to report the delivery of EBPs and track outcomes because providers are not paid for reporting the EBPs and/or the administrative claims data has not been set up to accept data associated with the costs of the care. This results in the underreporting of EBPs and undervaluation of EBPs even when they are provided in Medicaid.

Furthermore, the Washington State Medicaid State Plan is not written in such a way that EBPs are an entitlement for children. Other states utilize the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Medicaid benefit to reimburse for mental health treatment and specialized care to improve their mental well-being. Many states include basic children's EBPs in the State Plan, including MST, Functional Family Therapy, Trauma-Focused Cognitive Behavior Therapy (TF-CBT), Parent Child Interaction Therapy (PCIT), and Dialectical Behavior Therapy (DBT), just to name a few. Once a service is in the Medicaid State Plan, or even if it is not in the Medicaid State Plan, but it is medically necessary, children are entitled to reimbursement for the service if they are in the EBP target group under the EPSDT extended State Plan benefits at 1905(r)(5) under the Social Security Act.

Utilization of EBPs

The utilization and estimated number of children served for many of the common EBPs provided to Washington Medicaid children is low. As noted above, because providers are not paid to report the data, this likely underrepresents the true level of EBP delivery. While it is believed that more individuals have accessed these services, Mercer was only able to assess their availability based on geographic regions. To evaluate the geographic distribution of relevant EBPs, Mercer analyzed the eight most prevalent children's EBPs for statewide coverage:

- **Acceptance and Commitment Therapy (ACT)** for children with anxiety focuses on helping them accept difficult emotions and thoughts while committing to actions that align with their values, rather than trying to control or eliminate those feelings. There are 13 counties with providers reporting to provide ACT to Medicaid clients including: Chelan, Clallam, Clark, Cowlitz, Franklin, King, Lewis, Pierce, Snohomish, Spokane, Thurston, Whatcom, and Yakima.

- **Dialectical Behavior Therapy (DBT)** is a psychotherapy aimed at helping people with extreme and chronic emotion dysregulation — having emotions that are very strong, quick to start, and slow to end — learn to build new skills into their life while at the same time reducing the behaviors and patterns that cause them problems. There are only five counties with providers reporting to be trained and provide DBT: Clark, Cowlitz, King, Pierce, and Spokane.
- **Eye Movement Desensitization and Reprocessing (EMDR)** is a psychotherapy technique used to treat the distress associated with disturbing memories, particularly those related to trauma. There are nine counties with provider self-reporting that are trained and provide EMDR to Medicaid children's populations. Five counties report having a high EMDR provider density per 100,000 population: Chelan, Clallam, Clark, Lewis, and Spokane.
- **Multi-systemic Therapy (MST)** for youth with serious emotional disturbances is an intensive, family- and community-based intervention that addresses multiple systems impacting a youth's behavior, aiming to promote positive change within the youth's natural environment. While one of the most common EBPs in the nation, MST is only reported to be provided in two counties in Washington: King and Yakima. This EBP is relatively expensive to provide because of the high training costs in terms of price and lost productivity, and small caseloads.
- **Parent-child Interaction Therapy (PCIT)** is an evidence-based treatment for young children (ages 2 years–7 years old) with behavioral and emotional problems. It focuses on improving the relationship between the child and their parent or caregiver through coaching the caregiver on positive interactions and teaching the child new skills. PCIT is only reported to be provided in seven counties in Washington: Clallam, Cowlitz, King, Lewis, Pierce, Spokane, and Yakima. This EBP is also relatively expensive to provide because of the high equipment and/or space requirements, training costs in terms of cost and lost productivity, and small caseloads.
- **Trauma Focused Cognitive Behavior Therapy (TF-CBT)** is a specific type of cognitive behavioral therapy designed for children and adolescents (ages 3 years–18 years old) who have experienced trauma. It is an evidence-based treatment that addresses trauma-related symptoms like nightmares, difficulty sleeping, and intrusive thoughts, as well as other issues like depression, anxiety, and behavioral problems. TF-CBT is only reported to be provided in nine counties in Washington: Chelan, Cowlitz, Franklin, King, Lewis, Pacific, Pierce, Spokane, and Yakima. TF-CBT is one of the essential EBPs to treat childhood depression, anxiety, and behavioral problems.
- **The Triple P (Positive Parenting Program)** is a system of parenting support developed from a precursor behavioral family intervention. It aims to enhance parents' knowledge, skills, and confidence to prevent behavioral, emotional, and developmental problems in children and adolescents. Triple P is only reported to be provided in three counties in Washington: Chelan, Clark, and Spokane.

- **New Journeys Coordinated Specialty Care (CSC)** is an intensive, team-based, multi-intervention approach to treating youth and young adults who are experiencing the onset of psychosis. The CSC approach involves multiple services,[58] including individual and group psychotherapy; pharmacotherapy; family psychoeducation and support; case management; individualized assessments, training and supports integrated with treatment to achieve and maintain educational or vocational success; peer support, and primary care coordination.
  - To serve individuals with First Episode Psychosis, New Journeys has 15 teams statewide. Each team serves 30 individuals, or 450 individuals statewide at any given time. These teams were established beginning in 2019, when the Washington State Legislature passed Senate Bill 5903, requiring HCA to implement evidence-based services that provide early identification and intervention for individuals with psychosis. In response to both federal and State statutes, HCA now uses Mental Health Block Grant and Medicaid funding to implement evidence-based New Journeys early intervention services to meet statewide needs.[59]
- **Wraparound with Intensive Services (WISe)** is designed to provide comprehensive behavioral health services and supports to Medicaid-eligible youth, up to 21 years of age, with complex behavioral health needs and their families. While technically, a research-based process instead of an EBP, WISe brings together a team, including professionals and people to help support the youth and family goals. WISe is also available to children and youth with autism and or intellectual/developmental disabilities, if they meet mental health screening criteria and demonstrate medical necessity for WISe. WISe helps coordinate services and supports families during times of high need and then, over time, replaces formal intensive supports with natural supports. WISe helps families access and develop a network of formal and natural supports so that the youth and family can successfully continue to navigate the resources and services available to them, as needed. WISe intensive therapeutic services can include family therapy, peer services, teaching families to manage symptoms, and a variety of other interventions.[60] The current average length of services for WISe is approximately nine months, and discharge to a different level of care is based on child and family needs rather than time. All eligible referrals receive a Child and Adolescent Needs and Strengths tool screening.[61] The following figure identifies the number of youth served and screened by WISe in Washington State.

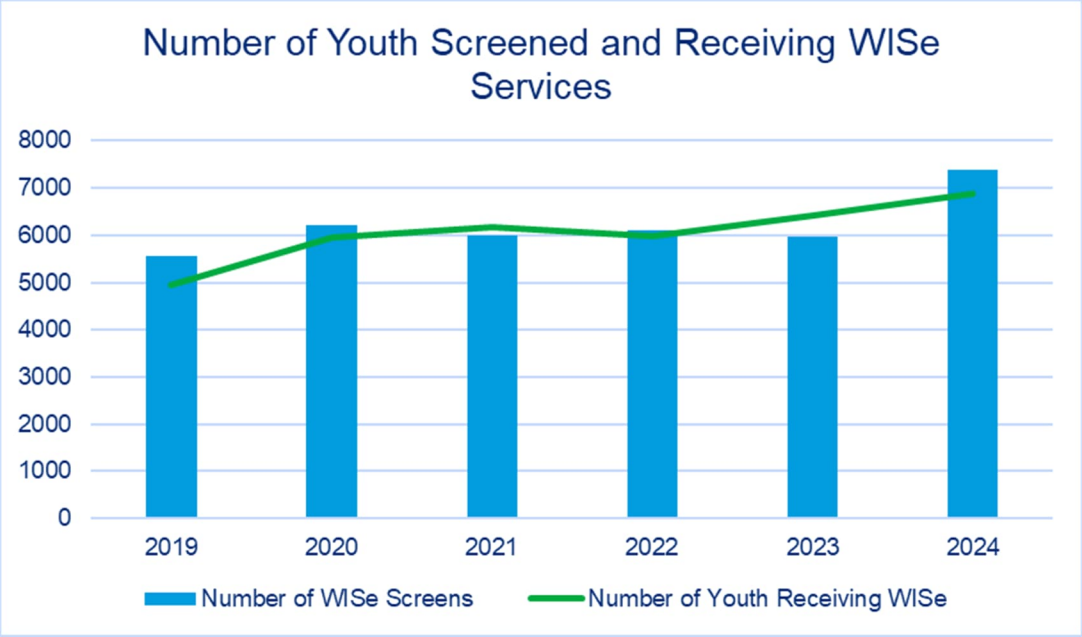
[58] Dixon, L. (2017, July 20). *Early psychosis treatment: How did we get here & where are we going?* Presentation at the Summer Institute Luncheon, Arizona State University Center for Applied Behavioral Health Policy. https://ubmm.med.buffalo.edu/uploads/MMU3/6-14-2019%20Before%20During%20After%20Buffalo%20-%20Copy.pdf

[59] Washington State Department of Social and Health Services. (2025, February). *First episode psychosis: Estimating annual incidence using administrative data in SFY 2023.* https://www.dshs.wa.gov/sites/default/files/rda/reports/research-3-62.pdf

[60] Washington State Healthcare Authority. (2023, November). *WISe Administrative Outcomes Measures*. https://www.hca.wa.gov/assets/program/wise-administrative-outcome-measures.pdf

[61] Washington State Healthcare Authority. (2025, April). *WISe and Youth with Intellectual or Developmental Disabilities including Autism Spectrum Disorder.* https://www.hca.wa.gov/assets/program/wise-info-idd-including-asd-20210930.pdf

Figure 8: Number of Youth Served and Screened by WISe



Source: WISe Dashboard: Wraparound with Intensive Services, 2025 Quarter 1 (Annual Update). DSHS Research and Data Analysis Division, April 2025. https://www.hca.wa.gov/assets/program/wise-dashboard-cy2025-q1.pdf

Section 7
Gaps in Services

In the last section, Mercer described the utilization of intensive, ambulatory, and evidence-based services as well as potential barriers for access to preventative services and necessary care. This included inequalities in service access with consideration to insurance coverage/affordability, cultural responsiveness, linguistic responsiveness, gender responsiveness, and developmentally appropriate service availability.

The following section focuses on the identification of the gaps and a quantification of the gaps in the behavioral health service continuum in Washington.

Current Gaps in Services Offered

Children Needing Behavioral Health Care are Not Receiving Treatment Consistently

Mental Health Need versus Treatment Received

In the Washington State Department of Social and Health Services Behavioral Health Dashboard from 2023,[62] Washington found that children not in foster care are less likely than children in foster care to receive behavioral health treatment. Figure 9 below shows that Medicaid children not in foster care with behavioral health treatment needs receive care only 36%–81% of the time. In contrast, Figure 10 shows that Medicaid children in foster care who have behavioral health treatment needs only receive care between 57%–94% of the time. This gap in care suggests that more outreach and capacity is needed in the system to address behavioral health treatment rate gaps for Medicaid children.

[62] Washington State Department of Social and Health Services. (2023, November). *Behavioral health treatment needs and outcomes among Medicaid enrolled children in Washington State*. https://www.dshs.wa.gov/sites/default/files/rda/reports/CHILDRENS_BH_DASHBOARD_2023NOV.pdf

Figure 9: Treatment Rate For Mental Health Therapy Needs — All Medicaid SFY 2021

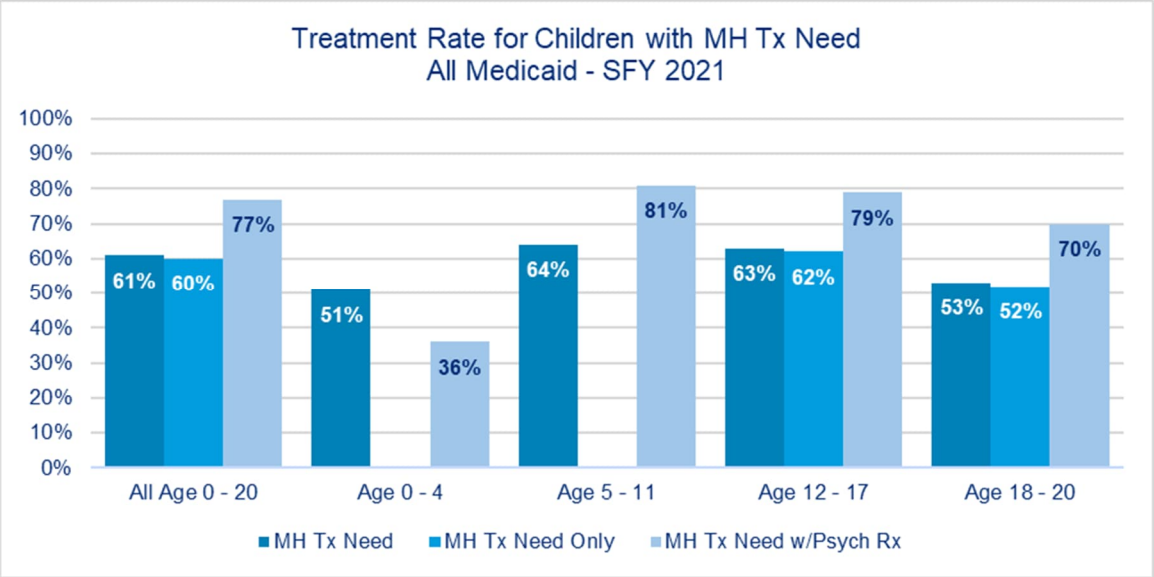
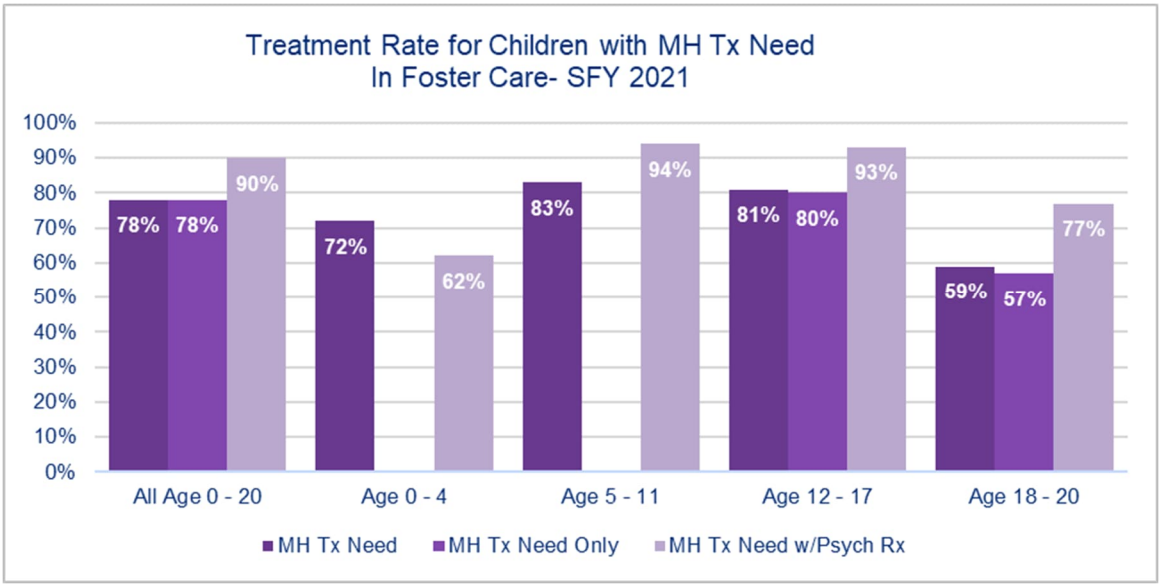


Figure 10: Treatment Rate For Mental Health Therapy Needs — In Foster Care SFY 2021



The gaps in need versus treatment found in the 2023 study are consistent with other similar studies. In a January 2025 report,[63] Washington found variations in individuals needing mental health (MH) treatment and those actually receiving MH treatment by region and by population of interest. On average statewide, 52% of individuals needing MH treatment were able to receive treatment in state fiscal year (SFY) 2022.

[63] Washington State Department of Social and Health Services. (2025, January). *Current state assessment, Report 2: Variations in behavioral health treatment rates SFY 2020–SFY 2022*. https://www.dshs.wa.gov/sites/default/files/rda/reports/research-9-130a.pdf

From SFY 2020 to SFY 2022, among pregnant and postpartum women, an additional 2,462 women needed MH treatment, but the same percentage of women (53%) received treatment at that time. For adolescents ages 13 years–18 years old, an additional 21,474 youth needed services during that time period, with the same percentage of youth (53%) receiving treatment in both SFY 2020 and SFY 2022. Finally, for transition age youth aged 16 years–25 years old, an additional 22,516 individuals needed services, but only 54% reported receiving those services. This represents a decrease in access of 1% for that population from SFY 2020 to SFY 2022.

There are access differences in MH treatment across regions. For example, the Salish and Spokane regions have approximately 54% of individuals with need receiving treatment in SFY 2022, about 2% above the statewide average. In contrast, in the North Central region, the treatment rate is only 48% of individuals with need, about 4% below the statewide average.

Table 13: Mental Health Treatment Rates Among Medicaid Eligibles

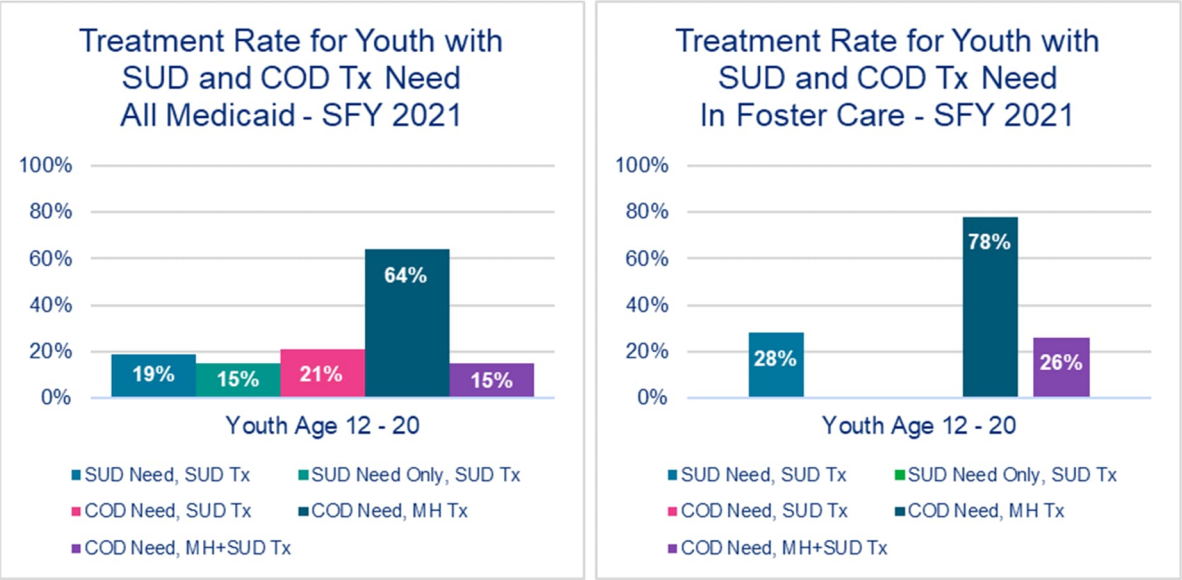
Group	SFY 2020		SFY 2021		SFY 2022	
	# Needing Treatment	% Received Treatment	# Needing Treatment	% Received Treatment	# Needing Treatment	% Received Treatment
Region						
Great Rivers	13,986	55%	14,197	51%	14,661	52%
Greater Columbia	24,261	53%	27,670	53%	29,883	53%
King	38,480	53%	46,608	54%	48,119	52%
North Central	8,830	49%	9,869	49%	10,527	48%
North Sound	30,201	53%	34,889	52%	36,229	51%
Pierce	23,499	50%	27,121	51%	28,465	50%
Salish	11,591	57%	12,550	54%	12,815	54%
Southwest	13,257	53%	15,345	52%	15,876	51%
Spokane	26,080	55%	29,774	56%	31,141	54%
Thurston-Mason	11,169	56%	12,082	53%	12,187	52%
Population of Interest						
Pregnant and Postpartum	11,490	53%	14,019	55%	13,952	53%
Adolescents (age 13–18)	45,627	62%	56,106	61%	67,101	62%
Transition Age Youth (age 16–25)	35,448	55%	49,646	56%	57,964	54%
Statewide	**201,362**	**53%**	**230,122**	**53%**	**239,920**	**52%**

Source: Washington State Department of Social and Health Services. (January 2025). Current State Assessment, Report 2: Variations in behavioral health treatment rates SFY 2020-SFY 2022. https://www.dshs.wa.gov/sites/default/files/rda/reports/research-9-130a.pdf

Substance Use Need versus Treatment Received

The Children's Behavioral Health Dashboard[64] also found that treatment gaps exist across substance use disorder (SUD) services for foster care and non-foster care Medicaid populations. In the figures below, we see that the treatment rate for youth needing SUD and co-occurring treatment ranges from approximately 25%–75% for foster care youth and 20%–60% for non-foster care youth.

Figure 11: Treatment Rate for Youth with SUD and Co-Occurring Disorder (COD) Therapeutic Need — All Medicaid versus Foster Care — SFY 2021



[64] Washington State Department of Social and Health Services. (2023, November). *Behavioral health treatment needs and outcomes among Medicaid enrolled children in Washington State*. https://www.dshs.wa.gov/sites/default/files/rda/reports/CHILDRENS_BH_DASHBOARD_2023NOV.pdf

Figure 12: Treatment Rate for Youth with SUD and COD Therapeutic Need — All Medicaid

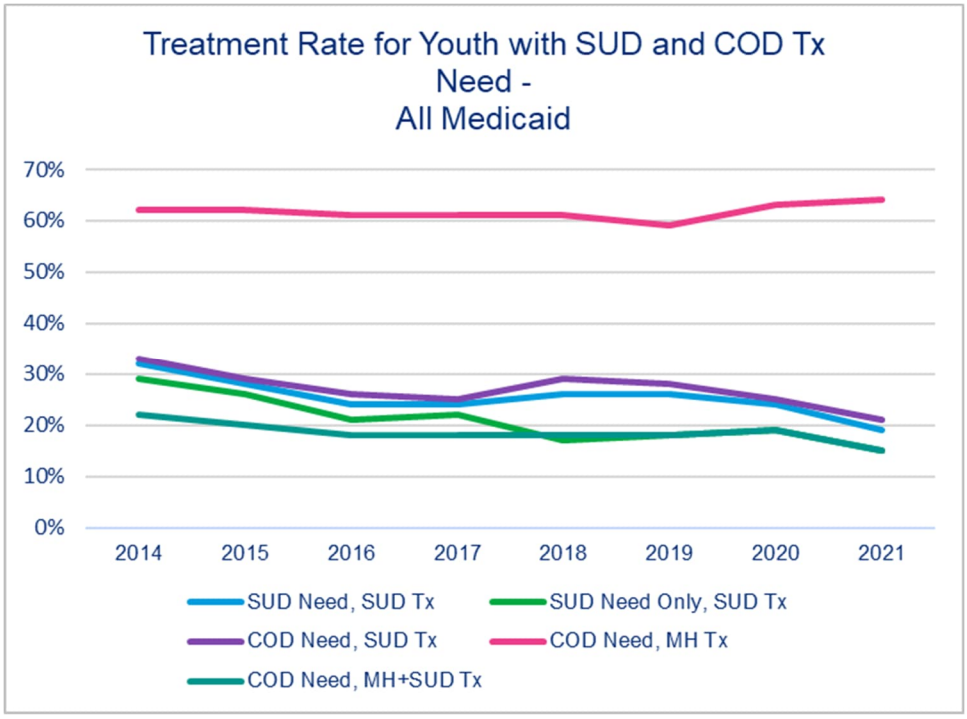
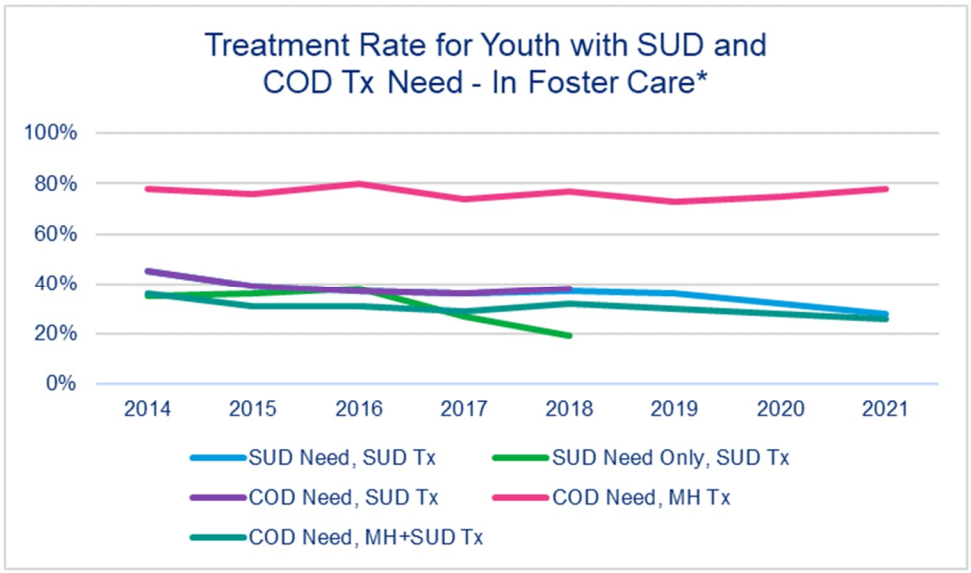


Figure 13: Treatment Rate for Youth with SUD and COD Therapeutic Need — Foster Care



** Some data were suppressed after 2018 due to small population numbers.*

The gaps in need versus treatment found in the 2023 study for SUD treatment are also consistent with other studies finding gaps between need and treatment received. In a January 2025 report, Washington found that variations in individuals needing SUD treatment and receiving SUD treatment by region and by population of interest varied. The statewide average was that 37% of individuals needing SUD treatment were able to receive treatment in SFY 2022.

From SFY 2020 to SFY 2022, among pregnant and postpartum women, 334 fewer women reported needing SUD treatment by SFY 2022, and only 34% received treatment at that time. For adolescents ages 13 years–18 years old, there were 438 more children reported to need SUD services during that time period, but only 23% of those children received the needed services. Finally, for transition age youth ages 16 years–25 years old, 2,611 more SUD services needed, but only 30% reported receiving those services, down from 32% in SFY 2020.

There are access differences in SUD treatment across regions. For example, in the Great Rivers and North Sound regions, approximately 42% of individuals who needed SUD treatment received it in SFY 2022, about 5% above the statewide average. In contrast, in the North Central region, only about 30% of individuals needing SUD treatment received it, about 7% below the statewide average.

Table 14: Substance Use Disorder Treatment rates among Medicaid Eligibles[65]

	SFY 2020		SFY 2021		SFY 2022	
	# Needing Treatment	% Received Treatment	# Needing Treatment	% Received Treatment	# Needing Treatment	% Received Treatment
Region						
Great Rivers	4,535	43%	4,779	42%	4,841	42%
Greater Columbia	5,823	34%	6,267	34%	6,549	35%
King	10,801	39%	11,816	38%	11,432	36%
North Central	1,944	31%	2,123	30%	2,197	30%
North Sound	10,179	45%	11,089	44%	10,930	42%
Pierce	6,836	37%	7,097	35%	7,133	35%
Salish	3,187	40%	3,661	41%	3,652	40%
Southwest	3,317	38%	3,487	36%	3,542	36%
Spokane	7,078	40%	7,626	39%	3,597	37%
Thurston-Mason	3,053	41%	3,257	38%	3,256	38%
Population of Interest						
Pregnant and Postpartum	3,821	38%	3,948	38%	3,487	34%
Adolescents (age 13-18)	2,644	26%	2,223	19%	3,082	23%
Transition Age Youth (age 16-25)	6,491	32%	8,068	30%	9,102	30%
Statewide	**56,754**	**39%**	**61,203**	**38%**	**61,129**	**37%**

[65] Washington State Department of Social and Health Services. (2025, January). *Current State Assessment, Report 2: Variations in behavioral health treatment rates SFY 2020–SFY 2022*. https://www.dshs.wa.gov/sites/default/files/rda/reports/research-9-130a.pdf

Pregnant Women Needing SUD Treatment

In Table 15 below, during each month in 2023, there were approximately 254 Medicaid pregnant women with SUD diagnoses, of whom about 40% received SUD treatment at any given time. Continuing care is widely believed to be important to ensure effective SUD treatment with studies finding that if care is not continued for at least 12 months there is a higher rate of relapse.[66] In 2022, about 50% of all pregnant women in Medicaid with an SUD diagnosis did not receive treatment. In 2024, about 54% of all pregnant women in Medicaid with an SUD diagnosis did not receive treatment. Additional case management and outreach to pregnant women may be necessary for this population.

Table 15: Medicaid Substance Use Disorder and Treatment Services for Pregnant Women — 2022 to 2023[67]

	Count of Pregnant Beneficiaries with SUD Diagnosis			SUD Services Utilization — Any SUD Treatment			Gap Between Diagnosis and Service Utilization	
Month of Service	2022	2023	%	2022	2023	%	Gap 2022	Gap 2023
January	121	230	90%	65	111	71%	46%	52%
February	119	252	112%	66	123	86%	45%	51%
March	106	269	154%	63	136	116%	41%	49%
April	230	267	16%	114	135	18%	50%	49%
May	240	273	14%	128	125	-2%	47%	54%
June	231	265	15%	114	116	2%	51%	56%
July	237	265	12%	107	106	-1%	55%	60%
August	223	260	17%	96	110	15%	57%	58%
September	230	252	10%	107	111	4%	53%	56%
October	221	241	9%	106	103	-3%	52%	57%
November	213	247	16%	102	120	18%	52%	51%
December	214	238	11%	98	113	15%	54%	53%

Estimated Number of Medicaid Eligible Individuals without Treatment Services

Mental Health

Studies show that between 38% and 52% of Medicaid eligible individuals need mental health services and are not receiving those services. Although not everyone with a mental health need will seek treatment, if the experience of uninsured and commercially insured individuals is similar

[66] McKay, J. R. (2021, January 21). Impact of continuing care on recovery from substance use disorder. *Alcohol Research Current Reviews*, 41(1), 01. https://doi.org/10.35946/arcr.v41.1.01

[67] Medicaid.Gov, Washington Medicaid Transformation Project. (2023). *Section 1115 demonstrations, state waivers list: SUD Part A metrics (October 1, 2023, through December 31, 2023) including 2023 and 2021/2022 retrospective metrics*. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83531

to Medicaid, there would appear to be a large amount of unmet need for mental health treatment in Washington.

Table 16: Percent of Population Unserved When Needing Behavioral Health Treatment[68, 69, 70, 71]

Population	Count Needing MH Treatment	Need But Did Not Receive Treatment	Percent Unserved
Age 0–4	14,804	7,254	49%
Age 5–11	70,716	25,458	46%
Age 13–18	67,101	25,498	38%
Age 18–25	57,964	26,663	46%
Pregnant Women	13,952	6,418	47%
Other Adults	239,920	115,162	48%

SUD

While not everyone needing care will seek treatment, there is a higher percentage of the population needing, but not receiving SUD treatment in Washington.

Table 17: Percent of Population Unserved When Needing SUD Treatment[72, 73, 74, 75]

Population	Count Needing SUD Treatment	Need But Did Not Receive Treatment	Percent Unserved
Age 13–18	3,082	2,373	77%
Age 18–25	9,102	6,371	70%
Pregnant Women	3,487	2,301	66%
Other Adults	61,129	38,511	63%

[68] SAMHSA, Center for Behavioral Health Statistics and Quality. (2022, 2023). *National surveys on drug use and health.*

[69] Washington State Department of Social and Health Services. (2023, November). *Behavioral health treatment needs and outcomes among Medicaid enrolled children in Washington State*. https://www.dshs.wa.gov/sites/default/files/rda/reports/CHILDRENS_BH_DASHBOARD_2023NOV.pdf

[70] Washington State Department of Social and Health Services. (2025, January). *Current State Assessment, Report 2: Variations in behavioral health treatment rates SFY 2020–SFY 2022*. https://www.dshs.wa.gov/sites/default/files/rda/reports/research-9-130a.pdf

[71] Kaiser Family Foundation. (2023). *Health Insurance Coverage of Adults Ages 19-64.* https://www.kff.org/other/state-indicator/adults-19-64/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[72] SAMHSA, Center for Behavioral Health Statistics and Quality (2022, 2023). *National Surveys on Drug Use and Health.*

[73] Washington State Department of Social and Health Services. (2023, November). *Behavioral health treatment needs and outcomes among Medicaid enrolled children in Washington State*. https://www.dshs.wa.gov/sites/default/files/rda/reports/CHILDRENS_BH_DASHBOARD_2023NOV.pdf

[74] Washington State Department of Social and Health Services. (2025, January). *Current State Assessment, Report 2: Variations in behavioral health treatment rates SFY 2020–SFY 2022*. https://www.dshs.wa.gov/sites/default/files/rda/reports/research-9-130a.pdf

[75] Kaiser Family Foundation. (2023). *Health Insurance Coverage of Adults Ages 19-64* https://www.kff.org/other/state-indicator/adults-19-64/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Commercial Out-of-Network Utilization and Commercial Gaps in Care

In general, a study by RTI, Inc. found that the disparity in out-of-network behavioral health care compared to medical surgical care for commercially insured individuals in Washington remained higher than the national average from 2019 to 2021. Out-of-network care is associated with higher out-of-pocket costs. As noted by RTI, Inc. "High out-of-network use is a consequence of health plans contracting with too few providers. Many studies completed as recently as 2023 demonstrate that behavioral health provider networks include too few providers. Studies also confirm that smaller provider networks relative to the need for services result in higher out-of-network use, higher patient out-of-pocket costs, and reduced access".[76]

In the Table 18 below, Washington commercial members experienced higher out-of-network utilization for behavioral health compared to medical/surgical care. For example, in 2021, members were 16.7 times more likely to access inpatient behavioral health out-of-network than to access medical/surgical inpatient care out-of-network. Similarly, for non-emergency room outpatient facilities, Washington members were 12.1 times more likely to access outpatient behavioral health services out-of-network than they were to access outpatient medical surgical services. For office visits, Washington commercial members were 7.1 times more likely to access behavioral health services out-of-network than they were to access medical surgical office visits out-of-network.

Table 18: Washington Out-of-Network Behavioral Health versus Medical Surgical Utilization for Commercial Insurers, 2021

Behavioral Health OON Compared to Medical/Surgical OON	Acute Inpatient Facility	Outpatient Facility (Non-Emergency Room)	Office Visits – All Behavioral Health Clinicians Versus All Medical/Surgical Clinicians
Washington	16.7×	12.1×	7.1×
All States	6.2×	1.5×	3.5×
Parity Would Be	1.0×	1.0×	1.0×

The study also found that the disparity for average in-network reimbursement levels relative to Medicare reimbursement for office visits remained higher than the national levels from 2019 to 2021 for behavioral health clinicians compared to Medical Surgical clinicians. See Table 19 below.

[76] Mark, Tami L., and William Parish.(2024, April 17). *Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue.* Page 8. https://dpjh8al9zd3a4.cloudfront.net/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf

Table 19: Washington Average In-Network Reimbursement Levels for Behavioral Health versus Medical Surgical Relative to Medicare Reimbursement for Office Visits for Commercial Insurers[77]

All Medical/Surgical Clinicians Versus All Behavioral Health Clinicians	Percent		
	2019	2020	2021
Washington All Medical/Surgical Clinicians	147.5%	146.2%	152.4%
Washington All Behavioral Health Clinicians	96.2%	101.4%	107.9%

Office visit in-network reimbursement levels were much lower for behavioral health providers than for medical/surgical providers creating disincentives for behavioral health providers to participate in-network. For example, psychiatrists and psychologists had lower reimbursements than physician assistants. Health plans' key levers for establishing the size of their provider networks are the in-network reimbursement rates that they offer to providers. Providers who are offered low reimbursement from health plans are less likely to participate in networks, resulting in smaller provider networks, more out-of-network use, and less access to treatment.[78]

Geographic Areas without Access to Services

As we saw in the demographic information above, the State of Washington is a large, diverse State with 39 counties. Because of that diversity and geography, it is important to understand where services are provided throughout the State. This section will begin with mapping the number of beds in the most intensive services accessed by children, youth, and transition age youth. Next, Mercer will highlight the geographic availability of ambulatory services that are often utilized by children, youth, and transition age youth. Finally, Medicaid provider data will be mapped to show the geographic accessibility of the most effective evidence-based practices (EBP) services for Washington child, youth, and transition age youth populations groups.

Accessibility of Intensive Services

Every state must have some deep end, intensive residential, and hospital beds available to serve children, youth, and transition age youth who require stabilization. While medical necessity for these beds are complex, deep end services should be reserved for individuals who may be a threat to themselves or others or those who need medical oversite. Medicaid provides publicly funded Children's long-term inpatient beds in four facilities. Inpatient and residential specialty beds also include youth detoxification services beds, SUD residential beds, child long-term treatment beds, and inpatient evaluation and treatment child beds. Mercer obtained the Department of Health (DOH) licensure information for these four types of children and youth beds, which are not limited to a single payer type.

Medicaid Children's Long-term Inpatient Program

Children's Long-Term Inpatient Program (CLIP) is a publicly funded program supported by federal and state Medicaid dollars. Most children and youth in CLIP received Medicaid funding during their stay. If a child has private insurance that covers inpatient psychiatric care, those

[77] Mark, T. L., & Parish, W. (2024, April 17). *Behavioral health parity – pervasive disparities in access to in-network care continue.* C-185. https://dpjh8al9zd3a4.cloudfront.net/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf

[78] Mark, Tami L., and William Parish. (2024, April 17). *Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue.* Page 8. https://dpjh8al9zd3a4.cloudfront.net/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf

benefits help cover the cost. Each child receives individualized treatment based on EBPs. The goal is to build skills, improve functioning, and support a successful return to the community. Children and youth ages 5 years–17 years old can apply for voluntarily admission. Youth ages 13 years–17 years old may be involuntarily committed under a 180-day Involuntary Treatment Court Act court order.

Washington has four CLIP inpatient psychiatric facilities with a total of 109 Medicaid-funded beds. These structured programs provide assessment, treatment, and stabilization for children and youth with severe psychiatric disorders.

Map 2: CLIP Facility Locations

Pierce County is home to the Child Study and Treatment Center (CSTC) as well as the Pearl Youth Residence.

- The CSTC is situated in Lakewood, adjacent to Western State Hospital, and comprises four cottages. Camano Cottage accommodates children aged 6 years to 11 years old, Ketron Cottage serves those aged 12 years to 14 years old, Orcas Cottage is for youth aged 14 years to 18 years old, and San Juan Cottage caters to both forensic and CLIP youth aged 14 years to 18 years old.
- Pearl Youth Residence is a nurturing environment for youth, families, and staff. The program serves young people aged 12 to 17 years old from across Washington State and has the capacity to accommodate up to 27 residents. Treatment is delivered by a multidisciplinary team that includes a case manager, therapist, psychiatrist, recreation therapist, youth peer, nursing staff, and milieu staff. On average, residents stay for approximately six months.

Spokane is home to the Tamarack Center.

- The Tamarack Center offers 16 beds, funded through both CLIP and private insurance companies.

Yakima is home to Two Rivers Landing.

- Two Rivers Landing, operated by Comprehensive Healthcare, features a total of 16 beds, with four specifically designated for youth in CLIP.

Licensed Children's Residential and Inpatient Beds

As can be seen in Table 20 below, there are 311 specialized behavioral treatment and evaluation beds licensed in Washington in eight counties for the four types of pediatric facilities examined. Some of these beds (109 beds) are available through the publicly available CLIP program. It is important to note that other licensed bed types might be available to children and youth such as Recovery Houses, which provide a less intense level of care or which Mercer was unable to categorize youth versus adult beds. Also, Transition Age Youth population 18 years–25 years old will access adult licensed beds, which are separately licensed. Only two counties hold beds for Youth Detoxification and Child Long-Term Beds. Children's inpatient and residential diagnostic and behavioral health treatment is needed when a child's SUD or mental health condition poses a threat to their safety or the safety of others, or when they are unable to care for themselves. It is also considered for severe symptoms that have not responded to outpatient treatment, such as suicidal thoughts, self-harm, or severe behavioral issues such as aggression or violence. It is vital to view these services as short-term, with discharge planning beginning on day one of an individual's stay. Discharge planning should be focused on finding lower end services to engage the youth, which may include anything from Intensive Outpatient to more community-based services.

View these services as short-term, with discharge planning starting on day one. Focus on engaging youth with lower-end services, ranging from Intensive Outpatient to community-based options.

Table 20: Type of Child and Youth Specialized Behavioral Health Treatment and Evaluation Licensed Beds Available to all Payers

Type of Treatment and Evaluation Licensed Beds	Number of Beds Statewide	Number of Unique Counties with Beds
Youth Detoxification Services Beds	15	2
Mental Health SUD Residential Beds	87	4
Child Long-Term Treatment Beds	49	2
Inpatient Evaluation and Treatment Child Beds	160	7
Total Child/Youth Treatment Beds in these Four Categories	311	8

These beds are distributed across 21 distinct facilities in 11 cities, offering four types of intensive care options.

Table 21: Facilities Providing Youth Residential and Inpatient Beds

Agency Name	City	County	Youth Detoxification Services Beds	Youth Residential Beds	Child Long Term Treatment Beds	Inpatient Eval Treatment Child Beds
Comprehensive Healthcare — Detox and Outpatient	Yakima	Yakima	4	0		
Excelsior Integrated Care Center	Spokane	Spokane	4	0	0	8
Inland Northwest Behavioral Health	Spokane	Spokane			0	25
MultiCare Behavioral Health — Adolescent Behavioral Health	Puyallup	Pierce			0	27
Pathlight Mood and Anxiety	Seattle	King			0	18
Providence Sacred Heart Medical Center — E and T	Spokane	Spokane			0	24
Sea Mar Visions Female Youth Treatment Center	Seattle	King	0	7		
South Sound Behavioral Hospital	Lacey	Thurston	0	0	0	10
Sundown M Ranch	Selah	Yakima	5	5		
The Healing Lodge — Butterfly PelPalWichiya Girls CD	Spokane Valley	Spokane	0	15		
Comprehensive Healthcare — Two Rivers Landing	Yakima	Yakima			6	10
Excelsior Wellness	Spokane	Spokane	0	14		
Kitsap Mental Health Services — Adolescent Inpatient	Bremerton	Kitsap			0	10
Newport Academy	Irvine	Orange	0	4		
Pearl Youth Residence	Tacoma	Pierce			27	0
Sea Mar Behavioral Health — Seattle	Seattle	King	0	12		
Smokey Point Behavioral Hospital	Marysville	Snohomish	0	0	0	28

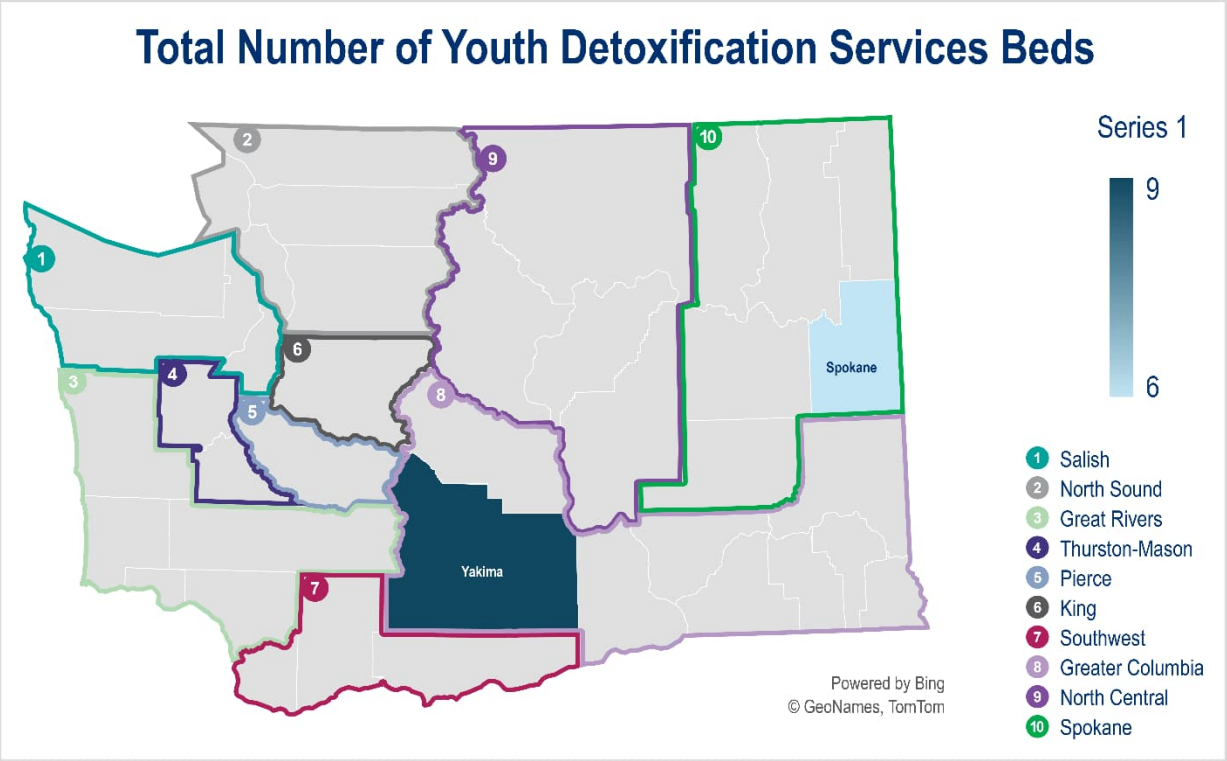
Agency Name	City	County	Youth Detoxification Services Beds	Youth Residential Beds	Child Long Term Treatment Beds	Inpatient Eval Treatment Child Beds
Spokane Treatment and Recovery Services: Outpatient and Community Diversion Division	Spokane	Spokane	2	0		
Tamarack Center	Spokane	Spokane			16	0
The Healing Lodge — Cedar Boys COD	Spokane Valley	Spokane	0	15		
The Healing Lodge — Sage Boys CD	Spokane Valley	Spokane	0	15		
Total			**15**	**87**	**49**	**160**

Note: While some agencies such as the Sundown M Ranch and Spokane Treatment and Recovery Services Outpatient and Community Diversion Division appear to serve adults at the same address as youth, it is not clear to Mercer that Washington licensure permits adult facilities to have youth beds in the same location. Many states require adult and youth licensed facilities to keep adult and child populations separate even if co-located.

Youth Detoxification Service Beds Licensed in Washington

If a child experiences SUD, detoxification services can help with withdrawal symptoms while the individual also receives support in developing healthy coping strategies. However, there are only 15 youth detoxification beds in Washington. The beds are concentrated in Yakima and Spokane counties. Children requiring these services are either treated at different levels of care in their communities or must travel to these locations away from their families. In the future, under the American Society for Addiction Medicine (ASAM) fourth edition (the current ASAM version), children's withdrawal management has been incorporated into treatment levels of care, which may expand the number of sites offering these services.

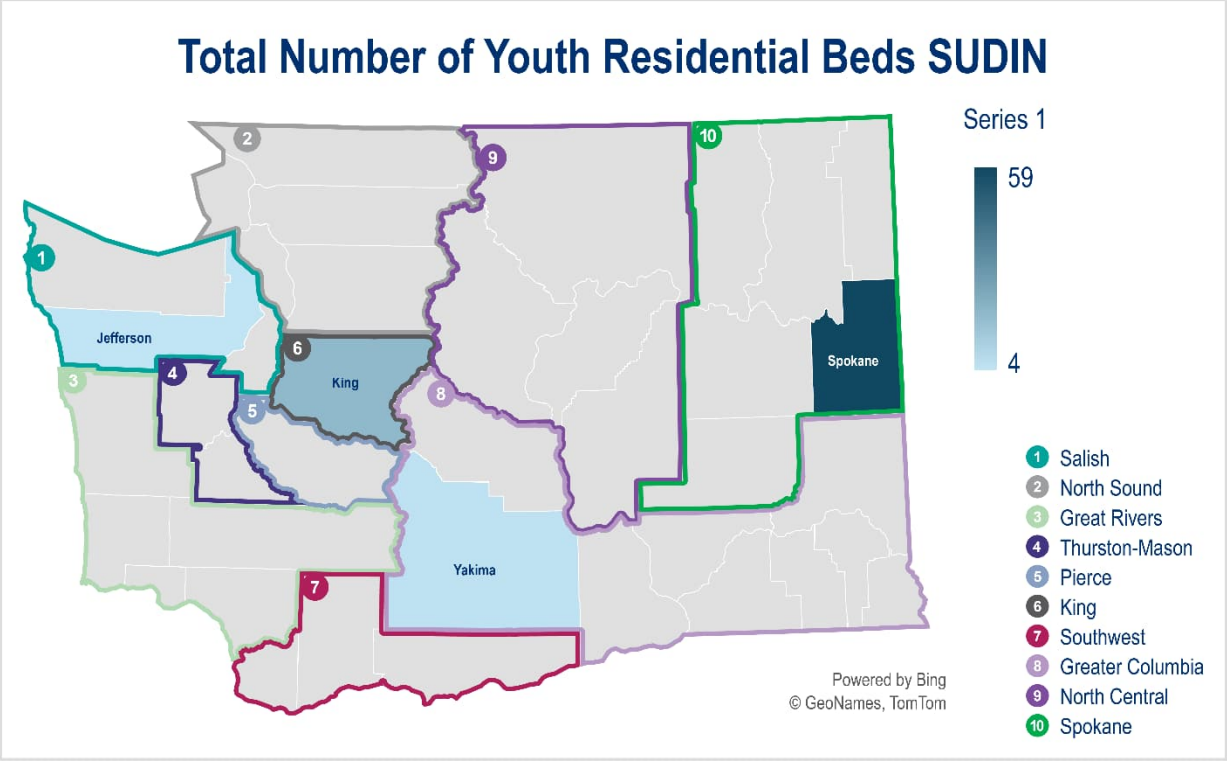
Map 3: Total Number of Youth Detoxification Service Beds Licensed in Washington



Source: Washington State Department of Health. 2024

Youth SUD Residential Treatment Beds Licensed in Washington There are only 87 youth SUD residential beds in Washington situated in four counties. Like detoxification services, children requiring these services are either treated at different levels of care in their communities or must travel to these locations away from their families for treatment. The geographic gaps are especially large in the North Central and Southeast areas of the State.

Map 4: Total Number of Youth SUD Residential Beds Licensed in Washington



Source: Washington State Department of Health. 2024

Child Long-Term Treatment Beds Licensed in Washington

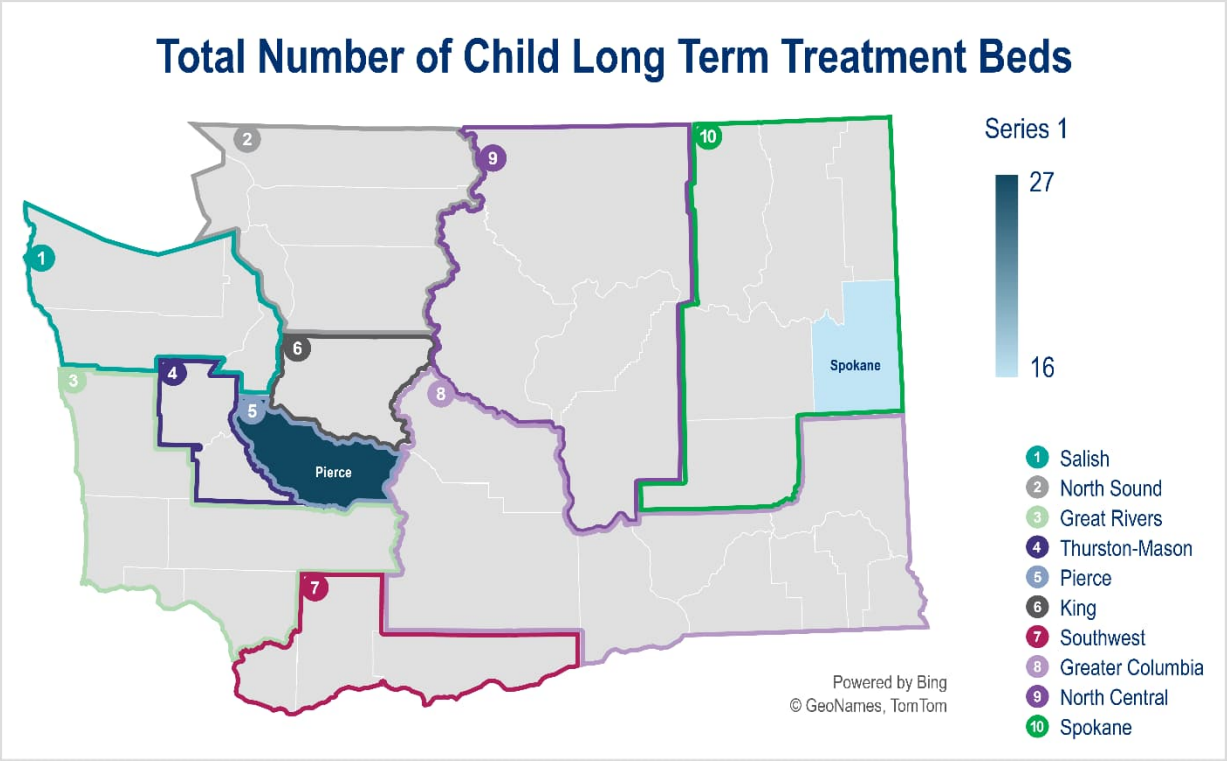
As discussed above, a child or youth may benefit for an inpatient or residential level of care if they need supervision and support to stabilize a crisis; help develop coping mechanisms and maintain urges in a controlled setting; develop anger management skills in a safe environment; introduce medication management and therapy; maintain a safe eating pattern; or provide supervision and support to regain activity of daily living skills. There are a variety of reasons an individual may be referred to for inpatient or residential care, including if they are:

- Actively suicidal;
- Regularly engaging in self-harming behaviors;
- Aggressive or violent towards themselves or others;
- Experiencing hallucinations or delusions; or
- If a child's depression or anxiety is severe, and:
  - The child does not respond to outpatient treatment;
  - The child is unable to maintain a safe eating pattern; or
  - They are unable to care for their basic needs, such as eating, sleeping, or hygiene where supervision and support can stabilize the crisis; help develop coping mechanisms and maintain urges in a controlled setting; develop anger management skills in a safe

environment; introduce medication management and therapy; maintain a safe eating pattern; or provide supervision and support to regain activity of daily living skills.

There are only 49 licensed Children's long-term treatment beds in two counties. The geographic gaps are especially large in the Central and Southern areas of the State. Notably, there are no long-term treatment beds in King County for children.

Map 5: Total Number of Child Long-Term Treatment Beds

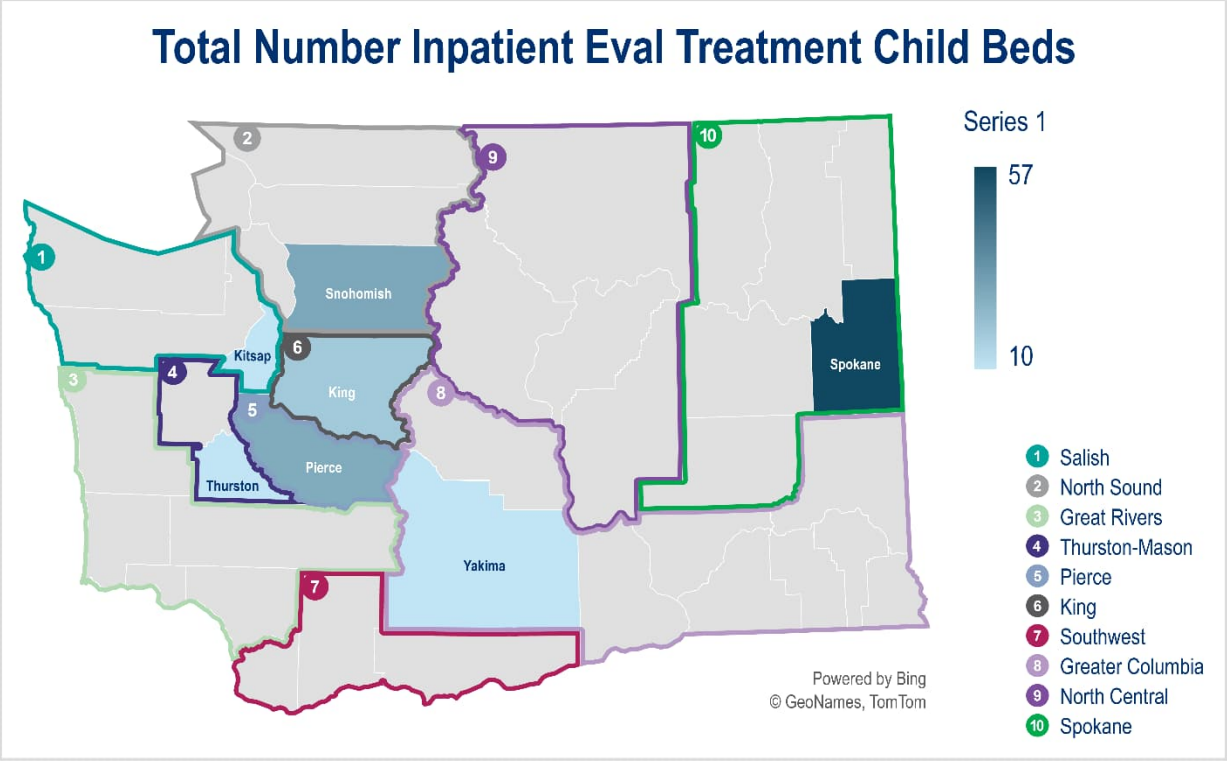


Source: Washington State Department of Health. 2024

Child Inpatient Evaluation Beds Licensed in Washington

There are only 160 inpatient evaluation beds in seven counties, which are utilized by mental health professionals to evaluate children, to obtain all pertinent information for determining a diagnosis, and to plan individualized services and supports. The geographic gaps are especially large in the Central, Northern, and Southeastern areas of the State.

Map 6: Total Number of Inpatient Evaluation Treatment Child Beds



Source: Washington State Department of Health. 2024

Accessibility of Ambulatory Behavioral Health Services

As noted in the System of Care in Section 2, children, youth, and transition age youth need access to ambulatory behavioral health services such as assessments, counseling and therapy, behavioral health outpatient interventions, medication management and evaluation, and treatment. In this section, Mercer reviewed the geographic availability of ambulatory services that are often utilized by children, youth, and transition age youth. Mercer obtained the DOH licensure data to look at the number of provider agencies and independently operating sole proprietors per 100,000 population in each county.

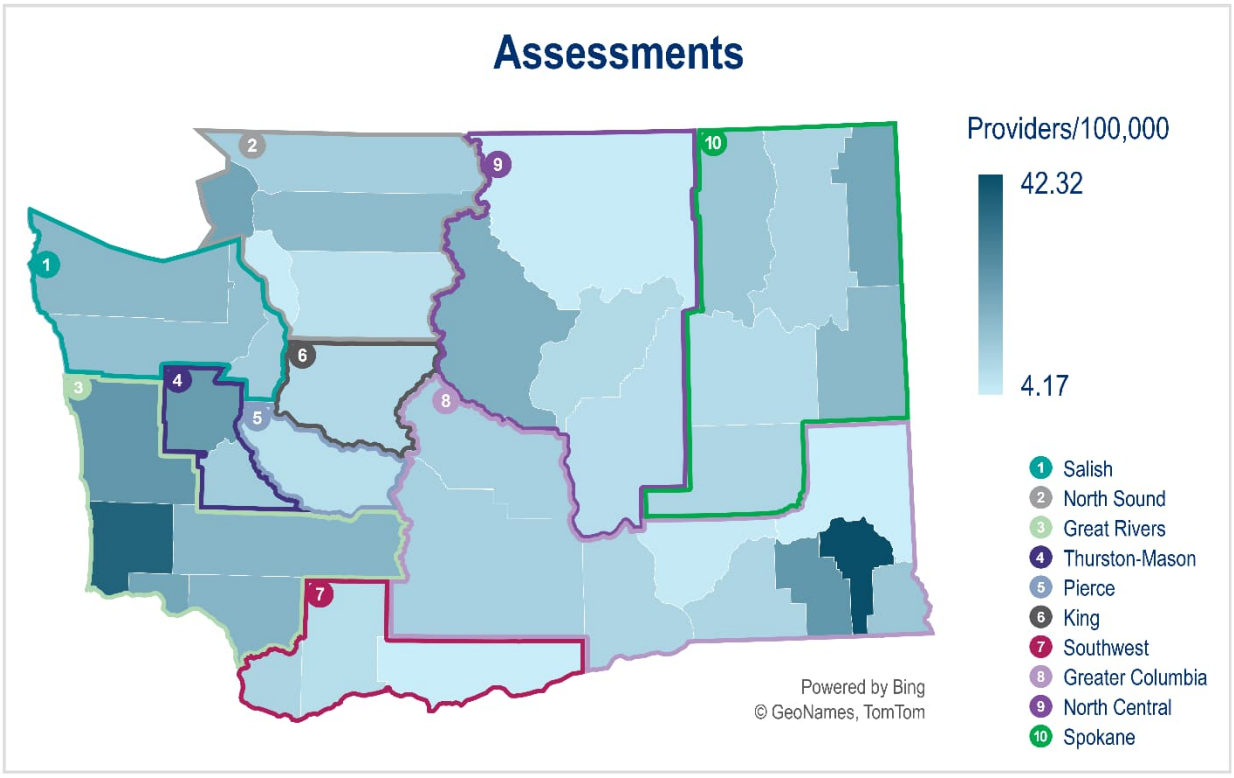
The first four services: assessments, counseling and therapy, behavioral health outpatient interventions, and psychiatric medication management have very similar provider densities, with the number of provider agencies per 100,000 population varying by just a few provider agencies in each county. While there are variations in provider agency capacity in ambulatory care, some access exists throughout the State. Applied Behavioral Analysis, however, has provider agencies in only 16 counties.

Please note that provider agencies and independently operating sole proprietors who are certified or licensed may not be actively providing services to children and youth. In addition, the number of practitioners at each provider agency was not collected. Mercer did not identify an ideal provider agency/practitioner density for this or other services in this section. Future analyses could focus on identifying the ideal provider/practitioner density and provider/practitioner recruitment strategies for low provider/practitioner density areas of the State.

Behavioral Health Assessments

Behavioral Assessments, which may also be called comprehensive or clinical assessment, involve diagnosing individuals of any age with potential mental disorders or other behavioral health conditions. Specifically, an assessment is a process where a mental health professional gathers information about a person's mental and emotional well-being to determine the presence of a mental health condition, including its severity and potential treatment needs. An assessment may include a number of diagnostic screens or tests delivered to the individual according to the clinical judgement and training of the mental health professional. The number of providers per 100,000 population licensed by DOH to perform assessments by county can be found on the map below. As noted, the density of providers per 100,000 varies from 4.17 to 42.32 providers per 100,000. There are pockets of low density in the central portion of the State and in King County, the most populous region of the State. Having access to assessments is an important part of the care continuum, as particular diagnoses may open doors to specific treatment options. A proper diagnosis can especially guide treatment teams to appropriate EBPs that are focused on treating specific disorders or MH symptoms.

Map 7: Number of Providers Licensed to Perform Assessments per 100,000 Population by County

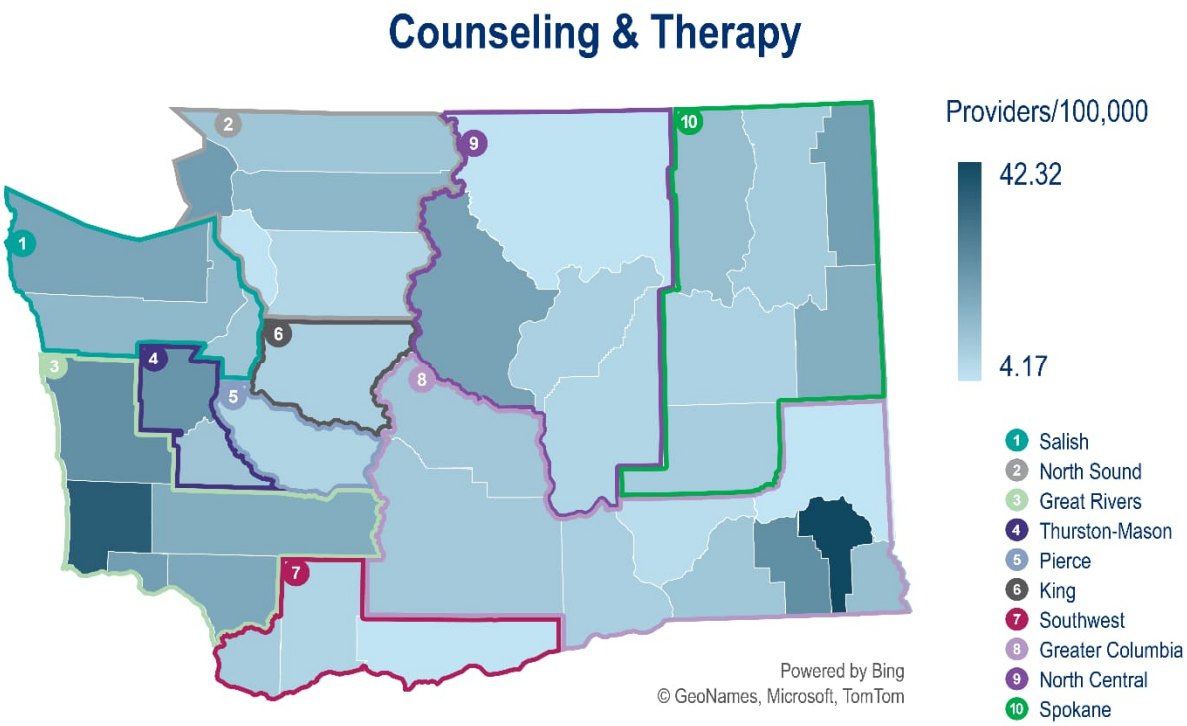


Source: Washington State Department of Health. 2024

Counseling and Therapy

Counseling and therapy are both forms of *talk therapy* that aim to help individuals address MH concerns. Counseling and therapy are the best-known services for MH concerns, and often the most sought out. The number of providers per 100,000 population licensed to perform counseling and therapy by county can be found on the map below. These densities are very similar— but not identical to— the density of assessments above. As noted, the density of providers per 100,000 varies from 4.17 to 42.32 providers per 100,000. There are pockets of low density in the Central portion of the State and in King County, the most populous region of the State.

Map 8: Number of Providers Licensed to Perform Assessments by per 100,000 Population by County

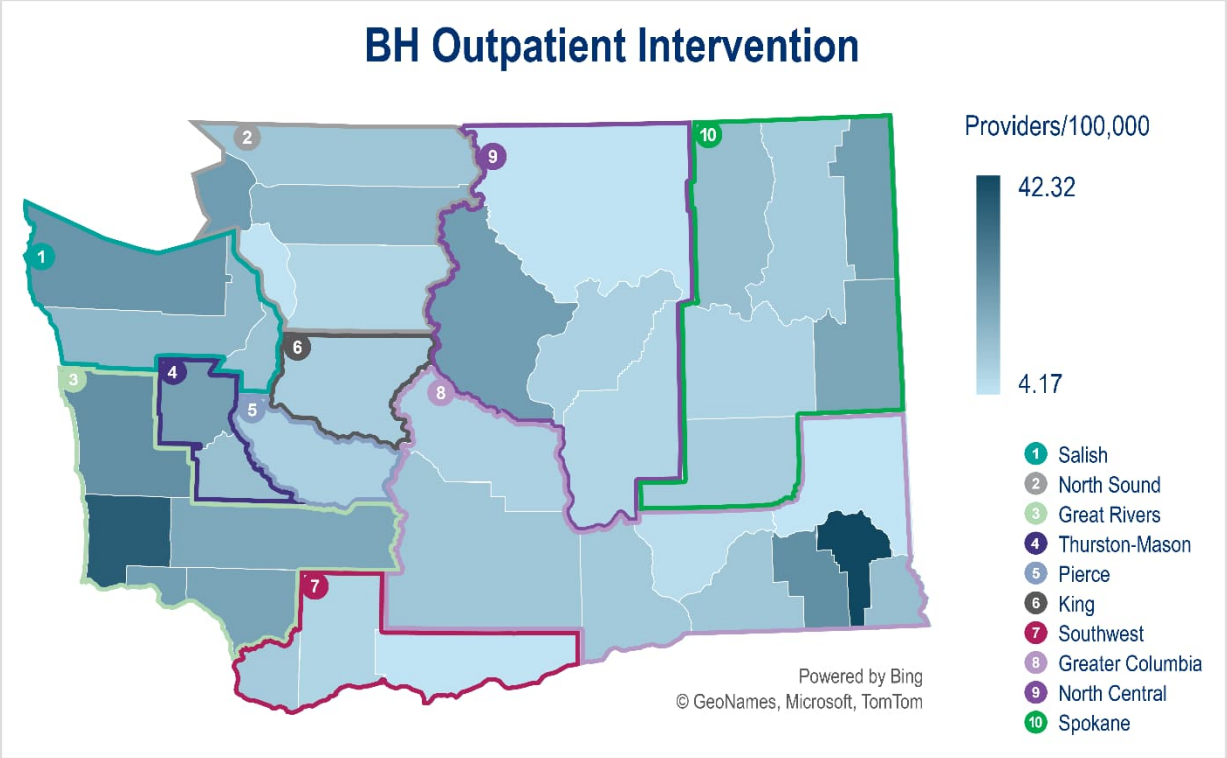


Source: Washington State Department of Health. 2024

Behavioral Health Outpatient Intervention

The behavioral health outpatient and intervention includes agencies that are certified for intervention for MH, substance use, or co-occurring disorders. Interventions available in these agencies may include assessments, counseling and therapy, psychiatric medication management, and outpatient involuntary court-ordered services.[79] The number of individual providers per 100,000 population licensed to perform behavioral health outpatient intervention by county can be found in Map 9. These densities are very similar— but not identical to— the density of assessments and counseling and therapy above. As noted, the density of providers per 100,000 varies from 4.17 to 42.32. There are pockets of low density in the Central portion of the State, including King County, the most populous region of the State. It should be further noted that even though a provider may be licensed, it does not mean they are currently providing behavioral health services to children.

Map 9: Number of Providers Licensed to Perform Behavioral Health Outpatient Intervention per 100,000 Population by County



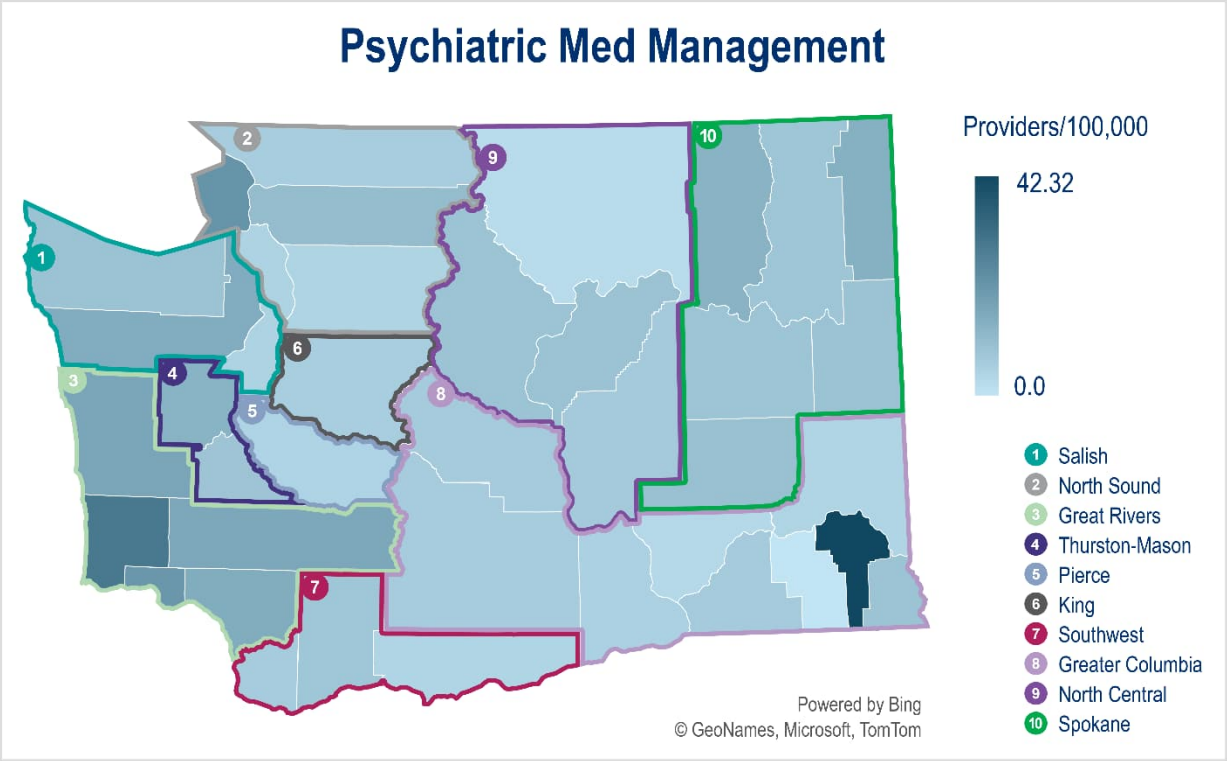
Source: Washington State Department of Health. 2024

[79] Washington Administrative Code. (n.d.). *WAC 246-341-0737: Behavioral health outpatient intervention, assessment and treatment services—Certification standards*. https://app.leg.wa.gov/WAC/default.aspx?cite=246-341-0737

Psychiatric Medication Management

The number of providers per 100,000 population licensed to perform psychiatric medication management by county can be found in the map below. These densities are very similar—but not identical to—the density of assessments and counseling and therapy above. As noted, the density of providers per 100,000 population varies from 0.00 to 42.32. There are pockets of low density in the Central portion of the State, including King County, the most populous region of the State. Columbia County does not have a provider licensed to provide this service.

Map 10: Number of Providers Licensed to Perform Psychiatric Medication Management per 100,000 Population by County

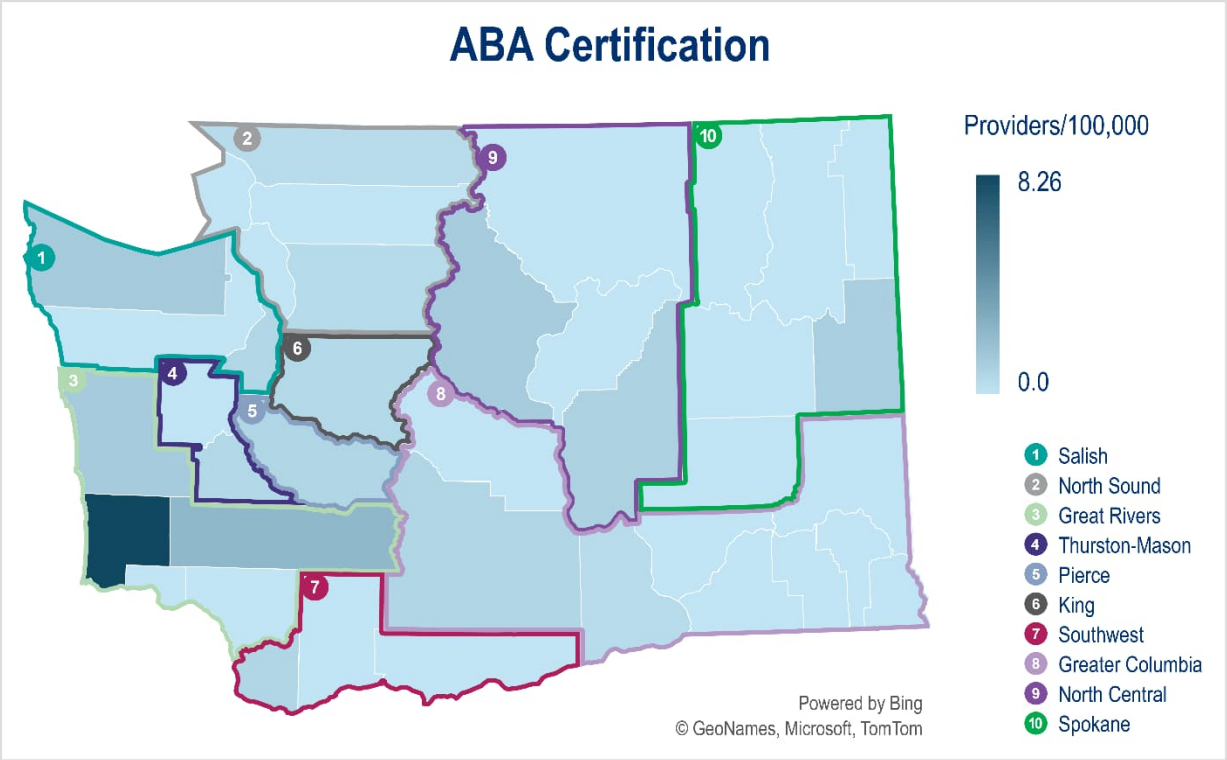


Source: Washington State Department of Health. 2024

Applied Behavior Analysis Certification

While often reserved for those on the Autism spectrum, Applied Behavior Analysis (ABA) can be beneficial for a wide variety of diagnoses, including developmental and behavioral. The number of providers per 100,000 population certified to provide ABA by county can be found on the map below. The density of providers varies from 0.00 to 8.26 providers per 100,000 population. There are only 16 counties with access to ABA-certified providers. There are pockets of no access in the Northeast and Southeast portions of the State.

Map 11: Number of Providers Certified in Applied Behavior Analysis per 100,000 Population by County



Source: Washington State Department of Health. 2024

Accessibility of the Most Effective EBPs for Children

To measure the adoption of EBPs in Medicaid, Mercer has obtained the number of providers self-reporting that they are trained and providing any utilization to Medicaid children as well as the utilization reported. In the table below, you can see the utilization and estimated number of children served for the eight most common EBPs provided to Washington Medicaid Children.[80]

As can be seen from the data, there are very few Medicaid children estimated to be served by some of the EBPs such as Multisystemic Therapy (MST), Parent Child Interaction Therapy (PCIT), Dialectal Behavior Therapy (DBT), and Triple P Precursor. For example, there are two providers reporting that they are trained and currently providing MST. If the MST teams were full

[80] Evidence Based Practice Institute, University of Washington. (2024). *Evidence-based mental health services for youth and children in Washington State: Performance report, Quarter 1-4.*

(i.e., 4–8 practitioners serving 8–10 children), we would expect to see multiple weekly encounters for 4–6 months for each child. However, the number of children who appear to be served by the two MST providers appears to be approximately four children among the two providers for the most recent quarters of the data that Mercer examined. Data for PCIT, Triple P Precursor, and DBT also appear to have smaller than expected Medicaid caseloads. While it is expected that each provider would have some commercially insured children, these numbers suggest that providers are underserving the Medicaid population or as noted above, because providers are not paid to report the data, the data may be underreported.

Table 22: Estimated Number of Children Receiving EBPs and Associated Cost to Provider[81]

Service	Number of Providers	Number of Encounters in 2024	Estimated Number of Children Served	Cost*
ACT for Children with Anxiety and Depression	41	9,618	1,603	$424 (Anxiety) -$735 (Depression)
Group and individual cognitive behavioral therapy (CBT) for children and adolescents with Anxiety and Depression	39	14,359	2,393	-$538 (Anxiety) -$539 (Depression)
DBT for Adolescents with Self-Harming Behavior	14	1,710	78	-$185
EMDR for Child Trauma	18	622	104	$733
MST for court-involved/post release youth	2	107	4	-$9,849
PCIT for families in the Child Welfare System	13	885	148	-$2,002
TF-CBT	28	3,112	159	$131
Triple P -Positive Parenting Program, Level 4, individual	3	152	25	-$928

***** *Amounts listed as negative indicate a cost, while positive amounts suggest that the cost is lower than the standard treatment.*

To further gain information on EBPs, Mercer recommends the review of service encounter reporting instructions, service manuals, carrier contracts, geo-access studies, and other public documents if necessary. As mentioned before, Mercer believes that EBP utilization in Washington is being under-reported. It is paramount that Washington has a better understanding of EBP availability and utilization to ensure the prenatal-through-25 population has access to these important services.

[81] Washington State Institute for Public Policy (WSIPP). (2024, December). *Cost Data*.

Acceptance and Commitment Therapy for Children with Anxiety and Depression

Acceptance and Commitment Therapy (ACT) for children with anxiety focuses on helping them accept difficult emotions and thoughts while committing to actions that align with their values, rather than trying to control or eliminate those feelings. It differs from traditional cognitive behavior therapy (CBT) in that ACT emphasizes acceptance and resilience, rather than solely targeting maladaptive thoughts.[82] ACT differs importantly from other talk therapies such as CBT because rather than focusing on changing maladaptive thoughts, ACT emphasizes acceptance of all psychological events, and therapists concentrate their attention on how a person's behavioral responses to these events work for them in terms of their self-identified values or goals. The focus on increasing acceptance within ACT has been shown to increase self-esteem and resilience.[83]

ACT has gained more and more empirical support in treating depression.[84,85] Studies have shown that ACT significantly improved participants' psychological flexibility and emotional regulation and ultimately reduced their depressive symptoms. ACT is an effective treatment for depression when assessed in individual, self-help, and group formats.[86,87] A recent meta-analysis showed that ACT significantly reduced depressive symptoms compared to controls.[88,89] Furthermore, ACT is often incorporated into behavior analysis, as it was originally developed as part of behavior analysis to further integrate CBT in working with varying populations.[90] This may cause even more under-reporting as it is naturally integrated into some ABA plans.

As shown in Map 12, there are 13 counties with providers reporting to provide ACT to Medicaid clients including: Chelan, Clallam, Clark, Cowlitz, Franklin, King, Lewis, Pierce, Snohomish, Spokane, Thurston, Whatcom, and Yakima.

[82] Flannery, Shelley. (2024, February 29). Acceptance and commitment therapy for teens. *Child Mind Institute*. https://childmind.org/article/acceptance-and-commitment-therapy-for-teens/

[83] Barbanel, Dorrie. (n.d.). What is acceptance and commitment therapy and how can it help kids? *Manhattan Psychology Group*. https://manhattanpsychologygroup.com/MPG-blog/what-is-acceptance-and-commitment-therapy-act-and-how-can-it-help-kids/

[84] Twohig, M. P., & Levin, M. E. (2017). Acceptance and commitment therapy as a treatment for anxiety and depression: A review. *Psychiatric Clinics of North America*, 40, 751–770. https://doi.org/10.1016/j.psc.2017.08.009

[85] A-Tjak, J. G., Morina, N., Topper, M., & Emmelkamp, P. M. (2018). A randomized controlled trial in routine clinical practice comparing acceptance and commitment therapy with cognitive behavioral therapy for the treatment of major depressive disorder. *Psychotherapy and Psychosomatics*, 87, 154–163. https://doi.org/10.1159/000486807

[86] A-Tjak, J. G., Morina, N., Topper, M., & Emmelkamp, P. M. (2018). A randomized controlled trial in routine clinical practice comparing acceptance and commitment therapy with cognitive behavioral therapy for the treatment of major depressive disorder. *Psychotherapy and Psychosomatics*, 87, 154–163. https://doi.org/10.1159/000486807

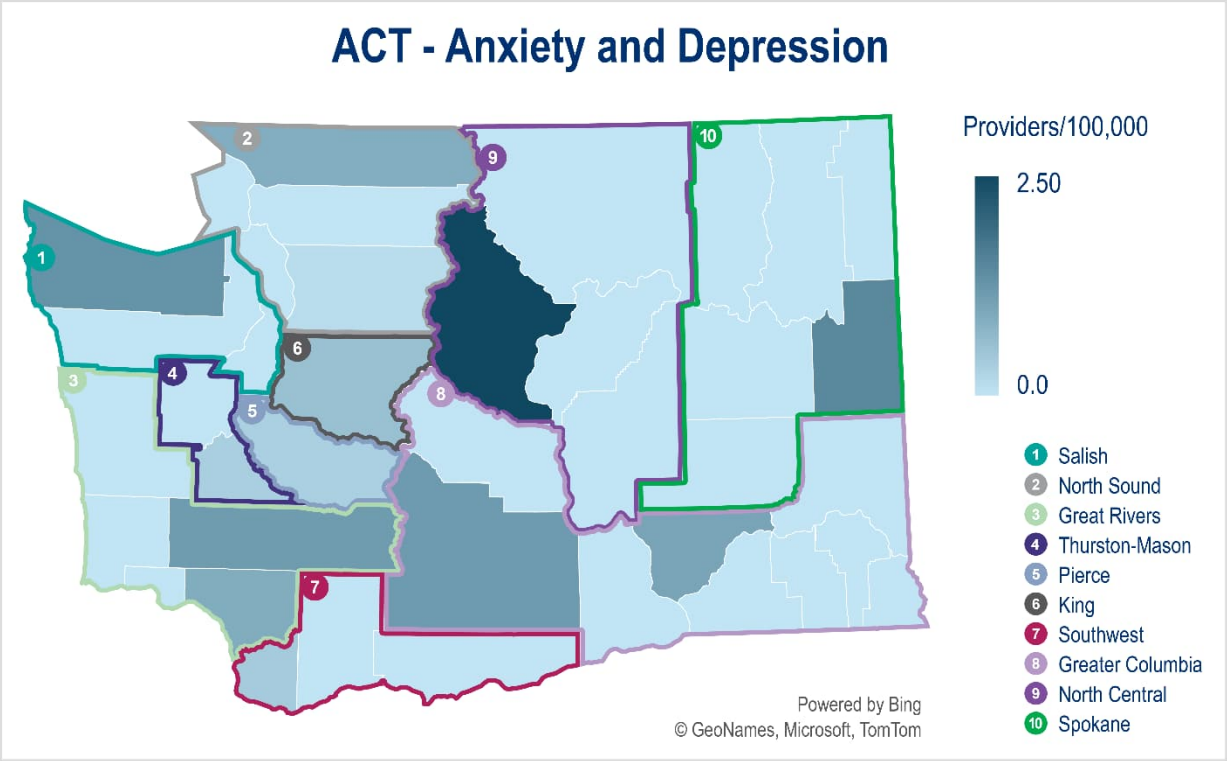
[87] Kyllönen, H. M., Muotka, J., Puolakanaho, A., Astikainen, P., Keinonen, K., & Lappalainen, R. (2018). A brief acceptance and commitment therapy intervention for depression: A randomized controlled trial with 3-year follow-up for the intervention group. *Journal of Contextual Behavioral Science*, 10, 55–63. https://doi.org/10.1016/j.jcbs.2018.08.009

[88] Bai, Z., Luo, S., Zhang, L., Wu, S., & Chi, I. (2020). Acceptance and commitment therapy (ACT) to reduce depression: A systematic review and meta-analysis. *Journal of Affective Disorders*, 260, 728–737. https://doi.org/10.1016/j.jad.2019.09.040

[89] Ma, J., Ji, L., & Lu, G. (2023). Adolescents' experiences of acceptance and commitment therapy for depression: An interpretative phenomenological analysis of good-outcome cases. *Frontiers in Psychology*, 14, 1050227. https://doi.org/10.3389/fpsyg.2023.1050227

[90] Hayes, Steven C., & Pierson, Heather. (2005). Acceptance and commitment therapy. *Springer US*.

Map 12: Number of Providers Reporting They Provide ACT per 100,000 Population by County[91]



Source: Washington State Department of Health. 2024

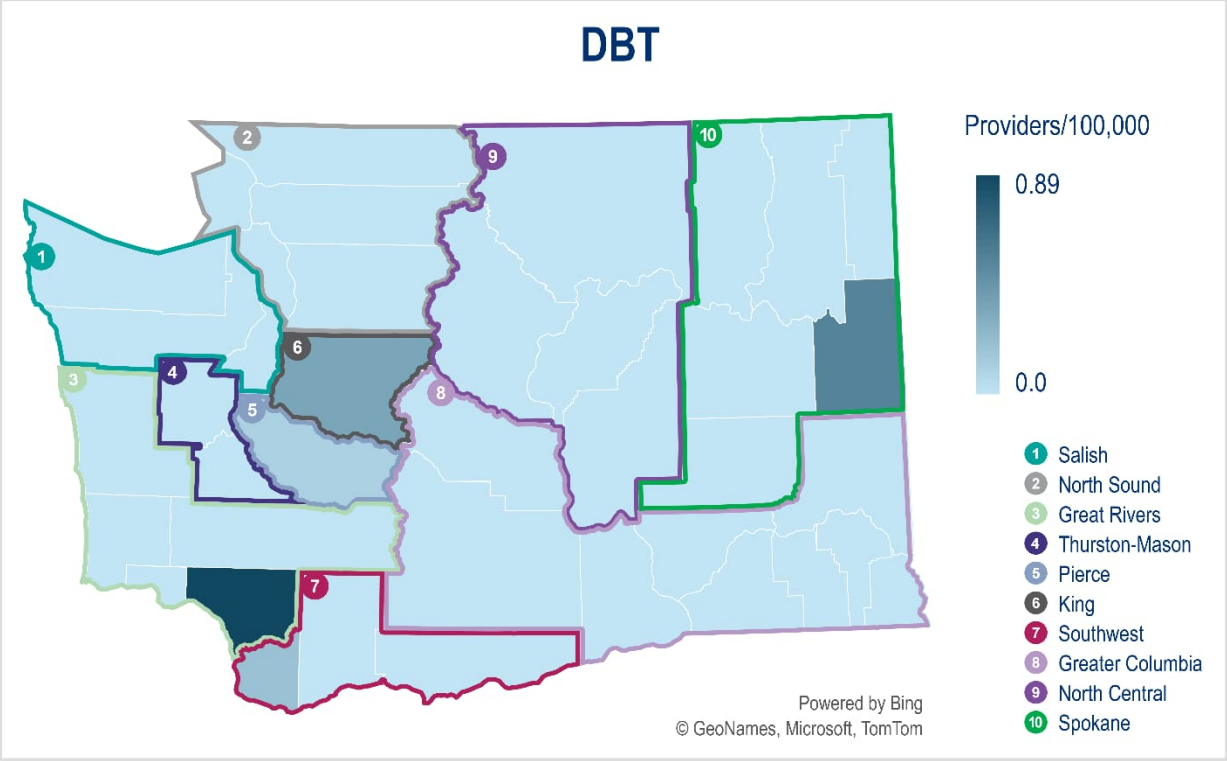
[91] Washington State Health Care Authority (HCA). (n.d.). Quarterly EBP Reports. https://www.hca.wa.gov/about-hca/who-we-are/legislative-reports

DBT for Adolescents with Self-Harming Behavior[92]

DBT is a psychotherapy aimed at helping people with extreme and chronic emotional dysregulation — having emotions that are very strong, quick to start, and slow to end — learn to build new skills into their life while at the same time reducing the behaviors and patterns that cause them problems. The significant and consistently large long-term reduction in self-harm behavior for adolescents having received DBT-A compared with enhanced usual care suggests that DBT-A may be a favorable treatment alternative for adolescents with repetitive self-harming behavior. DBT-A appears to be a valuable treatment in reducing both adolescent self-harm and suicidal ideation. Evidence that DBT-A reduces bipolar disorder symptoms has also been found in pre-post evaluations.

There are only five counties with providers reporting to be trained in and providing DBT: Clark, Cowlitz, King, Pierce, and Spokane.

Map 13: Number of Providers Reporting They Provide DBT per 100,000 Population by County



Source: Washington State Department of Health. 2024

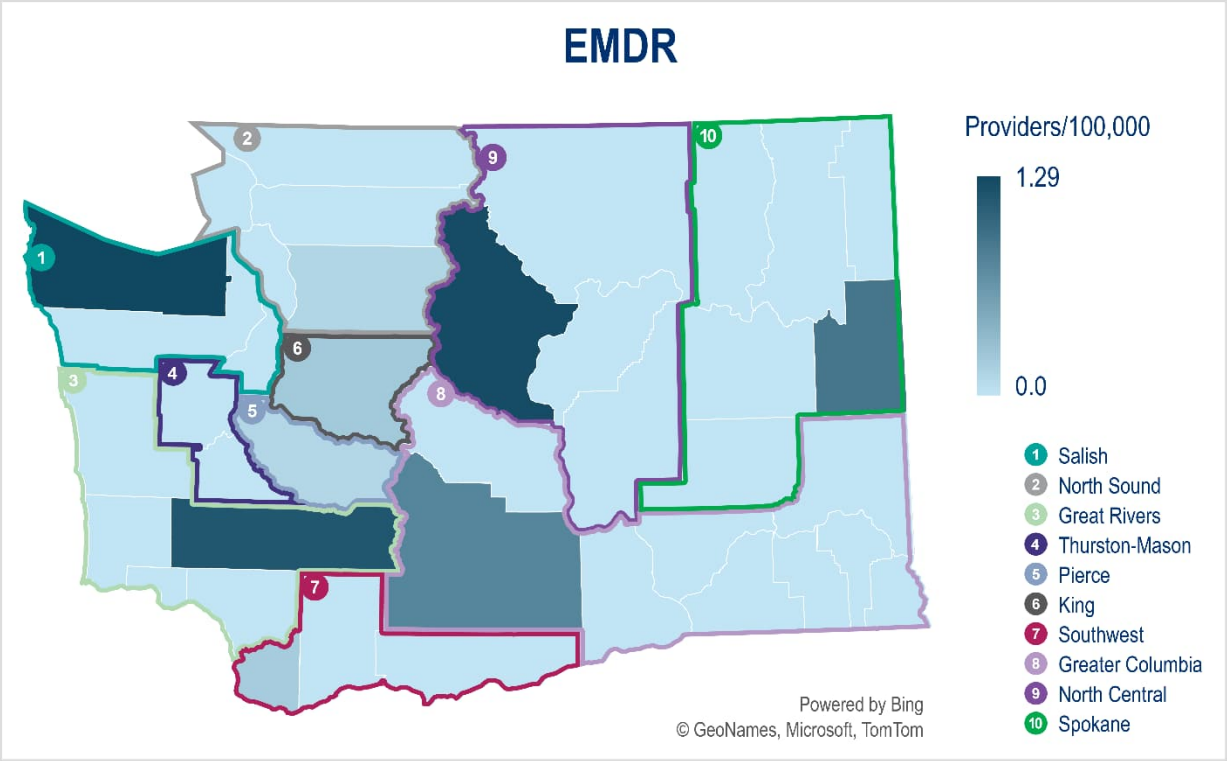
[92] Kothgassner, O. D., Goreis, A., Robinson, K., Huscsava, M. M., Schmahl, C., & Plener, P. L. (2021). *Efficacy of dialectical behavior therapy for adolescent self-harm and suicidal ideation: A systematic review and meta-analysis. Psychological Medicine,* 51(7), 1057–1067. https://doi.org/10.1017/S0033291721001355

Eye Movement Desensitization and Reprocessing for Child Trauma

Eye Movement Desensitization and Reprocessing (EMDR) is a psychotherapy technique used to treat the distress associated with disturbing memories, particularly those related to trauma. It involves recalling a traumatic experience while following a side-to-side visual stimulus, such as a therapist's finger or a light. The goal is to help process and desensitize the memory, reducing its emotional intensity and impact.

There are nine counties with self-reporting providers that are trained and providing EMDR to Medicaid children's populations. Five counties report having a high EMDR provider density per 100,000 population: Chelan, Clallam, Clark, Lewis, and Spokane.

Map 14: Number of Providers Reporting They Provide EMDR per 100,000 Population by County



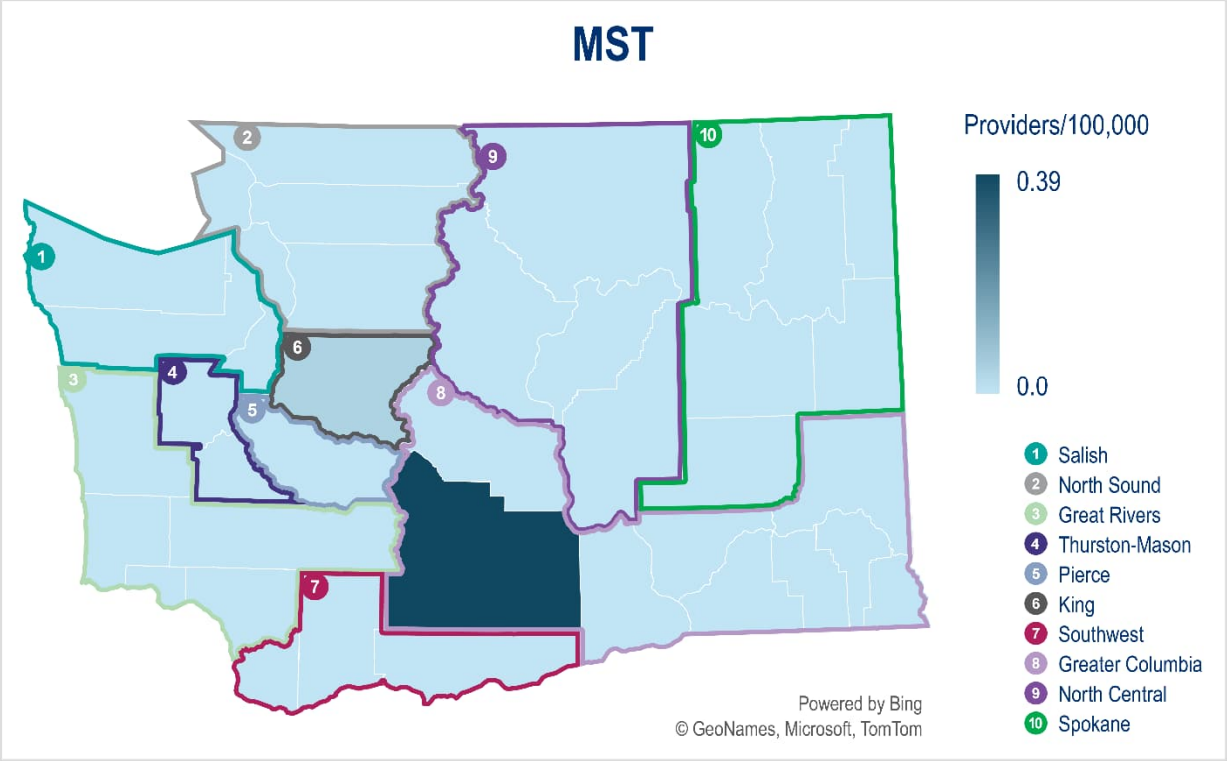
Source: Washington State Department of Health. 2024 MST for Youth with Serious Emotional Disturbances (SED)

Multi-Systemic Therapy for Court-Involved/Post Release Youth

MST for court-involved/post release youth as well as MST for youth with SED is an intensive, family- and community-based intervention that addresses multiple systems impacting a youth's behavior, aiming to promote positive change within the youth's natural environment. MST therapists work closely with families to identify and address factors contributing to the youth's SED, including individual, family, peer, school, and community issues. The goal is to keep youth at home, in school, and out of trouble by promoting pro-social behavior and reducing problem behaviors.

While one of the most common EBPs in the nation, MST is only reported to be provided in two counties in Washington: King and Yakima. This EBP is relatively expensive to provide because of the high training costs in terms of price, lost productivity, and small caseloads.

Map 15: Number of Providers Reporting They Provide MST per 100,000 Population by County



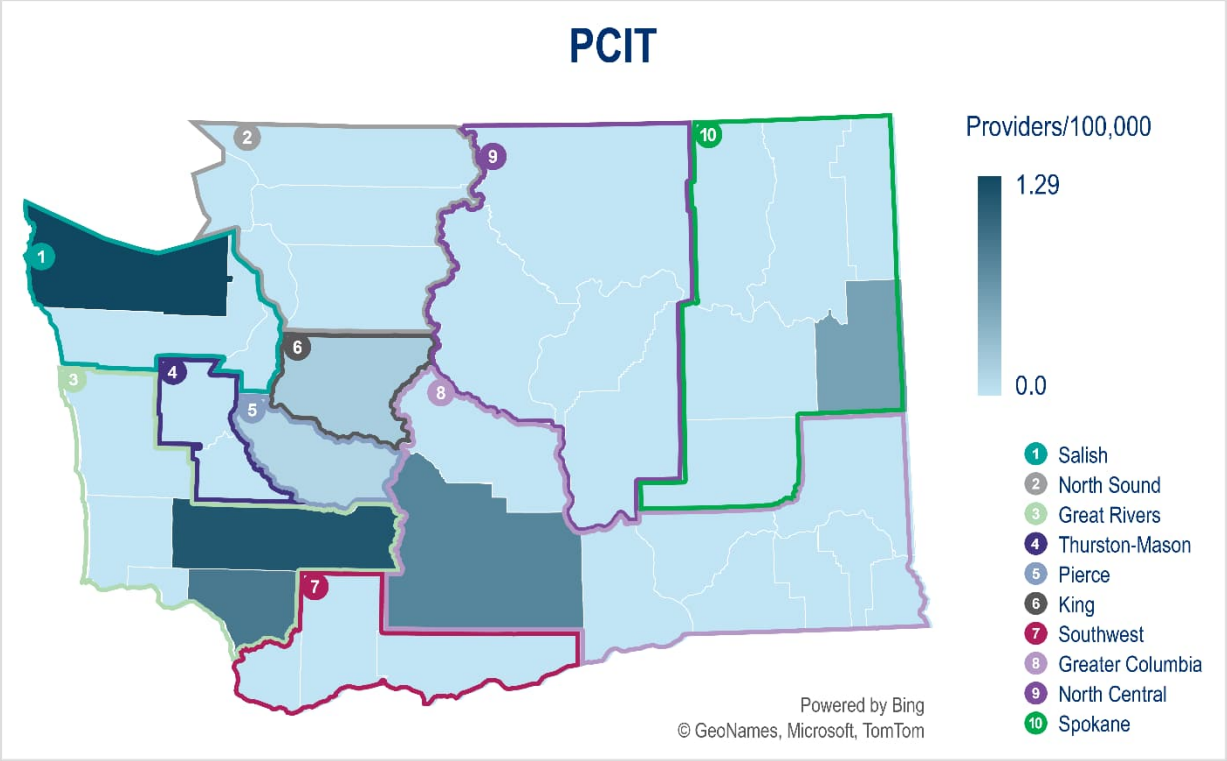
Source: Washington State Department of Health. 2024

PCIT for Families in the Child Welfare System

PCIT is an evidence-based treatment for young children (ages 2 years–7 years old) with behavioral and emotional problems. It focuses on improving the relationship between the child and their parent or caregiver through coaching the caregiver on positive interactions and teaching the child new skills. PCIT is often used for children experiencing frequent tantrums, defiance, aggression, or other disruptive behaviors. PCIT is one of the few EBPs for children age seven years old and under with behavioral issues.

PCIT is only reported to be provided in seven counties in Washington: Clallam, Cowlitz, King, Lewis, Pierce, Spokane, and Yakima. This EBP is also relatively expensive to provide because of the high equipment and/or space requirements, training costs in terms of cost and lost productivity, and small caseloads.

Map 16: Number of Providers Reporting They Provide PCIT per 100,000 Population by County



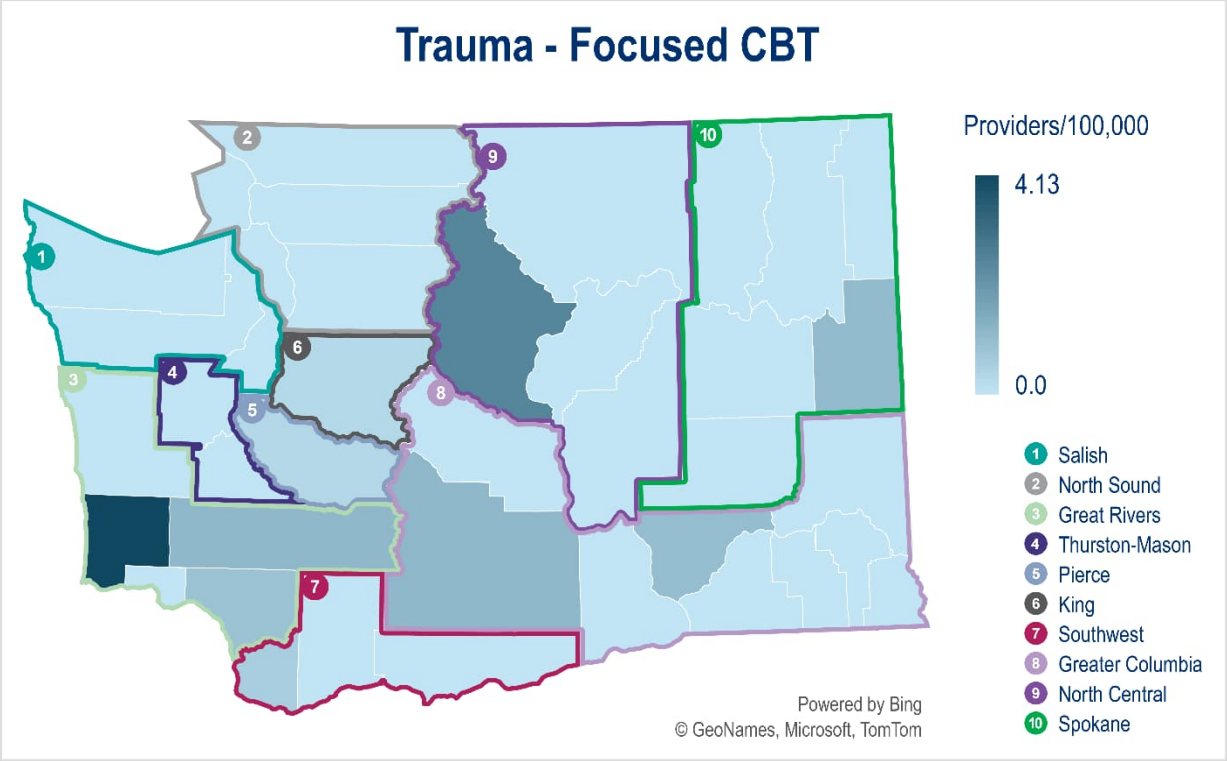
Source: Washington State Department of Health. 2024

Trauma-Focused CBT for Children

Trauma-Focused CBT (TF-CBT) for Children is a specific type of cognitive behavioral therapy designed for children and adolescents (ages 3 years–18 years old) who have experienced trauma. It is an evidence-based treatment that addresses trauma-related symptoms like nightmares, difficulty sleeping, and intrusive thoughts, as well as other issues like depression, anxiety, and behavioral problems. TF-CBT involves both individual and family therapy, with parents or caregivers participating in sessions to learn skills that support their child and their own well-being.

TF-CBT is only reported to be provided in nine counties in Washington: Chelan, Cowlitz, Franklin, King, Lewis, Pacific, Pierce, Spokane, and Yakima. TF-CBT is one of the essential EBPs to treat childhood depression, anxiety, and behavioral problems.

Map 17: Number of Providers Reporting They Provide TF-CBT per 100,000 Population by County



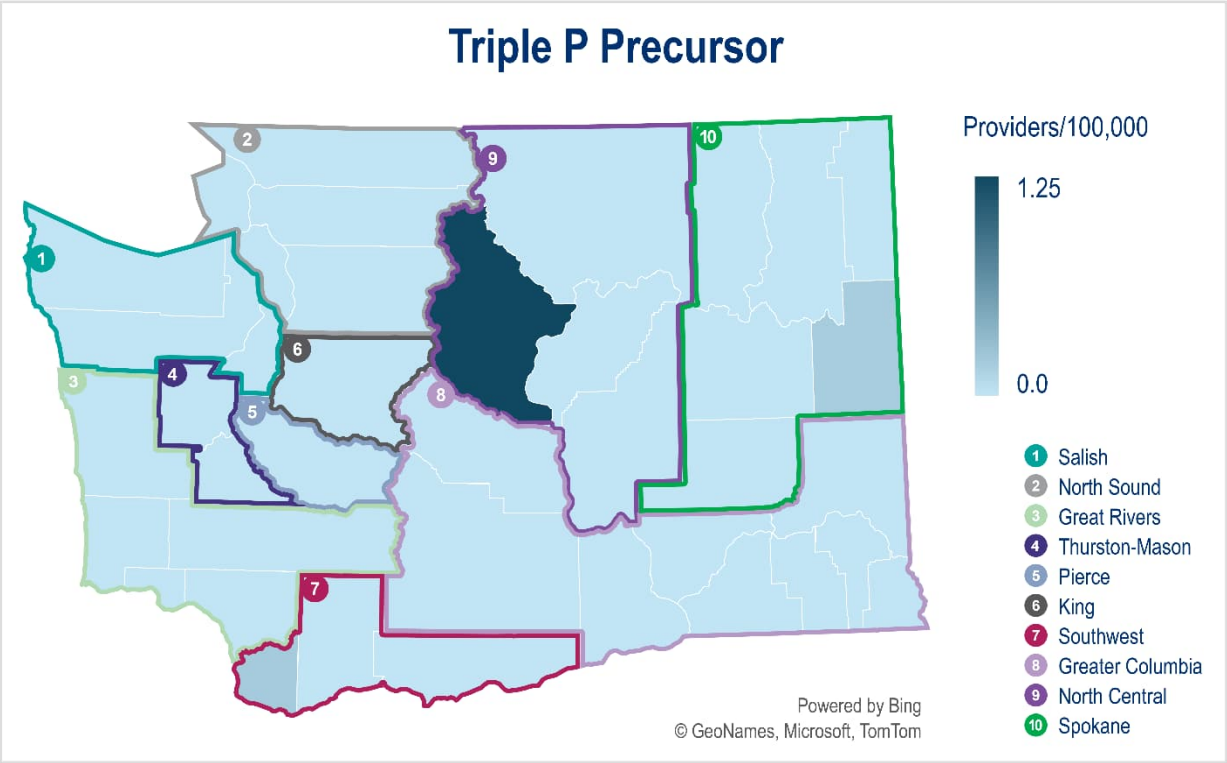
Source: Washington State Department of Health. 2024

Triple P — Positive Parenting Program: Level 4, Individual

The Triple P (Positive Parenting Program) is a system of parenting support developed from a precursor behavioral family intervention. It aims to enhance parents' knowledge, skills, and confidence to prevent behavioral, emotional, and developmental problems in children and adolescents. Triple P evolved from smaller, home-based training programs for parents of disruptive preschool children.

Triple P is only reported to be provided in three counties in Washington: Chelan, Clark, and Spokane.

Map 18: Number of Providers Reporting They Provide Triple P – Positive Parenting Program per 100,000 Population by County



Source: Washington State Department of Health. 2024

New Journeys Coordinated Specialty Care for First Episode Psychosis

Coordinated specialty care (CSC) is an intensive, team-based, multi-intervention approach to treating youth and young adults who are experiencing the onset of psychosis.

The CSC approach involves multiple services, including:[93]

- Individual and group psychotherapy.
- Pharmacotherapy.
- Family psychoeducation and support.
- Case management.
- Individualized assessments, training, and supports integrated with treatment to achieve and maintain educational or vocational success.
- Peer support.
- Primary care coordination.

To serve individuals with First Episode Psychosis, New Journeys has 15 teams statewide. Each team serves 30 individuals or 450 individuals statewide at any given time. These teams were established beginning in 2019, when the Washington State Legislature passed Senate Bill 5903, requiring the Health Care Authority to implement evidence-based services that provide early identification and intervention for individuals with psychosis. In response to both federal and State statutes, the Health Care Authority now uses Mental Health Block Grant and Medicaid funding to implement evidence-based New Journeys early intervention services to meet statewide needs.[94]

[93] Dixon, L. (2017, July 20). Early psychosis treatment: How did we get here & where are we going? Presentation at the Summer Institute Luncheon, *Arizona State University Center for Applied Behavioral Health Policy*. https://web.archive.org/web/20220128060247/https://cabhp.asu.edu/sites/default/files/keynote_the_promise_and_challenges_lisa_dixon_0.pdf

[94] Washington State Department of Social and Health Services. (2025, February). F*irst episode psychosis: Estimating annual incidence using administrative data in SFY 2023*. https://www.dshs.wa.gov/sites/default/files/rda/reports/research-3-62.pdf

Map 19: New Journeys Teams Locations

Figure 3. New Journeys Team Locations as of September 2023

Source: Washington State Health Care Authority. (2023). New Journeys Policy and Procedure Manual. https://www.hca.wa.gov/assets/program/new-journeys-manual.pdf

It is estimated that 4,106 Medicaid enrollees in Washington State received their first psychotic disorder diagnoses in SFY 2023, of which 2,541 individuals from the ages of 15 years to 40 years old, potentially meet the New Journeys admission criteria.

Table 23: Estimated Number of Medicaid Enrollees with First Episode Psychosis by Apple Health Managed Care Region, SFY 2023[95]

	Any FEP			Meeting New Journey Criteria		
	Individuals with FEP	Individuals enrolled in Medicaid	Incidence rate per 100,000	Individuals with FEP	Individuals enrolled in Medicaid	Incidence rate per 100,000
Apple Health Managed Care Region						
Great Rivers	**301**	86,487	**348**	185	36,750	**503**
Greater Columbia	**432**	232,468	**186**	269	103,647	**260**
King	**838**	352,541	**238**	524	158,551	**330**
North Central	**160**	85,540	**187**	101	36,566	**276**
North Sound	**595**	249,458	**239**	368	108,650	**339**

[95] Washington State Health Care Authority. (2023). New Journeys Policy and Procedure Manual. https://www.hca.wa.gov/assets/program/new-journeys-manual.pdf

	Any FEP			Meeting New Journey Criteria		
Pierce	**562**	208,446	**270**	319	91,832	**347**
Salish	**200**	72,159	**277**	113	31,748	**356**
Southwest	**271**	117,359	**231**	172	51,691	**333**
Spokane	**488**	175,892	**277**	315	78,407	**402**
Thurston-Mason	**257**	76,919	**334**	175	34,066	**514**
Statewide	**4,106**	1,657,734	**248**	2,541	732,123	**347**

Because the current New Journeys team capacity is only 450 individuals at any given time, it is estimated that team size or the number of teams will need to grow to meet the 2,541-person need. Even if only 50% of eligible and unserved individuals seek care (approximately 1,000 individuals), The rates for CSC in 2025 are $2,318 per member per month (PMPM) for the first six months. This then decreases to $1,622.60 PMPM for the next 18 months.[96] Consequently, it is estimated that the cost per person per year as well as the unmet need equals $21,557.40.

Washington Wraparound with Intensive Services

Since 2018, Washington has had statewide access to Wraparound with Intensive Services (WISe) services. In the map below, the location of the providers throughout the State can be seen.

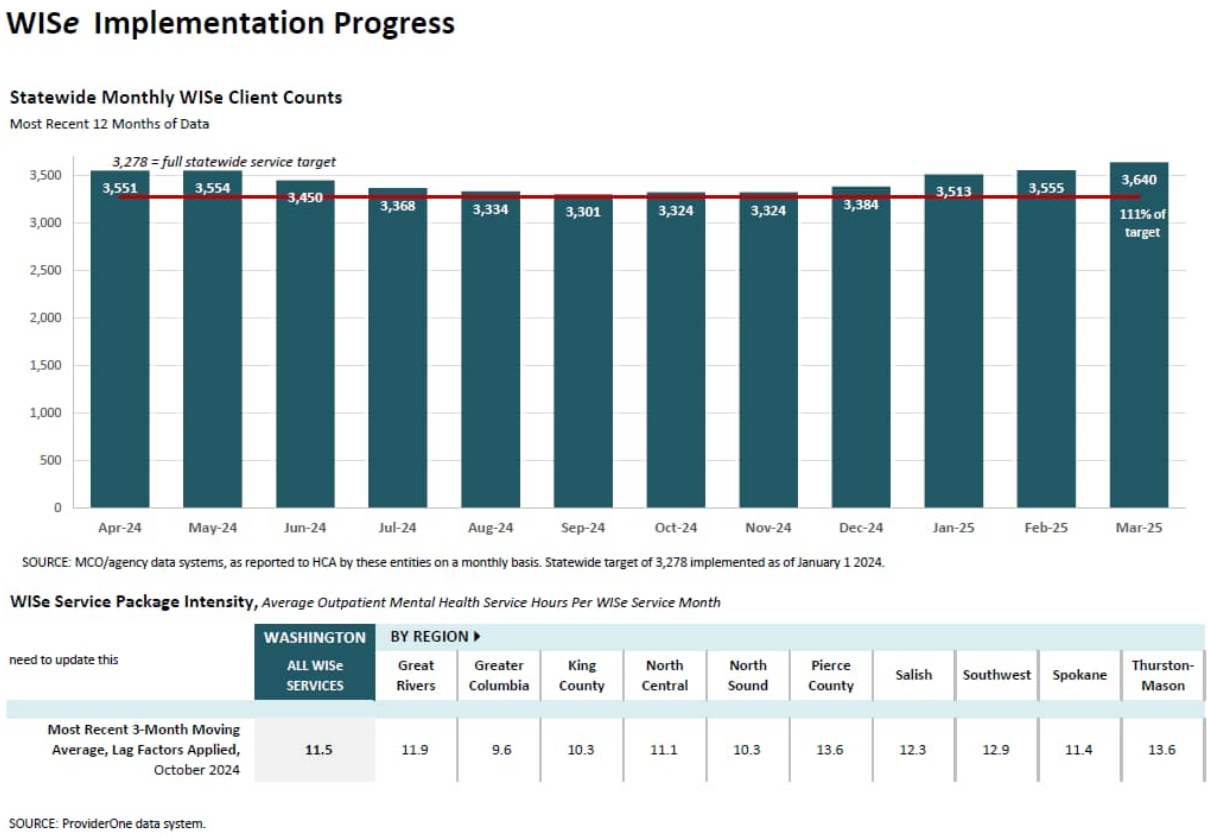
[96]Washington State Health Care Authority. (n.d.). *Provider billing guides and fee schedules. Specialized Mental Health Services.* Retrieved from https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules#billing-guides-fee-schedules

Map 20: WISe Service Providers as of April 2025

Source: Washington State Health Care Authority. WISE Administrative Outcome Measures. https://www.hca.wa.gov/assets/program/wise-administrative-outcome-measures.pdf

Each month, there are between 3,301 and 3,640 children receiving WISe. The average number of service hours provided to each child monthly in WISe averages from 11.5 hours to 13.6 hours in the 10 Apple Health Regions.

Figure 14: WISe Implementation Process — Monthly WISe Client Counts



In the 2023–2024 quality review of WISe, the evaluator found that teams might be understaff and recommended that Health Care Authority work with the managed care organizations to investigate underlying causes of these results such as workforce issues and WISe program processes to drive improvement efforts and reduce barriers to success. The findings suggest that workforce or understaffing issues could be contributing to these findings for WISe teams:

- The Child and Adolescent Needs and Strengths screening was completed in a timely manner 48% of the time.
- The *care planning* requirement was completed in a timely manner 39% of the time.
- Collaborative crisis plans were included in 42% of the enrollment charts reviewed.
- Crisis plans were included in 45% of transition charts reviewed.
- Formal transition plans were included in 31% of the transition charts reviewed.

Young Adults' Access to Program of Assertive Community Treatment

In December 2024, a report by the SPIRIT Center, University of Washington Department of Psychiatry & Behavioral Sciences in response to Engrossed Substitute Senate Bill 5950 (pp.359-360) Provision 5, found that Program of Assertive Community Treatment (PACT) teams served an average of 137 youth between 2019 and 2023. There were an additional 104–141 youth annually from 2019–2023 (excluding 2020 due to the Public Health Emergency) who met

PACT admission criteria but were not served by PACT. A small number of these individuals aged 18 years–24 years old were served by other high-intensity services and supports in a team-based care model such as WISe, Intensive Residential Treatment, and New Journeys CSC. However, the actual number of those served by other programs was suppressed because fewer than 11 individuals met the criteria annually.[97]

As noted in that report, while other service programs may have some overlap with PACT for this population, including MST, Telecare Community Alternatives Teams (T-CAT), and Youth and Young Adult Housing Response Teams (YYAHRT), there was not coding in the databased to distinguish utilization of MST, T-CAT, and YYAHRT.

The report also found that there were several challenges to Transitional Age Youth (TAY) individuals' access to PACT services including lack of housing, lack of public education about PACT, and that other programs may be more appropriate for some TAY.

Projected Costs of Implementing Services to fill the Gaps

Mercer leveraged the available data to project the costs associated with implementing services aimed at addressing gaps in behavioral health care.

Out-of-State and Out-of-District School Placements

As noted above, 88 children are served by their school districts in out-of-district and out-of-state Nonpublic Agencies (NPAs) due to unmet complex behavioral health needs in Washington State. The number of children served out-of-state has decreased in the past five years. A complete analysis is needed to address the remaining children served in the State. Mercer is providing a rough budget impact estimate below.

In 2020–2021, news accounts reported the cost of placing 80 students out-of-state was approximately $13.0 million or $162,500 each[98,99] in 2021 dollars ($190,834 in 2025 dollars), with the treatment costing up to $315,000 per student. A review of in-state out-of-district NPAs who are authorized by the Office of Superintendent of Public Instruction (OSPI) to accept placements for students with disabilities had costs ranging from around $20,000 to $40,000 annually. Using these numbers as approximations, Mercer estimates that the amount of funds being spent to serve children with complex behavioral health needs in NPAs is roughly $6.8 million. Serving these children with complex behavioral health needs in their home districts might be more expensive than placement in NPAs, which are specialized settings addressing the complex behavioral health and medical needs of placed children.

[97] SPIRIT Center, University of Washington Department of Psychiatry & Behavioral Sciences. (2024, December). *An Evaluation of Young Adults' Access to Program of Assertive Community Treatment (PACT) Services in Washington State.* (pp. 1-16). https://www.hca.wa.gov/assets/program/program-assertive-community-treatment-assessment-leg-report-2024.pdf

[98] Investigate West. (2023). *Lawmakers hope to end Washington's practice of shipping special-needs students out of state*. https://www.investigatewest.org/investigatewest-reports/lawmakers-hope-to-end-washingtons-practice-of-shipping-special-needs-students-out-of-state-17692378

[99] Washington State Department of Social and Health Services. (2023, November). *Behavioral health treatment needs and outcomes among Medicaid enrolled children in Washington State*. https://www.dshs.wa.gov/sites/default/files/rda/reports/CHILDRENS_BH_DASHBOARD_2023NOV.pdf

Table 24: Estimated Cost to Serve Children with Complex Behavioral Health Needs in NPAs

	Number of Children	Estimated Cost Per Child	Total Estimated Cost
Children Placed Out-of-State	22	$ 190,834	$ 4,198,353
Children Placed Out-of-District	66	$ 40,000	$ 2,640,000
Statewide Total	88		$ 6,838,353

Source: Washington State OSPI

Medicaid Mental Health and SUD Costs

Using the estimated costs of serving Children and Youth as well as adults in the All Claims Payer Database (ACPD), we have taken the number of individuals estimated to be underserved in Medicaid and projected the cost of serving them. Mercer acknowledges that not everyone who is untreated will seek care, but this is intended to be a starting estimate using the number of untreated individuals identified above in this section. If half of the Medicaid children, youth, transition age youth, pregnant and postpartum women, and caregivers diagnosed with behavioral health needs, but not receiving treatment were to seek treatment, then the total costs would be approximately $544,987,674.

Table 25: Estimated Annual Cost of Untreated Individuals for MH and SUD Services

Service	Average Cost Per Client for Gap Services	Needing but Not Receiving Treatment	Annual Cost
Average Annual Cost ACPD PMPM any MH			
Ages 0–17	$3,807	57,671	$219,547,568
Ages 18–64	$2,164	128,263	$277,516,711
Average Annual Cost ACPD PMPM SMI/SED			
Ages 0–17	$7,321	540	$3,950,315
Ages 18–64	$3,292	19,980	$65,779,206
Average Annual Cost SUD — Residential Rehab			
Ages 0–17	$61,742	119	$7,347,298
Ages 18–64	$61,742	7,078	$437,009,886
Average Annual Cost SUD — Outpatient Rehab			
Ages 0–17	$1,861	2,254	$4,194,528
Ages 18–64	$1,861	40,106	$74,629,837
Total Assuming 50% Take Up Rate			**$544,987,674**

Source: All Claims Payer Database (ACPD)

Projected Workforce Demand

In 2022, the Washington Workforce Training and Education Coordinating Board issued a report *2022 Behavioral Health Workforce: A report of the Behavioral Health Workforce Advisory Committee.*[100] The paper was a rigorous study that outlined the demands for skill sets and initiatives that have been taken to date to address the behavioral health workforce needs in Washington. The paper laid out initiatives in recruitment and retention, reimbursement, education and training, licensing, supervision, and care integration.

The report discusses the five reports issued by the Workforce Board on behavioral health workforce between 2016 and 2021, which discussed the challenges to recruitment and retention for a diverse and sufficient behavioral health staff.

Mental Health America in 2023 ranked Washington ninth in the nation for Behavioral Health Workforce Accessibility, with a ratio of 230 individuals for every one mental health provider. In the U.S., there are 350 individuals for every one mental health provider. The term *mental health provider* includes psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care. Mental health workforce availability is the ratio of the county population to the number of mental health providers, including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health care. In 2015, marriage and family therapists and mental health providers that treat alcohol and other drug abuse were added to this measure. These data come from the National Provider Identification data file, which has some limitations. Providers who transmit electronic health records are required to obtain an identification number, but very small providers may not obtain a number. While providers have the option of deactivating their identification number, some mental health professionals included in this list may no longer be practicing or accepting new patients. This may result in an overestimation of active mental health professionals in some communities. It is also true that mental health providers may be registered with an address in one county while practicing in another county.[101]

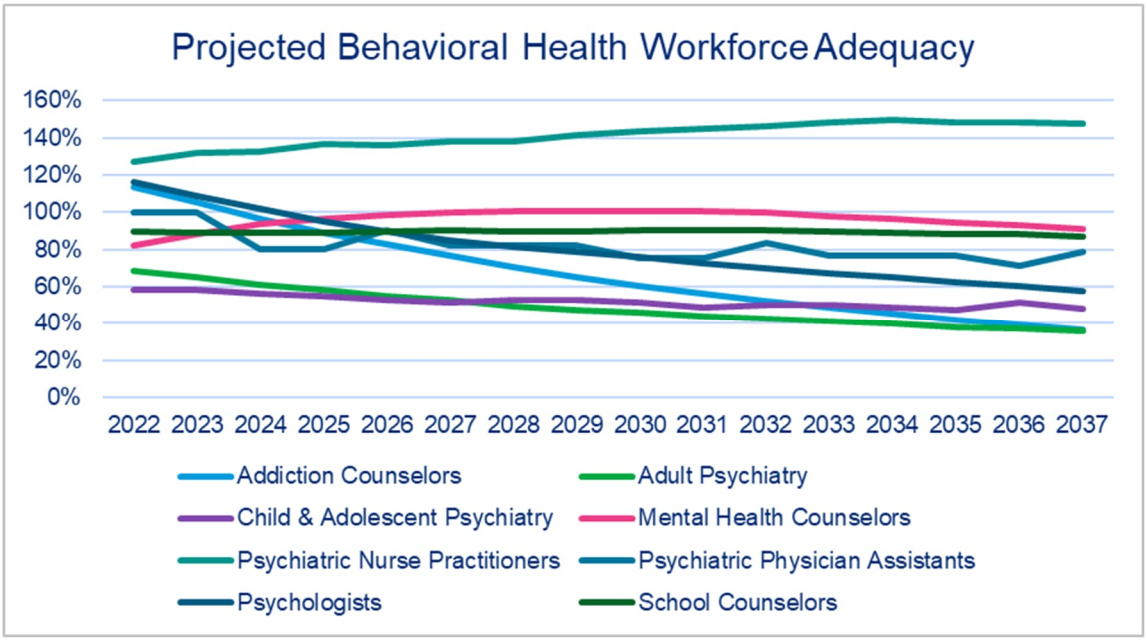
Health Resources and Services Administration (HRSA) estimates for behavioral health workforce adequacy suggest that Washington's better-than-average workforce accessibility is not evenly distributed across types of providers, though, nor are current accessibility levels expected to remain consistent. Between 2022 and 2037, HRSA projects that six of eight behavioral health professions' adequacies to meet anticipated need will decrease, and only one—psychiatric nurse practitioner—is projected to exceed demand by 2037.[102]

[100] Behavioral Health Workforce Advisory Committee. (2022). *2022 behavioral health workforce assessment: A report of the Behavioral Health Workforce Advisory Committee*. https://wtb.wa.gov/wp-content/uploads/2022/12/BHWAC-2022-report_FINAL.pdf

[101] Mental Health America. (2021). *Mental Health America survey*.

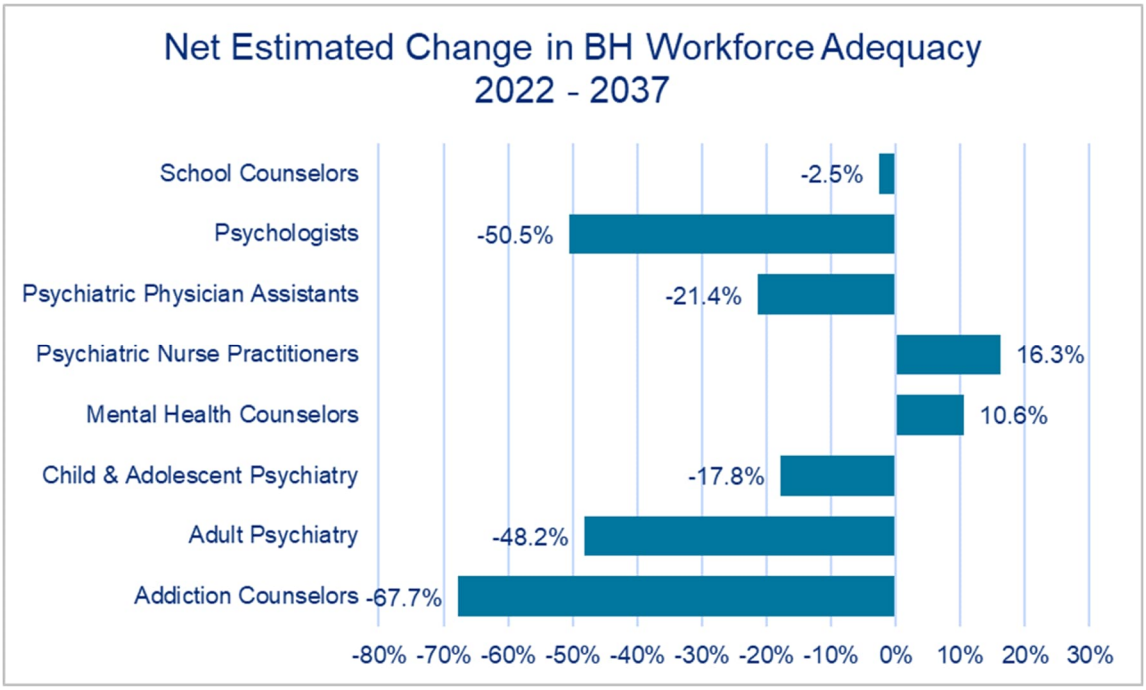
[102] Department of Health and Human Services, Health Resources and Services Administration. *Health Workforce Projections.* https://data.hrsa.gov/DataDownload/DD_Files/Workforce_Projections_FullData.xlsx

Figure 15: Projected Behavioral Health Workforce Adequacy



Source: HRSA: Department of Health and Human Services, Health Resources and Services Administration. Health Workforce Projections.
https://data.hrsa.gov/DataDownload/DD_Files/Workforce_Projections_FullData.xlsx

Figure 16: Net Estimated Change in BH Workforce Adequacy



Source: HRSA: Department of Health and Human Services, Health Resources and Services Administration. Health Workforce Projections.
https://data.hrsa.gov/DataDownload/DD_Files/Workforce_Projections_FullData.xlsx

As of June 2022, over 152 million people lived in the U.S. in a mental health workforce shortage area, and only 28% of the mental health need in shortage areas was being met by mental health providers. This measure is only indicative of the physical presence of mental health providers; it does not account for whether these providers are able to accept patients, are accepting insurance or providing in-network care, or are culturally or linguistically representative of the communities they work in. County Health Rankings, the source of the data for this indicator, notes that these figures may be an overestimate of active mental health professionals, as it may include providers who are no longer practicing or accepting new patients. The mental health workforce shortage cannot be addressed without revaluing provider reimbursement. Low reimbursement rates for mental health providers drive practitioners to other specialties and increase out-of-network participation. In 2017, 17.2% of behavioral health office visits were to an out-of-network provider, compared to 3.2% of primary care providers and 4.3% of medical/surgical specialists. With a growing demand for mental health services, a shortage of mental health providers, and an increase in out-of-network participation, the system is built in a way that only people with higher incomes can afford to receive care.[103]

As noted above, without reimbursing for EBPs, providers may be reluctant to invest in the training and development required to provide specialized services for target populations, especially higher cost EBPs. As Washington addresses the unmet behavioral health needs of its prenatal through age 25 populations, workforce needs including training in the latest research-based care will be needed.

988 Crisis Lifeline

As noted earlier, the 988 Lifeline meets two fundamental metrics for service and capacity. However, a recent Crisis Response Improvement Strategy Committee report recommends additional changes to further the system's capacity to serve youth. For example, the report recommended pursuing youth-specific crisis system coordination. In addition, youth contacting 988—whether via call or chat—should be connected with youth-specific resources. Next, current data agreements may be insufficient for adequate follow-up care. Additionally, the report recommends expanding programs that support specific youth populations, including justice-involved youth and youth with disabilities. Further, the system needs additional capacity to serve individuals with substance use and co-occurring disorders, as opposed to those experiencing mental health crises.[104] It is also recommended to increase prevention services for youth through programming in schools (social-emotional learning, onsite mental health services).

[103] County Health Rankings and Roadmaps. (2021). *Survey data year: 2021*. http://www.countyhealthrankings.org/

[104] Crisis Response Improvement Strategy Committee. (2024, December 31). *Washington behavioral health crisis response and suicide prevention system: Crisis Response Improvement Strategy Steering Committee final report*. https://www.hca.wa.gov/assets/program/cris-final-report-20250101.pdf

Section 8
Recommendations

Mercer suggests the following strategies to effectively address the identified quantitative gaps.

Target More Behavioral Health Skills-Building for Low-Income Children and Children in the Early Childhood Education and Assistance Program

- Behavioral health needs in children under five years old are growing. It is recommended for Washington to ensure that all young children who have been identified with behavioral health needs through early screening and diagnosis in schools receive intervention and prevention services before needing more complex or intensive care.

Educational Efforts for Specific Populations

- Multi-system-involved children often have behavioral health needs and complex socioeconomic and diagnostic co-morbidities. It would benefit Washington to continue to support and expand the Wraparound with Intensive Services (WISe) program to support families and to address the needs of children with behavioral health needs who are multi-system involved. This would involve expanding the workforce to better serve a greater number of families with complex needs.
- Additional case management and outreach to pregnant women may be necessary for this population. While efforts to provide services to all ages, races, and insurance are needed, substance use prevention services during pregnancy should target different individuals:
  - Alcohol prevention during pregnancy should specifically target White individuals and individuals in the King region.
  - Cannabis prevention during pregnancy should specifically target Native American and Alaska Native and multiracial individuals and individuals in the Spokane, Great Rivers, and Thurston-Mason regions.
  - Tobacco prevention during pregnancy should specifically target Native American and Alaska Native individuals and individuals in the King region.
- Ensure that interpreters and culturally appropriate assistance with language is available throughout the State where language is a barrier to accessing behavioral health care, especially in the Greater Columbia, King, and North Central regions.
- Develop training programs for practitioners on lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, and more (LGBTQIA+) issues to reduce stereotyping and the ongoing stigma and marginalization of individuals with behavioral health needs who are LGBTQIA+.
- Ensure that practitioners are trained to recognize gender- and race-specific behavioral health needs that are present differently in different demographic groups. This includes prioritizing

Native American and Alaska Native pediatric communities with additional prevention programs for alcohol, substance use, mental health disorders, suicide, and violence.

Develop Local Training and Resources to Better Serve Children and Youth in Local School Districts and Prevent Out-of-State and Out-of-District Placement

- Mercer recommends pursuing additional resources to serve children in their home districts. As noted in the Gaps in Services section, it is estimated that $6.8 million is being spent to serve children with behavioral health needs in out-of-district and out-of-state placements. To address this issue, additional resources are needed to invest in training and staffing to serve children closer to their families, which is more clinically appropriate as it allows family therapy and reintegration to occur.

Address Capacity and Geographic Gaps in Intensive Pediatric Inpatient and Residential Services

- Mercer recommends that the State of Washington continue to reinvest in inpatient and residential mental health services for children needing intensive mental health and stabilization services. Currently, Washington has a limited inventory of pediatric inpatient and residential beds, concentrated in a small number of geographically isolated locations. In addition, with one of the lowest pediatric per 100,000 population, there is a significant need for more beds overall.

Address Capacity Gaps to Serve a Higher Number of Children, Youth, Transition Age Youth, Pregnant Women, Parents and Caregivers, and Families Needing, but Not Receiving Behavioral Health Treatment

- Approximately 52% of all Medicaid populations over the age of 13 years old needing behavioral health care in Washington receive treatment. While some individuals will never seek treatment, even individuals who do seek treatment do not always receive the treatment needed because of workforce, capacity, and geographic limitations. Similarly, only around 37% of all Medicaid populations over age 13 years old needing substance use disorder treatment in Washington receive treatment.
- Mercer estimates that to address half of the Medicaid behavioral health need-treatment gap, it would cost the State of Washington $544,987,674.
- Workforce initiatives related to building and maintaining capacity would also need to be implemented to ensure that an ongoing workforce was available to provide necessary services in the future.

Reexamine the State's Coverage, Reimbursement, and Coding Strategies for Evidence-Based Practices to Make Evidence-Based Practices More Consistently Available Across the State

- Mercer recommends that the State reexamine its coverage, reimbursement, and coding strategies for evidence-based practices (EBPs) to make EBPs more consistently available across the State. For example, Health Care Authority (HCA) may want to submit Medicaid State Plans similar to those in Delaware, Louisiana, Nebraska, New Mexico, New York, and Ohio to cover EBPs for major target populations. These initiatives would create well-defined entitlements to research-based care for children, youth, and transition age youth.
- HCA may want to revisit EBP rates to cover a higher proportion of ongoing team costs for EBPs outside of Acceptance and Commitment Therapy, New Journeys, and WISe. For example, ensuring that multisystemic therapy (MST), Parent Child Interaction Therapy, Dialectal Behavior Therapy, and Triple P Precursor costs are more fully covered may result in higher take-up rates by providers.
- HCA may want to revisit EBP administrative coding to tie higher reimbursement to administrative data submission.

Develop Additional New Journeys Teams, Address Barriers to Program of Assertive Community Treatment, and Ensure that the WISe Team Workforce is Adequate

- New Journeys could serve approximately 450 individuals with the current team capacity, but estimates suggest that approximately 2,541 individuals are potentially eligible for the New Journeys admission criteria. Consistent with the 2023–2024 WISe summary findings and recommendations, HCA and managed care organizations should ensure that workforce development and team operations are sufficient to address the necessary capacity to serve the target population. Finally, consistent with the December 2024 report to the legislature for Engrossed Substitute Senate Bill 5950 (pp. 359–360) Provision 5,[105] Washington should address the barriers to transition age youth participating in PACT in larger numbers, including: 1) a more comprehensive investment in the system at large including safe, affordable and quality housing and resources to address other basic needs; 2) more public education about PACT to many transition age youth unaware of PACT, but who meet PACT admission criteria as well as hospital and emergency department staff; 3) expanding PACT admission criteria to better fit transition age youth; or 4) developing alternatives such as extending the WISe age range up to age 24 years old or implementing an evidence-informed model of Wraparound designed specifically for transition age youth at greatest risk of school dropout and alternative placement — RENEW (Rehabilitation, Empowerment, Natural Supports, Education, and Work).[106]

[105] Washington State Legislature. (2024). *Substitute Senate Bill 5950: Concerning state budget proposals*. https://fiscal.wa.gov/statebudgets/2024proposals/Documents/co/5950-S.SL.pdf

[106] Malloy, JoAnne and Manisco-Chapo, Sara (2024) *Moving Beyond Trauma: Activating Resilience to Support Our Most Vulnerable Youth, International* Journal of School Social Work: Vol. 9: Iss. 2. https://doi.org/10.4148/2161-4148.1078; Center for RENEW Implementation. University of New Hampshire & New Hampshire Institute on Disability. Retrieved from https://iod.unh.edu/renew

Improve Data Collection and Reporting Practices

- The State of Washington offers a wealth of robust, publicly available data and dashboards from various State programs and specific sources on multiple State websites. However, there are unique data collection and reporting practices that affect how data are shared. Most providers of data publish static tables from various timeframes and reports on their websites, while some offer online searchable systems and dashboards. Additionally, certain sites provide raw data files that may complicate efforts to compare and identify trends. There are some actionable items to be learned from this process.
  - Define behavioral health and children, youth, and transition age youth clearly and consistently across data sources. Having a standardized definition of behavioral health and the target ages of children, youth, and transition age youth that is defined prior to the beginning of data collection for the data dashboard will be key to more consistent reporting practices. Mercer recommends that data collection clearly include mental health, substance use disorder, and intellectual and developmental disabilities for:
    - Families in the prenatal and perinatal phases, including pregnant individuals.
    - Children age 0 years to 5 years old.
    - Youth age 6 years to 12 years old.
    - Youth age 13 years to 17 years old.
    - Transition age youth age 18 years to 25 years old.
    - Parents and caregivers of children and youth.
  - Improve coding practices to obtain complete data reflecting the use of EBPs in Medicaid and Department of Children, Youth, and Families. As noted in the December 2024 report on an Evaluation of Young Adults' Access to PACT Services in Washington State and also found in this report, actual utilization of EBPs was not included in the claims data and appeared to be significantly underreported in the separate reported data. While there was some data available for Medicaid eligible individuals, it appeared to be underreported because the national correct coding was not utilized for MST and other practices did not appear to have Medicaid rates that reimbursed for the specific costs associated with each EBP.
  - Encourage agencies to use common data standards including standardized definitions across all sources to ensure consistency, gender, gender identification, race/ethnicity, language, and age groups, to facilitate comparison and trend identification.
  - Create streamlined data use agreements for the data dashboard to ensure that sister agencies responding to legislative requests can access the data needed for statutorily required analyses and metrics. Such streamlined data use agreements may require the development of standardized data collection tools and a prescribed data storage and data retention policies so that analyses require less administrative burden when accessing data for statutory purposes.
  - Work with data owners to identify collection and analytic processes best suited for the data being collected. Ensure that data owners regularly assess the quality of the data

being collected and implement validation checks to ensure accuracy, completeness, and reliability.

- Ensure that the data dashboard uses data visualization software to create dashboards that can report and highlight trends and patterns, apply research-based statistical methods, machine learning, or predictive analytics to identify trends and to forecast future diagnostic and utilization patterns based on historical data.

Adopt Relevant Aspects of other Children's Systems of Care

Washington should examine and adopt aspects of other Children's Systems of Care for children with behavioral health and developmental disabilities in such locations as New Jersey.

The New Jersey Children's Support Services Program (CSSP) provides behavioral health care and home and community-based services (HCBS) and supports individuals under age 21 years old, that have a serious emotional disturbance which places them at risk of hospitalization, out-of-home treatment, or at hospital level of care. This program also provides supports to youth with individuals with intellectual/developmental disabilities (IDD) under the age of 21 years old. Individuals may also have a co-occurring IDD and mental health (IDD/MI). CSSP provides HCBS whether or not youth are involved in child protective services and coordinates access to substance use treatment services for eligible youth.[107,108,109]

- CSSP provides a family-centered, community-focused single point of entry for eligible children and families to obtain available behavioral health, substance use treatment, and developmental disability services.
- New Jersey provides expanded eligibility to children who are at risk of hospitalization, out-of-home treatment, or at hospital level of care by disregarding parental income just as would occur in an institutional setting. This ensures that children are eligible for specialized HCBS regardless of parental income. Children do not have to be institutionalized or forfeited to child welfare to be eligible for behavioral health services.
- New Jersey has developed specific programs and collaborations to support youth with complex severe behavioral health conditions. Starting in 2012, New Jersey developed several pilots for individuals with IDD/MI including a program for transition age youth who were placed out-of-state and seeking to return to New Jersey through the identification of acceptable alternative services. Today, New Jersey has several statewide programs for IDD/MI children, youth and transition age youth including Mobile Response Stabilization Services (MRSS), Behavioral Stabilization Programs, Short-Term Developmental Disability Crisis Stabilization and Assessment Centers, as well as a Severe Behavior Program.
  - MRSS interventions provide youth and their caregivers with short-term, flexible service coordination to assist in supporting youth who are vulnerable to or experiencing stressors, coping challenges, emotional or behavioral symptoms.

[107] PerformCARE®. (n.d.). *Behavioral Health*. https://www.performcarenj.org//families/behavioral/index.aspx.
[108] PerformCARE®. (n.d.). *Family Crisis Handbook.* https://www.performcarenj.org/pdf/families/family-crisis-handbook.pdf.
[109] PerformCARE®. (n.d.). *New Jersey Children's System of Care Resources for Educational Professionals*. https://www.performcarenj.org//educators/index.aspx.

- Behavioral Stabilization Programs are composed of behavioral professionals who identify challenging behaviors and develop treatment plan is developed to decrease these behaviors and foster more desirable behaviors in their place. The training of teachers, support staff and family members on the behavior management plan is fundamental to the ultimate success of these programs, as is the securing of a post-treatment.
- Short-Term Developmental Disability Crisis Stabilization and Assessment Centers are regionally based short-term emergency group homes that serve IDD individuals in urgent need of out-of-home services and support due to severe challenges (behavioral, emotional, co-occurring medical issues, or abuse/neglect) and a family member/caregiver's inability to safely and effectively care for the individual.[110]
- The Rutger's Severe Behavior Program provides intensive and highly specialized services to children and adolescents with autism spectrum disorder and other developmental disabilities who display dangerous behavior such as aggression, self-injury, or property destruction that pose a significant risk to themselves, others or the environment. It is intended for those who cannot be safely managed or effectively treated in a less-intensive program.[111]

Address Needs in the Crisis Response System

Washington should adopt the recommendations from the January 2025 Crisis Response Improvement Strategy (CRIS) Steering Committee. The CRIS Steering Committee issued a final report on the Washington Behavioral Health Crisis Response and Suicide Prevention System including needs and recommendations for the system. The recommendations pertaining to children, youth, transition age youth, and parents and caregivers are excerpted below:[112]

Table 26: CRIS Steering Committee Recommendations

Domain	Status	Recommendation
Promoting Equity	Legislative action needed	Establish requirements for translation and interpretation services to address gaps in current serivices.
Services	Legislative action needed	Ensure there are crisis response services available in all regions so that people have access to care wherever and whenever needed. Ensure response is tailored the unique needs and stressors of diverse communities, including but not limited to Tribal communities, rural and agricultural communities, individuals with IDD, LGBTQIA+ populations, Veterans, youth, and communities of color.
Prevention	Legislative action needed	Increase prevention services for youth, such as implementing social-emotional learning in schools, mental health care on school campuses, etc.

[110] PerformCARE®. (n.d.). *An Enhanced Family Support Crisis Handbook*. (pp. 36). https://www.performcarenj.org/pdf/families/family-crisis-handbook.pdf

[111] ROI New Jersey. (2021, April 7). *Children's Specialized Hospital, Rutgers Center for Autism Research Announce Creation of Severe Behavior Program*. https://www.roi-nj.com/2021/04/07/healthcare/childrens-specialized-hospital-rutgers-center-for-autismresearch-announce-creation-of-severe-behavior-program/

[112] Crisis Response Improvement Strategy Committee. (2024, December 31). *Washington behavioral health crisis response and suicide prevention system: Crisis Response Improvement Strategy Steering Committee final report.* https://www.hca.wa.gov/assets/program/cris-final-report-20250101.pdf

Domain	Status	Recommendation
Cross-System Collaboration	Agency action to implement system improvements	Pursue youth-specific crisis system coordination: Ensure youth 988 callers/chatters are connected with youth-specific resources such as MRSS; Explore data-sharing agreements with schools, with appropriate confidentiality safeguards, to provide students with better follow-up care.
Staffing and Workforce	Recommendation that requires further development	Develop diverse approaches for supporting parents and caregivers as a critical source of care for people in crisis.

Section 9

Sample Dashboard Design

Based on the envisioned System of Care for prenatal-through-25 Behavioral Health and comprehensive list of services, Washington should consider a dashboard design that can help the Children and Youth Behavioral Health Work Group (CYBWHG) Advisory Committee monitor trends across key indicators, starting with those the committee finds most compelling within this report.

A preliminary, proposed dashboard design matrix, developed during initial meetings with key Washington data informants and stakeholders, can be found in Appendix A. This data dashboard design was the focus of Stakeholder Dashboard Meeting #3 and was further refined during additional ad hoc data partner meeting(s), as well as meetings with the Health Care Authority (HCA) and other stakeholders. It should be noted that the indicators listed in the Dashboard matrix were included in the landscape analysis description in statute or available for this report.

Mercer recommends that the State assess data sharing feasibility among HCA and sister agencies, data availability, and select 6–12 measures from the metrics that can inform decision making on an on-going basis.

Mercer reviewed existing State dashboards used in other projects as examples of effective visualization strategies. Some examples the State may want to consider are:

- The North Carolina Child Behavioral Health Dashboard.[113]
- Arkansas Acute Behavioral Health Events.[114]
- Maine's Children's Behavioral Health Data Dashboard.[115]

Data partners endorsed the following techniques that will help dashboard users to easily understand data through visual depictions of metrics.

- Heat Maps — two-dimensional data visualization techniques that represent the magnitude of values within a dataset, usually displayed within specific defined boundaries.
- Concrete Metrics — quantifiable measures that can be observed over time. Process measures include indicators of services that can be counted (i.e., number of claims, number of available beds or treatment slots, the number of people served in a specified time period, etc.). Outcome measures indicate the effect of care on the patient's general health, typically displayed in graph form. Specific examples of concrete metrics can be found in Appendix F Number of Children requiring behavioral health.

[113] North Carolina Department of Health and Human Services. (n.d.). *Child behavioral health dashboard*. https://www.ncdhhs.gov/divisions/child-and-family-well-being/whole-child-health-section/child-behavioral-health/child-behavioral-health-dashboard

[114] Arkansas Center for Health Improvement. (2024, December 19). *Dashboard: Arkansas acute behavioral health events*. https://achi.net/publications/arkansas-acute-behavioral-health-events/

[115] Maine Department of Health and Human Services. (n.d.). *Children's behavioral health data dashboard*. https://www.maine.gov/dhhs/ocfs/data-reports-initiatives/childrens-behavioral-health

- Benchmarking — reference points that can be used for comparison. Benchmarking is the process of comparing a State, region, or population's performance against other states, regions, or populations that operate in the same niche, are of similar size, have a similar target population, and are measured in the same way. These are also typically displayed in graph form.

The dashboard should utilize performance metrics to identify gaps that the State is trying to close or the service the State is trying to improve. These metrics must be linked to on-going, consistent data sources that can measure gaps and progress over time. Framework for looking at Gaps in the Dashboard.

Looking at these four categories by Age, Cohort, and Payer:

Demand

- Changes in overall demographics.
- Identifications of populations of interest (e.g., unhoused, intellectual and developmental disabilities, racial/ethnic groups, and indigenous groups).

Capacity

- Workforce.
- Urban/rural or other demographic features.
- Promotion, prevention, and early intervention utilization.

Access/Service Utilization

- Holes in payer coverage.
- Disparities in access by socioeconomic, racial, or other populations of interest.
- Delivery system gaps by age or other populations of interest.
- Outpatient and integrated care.
- Intensive home and community based services.

Outcomes

- Juvenile Justice referrals/charges/dispositions.
- Emergency department (ED) visits.
- Inpatient hospitalizations.
- Residential treatment utilizations.
- Out-of-home placements.
- Use of crisis services.

The proposed sample Dashboard Design framework should encompass demographic information that tracks changes in service demand over time, including factors such as language and interpreter needs. It will incorporate capacity metrics, such as workforce and network capacity, as well as geographic considerations like urban versus rural areas and provider shortages. Additionally, the framework will feature access and utilization metrics that identify gaps in payer coverage and disparities in access based on socioeconomic status, race, and other populations of interest, as well as delivery system gaps categorized by age and other criteria. Finally, the Dashboard Design should include outcome metrics that assess the impact of insufficient behavioral health resources on children, youth, and young adults, such as referrals,

charges, and dispositions related to the Juvenile Justice system, inpatient hospitalizations, ED visits, out-of-home placements, school suspensions and expulsions, as well as positive outcomes like graduation and employment rates. The dashboard should look at each of these categories of metrics by age band as relevant — children ages zero to five years old, children in school ages five years to 17 years, and young adults ages 18 years–25 years old. Mercer recognizes that developmental stages do not always align with chronological age and thus will not always align into each of these categories. However, for the purposes of the dashboard and data collection, chronological age helps us to refine metrics and identify data sources that may be specific to an age group (e.g., Kindergarten readiness scores, or employment rates).

Appendix A

Sample Data Dashboard Design

The table below reflects the original sample data dashboard discussed and presented in phase 1 of the project in 2024.

all = all age groups | specific age groups = 0 years–5 years old; 6 years–17 years old; 18 years–25 years old

Delivery System	Demand	Capacity	Access/Utilization	Outcomes
General social services: • DOH • DSHS	• Total population by age, gender, race/ethnicity, sexual orientation, gender identification, income, and language and by county or by urban/rural counties (all) (source: U.S. Census data) • Specific populations of interest (all)[116] • Self-reported young adult cannabis and alcohol use (source: Washington Young Adult Health Survey) (18–25) • Prevalence of BH needs by age band (source: multiple Washington surveys; NSDUH) (all)	• Providers available (Ratio of BH providers to population) (all) (source: DOH) • Workforce capacity (all) • Urban/rural or other geographic features (all) • Number of children placed out-of-state due to lack of in-State placement (6–17) (source: Washington State OSPI)	• Promotion, prevention, and early intervention service utilization (all) • Differences in rates of promotion, prevention, early intervention utilization by race/ethnicity, geography, income (all) • Early childhood service utilization (all) • Differences in rates of early childhood service utilization by race/ethnicity, geography, income (all) • DSHS service utilization (Women, Infants, and Children, TANF, etc.) (all) (source: DSHS Children's Behavioral Health Dashboard) • Utilization of supports for transitions to adulthood/life skills (18–25)	• Number/rate per 1,000 of ED visits by age, gender, race/ethnic and by county (all) — all payers • Number/rate of juvenile offenses (6–17) • Arrest rates (18–25) (there are performance measures reflecting arrest) • Crisis line utilization (number of calls, by demographics, as available) (all) (sources: DSHS Children's Behavioral Health Dashboard; 988Lifeline State-based monthly reports) • Employment rates (18–25) • Housing instability rates (18–25) • Suicide hospitalizations and deaths (all)

[116] Including individuals with IDD, unhoused youth, children, youth, and young adults in foster care (including those considered Transition Aged youth), Native youth and young adults, refugees, immigrants, and LGBTQIA+.

Delivery System	Demand	Capacity	Access/Utilization	Outcomes
			• HEDIS related quality measures (all) (source: NCQA HEDIS)	
Medicaid	• Medicaid members with BH or SUD diagnosis (by race/ethnicity, county) (all) (source: HCA)	• Number of Medicaid providers (all) (source: HCA) • Child Medicaid eligibility (0–5; 6–17) (source: HCA)	• BH service utilization by age group: outpatient and integrated care, Intensive HCBS (all) (sources: DSHS Children's Behavioral Health Dashboard; HCA) • Quarterly clinical quality measures (e.g., source: NCQA HEDIS) (all)	• Number/rate per 1,000 Medicaid members with ED visits by age, gender, race/ethnicity (all) (source: HCA) • Utilization of inpatient/residential care by Medicaid members (all) (sources: DSHS Children's Behavioral Health Dashboard; HCA; Section 1115 Demonstrations, State Waivers List, SUD Part A Metrics)
Commercial: • OIC	• Number/percent of insured population (all)	• Providers available (Ratio of BH providers to population) (all)	• BH service utilization by age group: outpatient and integrated care, Intensive HCBS (all) • Gaps in payer coverage • Disparities in access • Delivery system gaps by populations of interest • Commercial reimbursement rates for MH and substance use services (all) • Quarterly clinical quality measures (all)	• Number/rate per 1,000 of commercially insured ED visits by age, gender, race/ethnicity (all) • Utilization of inpatient/residential care paid by commercial payers

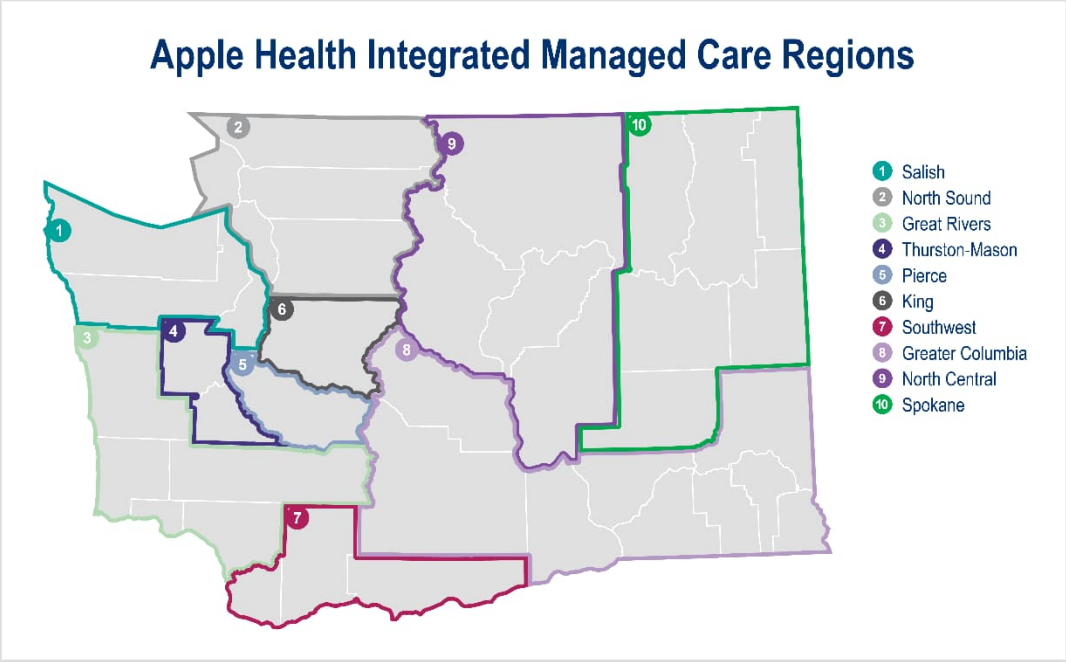
Delivery System	Demand	Capacity	Access/Utilization	Outcomes
Schools: • OSPI • OFM	• Washington Kids Kindergarten readiness scores — social/emotional (0–5) (sources: WAKIDS assessments, OSPI Comprehensive Report Card) • Percent students reporting suicide ideation (6–17; source: Healthy Kids survey) • Percent students reporting recent drug/alcohol use (6–17; source: Healthy Kids survey) • Prevalence of pre-Kindergarten BH plans • Prevalence of IEPs (source: Washington OSPI)	• In-school services provided with grant funding — Project Aware and Student Assistance program (amount of funding; number served) (6–17) • Number of coordinated school safety center positions, threat assessment positions, and BH navigators • Number/ratio of school social workers per population (6–17) • Number/percent of Medicaid eligible students (all)	• Disparities in IEPs, participation in school-based services (demographics served with grant funds) (0–5; 6-17) • Utilization of school-based services and other State (Title IV-E/TANF and State only funds from child welfare) (0–5; 6–17)	• Four-year graduation rate (6–17) • High School Graduate Outcomes (source: ERDC) (18–25) • School disciplinary incidents — number/prevalence (suspensions, expulsions) (0–5; 6–17)
• **DCYF**	• CANs	• Services provided by Department of HHS, voluntary family services, FAR, TANF, etc. (0–5; 6–17)	• Disparities in CANs reports (by race/ethnicity, county, income) (0–17)	• Number/rate of out-of-home placements (0–5, 6–17) (source: Washington State OSPI) • Removal from early childhood programs (0–5)

Appendix B
Demographics

Regions

Washington State consists of 39 counties with varying population sizes. They can be considered non-rural, rural, or frontier based upon the population density. The composition between frontier, rural, and non-rural areas adds complexity to the provision of behavioral health services and addressing gaps in needs and service delivery. The Apple Health Integrated Managed Care Regions further divides Washington into ten regions, each of which has their own demographic layout and needs.

Map B.1: Apple Health Integrated Managed Care Regions



Source: Washington State Health Care Authority

King, which includes Seattle, is the largest region with almost twice the population as the next largest regions of North Sound and Pierce. Great Rivers, Salish, and Thurston-Mason are the smallest regions with fewer than 106,000 inhabitants under the age of 26 years old.

Table B.1: Washington Population by Region from Age 3 years–25 years Old[117]

Region	Total Population
Great Rivers	87,369
Greater Columbia	273,349
King	656,886
North Central	108,988
North Sound	394,963
Pierce	304,245
Salish	104,567
Southwest	172,808
Spokane	206,192
Thurston-Mason	105,910
Statewide	**2,415,276**

Despite the overall population size differences, the percentage of population for each age group in each region roughly matches the statewide population averages by age as seen in Table B.2. However, there are some notable differences. For example, Great Rivers region, which is the smallest region, has the largest percentage of school age youth at 49% and the smallest percentage of transition age youth at 29%. Salish and King, however, have the largest proportion of transition age youth at 34%.

Table B.2: Percentage of Population in Child, Youth, and Transition Age Categories by Region

Percentage of Population per Age by Region			
Region	**0 years–5 years**	**6 years–17 years**	**18 years–25 years**
Great Rivers	22%	49%	29%
Greater Columbia	20%	48%	32%
King	21%	45%	34%
North Central	20%	47%	32%
North Sound	22%	46%	32%
Pierce	22%	47%	31%
Salish	21%	45%	34%
Southwest	21%	48%	31%
Spokane	21%	47%	32%

[117] U.S. Census Bureau. (2023). *U.S. Census data*

Percentage of Population per Age by Region			
Region	**0 years–5 years**	**6 years–17 years**	**18 years–25 years**
Thurston-Mason	22%	48%	30%
Statewide	**21%**	**46%**	**32%**

Source: U.S. Census Bureau. (2023). U.S. Census data.

Unlike the composition of the different age ranges of children and youth, the differences in the number of expectant caregivers are more profound. As can be seen in Table B.3, King has significantly more caregivers than any other expectant caregivers than any region. More interesting; however, is that all regions, independent of population, saw a significant decrease in the number of expectant caregivers, with a drop of ~4.8% statewide. From 2017 to 2022, the number of expectant individuals dropped from 87,461 in 2017 to 83,286 in 2022. The number of expectant caregivers decreased from 2017 to 2022 by almost five percent.

Table B.3: Estimated Number of Expectant Caregivers

Estimated Number of Expectant Caregivers							
Region	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**Change 2017-2022**
Great Rivers	3,080	3,077	3,057	3,012	2,977	3,061	-0.6%
Greater Columbia	9,198	9,029	8,780	8,726	8,647	8,600	-6.5%
King	25,274	24,337	24,090	23,638	23,390	23,010	-9.0%
North Central	3,778	3,714	3,643	3,451	3,510	3,561	-5.7%
North Sound	14,490	14,265	14,047	13,589	14,040	14,107	-2.6%
Pierce	11,285	11,462	11,051	11,045	11,070	10,963	-2.9%
Salish	3,804	3,779	3,738	3,529	3,501	3,587	-5.7%
Southwest	5,830	5,780	5,890	5,655	5,894	5,812	-0.3%
Spokane	7,008	6,824	6,839	6,744	6,960	6,926	-1.2%
Thurston-Mason	3,714	3,739	3,683	3,611	3,725	3,659	-1.5%
Statewide	**87,461**	**86,006**	**84,818**	**83,000**	**83,714**	**83,286**	**-4.8%**

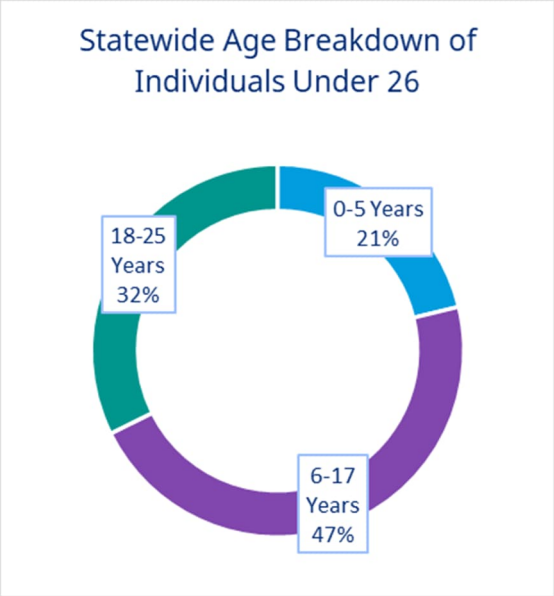
Source: Washington State Department of Health, Center for Health Statistics. (2025, February). Birth certificate data, 2017-2022. https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/county-all-births-dashboard

Population

Number of Children, Youth, and Transition Aged Youth

Washington State is home to approximately 2.4 million children, youth, and transition age individuals aged 0 years to 25 years. Among this population, around 46% (513,483) are school-age youth, while 32% (778,761) fall into the transition age category. Additionally, 21% (778,761) are young children aged 0 years to 5 years old.

Figure B.1: Number of Children, Youth, and Transition Age Youth



Source: U.S. Census Bureau. (2023). *U.S. Census Data*.

Parents and Caregivers

There were approximately 1.49 million families in Washington in 2023.[118] Mercer estimates that there is one caregiver per family. The number of families has increased at the statewide level from 1.34 million in 2018 to 1.48 million 2023, with a small decrease in 2021 as noted in Table B.4.

Table B.4: Number of Families Used to Estimate the Number of Adult Caregivers in Washington[119]

	2018	2019	2020	2021	2022	2023
Statewide	1,345,407	1,430,808	1,483,797	1,467,546	1,479,724	1,486,273

[118] U.S. Census Bureau, U.S. Department of Commerce. (2023). *Selected social characteristics in the United States*. American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP02. https://data.census.gov/table/ACSDP5Y2023.DP02?q=selected+social+characteristics&g=040XX00US53&moe=false

[119] U.S. Census Bureau, U.S. Department of Commerce. (2023). *Selected social characteristics in the United States.* American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP02, 2018-2023. https://data.census.gov/table/ACSDP5Y2023.DP02

Of the 1.49 million families, 103,155 families were estimated to be in the perinatal phase in 2022, defined as the time immediately before and after birth. Of these individuals, Medicaid finances approximately 35% of births. In 2023, 35.9% of mothers had Medicaid at the time of birth.[120]

All regions, independent of population, saw a significant decrease in the number of expectant caregivers, with a drop of ~4.8% statewide (Table B.5). From 2017 to 2022, the number of expectant individuals dropped from 87,461 in 2017 to 83,286 in 2022. While the overall expectant caregivers decreased, the rate of decrease varied by region. As can be seen in Table B.5, King had the largest decrease in percentage of population with 9%, while the Southwest region only saw the smallest decrease by 0.3%.

Table B.5: Estimate Number of Expectant Caregivers by Year[121]

Region	2017	2018	2019	2020	2021	2022	Change 2017-2022
Great Rivers	3,080	3,077	3,057	3,012	2,977	3,061	-0.6%
Greater Columbia	9,198	9,029	8,780	8,726	8,647	8,600	-6.5%
King	25,274	24,337	24,090	23,638	23,390	23,010	-9.0%
North Central	3,778	3,714	3,643	3,451	3,510	3,561	-5.7%
North Sound	14,490	14,265	14,047	13,589	14,040	14,107	-2.6%
Pierce	11,285	11,462	11,051	11,045	11,070	10,963	-2.9%
Salish	3,804	3,779	3,738	3,529	3,501	3,587	-5.7%
Southwest	5,830	5,780	5,890	5,655	5,894	5,812	-0.3%
Spokane	7,008	6,824	6,839	6,744	6,960	6,926	-1.2%
Thurston-Mason	3,714	3,739	3,683	3,611	3,725	3,659	-1.5%
Statewide	**87,461**	**86,006**	**84,818**	**83,000**	**83,714**	**83,286**	**-4.8%**

Source: Washington State Department of Health, Center for Health Statistics, Birth Certificate Data, 2017-2022, February 2025, https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/county-all-births-dashboard

Economic Status

Roughly 22.7% of the population in Washington is under 200% of the Federal Poverty Line (FPL). The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $24,526 in 2023. This is the official measurement of poverty used by the federal government, and the measure used for most poverty-based data presented on State Health Facts. The Department of Health and Human Services produces simplified, but very similar versions of these poverty thresholds called *poverty guidelines* that are used to assess eligibility for income-based programs such as Medicaid.

[120] U.S. Census Bureau. *American Community Survey Data*.

[121] Washington State Department of Health, Center for Health Statistics. (2025). *Birth certificate data, 2017-2022*. Retrieved February 2025, from https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/county-all-births-dashboard

Medicaid is a major public source of financing health care services provided to pregnant women, infants, and children under 200% of the FPL. In 2023, 35.9% of mothers had Medicaid at the time of birth. Medicaid covers roughly two out of five children. Medicaid covers about 21% of women ages 15 years–49 years old. In 2021, about one in 12 women of childbearing age (8.6%) were uninsured in Washington. In 2021, about one in 33 children under 19 years of age (3.1%) were uninsured in Washington.

Socioeconomic status (SES) has been strongly associated with a higher likelihood of children exhibiting both internalizing and externalizing behavioral problems.[122,123] SES can influence children's behavioral problems through social relations — including parent-child relations, peer relations, and teacher-student relations[124] — and a clear positive correlation has been found between SES and the dimensions of social relations of children and adolescents.[124] Children from low-SES backgrounds may experience less access to quality health care, nutritious food, and safe living environments, all of which can contribute to behavioral problems.

Lower levels of SES are associated with higher levels of emotional and behavioral difficulties, including higher rates of:

- Social problems, delinquent behavior symptoms, and attention deficit/hyperactivity disorder among adolescents;[125,126,127]
- Depression, anxiety, attempted suicide, cigarette dependence, illicit drug use, and episodic heavy drinking among adolescents;[128]
- Lower SES levels are associated with higher levels of aggression;[129] and
- Hostility, perceived threat, and discrimination for youth.[130]

As seen in the table below, the estimated percentage of families with incomes below the FPL decreased from 8% in 2017 to 6.4% in 2023, representing a 20% reduction. Economic stress can affect parental mental health, leading to less supportive and stable family environments that can negatively impact children's emotional and behavioral development as described above.

[122] PubMed. (2013). *Socioeconomic inequalities and mental health problems in childhood and adolescence.* https://pubmed.ncbi.nlm.nih.gov/23746605/

[123] PubMed. (2011). *Socioeconomic status and children's mental health: Results from a population-based study.* https://pubmed.ncbi.nlm.nih.gov/22183690/

[124] Zhang, Y., & Wang, L. (2022). *Socioeconomic status and behavioral problems in children: The mediating effect of social relations in mainland China. Children, 2(4), 37.* https://www.mdpi.com/2673-7051/2/4/37

[125] DeCarlo Santiago, C., Wadsworth, M. E., & Stump, J. (2011). Socioeconomic status, neighborhood disadvantage, and poverty-related stress: Prospective effects on psychological syndromes among diverse low-income families. *Journal of Economic Psychology*, 32, 218-230. https://doi.org/10.1016/j.joep.2009.10.008

[126] Russell, A. E., Ford, T., Williams, R., & Russell, G. (2016). The association between socioeconomic disadvantage and attention deficit/hyperactivity disorder (ADHD): A systematic review. *Child Psychiatry and Human Development*, 47(3), 440-458. https://doi.org/10.1007/s10578-015-0578-3

[127] American Psychological Association. (n.d.). *Children and families: A resource for understanding socioeconomic status and its impact on children and families*. https://www.apa.org/pi/ses/resources/publications/children-families

[128] Newacheck, P. W., Hung, Y. Y., Park, M. J., Brindis, C. D., & Irwin, C. E. Jr. (2003). Disparities in adolescent health and health care: Does socioeconomic status matter? *Health Services Research*, 38(5), 1235-1252. https://doi.org/10.1111/1475-6773.00174

[129] Molnar, B.E., Cerda, M., Roberts, A.L., & Buka, S.L. (2008). Effects of neighborhood resources on aggressive and delinquent behaviors among urban youths. *American Journal of Public Health*, 98(6), 1086-1093. https://doi.org/10.2105/AJPH.2006.098913

[130] American Psychological Association. (n.d.). *Children and families: A resource for understanding socioeconomic status and its impact on children and families*. https://www.apa.org/pi/ses/resources/publications/children-families

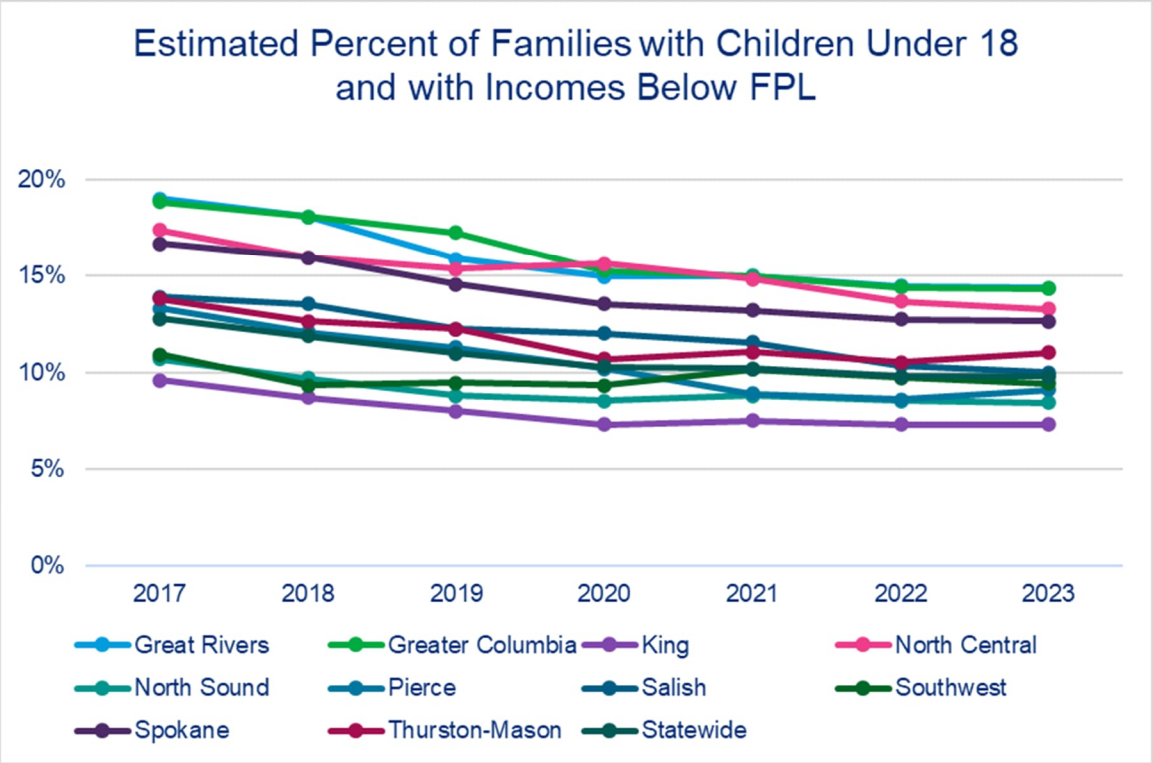
Table B.6: Estimated Percent of Families with Incomes Below FPL[131]

Region	2017	2018	2019	2020	2021	2022	2023
Great Rivers	11.0%	10.4%	9.2%	8.9%	8.8%	8.5%	8.7%
Greater Columbia	11.9%	11.2%	10.8%	9.8%	9.8%	9.6%	9.8%
King	6.4%	5.8%	5.4%	5.1%	5.2%	5.1%	5.1%
North Central	11.0%	9.9%	9.3%	9.6%	9.3%	8.8%	8.7%
North Sound	6.8%	6.1%	5.6%	5.5%	5.6%	5.6%	5.7%
Pierce	8.3%	7.5%	7.0%	6.4%	5.7%	5.6%	5.8%
Salish	7.6%	7.5%	6.7%	6.5%	6.3%	5.9%	5.9%
Southwest	6.8%	5.9%	6.0%	6.1%	6.2%	6.1%	5.9%
Spokane	10.0%	9.7%	8.8%	8.2%	8.1%	7.9%	7.9%
Thurston-Mason	8.4%	7.8%	7.4%	6.6%	6.8%	6.4%	6.7%
Statewide	**8.0%**	**7.4%**	**6.9%**	**6.5%**	**6.5%**	**6.3%**	**6.4%**

In line with the total number of Washington families with incomes under the FPL, the estimated percentage of families with children under 18 years of age who have incomes below the FPL has decreased from 12.8% in 2017 to 9.38% in 2023, representing a 23% reduction. Figure B.2 provides more specific information per region, although all regions show an overall decline in the percentage of families with a child under 18 years old living below the FPL.

[131] U.S. Census Bureau, U.S. Department of Commerce. (2023). *Poverty status in the past 12 months of families.* American Community Survey, ACS 5-Year Estimates Subject Tables, Table S1702.
https://data.census.gov/table/ACSST5Y2023.S1702?q=S1702:+Poverty+Status+in+the+Past+12+Months+of+Families&g=040XX00US53,53$0500000&moe=false

Figure B.2: Estimated Percent of Families with Children Under the Age of 18 Years Old and with Incomes Below FPL



Source: U.S. Census Data

Table B.7: Estimated Percent of Families with Children Under the Age of 18 Years Old and with Incomes Below FPL[132]

Region	2017	2018	2019	2020	2021	2022	2023
Great Rivers	19.0%	18.1%	15.9%	15.0%	15.0%	14.5%	14.4%
Greater Columbia	18.9%	18.1%	17.2%	15.3%	15.0%	14.4%	14.4%
King	9.6%	8.7%	8.0%	7.3%	7.5%	7.3%	7.3%
North Central	17.4%	16.0%	15.4%	15.6%	14.8%	13.7%	13.3%
North Sound	10.7%	9.7%	8.8%	8.5%	8.8%	8.5%	8.5%
Pierce	13.3%	12.1%	11.3%	10.2%	8.9%	8.6%	9.1%
Salish	13.9%	13.5%	12.3%	12.0%	11.5%	10.4%	10.0%
Southwest	10.9%	9.3%	9.5%	9.3%	10.2%	9.7%	9.4%
Spokane	16.7%	16.0%	14.6%	13.5%	13.2%	12.8%	12.6%
Thurston-Mason	13.8%	12.6%	12.2%	10.7%	11.1%	10.5%	11.0%

[132] U.S. Census Bureau, U.S. Department of Commerce. (2023). *Poverty status in the past 12 months of families*. American Community Survey, ACS 5-Year Estimates Subject Tables, Table S1702.
https://data.census.gov/table/ACSST5Y2023.S1702?q=S1702:+Poverty+Status+in+the+Past+12+Months+of+Families&g=040XX00US53,53$0500000&moe=false

Region	2017	2018	2019	2020	2021	2022	2023
Statewide	12.8%	11.9%	11.0%	10.3%	10.2%	9.8%	9.8%

Gender

Research and data continue to show how gender may affect mental health and how individuals may be more likely to experience specific mental health concerns based on their gender. This includes both the trans and gender fluid community, but also the cis-gendered population. These differences can be seen in prevalence, symptomology, availability to certain treatments, and outcomes to their mental health conditions. For example, cis females are more likely than cis males to experience depression and anxiety, without including post-partum anxiety. Even though women may experience these conditions at a higher prevalence, they often show signs of these mental health conditions that differ from males. This could include persistent sadness, withdrawal from social activities, and changes in eating or sleeping patterns. A further difference in males and females is often the causes of mental health concern. For women, this could include very specific things such as hormonal changes, higher rates of trauma and abuse, and societal pressures and stressors.[133] Similarly, the lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, and more (LGBTQIA+) community, including Native two-spirit individuals, has been historically marginalized and are still expected to experience poorer mental health outcomes compared with heterosexual and cis-gendered counterparts due to facing additional barriers to access. These barriers may include low practitioner knowledge of LGBTQIA+ issues, stereotyping of LGBTQIA+ behaviors, and ongoing stigma and marginalization.[134]

On the other hand, there is growing research that boys and men are falling behind in health, education, and employment stemming from crime, lack of male role models, lack of hands-on educational opportunities where boys struggle to sit still, and loss of relationships.[135] These issues are affecting mental health of boys that result in poorer effects later in life. Men die *deaths of despair* from suicide, drugs, or alcohol at nearly three times the rate of women. And often, those hit hardest by these trends are working-class, men of color, or both. A 2016 paper by Raj Chetty and colleagues describes how childhood environments affect boys and girls differently. Among children raised in the poorest households, researchers found boys were less likely than girls to work as adults. The gap was wider for boys raised by single parents, and those who grew up in high-poverty, high-minority neighborhoods. In 2018, Chetty found that boys are especially vulnerable to these effects. The research showed that boys may be more sensitive to their environments even in early childhood, with worse neighborhoods harming their kindergarten readiness more than girls. New programs are sought to improve mental health, social health, and academic engagement at younger ages to reverse these trends.

Race and Ethnicity

For several decades, research has shown that while Black individuals (or African Americans) often have higher rates of psychological distress compared to White individuals, some studies also find that Whites have elevated levels of depressive and anxiety symptoms compared to African

[133] Behavioral Hospital of Bellaire. (2024, July 15). *Women & mental health: Why gender matters*. https://bhbhospital.com/blog/women-mental-health-why-gender-matters/

[134] PubMed Central. (2020). *Mental health challenges of lesbian, gay, bisexual, and transgender people: An integrated literature review.* https://pmc.ncbi.nlm.nih.gov/articles/PMC7876969/

[135] Pasquini, Nina. (2025, May-June). The new gender gaps. *Harvard Magazine*, 24. https://www.harvardmagazine.com/2025/05/harvard-men-gender-gap-education-employment

Americans.[136] African Americans tend to report lower levels of psychological well-being on cognitively focused measures such as life satisfaction and happiness,[137] but also report higher levels of flourishing than Whites.[138] Here, flourishing is operationalized as the absence of mental disorders and the presence of high levels of psychological well-being. When considering psychiatric disorders, Hispanic/Latinos (with the exception of Puerto Ricans), African Americans and Asians all have lower rates of lifetime and past year psychiatric disorders than Whites.[139] However, when African Americans and Latinos experience mental illness, their episodes tend to be more severe, persist for longer periods of time, and are more debilitating than for any other race/ethnic group.[140]

Across all age groups, the percentage of individuals identifying as White ranges from 69% to 74%. The representation of individuals identifying as Asian is between 9%–10%, while American Indian and Alaska Native, Black, and Native Hawaiian groups have smaller proportions of the population (3%, 5%, and 1%, respectively). The percentage of individuals identifying as two or more races is between 11% in the 0 years–5 years old age group and 8% in the 8 years–25 years old age group. The breakdown by age of race in Washington can be seen in Figure B.3, with further breakdown of ethnicity in Figure B.4. Regarding ethnicity, across all age groups, the percentage of non-Hispanic individuals is greater than Hispanic individuals. The proportion of Hispanic individuals is higher in the 0 years–5 years old age group (24%) compared to 20% in the 8 years–25 years old age group, mirroring national trends. Overall, the percentage of Hispanic individuals decreases as age increases.

[136] Vega, William A., & Rumbaut, Ruben G. (1991). Ethnic minorities and mental health. *Annual Review of Sociology*, 17, 351–383.

[137] Hughes, Michael, & Thomas, Melvin E. (1998). The continuing significance of race revisited: A study of race, class, and quality of life in America, 1972 to 1996. *American Sociological Review*, 63, 785–795.

[138] Keyes, Corey L. M. (2007). Promoting and protecting mental health as flourishing: A complementary strategy for improving national mental health. *American Psychologist*, 62(2), 95–108. https://doi.org/10.1037/0003-066X.62.2.95

[139] Miranda, Jeanne, McGuire, Tomas G., Williams, David R., & Wang, Philip. (2008). Mental health in the context of health disparities. *American Journal of Psychiatry*, 165(9), 1102–1108. https://doi.org/10.1176/appi.ajp.2008.08030333

[140] Williams, David R. (2018). *Stress and the mental health of populations of color: Advancing our understanding of race-related stressors. Journal of Health and Social Behavior*, 59(4), 466–485. https://doi.org/10.1177/0022146518814251

Figure B.3: Race Breakdown by Age Group

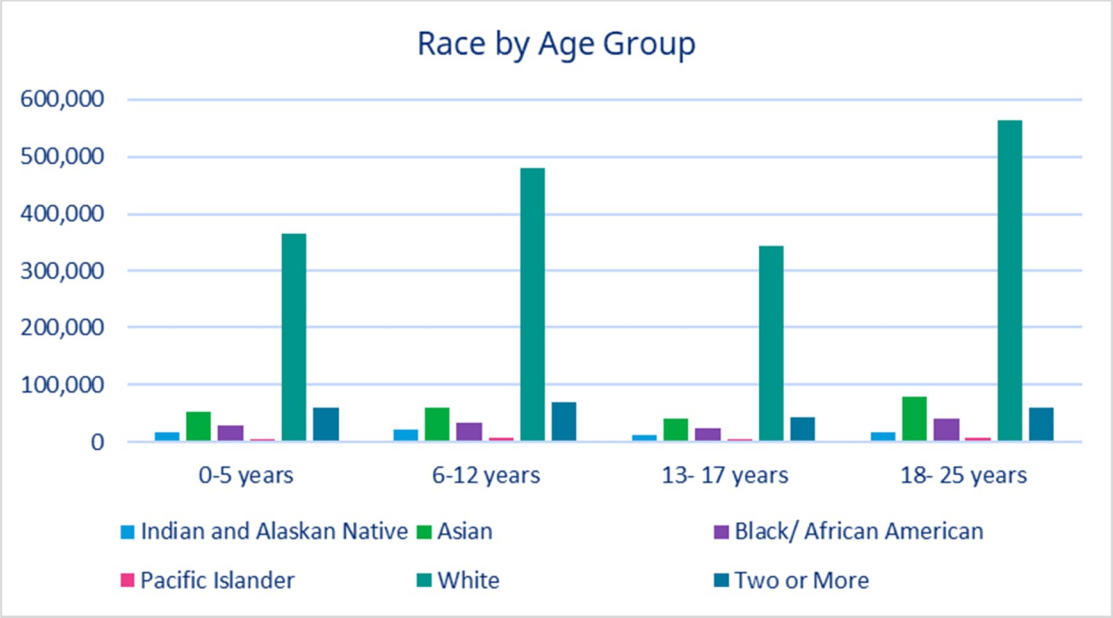
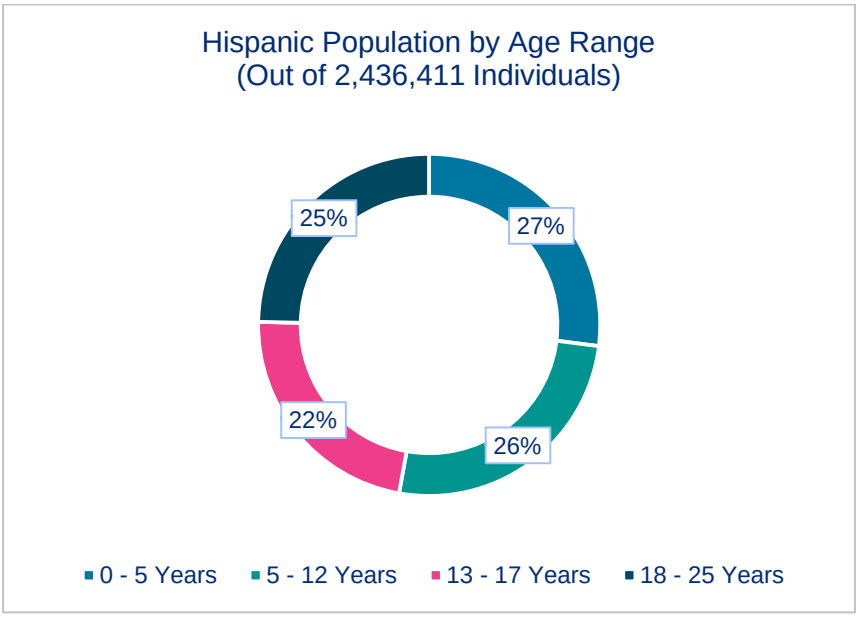


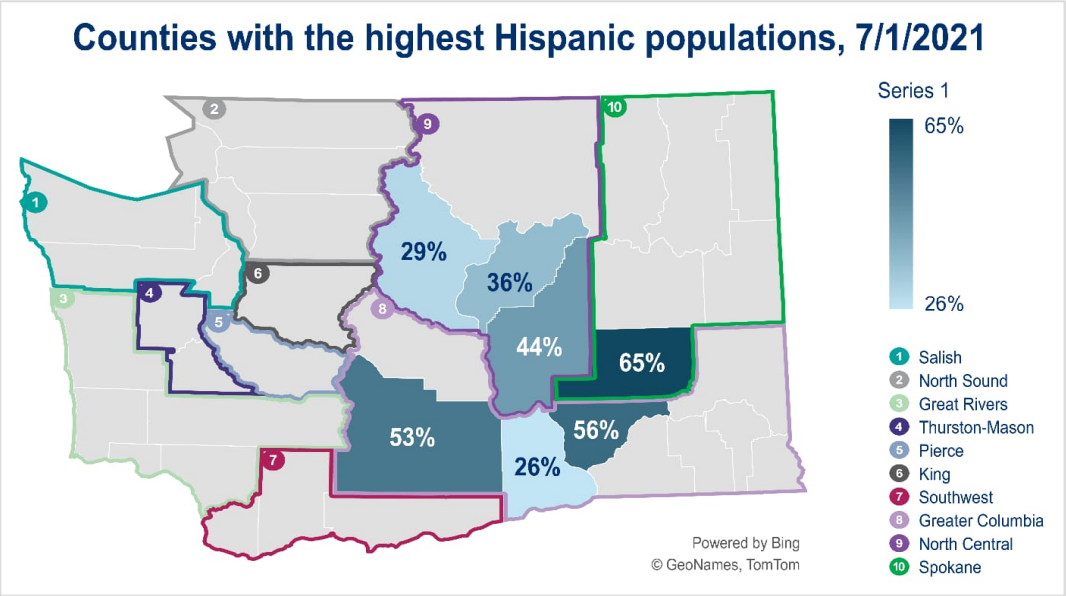
Figure B.4: Age Breakdown of Hispanic Population, July 1, 2021



Source: Washington State Department of Health. (n.d.). *Demographics data*. Retrieved April 11, 2025, from https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/demographics

Hispanic, Latino, and Latina people make up more than a quarter of the population in seven counties, much greater than the statewide average of 15%. These areas may need additional language support and culturally relevant services. As shown in Map B.2 below, the counties with the highest percentage of Hispanic individuals are clustered in the central portion of the State.

Map B.2: Counties with the Highest Hispanic Populations, July 1, 2021



Source: Washington State Department of Health. (n.d.). *Demographics data*. Retrieved April 11, 2025, from https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/demographics

Just over three-quarters of the Washington population (76%) is White. In 32 of the 39 counties, more than 82% of the population is White. The highest percentage of Black and African Americans live in Pierce and King counties. The highest percent of Asian Americans live in King and Snohomish counties. Six of the seven most racially diverse counties also have a 10% or higher Hispanic population.

Table B.8: The Seven Most Racially and Ethnically Diverse Counties, July 1, 2021

County	White	Black/ African American	American Indian	Asian American	Native Alaskan/ Hawaiian	Other/ Multiple	Hispanic
Kitsap	81%	3%	2%	6%	1%	7%	10%
Okanogan	81%	1%	12%	1%	0%	3%	21%
Thurston	80%	4%	2%	7%	1%	6%	11%
Ferry	76%	1%	17%	1%	0%	5%	4%
Snohomish	73%	4%	2%	15%	1%	5%	12%
Pierce	72%	8%	2%	8%	2%	8%	13%
King	63%	7%	1%	22%	1%	6%	11%

Source: Washington State Department of Health. (n.d.). *Demographics data*. Retrieved April 11, 2025, from https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/demographics

Seven counties have 5% or higher Native American population, compared to 2% statewide, though this number underrepresents the total population of Native Americans as Census data do not include individuals who identify as Native American in combination with any other racial group. Map B.3 shows the counties with the highest populations.

As can be seen below, the counties are clustered in the North Central, West, and Central portions of the State. The high rates of alcohol, substance use and mental health disorders, suicide, violence, and behavior-related morbidity and mortality in American Indian and Alaska Native communities continue to be disproportionately higher than the rest of the U.S. population. Studies show Indigenous people have disproportionately higher rates of mental health[141] problems such as suicide, post-traumatic stress disorder, violence, and substance use disorders. These high rates result in American Indian and Alaska Native people reporting serious psychological distress, 2.5 times more[142] than the general population over a month's time. Below are key statistics defining the health disparities experienced by the American Indian and Alaska Native population.

- Highest rates of suicide[143] of any minority group within the U.S. and rates are increasing since 2003, as well as high rates of substance use disorder[144] of both illicit drugs and alcohol use.
- From 2016 to 2020, they experienced alcohol-related deaths at significantly higher rates (51.9/100,000) than the rest of the U.S. population (11.7/100,000).[145]
- Highest prevalence of methamphetamine use, as well as methamphetamine use disorder, methamphetamine injection, and significant increases in methamphetamine overdose.[146]
- In 2019 and 2020, drug overdose death[147] rates were highest for non-Hispanic American Indian and Alaska Native people at 30.5 and 42.5 per 100,000, respectively.
- From 2019–2020, the American Indian and Alaska Native overdose death rates[148] increased by 39%.[149]

[141] Gone, J. P., & Trimble, J. E. (2012). American Indian and Alaska Native mental health: Diverse perspectives on enduring disparities. *Annual Review of Clinical Psychology*, 8, 131–160. https://doi.org/10.1146/annurev-clinpsy-032511-143127

[142] U.S. Department of Health and Human Services, Indian Health Service, Office of Public Health Support, Division of Program Statistics. (2014). *Trends in Indian health*. https://www.ihs.gov/sites/dps/themes/newihstheme/display_objects/documents/Trends2014Book508.pdf

[143] Leavitt, R. A., Ertl, A., Sheats, K., Petrosky, E., Ivey-Stephenson, A., & Fowler, K. A. (2018). Suicides among American Indian/Alaska Natives — National Violent Death Reporting System, 18 states, 2003–2014. *MMWR Morbidity and Mortality Weekly Report*, 67, 237–242. http://dx.doi.org/10.15585/mmwr.mm6708a1

[144] Kwon, S. C., Kabir, R., & Saadabadi, A. (2024, February 12). Mental health challenges in caring for American Indians and Alaska Natives. *In StatPearls*. https://www.ncbi.nlm.nih.gov/books/NBK570587/

[145] Centers for Disease Control and Prevention, National Center for Health Statistics. (2021). *National Vital Statistics System, mortality 1999-2020* on CDC WONDER online database.

[146] Han, B., et al. (2021). Methamphetamine overdose deaths in the United States by Sex and racial/ethnic differences. *JAMA Psychiatry*. https://doi.org/10.1001/jamapsychiatry.2020.4321

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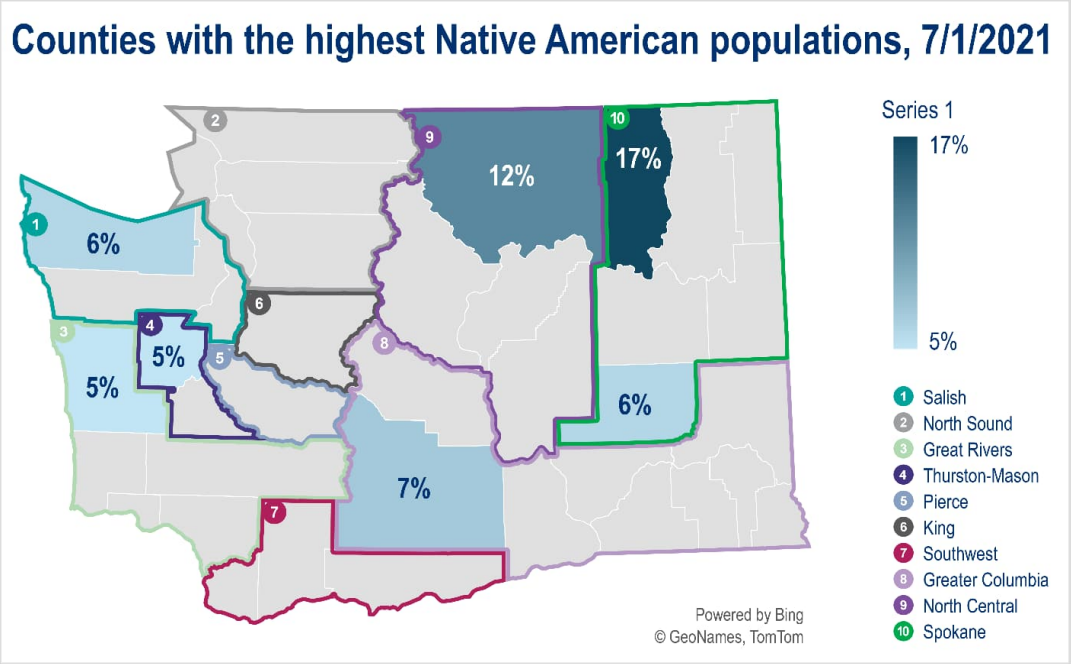
[148] Kariisa, M., Davis, N. L., Kumar, S., et al. (2022). Vital signs: Drug overdose deaths, by selected sociodemographic and social determinants of health characteristics — 25 states and the District of Columbia, 2019–2020. *MMWR Morbidity and Mortality Weekly Report*, 71, 940–947. http://dx.doi.org/10.15585/mmwr.mm7129e2

[149] Indian Health Service. (2023, June). *Fact sheet – Behavioral health*. https://www.ihs.gov/newsroom/factsheets/behavioralhealth

Map B.3: Counties with the Highest Native American populations, July 1, 2021



Source: Washington State Department of Health. (n.d.). *Demographics data*. Retrieved April 11, 2025, from https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/demographics

Language Barrier

Washington is a diverse State, with approximately 163 languages spoken. This includes Spanish, Vietnamese, Russian, Hindi, Arabic, Somali, Ukrainian, and eleven languages of the Pacific Northwest. Overall, approximately 80.9% of Washingtonians speak English, 8.4% speak Spanish, 5.7% speak Asian and Pacific Island languages, and 5% speak other languages.[150]

Table B.9: Language by Age Group by Region 2023[151]

	Spanish		Other Indo-European		Asian and Pacific Island		Other	
Region	**5-17 Years**	**18-64 Years**	**5-17 Years**	**18-64 Years**	**5-17 Years**	**18-64 Years**	**5-17 Years**	**18-64 Years**
Great Rivers	1.7%	4.2%	0.1%	0.6%	0.1%	0.7%	0.0%	0.1%
Greater Columbia	7.7%	18.4%	0.2%	1.0%	0.2%	1.1%	0.1%	0.3%
King	1.6%	5.0%	1.1%	5.7%	1.4%	9.6%	0.6%	2.1%
North Central	6.1%	16.3%	0.2%	0.7%	0.1%	0.4%	0.0%	0.2%

[150] Linguistics PSA Posters. *Western Washington University*. https://chss.wwu.edu/linguistics/linguistics-psa-posters

[151] U.S. Census Bureau, U.S. Department of Commerce. (n.d.). *Language spoken at home*. American Community Survey, ACS 5-Year Estimates Subject Tables, Table S1601. https://data.census.gov/table/ACSST5Y2023.S1601?q=s1601&g=040XX00US53,53$0500000&moe=false

	Spanish		Other Indo-European		Asian and Pacific Island		Other	
North Sound	1.8%	5.2%	0.7%	3.2%	0.7%	4.6%	0.3%	1.2%
Pierce	1.5%	4.7%	0.5%	2.1%	0.7%	3.7%	0.2%	0.6%
Salish	0.5%	2.5%	0.1%	1.0%	0.2%	1.8%	0.1%	0.3%
Southwest	1.7%	4.9%	1.0%	3.6%	0.4%	2.4%	0.1%	0.4%
Spokane	0.7%	2.7%	0.4%	1.6%	0.2%	1.1%	0.2%	0.6%
Thurston-Mason	1.1%	3.8%	0.3%	1.3%	0.5%	2.9%	0.1%	0.4%
Statewide	**2.2%**	**6.2%**	**0.7%**	**3.1%**	**0.7%**	**4.7%**	**0.3%**	**1.0%**

It is estimated that there are a growing number of individuals in the State with language barriers, defined as individuals who speak English less than *very well* and may need language services for themselves/their children/families to access health care. In 2017, approximately 6.9% of the population had language barriers, but by 2023, this figure increased to an estimated 7.4%.

Regionally, there are great variations in the percentage of the population with language barriers. Salish, Spokane, and Great Rivers have fewer than 3.2% of their populations having language barriers, while Greater Columbia, King, and North Central have more than 10% of their populations experiencing these barriers.

Statewide, the most common language other than English is generally Spanish. In King County, however, the most commonly spoken languages are Asian and Pacific Island languages (spoken by 12.8% of residents as opposed to 7% who speak Spanish).

Table B.10: Estimated Percent of the Population with Language Barriers

Estimated Percent of the Population with Language Barriers							
Region	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**
Great Rivers	3.5%	3.2%	3.0%	2.8%	3.0%	2.9%	3.2%
Greater Columbia	11.4%	11.5%	11.6%	11.4%	11.6%	11.8%	11.6%
King	9.5%	9.6%	9.8%	10.0%	10.1%	10.0%	10.3%
North Central	10.2%	10.1%	10.0%	9.4%	9.3%	9.6%	10.0%
North Sound	5.9%	6.0%	5.9%	6.1%	6.4%	6.6%	6.9%
Pierce	4.9%	5.1%	5.0%	5.1%	5.3%	5.4%	5.5%
Salish	1.8%	1.9%	1.9%	2.0%	2.1%	2.2%	2.2%
Southwest	5.1%	5.1%	5.1%	5.2%	5.3%	5.4%	5.5%
Spokane	2.5%	2.9%	2.9%	2.8%	2.8%	2.8%	3.0%
Thurston-Mason	3.8%	3.7%	3.7%	3.6%	3.7%	3.9%	4.1%
Statewide	**6.9%**	**6.9%**	**6.9%**	**7.0%**	**7.1%**	**7.2%**	**7.4%**

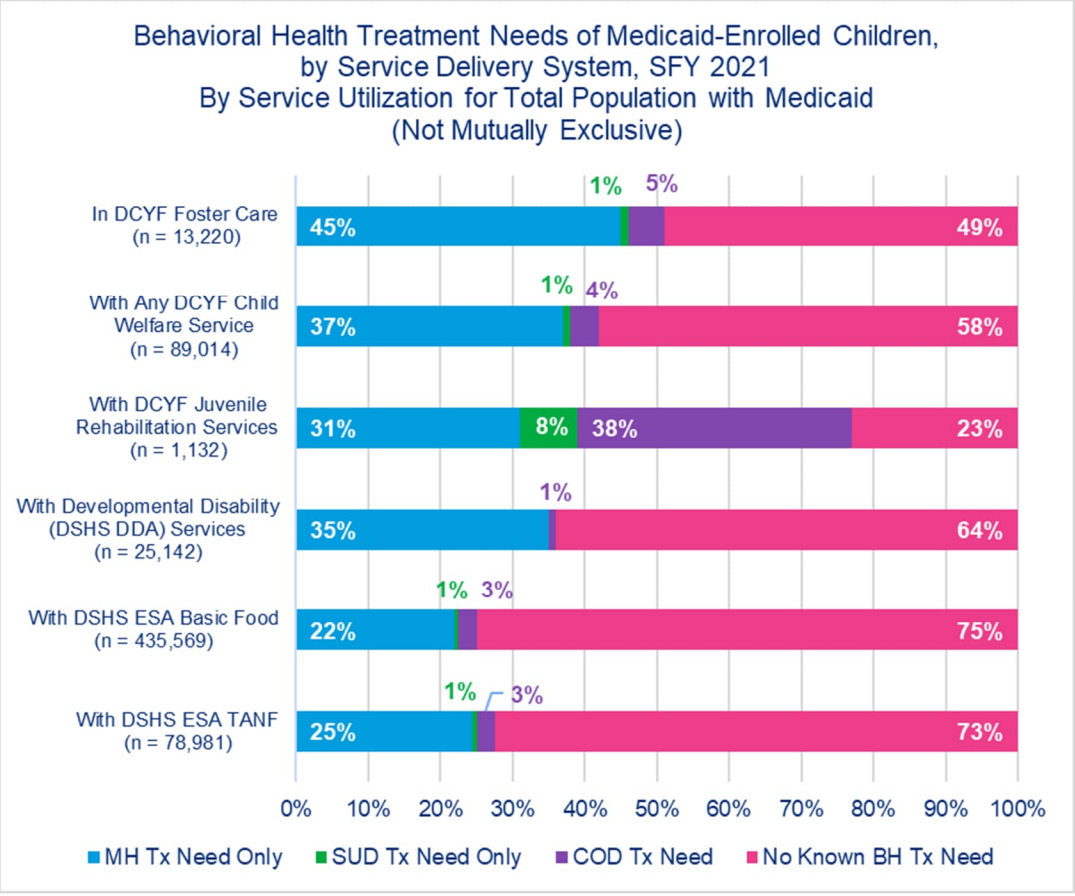
These observations suggest two key findings:

- A larger proportion of the population is requiring assistance with language to access health care services.
- The needs of individuals vary greatly by region, with at least one in ten individuals in Greater Columbia, King, and North Central needing assistance.

Characteristics of Medicaid Children

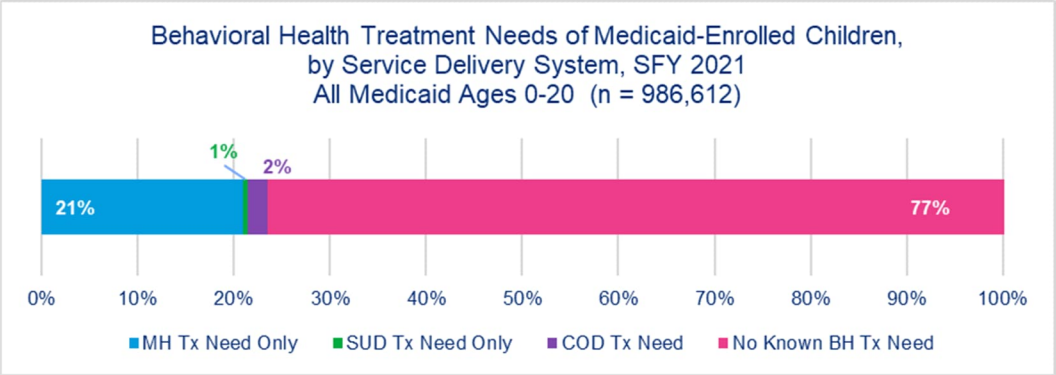
Many of the children needing behavioral health treatment are multi-system involved, have multiple co-occurring conditions compounding their behavioral health needs, or have other social determinants of health such as low-income or food insecurity affecting their health. The table below shows that 51% of Medicaid children in Department of Children, Youth, and Families (DCYF) foster care require behavioral health treatment, 42% of Medicaid children in DCYF child welfare services require behavioral health treatment, 87% of Medicaid children in DCYF juvenile rehabilitation services require behavioral health treatment, 36% of Medicaid children with developmental disability services require behavioral health treatment, 25% of Medicaid Children with Department of Social and Health Services (DSHS) Economic Services Administration (ESA) basic food assistance and 27% of Medicaid Children with DSHS ESA Temporary Assistance for Needy Families assistance require behavioral health treatment.

Figure B.5: Behavioral Health Treatment Needs of Medicaid Enrolled Children — Service Utilization for Total Population



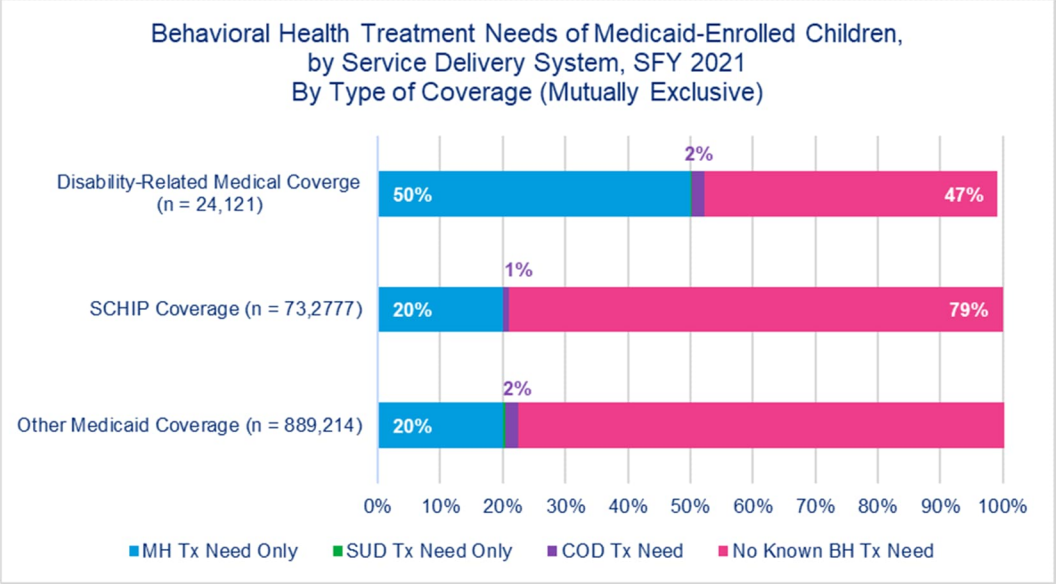
As seen in the figures below, 24% of Medicaid eligible children aged 0 years–20 years old need behavioral health treatment, with 21% needing mental health treatment only, 1% requiring substance use disorder treatment only, and 2% requiring co-occurring treatment. Most Medicaid children do not require behavioral health treatment.

Figure B.6: Behavioral Health Treatment Needs of Medicaid Enrolled Children — Service Delivery System



Medicaid children with disabilities are more likely than children with State's Children's Health Insurance Program (SCHIP) or other Medicaid eligibility coverage to need behavioral health treatment. Medicaid children with disability related coverage need behavioral health treatment 52% of the time compared to children who are eligible for Medicaid due to income (SCHIP — 21% or other Medicaid coverage 22%).

Figure B.7: Behavioral Health Treatment Needs of Medicaid Enrolled Children — Type of Coverage



Source: Washington State Department of Social and Health Services. (November 2023). Behavioral health treatment needs and outcomes among Medicaid enrolled children in Washington State.https://www.dshs.wa.gov/sites/default/files/rda/reports/CHILDRENS_BH_DASHBOARD_2023NOV.pdf

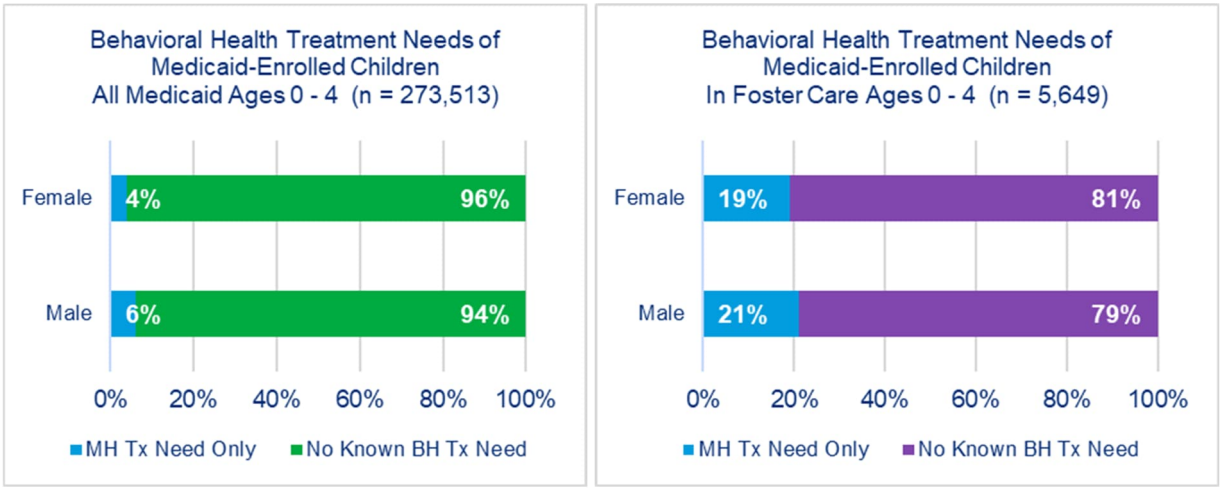
Appendix C
Children in Foster Care

Children, youth, and transitional age youth in foster care present added behavioral health needs and complexities within the system. While these children are included in the overall utilization data above, Mercer felt it important to highlight where the foster care population may differ from the rest of Washington's Medicaid population. When the rates of behavioral health were compared across foster care status, Medicaid coverage type, and cross-system involvement, Washington, like other states, found a substantially higher prevalence of behavioral health needs among children in foster care compared to children receiving publicly funded medical coverage more broadly. The Children's Behavioral Health Dashboard from November 2023 compared outcomes from 2014 to 2020, including behavioral health treatment penetration rates and utilization, psychotropic polypharmacy, juvenile legal involvement, emergency department (ED) utilization, and between children in the general Washington State Medicaid population and those in foster care by specific behavioral health needs and age groups.[152]

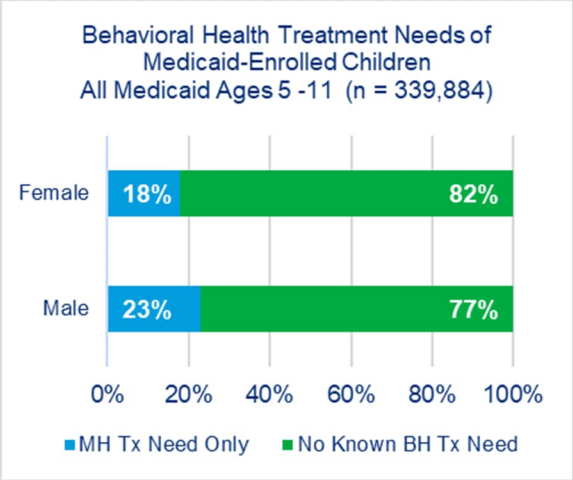
In the figures below, for example, children in foster care ages 0 years–4 years old were around four times more likely to require behavioral health treatment than non-foster care Medicaid children. For children in foster care ages 5 years–11 years old, the need for behavioral health treatment was about 3.5 times greater than in non-foster care Medicaid children.

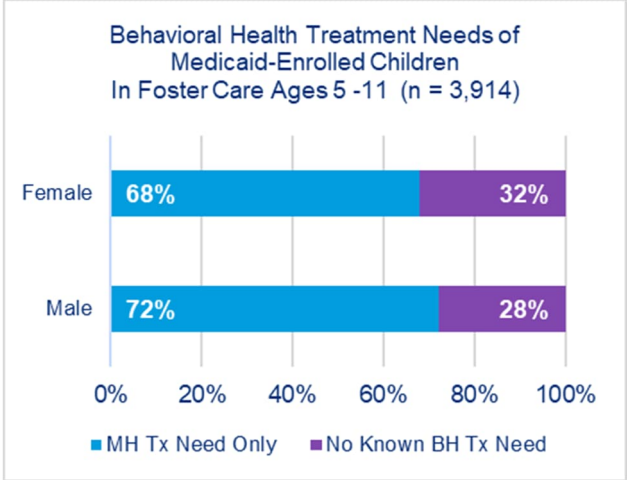
Behavioral Health Treatment Needs of Medicaid-Enrolled Children, by Gender and Age Group, State Fiscal Year 2021

Figure C.1: Behavioral Health Treatment Needs of Medicaid-Enrolled Children — Age 0 year–4 years old



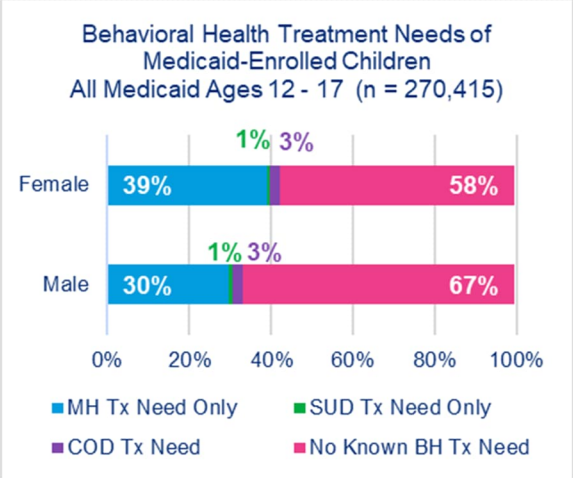
[152] Washington State Department of Social and Health Services. (2023, November). *Behavioral health treatment needs and outcomes among Medicaid enrolled children in Washington State*. https://www.dshs.wa.gov/sites/default/files/rda/reports/CHILDRENS_BH_DASHBOARD_2023NOV.pdf

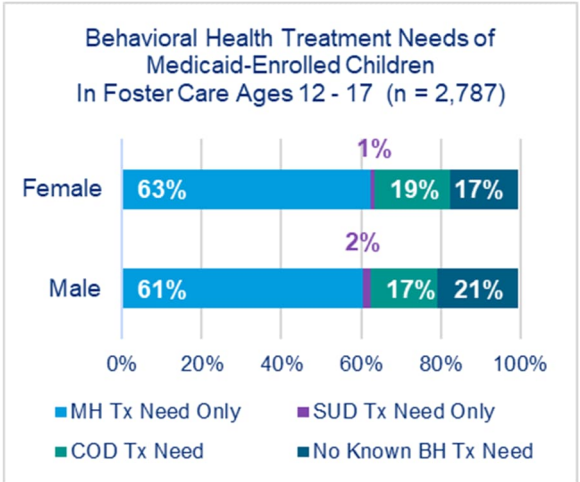


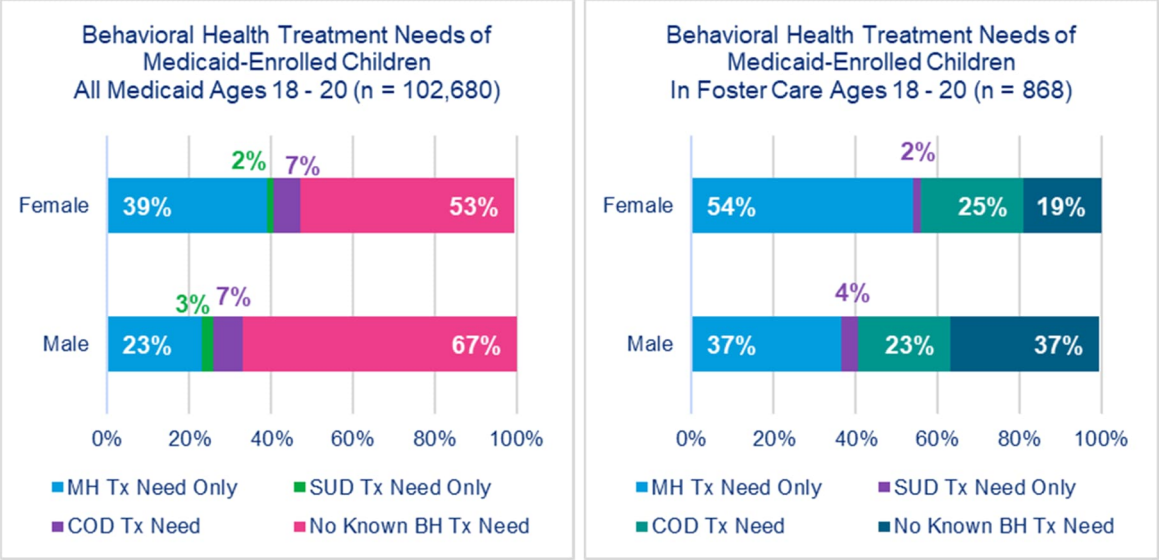


Older children in foster care (ages 12 years–17 years old) were two times more likely to require behavioral health treatment than non-foster care Medicaid children. However, over 80% of all children in foster care in that age range need behavioral health treatment. For transition age youth in foster care (ages 18 years–20 years old), the need for behavioral health treatment was not quite two times greater than in non-foster care Medicaid children, but between 60% and 80% of children in foster care (disproportionately more females than males) needed behavioral health treatment.

Figure C.2: Behavioral Health Treatment Needs of Medicaid Enrolled Children — Age 12 years–17 years old

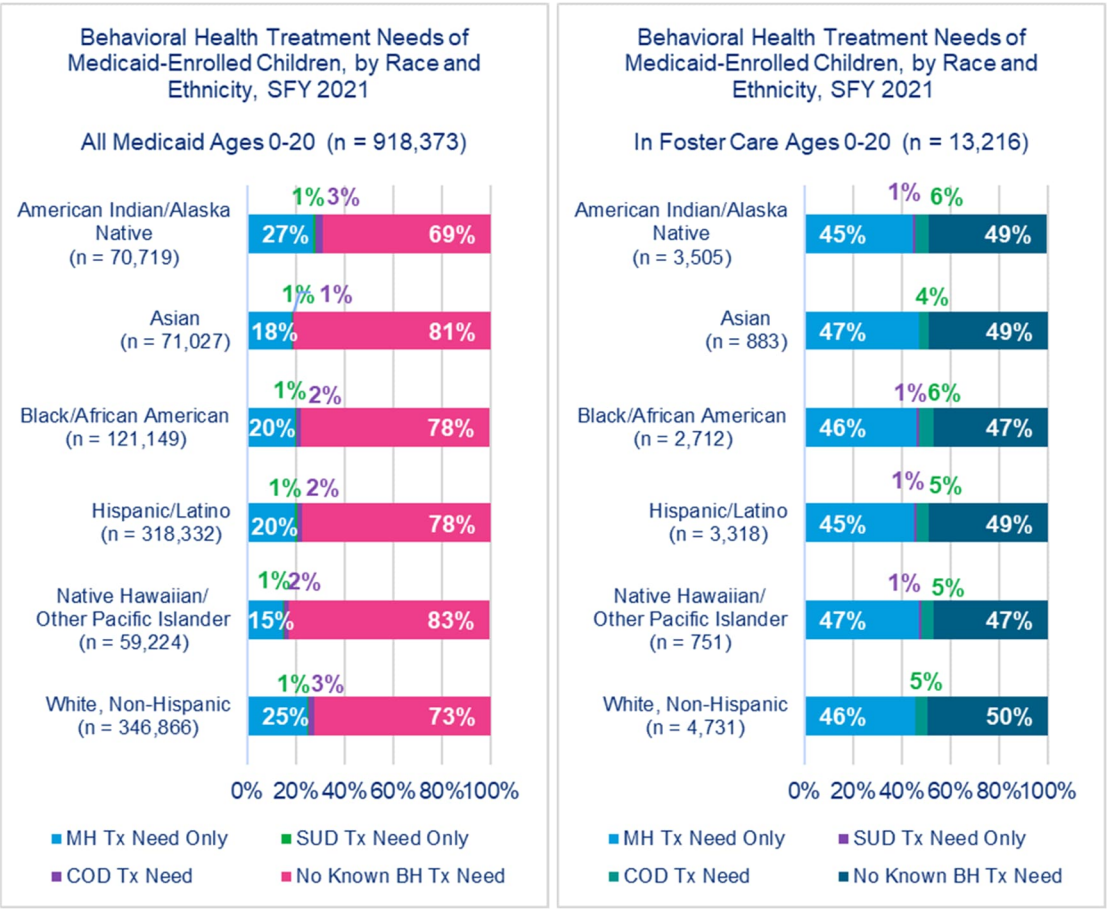






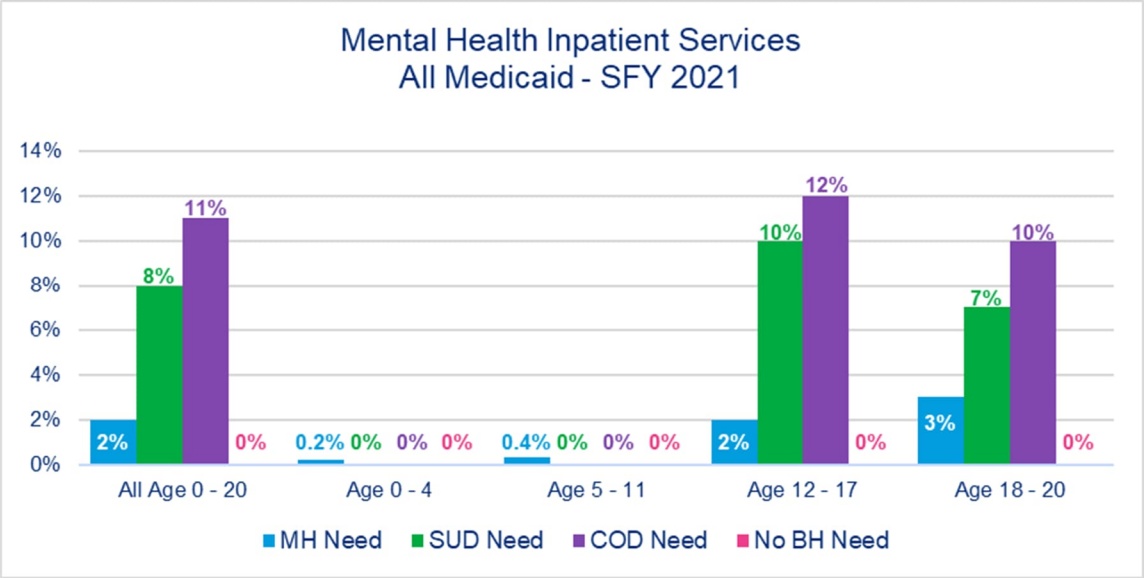
In the graphs below, comparing children in foster care to Medicaid children by racial identification, it can be seen that children in foster care are roughly twice as likely to require behavioral health treatment as their non-foster care Medicaid child counterparts.

Figure C.3: Behavioral Health Treatment Needs of Medicaid Enrolled Children — By Race and Ethnicity



The number of Medicaid children requiring inpatient hospital, ED services, and crisis services for mental health, substance use disorder (SUD), and co-occurring disorder (COD) varies depending on whether the child is in foster care. In the figures below,[153] we see that between 2%–11% of all Medicaid children ages zero to 20 years old needed mental health, SUD, and COD inpatient services, with children aged 12 years–17 years old having the most need. Between 4%–19% of children in foster care required mental health, SUD, and COD inpatient hospitalization with 9%–21% of children in foster care ages 12 years–17 years old needing hospitalization. As can be seen in the below figures, the need for mental health, SUD, and COD in Medicaid children and Medicaid children in foster care is growing over time.

Figure C.4: Mental Health Inpatient Services — All Medicaid by Age



[153] Washington State Department of Social and Health Services. (2023, November). *Behavioral health treatment needs and outcomes among Medicaid enrolled children in Washington State*. https://www.dshs.wa.gov/sites/default/files/rda/reports/CHILDRENS_BH_DASHBOARD_2023NOV.pdf

Figure C.5: Mental Health Inpatient Services — Foster Care by Age

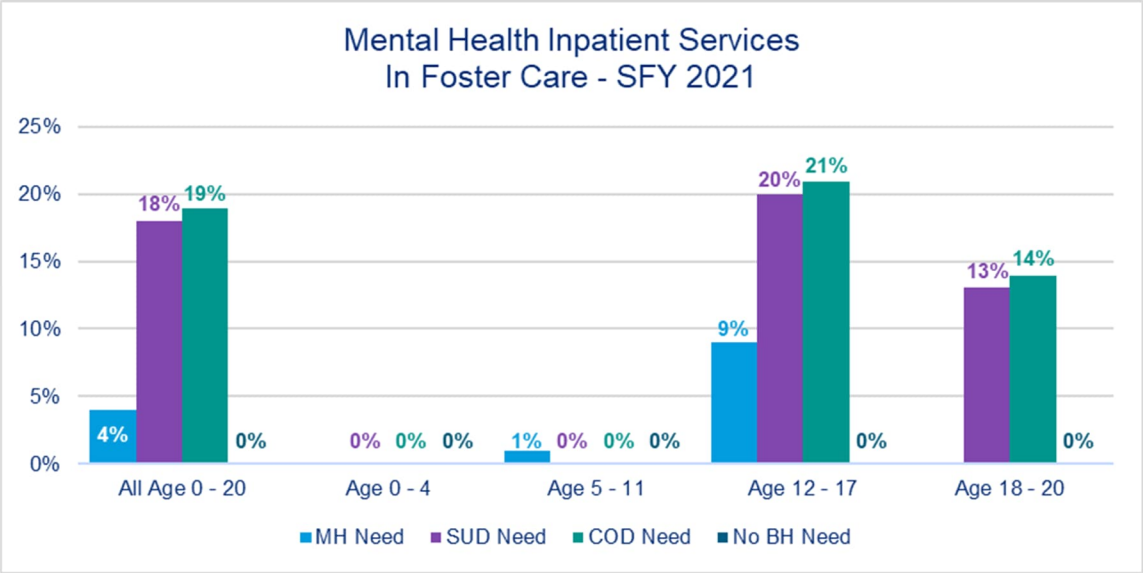


Figure C.6: Mental Health Inpatient Services — All Medicaid by Need

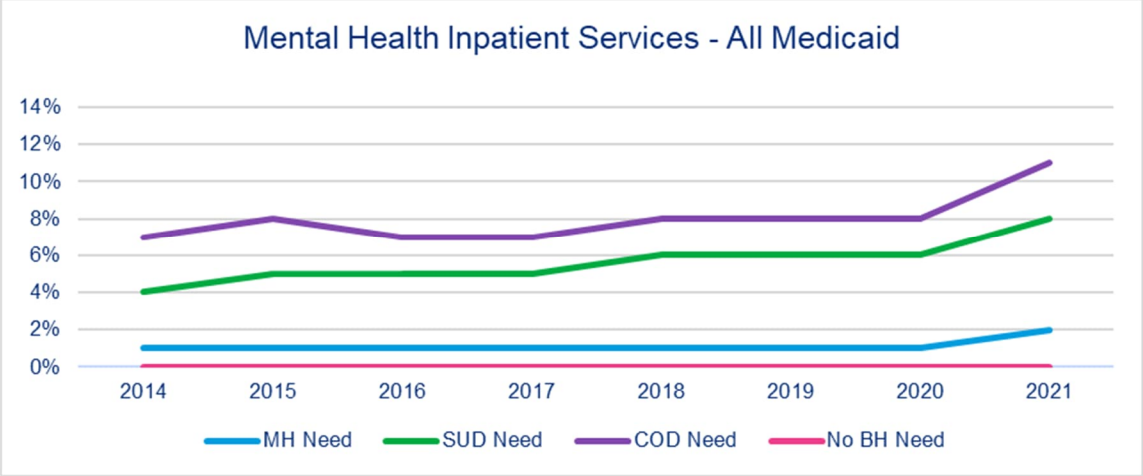
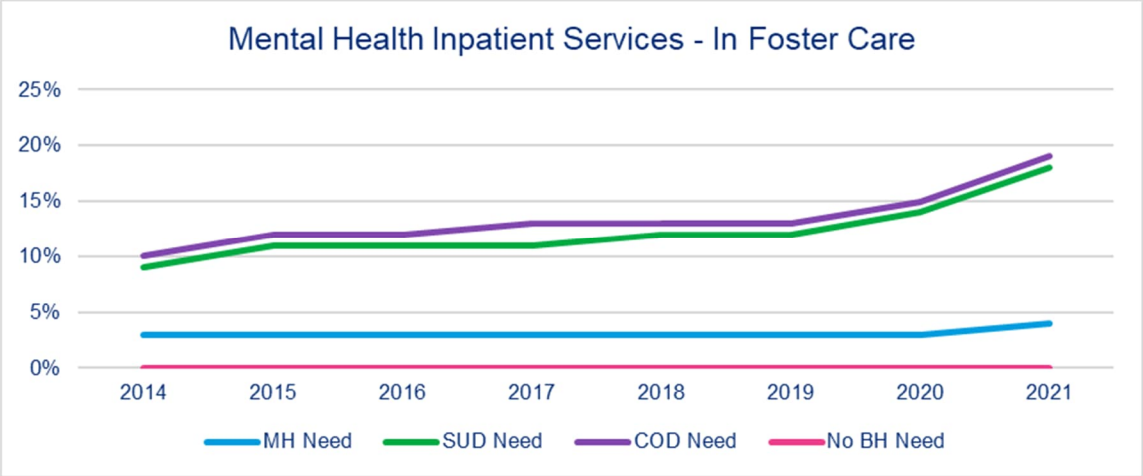
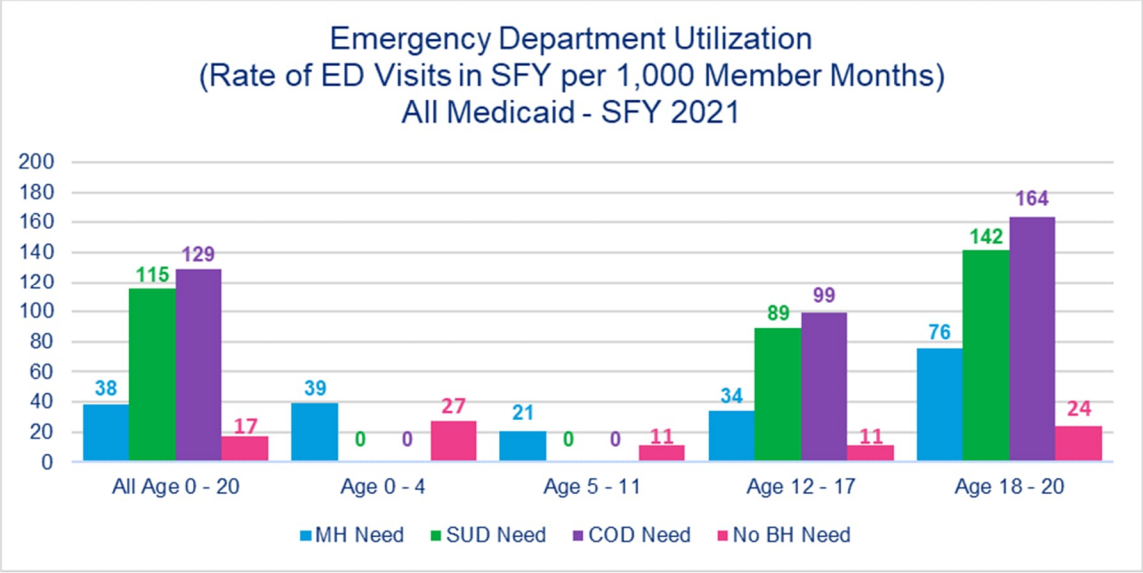


Figure C.7: Mental Health Inpatient Services — Foster Care by Need



In the figures below,[154] ED usage per 1,000 member months for children in foster care has increased for SUD and co-occurring behavioral health treatment but declined over the same period for Medicaid children. Mental health usage has remained relatively steady. The ED usage rate per 1,000 member months for children with foster care is 51% higher for foster care children with mental health than the regular Medicaid population (64/1,000 compared to 38/1,000), 49% greater for foster care children with SUD needs (190/1,000 versus 115/1,000), and 43% higher for foster care children with co-occurring needs (199/1,000 versus 129/1,000). For children without behavioral health needs, children in foster care required a 74% higher percentage of ED room visits compared to the regular Medicaid children's population (37/1,000 versus 17/1,000).

Figure C.8: ED Utilization — All Medicaid by Age



[154] Washington State Department of Social and Health Services. (2023, November). *Behavioral health treatment needs and outcomes among Medicaid enrolled children in Washington State.* https://www.dshs.wa.gov/sites/default/files/rda/reports/CHILDRENS_BH_DASHBOARD_2023NOV.pdf

Figure C.9: ED Utilization — Foster Care by Age

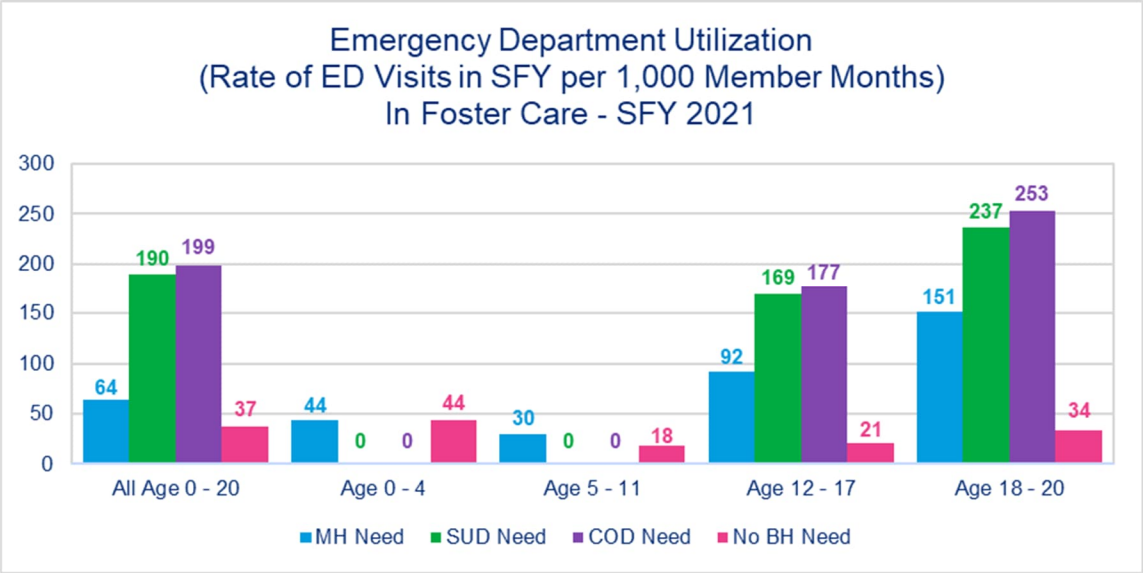


Figure C.10: ED Utilization — All Medicaid by Need

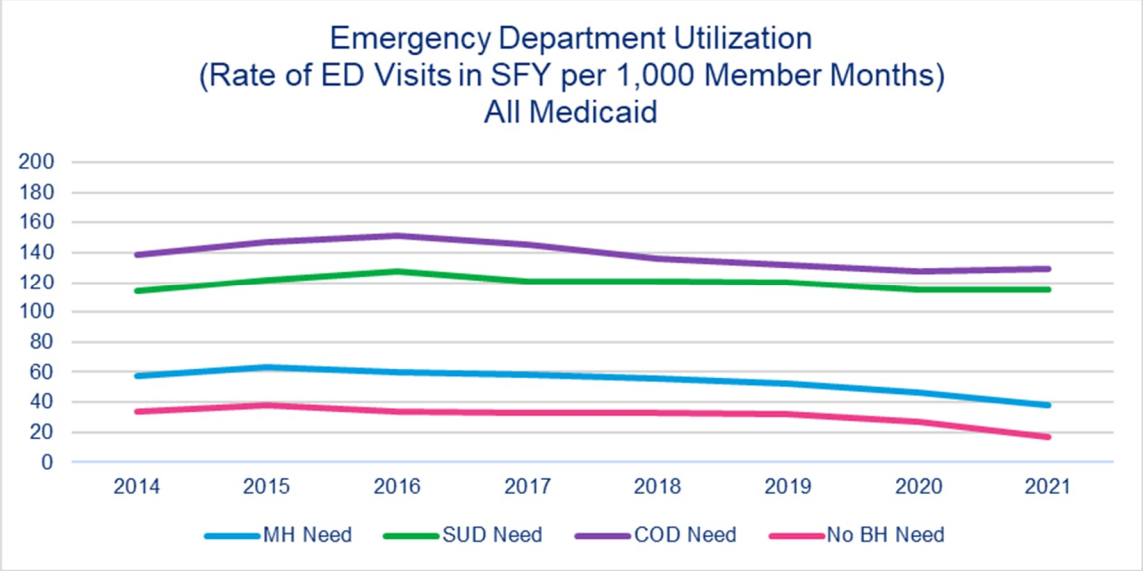
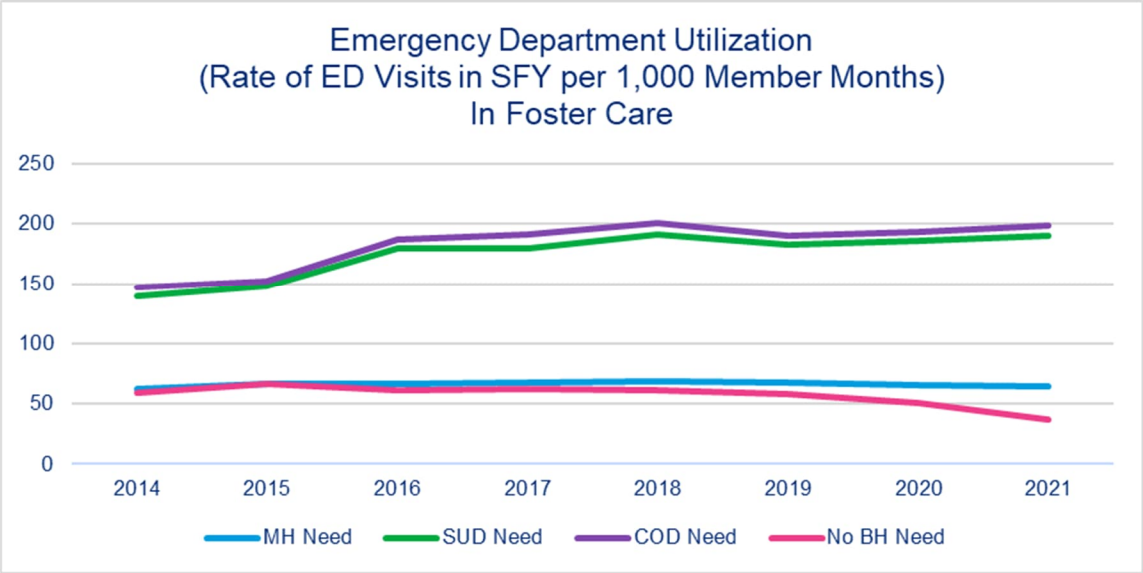
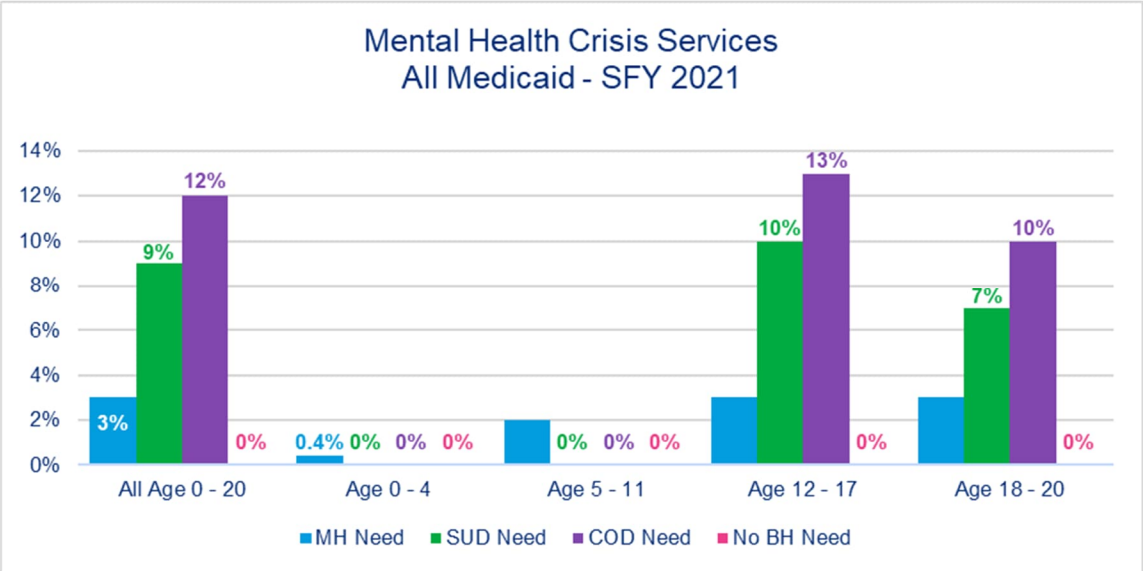


Figure C.11: ED Utilization — Foster Care by Need



Similarly, there is a need for mental health, SUD, and COD crisis services among children in Medicaid ages 0 years–20 years old that ranges from 3%–12% of the population depending upon age, with 3%–13% of children ages 12 years to 17 years old needing crisis services. 8%–24% of children in foster care require mental health, SUD, and COD crisis services from ages 0 years-20 years old, with 13%–26% of the population ages 12 years–17 years old requiring crisis services. The percentage of the children's populations requiring mental health, SUD, and COD crisis services was relatively constant prior to 2021 with a few fluctuations.[155]

Figure C.12: Mental Health Crisis Services — All Medicaid by Age



[155] Washington State Department of Social and Health Services. (2023, November). *Behavioral health treatment needs and outcomes among Medicaid enrolled children in Washington State*. https://www.dshs.wa.gov/sites/default/files/rda/reports/CHILDRENS_BH_DASHBOARD_2023NOV.pdf

Figure C.13: Mental Health Crisis Services — All Medicaid by Need

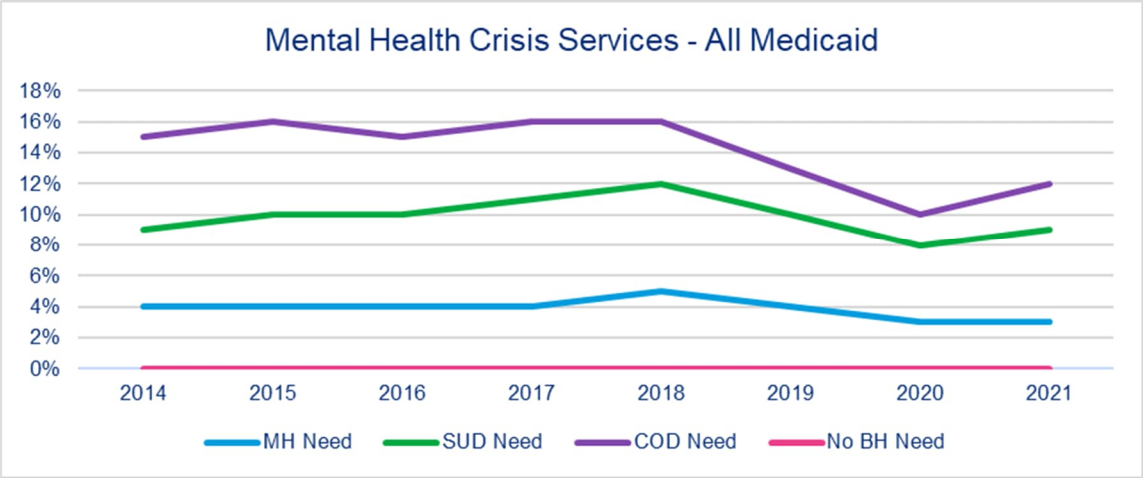


Figure C.14: Mental Health Crisis Services — Foster Care by Age

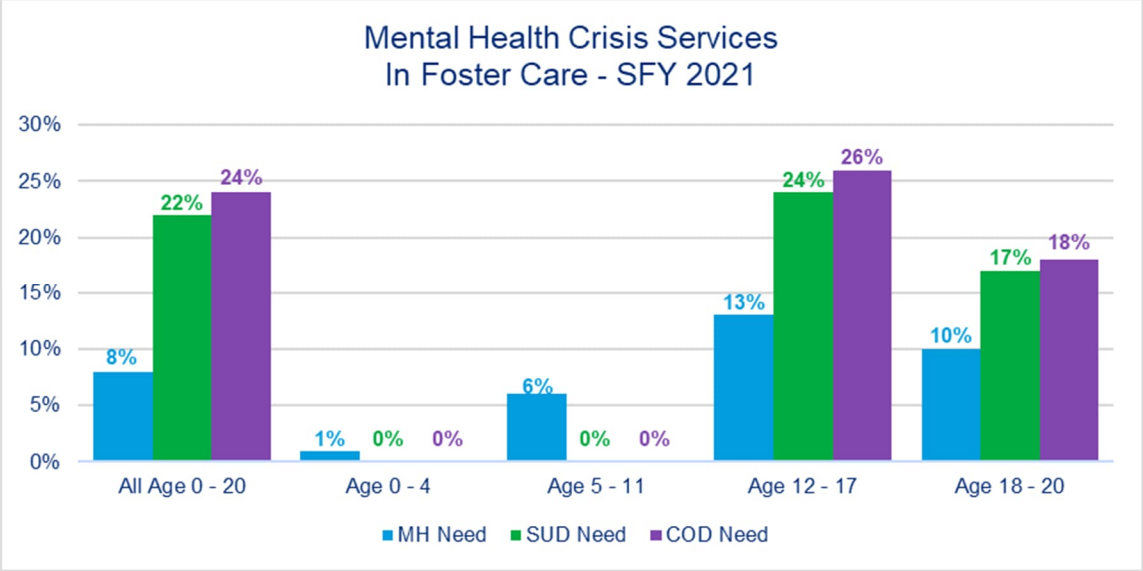
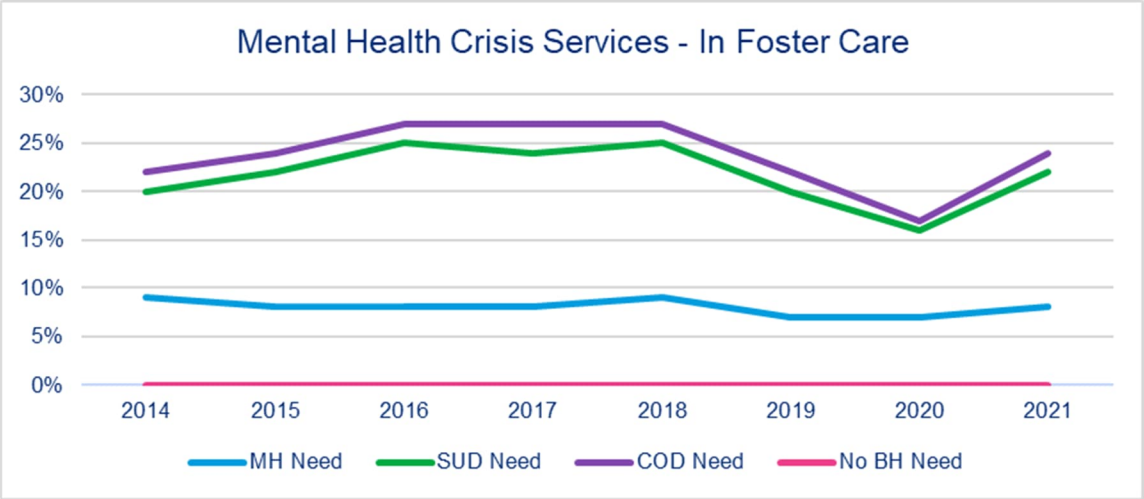
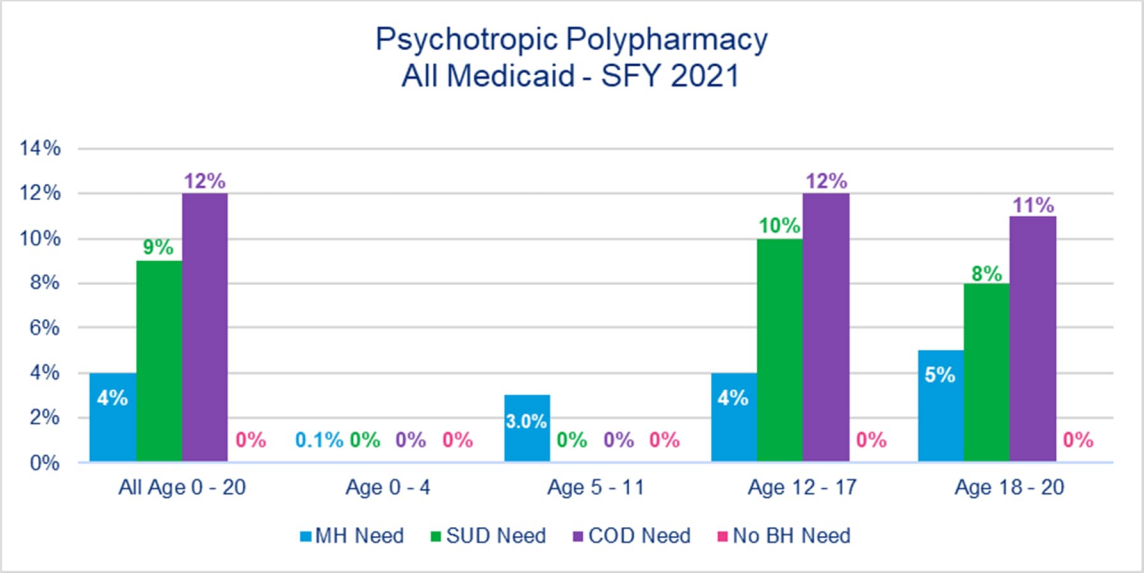


Figure C.15: Mental Health Crisis Services — Foster Care by Need



The number of children in Medicaid with psychotropic polypharmacy is growing. In state fiscal year (SFY) 2021,[156] between 4%–12% of the Medicaid population ages 0 years–20 years old used multiple mental health, SUD, and COD medications for mental function, behavior, or experience. Psychotropic medications can be used to treat a variety of behavioral health conditions and can impact mood, thoughts, and perceptions; these medications include antidepressants, anti-anxiety medications, and antipsychotics. The number utilizing multiple psychotropic medications was nearly double for children in foster care, where between 9%–22% utilized multiple medications. Similar to inpatient hospitalization and crisis services, youth ages 12 years–17 years old have the highest rates of utilization of psychotropic polypharmacy in both populations.

Figure C.16: Psychotropic Polypharmacy Utilization — All Medicaid by Age



[156] Washington State Department of Social and Health Services. (2023, November). *Behavioral health treatment needs and outcomes among Medicaid enrolled children in Washington State*. https://www.dshs.wa.gov/sites/default/files/rda/reports/CHILDRENS_BH_DASHBOARD_2023NOV.pdf

Figure C.17: Psychotropic Polypharmacy Utilization — Foster Care by Age

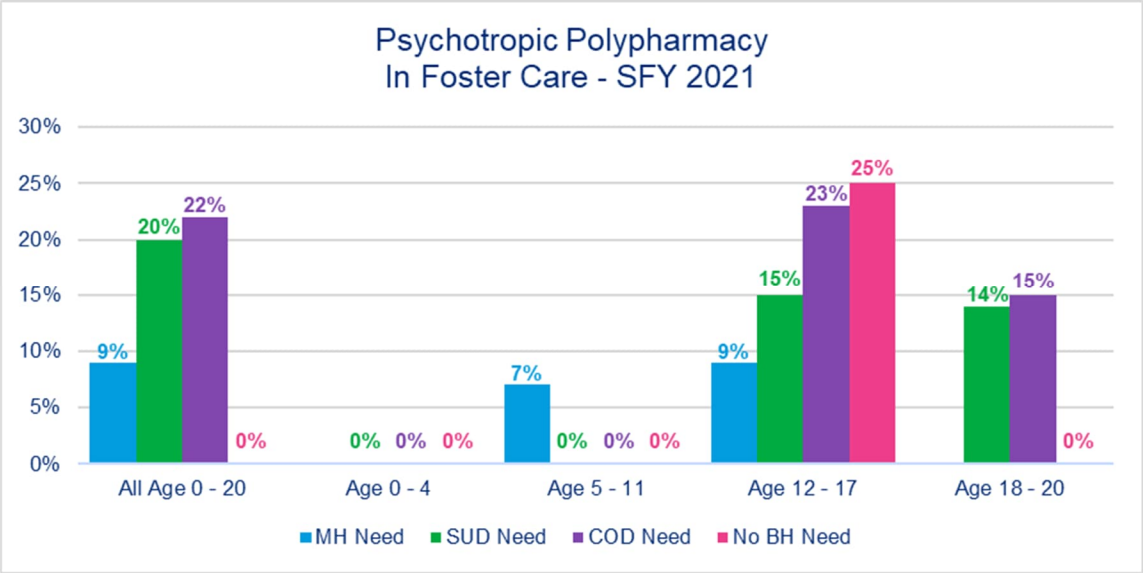


Figure C.18: Psychotropic Polypharmacy Utilization — All Medicaid by Need

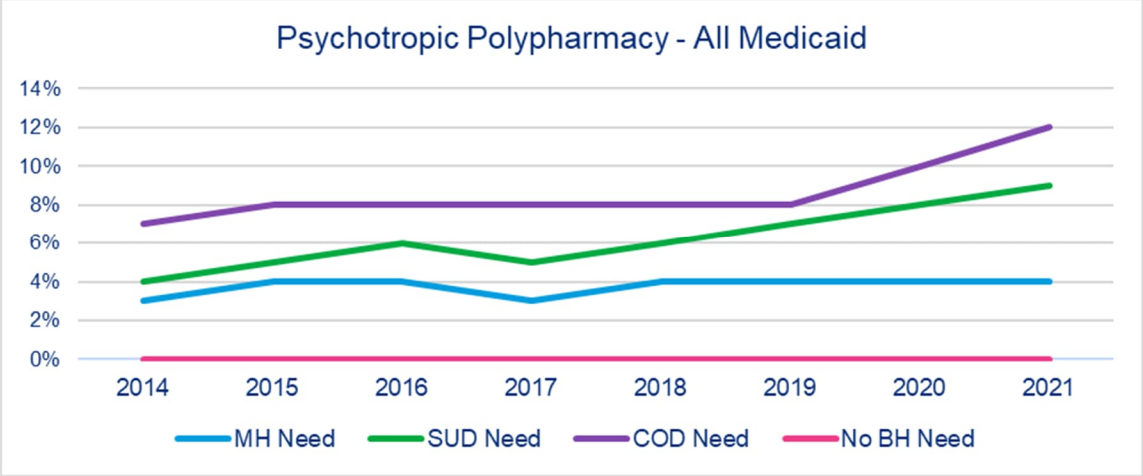
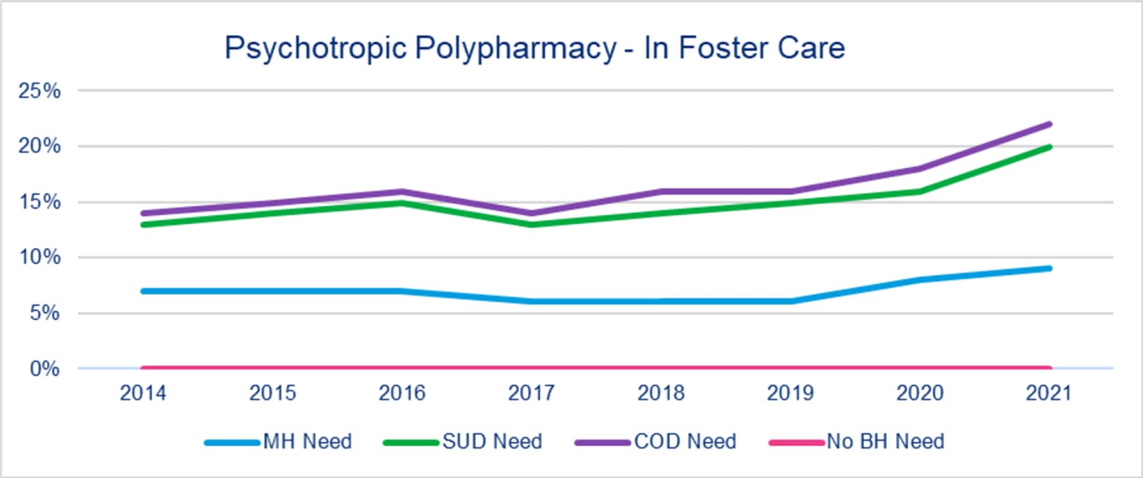


Figure C.19: Psychotropic Polypharmacy Utilization — Foster Care by Need



Criminal Justice Involvement and Behavioral Health Needs

The need for behavioral treatment for children in Medicaid and in foster care with criminal legal involvement has been declining since 2014. As can be seen in the figures below, the percentage of children in foster care needing SUD behavioral health services decreased from 40% in 2014 to a little over 20% in 2021.

Figure C.20: Criminal Legal Involvement — All Medicaid by Need

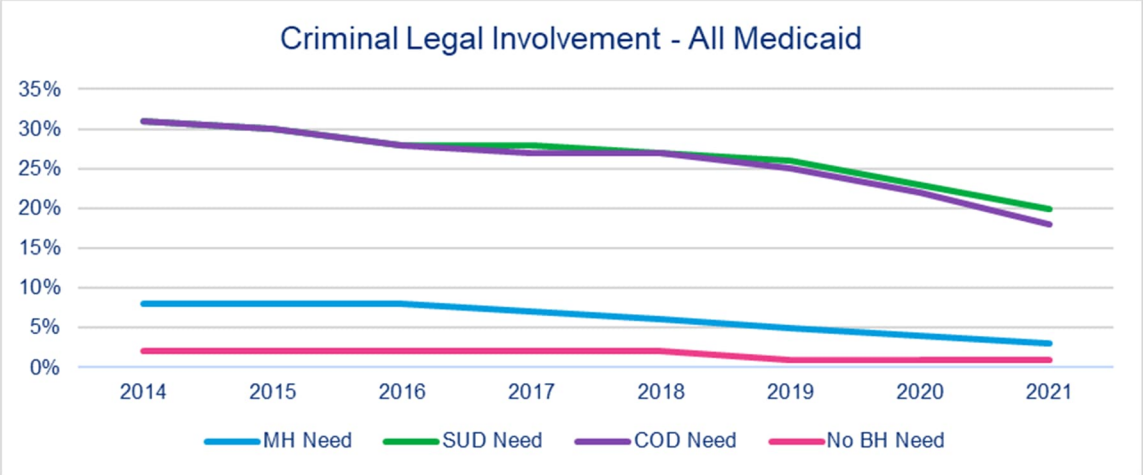
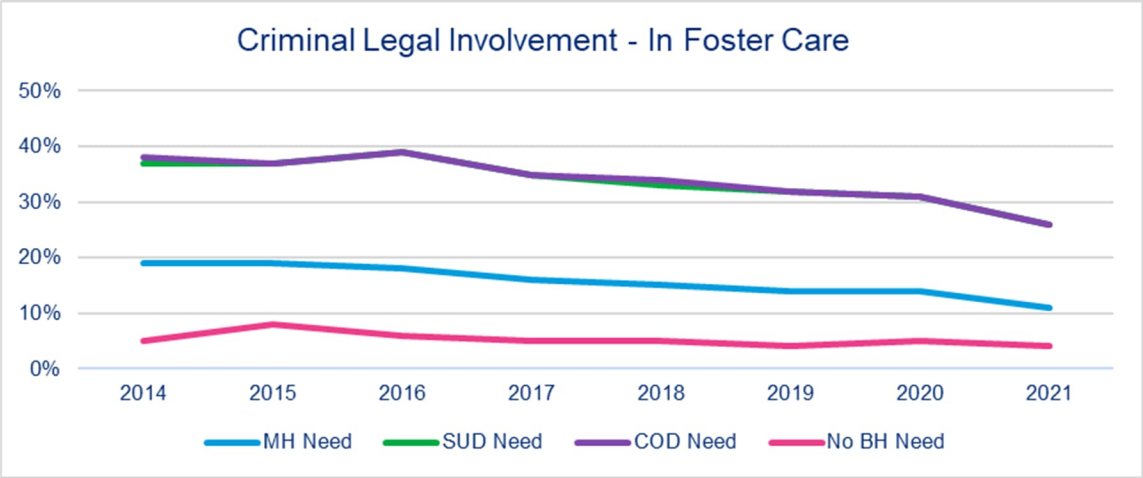


Figure C.21: Criminal Legal Involvement — Foster Care by Need



The number of children in with criminal justice involvement and requiring behavioral health services differs between the regular Medicaid population and the foster care population. Children and youth with criminal justice involvement and not in foster care needed behavioral health from ranged from 0.5%–25% depending upon the type of service needed and with more reported needs in children ages 18 years to 20 years old. For children in foster care with criminal justice involvement, the need for behavioral health ranged from 3%–33% depending upon ages and type of service needed.

Behavioral Health Treatment Needs of Medicaid-Enrolled Children, by Service Delivery System, SFY 2021

Figure C.22: Criminal Legal Involvement — All Medicaid Age

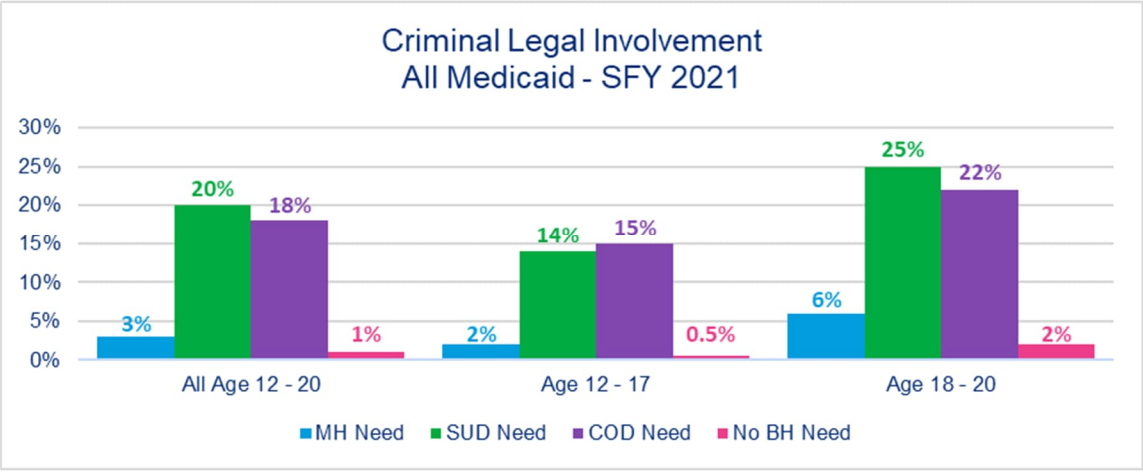
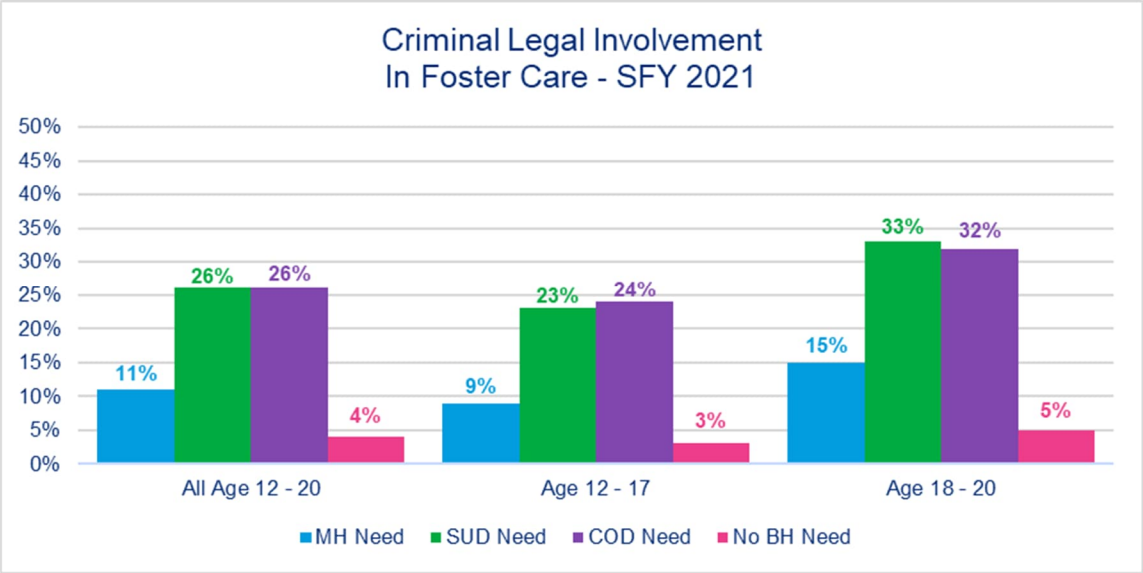


Figure C.23: Criminal Legal Involvement — Foster Care by Age



Appendix D
Percentages of the Population Requiring Behavioral Health Services

Children, Youth, and Transition Age Youth

The estimated number of children, youth transitioning into adulthood, and the parents and caregivers of those children and youth who need clinical behavioral health services or could benefit from preventive or early intervention services on an annual basis.

Educational Setting

The only statewide assessment of social and emotional health in the school settings reported to Mercer occurs through the Washington Kindergarten Inventory of Developing Skills (WaKIDS) Whole-child Assessment for teachers to observe children during the initial kindergarten period. Outside of the WaKIDS assessment, the utilization of individualized education program (IEP) behavioral health services or the placement of out-of-state/out-of-district care for behavioral health diagnoses can also be used to identify students with behavioral health (BH) needs. This data will only represent the number of students receiving services and not the number of students who would benefit from BH supports, but do not receive services.

A large number of children (4,848) receive BH services through educational settings, with 95% of the children being traditional school age between the ages of 6 years–17 years old.

Table D.1: Number of Children, Youth, and Transition Age Youth with Emotional/Behavioral Disabilities[157]

	3 Years–5 Years		6 Years–17 Years		18 Years–21 Years	
	Count	Percent	Count	Percent	Count	Percent
Total	2	0.04%	4,601	95%	245	5%

The distribution of children across the State receiving BH services varies by the Educational Service District (ESD).[158]

[157] Special Education Data Collection Summaries. (2024). *Annual Federal Child Count and Least Restrictive Environment (LRE) Data*.

[158] Note: ESDs are different than the Apple Health Integrated Managed Care Regions.

Map D.1: Distribution of Washington State Educational Districts

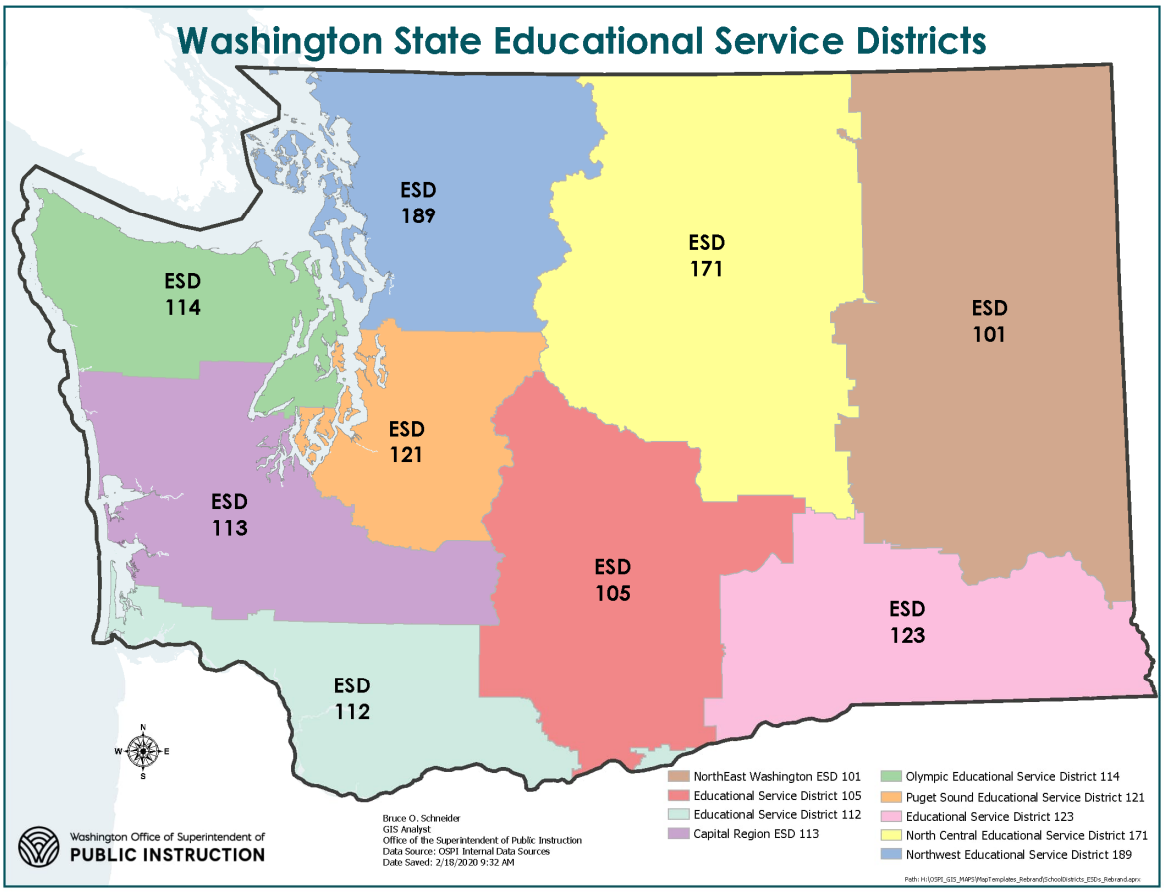


Table D.2: ESD Breakdown by County[159]

ESD	Counties (Unless Otherwise Noted)
ESD 101	Adams, Ferry, Stevens, Pend Oreille, Lincoln, Spokane, Whitman
ESD 105	Kittitas, Yakima, Grant (partial), Klickitat (partial)
ESD 112	Clark, Cowlitz, Skamania, Wahkiakum, Klickitat (partial), Pacific (partial)
ESD 113	Grays Harbor, Mason, Lewis, Thurston, Pacific (partial)
ESD 114	Kitsap (partial), North Mason School District, Jefferson, Clallam
ESD 121	King, Pierce, Bainbridge Island School District
ESD 123	Asotin, Columbia, Garfield, Walla Walla, Franklin, Benton, Othello School District
ESD 171	Chelan, Douglas, Okanogan, Grant (partial)
ESD 189	Island, San Juan, Skagit, Snohomish, Whatcom

[159] Special Education Data Collection Summaries/Annual Federal Child Count and Least Restrictive Environment (LRE) Data, 2024

Table D.3: Number and Percentage of Children with Emotional and Behavioral Disabilities by ESD[160]

	3 Years–5 Years		6 Years–17 Years		18 Years–21 Years	
ESD	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**
101	0	0%	403	96%	17	4%
105	0	0%	139	92%	12	8%
112	0	0%	648	95%	31	5%
113	0	0%	330	93%	26	7%
114	0	0%	216	94%	14	6%
121	1	0.1%	1,671	95%	90	5%
123	0	0%	211	94%	13	6%
171	0	0%	121	95%	6	5%
189	1	0.1%	860	96%	35	4%
Total	**2**	**0.04%**	**4,601**	**95%**	**245**	**5%**

Similar to the Apple Health Integrated Managed Care Regions, the region containing Seattle (ESD 121) has a larger percentage of the population than other regions. It is also notable that ESDs 105 (containing portions of the Greater Columbia and Southwest Apple Health regions) and ESD 113 (containing portions of the Great Rivers and Thurston-Mason regions) have a higher proportion of individuals ages 18 years–21 years old receiving behavioral health IEPs. Youth ages 18 years–21 years old continuing to receive IEP services tend to be more disabled than other students. A student on an IEP can remain in school until they turn 22 years old, even if they have met the district's diploma requirements, if the IEP team determines they need additional services to meet their IEP goals. The Individuals with Disabilities Education Act provides this right to students with disabilities.[161]

Children Placed Out-of-District and Out-of-State due to Emotional/Behavioral Disability

One measure of whether a student with behavioral health needs is adequately served is to see if the school district must place the child out-of-district and out-of-state because there are not enough services to serve them in their own school district or in Washington. In Washington, the number of children being served outside of their school district and outside of the State because of lack of resources within the school district and State to serve that child has decreased over time, from ESD 122 in 2021 to 88 in 2024. However, while emotional and behavioral disabilities were decreasing as a proportion of all disabilities, they were increasing as a proportion of all out-of-state placements.

The prevalence of children needing out-of-district and out-of-state services varies by ESD with the majority of placements originating from the ESD containing King County (ESD 121). It is notable

[160] Special Education Data Collection Summaries (2024). *Annual Federal Child Count and Least Restrictive Environment (LRE) Data.*

[161] Pacer Center. (2024). *A guide to the individualized education program (IEP).* https://www.pacer.org/guides/iep-504/iep-100/

that ESDs 105 and 171 have no children placed out of district or State with behavioral health issues.[162]

Figure D.1: Children Placed Out-of-District and Out-of-State due to Emotional/Behavioral Disability

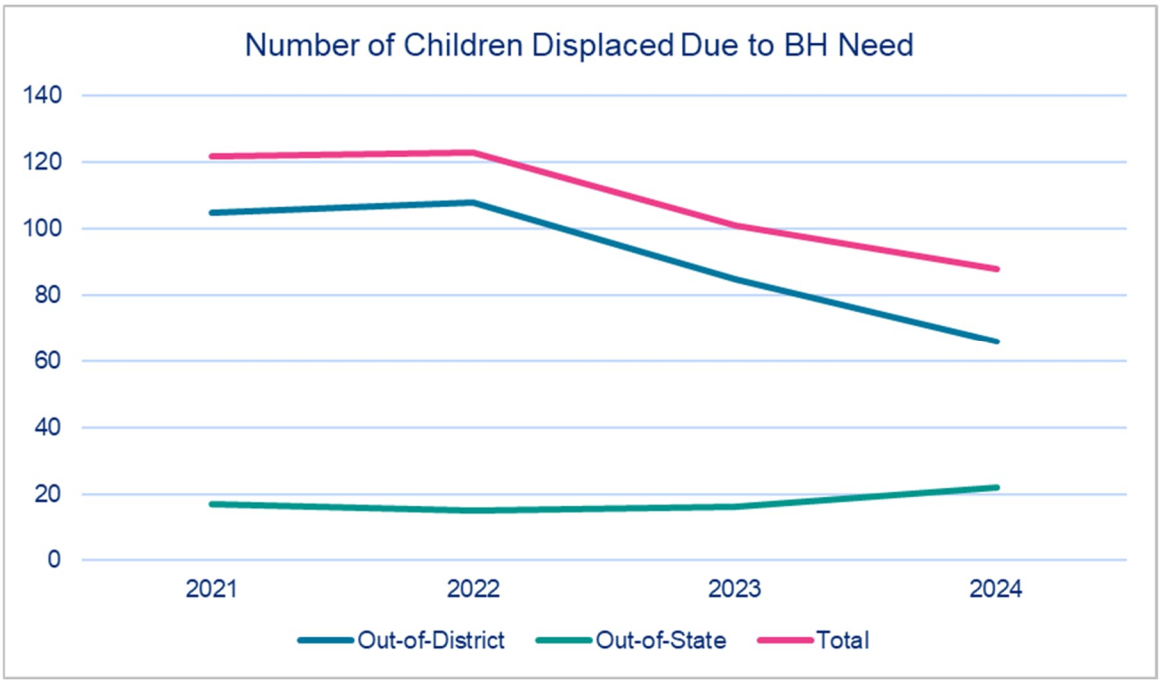


Table D.4: Children Placed Out-of-District and Out-of-State due to Emotional/Behavioral Disability by ESD – SFY 2024

ESD	In State	Out-of-State	Total
ESD 101			0
ESD 105			0
ESD 112		4	4
ESD 113	1		1
ESD 114	8		8
ESD 121	48	12	60
ESD 123		4	4
ESD 171			0
ESD 189	9	2	11
Total	**66**	**22**	**88**

[162] Washington Office of Superintendent of Public Instruction.

Placing children out of district or out-of-state due to a lack of available local resources results in the separation of the child from their family. Children placed out-of-state for behavioral health reasons often have difficulty meeting treatment goals because family travel to participate in family therapy and community reintegration activities is often difficult and limited by resources and logistics. Other states have found that out-of-state placements, because of the difficulties accomplishing transitions back to the home environment, may result in the child remaining in that placement until the educational funding ceases on the 22nd birthday.

These gaps in care often result in a *cliff* — where the services the child is eligible for drops significantly as educational and Medicaid Early and Periodic Screening, Diagnostic and Treatment entitlements dry up and families are unable to care for the individual in their home. States with high numbers of out-of-state placements find that increasing the resources available in the State to serve children with disabilities closer to home often prevents or reduces some of the struggles faced by families when their children *age out of the educational system*. For example, New Jersey developed a pilot program in 2012 that has since become permanent to serve youth with complex behavioral needs who are intellectual/developmental disable and mental health using in-state resources rather than placing youth in other states.[163]

In 2021, Washington estimated that 80 children placed in out-of-state settings cost an average of $162,000 or $13 million to be served out-of-state with some children costing up to $315,000.[164] Legislators made inquiry into the issue at the time and found that while there were some resources for children with mental illness, there were not sufficient resources to serve children and youth with developmental disabilities or with co-occurring developmental disabilities and mental illness in State. The Office of Superintendent of Public Instruction stressed the importance of differentiating students who are placed out-of-state who do not have an IEP from those students who do have an IEP. Currently there are no data markers that would count the number of students without an IEP.

Medicaid Children

In 2023, there were approximately 43,278 individuals under the age of 26 years old who had a severe emotional disturbance (SED) or severe mental illness (SMI) in Washington. Of those youth, 3%–4% were under the age of 16 years old and 13%–14% were transition age youth ages 16 years–24 years old.

Table D.5: Number of Children, Youth, and Transition Age Youth with SMI/SED Diagnosis in 2023[165]

Age	Count	Percent of SMI/SED Population
0 years–15 years	1,420	3%
16 years–25 years	5,602	13%
Total	**43,278**	**100%**

[163] PerformCARE©. (n.d.). *Family Crisis Handbook*, pp. 36. https://www.performcarenj.org/pdf/families/family-crisis-handbook.pdf

[164] InvestigateWest. (n.d.). *Lawmakers hope to end Washington's practice of shipping special-needs students out of state*. https://www.investigatewest.org/investigatewest-reports/lawmakers-hope-to-end-washingtons-practice-of-shipping-special-needs-students-out-of-state-17692378#:~:text=Those%20out%2Dof%2Dstate%20facilities%20provide%20special%20education%20services,while%20separating%20kids%20from%20their%20parents.%20Sen.

[165] Centers for Medicare & Medicaid Services. (n.d.). *Washington Medicaid transformation project*. https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83531

SMI/SED

There was a slight decrease in the number of youth and transition age youth with SMI/SED from 2022–2023 and slight decrease in the proportion of all Medicaid members with SMI/SED. Unlike under the SUD demonstration, Washington State does not report the annual denominator of these age groups served, so we are unable to examine how SMI/SED might be changing in those age groups overall. Other sources of reporting such as the SUD 1115 and the Substance Abuse and Mental Health Services Administration Uniform Reporting System data report the total populations using different age groups.

The number of children, youth, and transition age youth receiving Medicaid reimbursed mental health service monthly increased from 2018–2021 from 6,742 to 10,226 and then decreased in 2022–2023 to 10,116.

Table D.6: Monthly Unique Users of Mental Health Services Utilization — All MH Services[166]

Service Year*	Age 0–5	Age 6–17	Age 18–25	Total
2018	15	3,517	3,210	6,742
2019	19	3,847	3,863	7,729
2020	25	4,143	4,692	8,860
2021	31	4,828	5,367	10,226
2022	31	4,970	5,090	10,091
2023	35	4,905	5,176	10,116

* Values shown for each year and age range represent the maximum user count for any month within the year; individual-level data was not provided to calculate a unique user count for the year.

Inpatient Treatment

Of those unduplicated totals, the number and proportion of children, youth, and transition age youth receiving the most intensive mental health inpatient services has continued to increase over time. From 2018 to 2023, the number of children, youth, and transition aged youth monthly receiving inpatient mental health services doubled from 438 to almost 932. This occurred at a time when the number of children needing behavioral health services was dramatically increasing as well. Because of the two simultaneous increases, the proportion of children, youth, and transition age youth receiving inpatient mental health services grew from 6.5% to 9.2% of the population of all young individuals receiving mental health services. Inpatient hospitalization is the most intensive and restrictive service. Typically, inpatient stays are reserved for individuals who may be a risk to themselves or others and/or those individuals who have an extreme increase in their behavioral health symptoms where they may need more intensive and medically focused care.

[166] Washington State Health Care Authority. (2018-2023).

Table D.7: Monthly Unique Users of Mental Health Services Utilization — Inpatient[167]

Service Year*	Age 0–5	Age 6–17	Age 18–25	Total	Proportion of Individuals Receiving Care
2018	0	213	225	438	6.5%
2019	0	261	313	574	7.4%
2020	0	317	333	650	7.3%
2021	0	415	393	808	7.9%
2022	0	451	361	812	8.0%
2023	0	494	438	932	9.2%

* Values shown for each year and age range represent the maximum user count for any month within the year; individual-level data was not provided to calculate a unique user count for the year.

Trends in long-term inpatient hospital programs, also called Institutions for Mental Disease (IMD), reimbursed by Medicaid during that same time period reflect a growing number and proportion of individuals receiving mental health care in the highest level of inpatient facilities. While the number of individuals under age 26 years old hospitalized in an IMD increased from 16 to 109 (581% increase) from 2018 to 2023, the proportion of the population being hospitalized in IMDs increased from just 0.2% to 1.1%.

Table D.8: Monthly Unique Users of Mental Health Services Utilization — Individuals with SMI/SUD Treated in an IMD[168]

Service Year*	Age 0–5	Age 6–17	Age 18–25	Total	Proportion of Individuals Receiving Care
2018	0	0	16	16	0.2%
2019	0	0	22	22	0.3%
2020	0	18	30	48	0.5%
2021	0	38	31	69	0.7%
2022	0	58	30	88	0.9%
2023	0	71	38	109	1.1%

* Values shown for each year and age range represent the maximum user count for any month within the year; individual-level data was not provided to calculate a unique user count for the year.

Emergency Department

Trends in Emergency Department services reimbursed by Medicaid during that same time period reflect that a high number of youth and transition age youth were seeking assistance in the Emergency Department at the beginning of the period. The number of individuals under age 26 years old monthly seeking care in Emergency Department services decreased from 1,204 to 341 in the 2018 to 2021 time period (a 71.7% decrease). This number was probably affected in

[167] Washington State Health Care Authority. (2018-2023).
[168] Washington State Health Care Authority. (2018-2023).

2020 by the public health emergency. However, by 2023, the number of child, youth, and transition age youth using emergency room visits had increased back to 437 (a 28.2% increase), the proportion of the population seeking emergency department care decreased from just 17.9% of the population to 4.3%. This number is still dramatically less than the pre-public health emergency utilization.

Table D.9: Monthly Unique Users of Mental Health Services Utilization — Emergency Department[169]

Service Year*	Age 0–5	Age 6–17	Age 18–25	Total	Proportion of Individuals Receiving BH Care in an ED
2018	0	657	547	1,204	17.9%
2019	0	481	318	799	10.3%
2020	0	396	232	628	7.1%
2021	0	184	157	341	3.3%
2022	0	241	133	374	3.7%
2023	0	252	185	437	4.3%

* Values shown for each year and age range represent the maximum user count for any month within the year; individual-level data was not provided to calculate a unique user count for the year.

Outpatient Services

The services above represent the most intensive, restrictive levels of care where individuals are treated for safety to achieve stabilization. On the other end of the spectrum are ambulatory, or outpatient, services representing more diversionary, preventive, and step-down services.

From 2018 to 2023, the number of children, youth, and transition age youth receiving outpatient services continued to increase, growing from 6,555 to 7,921 (+20.8%). However, the proportion of children receiving outpatient services is a smaller percentage over time, decreasing from 97.2% of the population receiving outpatient services to just 78.3% receiving outpatient services.

Table D.10: Monthly Unique Users of Mental Health Services Utilization — Outpatient Services[170]

Service Year*	Age 0–5	Age 6–17	Age 18–25	Total	Proportion of Individuals Receiving Care
2018	15	3,469	3,071	6,555	97.2%
2019	19	3,749	3,656	7,424	96.1%
2020	21	4,029	3,695	7,745	87.4%
2021	26	3,236	3,634	6,896	67.4%
2022	26	3,825	3,760	7,611	75.4%

[169] Washington State Health Care Authority. (2018-2023).
[170] Washington State Health Care Authority. (2018-2023).

Service Year*	Age 0–5	Age 6–17	Age 18–25	Total	Proportion of Individuals Receiving Care
2023	31	3,964	3,926	7,921	78.3%

* Values shown for each year and age range represent the maximum user count for any month within the year; individual-level data was not provided to calculate a unique user count for the year.

Table D.11: Monthly Unique Users of Mental Health Services Utilization — Intensive Outpatient and Partial Hospitalization[171]

Service Year*	Age 0–5	Age 6–17	Age 18–25	Total	Proportion of Individuals Receiving Care
2018	0	657	591	1,248	18.5%
2019	0	495	413	908	11.7%
2020	0	438	351	789	8.9%
2021	0	228	257	485	4.7%
2022	0	270	242	512	5.1%
2023	0	303	286	589	5.8%

* Values shown for each year and age range represent the maximum user count for any month within the year; individual-level data was not provided to calculate a unique user count for the year.

One statistic that shows true promise is the number of children, youth, and transition age youth receiving mental health services via telehealth including online assessments, services delivered with a telehealth modifier or place of service, or a telephone visit. Telehealth services have gained consistent popularity due to the flexibility they provide to both the provider and individual/family receiving the service. While not every service is suitable for telehealth, studies continue to show similar efficacy and standards of care being met in telehealth versus in person services.[172] In 2018, the number of youth and transition age youth receiving mental health services via telehealth monthly was just 64 or 0.9% of the population receiving care. However, by 2023, the number of individuals receiving mental health services via telehealth had increased to 1,935 or 19.1% of the population receiving care. While this number was less than the utilization rate at the height of the public health emergency, the growth in the use of telehealth represents a 2923% increase.

[171] Washington State Health Care Authority. (2018-2023).

[172] Bulkes, N. Z., Davis, K., Kay, B., & Riemann, B. C. (2022). Comparing efficacy of telehealth to in-person mental health care in intensive-treatment-seeking adults. *Journal of Psychiatric Research*, 145, 347–352. https://pubmed.ncbi.nlm.nih.gov/34799124/

Table D.12: Monthly Unique Users of Mental Health Services Utilization — Telehealth[173]

Service Year*	Age 0–5	Age 6–17	Age 18–25	Total	Proportion of Individuals Receiving Care
2018	0	28	36	64	0.9%
2019	0	56	49	105	1.4%
2020	0	1,659	1,481	3,140	35.4%
2021	0	1,894	1,707	3,601	35.2%
2022	0	1,488	1,460	2,948	29.2%
2023	0	881	1,054	1,935	19.1%

* Values shown for each year and age range represent the maximum user count for any month within the year; individual-level data was not provided to calculate a unique user count for the year.

These trends show that over time, more Medicaid-eligible children, youth, and transition age youth need mental health services; more of these young individuals are being hospitalized and placed in IMDs and a growing number are seeking care in emergency departments again for mental health conditions. Conversely, while there continues to be a growing number of individuals seeking outpatient care, a growing proportion of children, youth, and transition age youth are not receiving outpatient or intensive outpatient/partial hospitalization.

For substance use needs in the Medicaid child, youth, and transition age youth population, Washington tracks the number of children and youth under age 18 years old who have a substance use disorder (SUD) diagnosis. In 2023, on a monthly basis, there were 2,142 individuals under the age of 18 years old with an SUD diagnosis. There were also 68,527 adults aged 18 years–64 years old monthly who were under the age of 26 years old with an SUD diagnosis.

Table D.13: SUD Services — 2023 Monthly Max[174]

Category	Count of Beneficiaries with SUD Diagnosis
Children <18 years old	2,142
Adults 18 years–64 years old	68,527

Note: Utilization of SUD services represents the maximum monthly user value for each service during the year; individual-level detail was not available to calculate a unique user count for the year.

On a monthly basis, 50 children received SUD intensive residential and inpatient services in 2023. Separate withdrawal management treatment is not typically considered appropriate for youth and children, so it is expected that the utilization for children under age 18 years old is low (i.e., six children per month). However, adults requiring residential and inpatient treatment as well as withdrawal management services on a monthly basis are quite high (1,976 and 1,306 adults

[173] Washington State Health Care Authority. (2018-2023).

[174] U.S. Department of Health and Human Services. (2023). *Section 1115 Demonstrations, State Waivers List, SUD Part A Metrics (October 1, 2023 through December 31, 2023) Including 2023 and 2021/2022 Retrospective Metrics.*

monthly, respectively). As noted elsewhere in this report, transition age youth, pregnant women, and parents and caregivers are a substantial portion of adults receiving intensive SUD services.

Table D.14: Monthly Users of SUD Services — 2023 Monthly Max[175]

Category	SUD Services Utilization — Residential and Inpatient	SUD Services Utilization — Withdrawal Management
Children <18 years old	50	6
Adults 18 years–64 years old	1,976	1,306

Note: Utilization of SUD services represents the maximum monthly user value for each service during the year; individual-level detail was not available to calculate a unique user count for the year.

Of the children and youth under 18 years old, only 868 monthly received any SUD treatment. This included 29 individuals receiving Early Intervention, 762 receiving outpatient care (87.8%), and 90 receiving medication-assisted services (MAT) services. These services represent early intervention, prevention, diversion, and step-down care to treat individuals in the least restrictive environment. Treatment of youth in outpatient care is more likely to occur in SUD than in mental health, with fewer youth receiving residential and hospital care compared to the more preventative outpatient care.

Table D.15: Monthly Users of SUD Services in 2023[176]

	SUD Services Utilization — Any SUD Treatment	SUD Services Utilization — Early Intervention	SUD Services Utilization — Outpatient	SUD Services Utilization — MAT
Children <18 years old	868	29	762	90
Adults 18 years–64 years old	38,156	241	13,594	29,764

Note: Utilization of SUD services represents the maximum monthly user value for each service during the year; individual-level detail was not available to calculate a unique user count for the year.

Percentage of Pre-Kindergarten Children with Behavioral Health Needs

Washington assesses children's health and well-being prior to entering kindergarten using the Washington Kindergarten Inventory of Developing Skills (WaKIDS) protocol. The whole-child assessment uses an observational assessment tool, GOLD®, to observe, collect documentation, and level children's knowledge skills and abilities across the six areas of development and learning: social-emotional, physical, cognitive, language, literacy, and mathematics. The WaKIDS assessment is administered during the first two months of kindergarten, specifically targeting children who are five years old by August 31st. Kindergarten teachers observe and record each child's skills in six areas.

[175] U.S. Department of Health and Human Services. (2023). *Section 1115 Demonstrations, State Waivers List, SUD Part A Metrics (October 1, 2023 through December 31, 2023) Including 2023 and 2021/2022 Retrospective Metrics.*

[176] U.S. Department of Health and Human Services. (2023). *Section 1115 Demonstrations, State Waivers List, SUD Part A Metrics (October 1, 2023 through December 31, 2023) Including 2023 and 2021/2022 Retrospective Metrics*.

Social-emotional needs in the assessment are defined as an inability to:

1. Regulate own emotions and behaviors.
    A. Manages feelings.
    B. Follow limits and expectations.
    C. Take care of own needs appropriately.
2. Establish and sustain positive relationships.
    A. Form relationships with adults.
    B. Respond to emotional cues.
    C. Interact with peers.
    D. Make friends.
3. Participate cooperatively and constructively in group situations.
    A. Balance needs and rights of self and others.
    B. Solve social problems.

Table D.16 below shows that lower income children and children in the Early Childhood Education and Assistance Program (ECEAP) program are more likely at the WaKIDS pre-kindergarten testing to have social/emotional needs. Kindergarten students were included in the ECEAP cohort group if they were enrolled for six or more months at an ECEAP the previous year and were assessed on the WaKIDS during kindergarten. Within the kindergarten-grade 12 system, a *lower-income student* means a student who qualifies for free or reduced-price lunch (FRPL) because his/her parent(s) or guardian(s) have an annual income equal to or less than 185% of the Income Poverty Guidelines. The lower-income cohort included those eligible for FRPL and the higher-income cohort included those who were not FRPL eligible.

Over time, the number of children in the pre-kindergarten group presenting with behavioral health needs — including social/emotional needs — has grown. This means that a larger percentage of pre-kindergarten children have behavioral health needs in 2023–2024 than just a decade ago (i.e., 13% more for the ECEAP program; 6% for low-income children and 4% for higher income children). These data suggest that more targeted behavioral health skills are needed for children in the ECEAP and low-income groups. Note: the increase in behavioral health needs among children in ECEAP may be an indication that ECEAP is targeting the children most in need of services over time. However, the growth in low-income and high-income children with behavioral health needs is indicative of increased behavioral health needs in the underlying population.

Table D.16: Number of Children with Social/Emotional Needs Identified Pre-Kindergarten for ECEAP, Lower Income, and Higher Income Children[177]

School Year	ECEAP	Lower Income	Higher Income
2013–2014	9%	12%	8%
2014–2015	12%	13%	8%
2015–2016	13%	14%	8%
2016–2017	15%	14%	9%
2017–2018	15%	15%	10%
2018–2019	16%	16%	10%
2019–2020	17%	16%	10%
2021–2022	20%	17%	11%
2022–2023	21%	17%	11%
2023–2024	22%	18%	12%

Demand for Crisis Services

What is 988 and how was it established in Washington?

In 2020, Congress passed legislation establishing the 988 Lifeline to improve access to immediate support to meet the nation's growing mental health, suicide, and substance use distress needs. Washington adopted 988 in 2021 with the passage of House Bill 1477, establishing 988 contact hubs to improve the State's behavioral health crisis response and suicide prevention system. The 988 Lifeline was launched in 2022 and transitioned existing suicide prevention call lines to the new authority.

The 988 Lifeline provides easy access to emotional distress care, which is distinct from 911, where the focus is on dispatching emergency medical services, fire, and police, as needed. Only a small percentage of 988 Lifeline calls require a transfer to the 911 system, and most of these are done with the consent and cooperation of the caller. This occurs when there is imminent risk to someone's life that cannot be reduced during the call. In these cases, the crisis counselor shares information with 911 that is crucial to saving the caller's life.[178]

The 988 Lifeline offers free and confidential support for anyone in crisis. That includes people who need support for a suicidal, mental health and/or substance use crisis, or who are in emotional distress. When a person calls or texts 988 or chats 988lifeline.org, they are connected with a crisis counselor who listens, tries to understand how the problem is affecting the person, provides support, and shares resources. 988 Lifeline crisis counselors are trained to help reduce the intensity of a situation for the person seeking help and connect them to additional local resources to support their wellbeing.[179]

[177] Education Data and Research Center. (2025). *Early learning feedback report*. https://erdc.wa.gov/publications-and-reports/early-learning-feedback-report
[178] 988 factsheet. (n.d.). *Substance Abuse and Mental Health Services Association*. https://www.samhsa.gov/sites/default/files/988-factsheet.pdf
[179] 988 factsheet. (n.d.). *Substance Abuse and Mental Health Services Association*. https://www.samhsa.gov/sites/default/files/988-factsheet.pdf

Washington's Native and Strong Lifeline — which offers 988 Lifeline services for Native American/Native Alaskan people — has become an exemplar service for other crisis response systems across the U.S. in order to publicize the Native and Strong Lifeline, the State fielded a multilingual communications campaign to promote awareness of the 988 and Native and Strong Lifelines and help reduce the stigma associated with seeking help. Rules were established for the designation of 988 contact hubs to streamline access to care. Mobile crisis response teams have expanded for youth and adults, and new mobile response endorsement standards were established for teams meeting specified response times.

Legislation created 23-hour Crisis Relief Centers, a new model for providing short-term stabilization services for adults and youth in crisis. Legislation passed to expand the crisis response workforce, including establishing Certified Peer Specialists as a new health profession which will expand opportunities to participate in the crisis response system. The State has also made progress on minimizing law enforcement involvement in a behavioral health crisis, including a pilot program to divert behavioral health calls from 911 to 988.[180]

Automated Call Distribution Call Statistics Standards

The abandon rate is the percentage of calls that are dropped by callers before they are able to reach an agent. The call center industry standard for call abandon rate is 6%. Generally, call center abandonment rates of less than 5% are considered good. Sometimes it is acceptable if the rate is between 5% and 10%. However, in most cases, over 5% is considered too high.[181] As shown in Figure D.2, Washington met the average speed to answer standard every month since July 2022, even with generally increasing call volume.

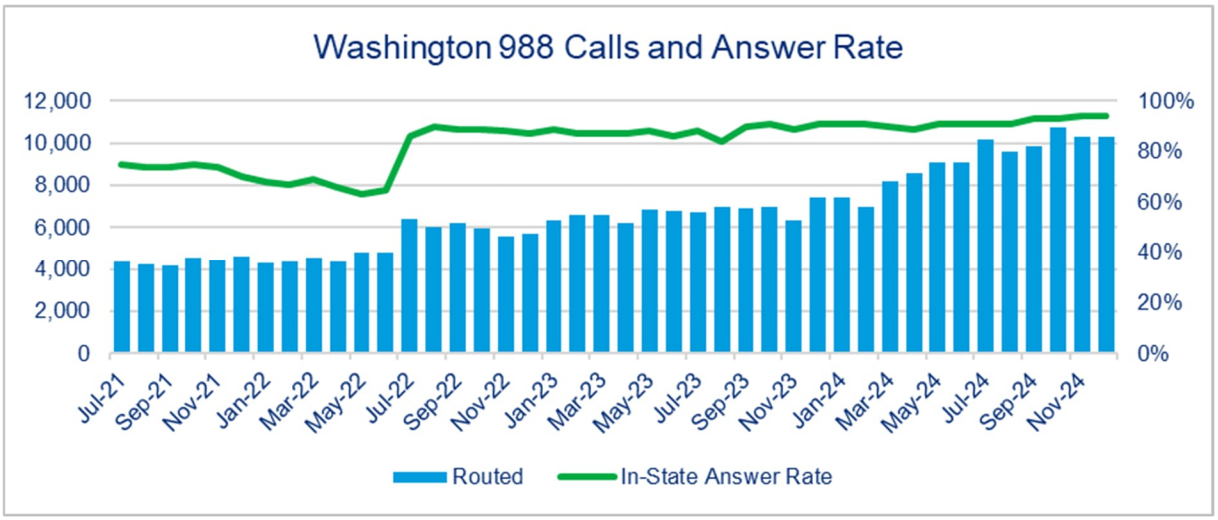
Meanwhile, service level metrics also measure a call center's ability to answer a certain number of calls in a predetermined amount of time, making it an essential call center metric. The call center industry standard for service level is to answer 80% of calls in 20 seconds.[182] As noted in Figure D.3, the Washington 988 call volume has increased steadily since July 2022. With the inception of the 988 Lifeline in July 2022, there was a marked drop in the call abandonment rates in Washington.

[180] Crisis Response Improvement Strategy Committee. (2024, December 31). *Washington behavioral health crisis response and suicide prevention system: Crisis Response Improvement Strategy Steering Committee final report*. https://www.hca.wa.gov/assets/program/cris-final-report-20250101.pdf

[181] SQM Group. (n.d.). *Industry standards for the top 10 KPIs.* https://www.sqmgroup.com/resources/library/blog/industry-standards-top-call-center-kpis

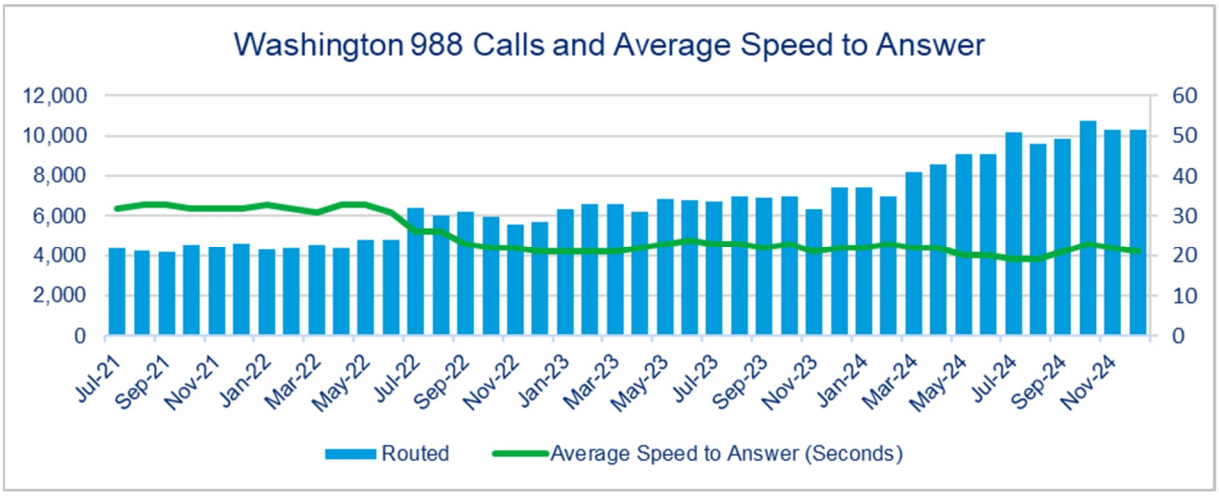
[182] SQM Group. (n.d.). *Industry standards for the top 10 KPIs*. https://www.sqmgroup.com/resources/library/blog/industry-standards-top-call-center-kpis

Figure D.2: Washington 988 Calls and In-State Answer Rate



Source: 988Lifeline. State-based monthly reports. https://988lifeline.org/professionals/our-network/state-based-monthly-reports/

Figure D.3: Washington 988 Calls and Average Speed to Answer



Source: 988Lifeline. State-based monthly reports. https://988lifeline.org/professionals/our-network/state-based-monthly-reports/

Overall, the data indicates a stable and high demand for crisis support services over the period analyzed, with the 988 Suicide and Crisis Lifeline being the most utilized services.

Families in the Perinatal Phase

To estimate the number of parents and caregivers' postpartum who need clinical behavioral health services or could benefit from preventive or early intervention services on an annual basis, we have included the percentage of individuals reporting postpartum depression by Maternal age, Medicaid status, race/ethnicity, and region. Individuals receiving Medicaid are almost twice as likely to report suffering postpartum depression than non-Medicaid individuals (16.5% compared to

8.8%). Younger individuals are more than twice as likely to report postpartum depression than older individuals (19.9% for individuals aged 20 years–24 years old versus 8.7% for individuals aged 35 years–39 years old). Individuals who are Native American or Alaska Native (16.4%) or Black (20.2%) are more likely to report suffering from postpartum depression than White individuals (10.8%).

Table D.17: Postpartum Depression Reported by Individuals by Age, Race, and Medicaid Status[183]

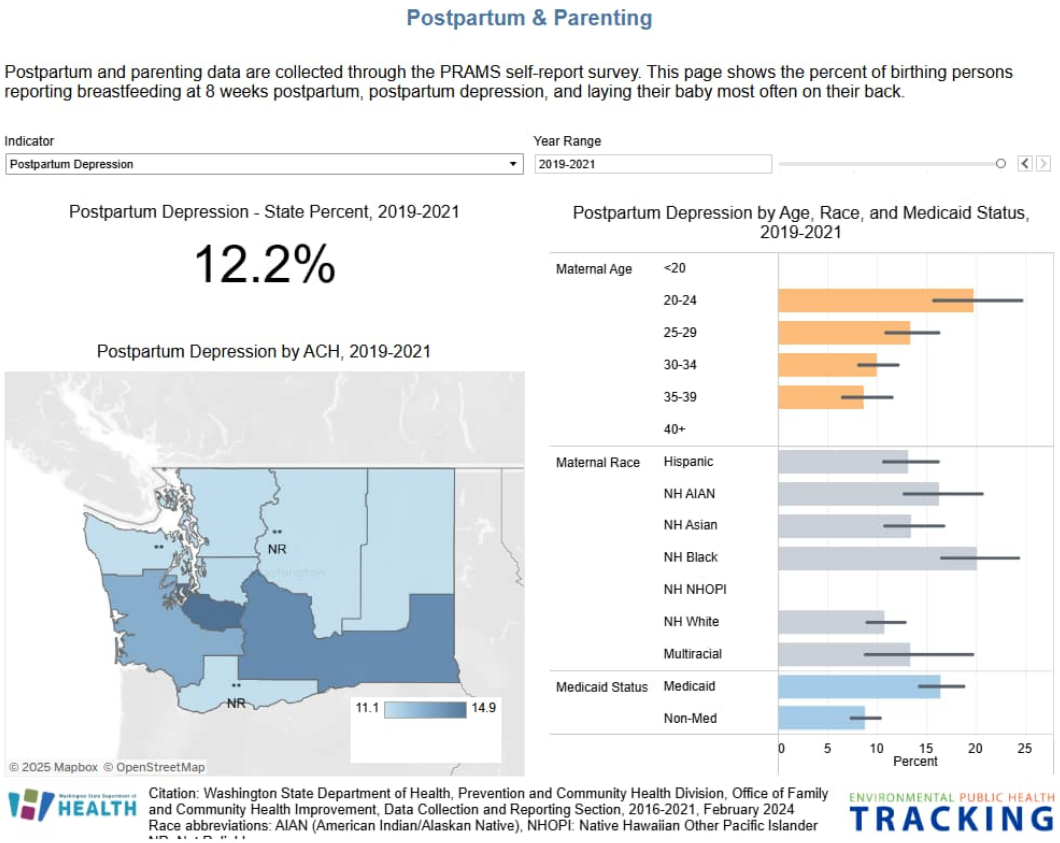
Group	2016–2018	2017–2019	2018–2020	2019–2021
Maternal Age				
<20	N/A	31.3%	N/A	N/A
20–24	12.6%	15.8%	15.7%	19.9%
25–29	11.0%	11.2%	13.6%	13.4%
30–34	11.1%	10.8%	10.9%	10.0%
35–39	11.2%	9.4%	8.8%	8.7%
40+	N/A	N/A	N/A	N/A
Maternal Race/Ethnicity				
Hispanic	10.4%	11.6%	12.7%	13.2%
NH AIAN	15.7%	15.7%	17.6%	16.4%
NH Asian	16.6%	14.3%	14.3%	13.5%
NH Black	18.9%	20.5%	21.6%	20.2%
NH NHOPI	N/A	N/A	N/A	N/A
NH White	9.5%	10.3%	10.1%	10.8%
Multiracial	16.4%	13.1%	16.0%	13.4%
Medicaid Status				
Medicaid	13.7%	15.2%	15.0%	16.5%
Non-Medicaid	9.4%	8.6%	9.7%	8.8%
Statewide	**11.5%**	**11.9%**	**12.2%**	**12.2%**

The trend indicates a gradual increase in the percentage of all individuals with postpartum depression from 2016 to 2021, with a rise from 11.5% to 11.9% from 2016–2018 to 2017–2019. This increase continues to 12.2% from 2018 to 2020. However, from 2019 to 2021, the percentage remains stable at 12.2%, showing no further increase during that period. The data indicates a higher incidence of postpartum depression among Medicaid recipients compared to non-Medicaid recipients. Regarding maternal age, there is a higher incidence of postpartum depression among younger individuals compared to older age groups. Regarding maternal race and ethnicity, the data

[183] Washington State Department of Health, Prevention and Community Health Division, Office of Family and Community Health Improvement, Data Collection and Reporting Section, 2016-2021. (2024, February). *Perinatal dashboard.* https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/perinatal-data/dashboard

indicates a gradual increase in the prevalence of postpartum depression in all groups, except for non-Hispanic Asians and the multiracial group.

Map D.2: Postpartum and Parenting



Source: Washington State Department of Health, Prevention and Community Health Division, Office of Family and Community Health Improvement, Data Collection and Reporting Section, 2016–2021. (February 2024). Perinatal dashboard. https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/perinatal-data/dashboard

Unfortunately, this information does not include how many individuals suffering from postpartum depression received the services and supports they needed. It does suggest that while efforts to provide services to all ages, races, and insurance are needed, postpartum depression services should target younger individuals who are non-White and receiving Medicaid.

For alcohol, cannabis, and tobacco usage during pregnancy, Washington tracks usage before and after pregnancy start, as well as by race and region, using the Pregnancy Risk Assessment Monitoring System self-report data. The most recent data available is from 2015 to 2021. Over time, alcohol and tobacco use during pregnancy is reported to have declined while cannabis use has increased.[184] The reported use of alcohol during pregnancy is 6.5% and varies by race and

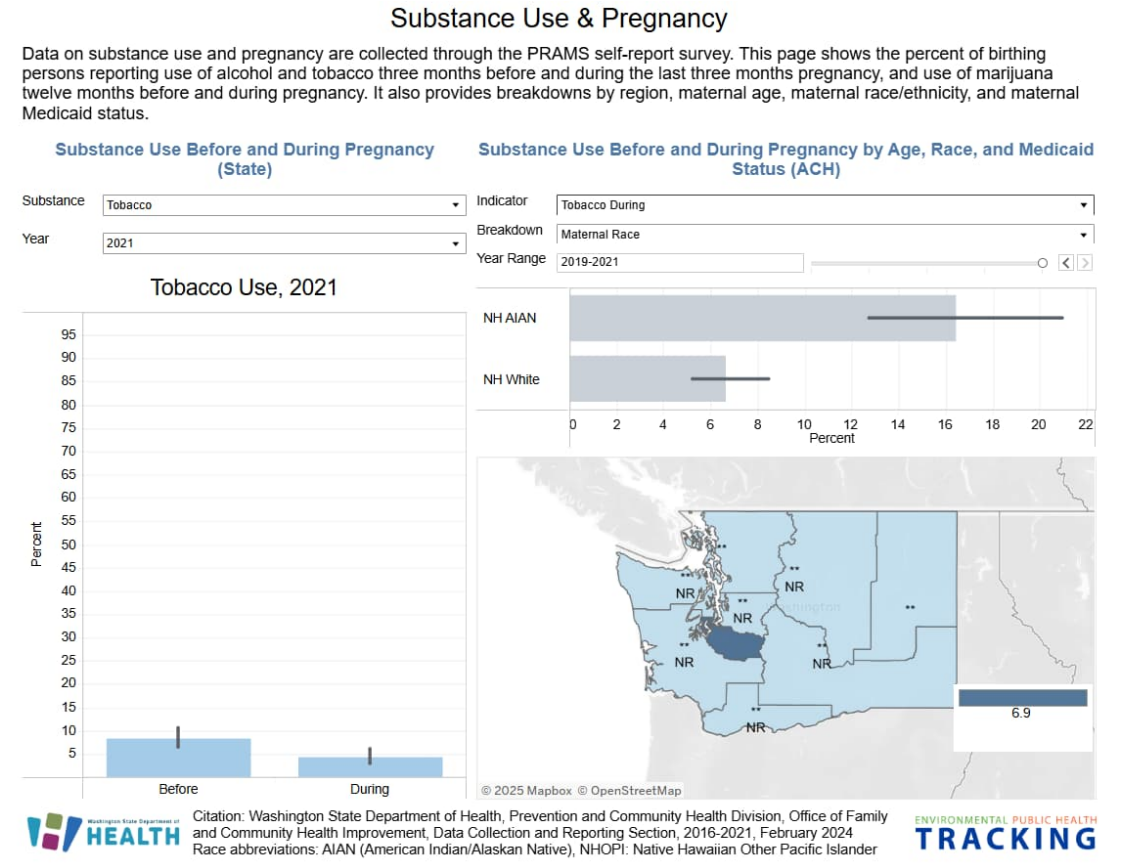
[184] Washington State Department of Health, Prevention and Community Health Division, Office of Family and Community Health Improvement, Data Collection and Reporting Section, 2016-2021. (2024, February). *Perinatal dashboard.* https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/perinatal-data/dashboard

region. White individuals (8.6%) and individuals in King County (9.6%) report higher alcohol consumption compared to other races and other region.[185]

Similarly, the use of cannabis reported to be used during pregnancy (6.7%) varies by race and region. AIAN (19.4%), multiracial individuals (15.6%) report higher usage than other races. Individuals in Spokane, Great Rivers, and Thurston-Mason regions (up to 10.4%) report higher usage than other regions of the State.[186]

Similarly, tobacco use during pregnancy stands at 4.2%, with Native American and Alaska Native individuals (16.4%) and those in King County (6.9%) exhibiting higher usage rates. As with postpartum depression data, it is important to note that this information does not indicate how many individuals using alcohol, tobacco, or cannabis during pregnancy received the necessary services and support.[187]

Map D.3: Substance Use and Pregnancy



[185] Washington State Department of Health, Prevention and Community Health Division, Office of Family and Community Health Improvement, Data Collection and Reporting Section, 2016-2021. (2024, February). *Perinatal dashboard*. https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/perinatal-data/dashboard

[186] Washington State Department of Health, Prevention and Community Health Division, Office of Family and Community Health Improvement, Data Collection and Reporting Section, 2016-2021. (2024, February). *Perinatal dashboard*. https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/perinatal-data/dashboard

[187] Washington State Department of Health, Prevention and Community Health Division, Office of Family and Community Health Improvement, Data Collection and Reporting Section, 2016-2021. (2024, February). *Perinatal dashboard*. https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/perinatal-data/dashboard

Similar to the postpartum depression data, this information does not include how many individuals reporting to use alcohol, tobacco, or cannabis during pregnancy received the services and supports they needed. It does suggest that while efforts to provide services to all ages, races, and insurance are needed, substance use prevention services during pregnancy should target different individuals:

- Alcohol prevention during pregnancy should specifically target White individuals and individuals in the King region.
- Cannabis prevention during pregnancy should specifically target American Indian and Alaska Native and multiracial individuals and individuals in Spokane, Great Rivers, and Thurston-Mason regions.
- Tobacco prevention during pregnancy should specifically target Native American and Alaska Native individuals and individuals in the King Region.

To estimate the number of expectant parents and caregivers who need clinical behavioral health services or could benefit from preventive or early intervention services on an annual basis and are not receiving treatment, Mercer used the number of Medicaid pregnant individuals with a SUD diagnosis who are and are not utilizing SUD services. Washington consistently tracks and reports the number of pregnant individuals utilizing SUD treatment under its 1115 demonstration. In the table below between 18%–30 % of pregnant women with a SUD diagnosis use outpatient care and between 22% and 44% utilize MAT each month. About two percent of Pregnant Women are hospitalized and about 1% use Withdrawal Management Services each month.

Table D.18: SUD Services (Pregnant Women Only) — Year 2022 to 2023 by Month for Outpatient and MAT[188]

	Count of Beneficiaries with SUD Diagnosis		SUD Services Utilization — Outpatient				SUD Services Utilization — Medication Assisted Treatment			
Month of Service	2022	2023	2022	% Using OP	2023	% Using OP	2022	% Using MAT	2023	% Using MAT
January	121	230	28	23%	58	23%	49	40%	46	24%
February	119	252	30	25%	73	29%	52	44%	58	23%
March	106	269	33	31%	78	29%	46	43%	64	24%
April	230	267	69	30%	71	27%	52	23%	69	26%
May	240	273	79	33%	73	27%	56	23%	59	22%
June	231	265	63	27%	62	23%	52	23%	56	21%
July	237	265	56	24%	49	18%	56	24%	56	21%
August	223	260	55	25%	58	22%	48	22%	62	24%
September	230	252	62	27%	66	26%	55	24%	59	23%
October	221	241	64	29%	55	23%	54	24%	60	25%
November	213	247	54	25%	69	28%	52	24%	67	27%

[188] Medicaid Gov. (2023). *Washington Medicaid Transformation Project. Section 1115 Demonstration. State Waivers List. SUD Part A Metrics (October 1, 2023 through December 31, 2023 and 2021/2022 Retrospective Metrics*). http://medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83531

	Count of Beneficiaries with SUD Diagnosis		SUD Services Utilization — Outpatient				SUD Services Utilization — Medication Assisted Treatment			
Month of Service	2022	2023	2022	% Using OP	2023	% Using OP	2022	% Using MAT	2023	% Using MAT
December	214	238	52	24%	65	27%	48	22%	62	26%

Table D.19: SUD Services (Pregnant Women Only) — Year 2022 to 2023 by Month for Inpatient Hospitalization and Withdrawal Management[189]

	Count of Beneficiaries with SUD Diagnosis		SUD Services Utilization — Residential and Inpatient (Hosp.)				SUD Services Utilization — Withdrawal Management (WM)			
Month of Service	2022	2023	2022	2022 % Hosp.	2023	2023 % Hosp.	2022	2022 % WM	2023	2023 % WM
January	121	230	2	2%	13	6%	5	4%	1	0%
February	119	252	1	1%	3	1%	4	3%	0	0%
March	106	269	2	2%	7	3%	3	3%	4	1%
April	230	267	7	3%	6	2%	3	1%	4	1%
May	240	273	3	1%	6	2%	3	1%	2	1%
June	231	265	3	1%	4	2%	2	1%	2	1%
July	237	265	4	2%	7	3%	2	1%	2	1%
August	223	260	5	2%	5	2%	0	0%	2	1%
September	230	252	10	4%	3	1%	3	1%	2	1%
October	221	241	4	2%	2	1%	1	0%	4	2%
November	213	247	9	4%	3	1%	2	1%	4	2%
December	214	238	3	1%	5	2%	1	0%	3	1%

Families, Parents, and Caregivers

Mercer estimates that the number of families with an adult caregiver who needs clinical behavioral health services or could benefit from preventive or early intervention services on an annual basis ranges from 10.7% (those experiencing a major depressive episode) to 28% (those with any mental illness). Additionally, an estimated 20.5% need SUD treatment. All of these rates for Washington are higher than national rates (8.6%, 22.9%, and 19.2%, respectively).

[189] Medicaid Gov. (2023). *Washington Medicaid Transformation Project. Section 1115 Demonstration. State Waivers List. SUD Part A Metrics (October 1, 2023 through December 31, 2023 and 2021/2022 Retrospective Metrics*). http://medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83531

Table D.20: Estimated Number of Adult Caregivers who Could Benefit from Preventive or Early Intervention Services[190]

Region	Any Mental Illness	Major Depressive Episode	Need SUD Treatment
Great Rivers	13,871	5,291	10,158
Greater Columbia	38,335	14,621	28,073
King	122,836	46,850	89,954
North Central	17,003	6,485	12,452
North Sound	72,430	27,625	53,041
Pierce	52,285	19,942	38,289
Salish	18,412	7,022	13,483
Southwest	29,765	11,353	21,797
Spokane	32,441	12,373	23,757
Thurston-Mason	18,685	7,127	13,683
Statewide	**416,065**	**158,688**	**304,689**

Families, Parents, and Caregivers in the Perinatal Phase

There are an estimated 7% of female caregivers who suffer from anxiety, 4% who suffer from obsessive compulsive disorder (OCD), 14% who suffer from depression and an additional 9% who suffer from post-traumatic stress disorder (PTSD).[191] 75% of individuals impacted by these maternal mental health conditions do not receive treatment. The estimated cost of these untreated perinatal mood and anxiety disorders is $32,000 per mother-child pair from birth to five years postpartum in 2017 dollars. In 2025 dollars, that equates to $41,000 per mother-child pair. The costs are due to reduced economic productivity across mothers, more premature births, and increases in other maternal health costs.[192] Women of color are three to four times more likely to experience pregnancy complications, leading to higher rates of PTSD for these populations. Thus, Washington can expect to see higher needs in the counties with larger populations of women of color.

Table D.21: Estimate Number of Families Who Could Benefit from Preventive or Early Intervention in the Perinatal Phase[193]

Region	Anxiety Disorders	OCDs	Depression	PTSD
Great Rivers	257	147	514	331
Greater Columbia	728	416	1,455	935
King	2,072	1,184	4,144	2,664

[190] SAMHSA, Center for Behavioral Health Statistics and Quality (2022, 2023). *National Surveys on Drug Use and Health.*

[191] Maternal Mental Health Leadership Alliance. (2024, October 10). *Maternal mental health conditions statistics: An overview.* https://www.mmhla.org/articles/maternal-mental-health-conditions-and-statistics

[192] Luca, D. L., Margiotta, C., Staatz, C., Garlow, E., Christensen, A., & Zivin, K. (2020). Financial toll of untreated perinatal mood and anxiety disorders among 2017 births in the United States. *American Journal of Public Health*, 110, 888-896. https://doi.org/10.2105/AJPH.2020.305619

[193] Washington State Department of Health.

Region	Anxiety Disorders	OCDs	Depression	PTSD
North Central	289	165	578	372
North Sound	1,201	686	2,401	1,544
Pierce	981	561	1,962	1,261
Salish	306	175	611	393
Southwest	483	276	966	621
Spokane	582	333	1,164	748
Thurston-Mason	320	183	640	411
Statewide	**7,221**	**4,126**	**14,442**	**9,284**

Appendix E
Data Partner Findings

Summary of Data Partner Findings

Mercer facilitated discussions with many Washington State data partners, beginning in the spring of 2024. Below is a summary of the findings from these discussions.

Topic-Focused Discussions Community and School Service Delivery Systems

The service delivery systems in community and school settings encompass Community-Based Organizations, Faith-Based Organizations, and the Educational System, which collaborate to provide vital services focused on mental health, educational support, and overall well-being for students and families. A range of data sources were identified to enhance understanding and improve service delivery, including the Office of Superintendent of Public Instruction (OSPI), the Washington Kindergarten Inventory of Developmental Skills, and the Healthy Youth Survey, among others. Key discussions among data partners emphasized OSPI's role in local control and funding initiatives, the importance of early learning services for mental health, and the variability in service provision across schools. Additionally, potential heat maps were suggested to visualize costs related to behavioral health services, while disparities in access and outcomes based on demographic factors were noted, alongside various funding sources like Medicaid to support these initiatives.

Promotion, Prevention, and Early Intervention

The focus on promotion, prevention, and early intervention involves a variety of service delivery systems and programs aimed at enhancing mental health and well-being. Key initiatives include Social and Emotional Learning programs that foster emotional intelligence in youth, Behavioral Health Literacy efforts to improve understanding of mental health issues, Home Visiting Programs that support families in nurturing child development, and strategies for Violence and Suicide Prevention. To inform these initiatives, several data sources were identified, such as the OSPI, the Department of Children, Youth, and Families (DCYF), and the Washington State Healthy Youth Survey. Discussions among data partners highlighted the integration of DCYF data with Medicaid claims, the need to explore funding disparities between preventive and intensive services, and the challenges in linking prevention data to Medicaid. Additionally, there was a proposal to enhance collaboration with local school-based services, and that the analysis considers important demographic metrics and successful reintegration strategies, emphasizing the need for behavioral health treatment for parents and services for neonatal substance-exposed infants.

Outpatient and Integrated Care

Outpatient and integrated care involves a range of service delivery systems and programs aimed at providing comprehensive mental and behavioral health services. Key components include the Collaborative Care Model, which integrates mental health care into primary care settings; Integrated Primary Care, which addresses both physical and mental health; and specialized resources like the Washington Partnership Access Line (PAL) and the Perinatal Psychiatric Consult Line. Various data sources were identified to enhance these initiatives, such as the 2023

behavioral health (BH) and Consultation PAL Report, the Washington All Payer Claims Database (APCD), and Substance Abuse and Mental Health Services Administration's Treatment Episode Data Set. Discussions among data partners highlighted critical issues, including the lack of centralized data on juvenile detention, the need for data matching to confirm Medicaid eligibility for youth on probation, and gaps in community-based prevention services. Additionally, while the APCD provides insights into insurance coverage and out-of-network utilization, it has limitations regarding commercial insurance and substance use disorder (SUD) data. Ongoing evaluation through quarterly clinical quality measures for Medicaid services was also emphasized as essential for improving care outcomes.

Intensive Home and Community Based Services

Intensive home and community-based services encompass a variety of programs designed to support individuals with complex mental health and behavioral health needs. Key service delivery systems include Rehabilitative Skills Training, Multi-Systemic Therapy, Family Functional Therapy, First Episode Psychosis Care, Intensive Outpatient Programs, and Recovery Support. Potential data partners and sources for enhancing these services include the 2023 BH and Consultation PAL Report, the Washington APCD, and various program data such as the Wraparound with Intensive Services (WISe) and Peer Support Programs. During discussions among data partners, a few areas were highlighted including the need for a comprehensive list of juvenile rehabilitation programs, the importance of comparing these services to Medicaid and the APCD, and the identification of geographic disparities in service availability. Additionally, there was a focus on confirming Medicaid coverage for probation services, exploring gaps in secure care, and utilizing intensive home-based therapies. Ongoing projects by the Department of Social and Health Services (DSHS) aim to produce cross-system measures relevant to children's behavioral health, particularly for those in the child welfare system, while addressing the unique challenges faced by young adults aged 18 years to 25 years old, especially those who are unhoused or transitioning from education to employment.

Comprehensive Crisis Care

Comprehensive crisis care encompasses various service delivery systems and programs designed to address urgent mental health needs, including 988/911 services, Mobile Response and Stabilization Services, Crisis Respite, and Emergency Shelters. Key data sources identified for enhancing these services include the 2023 BH and Consultation PAL Report, the Washington APCD, and 988 Call Data/Performance Metrics Reports, along with hospital data on emergency department utilization. During a recent data partners meeting, discussions highlighted the need for data on cross-trained crisis response teams, particularly those serving foster care and individuals with intellectual and developmental disabilities (IDD). During data partner discussions, it was noted that IDD service data is maintained in a Developmental Disabilities Administration database, while services provided through the DSHS are stored in an integrated client database, indicating a structured approach to managing crisis care data.

Inpatient Psychiatric Care

Inpatient psychiatric care encompasses essential services such as Emergency Psychiatric Consultations and inpatient treatment programs. Key data sources identified for enhancing these services include the Transitional Age Youth Community Health Plan of Washington, the Health Care Authority (HCA) Analytics, Research, and Measurement Dashboard Suite, and various reports from the Health Resources and Services Administration (HRSA). During data partner

discussions, it was noted that the Department of Health (DOH) maintains critical data on 988 calls, emergency department visits, emergency medical services, and youth health surveys. Data partners emphasized the importance of including demographic longitudinal trends and prevalence of needs in the dashboard, as understanding whether mental health needs are stable or increasing is crucial for developing effective prevention and support strategies. The discussions highlighted alarming trends, such as the doubling of national teen depression rates, emergency department visits for self-harm among youth aged 10 to 19 years old, and suicide rates since 2010, underscoring the urgent need for targeted interventions.

Other Considerations

Other considerations in service delivery systems include treatment provided in residential settings, which is crucial for addressing various mental health needs. Key data sources identified for enhancing these services encompass the Transitional Age Youth Community Health Plan of Washington, the HCA Analytics, Research, and Measurement Dashboard Suite, and reports from the HRSA on behavioral health workforce trends. During data partner discussions, data partners discussed the importance of focusing on services available across the envisioned System of Care (previously the Ideal Service Array), which includes Tiered Care Coordination, Cross-System Integration, and Transitional Age Youth Case Management. The discussions also highlighted the need to consider recovery support services, particularly peer support for individuals aged 18 years to 25 years old, as well as addressing the challenges faced by the uninsured and underinsured populations, and those experiencing homelessness. This comprehensive approach aims to ensure that services are tailored to meet the diverse needs of different age groups and circumstances.

One-on-One Data Partner Discussions

Due to scheduling conflicts encountered during the initial phase of the project, coupled with the significant amount of information to be addressed, Mercer conducted additional one-on-one meetings with select Data Partners. The insights obtained from these supplementary discussions are illustrated below.

Department of Health

The DOH identified several potential data sources during a one-on-one discussion, including the Healthy Youth Survey (HYS), the State Epidemiology Outcomes Workgroup, the Washington Young Adult Survey, the Community Funding Initiative, the Injury Prevention Group Data, and the Information by Location (IBL) Data Dashboard. The DOH emphasized the HYS as a key ongoing data source and highlighted the Washington Young Adult Survey's focus on substance use and mental health, which could provide valuable insights. However, access to data from the Community Funding Initiative is restricted due to geographical reporting requirements and the need for data sharing agreements with superintendents. DOH advised that the Injury Prevention Group manages critical suicide-related data, while the IBL offers environmental metrics and social vulnerability data statewide. Additionally, DOH mentioned an upcoming work group meeting in November 2024, which could be an opportunity for Mercer to discuss the Washington Thriving project and engage with tribal communities, as obtaining accurate children's behavioral health information from tribal governments is essential due to their independent operations within the State.

Department of Social and Health Services

The DSHS identified several potential data sources during the one-on-one discussion, including the APCD for school-based services, Healthcare Effectiveness Data and Information Set related

quality measures from the Economic Services Administration, the Crisis Line, and metrics from the WISe program. DSHS highlighted the historical collaboration between the Child Welfare System and the DCYF to address the behavioral health needs of children in foster care. DSHS discussed the importance of incorporating various data streams, such as statewide Medicaid data and utilization metrics, while also considering the need for data from the APCD and the OSPI for school services. The team emphasized the significance of State-funded data for research, particularly from DCYF and the Economic Services Administration, to identify indicators of children lacking necessary behavioral health services, including insights from the Crisis Line. Additionally, the meeting addressed challenges faced by young adults aged 18 years to 25 years old, especially those who are unhoused or transitioning from education to employment, suggesting that employment rates and educational background could serve as important indicators of support during this critical transition to adulthood.

Office of the Insurance Commissioner

The Office of the Insurance Commissioner (OIC) identified potential data sources, including the APCD and the Washington OIC Final Report on Health Care Affordability from July 29, 2024, during the one-on-one discussion. OIC explained that while states can fully regulate insured health plans under federal law, they face challenges with self-funded plans. The discussion focused on issues related to commercial insurance, such as the number of insured populations, provider participation, and out-of-network usage rates. OIC highlighted the absence of a centralized database for provider networks, complicating efforts to obtain accurate data on provider availability. They emphasized the importance of ongoing compliance work with carriers, particularly regarding parity compliance, and discussed the need to analyze out-of-pocket expenditures, referencing a recent affordability report that revealed low reimbursement rates for mental health and SUDs. The team considered the methodology used by the Research Triangle Institution for repricing health care spending and discussed consulting with a third-party consulting firm, who recently completed a report for the OIC using APCD data, to explore feasibility and trade-offs. Additionally, they recognized the necessity for actuarial analysis and the development of an instructional database to support future repricing efforts, while also noting the limited availability of SUD data in the APCD due to submission issues.

Office of Financial Management

During a one-on-one discussion, the Office of Financial Management (OFM) explored potential data partnerships and sources, particularly focusing on the Education Research and Data Center (ERDC) Data Dashboards. The team discussed how the ERDC regularly receives data from various State agencies, encompassing kindergarten through grade 12, higher education, and workforce data, and noted their existing data sharing agreements with other projects and institutions. OFM outlined ERDC’s mission to analyze student transitions across the education system and support policy and budget decisions aimed at ensuring successful outcomes and equity. They showcased several dashboards, including one that tracks high school graduate outcomes, and highlighted their publications, such as a report on students from Medicaid-eligible families. Mercer raised questions about data sharing agreements and access, to which OFM clarified that data sharing is regulated by law, with processes varying by data type. They explained that organizations can request de-identified student data, provided that the requests comply with the Family Educational Rights and Privacy Act standards for approval.

Appendix F
Summary of Data Sources

To further aid the development of the current behavioral health (BH) landscape with quantitative measures in the State, Health Care Authority (HCA) has shared a list of publicly available reports and data. In Phase 1, Mercer categorized these reports and data by including a summary of the report and/or data, identifying the population mentioned and cross-walking to the envisioned System of Care for parents and caregivers of children, youth transitioning to adulthood through the age of 25 years old. The documents are organized in an Excel database that allows the State to sort reports with the following information:

- Population of Interest.
- If the data source was qualitative or quantitative in nature.
- The age group notes the age group addressed in the data source.
- If the data source was a one-time only report or an on-going data source.
- If the data source identifies improvement opportunities.
- If the data source identifies unmet needs.
- If the data source addressed a data partner meeting topic.

Criteria	Categories	Number of Data Sources
Population of Interest	Child welfare Early childhood Individuals at risk of homelessness Individuals with BH needs Individuals with Juvenile Justice Individual with IEP Individuals with traumatic brain injury Washington State Utilization Data Workforce	7 6 12 53 7 1 1 7 6
Qualitative or Quantitative	Qualitative Quantitative Both N/A, Blank	27 37 25 30
Age Group Addressed	Children 0–5 Children 6–17 Young Adults 18–25 All Ages	36 73 41 25
On-Going Data Sources	On-going data source One-time report N/A	42 57 19
Identifies Improvement Opportunities	Yes	31
Identifies Unmet Needs	Yes	30

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
Child Welfare						
Child Well-Being Data Portal	The Child Well-Being Data Portal is a joint project of the Center for Social Sector Analytics & Technology (CSSAT) and Partners for Our Children (POC). CSSAT and POC work to bring tools such as the Data Portal to social workers, parents, advocates, and policy-makers that will help improve the lives of vulnerable children and families in Washington State, especially those touched by the child welfare system.	X		X	X	
Indian Child Welfare Act (ICWA)	ICWA provides guidance to States regarding the handling of child abuse and neglect and adoption cases involving Native children and sets minimum standards for the handling of these cases.			X	X	
State Automated Child Welfare System	Unable to locate information.					
US DHHS, Children's Bureau, Adoption and Foster Care Analysis and Reporting System (AFCARS)	AFCARS collects case level information on all children in foster care for whom State child welfare agencies have responsibility for placement, care, or supervision, and on children who are adopted under the auspices of the State's public child welfare agency. AFCARS also includes information on foster and adoptive parents.	X		X	X	
Washington DCYF, Agency Performance	The availability of data varies by measures.	X		X	X	
Washington DCYF, Reports	Contains 269 reports consisting of legislative, federal, and DCYF programs. The site also contains information on pre-expenditure report for federal fiscal year (FFY) 2025 social service block grant and the Office of Innovation, Alignment, and Accountability (OIAA) reports of new research and analysis conducted on DCYF programs.	X		X	X	
Washington DCYF, Assessment Oversight Group (AOG)	This site contains information on the AOG, which monitors and coordinates DCYF's ongoing use of assessments and approves the use of new assessment tools.			X	X	

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
Early Childhood						
Arizona's smart support evaluation report: The first four years	Focus on working with teachers and childcare providers to increase their skills and capacities.		X	X		
Expansion of trauma-informed childcare in Washington State, March 2019	In 2018, a Trauma-Informed Care Advisory Group (Advisory Group) was established by the Legislature in Engrossed House Bill 2861. Its task was to develop a five-year plan for expanding the availability of trauma-informed early care and education experiences. The report recommends expanding the availability of trauma-informed early care.		X	X		
Supporting resilience in black families: Advancing racial equity in early childhood mental health policy	Report addresses racial disparities in health care, specifically for black youth and advocate for teachers in Pre-Kindergarten to have access to MH consultants, expanding network for Infant and Early Childhood Mental Health Consultation, and expanding comprehensive trauma-informed care coordination services.		X	X		
Washington ERDC	ERDC focuses on providing longitudinal information and research about transitions between the education and workforce sectors to assist students, parents, educators, and policy makers when making decisions. Information and research provided by ERDC typically begins in one sector and reports outcomes achieved in other sectors. The dashboards below represent some of the ongoing research conducted by ERDC.	X		X	X	
Washington State Child Care Access Strategy: A strategy, timeline, and implementation plan to reach the goal of accessible, affordable childcare for all Washington families	Outlines goals of the Child Care Collaborative Task Force and policy implementation plan to improve access to care for children including BH and MH — outline steps taken, actions, and proposed steps.		X	X	X	

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
Individuals at-Risk of Becoming or Experiencing Homelessness						
2021 Update Improving Stability for Youth Exiting Care	Homeless youth.				X	X
2024 WA Unaccompanied YYA Landscape Scan_Final.pdf	Data to estimate the number of unaccompanied young people who experienced homelessness in 2022 and understand their characteristics.				X	X
A Way Home Report: From Inpatient Treatment to Homelessness, December 2018	Provides a review of the current information available about youth homelessness from the inpatient BH perspective, offers insight into massive system initiatives underway around BH and youth homelessness. The report also provides information about the inpatient BH landscape that serves young people in Washington.				X	X
Access to behavioral health services for children and youth, December 2022 and December 2023	Medicaid and Children's Health Insurance Program MH/SUD penetration data, number of MH and SUD providers in Apple Care, and information on individuals with eating disorders and treatment providers.			X	X	
Best practice recommendations for safe and supportive transition to stable housing for youth ages 16–25, July 2021	Best practices to transition youth and young adults ages 16 years to 25 years old who experience homelessness from inpatient to outpatient behavioral care and stable housing.				X	X
Community Feedback on Substitute Senate Bill (SSB) 6560 Progress Report, May 2024	This is an annual progress report on SSB 6560 which was passed in 2018. SSB 6560 was intended to ensure that no youth is discharged from a public system of care into homelessness, and the annual progress report contains feedback from interested parties. The purpose of this report is to inform communities about progress made through changes in law or funds available to prevent and end youth homelessness.				X	X

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
Findings and recommendations to the OIC related to access to behavioral health services, December 2019	The goal of this project is to confirm that health insurers offer comprehensive and affordable health benefit designs by examining access to MH/SUD treatment in the fully insured individual, small group, and large group health insurance markets.			X	X	X
Homelessness among youth exiting systems of care in Washington State, March 2024	This report provides information on the housing status of a cohort of youth (ages 12 years to 17 years old) and young adults (ages 18 years to 24 years old) exiting Washington State inpatient BH, foster care, and criminal legal systems from January 1, 2021 to December 31, 2021.				X	
Preliminary strategic plan: Prevention of youth homelessness, January 2021	Contains overview of existing efforts to prevent youth homelessness, data on demographics of homeless youth including structural and systemic and identifies gaps in State-system led interventions. Also discusses funding streams.				X	X
Rights of Youth and Young Adults in Residential Programs, January 2020	The Washington State Department of Commerce, Office of Homeless Youth report contains information on homeless youth programs and recommendations.				X	X
Washington OSPI Update: Data on students experiencing homelessness, 2021	Presents findings on the number of high school students experiencing homelessness by grade level, graduation rates, and suspensions and expulsions.				X	
Washington State Department of Commerce, Data, Research, and Reports	Contains 21 data, research, and reports on a wide range of topics impacting youth at risk of becoming or experiencing homelessness.				X	

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
Individual Involved in the Juvenile Justice System						
Uniform Reporting System (URS) (samhsa.gov)	The URS, comprising 21 tables developed by the federal government in consultation with State mental health agencies (SMHAs), compiles state-by-state aggregate information, including numbers and sociodemographic characteristics of clients served by the states, outcomes of care, use of selected evidence-based practices, client assessment of care, insurance status, living situation, employment status, and readmission to State psychiatric hospitals within 30 days and 180 days.	X			X	X
Washington DCYF, Treatment Programs	Contains information on available treatment programs.			X	X	
Washington State Juvenile Law Enforcement Data Analysis Dashboard	Dashboards show the number of juvenile arrests for every 1,000 youth. Rates are based upon the demographics (race, ethnicity, and gender) of the cities or counties selected by user, and arrest demographic and offense information as reported by city policy department, county sheriffs, and other law enforcement agencies.				X	
Individuals with Behavioral Health Needs						
988 Call Data/Performance Metrics Reports	This report provides data from July 2022 through June 2023 on the usage of the 988 Lifeline, call outcomes, and the provision of the crisis services inclusive of mobile rapid response crisis teams and crisis stabilization services.		X	X	X	X
2023 Behavioral Health and Consultation (PAL) report	Behavioral health referral and consultation to providers of children, individuals who are pregnant, postpartum, or planning pregnancy.		X	X	X	X
Access to behavioral health services for children, youth, and young adults, December 2023	This report is an annual report from HCA to the legislature in accordance with the Revised Code of Washington (RCW) 74.09.495. This report contains the status of access to BH services for children (birth through age 17 years) enrolled in Apple Health (Medicaid).	X		X	X	

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
Maple Valley Community Resource Coordinator Pilot Project	Reported submitted by HCA about the findings of a pilot project involving community resource coordinator pilot project, key takeaways, and future plans.		X	X		
Addressing the youth mental health crisis: The urgent need for more education, services, and supports, 2020	Report targeted at State policymakers and advocates which details the MH crisis among youths, State policy recommendations to alleviate this, and a section on school-based MH education. Mentions the Mental Health Association in New York which helped pass the nation's first law mandating schools to teach students about MH.			X	X	
Ages 15–25 years, Transitional Age Youth — Washington State Local Health Insurance — Community Health Plan of Washington	Resource site and member portal.				X	X
Athena — Washington Young Adult Health Survey (WYAHS)	The WYAHS is a statewide online survey that measures cannabis and other substance use, perceptions of harm, risk factors, and consequences among young adults (18 years to 25 years old) living in Washington State.	X				X
Certified Community Behavioral Health Clinic (CCBHC) impact report, 2021	A CCBHC is a specially designated clinic that receives flexible funding to expand the scope of MH/SUD services available in its community. CCBHCs provide care for people with unmet needs.		X	X	X	X
Children and youth behavioral health work group recommendations, 2016–2020	Contains summary of the CYBHWG recommendations from 2016–2020 regarding BH.	X		X	X	
CYBHWG	The website contains reports generated by and for the CYBHWG as well as reports that relate to BH services for children, youth, young adults, and their families.			X	X	X

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
Children and Youth BH Work Group Strategic Plan Landscape document	A description of the data gathered by King County BH Administrative Services Org (BH-ASO) to continue the Children's Crisis Outreach Response System (CCORS) in King County.	X		X	X	X
CCORS and King County Behavioral Health — ASO contracting, December 2021	A description of the data gathered by King County BH-ASO to continue the CCORS in King County.		X	X	X	
Family initiated treatment (FIT) expansion, November 2020	Discusses results of FIT survey developed by HCA to assess the impact of FIT, which is an admission pathway for youth to access MH/SUD services across continuum of care. The report concludes that there are opportunities to increase youth, provider, and parent voices for future surveys and stakeholder work as well as continued training and education on what FIT is and implementation strategies for communities and providers.		X		X	
FIT expansion survey results impact report, November 2021	A summary of the 2020 survey results. It states that HCA faced challenges and was unsuccessful at completing the FIT system impact survey for the fiscal year 2021 due to technological system changes inside the agency.				X	
First Episode Psychosis: Estimating annual incident using administrative data, 2021	Contains state fiscal year 2021 data on the number of Medicaid enrollees that received their first psychotic disorder diagnosis and estimates how many Medicaid enrollees in the State experienced a first-episode psychosis by county using data from Integrated Client Databases, which breaks down demographics of these individuals.		X	X	X	X
Five-year outcomes of behavioral health integration in primary care, July 2019	A study that found that BH integration in pediatric primary care can increase access to BH services. It also looks at outcomes such as access, quality, cost, and provider satisfaction.		X	X	X	

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
Food Safety Preventive Controls Alliance Plan	The U.S. Food and Drug Administration in cooperation with the Illinois Institute of Technology's Institute for Food Safety and Health, a nationally recognized leader in food safety, created the Food Safety Preventive Controls Alliance. External Link Disclaimer to develop training courses and technical information on preventing contamination for both human and animal food during production.					
Healthy Youth Survey	The Healthy Youth Survey (HYS) is a biennial, cross-sectional survey of 6–12 graders that measures adolescent health and wellbeing in Washington State administered since 2002.	X			X	
Kids' Mental Health Washington	Kids' Mental Health is a Youth Regional Behavioral Health Navigation team which was formed in partnership with the HCA, Pierce County, and Developmental Disabilities Administration. The Youth Regional Behavioral Health Navigation teams focus on improving collaborative communication, service connection processes, and the deployment of Multidisciplinary Teams, all of which are designed to improve access to and the coordination of services for children and youth experiencing BH challenges.				X	
Languages Spoken at Behavioral Health Agencies Serving Children and Youth in Washington State, 2020	Information on linguistic competency of BH care providers (languages other than English) and agencies.		X	X	X	
Maple Valley community resource coordinator pilot project	Reported submitted by HCA about the findings of a pilot project involving community resource coordinator pilot project, key takeaways, and future plans.		X	X	X	X
Mental Health Service Costs and Use Trends — OIC, Washington State	To help policymakers and interested parties better understand how consumers use MH services and the cost of those services, the OIC contracted with Onpoint Health Data to create a searchable dashboard of BH-specific claims.	X		X	X	X

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
Minerva database	A database of clinical trials with patients with attention deficit hyperactivity disorder that allows for quick queries, reviews, and meta-analyses as the researcher skips the study identification and extraction stages of data.	X		X	X	X
National Indian Child Welfare Association	The purpose of this data brief is to review data related to American Indian and Alaska Native children and child welfare.		X	X	X	
National Survey on Drug Use and Health — SAMHSA	The 2021–2022 NSDUH State data tables provide estimates for 35 measures of substance use and MH by age group across 37 tables.	X			X	X
New Journeys and First Episode Psychosis	New Journeys coordinated specialty care is a treatment curated to meet the needs of those experiencing a first episode of psychosis with treatment services of a higher intensity than those offered in regular outpatient settings. Treatment provides evidence-based health and recovery support interventions for youth and young adults when first diagnosed with psychosis.					
New Journeys: Coordinated Specialty Care for first episode psychosis, January 2021	Contains the statewide implementation plan of coordinated specialty care for early psychosis.				X	X
Ninth Grade Success	This grant program was created to help ninth grade teacher teams to analyze data visualizations to pinpoint students that need additional supports and offer them as soon as possible. The grant provides professional development on best practices, opportunities to network success with other regional teams, coaching support, and quarterly collaboratives to monitor progress and problem solve.				X	
OIC Data and Reports	Annual reports that contain a number of insurance companies offering health insurance through the Washington State Health Benefit Exchange and/or outside the Exchange (in 2023, there were 14 insurers).	X		X	X	X

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
PAL for Moms	PAL for Moms is a free State-funded program providing perinatal MH consultation, recommendations, and referrals for providers caring for pregnant or postpartum patients.			X	X	X
PAL funding recommendations, December 2019	Recommendations developed by the PAL committee to develop a funding model for all operating BH consultation and referral services. Discusses current PAL programs and their current status, as well as current funding.		X	X	X	
PAL Plus program, December 2018	This is a final report for the PAL Plus pilot that includes a summary of children and families referred to, and their participation in the program.		X	X	X	
Peer Support Programs	The HCA's Peer Support Program trains and qualifies BH consumers as certified peer counselors. By BH, we mean both MH and SUD.					X
Project Aware	Project AWARE is a grant from SAMHSA. It is spread over five years to both build and grow MH services and BH education within awarded districts. OSPI's Project AWARE is now in its third cycle.				X	X
Reimagining access: Co-designing treatment policy with youth and their communities, 2022	Summary of collaborative efforts between HCA and firm Do Big Good to form a process that supports youth access treatment for SUD. Includes five stages: increase access to information, provide social support, unplug bottlenecks (where potential gaps can be found), connect marginalized youth (gap), and addresses concerns beyond access.		X		X	X
Rights of Youth and Young Adults in Residential Programs, January 2020	Washington State Department of Commerce, Office of Homeless Youth report that contains information on homeless youth programs and recommendations.		X		X	X
Staffing enrichment work group recommendations, 2019	Recommendations from Staffing Enrichment Workgroup which found that public education in the State needs to invest in BH of students by employing and training various BH professionals.			X	X	

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
State Health Facts | KFF	State Health Facts is comprised of more than 800 health indicators and provides users with the ability to map, rank, trend, and download data. Data comes from a variety of public and private sources, including KFF reports, public websites, government surveys and reports, and private organizations.	X		X	X	X
Teaching clinic enhancement rate, status report of teaching clinic enhancement rate workgroup, October 2021	HCA report on status update regarding developing recommendations for teaching clinic enhancements for BH agencies to use when training those seeking their license.		X		X	X
The state of mental health in America, 2022	Contains information on general State ranking on MH indicators and access to care for both adults and youth, and how disparities in MH exist for youth of color.			X	X	X
Treating Symptoms of Trauma in Children and Teenagers, 2022	Contains information on treating symptoms of trauma in children and teenagers.			X	X	
Treatment Episode Data Set (samhsa.gov)	Contains information on treating symptoms of trauma in children and teenagers.	X			X	X
URS (samhsa.gov)	The URS, comprising 21 tables developed by the federal government in consultation with SMHAs, compiles state-by-state aggregate information, including numbers and sociodemographic characteristics of clients served by the states, outcomes of care, use of selected evidence-based practices, client assessment of care, insurance status, living situation, employment status, and readmission to State psychiatric hospitals within 30 days and 180 days.	X			X	X
University of Washington and Seattle children's consultation and referral lines for mental and behavioral health final report, 2022	Evaluation of four mental and BH consultation and referral lines — found that families are satisfied with process steps, but not timeliness of process. Report suggests working on timeliness and low participation in East Washington. Looked at data provided by BH care providers using PAL (calling about children		X	X	X	X

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
	aged 0 years to 19 years old), and Perinatal Psychiatry Consultation Line (any age).					
Washington State Healthy Youth Survey	The purpose of the HYS is for youth to share their wellbeing behaviors, attitudes, community, school experiences, and more.			X	X	
Wilderness therapy programs: A systematic review of research, June 2022	Literature review on existing research surrounding wilderness therapy also defines the various programs under wilderness therapy and evidence-based practices in wilderness therapy.				X	
Wilderness therapy programs: Stakeholder perspectives in Washington, December 2022	Survey results of asking stakeholders of their perception, questions, concerns regarding wilderness therapy programs in the State. Also references the first report in this series which summarizes existing research on wilderness therapy.				X	
The World Mental Health International College Student (WMH-ICS) Initiative for ages 18-24 found at www.hcp.med.harvard.edu/wmh/college_student_survey.php	WMH-ICS Initiative is designed to: generate accurate epidemiological data on unmet for treatment of mental, substance, and behavioral disorders among college students worldwide; implement and evaluate web-based interventions for both the prevention and treatment of these disorders; and disseminate the evidence-based interventions found to be effective using a continuous quality improvement approach designed to prevent degradation of these interventions in dissemination and successively to improve targeting of interventions using precision medicine procedures.		X			X
WISe	The WISe program model provides comprehensive services and support to eligible children and youth in Washington. Data reports related to WISe are publicly available on this page.				X	

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
WISe Summary of Results from the 2023 Survey	The purpose of this report was to summarize the findings from the 2022 annual survey of children, youth, and their caregivers who participate in WISe to assess participant engagement in WISe and provider competence which is broken down by age group, race, gender, and county. The report ultimately did not offer any insights into disparities or gaps but concluded that most youth and caregivers of all age groups had a positive experience with WISe.				X	
Youth risk behavior survey: data summary and trends report	Contains information on substance use (current and prior experience with substance abuse) as well as on suicidality. The report also contains a section on School Connectedness which may address how schools are addressing these issues.				X	X
Individuals with IDD						
"I want to go home" Reevaluation DDA children's services to prevent hospitalization and out of-state placement, September 2022	Navigating BH for developmentally disabled youth.		X		X	
Individual with IEP						
IDEA Data Center (IDC)	Funded by the U.S. Department of Education's Office of Special Education Programs, the IDC supports states as they work to improve the collection and reporting of their IDEA data and as they analyze and use these data to make programmatic improvements.	X	X	X		
IDEA Section 618 State Level Data Files Part B Assessment	Data available from 2007–2022 by State level. Children and youth ages 3 years old through 21 years old receive special education and related services under IDEA Part B. BH referral and consultation to providers of children, individuals who are pregnant, postpartum, or planning pregnancy	X		X		

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
PAL funding recommendations, December 2019	Recommendations developed by the PAL committee to develop a funding model for all operating BH consultation and referral services. Discusses current PAL programs and their status, as well as current funding.			X	X	
PAL Plus program, December 2018	This is a final report for the PAL Plus pilot that includes a summary of children and families referred to, and their participation in the program.			X	X	
Post-School outcomes for students with disabilities, 2021	Findings of 2020 Post-School Survey of former students who received special education services from school, one year after graduating high school to see the impact it had on employment opportunities.		X		X	X
University of Washington and Seattle children's consultation and referral lines for mental and behavioral health final report, 2022	Evaluation of four mental and BH consultation and referral lines which found that families satisfied with process steps, but not with timeliness of process. The report suggests working on timeliness and low participation in the eastern part of the State. Looked at data provided by BH care providers using PAL (calling about children aged 0 years to 19 years old), and Perinatal PCL (any age).			X	X	X
School-Based Mental Health and Education						
Brief: The case for school mental health, 2021	Supports development and deployment of a statewide accountability framework for a multi-tiered system of school mental health support, that can aid districts to develop plans and stay on track.			X	X	
Building Bridges Legislative Report, 2023	The legislature created the Building Bridges Program to support a comprehensive engagement and reengagement system. This program includes grants to local partnerships of schools, families, and communities, attendance initiatives, engagement and reengagement, school leadership support, and shared best practices. The efforts are led through recommendations of the Graduation A Team Effort Advisory Committee.				X	

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
Educational Opportunity Gap Oversight and Accountability Committee (EOGOAC)	The EOGOAC was created by the 2009 legislature to synthesize the findings and recommendations from the 2008 Achievement Gap Studies into an Achievement Gap Studies Implementation Plan.			X	X	
Ninth Grade Success	This grant program was created to help ninth grade teacher teams analyze data visualizations to pinpoint students that need additional supports and offer them as soon as possible. The grant provides professional development on best practices, opportunities to network success with other regional teams, coaching support, and quarterly collaboratives to monitor progress and problem solve.				X	
OSPI Adolescent Substance Use report (2018–2019)	Assessed the effectiveness of Student Assistance Prevention Intervention Services Program.		X		X	
OSPI Data and Reporting	Data on school facilities, school accountability, educators, and finances. At a glance, this source does not seem to be useful for garnering health-related data but could be useful for understanding the demographics of school-aged youth in Washington.	X			X	
Project Aware	Project AWARE is a grant from SAMHSA. It is spread over five years to both build and grow MH services and BH education within awarded districts. OSPI's Project AWARE is now in its third cycle.				X	
WaKIDS	WaKIDS is a transition process that helps to ensure a successful start to the kindergarten–grade 12 experience and connect the key adults in a child's life. These data help inform State and district-level decisions about education policy and investments, and classroom decisions about individualized learning.			X		

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
Washington ERDC	Contains a list of data available, organizations that provide the data, and file descriptions for: • Early learning • Kindergarten to Grade 12 • Postsecondary • Apprenticeship • Financial aid • Workforce • Other • Data available years vary by files	X		X	X	
Telehealth Practices						
Best telehealth practices for prenatal to young adult behavioral health, June 2022	This interim report summarizes processes, preliminary findings, and emerging recommendations from a seven-step framework (below) guiding Mercer's review of best practices for telehealth for clients P-25. This report reflects completed work through Step 3 and partially completed work through Step 4 and Step 5.			X	X	X
State Department						
Office of Financial Management Relationships between cost, utilization, and quality measures in health care — data dashboard	This dashboard allows comparison at a zip code level results from a select set of health care quality and cost measures, including adult access to preventative care and total cost per member per month, to socioeconomic characteristics, such as the percentage of population living below the poverty line.			X	X	X
Office of Financial Management ERDC	Website contains data dashboards and publications pertaining to, but not limited to, student enrollment, graduation rates, and demographic information.			X	X	X

Report	Description	Data Source Status		Age Group		
		Ongoing	One-time	Children	Youth	Young Adult
Washington State OIC	Contains the following reports: OIC annual, market information, and legislative and commissioner. To help policymakers and interested parties better understand how consumers use MH services and the cost of those services, the OIC contracted with Onpoint Health Data to create a searchable dashboard of BH-specific claims. The data is from the Washington APCD and includes claims between 2017–2022 for all State-regulated health plans and Washington's Public and School Employee Health Benefit Programs.			X	X	X
Washington OSPI	This page contains information about reporting to OSPI, the State Report Card, requesting data from OSPI, and other financial and programmatic reports.			X	X	
Washington State DCYF	The State Department focused on serving at-risk children and youth, with the goal of producing better outcomes in all statewide communities. State website contains a compendium of four (4) report types: legislative, federal, OIAA research and analysis, and the DCYF program. Report categories include adolescents/youth, birth-to-three, budget and rates, child welfare, DCYF organization, early learning, evidenced informed practices, family support services, foster care, health, homelessness and housing, innovative practices, juvenile justice/rehabilitation, pre-kindergarten, prevention, providers, racial equity/disproportionality, Tribal affairs, and workforce. Website also contains an agency performance dashboard for six strategic priorities and nine outcome goals and a compendium of reports to include legislative reports, federal reports, the OIAA research and analysis, DCYF program reports, and pre-expenditure reports for FFY 2025 social services block grant.			X	X	

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
Washington State DOH Information by Location (IBL)	The IBL mapping tool lets you explore and compare communities. It displays information about a variety of topics by presenting a community's rank by a variety of topics, themes, and measures (i.e., environmental health disparities, diesel pollution and disproportionate impact, social vulnerability index, lead exposure risk, health disparities, planning for health).			X	X	X
Washington State DSHS	State Department focused on transforming lives through seven administrations: Aging and Long-term Support, BH, Developmental Disabilities, Division of Vocational Rehabilitation, Economic Services, Financial Services, and Office of the Secretary. Website also contains research and resources for individuals with traumatic brain injury.			X	X	X
Washington State DSHS, Client Data Report	Unduplicated client count and service utilization by race/ethnicity, age, or county.			X	X	X
Washington State DSHS, BH Treatment Needs and Outcomes Among Medicaid-Enrolled Children	Report provides a snapshot of the BH needs, characteristics, and outcomes of children and youth (age 0 years–20 years) on Medicaid in Washington State. Differences between BH needs and outcomes of children and youth enrolled in Medicaid and those in foster care are also highlighted. This information can help to identify cross-system opportunities for BH service delivery.		X	X	X	
Washington State HCA Analytics Research & Measurement (ARM) Dashboard Suites	The website contains information to address questions around health service utilization by Washington State Medicaid enrollees.			X	X	X
Washington State HCA, Data and Reports	Website contains information on health enrollment reports, legislative reports, budget information, and agency data dashboards.			X	X	X
Washington State HCA, Legislative Reports	The website contains reports submitted by the HCA to the State Legislature.			X	X	X

Report	Description	Data Source Status		Age Group		
		Ongoing	One-time	Children	Youth	Young Adult
Washington State HCA, Teaching clinic enhancement rate, status report of teaching clinic enhancement rate workgroup, October 2021	HCA report on status update regarding developing recommendations for teaching clinic enhancements for BH agencies to use when training those seeking their license.			X	X	X
Washington State HCA, Washington State APCD	A tool used to collect health care claims data for reporting, analytics, and to support the public making health care decisions. It supports health care and payment reform while addressing the need for cost, quality, and utilization transparency.			X	X	X
Utilization						
Comprehensive Hospital Abstract Reporting System (CHARS)	CHARS is a DOH system which collects record level information on inpatient and observation patient community hospital stays.	X	X	X	X	
HCA ARM Dashboard Suite	HCA's ARM dashboards focus on health service utilization by Apple Health (Medicaid) enrollees.	X		X	X	X
HRSA Health Center Program Uniform Data System (UDS) Data	Health Center Program awardees and look-alikes are required to report on a core set of measures each calendar year as defined in the UDS, a standardized reporting system. HRSA uses UDS data to assess the impact and performance of the Health Center Program, and to promote data-driven quality improvement.					X
Washington All Payers Claims — Early Intervention Current Procedural Terminology Codes	Could not find information.					
Washington DSHS Client Service Data	Contains an unduplicated client count for DSHS services used since 2021.	X		X	X	

Report	Description	Data Source Status			Age Group	
		Ongoing	One-time	Children	Youth	Young Adult
Workforce						
2022 Behavioral Health Workforce Assessment: a report of the Behavioral Health Workforce Advisory Committee	Provides information on recruiting and retaining BH professionals, how they are reimbursed, educated, and trained, along with updates on current projections regarding care integration.					
data.wa.gov Health Care Provider Credential Data	Provider credential search site.					
data.wa.gov Washington Health Workforce Survey	This includes information on the work status, practice characteristics, education, and demographics of health care providers, provided in response to the Washington Health Workforce Survey.					
HRSA BH Workforce Trends	The Workforce Projections Dashboard is an interactive Tableau Dashboard that shows projections of the supply of and demand for health care workers across the United States.		X			
Washington's Behavioral Health Workforce: Barriers and solutions — Phase II report and recommendations, December 2020	Identifies the BH workforce landscape and workforce barriers as well as recommendations put forth by a workgroup to address these barriers such as reimbursement/incentives for supervision of trainees and competency-based training					

Section 10

Disclosures and Limitations

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