Washington Thriving Strategic Plan

A Roadmap to Well-Being for Every Child, Youth, and Young Adult

Washington Thriving

Contents

Executive Summary

The Challenge

Despite investments to increase care especially for young people in crisis, Washington is ranked 48th in the nation for youth flourishing—a metric indicative of the comprehensive well-being of our children.

Conversations with young people, families, providers, and administrators throughout Washington reveal a common reality: the current fragmented behavioral health system fails to adequately address the needs of young people starting before birth through age 25, and those that care for them.

- **Parents and caregivers** spend countless hours navigating a maze of disconnected agencies, each with different rules and requirements.
- **Young people and families** wait months for services while missing critical early intervention opportunities.
- **Teachers and school staff** struggle to help students who show warning signs of mental health challenges.
- **Behavioral health workers** burn out and leave the profession due to inadequate support, high caseloads, and overwhelming administrative demands.
- **Community members and system partners** alike know from experience that there simply aren't enough behavioral health providers, services, and supports available.

Statewide data reflects these lived realities:[i,ii,iii]

The need for behavioral supports in early childhood has **increased by 13%** in recent years, and the need is rising fastest among families who can least afford private options.

Among middle-aged and high-school students surveyed, roughly **one-quarter to one-third** reported experiencing depression symptoms and high levels of anxiety.

Only about half (52%) of youth and young adults on Medicaid receive the mental health treatment they need, and even fewer—**just one in three** (37%)—get substance use services when needed.

The state has fewer pediatric inpatient beds per person than the national average, even as the number of young people needing intensive care **doubled** from 2018 to 2023.

Turnover rates are as high as **40% annually** in behavioral health workforce.

Washington's current behavioral health system serving young people, caregivers, and families is:

- **Designed for adults:** The system fails to address the unique developmental, family, and community needs of babies, children, youth, and young adults. This also includes young people who are unaccompanied—without a caregiver or other supportive adult present—as well as those in foster care, state guardianship, juvenile justice settings, or other institutional care arrangements.
- **Reactive, rather than proactive:** Washington's system responds predominantly to crises, missing key opportunities to promote well-being and build resilience in its youngest residents.
- **Structured with access barriers that force deterioration:** Young people's health and well-being often must worsen significantly before they qualify for care.
- **Facing significant workforce and capacity shortages:** Low reimbursement rates, high training costs, and lack of workforce well-being supports make it difficult to recruit and retain providers, leaving young people and families with few options and long wait times.
- **Fragmentation increases barriers:** Money and services flow through multiple agencies with incompatible systems and overwhelming administrative complexity – each with different rules, making it hard for providers to stay in business and families to get comprehensive care.

The result is a strained, siloed, crisis-driven system whose effects ripple outward, impacting individual, family, and community health and well-being.

The Ambition

The Washington Thriving Strategic Plan aims to transform how Washington approaches behavioral health for its youngest residents, from before birth to age 25. (See the detailed vision here)

Figure 1. The elements of the Strategic Plan

The vision describes the future we want

The goals describe what we need to achieve to realize the vision

The foundational dimensions describe all that's required of the future system

The longterm roadmap charts the course over 10+ years

The first initiatives describe where to begin

Vision

Washington Thriving envisions a future where every pregnant person, baby, child, youth, and young adult is thriving, supported by their caregivers, families, and communities. The Strategic Plan lays out a detailed vision and defines guiding principles for the system that will realize this future.

Goals

Washington Thriving has identified five ambitious system-level goals that summarize the most essential work:

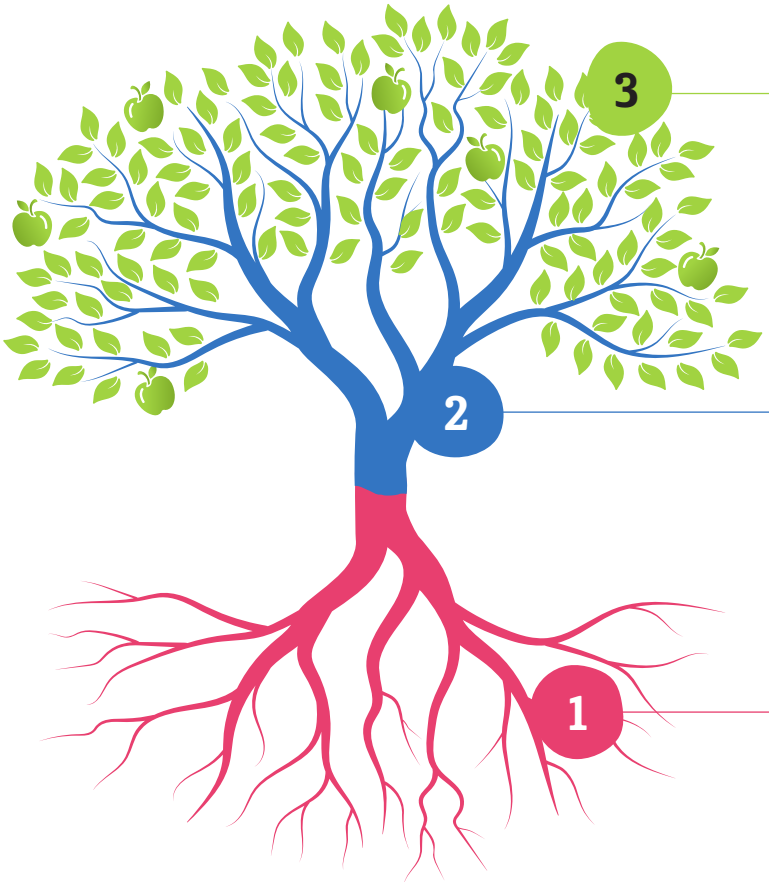
1. **Focus on what matters to young people, caregivers, families, and the workforce:** ensure services, supports, and policies are attuned to the strengths, desires, and needs of each young person, caregiver, family, and member of the workforce.
2. **Serve Washingtonians equitably:** ensure reach and quality across the state, with extra attention and resources directed toward those who face the greatest barriers and disadvantages.
3. **Expand upstream:** Build strong wellness foundations, prevention, and early supports while strengthening, not losing, intensive services for young people with the most complex needs. The services must expand to be comprehensive, filling gaps in the care continuum to serve children, youth, young adults, caregivers, families, and communities effectively.
4. **Strengthen the foundation:** ensure a connected, coordinated, collaborative, informed, adaptive, accountable, values-driven, and sustainable behavioral health ecosystem (See Appendices E and G for more detail on values and structures).
5. **Make help easy to find and get:** ensure coordinated, accessible, effective services and supports across a full continuum of comprehensive offerings, connected to the places where young people, caregivers, and families spend their time.

Three foundational dimensions

Achieving this vision requires sustained, coordinated action across the system. The Washington Thriving Strategic Plan provides a comprehensive framework to guide investment, policy development, and coordinated action. Evidence from over 20 years of System of Care implementation demonstrates that transformation like this requires work across three foundational dimensions. Each of the three dimensions presented in Figure 2 are vital and must support each other to build a behavioral health system that is coordinated, efficient, and, most importantly, working for Washingtonians' needs.

Other states who are ahead of Washington in this work show remarkable results: reduced hospital stays, fewer school suspensions, decreased juvenile justice involvement, and healthier young people, families, and communities. These investments will save both money and lives while establishing a strong behavioral health foundation for future generations.

Figure 2. The three foundational dimensions of Washington's future system



People and relationships

Like the leaves and fruit that make a tree beautiful and life-sustaining, THE INTERPERSONAL DIMENSION represents the visible, tangible expressions of care through relationships, interactions, and values-driven practice that make support feel meaningful and affirming.

Services and supports

Like the branches that extend outward in multiple directions, THE SERVICES DIMENSION expands the array of offerings and access points across the care continuum, reaching into communities to meet diverse needs wherever people are.

System infrastructure

Like the roots and trunk that anchor and nourish a tree, THE SYSTEMS DIMENSION provides the foundational infrastructure—policies, funding, governance, and coordination mechanisms—that sustain the entire behavioral health ecosystem and enable its healthy growth and development.

With everything working together, the tree flourishes—rooted in strong systems, branching out through comprehensive offerings, and bearing the fruit of relational, people-centered care that supports young people, families, and communities.

The Plan

A Roadmap to Well-Being for Every Child, Youth, and Young Adult

The Washington Thriving Strategic Plan outlines the roadmap of sequenced, coordinated, sustained actions needed to realize the vision. Building this comprehensive system will take years and will ultimately require additional investment, but the work must start now.

The first initiatives offer strategic first steps. They tackle urgent needs and aim for early wins that build movement, while also laying the groundwork for the road ahead. Washington Thriving has identified initial actions to advance work over the next 1-3 years. These initiatives balance the constraints of the 2025-2027 state budget with the urgent need for action.

System of Care Infrastructure. Establish the governance, outcome monitoring, and funding coordination necessary to deploy existing resources effectively while building the foundation for future coordination.

Supports for Perinatal Well-Being. Develop culturally responsive, non-stigmatizing screening and overcome barriers to family-centered care for pregnant and parenting people. Improved approaches to addressing perinatal behavioral health affect 17,300 Washington families annually and interrupts intergenerational trauma cycles, creating cascading benefits for future generations.

Kindergarten through Grade 12 (K-12) Student Behavioral Health. Providing schools with access to tools and resources, along with support and guidance, for supporting student well-being and readiness to learn. Since nearly all children attend school, this makes early identification and help available where kids spend most of their time.

Treatment Services Expansion. Expand crisis and stabilization services while also expanding services to prevent escalation to crisis. Build more specialized capacity for high-need populations and those with complex conditions. Young people and families currently can't get the behavioral health treatment they need, leading to preventable crises.

While these first initiatives establish strategic next steps, Washington Thriving acknowledges that comprehensive systemic transformation requires sustained progress across many different areas —advancing progress, preserving gains, and recovering ground when needed.

Leadership and Partnership

This plan represents a legislatively-mandated, collaborative effort led by an Advisory Group of young people, caregivers, and community members with lived experience, alongside educators, health providers, and professionals from across the state—ensuring that solutions are grounded in real experience and community wisdom. Washington Thriving is co-chaired by Representative Lisa Callan and Diana Cockrell from the Health Care Authority (HCA).

The stakes

Washington cannot afford to continue on the current path. The cost of inaction—measured in young lives disrupted, families struggling, and communities weakened—far exceeds the investment required to build an effective System of Care (see definition here).

The state's young people need more and deserve better. Young people and families shouldn't navigate these challenges alone—they need and deserve coordinated support. And our communities will reap the benefits when we invest in helping young people thrive from the start.

The Washington Thriving Strategic Plan charts the course toward this better future. With coordinated action, strategic investments, and sustained commitment of system actors and communities across the state, Washington can transform its approach to behavioral health for its youngest residents and ensure that thriving becomes the norm rather than the exception.

The time to act is now. Washington's children and young people's futures—and the state's—depend on it.

I. Context and Introduction

> **"For years, I sat in stakeholder groups and statewide conversations—sharing my story, bringing other families, repeating the same feedback again and again. Yet little changed, and it was painful to watch families like mine continue to suffer while our voices felt unheard.**
>
> **For the first time, I see our fingerprints throughout the Washington Thriving Strategic Plan. If implemented with the same commitment to lived experience that has shaped it, we may finally have a system that serves families instead of failing them. The hope I'm feeling has been a long time coming. But real change will only happen if families and systems keep moving forward together. It will take all of us!"**
>
> ~Richelle Madigan
> Executive Director, Washington State Community Connectors, and mom of 8

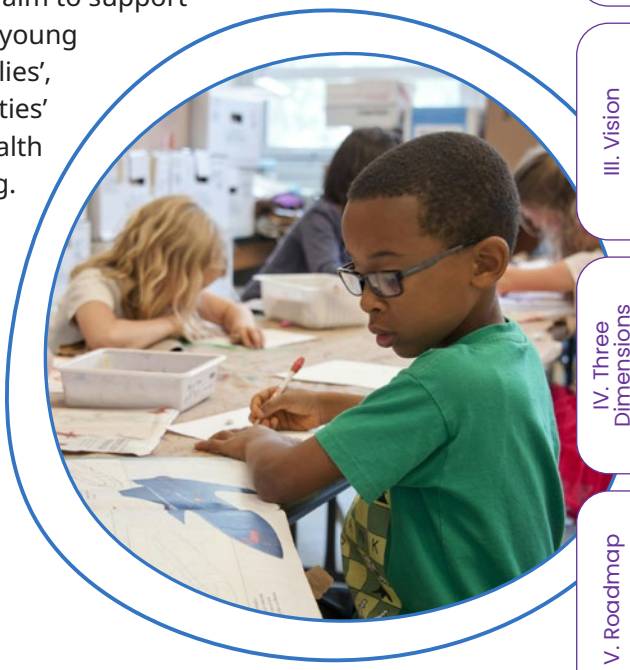
Scope and Legislative Charge

The Children and Youth Behavioral Health Work Group (CYBHWG, see members here) was first convened in 2016 with the passage of HB2439. Its mandate is to provide recommendations to the Governor and the Legislature to improve behavioral health services and supports for children, youth, young adults, and their families.

In 2022, the legislature directed the CYBHWG to establish an advisory group to develop a strategic plan focused on improving behavioral health support systems to address the growing behavioral health epidemic among children and youth. The resulting effort to develop this strategic plan is now referred to as Washington Thriving.

The Washington Thriving Advisory Group is made up of young people, parents, and caregivers with lived experience, providers, agency representatives, and other system partners. The Washington Thriving Strategic Plan is the result of their collective efforts and vision.

The Washington Thriving Strategic Plan provides a comprehensive framework to guide investment, policy development, and coordinated action. It offers a detailed vision and lays out what it will take to transform the system. It looks at the full continuum of need, encompassing both formal clinical services and informal community supports. It addresses the diverse set of providers and other actors – state agencies, private organizations, and community-based entities – that aim to support Washington's young peoples', families', and communities' behavioral health and well-being.



Definition of Behavioral Health

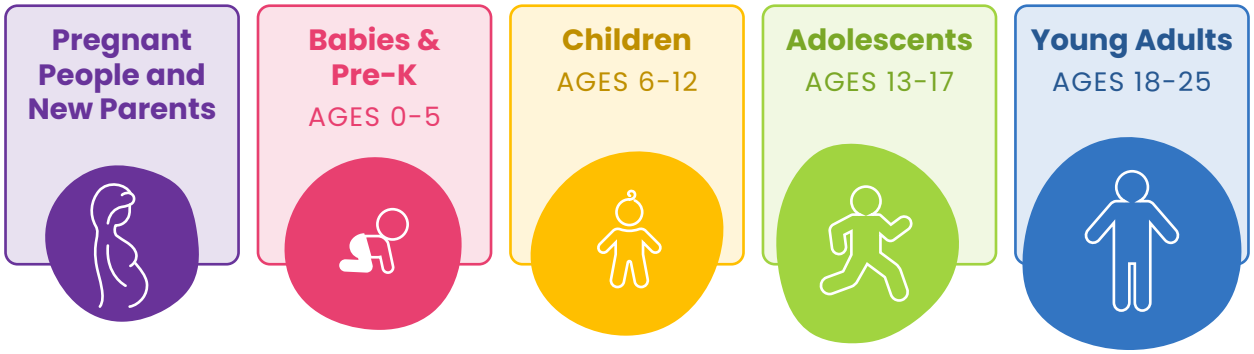
The Washington Thriving Advisory Group developed a clear and accessible definition of behavioral health, informed by community. This definition reduces stigma and recognizes that good behavioral health is a positive state of well-being, and as important as physical health.

Definition:
Behavioral health involves the interaction between a person's body, brain, and the people and places around them, and includes the feelings and actions that affect their overall well-being.

A person's behavioral health is influenced by social, developmental, physical, and psychological factors. Behavioral health challenges include mental health conditions such as depression and anxiety, substance use disorder (SUD), severe mental illness, and the co-occurrence of these with other factors such as intellectual and developmental disabilities and trauma. See Appendix A for the more detailed definition.

Behavioral Health From Before Birth into Early Adulthood

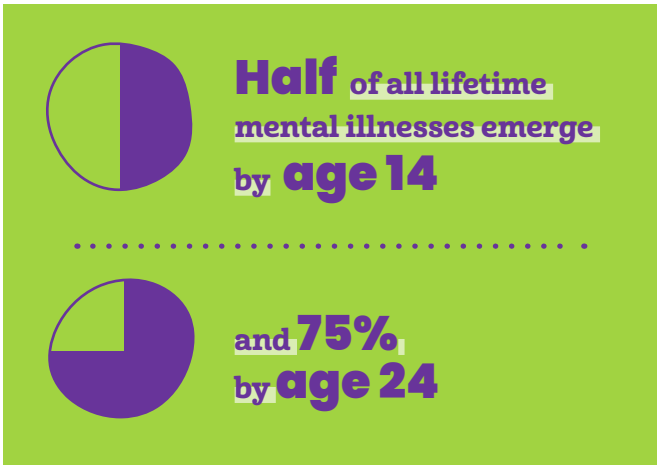
The Washington Thriving Strategic Plan spans all phases of early life—prenatal, infancy, childhood, adolescence, and young adulthood.



The foundation for lifelong well-being is established before birth and continues until around age 25. These years shape a person's social, emotional, and relational development.

In each phase of these formative years there are risks to long-term health, as well as opportunities to build wellness and resilience. These are the years when serious mental illness (SMI) is most likely to emerge. And these are the years when prevention and early intervention efforts can be most effective in addressing behavioral health challenges before they become more severe, or result in social or educational consequences that persist throughout the young person's life.[iv]

A behavioral health system that supports young Washingtonians will improve the lives of tomorrow's adults, creating a generational ripple effect.



Box 1

Why a Systems Perspective

This plan talks about Washington's "behavioral health system", meaning everyone and everything that helps support the behavioral health and well-being of young people and their families, as well as where and how services are provided. This includes those seeking and receiving care, those providing care, and those who pay for and manage programs and services.

Many different people and groups are part of this system: young people, caregivers and families, community organizations, state agencies, lawmakers, doctors, therapists, teachers, advocates, insurance companies, and more.

Complex systems like this often don't work as well as they should. Here's why:

- **Reality is messy:** The interactions between people, policies, and programs are more complicated than any plan can predict. The real reasons systems don't work are often hidden.
- **Not enough resources:** There is an assumption that there will be enough workers, money, and coordination to make things work, but that's usually too optimistic.
- **Unequal power:** The young people and families who need support usually have the least power in shaping the system that provides support.
- **Systems naturally resist change:** It is well understood that systems work to preserve themselves.

To make things better, it needs to be clear how all these pieces connect and impact one another. Washington Thriving zoomed out to look at the whole system—what services exist, how people experience them, who pays for them, who provides them, and what gets in the way of delivering help that feels meaningful and accessible to Washington's young people and families.

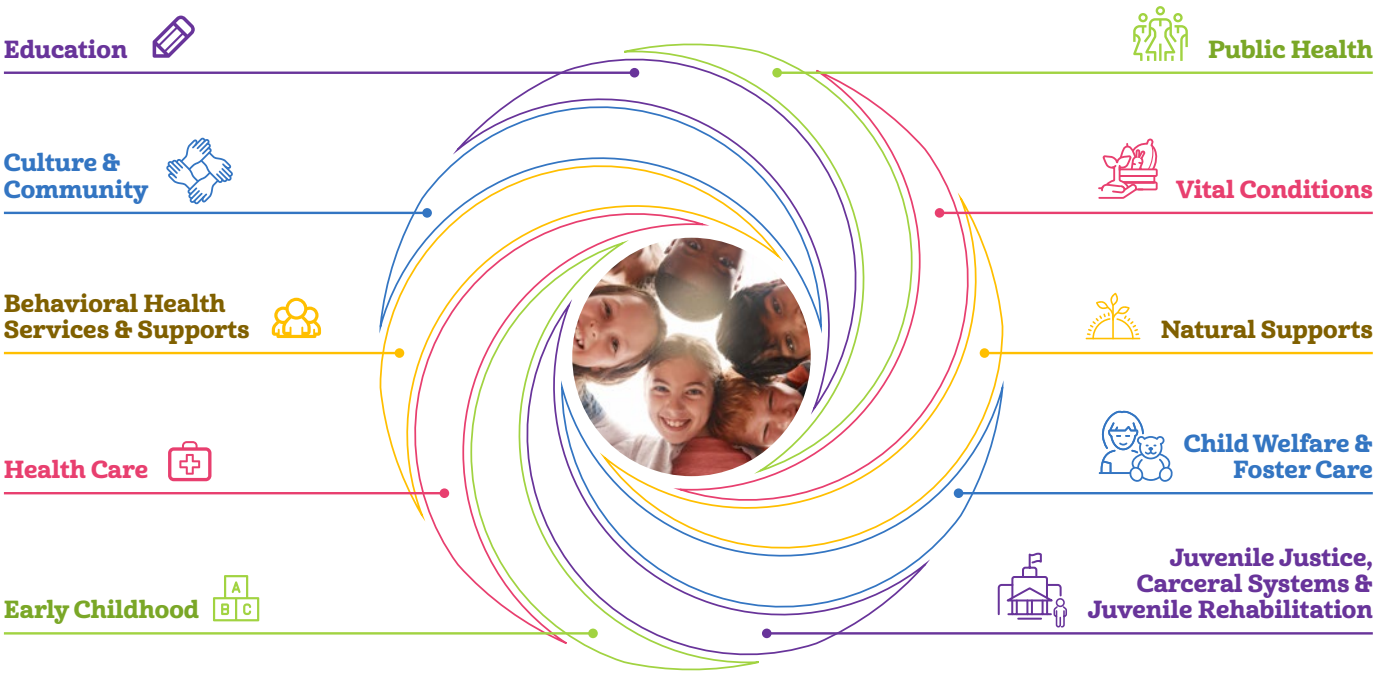
This plan focuses on behavioral health while highlighting the connections and need for coordination across all the systems that address vital needs and social determinants of health—such as housing and economic security.

The development of the plan relied primarily on data and perspectives associated with Medicaid-provided services, because the state supports these services directly. Despite this limitation, the system envisioned by the plan should be the reality for all Washingtonians, regardless of who is paying for care, as a comprehensive ecosystem of supports extends beyond any single funding mechanism.

While this plan focuses on behavioral health for young people and families, successful implementation will require coordination with existing adult systems. As a result, improving the systems serving young people and families has the potential to strengthen the entire behavioral health system for all Washingtonians.

People experience life as a whole, not as a siloed set of services. Washington Thriving's definition of the Behavioral Health System goes beyond mental health and substance use services. It includes the workforce, funding, policies, and other factors that affect the behavioral health and well-being of Washington's children, youth, parents and caregivers. This includes all their experiences, such as their education, involvement with the justice system or child welfare, where they live, whether they have disabilities, and how the community responds when they're in crisis. All these pieces connect and influence each other, which is why we think about them as one interconnected system.

Figure 3. A Holistic Cross-System Approach to Behavioral Health



How the Plan Was Developed

The Washington Thriving Strategic Plan centers the voice of people with lived and living experience—those who have sought, received, and directly provided behavioral health services. They know best what works and what doesn't. The Advisory Group was primarily comprised of those with lived and living experience, and the process to develop the plan involved extensive outreach to consult with young people, parents and caregivers, and service providers across the state.

The process brought together people from different systems—health care, education, early learning, child welfare, justice, and community organizations—to work as partners rather than in separate silos.[1] This collaborative approach didn't just create the plan—it also built the foundational relationships and partnerships needed to make the plan a reality.

Washington Thriving also considered what's already working in Washington, consulted literature and subject matter experts, learned from the experiences of other states, and analyzed quantitative data to reinforce the qualitative data collected throughout the process.

For detailed information on the workstreams and engagement that shaped the plan, see Appendix B. For information on key contributors to the planning effort, see Appendix C. To read a sampling of firsthand accounts from young people and caregivers on what they want state leaders to know, see Appendix D.

1 There is more to do on this front. In particular, Washington Thriving aspires to increase its collaboration with tribal governments as part of implementation.

II. Current State of Behavioral Health for Young People and Families

> **“Every year we have to take the approach of figuring out what is most on fire and throwing dollars at that. What we should be doing is building a fireproof system, so that in 10 to 20 years we’re not still perpetually firefighting.”**
>
> -System partner

Responding to the Moment

Changes in the federal funding landscape for Medicaid, block grants, kindergarten through grade 12 (K-12) education, and other programs serving children, youth, and families are undermining Washingtonians' well-being and will have dire consequences for our most vulnerable populations. The 2025-2027 state budget deficit adds further strain as programs are cut and staff are laid off.

While current circumstances make it hard to fund immediate implementation of the major changes called for in this Strategic Plan, they also demand that we assess what is most important to Washington's well-being and act strategically to build a more resilient system. The Washington Thriving Strategic Plan provides a framework and long-term roadmap to ensure that the state is ready in any economic context to deploy its resources toward what matters most to its residents.

> **"None of the providers we went to had… access to [my daughter's] history. I'm an overwhelmed parent … who is constantly in a state of hypervigilance … trying to manage my child's anxiety and behaviors. I needed an easy system."**
>
> -Michelle, a parent of a child with complex needs

The Experience of Washingtonians

The current system frustrates young people, families, providers, and agencies alike.

Young people and families report having to navigate an "alphabet soup" of agencies and programs when seeking care. They often reach out to multiple agencies, get evaluated and must recount traumatic stories repeatedly, and still may not find the care they need. Those who do find what they're looking for may wait months or years to access care. Without timely support, peoples' needs escalate. When services are available, they often don't fit what individuals and families need, especially for young people with complex, co-occurring needs or severe mental illness.

Providers report spending more time on documentation and compliance than serving clients. They experience burnout, and turnover rates as high as 40% annually[v] inflate caseloads for remaining providers. In turn, young people and families lose trusted relationships. Providers struggle to navigate training and certification requirements and worry about liability. Behavioral health professionals aren't getting paid enough or receiving the support they need to sustain a career in what can be an emotionally and physically draining field.

State and local agencies and other system collaborators also struggle. Complex and conflicting policies and rules obstruct collaboration and information sharing. Data trapped in separate systems prevents leaders from seeing how the larger behavioral health system is performing, making it difficult to make informed decisions. Agencies constantly juggle new mandates with limited resources.

Gaps, Barriers, and Challenges

Washington Thriving's findings highlight widespread and serious challenges that contribute to the experiences noted above.

Fragmentation and complexity

Responsibility for administering Washington's behavioral health services and supports for young people and families is scattered across dozens of separate agencies. Similarly, a plethora of programs and initiatives exist at state and local levels, many mandated by legislation.

Each state and regional agency serving Washington's communities follows different regulations and each is judged on its own performance, rather than on how well the system works as a whole in meeting Washingtonians' needs. (Key state and regional actors that intersect with Washington's prenatal-through-age-25 behavioral health system can be found in Appendix E).

This complex mix of rules and incentives discourage coordination, obstruct information sharing, place significant administrative burden on providers and professionals, and make it impossible to see a complete picture of the investments being made across the state – and whether they are meeting the needs of Washingtonians.

The Children's Behavioral Health Statewide Family Network found over 60 state workgroups focused on aspects of Washington's Behavioral Health system. This represents tremendous collective expertise and energy that, with enhanced coordination, could amplify impact, and reduce duplicate efforts that risk working at cross purposes or spreading limited resources too thin across agencies, providers, and communities.

Box 2

Today, two families seeking help for a young person with behavioral health needs face different experiences in Washington. Their experience depends not on their need, but on their insurance (e.g. Medicaid or private), where they live, first contact point (e.g. primary care, ER, community behavioral health clinic), whether they qualify for specific programs (e.g. special education, disability services), and what state systems they are involved in (e.g. justice, child welfare). Each of these circumstantial factors bring them into contact with different state and regional agencies.

Barriers to prevention and early intervention

Most people agree that prevention matters, but state resources are primarily consumed by a cycle of crisis response and intensive treatment. In many cases, these crises and treatment needs could have been avoided or reduced. Not every behavioral health need is preventable, but even for those with severe mental illness, early identification and intervention improve outcomes.[vi] Multiple factors block efforts to help young people before their problems progress far enough to require clinical treatment.

Structural barriers. Prevention and early help that would reduce the demand for intensive services over time is underfunded. Washington does not invest enough in mental health education, early family support, or community connections that promote well-being. The results of prevention programs are largely invisible; it's hard to "see" the negative outcomes that they prevent and results take years to show at the population level. State budgets are planned two years at a time, and when resources are constrained it's difficult to make the case to invest now in efforts that won't pay off during this budget cycle. To the extent Washington does invest in prevention, different agencies get funding from different sources with different rules, leading to disjointed prevention efforts.

Lack of consistent awareness and access to early supports. The system lacks consistent, age-appropriate tools and knowledge to identify early signs of distress and behavioral health needs, especially in early childhood, so they often go unnoticed or untended. Additionally, insurance doesn't consistently cover supports prior to a diagnosis, which limits access to early intervention. Many young people face a combination of emotional, developmental, and educational challenges that either don't fit neatly into narrowly defined programs or don't individually meet the threshold for entry into such programs, limiting care or further fragmenting services.

Long waits. When young people and families do seek help, long wait lists or lack of available services often mean young people don't receive care until they reach crisis levels.

> **"It was very hard to find the right services and support for my daughter's behavioral health needs. I first noticed delays around her first birthday, but as a first-time parent my concerns were brushed off... Thankfully, her pediatrician took me seriously and recommended an evaluation. Unfortunately, the appointment was booked six months out... What would have helped us get services faster is shorter wait times for evaluations, more affordable options for families, and a system that listens to parent concerns earlier instead of dismissing them."**
>
> -Jenny, a parent of a child with complex needs

> **"In many cases early symptoms are disclosed in primary care, or children are referred to primary care from schools. This makes behavioral health integrated into primary care a critical link for early intervention."**
>
> -Provider

Financing issues

How Washington funds services determines which programs can survive, who can get help, and whether providers can keep good workers. Behavioral health services for young people have long operated in the shadow of adult-focused systems, competing for resources within structures not originally designed with young people's developmental needs in mind. In the current funding structure, some services get money while others get much less.

Total investment is hard to track. It is difficult to determine exactly how much Washington invests in behavioral health for young people because funding flows from multiple sources through multiple agencies, programs, and funding streams across state and local government. This fragmentation makes it nearly impossible to quantify total investment or to assess whether current spending allocations match the scale of need among Washington's young people and families. The inability to easily track and report on these investments underscores why focused attention on behavioral health financing is critical—Washington cannot effectively manage what it cannot measure.

Historical gaps in substance use funding. For years, most behavioral health money went to mental health services, while substance use treatment received much less funding resulting in too few drug and alcohol programs specifically designed for young people and families.

Complex funding sources create barriers. Most of the funding for services depends on what kind of health insurance a young person has and what behavioral health services their plan covers; however, insurance isn't the only source of funding. Behavioral health care is also paid for with funding from federal grants, the state budget, and local governments. Each funding source has different rules and restrictions. To make services work, providers must piece together funding from all of these sources to cover their costs.[vii] Current funding models do not fully support the breadth of workforce best suited to address behavioral health needs among young people and families—including peer supports, Community Health Workers (CHWs), and other underutilized workforce.

> **"Medicaid and private insurance generally don't pay for more than one professional to be in a therapeutic engagement at a time. They also generally don't pay for the time to coordinate care, or travel to and from home and community settings."**
>
> **-State agency employee**
>
> *During public comment, participants emphasized that a **core issue is funding to develop and sustain services**, noting "providers cannot survive financially" without sufficient sustained investment.*

Insurance-related issues

In Washington, public insurance plans cover about 50% of young people under 18, private plans cover about 40%, and the remaining 10% receive coverage through other means. Only about 3% do not have any health insurance.[viii]

Disparities in public v. private insurance coverage. Public and private insurance each limit access to behavioral health services in different ways. Medicaid (Apple Health in Washington) offers families more predictable costs with little to no copays or deductibles, but provider networks may be more limited and include newer practitioners due to lower reimbursement rates. Private insurance typically offers broader provider networks with more experienced clinicians, but families face higher out-of-pocket costs, complex prior authorization requirements, and provider shortages caused by the same low reimbursement rates. Additionally, about two-thirds of the Washingtonians who have coverage through their employer get health insurance through employer plans that the state government does not regulate or oversee.[ix] Reports suggest that although these plans offer mental health coverage in compliance with parity laws, claims are often denied or not covered at sustainable rates.

In Washington, roughly a quarter of 6–12-year-olds enrolled in Apple Health in 2023 had an identified mental health need. One in three of them received no services – in part because limited provider capacity is often consumed by more urgent, intense needs presenting in teenagers and young adults. Many of these later needs could be prevented with earlier intervention.

Box 3

Reimbursement rates. Reimbursement rates for providers systemically fall short of covering the cost of care. Providers who are offered low reimbursement from health plans are less likely to participate in networks. This limits young people's and families' choices when they are trying to find an in-network provider, and forces families to use more expensive out-of-network providers, undermining access to treatment.

Misaligned incentives. While commercial insurers cover well-child visits and certain preventive services, they have limited financial motivation to contribute to population-level prevention efforts. Financial incentives do not exist to catch emerging problems, so treatment is unavailable until needs are far more significant. When left untreated, the costs of serving individuals with serious behavioral health conditions often fall to the state when these individuals seek care via emergency departments or end up needing long term treatment.

Unmet needs for young people and families

The following are some of the largest and most pressing gaps in behavioral health services and supports for young people and families that have been identified by Washington Thriving:

Care for the youngest. Finding behavioral health care for children younger than 13 is extremely difficult in Washington. Most providers aren't trained to work with young children – only one in three agencies serves children under 6, and just 8% help toddlers under 3.[xi] Many don't realize that infants and young children even have treatable mental health needs. This means the youngest children can't get help when they need it most, or may not receive interventions designed for their age group.

Youth transitioning to adulthood. Almost one-third of Washington's youth do not get the support they need during their transition from teenage years to adulthood. From 2020 to 2022, nearly half of young adults needing mental health care didn't receive it, and 70% needing SUD treatment went without help.[xii] Of those youth and young adults who did receive inpatient treatment for mental health or substance use, 7% were unhoused within 3 months of exit, and 15% by month 12.[xiii] Overdose and suicide rank among the top three causes of death for this age group.[xiv] The system creates harmful "cliffs" where youth lose services at key ages and stages—18, 21, and various points in foster care and carceral systems—instead of being supported through these transitions based on their individual needs.

Unaccompanied youth. Young people who lack the protection, support, and guidance of an engaged parent or adult face significant challenges and are at greater risk of experiencing unaccompanied homelessness. This includes young people who have had to leave home, aged out of foster care, fled abuse or unsafe environments, whose families are unable to care for them, and unaccompanied immigrant youth. Living on the streets, "couch hopping", and moving between shelters, these young people are forced to navigate their adolescent and young adult years through a survival-based, nomadic lifestyle. This constant instability damages their mental health, and untreated behavioral health conditions often make things worse. Housing and other services that are developmentally and culturally responsive are limited, especially in rural areas. The trauma and resulting hyper-vigilance of these young people make it hard for them to trust and engage with typical therapeutic approaches. Legal constraints that require parental consent or involvement put minors at a particular disadvantage.

Anxious and depressed youth. Washington's Healthy Youth Survey found that in 2023, about one in four to one in three students in grades 8, 10, and 12 reported symptoms of depression, and a similar percentage reported high levels of anxiety.[xv] Nationally, rising depression and anxiety rates have been attributed to a complex mix of factors including concerns about violence and safety, persistent loneliness and feelings of hopelessness, academic and social pressures to succeed, experiences of trauma and loss, the broader political and economic climate, financial instability, social-media fueled comparison, bullying, and more.

Mid-continuum. Routine outpatient care like basic counseling and therapy is in high demand, and issues with reimbursement rates and network coverage mean families struggle to find providers. Meanwhile, there is an absence of short-term treatment that's more intensive than regular counseling and of services that bring intensive help to young people while they remain at home with their families and communities. This includes day programs where young people can get intensive help but still sleep at home. The limited number and lack of diversity of these middle intensity options leads young people to being enroll in more costly, higher-intensity programs, which – while more intensive than necessary – may be the only ones available.

> **"When young people cross over from needing more than routine outpatient care, they face a bleak landscape until they need hospitalization."**
>
> -Provider

In-home supports. Washington has almost no in-home support for children with intellectual and/or developmental disabilities (IDD) or autism spectrum disorder (ASD) who demonstrate physically harmful or disruptive behaviors. This is especially hard for young people and families who don't yet qualify for state disability services or lack specific qualifying diagnoses, often leaving them with nowhere to turn for these much-needed supports. This population of young people also lacks providers, especially those trained in high acuity needs.

> **"They told me just to come in whenever but that was not the case. I packed my bag, went to the ER, did a simplistic intake, and then they told me there were no beds and to come back tomorrow. If you are pregnant and using, you need a bed right now."**
>
> -A Washington parent, excerpt from Voices of Families: Insights from WA State Listening Sessions

Substance use treatment services for young people and families. The state has a shortage of SUD programs designed for young people and very few that include families as part of the care model. Washington lacks robust outpatient substance use treatment options, so young people who could not access support when they were starting to struggle end up in residential care in deeper crisis and with more complex treatment needs. This creates additional strain on the limited available beds in facilities. The state has just 87 specialized youth residential beds across four counties that will take young people with SUD treatment needs.[xvi] Data shows that most young people who need help with substance use don't get it – even after ending up in the emergency room.[xvii] Many programs do not accept pregnant people[xviii] and there are almost no family-based treatment options for pregnant and parenting people. Additionally, most SUD providers don't address co-occurring conditions (including IDD, ASD, and mental health conditions) which are often a factor in substance use. When people leave treatment, a lack of ongoing support services to maintain stability over the long term creates risks to sustained recovery.

In Washington State, the Involuntary Treatment Act (ITA) allows for the court-ordered evaluation, detention, and treatment of individuals experiencing behavioral health disorders so acute that the individual may need to be treated on an involuntary basis in a designated facility. Whereas ITA previously focused on mental illness, Ricky's Law expanded ITA's scope to include SUDs as a qualifying condition for involuntary treatment for those who meet specific criteria including being a danger to themselves or others, or being gravely disabled due to their addiction. Since its inception in 2018 the law has been underutilized, primarily due to emergency departments not summoning Designated Crisis Responders to initiate the process. Other challenges have included general lack of awareness of the law and inadequate geographic coverage of the secure withdrawal management and stabilization (SWMS) facilities needed to receive individuals who qualify for the process.

Further, ITA and Ricky's Law policies and facilities were developed for adults and have not been revisited to address the developmental needs and considerations of youth and young adults. As a result, there is a systemic shortage of SWMS facilities designed specifically for young people. Additionally, permanent records documenting involuntary treatment decisions can follow young people throughout their lives with potential negative impacts, without consideration of potential alternative approaches that could better safeguard young people's future opportunities.

Specialty care for First Episode Psychosis. Far more young people experience psychosis than Washington has the capacity to care for. For example, New Journeys, Washington's Coordinated Specialty Care program, can serve 450 people statewide but over 2,500 people qualified for help in 2023.[xix] This means only one in six people who need a program like this can receive care, with the majority of those needs coming from youth and young adults during the peak time for first episode psychosis in late teens to mid-20s.[xx] Individuals who receive effective treatment during their first episode have measurably better lifetime outcomes.[xxi]

Highly complex needs. Washington has too few intensive treatment options for young people with the most serious, complex, and/or co-occurring needs. The state has fewer pediatric inpatient beds per person than the national average, even as the number of young people needing intensive care doubled from 2018 to 2023.[xxii] For those who need the most intensive options, there are not enough in-home supports, inpatient or community-based residential treatment in Washington State. This includes options for children who may be non-verbal, those profoundly impacted by IDD and/or ASD, and those that require specialized physical infrastructure such as protective equipment and intentionally designed spaces needed to support sensory needs and daily living.[xxiii] This means these young people often get stuck in emergency rooms waiting to be transferred to expensive residential treatment centers in other states.

Sending our children away from home. Washington State spends over $6.8 million each year to send 88 students with emotional and behavioral disorders away from home for treatment (both in-state and out-of-state) – an average of $77,000 per child annually. This high cost reflects the intensive, specialized care these children require, and demonstrates how expensive it becomes when a state lacks adequate community-based options.

This $6.8 million doesn't account for young people sent for out-of-home treatment who have developmental disabilities, serious co-occurring medical conditions, or sensory challenges that affect their behavioral health. It also doesn't include what families pay out of their own pocket to send children to residential treatment in other states, which can cost hundreds of thousands of dollars.

Sending young people away from home is costly, emotionally taxing for families, and – in the case of out of state – makes it difficult for the state to ensure high quality care and proper oversight. It not only separates young people from their support systems at critical moments, but also potentially undermines their recovery progress and weakens family ties. Often, when the young person is discharged, they return to a home environment where families have not been provided with the training and support needed to provide appropriate care and assistance that is vital to transition back to day-to-day life.

> **"I lost complete trust in the system… and ended up sending my children to out-of-state care where we finally got the help we needed, but not without more trauma and a huge financial cost." [Read more here]**
>
> -Peggy, a Washington parent trying to access crisis services for their children in-state

Box 4

Behavioral health deserts. Many areas in Washington don't have enough behavioral health providers to serve local demand. Families in these areas often travel for hours to get necessary care. Of Washington's 39 counties, for example, only two have withdrawal management centers for youth.[xxiv] Families are forced to make impossible choices that affect their well-being and finances.

> **"We live in a behavioral health desert [where] there is literally one behavioral health organization who accepts Medicaid Apple Health. I sought jobs based on the insurance the company had, not based on what the job description said."**
>
> -Michelle, a Washington parent

Underserved communities and inequitable access. Communities of color make up nearly half of young children in Washington[xxv] and face major barriers to getting care.[xxvi] Suicide rates in American Indian/Alaska Native (AI/AN) communities are 50% higher than average,[xxvii] while nearly half of 2SLGBTQIA+[2] youth can't access the mental health care they want.[xxviii] Rural families and tribal communities struggle with limited local providers, long travel times, and poor internet for telehealth.[xxix] Immigrants, non-English speakers, and children with IDD and/or ASD also struggle to find appropriate care.

Need for whole-family models. Multigenerational approaches and whole-family programs that address relational health are missing. This includes whole-family mental health and substance use treatment programs, as well as behavioral health services and supports designed to engage family members – including primary and secondary caregivers, siblings, and the entire family unit. Programs that intentionally engage fathers in caregiving roles are in short supply.

2 Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and other sexual and gender diverse

System design flaws

Sequential vs. integrated treatment. The system mostly treats co-occurring needs separately, despite the interconnectedness of these needs and the fact that leaving one untreated (e.g. depression) can limit the effectiveness of treatment for the other (e.g. SUD).

Broken feedback loops. Community partners describe a cycle of engagement that rarely leads to visible change. The problem isn't just that change happens slowly—it's that the process itself makes meaningful participation nearly impossible. When someone is devoting time every month to show up in these spaces, it's because they have real, immediate frustrations. But responses from the state, if they come at all, unfold over years. The incentive to keep showing up simply vanishes.

The settings themselves create additional barriers—often boring, unattractive, and jargon-filled spaces that can feel intimidating to people who already feel like outsiders to the system.

For young people, caregivers, and families with behavioral health needs—who feel like they are already drowning—spending hours in meetings that produce no tangible results isn't time they can afford to lose.

Limited visibility and investment in what works. The state doesn't have the quantitative or qualitative data, measurement, and feedback infrastructure necessary to evaluate which programs actually help young people and families, making it hard to know what should be expanded or stopped. Washington Thriving feedback consistently highlighted this dynamic, with system partners describing the recurring challenge of securing continuation funding for small but effective programs to move beyond pilot scale. Meanwhile, the absence of systematic performance monitoring or robust shared accountability systems to evaluate existing program effectiveness means funding often flows based on precedent rather than performance.

Making services work together. Washington has recognized the critical importance of making sure behavioral health services work together effectively for young people and families. As a result, systems to connect services have been built into many programs and initiatives across the state including in some crisis care initiatives; in programs with team-based approaches, in the dedicated coordination functions within behavioral health organizations and primary care teams; and within some regional networks that support children, youth, and families in behavioral health. Each of the efforts has its own approach with unique eligibility criteria and funding requirements. Because of this, the efforts to connect services is another example of multiple disconnected but similar efforts that still don't reach or support every young person and family. The challenge is transforming these duplicated investments into a streamlined, connected system that serves all young people and families consistently across any number of supports, regardless of where they are engaged with the system.

Integration with justice and child welfare systems. Insufficient integration and collaboration between local juvenile justice and child welfare systems, behavioral health providers, and community supports hinders timely, frontloaded supports that could divert young people from carceral systems and prevent more children from entering foster care. For those young people who end up in carceral or child welfare systems, over half need behavioral health support,[xxx] but these systems have not historically coordinated with each other or with behavioral health providers to meet the needs of young people effectively during transitions in and out of these systems. Young people get released from detention or age out of foster care without much needed behavioral health supports. Two-thirds of youth and young adults exiting detention in Washington go without mental health care and nearly 9 out of 10 go without substance use treatment in the critical three months following release.[xxxi] These intersecting systems regularly encounter young people with behavioral health needs and significantly influence their outcomes; however, they lack specialized behavioral health expertise, as well as coordinated approaches that follow young people as they move between systems.

Conflicting policy impacts across populations. Well-intentioned policies that protect one group can inadvertently create challenges for others. For example, state efforts to ensure adequate provider networks can have unintended consequences like higher premiums getting passed on to consumers. Washington's age of consent law for behavioral health treatment[3]—which allows adolescents starting at age 13 to seek treatment independently to remove the barriers to care that some young people face—is another example of this. When young people refuse critical treatment, it can become challenging for families to access needed services. There are policies that exist to help families when these situations arise, but these policies are hard to navigate, unknown by families and providers alike, and subject to wildly varying interpretations. As a result, the same policies meant to facilitate access can inadvertently hinder families from getting much needed behavioral health services for their young people.

> **"One diagnosis can change the entirety of the continuum a child has access to. A child with anxiety has a relatively complete continuum available, whereas with an autism diagnosis the continuum falls away completely."**
>
> -Provider

Diagnosis-based exclusions. Many services can't be billed unless a young person has a formal diagnosis. This inhibits providers from offering proven supports that could resolve concerns while also avoiding a premature diagnosis. Young people with IDD in particular face systematic exclusion—their behavioral health needs get dismissed as "just part of their disability" instead of being recognized and treated as co-occurring needs.

Families describe having to seek multiple diagnoses for their children to unlock access to services and worry about how repeated labeling affects their child's developing sense of self.

> **"We had to label my kids over and over and over to get the help we needed,"** Carolyn, a parent shared.

Quality concerns. Training and knowledge gaps, resource constraints, and limited or inconsistent oversight and accountability measures mean that some providers deliver high-quality, evidence-informed care while others may not. Efforts to ensure quality often result in added administrative burden in the form of documentation or duplicative training that isn't proven to result in improved outcomes.

Workforce shortage

Staff shortages and turnover cycle. Staffing shortages make it harder to meet the needs of young people and families. Research shows that the state will face shortages of behavioral health professionals, especially psychiatrists, psychologists, and addiction counselors through 2037.[xxxii] This creates a harmful cycle: fewer workers handle bigger workloads, get overwhelmed, and quit—leaving even fewer workers behind. A survey by the Washington Council for Behavioral Health found that, in 2021, over half of agencies had to close or reduce services because they couldn't find enough staff. While this survey captured conditions during a particularly challenging period for healthcare workforce retention, staffing shortages have remained a persistent issue in the behavioral health system.[xxxiii]

> **"Community agencies are staffed with new therapists seeking supervision, who leave for private practice after licensure."**
>
> -Provider

Lack of workforce diversity. The behavioral health workforce also lacks diversity. Nearly half of Washington's children under age 8 are children of color, but most providers and decision-makers do not reflect that diversity.[xxxiv] Additionally, the majority of the behavioral health workforce identify as women, leaving men, nonbinary individuals, and people of other genders underrepresented in the field.[xxxv]

3 Chapter 71.34 RCW: Behavioral Health Services for Minors

Cultural and historical factors

Formal systems have not always served young people, families, and communities well, creating frustration and distrust that continue to affect how they engage with formal systems and services today. Stigma surrounding behavioral health challenges also prevents many young people and families from seeking support until problems reach crisis levels, making treatment more difficult than it might have been with earlier intervention.

Insufficient youth and family engagement. Although the system talks about being family-driven and youth-led, real barriers still get in the way. Families and youth are often asked for input after key decisions are already made. Professionals determine the treatment plan instead of sharing decision-making with families and young people who often aren't given the opportunity.

Lack of cultural and linguistic responsiveness. The system doesn't do enough to meet the linguistic and cultural needs of young people and families.[xxxvi] Many services don't offer help in different languages or provide interpreters. Providers often don't get enough training on how to deliver culturally responsive care, and past harm from formal systems has caused many communities to lose trust.

Available data suggests that

only 17% of providers

speak a language other than English.

1 in 10 Washington households

need interpreter services, but not enough linguistically or culturally adapted service models exist.

Box 5

These gaps—while not exhaustive—clearly show that Washington's system isn't working for many.

> Washington community members have raised concerns about "planning fatigue," noting that while Washington has developed multiple strategic initiatives over the years, fundamental access barriers remain unchanged.

Strengths and Assets

Washington has strong foundations on which to strengthen the behavioral health system for young people, caregivers, families, providers, and communities alike. (See Appendix F for an inventory of the many existing efforts in Washington State.)

National leadership. Washington has a strong history of leading important behavioral health efforts. The state has successfully managed several SAMHSA grants such as those for community mental health services and substance use prevention, treatment, and recovery. The state has led the way in policy innovation like integrating behavioral health into overall care[xxxvii] and improving crisis response.[xxxviii] Departments at Washington's universities are recognized nationally for their innovative and authoritative work on many issues related to behavioral health.

System bright spot in national leadership. Washington State's multi-level, collaborative approach to community and school-based behavioral health promotion and prevention services has been recognized by the National Academies of Sciences, Engineering, and Medicine (NASEM) in its Blueprint for a National Prevention Infrastructure for Mental, Emotional, and Behavioral Disorders. By empowering communities to tailor effective solutions to their needs, the approach sets a national benchmark for prevention excellence. This framework can be expanded upon to address the full range of behavioral health promotion and prevention needs across the state. **[Read more here]**

Box 6

Cross-system collaboration. The state has a history bringing together state agencies and community partners in workgroups to align policies and achieve improved outcomes in some of the areas and systems to which this plan speaks, including the Children and Youth Multisystem Care Coordination team (HB1580 in 2023), the Washington Economic Justice Alliance, and interagency groups like the Bridge Coalition and the Washington Developmental Disabilities Council. The state can leverage these structures, learnings, and experiences with results tracking, quality improvement initiatives, and cross-agency data sharing.

System bright spot in cross-system collaboration. The 1580 Children in Crisis Rapid Care Team coordinates timely problem-solving for young people with the most complex needs who are stuck in hospitals awaiting the appropriate next level of care, as well as those who are dependent on the Department of Children, Youth, and Families (DCYF).

Led by a dedicated coordinator in the Governor's Office, the multi-agency team provides single-point accountability and rapid response capability with access to flexible funding. This model demonstrates how dedicated leadership, shared resources, and collaboration across systems, and the flexibility to create individualized solutions can effectively serve young people and their families. **[Read more here]**

Regional delivery systems and networks. Washington has a long history of delivering services through regional and local structures attuned to local needs. The state framework outlined in this plan is designed to be connected into local communities and county jurisdictions, creating consistency in approach while allowing for regional customization based on community strengths and needs.

In the past, regional networks focusing on children's mental health helped build local systems and services by contracting with local providers to deliver key services. This knowledge and experience still exists in Washington and could be built out further to include more expansive services—such as SUD infrastructure—for young people.[xxxix,xl] Educational Service Districts (ESDs), Accountable Communities of Health (ACHs), and Behavioral Health-Administrative Services Organizations (BH-ASOs) are other existing regional network assets that could be intentionally built into the future System of Care.

System bright spot in regional delivery systems and networks. Kids' Mental Health Washington is a partnership between the Health Care Authority (HCA), Developmental Disabilities Community Services (DDCS), and Kids' Mental Health Pierce County. Ten regional teams with community-based youth behavioral health navigators help children and youth access coordinated behavioral health support, regardless of insurance or funding type. The model reduces fragmentation by aligning public and private systems and community partners around a clear point of access for youth and families. **[Read more here]**

Community assets and community-based organizations. Washington has strong community organizations that provide services and supports directly, while youth, parent, family, and issue-based advocacy groups help to keep the behavioral health system accountable. The state has demonstrated the value it places on the insights and wisdom of those with lived experience by offering stipends for their participation in advisory groups.

System bright spot in community assets and community-based organizations. Washington State Community Connectors (WSCC) is a statewide, family-run nonprofit that equips parents and caregivers to transform Washington's children's behavioral-health system from the ground up. Rooted in lived experience and System of Care values, WSCC trains and supports hundreds of families each year to navigate services, build peer networks, and advocate for the care their children deserve. This work contributes to stronger families, more responsive services, and a statewide system that learns directly from those it serves. **[Read more here]**

Tribal Wisdom & Traditions. Washington is home to 29 federally recognized tribes, representing a tremendous asset to the state's overall behavioral health landscape. These sovereign nations provide services and supports to their members through their own behavioral health systems. Their deep knowledge, traditional healing practices, and thousands of years of experience in caring for community and family wellness are essential resources within their own systems and contribute valuable perspectives and methods that can inform and strengthen behavioral healthcare throughout Washington. Coordination and partnership between tribal and state systems create opportunities for mutual learning and enhanced care.

System bright spot in tribal programming

Tribal programs in behavioral health for young people and families include these examples and more:

bədaʔčəɬ (Lushootseed for "our children") is a Tulalip Tribes program that integrates prevention, case management, placement, visitation, and guardianship social worker services to promote health, and resiliency. The program preserves and strengthens family ties and children's cultural and spiritual identities by prioritizing placements with, near or adjacent to families on/near the Tulalip Reservation.

Sche'lang'en Village Transformational Wrap-Around Program assists members of the Lummi Nation and their families who are in need of multiple wraparound services such as mental health, chemical dependency, family counseling, parenting services, and special medical needs. The program collaborates with several Lummi agencies to provide comprehensive support across housing, counseling, courts, and other systems.

Healing Lodge of the Seven Nations (HL7N) is an indigenous-focused comprehensive health organization in the Spokane area. HL7N has a licensed 45-bed adolescent inpatient treatment center and offers outpatient behavioral health services to both Native and Non-Native youth experiencing substance use, mental health, and behavioral issues. Their wellness program is grounded in traditional, cultural, and spiritual values and integrates culture with comprehensive behavioral health and medical care to create a holistic, trauma-informed approach towards healing.

[Read more here]

Innovation and philanthropy. Washington's universities and research centers play an invaluable role in improving the behavioral health system. They help put evidence-based programs into practice, train the workforce, and find ways to keep improving the system. Washington's philanthropists fund new ideas, support pilot projects, and push for change in ways that government funding can't always do.

System bright spot in systems learning and innovation. University of Washington's CoLab has a track record of guiding collaborative processes to translate evidence and insights into effective, sustained practice in real community contexts. The processes CoLab recently guided to develop King County's and Okanogan County's Youth Wellness Policies exemplify many of the principles and aspirations outlined in Washington Thriving's Strategic Plan.

University of Washington's SMART Center has worked to build a K-12 social worker workforce in rural districts, and worked with Washington's school districts and ESDs to define and assist with Multi-Tiered System of Support (MTSS) and screening needs in K12 settings.

Technology and private sector. Washington's robust technology sector brings significant resources and innovation capacity to behavioral health challenges. These tech leaders have invested in mental health initiatives, digital health platforms, and workforce mental health programs that can inform broader system approaches. They also have technical expertise that can be utilized to build integrated information systems that connect fragmented data across agencies. They bring expertise in user engagement and digital experiences that could inform youth-friendly behavioral health platforms. The state's robust network of tech startups and established private sector organizations creates opportunities to pilot innovative solutions and scale digital health interventions in ways that advance Washington Thriving's vision.

System bright spot in collaborative technology. Washington State's Health Information Exchange (HIE) enables the Department of Health and a range of providers to exchange secure, real-time information that improves care coordination and transitions between services and supports public health initiatives. This platform has emerged from a public-private partnership and offers a potential foundation for the future data and reporting system envisioned by Washington Thriving.

By building on and strengthening these foundational assets, Washington is well-positioned to move from a fragmented crisis-response system to an integrated system that promotes wellness and provides timely, effective care when needed.

III. Vision

Vision & Goals

The Washington Thriving Advisory Group developed a detailed vision and guiding principles for the system that will realize this future.

The detailed vision touches every aspect of behavioral health—from prevention to crisis response, from individual care to system coordination.

Figure 4. Washington Thriving's Vision

Washington Thriving envisions a future where every pregnant person, baby, child, youth, and young adult is thriving, supported by their caregivers, families, and communities.

Every Washingtonian understands how behavioral health affects well-being and recognizes when young people need support.

WHAT THE SYSTEM DOES

Funding, providers and systems work together so that services are seamless, accessible, and adapt to the changing needs.

Behavioral health services and supports:

- ➔ Holistically address mental health, substance use, developmental, physical health, and co-occuring needs
- ➔ Connect into people's communities where they spend time
- ➔ Are available when needed
- ➔ Are available for all developmental stages, all cultures and languages, in all parts of the state

GUIDING PRINCIPLES FOR WASHINGTON'S PRENATAL-THROUGH-AGE-25 BEHAVIORAL HEALTH SYSTEM

Is informed by children, youth, caregivers, and families

Ensures that all doors lead to support

Offers services to meet the individual needs of children, youth, families, and caregivers

Is equitable, anti-racist, and culturally and linguistically responsive

Changes in response to new information

Invests in prevention and well-bring

Includes families, caregivers and communities as key contributors to well-being

The richness of this vision can be translated into **five overarching goals** that capture our most essential work:

Focus on what matters to young people, caregivers, families, & the workforce: ensure services, supports, and policies are attuned to the strengths, desires, & needs of each young person, caregiver, family, and member of the workforce

Serve Washingtonians equitably: ensure reach and quality across the state, with extra attention and resources directed toward those who face the greatest barriers & disadvantages

Expand upstream: build strong wellness foundations, prevention, and early supports while strengthening—not losing—intensive services for young people with the most complex needs. The services must expand to be comprehensive—filling gaps in the care continuum to serve children, youth, young adults, caregivers, families, and communities effectively.

Strengthen the foundation: ensure a connected, coordinated, collaborative, informed, adaptive, accountable, values-driven, and sustainable behavioral health ecosystem (See Appendix E and G for more detail on values and structures)

Make help easy to find and get: ensure coordinated, accessible, effective services and supports across a full continuum of comprehensive offerings, connected into the places where young people, caregivers, and families spend their time.

To ensure these goals turn into action, success needs to be measured, and progress monitored. Defining measurable system-level outcomes is a critical first step. (See Section V - First Initiatives for more details.)

A complete continuum includes a full array of comprehensive offerings that span supports for everyone from health education and promotion, prevention, natural supports and support for basic needs; through extra supports for some people who are struggling and need early identification and intervention; to intensive supports for those who need it including treatment, stabilization, recovery and ongoing wellness supports. It includes comprehensive, individualized services and supports that "wrap around" a person and their family to address multiple needs simultaneously, and ways of supporting people through transitions between different types and levels of help throughout their lives. (See Figures 5 & 9 for more detail on the continuum.)

System performance and population level outcomes. In implementation, Washington Thriving will need to identify key measures to track success in the systems transformation necessary to help young people thrive. Over time the measures should demonstrate that more young people are doing well in school, at home, and in their communities—through higher graduation rates, improved school attendance, stable housing, young people feeling supported by their families, and youth actively participating in their communities with trusted adults who care about them. At the same time, the measures should show fewer young people feeling anxious or depressed, and experiencing serious challenges like unsupported pregnancy, houselessness, dropping out of school, suicide, substance use problems, school violence, time in carceral settings, or needing foster care or intensive residential treatment. These measures help to evaluate if the system is making a positive difference in young people's lives.

Building a thriving Washington requires more than good intentions—it demands systems that work. When young people can access help early, when families don't have to navigate services alone, and when communities have strong safety nets, everyone benefits.

A System of Care for Washington

Washington Thriving's vision and goals call for a System of Care[4,5]. System of Care is a formal term for a simple, proven model built on foundational values and a "no wrong door" philosophy that aligns with Washington Thriving's vision.

A System of Care is a network of comprehensive services and supports for young people, their caregivers, and families that:

- offers help in the community, close to home, wherever possible
- coordinates across different programs
- partners with families and young people in real ways
- meets cultural and language needs
- focuses on early identification and prevention while ensuring intensive services remain coordinated and community-focused when needed
- helps young people thrive at home, school, and in their communities

Evidence from states that have implemented comprehensive Systems of Care shows improved outcomes and significant cost savings, including reductions in incidences of juvenile detention and out-of-home treatment services.

See Appendix G and Annex 4 for more detail on System of Care.

Evidence from states with high-performing Systems of Care

Evaluations of the Substance Abuse and Mental Health Service Administration's (SAMHSA's) Children's Mental Health Initiative (CMHI) have found that System of Care implementation resulted in improvements in behavioral health outcomes and significant estimated cost savings. After enrollment in a System of Care, young people were less likely to receive psychiatric inpatient services, visit an ER for behavioral and/or emotional needs, be arrested, or repeat a grade. In addition, their caregivers missed fewer days of work due to caring for their children's behavioral and/or emotional needs.

New Jersey's Children's System of Care has been in operation for more than 20 years. As of December 2024, no New Jersey children were placed in out-of-state behavioral health treatment settings. From 2016 to 2023, the number of children served each year in out-of-home settings declined by 50%. For children who did require out-of-home treatment, New Jersey's approach was associated with fewer costly emergency department visits, inpatient admissions, and psychiatric admissions five years after initial out-of-home treatment.

Ohio is just embarking on its System of Care journey. OhioRISE launched in 2022 to support youth with complex behavioral health needs. The multi-agency Medicaid managed care program was built to address longstanding gaps in care and coordination that often result in families having to navigate complex, siloed systems. OhioRISE now serves 50,000 youth - nine times more than it did just three years ago - including 4,300 children in foster care.

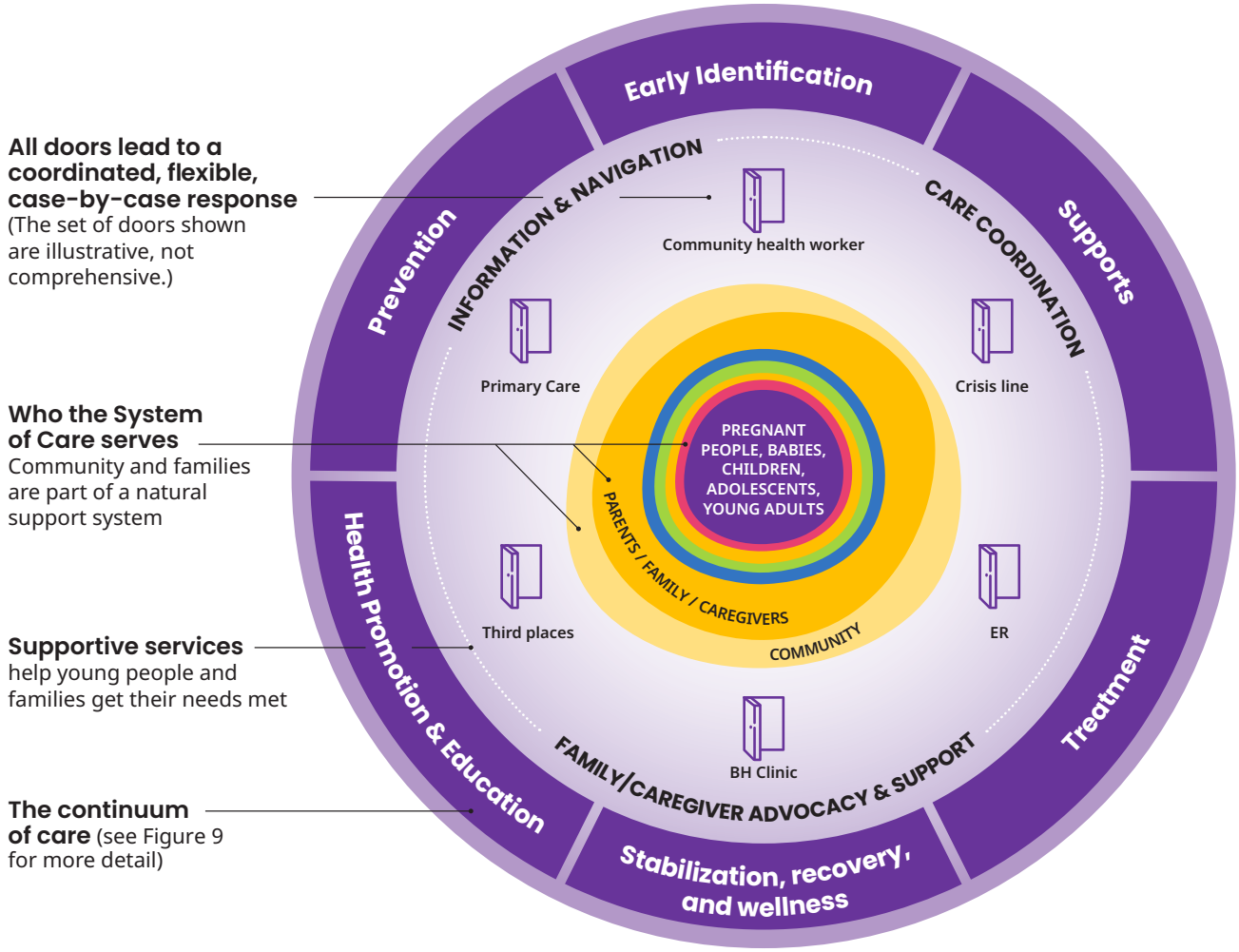
4 System of Care is a framework developed by Georgetown University Center for Child and Human Development.
5 This is in alignment with the HB1580 Children and Youth Multisystem of Care project findings.

The System of Care envisioned by Washington Thriving builds upon existing frameworks from other states. At its center is the concept of supporting individuals at every stage of early life, along with their families and the people and communities who care for them.

The system includes the full continuum of offerings (see Figures 5 & 9) designed to support everyone across three levels of need: universal offerings that a System of Care can provide proactively to encourage health and well-being for all; focused offerings that support some who may need extra help when they start to struggle and show early signs of needing additional support; and intensive offerings that support the relatively few but important young people and families who may have intensive needs, experience serious behavioral health challenges or severe mental illness and need treatment and support to recover or maintain stability. This " all, some, few" framework is commonly used in public health to reflect different tiers of support.

This system also includes three types of supportive services for young people and families: information & navigation, care coordination & sequencing, and family/caregiver advocacy & support.

Figure 5. Washington's Envisioned System of Care



Evidence from over 20 years of System of Care implementation demonstrates that transformation like this requires work across three foundational dimensions: systems, services, and interpersonal. Each of these three dimensions are vital and must support each other to build a behavioral health system that is coordinated, efficient, and most importantly, working for Washingtonian's needs.

The system must ensure that all parts of the infrastructure are established and well-coordinated to achieve outcomes.

The services must expand to be comprehensive and fill gaps in the care continuum to serve children, youth, families, and communities effectively.

The system must be interpersonal and focus on what matters to people and ensure that values and principles are put into practice.

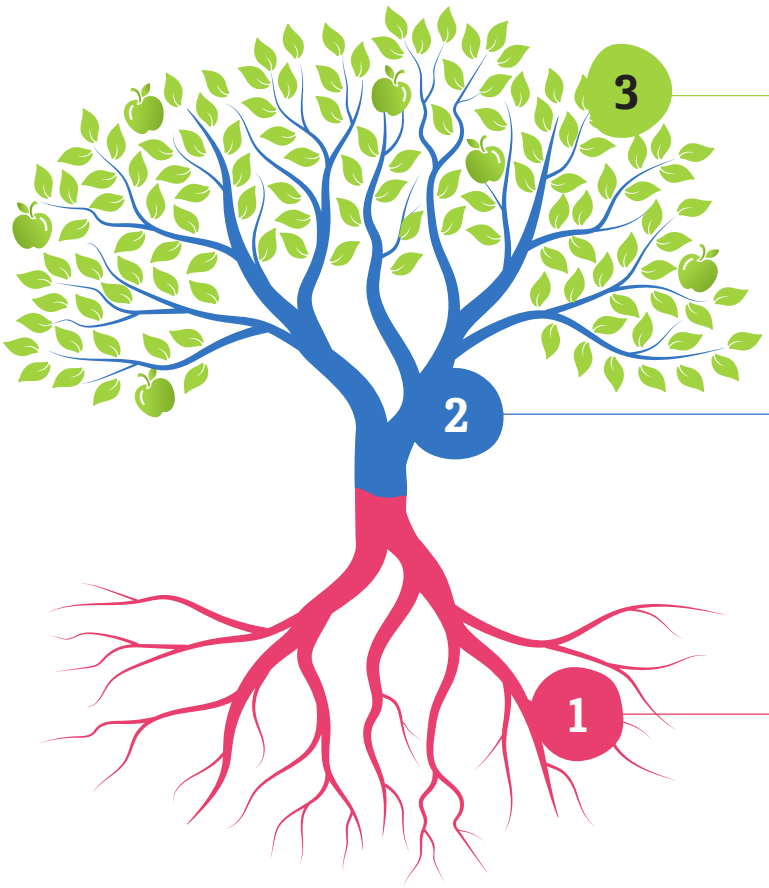
Section IV will describe what is required within each of these three foundational dimensions to build a true System of Care.

IV. Requirements Across Three Dimensions

This section describes what is required within each of the three dimensions described above to build a coordinated System of Care that achieves Washington Thriving's vision and goals. The long-term roadmap in Section V describes the phases of work anticipated.

Find all of this content and more at: washingtonthriving.org/strategic-plan

Figure 6. Foundational Dimensions



People and relationships

Like the leaves and fruit that make a tree beautiful and life-sustaining, **THE INTERPERSONAL DIMENSION** represents the visible, tangible expressions of care through relationships, interactions, and values-driven practice that make support feel meaningful and affirming.

Services and supports

Like the branches that extend outward in multiple directions, **THE SERVICES DIMENSION** expands the array of offerings and access points across the care continuum, reaching into communities to meet diverse needs wherever people are.

System infrastructure

Like the roots and trunk that anchor and nourish a tree, **THE SYSTEMS DIMENSION** provides the foundational infrastructure—policies, funding, governance, and coordination mechanisms—that sustain the entire behavioral health ecosystem and enable its healthy growth and development.

With everything working together, the tree flourishes—rooted in strong systems, branching out through comprehensive offerings, and bearing the fruit of relational, people-centered care that supports young people, families, and communities.

The Systems Dimension: Strengthen System Infrastructure

An effective and coordinated System of Care requires leadership and governance, shared goals, integrated information systems, sustainable financing, and workforce.

Figure 7. Requirements for System Infrastructure

Unified governance and leadership	Sustainable financing	Sustainable workforce
Accountable leadership	Sustainable rates & payment models	Workforce retention & support
Lived experience decision-making power	Integrated funding	Workforce pipeline development
Cross-system coordination	Sustainable funding sources	Workforce expansion & diversification
Shared outcomes & integrated information systems		Technology-supported workforce
Shared system-wide learning & adaptation		

The impact of a fragmented system on caregivers and families.

> **"I want to share the reality of what it costs a family to advocate for a child with complex needs, and to implore you to recognize the severe systemic failures that put this burden on parents."**

As a parent, Jenny struggled even with advantages she recognized many caregivers and families lack.

> **"The process of identifying and securing appropriate resources became a full-time job. I was in a privileged position—a stay-at-home parent with the time and resources to dedicate myself entirely—yet I still constantly felt like I was failing my daughter. It exacted a tremendous toll on my mental health, my marriage, and the emotional well-being of my child, who undoubtedly felt the stress I was carrying."**

Her experience led her to reflect on what the system demands of families with far fewer resources. "If I, with all my resources, felt isolated and exhausted, what chance do they have?"

[Read more here]

System Governance, Leadership, and Coordination

Coordinated effort requires clear direction, shared goals, accountability, and well-defined rules of engagement.

Accountable leadership

Washington needs accountable leadership with clear authority to coordinate across state, regional, and local agencies and organizations. This leadership must align policies, resolve service gaps, and address conflicts between agencies, ensuring everyone understands their respective roles in advancing shared systems-level goals and outcomes related to young people's well-being. This requires adaptive leadership and strong executive management capabilities to drive systematic, accountable, and measurable progress.

Ensure young people, caregivers, and families have real power in decisions

Washington's System of Care must ensure that families and youth have actual decision-making authority, not just advisory roles. This requires empowering youth and family representatives with voting rights as part of system governance; compensating community members for their expertise when serving on committees or providing consultation; creating regular community forums where young people and families directly shape what services look like; implementing feedback systems that work in multiple languages and community settings; and, most importantly, making changes based on what families say with clear communication about how their input has shaped decisions. It also includes ensuring that the values of the System of Care are strongly represented and evaluated in state contracts.

Promising practice in shared decision-making. Washington's Statewide and Regional Family, Youth, System Partner Round Tables (FYSPRTs) are based on System of Care values and recognize that youth and families can and should have an active role in how behavioral health systems serve them. Their innovative **tri-lead structure** is designed to promote meaningful power-sharing by giving families, youth, and youth-serving-system representatives equal voice in identifying service gaps and needs and influencing local and state level policymaking and program implementation. This established structure can be strengthened as part of the envisioned System of Care. **[Read more here]**

Experts point to system infrastructure as "the bridge between the system of care philosophy and the comprehensive array of services and supports where those principles are put into action."

Box 7

> **"We love our children. We work hard to get by. We are smarter than we are typically given credit for. How do you design a system without the input of the people using it and expect it to work? The greatest opportunity we have is to build understanding about our experiences, and design a system together that is based in reality and believes we can be successful."**
>
> -Parent participant of a state level steering committee

Box 8

Cross-system coordination

The state needs clear rules and processes for how agencies, tribal governments, and system actors work together and share information; and a unified framework that creates shared standards, common definitions, and clear protocols so that when a young person or family needs help, systems can work as one instead of in silos. This means combining state-level functions that can provide direction, resourcing, and administrative supports, connecting and supporting regions and communities in adapting these rules to fit their local needs, and meaningful and consistent collaboration with tribal governments.

Seeing the full picture. Washington's current information systems tell incomplete stories. Most systems rely too heavily on simple numbers, like how many people were served last year. These metrics, out of context, don't tell us important information like how many people compared to total need, or whether services are improving or degrading over time. The system also misses crucial voices. Those who have been harmed by the system or worry about how their information will be used have little incentive to share honestly. People who were turned away or had bad experiences with services won't stick around to fill out surveys from that same program. Those who do provide feedback do so at a point in time, but the feedback design process doesn't include enough follow up weeks or months later to see if initial benefits have lasted. One participant involved in supporting unhoused youth shared *"the word on the street is, don't go to inpatient because you'll suffer and then be back on the street without support."*

Washington Thriving participants with lived and living experience emphasize the need to hear from those who have had negative experiences with the system to understand what works, what doesn't, and how services actually feel to those receiving them. Peer supported data collection, as well as working closely with community and consumer organizations, could support these aims.

Shared outcomes and integrated information systems

Accountability for shared outcomes promotes coordination. Washington needs unified data and information systems that help leaders make informed decisions and allow providers to seamlessly support young people and families, while ensuring data gathering methods safeguard confidentiality and do not add undue burden on providers. Integrated systems allow for sustainable and ongoing real-time tracking of shared outcomes and service gaps, which allow the system to continually monitor and evaluate performance.

Shared system-wide learning and adaptation

Adaptation requires ongoing learning where data and experience inform how the system evolves. The System of Care should support learning with families, communities, and providers by creating safe, collaborative spaces that aim to make sense of clinical data, Practice-Based Evidence (PBE)[6], lived stories and experience, and community wisdom. These spaces must welcome those facing the greatest barriers and ensure their feedback and insights drive real change. The system must also be capable of tracking dynamic data on how the system responds to young people and families—capturing how services reach out and connect with young people and families through their preferred channels and touchpoints, how assessment and enrollment adapt to each young person's and families' circumstances and readiness, and how providers actively remove barriers and create flexible pathways that fit into their lives. This information reveals when the system is asking families to navigate unnecessary complexity, what obstacles need eliminating, and how to redesign pathways that bend toward families rather than the reverse.

6 Practice-Based Evidence (PBE) derives data and insights from the practitioner's direct interactions and experiences with those they serve in a specific context, and/or practices that come from local community, are embedded in the culture, are accepted as effective by local communities, and support healing of young people and families from a cultural framework.

This requires quick feedback loops, community-led research where young people and families set priorities, and building data systems that communities can access and understand themselves. It also needs dedicated funding and time for these ongoing efforts.

Washington Thriving's understanding of evidence. Many evidence-based practices (EBPs) were developed and tested in controlled settings that may not reflect the complexity of real-world settings and community needs. To address this, many systems invest in adaptation research and implementation science to understand how to modify EBPs while maintaining their effectiveness within the System of Care context.

The approach treats evidence as dynamic rather than static, recognizing that effective practice emerges from the intersection of research evidence, clinical expertise, and community wisdom.

Sustainable Financing

Important financing reforms create the sustainable funding foundation necessary for the other system changes to work. The state needs to reform payment models, integrate funding, and establish sustainable funding sources to increase equitable access to behavioral health care.

Sustainable rates and payment models

The state needs sustainable financing for the System of Care to close reimbursement gaps that undermine service quality and provider sustainability. This requires investment in provider compensation with updated policies that ensure rates and payment models are adequately covering the true cost of care. Rates and payment models should incentivize specialized skills and training and adequately compensate providers for family-based models, mobile crisis response, early intervention before formal diagnosis, and team-based care. Payment structures must incorporate payment for travel time, administrative compliance, and other essential business-related activities. Ensuring every Washingtonian has access to the full spectrum of behavioral health care requires aligning the large state purchasers of health care (i.e. MCOs/ Medicaid, Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB)), those plans overseen by Washington's Office of the Insurance Commissioner (OIC), and large employer-funded plans to create payment incentives toward the desired outcomes.

Promising practice in expanding Medicaid eligibility. Many leading System of Care states use comprehensive assessment tools like the Child and Adolescent Needs and Strengths (CANS) as a systematic approach for defining eligibility for behavioral health services based on functional needs rather than diagnostic criteria. Several states have successfully leveraged such tools to establish Medicaid eligibility pathways that connect families to behavioral health services in early stages of need.

Integrated funding

Washington can strategically deploy resources by combining federal, state, and local funding. If done well, integrated funding can provide equitable access for young people and families regardless of insurance type and ultimately save the state money by using funds efficiently without redundant oversight. This requires an entity to coordinate funds from various sources, understanding available funding and applicable rules. With this complete picture, the state can maximize each funding stream and use flexible funding to cover gaps in both services and supports, as well as critical underfunded upstream offerings.

Promising practice in integrated funding. New Jersey's Children's System of Care pools all of the non-Medicaid federal funding it receives across mental health, substance use treatment, and child welfare to maximize its use of federal Medicaid match funding. This has freed up state dollars to cover services for populations that might have otherwise had to pay out of pocket.

Sustainable funding sources

The behavioral health system needs stable sources of funding. The state must find new revenue streams that survive budget cuts and federal policy change. For example, in 2025, state legislators considered a new tax on social media revenue to help fund behavioral health care for Washington's youth—which would establish a more sustainable source of funding that doesn't fall on households. Long term, the state should also develop mechanisms to quantify and reinvest savings from successful prevention and early intervention efforts back upstream.

Sustainable Workforce

Washington faces a behavioral health workforce crisis that reflects nationwide challenges. To attract and retain providers, the state must recognize the need to care for the carers—ensuring healthy and sustainable careers so they can continue supporting others.

Workforce retention & support

While competitive compensation remains a long-term goal tied to sustainable financing, the state can demonstrate immediate commitment through practical improvements that reduce barriers and enhance job satisfaction. These include streamlining administrative requirements and improving existing credentialing processes. The System of Care must support viable team-based supervision models that connect frontline workers with specialists and reduce isolation while building skills. The system needs quality training and streamlined training requirements, clear advancement pathways to enable in-role growth, and cross-training for easy navigation between behavioral health specialties.

Workforce pipeline development

Attracting future workforce requires partnering with high schools, community colleges, trade schools, universities, and employers to create clear pathways from entry-level positions to leadership roles. This includes expanding opportunities for paraprofessionals and peer workforce to join the field, and enhancing supports to help pay for education such as tuition assistance, conditional scholarships, ands other supportive initiatives like those of the Washington State Behavioral Health Workforce Development Initiative and the Washington Student Achievement Council. Also critical is ensuring behavioral health providers receive specialized training in youth-centered care delivered in settings where young people naturally are—schools, community centers, and youth programs—rather than simply adapting adult treatment models and approaches for younger populations.

Supporting Washington's Behavioral Health workforce. Washington's Health Workforce Sentinel Network reports that the primary barrier to recruiting and retaining staff is low pay that doesn't match current market rates. One respondent explained: "Over 90% of our mental health applicants are interns at this agency and enjoy the work environment, but they can't afford to stay due to the low pay."

The recent People Powered Workforce report reveals another critical retention factor: the toll of workplace trauma and secondary traumatic stress on behavioral health providers, particularly those serving young people and families. It points to a clear solution: diversity-informed, reflective supervision and consultation—regularly scheduled, relationally safe partnerships between providers and supervisors—have been empirically shown to reduce burnout, prevent vicarious trauma, and significantly improve staff retention.

Accessible routes to behavioral health work. Many of the communities that are hit hardest by mental health challenges and SUD also face barriers to higher education. To build a workforce that reflects those it serves, Washington needs more behavioral health career pathways that don't require expensive four- to eight- year degrees. This means building behavioral health career tracks into existing programs, including high school career and technical education programs, community college certificates, and on-the-job training with local employers. Washington can get the word out about these careers through campaigns like Start Your Path.

Workforce expansion and diversification

Diverse behavioral health teams—reflecting different identities and life experiences—enable young people and families to find providers who truly understand their situations. This requires intentionally developing pathways for workforce from underrepresented communities, including people of color, 2SLGBTQIA+ individuals, rural residents, immigrants, and those with lived behavioral health experience. It also requires rethinking qualifications—valuing life experience over college degrees for peer support roles—and expanding beyond traditional therapist positions to include paraprofessionals, peer specialists, cultural practitioners, community health workers, and others who serve young people in communities. Supporting this diversification means educating underrepresented candidates about scholarship and financial aid opportunities, implementing mentorship programs, and partnering with trusted community organizations for recruitment.

Technology-supported workforce

Given Washington's workforce shortage, the state must maximize capacity by helping existing providers serve more people effectively, without increasing burnout. Technology offers powerful solutions: telehealth enables urban specialists to reach rural or remote families, digital tools help people stay engaged with therapeutic treatment between sessions, and automated systems handle scheduling and follow-up tasks, freeing workers for direct care.

Technology should enhance—not replace—the human relationships that are essential to behavioral health. Strategic implementation requires investing in user-friendly platforms, ensuring reliable rural internet access, and training workers to blend digital and in-person care. This approach enables each worker to serve more people sustainably while preserving the personal connections that drive quality care.

The importance of a diverse and representative workforce. A diverse and representative workforce improves patient outcomes by building trust and encouraging honest communication. Stanford research found that Black patients treated by Black providers were more likely to seek preventive services and discuss health concerns openly. Similarly, 70-80% of 2SLGBTQIA+ say they would feel less judged by a provider who shares their sexual orientation and/or gender identity.

Young Women Empowered's Healing Justice Collective is a network of BIPOC/QT (Queer and Trans) mental health practitioners providing free access to therapy sessions for qualifying youth. One youth participant reflected that *"having a therapist with similar life experiences helped a lot with my healing and understanding that my problems are valid."*

Across communities, representation directly impacts willingness to discuss sensitive issues where honesty is critical for effective treatment. One Washington resident put it this way: *"This was the only time I felt that I could talk about my family and not be judged, or about my partner who is also BIPOC and talk about the distinct challenges of undoing trauma."*

Box 9

Safeguarding youth from technology-related harm. While technology can extend workforce capacity, it can also negatively impact young people. Research demonstrates clear risks: artificial intelligence (AI) chat bots damage mental health and foster unhealthy attachments, social media use shows documented harmful effects on mental health, and excessive device use disrupts sleep, learning, and well-being.

Many states are proposing legislation and implementing solutions to mitigate these harms. Illinois recently passed legislation limiting the use of AI in therapy and psychotherapy services—one of many states moving to regulate the use of AI in behavioral health care and patient communications. Proposed 2025 Washington legislation sought to require online services companies (including social media) to protect children and teens online by stopping addictive feeds and preventing late-night notifications.

Box 10

The Service Dimension: Expand Comprehensive Offerings

A true System of Care recognizes that each young person and family is unique and will need different support at different times in their lives. Washington must therefore have diverse offerings that create a flexible and adaptive constellation of support, considered from multiple perspectives to ensure seamless, comprehensive care. This section lays out what is required to ensure a seamless, comprehensive array of offerings, looking at the system from five perspectives.

Figure 8. Requirements for Comprehensive Offerings

Through developmental stages	Throughout the continuum of needs	In relevant settings	For access and coordination	For most significant & complex needs
Perinatal period	Education & promotion	At home	Information & navigation	Co-occurring behavioral health & IDD/ASD
Infancy and early childhood	Prevention	In primary care	Advocacy & support to caregivers & families	Co-occurring SUD & mental health
Middle childhood	Early identification & intervention	In educational settings	Sequencing & connecting	Co-occurring medical & behavioral health
Adolescence	Middle-intensity	Community "third places"	Support through transitions	Serious Mental Illness (SMI)
Young adulthood	Crisis response	Mobile & virtual	Team-based & multidisciplinary	Multiple systems involvement
	Highest-intensity			Other requiring intensive, specialized care
	Stabilization, recovery, & ongoing wellness			

Support Through Developmental Stages

Behavioral health needs emerge and change predictably as young people grow, creating both risks and opportunities that require services and supports to fit each developmental stage for young people and their families.

Perinatal period

The System of Care must offer comprehensive perinatal wellness supports for the parent-infant pair and entire family unit that address mental health and substance use for pregnant people, expecting parents, and families; focus on normalizing perinatal mental health discussions; eliminate screening bias; and create family-based treatment pathways separate from punitive consequences. Key mechanisms include culturally responsive population-level education, universal screening protocols across healthcare and community settings, and specialized family-based substance use treatment using harm reduction and family preservation approaches.

Untreated perinatal mood and anxiety disorders cost approximately $41,000 per mother-child pair from birth through the child's fifth birthday.[x]

Young people's brains, relationships, and needs change dramatically as they grow. The earliest years are especially critical—children's brains grow the fastest during the perinatal and early childhood periods, making parental stress and early relationships particularly impactful. Children between the ages of 6 and 12 begin to form foundational beliefs about themselves as learners and social beings, making behavioral health support during this time particularly valuable in preventing persistent difficulties throughout life. Throughout childhood and adolescence, young peoples' behavioral health continues to be shaped by the harmful effects of trauma and adverse childhood experiences (ACEs), and the protective power of positive childhood experiences (PCEs) that foster connection and resilience. Young adults are still forming new brain connections for emotional regulation, problem-solving, decision-making, and impulse control through experiences that shape long-lasting behaviors and habits.

Research consistently shows that addressing behavioral health needs early prevents cascading challenges like academic struggle, physical health issues, and deeper systems involvement later in life. When young people and families receive developmentally-appropriate support, they achieve significantly better outcomes across all areas of life.

Box 11

Infancy and early childhood

Washington must grow the capacity of its early childhood system to educate parents and providers about the importance of early relational health, identify emotional and developmental concerns early, and refer families to a full continuum of relational supports and treatment for infants, young children, and their primary caregivers. The first five years of a child's life provide the foundation for lifelong social-emotional health, resilience, and well-being. While infancy and early childhood can build a foundation for lifelong well-being and resilience, it is also a period of potential risk with lifelong consequences.[xli] A comprehensive system must include childcare programs, home visits, and pediatric primary care checkups as crucial settings, and requires compensating providers adequately for specialized therapy and family-based treatment.

The need for behavioral supports in early childhood has jumped 13% in recent years, and the need is rising fastest among families who can least afford private options.

One parent of a young child with behavioral health needs recounts her experience searching for much needed help: "I tried everything I could...Waitlists stretched years, and the cost of private evaluations was overwhelming. In the end, I paid over $12,000 out-of-pocket for multiple evaluations." **[Read more here]**

Box 12

Early childhood return on investment.

> **Extensive analysis by economists has shown that education and development investments in the earliest years of life produce the greatest returns...through reduced crime, welfare, and educational remediation, as well as increased tax revenues on higher incomes for the participants of early childhood programs when they reach adulthood."**
>
> -Center for the Developing Child, Harvard University

Quality early childhood programs help young people and families for their entire lives—children do better in school, stay on positive paths and avoid the justice system, and have better health as adults. Washington's investments in early learning (e.g., ECEAP and Early ECEAP) have shown strong results, but experienced significant cuts in the state budget.

Box 13

Middle childhood

Washington's System of Care must support a network of providers dedicated to working with children in middle childhood (ages 5-12) through developmentally appropriate services delivered in schools, homes, primary care, and other places where young people and families spend their time. It must include care pathways that don't require a diagnosis—because waiting for behavioral health needs to reach clinical thresholds misses the ideal intervention window, when children's brains are most responsive and behavioral patterns haven't yet become well-established.

Adolescence (teenage years)

Washington needs behavioral health services built specifically for teenagers and their families—services tailored to adolescents who need independence while still living at home within family structures, and who value peer relationships most of all. This requires services and providers that specialize in education, prevention, early intervention, and treatment for challenges—such as SUD or SMI—that typically start during this life stage.[xlii] These services should be designed to help teenagers stay in school and maintain their friendships and family relationships while receiving help, and to gradually prepare them to become adults and transition into adult services. The system must also serve young people experiencing particularly vulnerable situations: unaccompanied minors, youth aging out of foster care, those experiencing houselessness, and others who lack stable family networks. These youth—and those who care for them—require specialized services that address both their behavioral health needs, and the practical challenges of navigating multiple systems while building toward independence.

Age of consent for behavioral health treatment.
In Washington, young people can consent to their own behavioral health treatment starting at age 13. When a child lacks the developmental capacity to navigate decisions alone or has behavioral health conditions that affect judgement, Washington law provides pathways for families through the Family Initiated Treatment (FIT) process or an involuntary commitment determination from a designated crisis responder in some cases. However, many providers either won't accept these young people or struggle to work with reluctant teens. Though families across the state have different views on additional solutions, greater implementation effectiveness of FIT represents a path to immediate progress.

Young adulthood (transition-age youth or TAY)

Washington needs flexible services that help young adults gradually build independence while continuing to receive behavioral health support. This requires support in developing life skills, providing individualized transition planning and assistance with basic needs like housing, food, and transportation when needed. Services must also respond quickly when crises arise. Success depends on creating a truly integrated continuum for TAY that includes staff trained to work with young adults; flexible service delivery that wraps behavioral health care together with concrete supports for housing stability, food, and transportation access; seamless insurance transitions; better coordination between child and adult systems; and robust peer support. This coordinated approach addresses one of Washington's most expensive behavioral health challenges—the revolving door where young adults are discharged from mental health services to the street and end up cycling through crisis in jails or emergency rooms.

Young adults directly intersect with adult behavioral health systems. Services for this group must be designed for their unique needs distinct from child or adult care, while still bridging the different system approaches between child- and adult- serving systems and requirements to ensure smooth and supported transitions.

System bright spot in support to youth and young adults. The Youth and Young Adult Housing Response Team (YYAHRT) connects youth and young adults with housing and support programs as they transition out of systems such as foster care, behavioral health treatment, and juvenile justice. Several state agencies work together to identify service gaps, track outcomes for youth and young adults for up to 12 months, and coordinate resources based on each young person's individual needs, strengths, and goals. The YYAHRT reflects Washington State's commitment to no young person being discharged from a publicly funded system of care into homelessness. **[Read more here]**

The importance of peer support in youth and young adulthood. The teenage years are when stigma around mental heath begins to impact young people seeking help. As one youth explains, "there's stigma attached to getting mental health support [and fear of] being looked down upon."

Angela, a young adult in Washington, emphasized the importance of peer support: "Therapy didn't work for me. Traditional therapy isn't working for young people. Not every young person is going to open up in the first one to five sessions [as traditional therapy models typically expect]." Young people need environments where they can build authentic relationships with peers who truly understand their struggles.

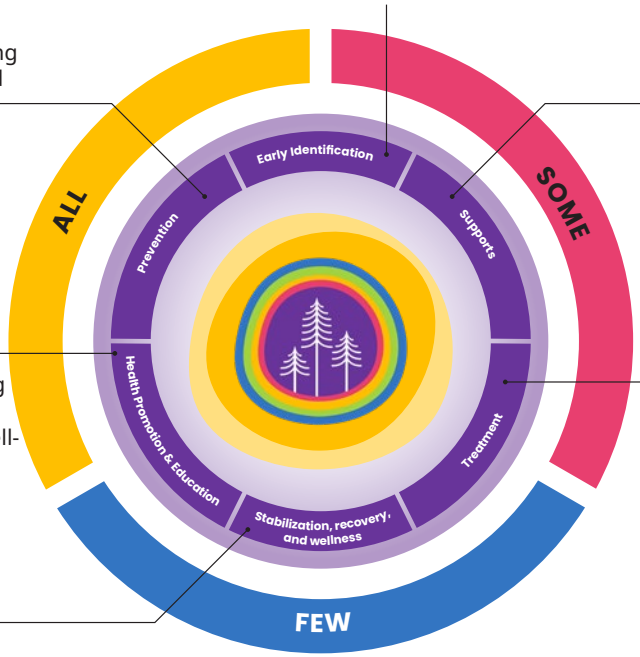
Angela's experience illustrates this. Navigating foster care and trauma, she found that connecting with a peer support staff member who shared similar lived experiences was transformative in ways traditional therapy could not replicate. Meeting other youth with similar backgrounds –who understood the constant anxiety of being moved, the struggle to feel safe, and the weight of accumulated trauma—created the first space where she felt she could finally let her guard down and begin genuine healing. **[Read more here]**

Box 14

Support Throughout the Continuum of Needs

Washington's System of Care must include an array of interconnected services and supports that cover the full spectrum of behavioral health needs, starting with education, promotion, and prevention, and including early intervention when needs are identified, treatment and supports at varying levels of intensity, and support for ongoing wellness whether after diagnosis, in crisis, or in recovery.

Figure 9. Continuum of Care



Early Identification

Spot behavioral health concerns early so they can be addressed quickly.

Prevention

BH-Specific: Focus on preventing behavioral health problems and addressing risk factors.

Basic Needs Support: Help with everyday needs that affect behavioral health.

Supports

Provide ongoing help & support for those with behavioral health needs and their families/caregivers.

Health education & promotion

Health Education: Teach young people and families/ caregivers about behavioral health and well-being.

Promotion: Actively build behavioral health and wellness.

Treatment

Outpatient & Integrated Care: Clinic-based, time-limited behavioral health treatment.

Intensive Home & Community Services: Provide strong supports over longer engagement periods where young people & families/ caregivers live and spend time.

Crisis & Acute Services: Provide urgent / emergency services when immediate help is needed.

Inpatient & Residential Care: Provide most intensive services for young people with behavioral health needs who cannot live at home (either temporarily or long-term) and their families/caregivers.

Stabilization, recovery, and wellness

Help young people and their loved ones recover, continue to grow, and stay well after intensive treatment.

ALL *need holistic supports and anticipatory actions for overall health and wellbeing*

SOME *need engagement and supports at earliest possible stage of need*

FEW *need management and care across acuity, complexity, intensity, and duration of need*

Education and promotion

Washington must develop integrated behavioral health education and wellness promotion strategies that coordinate existing agency efforts while leveraging the state's extensive community networks and other trusted messengers. This should include specific priorities for digital wellness education addressing social media's mental health impacts on young people, teen dating violence, sexual violence and suicide prevention messaging.[xliii] This also includes training for parents and family members, as well as other trusted adults and caregivers, on how to recognize and respond effectively to behavioral health situations that young people face—integrated into places such as family resource centers, that already offer a variety of services to support families including parenting education, mental health services, and youth programs for tweens and teens.

One-third of young people report using social media **"almost constantly"** with documented negative mental health impacts, yet the state lacks systematic digital wellness education to help families navigate these challenges.

Box 15

System bright spot in education and promotion. Washington State's Communities Building Resilient Youth program awards grants to community-led organizations that create regular activities and events—from student social media campaigns to community service projects—to support youth mental health and well-being. These grassroots initiatives work directly with at-risk youth and their communities to build protective factors and decrease risk factors associated with suicide, violence, and harm through ongoing engagement and connection.

Prevention

Washington needs to invest more in prevention to help everyone, especially groups at high risk, build resilience and avoid challenges where possible. Washington should build on proven models already working within our state and resource communities to implement the best practices and strategies outlined in the multi-agency Washington State Substance Use Disorder Prevention and Mental Health Promotion Five-Year Strategic Plan (2023-2027). By expanding prevention, Washington will see better outcomes for young people, with less harmful behaviors, fewer crises, and less demand over time for more intense services.

"The wrong pocket problem." Prevention programs often save money, but the savings show up in a different government department's budget than the one that paid for the program. They also don't show up in the same year the investment was made. This makes it hard to justify investing in prevention, even when we know it works.

Early identification and early intervention

While prevention aims to stop behavioral health challenges from developing in the first place, early identification happens when risk factors or early warning signs appear and stepping in with support before things worsen.

Washington's System of Care must have strong early identification systems across all communities and across all developmental stages, especially in places where access or awareness may be limited. This requires training primary and specialty healthcare providers, educators, and childcare workers to spot warning signs; creating clear pathways with warm handoffs that seamlessly connect families to support; and developing systems to ensure no child falls through the cracks. The state needs to eliminate barriers that prevent families from accessing services before symptoms are critical, including language differences, transportation challenges, and insurance coverage gaps.

Young people who get early support are more likely to succeed in school, build healthy relationships, and have better lives overall, while early intervention costs far less than waiting until behavioral health conditions become chronic or severe.

For children with ASD, experts suggest that the earlier in childhood an intervention is initiated, the better clinical outcomes will be, including greater long-term independence and lower medical, education, and social support costs.

Box 16

Middle-intensity services and supports

Washington must develop and scale up middle-intensity services including routine outpatient care and short-term treatment options that are more intensive than regular counseling, as well as programs that bring ongoing support to young people and families in home, school, and community settings. This includes day programs where young people can get intensive help but sleep at home. These services should be specifically designed for young people and families, with flexible delivery options that accommodate school schedules, family work obligations, and transportation challenges. Additionally, these services need clear pathways for stepping up or down in intensity as a young person's needs evolve.

Crisis response services and supports

Washington must continue to invest in expanding developmentally appropriate crisis support for young people and families. A cornerstone of this effort is expanding its mobile crisis services—both geographically and in alignment with best practices for serving young people and families. Mobile Rapid Response Crisis Teams (MRRCT)[xliv] should be trained specifically to work with children, teenagers, and those with complex developmental and behavioral needs; understand trauma; and include the whole family as essential partners. These teams must be available around the clock and deployed as the first response when families call for help, unless families specifically request otherwise. Effective crisis support extends beyond the initial intervention response, and includes making safety plans with families, following up within 48 hours, and ensuring smooth connections to ongoing community-based supports. Families also need access to respite services for relief during high-stress periods, as well as crisis stabilization support—whether at home or in short-term residential settings, when necessary. Mobile crisis teams must work closely with schools, police, emergency services, and treatment providers to keep young people out of emergency rooms and handle crises in the most supportive and least restrictive way possible.

As one parent, Jessica, shared: "We were in crisis for years with little to no resources that actually helped. By the end of 2022, we had a serious incident that had us needing out of home care… Once community-based services were not enough, there was nowhere to go but the hospital and wait." **[Read more here]**

System bright spot in crisis response services and supports. Seattle Children's Hospital recently opened a psychiatric urgent care program offering same-day in-person and video visits for children and teens ages four through 17 across the state who need urgent mental health support but don't need emergency department services.

Highest-intensity services and supports

Washington needs to build and expand the most intensive treatment services in the state—including both inpatient and residential treatment options that reduce the state's reliance on costly out-of-state treatment. This includes developing more residential treatment facilities with therapeutic supports that aim to get young people back home, when possible, with a focus on intensive skill-building and family preparation. The state must also create supportive residential homes close to caregivers and families for young people who need full-time care and cannot live at home due to severe disabilities or complex medical needs. The System of Care must also strategically expand the availability of shorter-term intensive treatment centers with special programs for children with IDD, ASD, and/or neurodiversity; and create new residential options for children with severe behavioral challenges, multiple conditions at once, and complex behavioral challenges that require specially designed buildings, enhanced staffing, and intensive treatment programs that regular hospital units can't provide.

Stabilization, recovery, and ongoing wellness support

Washington needs to build complete support systems that help young people and their families transition back into their communities and everyday lives after intensive treatment ends. These services should support stability and sustained well-being as young people and their families navigate daily life. For some, support needs may continue long-term or throughout their lives, requiring ongoing stabilization with appropriate supports for sustained well-being even while treatment is ongoing. Essential transition

services include life skills training and planning before leaving treatment. Those young people who need additional support also need access to specialized recovery schools and academic assistance; safe, stable living environments—whether provided through recovery housing or in help securing permanent housing; and family strengthening programs that teach parents and caregivers how to support their young person's wellness, while also providing respite care when caregivers need breaks or relief. Young people additionally need supportive connections with peers who understand their experiences firsthand. These services should remain flexible—adapting as young people grow and their needs evolve, and helping them develop the tools and support systems they need for lasting wellness and successful futures. For those recovering from SUD, this includes sustained recovery support mechanisms.

System bright spot in stabilization, recovery, and ongoing wellness support. The Interagency Recovery Campus (IRC) is a public recovery high school that provides a safe and sober environment where young people in recovery from SUD and other conditions pursue their academic and career goals. After enrolling in the program, 53% of IRC students have more than one year of recovery. In the words of a graduate: *"...if it weren't for the school, I'd probably be dead. I was immersed in a community that was doing the work to stay sober...and I was taught how to do that."*

Support in Relevant Settings

Behavioral health support must be built into environments where young people and families naturally spend their time to reduce the need for specialized clinical interventions, reduce stigma, and increase accessibility. This is particularly important for reaching marginalized populations who may distrust and avoid traditional institutional settings, as well as settings where trauma has occurred or can be reduced such as juvenile justice, foster care, and more.

There is a robust body of research that shows that community- and home-based interventions, including approaches using trusted messengers, produce significant improvements in behavioral health.[xlv,xlvi,xlvii,xlviii,xlix,l,li,lii,liii]

At home

Services that meet families in their most comfortable environment, providing support at home, where daily routines and crisis situations most often occur, are critical. Home based treatments are important for children with the most intensive needs whose behaviors make travelling for care challenging or even unsafe. Mobile and in-home services bring trained providers directly to families, allowing them to see what's really happening and teach skills during the actual moments when children and families need help most. This means training providers to work safely and respectfully in diverse home environments, investing in the scale up of mobile crisis teams that can prevent hospitalizations by stabilizing children at home, and covering the costs of the extra time and travel required for effective in-home work.

Home visiting programs like Nurse-Family Partnership, Outreach Doula, Parents as Teachers and other models deliver services directly in families' homes, where parents feel most comfortable and children's natural environments can be observed and supported. Trained home visitors build trusting relationships with families in their own settings, providing personalized guidance on prenatal care, child development, and parenting skills while connecting families to community resources and coordinating care. This place-based approach has proven effective in improving child health outcomes, strengthening parent-child bonds, reducing abuse and neglect, and empowering parents to make positive life changes.

In primary care

Primary care settings—whether pediatric practices or family medicine clinics serving children—are ideal places to check in on young people's behavioral well-being during regular health visits. Families often already trust their children's doctors and nurses, see them routinely, and can find primary care even in areas where behavioral health specialists aren't available. The System of Care needs integrated behavioral health support in primary care settings through embedded therapists who work closely with doctors, nurses, and support staff; regular behavioral health check-ins during routine visits; and providers trained to deliver basic interventions and connect young people and families smoothly to specialized help when needed. This requires funding models that pay for behavioral health services in medical settings (and vice versa), staff training to recognize and respond to behavioral health concerns, team-based models, and easy referral pathways. Further, holistic approaches and bi-directional tools, resources, and incentives are needed that can not only help medical staff bring behavioral health support into primary care settings, but also that help behavioral health agencies bring medical care into behavioral health settings.

In educational settings (early childhood centers, K-12 schools, higher education)

Given that nearly every young person attends early childhood programs, K-12 schools, and/or higher education settings, these educational environments are uniquely positioned to support behavioral wellness and early behavioral health supports. These settings are ideal venues for teaching foundational social-emotional skills, implementing universal wellness initiatives, and conducting behavioral health screening. Childcare workers, educators, and school staff are naturally situated to identify early behavioral health challenges and provide timely support.

While the public education system has distinct goals for student learning and achievement, behavioral health is a foundational element of learning readiness. The System of Care should establish an evidence-based framework for student behavioral health with technical assistance from the State, providing clear statewide guidance that defines how educational settings support student behavioral health and well-being with services offered to all students regardless of their insurance coverage ("insurance blind"). It should be connected to tiered service levels (Multi-Tiered System of Support, or MTSS): universal supports for all students, focused supports for students showing early difficulty, and intensive individualized supports for students with significant needs. Support should include all students (including those with disabilities or behavioral challenges) in inclusive general education settings, use evidence-informed practices, and be adaptable to meet the young person's needs in all education settings.

Using school-linked services to get help.

"A year ago my youngest teen had some serious mental health challenges. They had become severely depressed, evasive about communicating the causes with either parent. We were aware they were struggling...but it was hard to connect with them about what was happening.

Their school has a therapist with an office in the school building. They had already independently sought out help there, after filling out mental health questionnaires at school with responses that were flagged for follow-up by a teacher.

At the worst of their issue, there was self-harm and suicidal ideation. The counselor encouraged our kid to have an honest discussion with us, and contacted us directly to discuss some routes forward. There was still a lot to do to get them the help they needed – insurance, intake interviews, and finding the right program fit – but the services linked to the school were key to getting the right care quickly.

They attended an intensive outpatient program that included weekly parent education and support. Through the careful help of the program, their outlook on life turned around. They have some tools and resilience to weather the struggles."

-Washington parent

Bullying, school violence, and punitive discipline practices all threaten student mental health and often worsen underlying problems. Among these issues, the school-to-prison pipeline represents a particularly troubling pattern where certain disciplinary policies—rather than supporting students to change behavior—can instead criminalize it, creating pathways that push vulnerable students away from education and toward the justice system. This pattern often involves intensive police presence in schools, zero-tolerance policies that treat minor infractions with severe consequences, and automatic suspensions or expulsions that disconnect students from the very educational support they need. Research consistently shows that students of color, students with disabilities, and those from low-income families experience these practices disproportionately. The long-term impact goes far beyond a single incident, potentially affecting students' entire life trajectories. Challenging behaviors often signal unmet needs rather than defiance. The challenge many schools face is responding effectively when resources, trained staff, and comprehensive support services are limited or unavailable. While Washington State has made efforts to reduce discipline disparities across student groups, significant work remains to ensure equitable outcomes for all students.

Addressing this pattern requires examining how we can better equip schools with the resources, training, and support systems needed to respond to behavioral health needs in ways that keep students connected to education and opportunity. This includes investing in counselors, social workers, restorative practices, and trauma-informed approaches that address root causes rather than symptoms.

Box 17

Community "third place" supports

Trusted spaces where young people and families spend time, like libraries, community centers, childcare settings, faith organizations, and after-school programs, can be better leveraged to support behavioral health and wellness. These places are uniquely suited to reach families, including those who avoid clinical settings due to stigma, system mistrust, or cultural differences, while also providing accessibility to support in rural areas with fewer options for care. These "third places" naturally provide peer connection through shared activities, early identification through existing trusted relationships, and culturally-grounded support that builds on community strengths—representing the most upstream investment possible to prevent behavioral health clinical intervention.

System bright spot in community supports. Akin is a non-profit serving young people and families statewide. Akin's Family Resource Centers (FRCs) in Washington State serve as vital third places where families can gather, build connections, and access community support in welcoming, no-cost environments. Additionally, Akin coordinates the Washington Family Support Network, which reaches hundreds of additional families. FRCs exemplify how third places can address both practical needs and the human need for belonging, building healthier communities through accessible spaces where neighbors become support networks. **[Read more here]**

Natural community settings have the potential to **more effectively reach underserved populations** while achieving comparable outcomes at **lower cost**.

The need for accessible gathering places. Youth describe how few spaces welcome them to gather without spending money—whether parks, stores, or community centers. "Everywhere I go, I have to spend money if I want to do something fun or interesting," one teen explains. This effectively excludes young people who lack financial resources from activities that promote well-being and belonging.

Community member Shiyah articulates what mattered during her youth, as she grappled with substance use, mental health issues, and found herself repeatedly in trouble: "Things could have gotten a lot worse, but having community around me through sports, after-school activities, and youth groups kept me from completely falling apart. Those spaces gave me people who cared, who noticed when I was slipping, and who reminded me I wasn't alone...Looking back now, I can see that having those natural supports built me up enough to completely change my life." **[Read more here]**

Box 18

Washington needs to embed behavioral health promotion, early identification, and support into community settings. Librarians, coaches, community center staff, and faith leaders in these environments can be trained to recognize early warning signs and make warm referrals to care. This requires developing flexible service models that adapt to different community environments, and investing in enhancing their natural capacity to support youth and family wellness.

System bright spot in community supports. Only7Seconds is a Washington-based nonprofit organization on a mission to end the youth loneliness epidemic by inspiring intentional, meaningful connection through action and youth-led programming. Its programs are designed for use by schools, by community-based organizations, and in third places. **[Read more here]**

Pioneering solutions to mobile crisis response in rural settings

South Dakota has developed a Virtual Crisis Care program that connects law enforcement with behavioral health professionals via technology for 24/7 crisis support. Arizona achieves 30-40 minute response times statewide by using GPS coordination to dispatch the nearest available team across jurisdictional boundaries. Both states use creative funding approaches and community partnerships to ensure consistent crisis response regardless of location or insurance status.

Mobile and virtual services

Washington needs mobile options and teams that can deploy directly to wherever young people and families are without requiring young people or family members to travel. This is particularly important in crisis situations, for rural or remote settings where providers are not nearby, and for unhoused populations including unaccompanied youth who may be experiencing behavioral health needs in unconventional locations such as vehicles, parks, emergency rooms, or temporary shelters. The mobile teams should have specialized training for working with young people with trauma-informed approaches, and the ability to conduct assessments that consider how someone's immediate circumstances—such as housing instability, lack of basic needs, or unsafe living conditions—contribute to their needs. By meeting young people and families where they are and understanding the context of their lives, these services can provide immediate support, stabilization, safety planning, and connection to ongoing support that addresses both the immediate needs and the underlying environmental factors.

System bright spot in virtual services. HearMeWA is a free, 24/7 helpline dedicated to supporting youth up to age 25 by connecting them with local resources. It was created through youth advocacy and is guided by a youth advisory group. Youth can connect via phone, text, mobile app, or online tip form—all are available in multiple languages and ADA compliant. Youth can choose to remain anonymous. Reports are directed based on the situation—from immediate 911 response for life threatening situations to school notifications, regional crisis lines, 988, or other community resources for less urgent needs. **[Read more here]**

Support for Access and Coordination

In order to be most effective, services must operate independently of conflicts of interest or create the ability to self-refer.

Information and navigation support

The System of Care should ensure that families, caregivers, and young people find appropriate help no matter where they first ask for support. This requires a coordinated infrastructure with a comprehensive "no wrong door" or "any door" approach to connecting young people and families with trusted providers who can share accurate guidance and connection to all available resources, regardless of which agency provides them. This navigation support should be delivered with respect for privacy and confidentiality, ensuring that personal information is protected and shared only with informed consent and in the best interest of young people and families.

While digital platforms can support this coordinated approach, most people find help through conversations with someone they trust, rather than through technology alone. The system requires training and supporting these trusted community helpers with the tools, information, and backup they need to provide effective guidance, while developing digital platforms that serve as resources for navigators rather than replacements for human connection.

Promising practice in coordinated support and access. New Jersey is recognized as one of the best children's behavioral health systems in the country, in part because of its supports for access and coordination. Families can access all services by calling PerformCare, the state's single entry point for behavioral health. Each county has an independent, family-run Family Support Organization (FSO) with state funding and accountability to provide advocacy, peer support, and system navigation services. Local Care Management Organizations (CMOs) create care plans tailored to each child's needs, bringing together child-and-family teams using the wraparound approach. FSOs and CMOs ensure different perspectives are heard and provide space for healthy debate in case planning.

Evidence shows that **multi-access point** strategies—including door-to-door outreach and integrated platforms connecting people to resources—**improve engagement and reduce access barriers**.

Box 19

Advocacy and support to caregivers and families

Washington needs advocates who can help caregivers and families navigate complicated systems and manage challenges that arise when a family member is experiencing a behavioral health crisis. This means creating dedicated, paid positions for people whose only job is to support and advocate for young people, caregivers, and families—not to provide treatment or run programs that might create conflicts of interest. These advocates need real authority to help, peer support programs that work for Washington's diverse communities and languages, and ways to measure whether young people and families actually feel empowered and supported. Caregivers consistently emphasize that when they have dedicated support that operates with real authority, they become better partners in their young person's treatment while maintaining their own mental health and family stability.

Sequencing and connecting services

The System of Care should transform existing investments into a unified, statewide system that provides seamless, consistent support to all young people, caregivers, and families regardless of their insurance, location, or which systems they're involved with. This function ensures services are sequenced appropriately, complement each other, and adapt to changing needs over time. This requires resources to support individualized team-based care with dedicated staff to develop care plans that use approaches that "wrap around" the whole person, standardized coordination methods to keep providers connected, and the flexible funding needed for complex care management.

Promising practice in sequencing and connecting services. New Hampshire is an example of a state that funds community organizations to provide family-centered care coordination. Care Management Entities (CMEs) are contracted by the state to deliver intensive care coordination using a high-fidelity wraparound approach. They connect families to a wide range of services, including peer support. The state requires CMEs to stop delivering their own direct behavioral health services to ensures that CMEs can focus entirely on linking families to the highest-quality, best-fit services available, rather than filling openings in their own programs.

System bright spot in support through transitions. The Bridge Coalition is a statewide collaboration working to prevent unaccompanied young people, ages 13 to 24, from discharging from inpatient behavioral health settings into homelessness. The Bridge Housing Program provides provides up to 90 days of recovery-focused housing with behavioral health support for unaccompanied young adults aged 18–24, with current facilities in Kirkland and Spokane. The Bridge Coalition provides monthly training and input to the program to ensure the voices of those with lived experience remain central to the program's design and delivery. **[Read more here]**

Support through transitions

Moments of change for young people, caregivers, and families present the greatest risks for falling through the cracks in the system—whether developmental milestones, life events, or moves between services and settings. Without intentional transitional support in young lives, progress can be lost and trust broken. Continuity of care and warm handoffs between providers and settings are fundamental requirements for sustaining progress and preventing re-traumatization. This requires clear protocols for information sharing and joint transition planning that involves families, current providers, and future providers working together. Ideally, key providers can maintain supportive relationships across service boundaries so that young people don't experience sudden cutoffs. Families should be led through transitions by coordinators and navigators, while shared information systems allow the right information to flow as needed. Flexible funding to cover gaps in services and strong cross-system partnerships between agencies are essential. Finally, the system must build in adequate preparation time rather than forcing crisis-driven, last-minute handoffs.

Team-based care and multidisciplinary approaches

An effective System of Care requires building robust multidisciplinary care teams. When providers from different specialties collaborate and consult, they offer more comprehensive, effective support for young people and families facing complex circumstances. By creating structures where providers can easily access specialized expertise and share responsibility for high-risk situations, the system empowers each provider to work at what they're uniquely qualified to do, while ensuring young people receive the right care. Investing in training that helps providers recognize when to bring in additional expertise—and creating seamless pathways to do so—transforms isolated practice into collaborative care. This approach not only improves safety and treatment quality for young people and families but also supports provider well-being by ensuring no one carries unsustainable burdens alone.

One Washington parent, Lori, knew the transition home from treatment would be critical. "After fighting for 2 years to get my child in district-funded residential treatment, upon coming home I needed a safe wrap around to assist with home stabilization."

But the supports that were supposed to catch her family weren't there. A 3-day summer camp meant to provide respite instead exposed their child to harmful behaviors. The family therapy offered ended up not being covered by insurance. Without the stabilization supports she'd fought for, Lori watched her child lose the ground they'd gained. "Now instead of stabilizing, my child is unraveling."

Young People with the Most Significant and Complex Needs

Washington needs to strengthen its care capacity for young people with co-occurring needs, SMI, those involved in multiple systems, and those with specialized needs requiring intensive care.

Young people who have co-occurring behavioral health and IDD and/or ASD needs

Washington needs integrated services that combine expertise and services related to behavioral health needs and IDD, ASD, and/or other forms of neurodiversity. This means training individual providers and entire agencies to address all needs together through team-based care. Services must be adapted for different thinking and learning abilities, use communication strategies that work for each person, and provide the daily living support young people and families need. This integrated approach should be available at all levels of care intensity, ensuring young people get coordinated care that addresses their whole person, not just symptoms.

Young people who have co-occurring SUD and mental health needs

Washington needs treatment programs and facilities that can handle both mental health and SUD treatment needs simultaneously with dual-diagnosis capable staff and flexible services that recognize how these conditions can be mutually reinforcing. This means training providers in integrated approaches, using assessment tools designed for co-occurring needs, and creating treatment plans that work on mental health and substance use together. This requires funding for comprehensive integrated care models.

Young people who have co-occurring medical and behavioral health needs

Washington needs integrated care that recognizes the deep connections between physical health and behavioral health, particularly for young people with chronic illnesses, pain conditions, or disabilities. Medical conditions can create behavioral health challenges (e.g., diabetes management affecting depression), and behavioral health needs impact one's physical health (e.g., eating disorders or medication management concerns). This means primary care and behavioral health providers improving in their capabilities to screen for and coordinate the management of both physical and behavioral health conditions, in settings such as primary care and Certified Community Behavioral Health Clinics (CCBHCs).

When behavioral health and medical teams work in isolation, critical symptoms – whether behavioral of physical - can be overlooked, preventing clinicians from seeing the whole person. This fragmentation allows treatable conditions to worsen and can lead to missed or delayed treatment needs.

One parent shared how her child's care journey highlighted the importance of looking at the whole picture. While her child received support for behavioral health challenges, it took time to identify the underlying medical factors that were contributing to their symptoms. This experience reinforced for her the value of integrated care: "There needs to be a holistic look at each person [that stops] separating mental health from physical health." **[Read more here]**

A 2021 review of **129 studies** found that the longer psychosis goes untreated, the worse the outcomes. **Delays in treatment** increase the risk of severe symptoms, self-harm, poor daily functioning, and lower chances of remission.

In Washington, **over half** of the 210,000 **individuals with SMI receive no treatment**.

Box 20

Young people experiencing Serious Mental Illness (SMI)

Washington's System of Care must have enough services to help people with SMI—such as first episode psychosis, schizophrenia, severe depression, and bipolar disorder. This means having the right level of care available when needed. With community-based support as the foundation, intensive hospital and residential treatment must be available when help is needed beyond the scope of community services.[liv] Just as important, is ongoing support to help young people stay well: medication management, relapse prevention, cognitive rehabilitation, and specialized family education. Success requires strong care coordination, family support, training for staff who understand these conditions, and payment systems that reward quality care. This creates the stability needed for long-term therapeutic relationships between young people and their providers.

Jerri, a parent of a transition-age son with severe psychosis symptoms and behaviors shares her story of waiting for a crisis considered severe enough to warrant intervention.

> "My son's psychosis spiraled out of control in our home in the months leading up to his first serious suicide attempt…A psychiatric facility treated him for less than a week, not nearly long enough to stabilize his symptoms, and offered … nothing to help us better understand his severe mental illness or how we might support him post-discharge. He ended up cycling through homelessness, incarcerations, and additional suicide attempts before he succeeded in taking his own life when he was 23. Early intervention was not only unavailable but actively withheld on the premise that he wasn't sick enough… My son's autonomy was taken from him by psychosis [that ruled] his behaviors until those behaviors killed him. Involuntary early interventions give a person a chance to reclaim their grasp on reality."

[Read more here]

Young people involved in multiple systems

All young people interact with multiple systems—they go to school, need behavioral health support, seek medical care, and use community services. But some young people in formal systems like foster care, carceral systems, specialized disability services, homeless services, and military service, can face more serious challenges.

Washington needs specialized services that coordinate across the juvenile justice, carceral, child welfare, disability, veteran's affairs, special education (Individualized Education Programs (IEPs)/504 plans), homeless services, and behavioral health systems. This requires training all staff to understand how trauma affects young people and families, and creating shared plans for treatment and support. It means teaching workers how to coordinate across different systems, setting up clear ways for systems to communicate with one another, and connecting young people to peers who have successfully gotten through similar challenges. It also means making sure young people get the right services early enough in their lives and when needs arise to avoid unnecessary system involvement.

Young people involved in foster care or juvenile justice systems have much higher rates of mental health and substance use but face extra barriers getting help. Many youth with IDD and/or neurodiversity who don't get proper support, end up cycling through detention centers, making their situations worse over time.

Youth with foster care experience are up to 62% more likely to face mental health challenges including depression, anxiety, and PTSD than their peers in the general population.

For young people in foster care, substance use rates are estimated to be as high as 49%.

Young veterans show higher rates of depression than the general population, with one study showing a 9.6% rate of major depressive episodes among 18-25-year-old veterans.

Box 21

Other behavioral health conditions that require intensive, specialized care

The system should be designed to support individuals as whole people with unique, multifaceted experiences. Despite diverse circumstances, some young people and their families share a common need for intensive, specialized care that acknowledges their complex realities, without requiring them to conform to narrow and rigid eligibility requirements. The system should provide coordinated services and support that "wraps around" young people and families and seamlessly connects all the systems in their lives—healthcare, education, social services, and community resources—to provide the stability, healing, and genuine assistance necessary for their stabilization and ongoing wellness.

The current system's reliance on specific diagnostic labels and predetermined program criteria often fails to capture the full reality of young people whose development and ability to thrive are shaped by intersecting challenges—those with significant behavioral health needs linked to physical disabilities, diagnoses such as ADHD, PTSD, or Fetal Alcohol Spectrum Disorder, trauma-induced attachment disorders, eating disorders, non-substance based addictive disorders, anosognosia[7], and countless other combinations of circumstances that defy simple categorization.

The Interpersonal Dimension: Values in Action and What Matters Most to People

Figure 10. Requirements for Values in Action

7 Anosognosia is a condition where brain damage, mental health issues, or substance use prevents individuals from recognizing their own symptoms or disabilities, severely limiting their ability to manage their condition, follow treatment plans, or live independently.

Centering the Experience of Young People and Families

Centering the experience of young people and families requires empowering them to determine what form their care takes, building enduring relationships and trust, and actively tending to past and potential trauma.

Relational, people-centered care

Washington's System of Care must prioritize what matters most to young people, caregivers, and families. This requires enabling individuals and families to lead their own care planning and decide what their goals are, with increasing independence as youth and young adults develop. Services must be individualized and strengths-based, adapting to each person and family's unique needs rather than forcing conformity to rigid program structures. Practitioners must be knowledgeable about trauma-informed and healing-centered practices, employing relational approaches that focus on goals, capabilities, assets, and positive qualities rather than primarily on problems, deficits, and diagnoses. Services should be available in preferred languages and cultural contexts, integrating traditional healing practices with clinical services when individuals and families want them, and providing multiple ways to receive services (in-person, virtual, group, individual) based on choice rather than program availability.

> **"I don't think healing has to be 'I'm completely fixed'. I think healing is taking care of yourself, talking to people who are like minded and have similar interests. Keeping yourself social and doing things that make you happy and just being. You just have to put yourself first sometimes and take care of yourself and do the things that nourish you. I think that's what healing is." [Read more here]**
>
> --Andrea, a young person in Washington State

Build relationships and trust

First encounters with formal systems become critical gateway experiences that can either build trust and engagement or drive families away entirely. Front-line staff need training to recognize that how they show up in the first moments often determines whether families will engage with services at all. Intake practices must be strengths-based and culturally responsive, with initial conversations focused on understanding young people's and families' goals and priorities rather than cataloging deficits. Environments should be warm, welcoming, and culturally familiar. The system needs trauma-reducing processes that minimize re-traumatization while centering safety and choice.

Staff need supervision that goes beyond administrative oversight to collaborative relationships that build self-awareness and strengthen therapeutic connections. The system must build trust with providers by focusing oversight on agreed-upon outcomes—whether young people are improving and meeting their goals—rather than on rigid compliance. This approach demonstrates trust in providers' judgment about what is best for their clients.

Building trust takes time—but the system rarely gives providers and families the time they need. One parent describes how providers disregarded what the family was seeing: "Our daughter has had a complex medical history since birth. We heard endless 'It's just _____' comments [anxiety, for example]. It took two years to learn she had brain inflammation caused by an illness. A simple course of antibiotics reduced her symptoms drastically. But the damage from the delayed diagnosis is permanent and has irrevocably harmed our daughter and family." **[Read more here]**

Anti-Racist, Equitable, and Culturally Responsive Practices

Putting this System of Care value into practice requires allocating resources to address disparities, ongoing training and supervision, and valuing the wisdom and traditions that communities carry.

Make access to services equitable and culturally affirming

Washington's System of Care must actively address racism and oppression while serving all communities well. This requires identifying and addressing disparities through specific goals and dedicated funding. The system must recruit, retain, and support providers who reflect the communities they serve, and ensure available knowledge and training on anti-racism and cultural humility. Equally important is funding organizations led by people from the communities being served and investing in community infrastructure (transportation, childcare, technology) that removes barriers to access.

Designing services with communities in mind. Changing immigration enforcement practices are contributing to noticeable anxiety and depression for immigrant communities seeking services and for those who aim to serve them. This climate of fear intersects with longstanding barriers in how behavioral health services are designed and staffed:

> **"Organizations offer services to immigrants or refugees, but format them like other US-centric services…and do not hire people who have the backgrounds of the people they serve."**

Immigrant and refugee families often bypass the formal system entirely.

> **"Refugees don't go to white people. Because of their accents, they ask neighbors or people like them."**

*Quotes from FFI listening sessions, Annex 2

Box 22

Develop provider skills for quality, culturally-responsive care

Washington's System of Care must ensure that all providers have the skills needed to deliver quality care in culturally-responsive, healing-centered ways. This requires quality training that builds providers' capacity to engage families through trauma-informed, culturally-responsive approaches and to practice ongoing reflection and self-awareness. This also requires creating ongoing supervision and support structures that help providers continue developing these skills throughout their careers, not just during initial training and education.

Promising practice in culturally responsive care. Community Health Workers (CHWs) advocate for young people and families' needs, help them navigate complex systems, and promote well-being. In Washington, Medicaid supports CHWs who work in team-based care to promote behavioral health. By sharing language, culture, or lived experiences with the communities they serve, CHWs build trust that helps people stay engaged with care, even during difficult circumstances.

A pediatrician recalls treating a newborn at her first well-baby visit. The infant was healthy, but the family was experiencing housing instability. The mother's primary language was Spanish. The pediatrician connected the mother with a Spanish-speaking CHW at the clinic. After missing a subsequent appointment, the mother returned to the clinic a few weeks later asking specifically for the CHW. They worked together to find the family housing—a foundational determinant of the child's health and development.

Balancing clinical evidence and community wisdom

Washington's System of Care must thoughtfully balance the promotion of Evidence-Based Practices (EBPs) with recognition that effective, culturally-grounded approaches often exist outside traditional research models, and that imposing interventions not designed for or tested with specific communities can perpetuate harm.

Building "practice-based evidence" involves evaluation frameworks that recognize effectiveness across different cultural contexts and healing approaches. It means ensuring that new technologies or interventions are developed in partnership with the communities they're intended to serve, and recognizing the impact of relationship-based, community-centered approaches that aren't currently embedded in the clinical system. Finally, it involves building bridges between community wisdom-keepers and clinical providers to create integrated approaches that honor different ways of knowing.

Promising practice in balancing clinical evidence and community wisdom. Some states recognize the value of returning to relationship-based, community-centered approaches and natural supports for behavioral health.

In California, Arizona, New Mexico, and Oregon, Medicaid covers traditional practices such as music therapy, sweat lodges, and dancing to support the physical and mental health of Native American communities. Native American health leaders have advocated for this coverage in Washington State.

Community Orientation

Supporting communities' well-being requires consistent, intentional engagement, flexibly funding, and attention to vital conditions.

Strengthen mechanisms for authentic partnership with communities

Washington's System of Care must start with the foundational belief that community members are partners, not beneficiaries. This requires building intentional partnerships across all the communities in the state—seeking out voices and perspectives beyond the familiar to ensure a broad range of experiences and identities influence how the system operates. This also includes compensating community members for the time and expertise they contribute, and providing training and leadership development opportunities. Communication must happen in plain language and multiple formats, with technology supports that enable full participation.

System bright spot in supporting communities. The Children's Behavioral Health Statewide Family Network (CBHSFN) embeds families as ongoing advisors and co-designers of systems serving children with complex needs. It simultaneously builds families' capacity through workforce development and technical assistance, empowering them to use their lived experience in system design. The CBHSFN also serves as a platform for parents and caregivers to network and support each other, which often results in lifeline connections for hope, healing, and support.

Community-led investments to build local capacity

A statewide System of Care should direct flexible funding to communities, so they can strengthen natural supports and address upstream needs according to their own priorities, rather than limiting resources to state-administered programs and services. The state's role in providing financial resources—alongside technical assistance, training, and opportunities from cross-community learning—builds local capacity. This approach supports communities in developing their own local systems of care that reflect each community's unique strengths, priorities, and cultural context. This includes important investments in AI/AN communities through government-to-government partnership in tribal behavioral health.

Strengthen communities through vital conditions and collective action

Washington's System of Care must integrate with systems that support strengthening communities and addressing the vital conditions and social determinants of health. This requires addressing the underlying drivers of poor outcomes: social isolation and disconnection, lack of economic opportunity and wealth-building pathways, food insecurity and limited access to healthy environments, inadequate safe and affordable housing, and insufficient opportunities for civic engagement and youth development. These investments work synergistically, creating conditions where behavioral health challenges are less likely to emerge and communities have the resilience to address challenges before they become crises.

System bright spot in system collaboration and collective action. The Washington Economic Justice Alliance (WEJA) is a collaboration between experts with lived experience, community and tribal partners, and agencies to implement the 10-Year Plan to Dismantle Poverty. Its mission is to ensure every Washingtonian can meet their basic needs, fully contribute their talents, and pass well-being on to future generations.

The 10-Year Plan debuted in 2021, outlining a bold vision for the future: a Washington free of poverty and full of abundant opportunity, where everyone can thrive and experience joy, belonging and well-being. The plan contains eight strategies and 60 policy recommendations aimed at addressing the root causes of poverty and investing in the social and economic conditions all Washingtonians need to thrive. Together, Alliance partners have taken more than 270 policy, program and funding actions to implement the 10-Year Plan.

V.

Longterm Roadmap and First Initiatives

Building and maintaining a unified, responsive System of Care that puts children, youth, young adults, and those who care for them at its center requires sustained, coordinated progress toward the vision over many years, while meeting immediate needs and responding to changing circumstances. This is a 10+ year endeavor that requires strategic patience and persistence to achieve system-wide transformation.

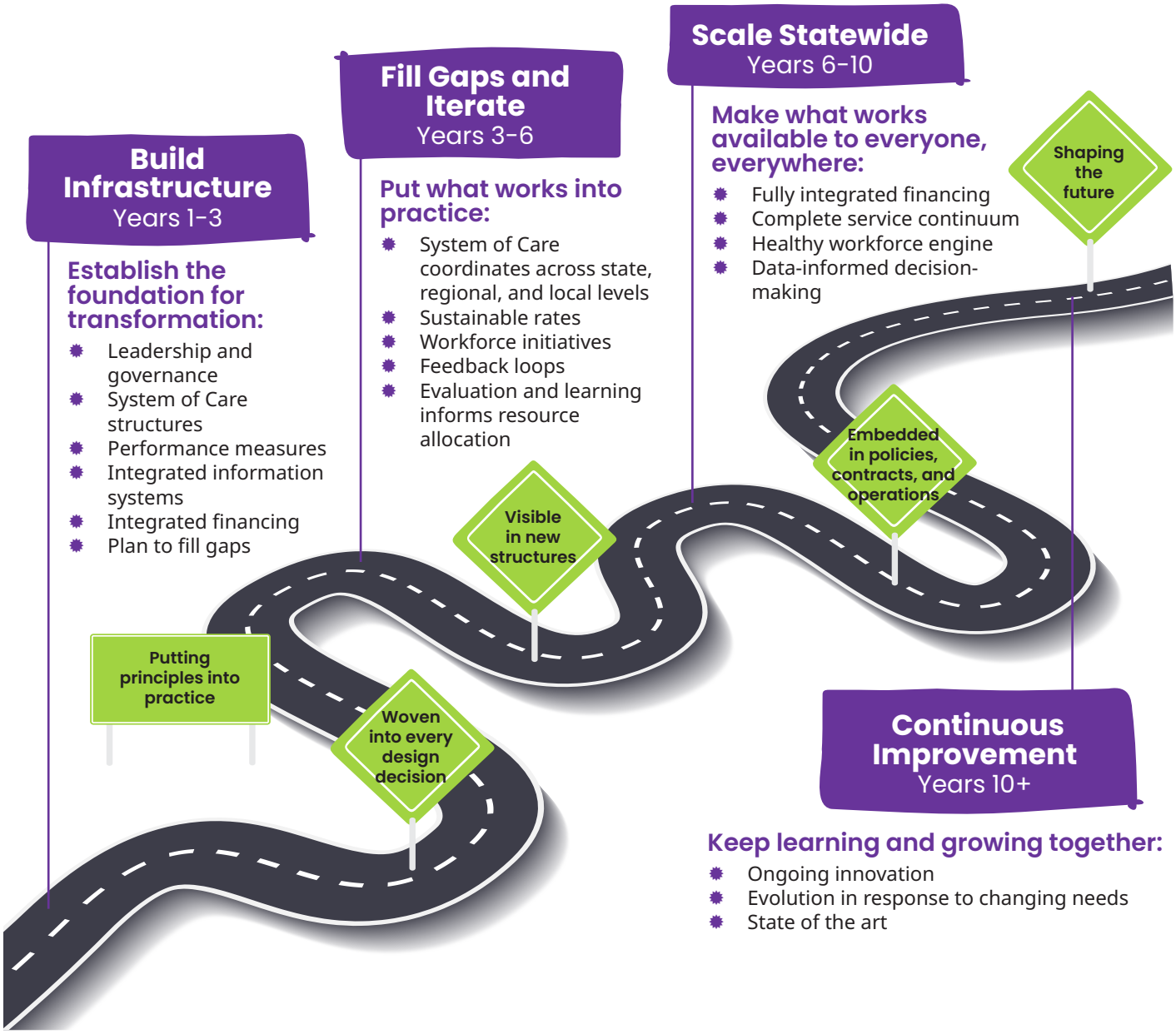
> **"There is no silver-bullet policy, program, or practice.... There is no one-size-fits -all solution. Systemic change becomes possible when we recognize the 'system' is us — people working in state and local government, non-profits, businesses, and philanthropic entities across the state all have a role to play, and implementation of the strategies and recommendations can be organized over the next ten years."**
>
> ~Excerpt from the Washington Economic Justice Alliance 10-Year Plan to Dismantle Poverty

Box 23

The many states and jurisdictions who have done this work successfully did not implement comprehensive systems all at once, and there is no single starting point. Ohio began with a leadership council, while New Jersey launched a targeted initiative. Some states started from scratch; others adapted existing systems and assets to work more cohesively. Those who made infrastructure a top priority did better overall. Establishing clear leadership from the start has proven essential. This informs Washington Thriving's Long-term Roadmap and near-term First Initiatives.

The Longterm Roadmap

Figure 11. Roadmap



Leadership for Immediate Action

The structural shifts necessary to realize the vision will take extended time and resources. To kickstart this process, the Legislature should establish Washington Thriving as a cross-agency state initiative and collaborate with the Governor's office to put leadership and governance in place to guide near-term action.

Working within the current state budget constraints, Washington Thriving leadership and staff will coordinate immediate actions across each of the "First Initiatives" described below. They will identify and advocate for legislative and budget actions needed to advance the work and work with partners who have existing capacity to contribute.

Figure 12. Model leadership and governance structure for Washington Thriving Implementation

The leadership and governance structure outlined here is only for the near term. Once a permanent leadership structure for the System of Care has been put in place, Washington Thriving as an initiative will evolve to support the priorities at that time, or dissolve.

In the near term, implementation of the Strategic Plan should be guided by:

- **Executive Coordinator.** A dedicated executive branch role with statutory authority to coordinate and align all relevant agencies and systems to begin implementing the Strategic Plan. This is a full-time job.
- **Washington Thriving Implementation Council.** A decision-making body with authority to prioritize and direct the executive leader toward implementation. This council must be small enough to make decisions, and its members must be obligated to participate actively. It should include decision-makers from each state agency that will need to take action, as well as representatives of providers, young people, and families.
- **Advisory Body.** An advisory body to observe and evaluate Washington Thriving's progress on its First Initiatives and make recommendations for improvement. The CYBHWG is an established entity that can serve this purpose, with the addition of the meaningful participation from young people, families, caregivers, providers, and community representatives that the temporary Washington Thriving Advisory Group brought to the plan's development.

Staffing. Assuming state and philanthropic funding continue, Washington Thriving will be staffed by the team that has supported the development of the Strategic Plan.

Partnerships. Washington Thriving will partner with state agencies, regional entities including BH-ASOs, community-based organizations, advocates, academic institutions, and other groups from across the state to undertake its First Initiatives.

First Initiatives

To get started, Washington Thriving has identified four First Initiatives. These consider the constraints of the current 2025-2027 state budget and will be undertaken over the next 1-3 years, with timelines dependent on available resources. In each case, there are immediate steps that can begin even without additional state funding. For these approaches to deliver the outcomes we seek, the System of Care principles must be woven into how we implement them.

Initiative 1 focuses on infrastructure and sets the necessary foundation for system transformation.

Initiative 1
System of Care Infrastructure

Initiative One will work with government leaders to design and set up **three foundational elements** of the permanent System of Care infrastructure:

Design the recommended **leadership, governance, and coordination structures** to determine who should be accountable for managing the System of Care, who does what for the system to function, and planning the transition to this new framework.

Define the **shared outcomes** that different agencies, organizations, and other cross-system actors will work toward together, identify what data is available to measure progress against these goals and make informed decisions throughout implementation, and develop plans for data integration.

Map out **current funding sources** and find **ways to integrate them**, accounting for each source's specific requirements and limitations, and focused on service use and spending for "high-opportunity" funding sources first.

Why start here: In today's constrained funding environment, this infrastructure will be critical to deploying existing resources more strategically while building the structural foundation for future growth. All the other changes envisioned in this Strategic Plan depend on this foundation. Putting this in place now will enable more informed near-term decisions and position Washington to build other elements of the System of Care quickly and effectively when additional resources become available.

The next three initiatives aim to make progress in filling notable gaps in services and supports. Among the many important areas for improvement in our current behavioral health system, these were chosen to span the phases of early life and to invest in key prevention opportunities while also addressing the acute gaps in services for young people with the most complex needs. There is strong support among legislators, agencies, and partners for action in each of these areas, and potential for private funding partnerships.

Initiative 2

Supports for Perinatal Well-Being

This initiative will collaborate with agency and community partners to advance two efforts in parallel:

1. Develop a plan to advance culturally-responsive, non-stigmatizing perinatal mental health screening and care with supported connections to appropriate services in perinatal and pediatric settings, building on the First Steps program and other current initiatives that support relational health by meeting families where they are and providing accessible, timely supports, tailored to their needs.
2. Develop a shared action plan to build family-centered SUD treatment services for pregnant and parenting people that keep families together and address the whole family unit, on the way to developing a full continuum of family-centered SUD care. This work must ensure babies are cared for and families feel safe, supported, and empowered throughout their treatment journey.

This work will be guided by insights from front-line providers and people with lived experience and undertaken in partnership with HCA and DCYF, and other organizations including the WA State Perinatal Collaborative, WA State's Parent-Child Assistance Program, Start Early, Perinatal Support Washington, the UW PERC Center and others.

Why start here: The Maternal Mortality Review Panel identified addressing perinatal mental health and SUD as one of its six priority recommendations.

Behavioral health in the perinatal phase provides the foundation for relational health in infancy and beyond, creating cascading benefits across generations. Perinatal mood and anxiety disorders (PMADs) are diagnosed in an estimated 20% of new and expectant parents nationally, which suggests at least 16,000 diagnoses each year in Washington State.

Approximately 870 babies[lv] are born with Fetal Alcohol Spectrum Disorder (FASD) in Washington State annually, and between 600-900[lvi] are born with neonatal abstinence syndrome due to drug exposure in utero.[lvii] Of children with indicated parental substance use who enter out-of-home care, 50% do so within the first year of life.[lviii] Currently, the adult behavioral health system treats pregnant and parenting people in isolation with no infrastructure for family involvement or wraparound support (such as services to address parenting, housing, childcare, and other family needs) to help preserve family cohesion.

Nationally, **untreated perinatal mood and anxiety disorders cost $14.2 billion** annually.

Initiative 3

K-12 Student Behavioral Health

This initiative will work closely with the Office of Superintendent of Public Instruction (OSPI), ESDs, the UW SMART Center, and State and Regional School Safety Centers to clarify the important ways schools can support students' behavioral health. It will provide schools with tools and resources they can apply to support students' well-being and readiness to learn, and will lay out a pathway toward all public schools across Washington's 295 districts being able to apply those approaches. A key component of this pathway will be helping schools determine, implement, and fund their approach. This initiative will also advocate for scaling the role of Student Assistance Professionals, which are proving themselves as an impactful component of MTSS. Most importantly, this initiative will take care not to impose unfunded mandates on schools.

Why start here: Almost every child aged 5-18 in Washington State goes to school, regardless of family income, insurance status, or geographic location. 1.1 million children (nearly 70% of school-aged children)[lix] in Washington State go to public school. School is a place where young people spend most of their waking hours, where trusted relationships with adults naturally develop, and where early identification and intervention can occur within a familiar environment. Few public schools across Washington currently are equipped with the guidance and/or resources to support these students, and special education programs are not equipped to address the growing demand for behavioral health supports.

> **"We can't ask school districts to take on more unfunded mandates."**
>
> - CYBHWG Member

25.9% of Washington children aged 3-17 **experience mental, emotional, developmental, or behavioral problems.**

Among students, **15%** seriously considered suicide, **12%** made plans, and **7-9%** attempted suicide.*

*2023 Healthy Youth Survey

Initiative 4

Treatment Services Expansion

This initiative will work closely with state partners and initiatives like those engaged in HB1477 and HB1580 to lay the groundwork for establishing critical behavioral health treatment capacity with three areas of focus:

1. Expanding crisis and stabilization services for young people and families across the state.
2. Developing specialized capacity for high-need populations, including those with complex needs or those transitioning from state systems (foster care, justice and carceral systems, facilities-based behavioral health treatment).
3. Expanding middle intensity services designed to catch more young people in distress before they are in need of higher-intensity, higher-cost services.

Washington Thriving will create the conditions for partners, including health systems, children's hospitals, university medical centers, behavioral health agencies, BH-ASOs, and Certified Community Behavioral Health Clinics (CCBHCs), to lead in building this capacity by converting existing research into actionable roadmaps, identifying and addressing critical uncertainties through feasibility studies that consider cost, and identifying policy barriers and necessary system alignments.

Why start here: It is well-documented, and echoed by the work of the Children and Youth Multisystem Care project team (HB1580), that across Washington State, young people and families can't get the behavioral health treatment services they need. While investing in prevention and early intervention, a comprehensive system must also care for those struggling or in crisis today, and those who will always need intensive support regardless of upstream efforts. Washington has a strong base of analysis, established working relationships across agencies and providers, and sustained legislative interest to build upon.

> Children with profound ASD, IDD, and other complex behavioral health conditions that require intensive, specialized care have **extremely limited access** to appropriate home- and community- based services, inpatient beds statewide or in-state therapeutic residential options.
>
> Box 24

Implementation Philosophy

These implementation principles will ensure that implementation of the Strategic Plan stays aligned with Washington Thriving's vision.

- **Center lived and living experience.** Ensure young people, families, and providers with experience of behavioral health systems and needs are true partners in implementation.
- **Adapt and learn.** Be iterative and intentional about learning, measure outcomes, and adapt based on what is working. Evaluate progress and reprioritize at regular intervals while maintaining a throughline and keeping sight of the long-term vision.
- **Function over form.** Avoid cumbersome reorganization. Incentivize collaboration.
- **Design for the margins.** Build infrastructure and policies that work for the smallest, most rural, and least-resourced communities first, ensuring that system improvements reach those historically left behind.
- **Make decisions as close to service delivery as possible.** Ensure that communities of all sizes have both voice and power in shaping the system. Design state-level coordination to support—not supplant—local capacity.

- **Focused interventions.** Resolve specific gaps and challenges while working toward broad system overhaul.
- **Fiscal and practical realism.** Acknowledge constraints and the pace of change.
- **Evidence-informed approach.** Incorporate proven models and best practices, adapted to communities' specific needs.
- **Build on success.** Build on and strengthen what Washington already has, ensuring that progress is cumulative. Don't start from scratch.
- **Reduce complexity and administrative burden.** Simplify processes and reduce administrative complexity for families, providers, and agencies.
- **Consider sustainability.** Design the system to withstand political transitions and budget pressures by building broad support and demonstrating clear results.
- **Collaborative but distinct partnership.** Importantly, the behavioral health system must operate as a collaborative but distinct partner to child welfare, juvenile justice, and carceral systems. Behavioral health services are more accessible when families trust that seeking help won't automatically trigger negative consequences. Though these systems share the goal of supporting young people and families, their mandates influence how they are perceived. Behavioral health services must be perceived as independent of these systems, while coordinating closely to prevent initial involvement, reduce current involvement, prevent recurrence, and support sustained well-being post-involvement.

Call to Action

Transforming a system is neither quick nor simple, but it is achievable. With clear direction, sustained commitment, and the flexibility to adapt as we learn, Washington can build the responsive, unified System of Care that its young people and families deserve.

The journey from vision to action begins now—not with perfection, but with the willingness to build differently, courage to take the first steps, and wisdom to learn as we go. By centering those with lived and living experience, the System of Care works with and alongside Washington's young people, caregivers, and families in unwavering commitment to collective well-being.

> **"I'm energized and hopeful. Yes there is a lot to do, and also YES we have resources, and so many capable passionate people wanting to make this happen."**
>
> - System partner involved in Washington Thriving

Annexes and Appendices

- Annex 1. Quantitative Landscape and Gap Analysis Report
- Annex 2. Qualitative Perspectives on Washington's Prenatal-25 Behavioral Health System
- Annex 3. Report on Funding, Oversight, and Administration of Washington's Prenatal through Age 25 Behavioral Health Services
- Annex 4. The Evolution of the System of Care Approach

Appendix A. Definition of behavioral health

The Washington Thriving Advisory Group developed a **clear and accessible definition of behavioral health**, informed by community. This definition reduces stigma and recognizes that good behavioral health is a positive state of well-being, and as important as physical health.

Behavioral health involves the interaction between a person's body, brain, and the people and places around them. It includes the feelings and actions that can affect one's overall well-being.

Just like a person can have a short-term or long-term illness that affects their physical body and overall well-being, the same is true for behavioral health. In the case of serious mental illness, young people may not understand their condition and experience cycles of crisis. Many things can affect someone's behavioral health including stress and trauma, developmental delays or disabilities, genetics, and challenges with substances or other ways of coping that get in the way of overall well-being.

Behavioral health challenges can:

- Impact how a person relates to and interacts with their families and communities and maintains long-term positive relationships that are vital for well-being.
- Affect a person's physical body and overall well-being in the same way that a short-term or long-term illness might.
- Stem from many things, including the stress and trauma they have experienced or are experiencing or challenges with substances or other ways of coping that get in the way of overall well-being.
- Include a broad range of symptoms and diagnoses and change or be exacerbated by lack of intervention.
- Coincide with other challenges and risks, including the impacts of communities being under-resourced, homelessness, disruption of schooling, challenges finding employment, and youth being at risk of incarceration. These other things can be both a "cause of" or "result of" behavioral health challenges.
- Lead to children, youth, and young adults struggling to navigate life, maintain positive relationships, achieve their educational goals, and adapt to change.
- Intersect with intellectual and developmental disabilities; as a person grows and develops, these challenges can show up in a variety of ways.
- Be impacted even before birth and through exposure to maternal stress or substances and/or poor social and emotional connections during the earliest months and years of life.

Appendix B. Workstreams

Washington Thriving engaged multiple streams of work to develop and deliver the Strategic Plan. This included engagement with advisory and work groups, performing and reviewing research and reports, cross-system engagement, communications, and other deliverables and Strategic Plan drafting and iteration. These various workstreams are summarized below.

Advisory and Work Groups

1. **The Washington Thriving Advisory Group** is the primary body informing the development of the Strategic Plan. The Advisory Group is made up of youth and caregivers with lived and living experience as well as professionals from various state agencies and other organizations involved in behavioral health.

   The Advisory Group meets six times per year to provide input and feedback on emerging pieces of the Strategic Plan. This group developed Washington Thriving's vision and definition of behavioral health.

   Discussion Groups: To create space for specific perspectives, three "Discussion Groups" have at various points throughout the process convened as ad hoc subcommittees of the Advisory Group: one for parents and caregivers with lived experience, one for youth and young adults with lived experience, and one for system partners and providers. These one-to-two-hour meetings are open to the public. Participants give feedback and suggestions on emerging pieces of the Strategic Plan.

2. **The Children and Youth Behavioral Health Work Group** (CYBHWG) provides recommendations to the Governor and the Legislature to improve behavioral health services and strategies for children, youth, young adults, and their families. The development of a prenatal-through-age-25 Strategic Plan was a recommendation of the CYBHWG in 2022. The CYBHWG is the body that will submit the Strategic Plan to the Legislature in November 2025.

   The CYBHWG membership is comprised of agency representatives, youth and parents/caregivers with lived and living experience, and system partners.

   CYBHWG Subgroups: CYBHWG has five established subgroups working in specific areas to focus on unique aspects or populations within the behavioral health system. These include:

   - Behavioral Health Integration (BHI)
   - Prenatal-to-Age-5 Relational Health (P5RH)
   - School-Based Behavioral Health and Suicide Prevention (SBBHSP)
   - Youth and Young Adult Continuum of Care (YYACC)
   - Workforce and Rates (W&R)

   Each of the CYBHWG subgroups provided inputs to the Strategic Plan on their particular focus areas.

3. **Ad Hoc Groups** have been convened for specific workstreams throughout the Washington Thriving process. This has included groups focused on discovery sprints, system modeling, and more. Participation in these groups depended on particular subject matter expertise and the objectives of the convenings. The findings from these workstreams, and from the work done by contractors (reports can

be found here), fed into the Advisory Group and served as inputs to the Strategic Plan. The outputs were also shared widely with the public through various channels.

Research and Reports

1. **Landscape & Gap Analysis:** qualitative and quantitative research was commissioned through state contractors to get a foundational understanding of the current state of Washington's behavioral health landscape and identify gaps
    a. **Qualitative Perspectives on Washington's Prenatal-25 Behavioral Health System**- this report was developed by contracted partners, Health Management Associates
    b. **Funding, Oversight, and Administration of Washington's Prenatal Through Age 25 Behavioral Health Services** - this report was developed by contracted partners, Health Management Associates
    c. **Washington Thriving Quantitative Landscape and Gap Analysis Report** – this report was developed by contracted partners, Mercer Government Human Services Consulting (Mercer)
    d. **Overview of Emerging State Approaches and Practices** – this report was developed by contracted partners, McKinsey & Company
2. **Discovery Sprints:** research commissioned through Bloom Works looking into four significant challenges and gaps in our behavioral health system.
    a. **Behavioral health during pregnancy**: How might the State of Washington better connect pregnant people experiencing behavioral health concerns, including use of substances, to services while pregnant?
    b. **Behavioral health in schools**: How might the State of Washington better connect middle and high school students to behavioral health (mental health and substance use) services through school?
    c. **Transition-age youth (TAY)**: How can the State of Washington improve the experience for youth and young adults with complex behavioral health needs by creating a more integrated approach that addresses service gaps and is designed with their direct input to meet their needs?
    d. **Complex hospital discharge**: How might we better support youth with complex behavioral health needs and their caregivers as they reintegrate into their communities after a hospital discharge?
3. **Data Collection**
    * **5-Part Survey Series** – This series of surveys was designed to provide anyone in Washington a forum to provide their feedback to the developing Washington Thriving Strategic Plan. Participants were able to provide input on:
        i. Strategic Plan high level goals and framing
        ii. Requirements for strengthening system infrastructure, connected to the requirements in Section IV
        iii. Requirements for expanding comprehensive offerings, connected to Section IV
        iv. Requirements for embedding core values into practice, connected to Section IV
        v. Additional comments not covered in previous surveys, remaining questions and feedback

The majority of survey respondents who opted to report their identity demographics were largely white women and over the age of 25. There were a very small number (both absolute and proportional) of responses from tribal community members and rural residents.

Respondents' behavioral health connections included:

- Current or former behavioral health service recipients
- Family members or caregivers of someone receiving behavioral health services
- Physical healthcare professionals or service providers
- K-12 educators, Special Educators, or other school system employees
- Other children- or youth- serving system professionals or service providers
- Community based organization workforce members

b. Lived/Living experience stories – A brief questionnaire was sent to the CYBHWG and the Washington Thriving Advisory Group, along with other engaged persons from throughout the process to provide an opportunity for them to share their lived/living experience stories to be included within the Strategic Plan.

c. Listening sessions – In partnership with Health Management Associates and the Full Frame Initiative, Washington Thriving hosted 9 community listening sessions from August to October 2024 designed to understand the needs of young people and their families and caregivers to improve their behavioral health.

d. Discussion Groups –Through the Discussion Group sessions (detailed under the above Advisory Group and Workgroup Section) hosted throughout the process, the project team was able to hear unique experiences from different perspectives within the system to further understand the needs to address within a future behavioral health system.

4. **Literature Review** – The project team performed literature reviews throughout the development of the Strategic Plan to understand best practices across other states, and inform the process to achieving a System of Care for Washington's behavioral health system

Cross System Engagement

1. **System Modeling:** In partnership with Systems Dynamics expert Chris Soderquist, Washington Thriving facilitated a multi-session process for system partners from different agencies to think through and begin to develop a system map to support shared understanding of the dynamics of Washington's prenatal-through-age-25 behavioral health system. The objective of this work was to promote system level thinking across different groups involved with behavioral health, to create conversation and collaboration opportunities that further connect actors working across the system, and to begin development of a tool that has the potential to be used in the future to weight the trade-offs of different investment decisions as Washington Thriving moves into implementation. More information about the effort can be found here.
2. **Expert consultation:** Throughout the process, the project team has consulted with various experts across other states and at national policy centers to learn more about experiences, as well as emerging and best practices in transforming behavioral health systems to better serve children, young people, and their families.

Strategic Plan Materials Consolidation and Deliverables

The Washington Thriving project team – under the direction of the Advisory Group co-chairs – compiled the findings and insights across the various workstreams and iteratively shared progress on draft frameworks and deliverables throughout the process. Feedback over the duration of the planning process refined the final presentation of materials to final state.

Communications

The Washington Thriving project team leveraged tools for regular communication to share information about the Washington Thriving planning process, including key workstreams, frameworks, and to provide transparency on feedback and iteration cycles. This work was done through **newsletters, a blog,** and other content shared on the Washington Thriving **website**.

Appendix C. Contributors

The following individuals have served as either Children and Youth Behavioral Health Work Group or Washington Thriving Advisory Group members from 2023 to present and have contributed to the development and submission of the Washington Thriving Strategic Plan.

Name	Organization or Role	Group Affiliation
Amber Leaders	Office of the Governor	CYBHWG & Advisory Group
Alexie Orr	Parent/Caregiver	Advisory Group
Alyssa Cruz	Parent/Caregiver	Advisory Group
Amanda Shi	Youth/Young Adult	Advisory Group
Amy Fumetti	Parent/Caregiver	Advisory Group
Andrew Hudson	Parent/Caregiver	Advisory Group
Andrew Joseph, Jr.	Confederated Tribes of the Colville Reservation	CYBHWG
Angela Cruze	Parent representative	CYBHWG
Anna Marie Dufault	Office of Superintendent of Public Instruction	CYBHWG
Annie Gabriel	Healthcare provider	CYBHWG
April Palmanteer	Parent/Caregiver	Advisory Group
Avreayl Jacobson	King County Behavioral Health and Recovery	CYBHWG
Barb Jones	Office of Insurance Commissioner	CYBHWG
Brandi Kingston	Parent/Caregiver	Advisory Group
Bree Karger	Youth/Young Adult	Advisory Group
Brendan Smith	Parent/Caregiver	Advisory Group
Bridget Lecheile	Washington Association for Infant Mental Health	CYBHWG
Bridget Underdahl	Office of the Superintendent of Public Instruction	Advisory Group
Brittany Miles	Parent/Caregiver	Advisory Group
Byron Eagle	DSHS	Advisory Group
Cacey Hanauer-Sutton	Commerce Department of Homeless Youth	CYBHWG
Carolyn Cox	Advocate	Advisory Group
Casi Sepulveda	Youth/Young Adult	Advisory Group
Celeste Taylor	Parent/Caregiver	Advisory Group
Chanson Toyama	Youth/Young Adult	Advisory Group
Christi Cook	Parent/Caregiver	Advisory Group
Cindy Myers	Children's Village	CYBHWG
Danna Summers	Parent/Caregiver	Advisory Group
Darren Bosman	Youth/Young Adult	Advisory Group
Delika Steele	Office of the Insurance Commissioner	CYBHWG & Advisory Group
Desi Quenzer	Youth/Young Adult	Advisory Group
Diana Cockrell	Health Care Authority	CYBHWG & Advisory Group
Dillon Hill	Youth/Young Adult	Advisory Group
Dr. Avanti Bergquist	Child and Adolescent Psychiatry	CYBHWG

Dr. Bob Hilt	Seattle Children's and University of Washington Psychiatry	CYBHWG
Dr. Eric W Trupin	University of Washington	CYBHWG
Dr. Keri Waterland	Health Care Authority	CYBHWG & Advisory Group
Dr. Larry Wissow	University of Washington/Seattle Children's	CYBHWG
Dr. Thatcher Felt	Yakima Valley Farm Worker's Clinic	CYBHWG
El Dolane	Youth/Young Adult	Advisory Group
Elizabeth De La Luz	Parent	CYBHWG
Erin Wick	Educational Service District representative	CYBHWG
Eve Li	Youth/young adult representative	CYBHWG
Hannah Adira	Youth/young adult representative	CYBHWG & Advisory Group
Heather Fourstar	Parent/Caregiver member	Advisory Group
Hugh Ewart	Workforce & Rates subgroup (shared position)	Advisory Group
Jackie Yee	Educational Service District 113	CYBHWG
Jamie Elzea	Parent/Caregiver	Advisory Group
Jane Beyer	Office of the Insurance Commissioner	Advisory Group
Janice Schutz	Advocate	Advisory Group
Javiera Barria-Opitz	Youth/Young adult	CYBHWG
Jeannie Nist	School-based Behavioral Health & Suicide Prevention (shared position)	Advisory Group
Jessica Russell	Parent/Caregiver	Advisory Group
Jessica Schutz	Parent/Caregiver	Advisory Group
Jim Theofelis	Northstar Advocates	CYBHWG
Joel Ryan	Washington State Association of Head Start and Early Childhood Education and Assistance	CYBHWG
Jordyn Howard	Youth/Young Adult	Advisory Group
Judy King	Washington State Department of Children Youth and Families	CYBHWG
Kacie Smarjesse	Department of Social and Health Services Developmental Disabilities Administration	CYBHWG
Kaleb Lewis	Youth/Young Adult	Advisory Group
Kaneesha Roarke	Provider	Advisory Group
Karen Kelly	Parent/Caregiver	Advisory Group
Katherine Seibel	School-based Behavioral Health & Suicide Prevention (shared position)	Advisory Group
Kelli Bohanon	Akin	CYBHWG & Advisory Group
Kelly Duong	Youth/Young Adult	Advisory Group
Kelly Sweeney-Widman	Parent/Caregiver	Advisory Group
Kim Justice	Department of Commerce Office of Homeless Youth	CYBHWG & Advisory Group
Krista Perleberg	Parent/Caregiver	Advisory Group
Kristin Houser	Parent representative	CYBHWG & Advisory Group
Kristin Wiggins	Prenatal-5 subgroup (shared position)	Advisory Group
Lamara Shakur	Parent/Caregiver	Advisory Group

Laurie Lippold	Advocate for children and youth behavioral health issues	CYBHWG & Advisory Group
Lee Collyer	Office of the Superintendent of Public Instruction	CYBHWG
Libby Hein	Molina Healthcare	CYBHWG
Lillian Williamson	Youth/Young adult	CYBHWG & Advisory Group
Liz Perez	Parent/Caregiver	Advisory Group
Marcella Taylor	Parent/Caregiver	Advisory Group
Marta Bordeaux	Parent/Caregiver	Advisory Group
Mary McGauhey	Foster parent	CYBHWG
Mary Stone-Smith	Catholic Community Services of Western Washington	CYBHWG
Matt Davis	Department of Commerce (alternate)	Advisory Group
Maureen Sorenson	Coordinated Care	CYBHWG
Mayauna Renae Jones	Youth/young adult	CYBHWG
Melia Hughes	Parent/Caregiver	Advisory Group
Melissa Brooks	Parent/Caregiver	Advisory Group
Michele Roberts	Department of Health	CYBHWG & Advisory Group
Michelle Karnath	Family Youth and System Partner Round Table (FYSPRT) Tri-lead	CYBHWG & Advisory Group
Michelle Roberts	Department of Health	CYBHWG
Natalie Gustafson	Provider	Advisory Group
Nicole Latson	Parent/Caregiver	Advisory Group
Niki Lovitt	Parent/Caregiver	Advisory Group
Noah Seidel	Developmental Disabilities Ombuds	CYBHWG
Nucha Isarowong	Provider	Advisory Group
Oscar Villagomez	Youth/Young Adult	Advisory Group
Patricia Leckenby	Provider	Advisory Group
Peggy Dolane	Parent/Caregiver	Advisory Group
Preet Kaur	Premera Blue Cross	CYBHWG
Representative Carolyn Eslick	Washington State House of Representatives	CYBHWG & Advisory Group
Representative Lisa Callan	Washington State House of Representatives (co-chair)	CYBHWG & Advisory Group
Representative Michelle Caldier	26th legislative district	CYBHWG
Representative My-Linh Thai	41st legislative district	CYBHWG
Richelle Madigan	Parent/Caregiver	Advisory Group
Rokea Jones	Parent/Caregiver	Advisory Group
Rosemarie Patterson	Parent/Caregiver	Advisory Group
Sage Dews	Youth/Young Adult	Advisory Group
Sarah McNew	Parent/Caregiver	Advisory Group
Sarah Rafton	Behavioral Health Integration subgroup (shared position)	Advisory Group

Senator Claire Wilson	30th legislative district	CYBHWG
Senator Judy Warnick	13th legislative district	CYBHWG
Sharon Shadwell	Parent/Caregiver	Advisory Group
Shelley Bogart	DSHS-Developmental Disabilities Administration	CYBHWG & Advisory Group
Sierra Camacho	Youth/Young Adult	Advisory Group
Sol Rabinovich	Youth/Young Adult	Advisory Group
Starleen Lewis	Parent/Caregiver	Advisory Group
Steven Grilli	Department of Children Youth and Families	Advisory Group
Summer Hammons	Tulalip Tribes	CYBHWG & Advisory Group
Taku Mineshita	Office of the Governor	CYBHWG
Teesha Kirschbaum	Health Care Authority	CYBHWG
Tessa McIlraith	Provider	Advisory Group
Tina Barnes	Parent/Caregiver	Advisory Group
Tracey Hernandez	Youth/Young Adult	Advisory Group
Tui Shelton	Parent/Caregiver	Advisory Group
Val Jones	North Sound Youth and Family Coalition	CYBHWG
Vickie Ybarra	Department of Children Youth and Families	Advisory Group
Xana Caillouet	Youth/Young Adult	Advisory Group
Xochi Wade	Provider	Advisory Group

Appendix D: What state leaders need to know

People with lived and living experience were provided an opportunity to submit their personal stories around the behavioral health system and were asked to answer the questions, *"What else do you want state leaders to know? What would you want lawmakers to understand about behavioral health in Washington for young people, caregivers, and families?"*

High level key takeaways:

- Every young person's behavioral health journey is different
- While prevention is important, not all behavioral health needs are preventable
- Gaps in the service continuum leave many young people and families in hospitals waiting for the right level of supports and care
- Funding should continue to go to the parts of the system that are working
- People need to be cared for holistically, mental, behavioral, and physical care should not be separate
- The burden of navigating, accessing, and affording behavioral health support and services should not fall on families and young people to figure out – there system should include professionals who can listen to families, provide support, advocate with/for them, and navigate the system
- The existence of consistent and reliable support systems, including peer support, for young people in their communities is important to improving their behavioral health and building resilience
- Laws need to be aligned with System of Care principles and values

Direct written contributions:

"It's a myth that everyone can recover with outpatient services in the community if they are offered "preventatively." Some people will always develop psychosis and need intensive, high-quality inpatient services from the beginning to offer them a chance for lifelong management of symptoms. Many will immediately experience the common neurological symptom of anosognosia, which blocks self-awareness of illness. Involuntary treatment is often the only choice to save their lives and establish a route to recovery. Thus, early intervention services that are involuntary must be planned for as part of the state's continuum of care, including both inpatient and assisted outpatient treatment (AOT) options. These intensive services restore autonomy by giving a person a chance to reclaim their grasp on reality. My son's autonomy was taken from him by psychosis, while the state pretended to "protect" that already absent autonomy by allowing his psychosis to rule his behaviors until those behaviors killed him. This is not a protection of rights--it's neglect."

"We need more resources in all areas! In my son's case, he fell in a gap in services. Once community-based services was not enough, there was nowhere to go but the hospital and wait- for something that seemed to far out of reach."

"If I could sum everything up: there needs to be rapid and widespread change in how mental health is assessed and treated. There needs to be a holistic look at each person. The psych providers need to stop separating mental health from physical health. Part of a mental/behavioral crisis assessment needs to include recent *medical* history and labs to assess inflammation, autoimmunity, and infectious status."

"I am writing to share the reality of what it costs a family to advocate for a child with complex needs, and to implore you to recognize the severe systemic failures that put this burden on parents. I was in a privileged position—a stay-at-home parent with the time and resources to dedicate myself entirely to this task—yet I still constantly felt like I was failing my daughter. The process of identifying and securing appropriate resources became a full-time job. It exacted a tremendous toll on my mental health, my marriage, and the emotional well-being of my child, who undoubtedly felt the stress I was carrying. My heart constantly broke for the families who must navigate this broken system with none of my advantages: single parents, families with two working adults, or those whose first language is not English. If I, with all my resources, felt isolated and exhausted, what chance do they have?

What my family truly needed was timely support from knowledgeable professionals who would see my daughter for the amazing person she is, not dismiss her needs. We needed an expert to say, 'She is not fine, and here is how we can help.' Instead, the only people who agreed with me came at a significant financial cost to my family. The most egregious failure occurred when we brought these privately retained, degreed professionals into the public school setting—the system I believed was our right to support. Their expert opinions were aggressively dismissed, and my family was treated with hostility. This alienation was so severe that these professionals were forced to withdraw from the process entirely because they did not wish to be treated poorly. Our community was a lifeline, but no parent should have to rely on informal networks to survive a process that is supposed to be supportive and legally mandated. Our state must commit to creating a system where:

- Support is proactive and timely, not adversarial.
- Families are respected and empowered, not dismissed and alienated.
- Professionals are knowledgeable, accessible, and centered on the child's true needs.

The current process punishes the parents who fight the hardest and, tragically, ensures that the most vulnerable families are left behind. This must change."

"I want state leaders to know that behavioral health struggles don't happen in a vacuum. When I was a teenager, I was dealing with substance use, mental health issues, and constant crises, and the difference between falling apart and finding my footing was having people around me who actually cared through sports, youth groups, or mentors etc. Too many young people don't have that, and too often, we spend more time preparing for their failure than actually building supports to help them succeed."

"Lawmakers need to understand that early support and natural connections, family, community programs, safe spaces, can literally change the trajectory of a young person's life. It's not just about intervening after a crisis it's about creating consistent, reliable support systems that give kids a sense of belonging, guidance, and hope. When young people feel seen and valued, they're more likely to make positive choices and build real resilience."

"I want to emphasize the importance of peer support. Therapy didn't work for me. Traditional therapy isn't working for young people. We have a lot of overlapping components. And a mass integration space that needs to be reformed. I think are very important to help give diagnoses, but they are part of a revolving space for each individual. I think what's really important, we recognize that every young persons Journey is going to be different. Not every young person is going to open up in the first 1 to 5 sessions. Diagnoses are really important in our recovery journey. But we have to remember there's building blocks to get to a recovery journey."

"Lawmakers need to understand that lived experiences often don't match the goal or desired outcome for a law and when barriers are identified, they must move quicker to support families. Lawmakers need to understand the value of the System of Care principles and values because when laws are designed that don't support those principles and values, families are destroyed. Prevention needs to be a focus, rather than being reactive. Families can tell you what will work for them, please listen."

"Please fund things BEFORE a lawsuit and then continue funding what is working; WISe/Wraparound, FYSPRTs, Family Peer Support programs"

"People are often distressed and overwhelmed when their child (ren) are in pain, suicidal, acting out, behaving erratically and hurting themselves and others. There is a great deal of shame involved, and feelings of failure. Hiring and providing monies for CHW's or case managers can make a world of difference for families to have an advocate, someone to listen to them, help them navigate a system(s), and provide support. It truly is life changing. I see it daily!"

Appendix E: State and regional structures in Washington related to prenatal through age 25

Many state and regional agencies are a part of Washington's behavioral health system for pregnant people, expecting parents, children, youth, and young adults.

At the state level

- **Health Care Authority (HCA)** runs Medicaid and the Children's Health Insurance Program (CHIP), which are called Apple Health in Washington. HCA also manages contracts with five health insurance companies (MCOs) that pay for services under Apple Health, and has a division focused specifically on behavioral health for the P-25 population. It also houses the Office for Community Voices and Empowerment (OCVE).
- **Department of Social and Health Services (DSHS)** provides specialized services for youth with developmental disabilities and runs the Child Study and Treatment Center psychiatric hospital for children and youth
- **Department of Children, Youth, and Families (DCYF)** oversees early learning, juvenile rehabilitation, and child welfare programs.
- **Department of Health (DoH)** licenses behavioral health professionals and facilities, runs public health campaigns, and manages the School-Based Health Center program.
- **Office of Superintendent of Public Instruction (OSPI)**
- **Office of the Insurance Commissioner (OIC)**
- **Department of Commerce's Office of Homeless Youth (OHY).**

At the regional level

- Behavioral Health Administrative Service Organizations (BH-ASOs) manage state funding for behavioral health crisis services and care for people without insurance.
- Counties also run and fund local behavioral health programs.

The key state and regional actors serving our community include the list below. Each of these agencies follow different regulations and each is judged on its own performance, not on how well the whole system works together:

Appendix F. Related Efforts and System Assets

Understanding the efforts in Washington that are related to the prenatal-through-age-25 behavioral health system and other system assets in this space was critical to informing the Current State section of the Strategic Plan.

The list below **is not an exhaustive list** of all the related efforts and system assets that the Washington Thriving project team are aware of, but instead it serves to **demonstrate the variety and types of programs, knowledge, and information** that informed this process. While the effort continues into implementation, the inventory of related efforts and system assets will continue to grow to further understand and improve the system.

State agencies administering aspects of behavioral health system for young people, caregivers, and families & associated agency and department level strategic plans	• Health Care Authority (HCA) • Department of Children, Youth, and Families (DCYF) • Department of Social and Health Services (DSHS) • Department of Health (DoH) • Office of the Superintendent of Public Instruction (OSPI) • Office of the Insurance Commissioner (OIC) • Department of Commerce's Office of Homeless Youth (OHY)
Regional entities administering aspects of behavioral health system for young people, caregivers, and families	• Behavioral Health – Administrative Service Organizations (BH-ASOs) – 10 • Counties – 39 • Educational Service Districts (ESDs) – 9 • School districts - 295
Linkages to clinical/health systems & providers	• Pediatrics, general practitioners, family medicine • Behavioral health specialists – mental health, SUD • Paraprofessionals & peer specialists • Clinics, hospitals and hospital systems, facilities • Children's hospitals & departments • Consulting lines • Provider agencies • Federally Qualified Health Centers (FQHCs) – 29 • Patient-Centered Medical Homes (PCMHs) • SEIU Healthcare 1199NW – union of health workers • Washington's OneHealthPort Health Information Exchange, Clinical Data Repository, and Statewide Provider Directory
Family, social, human services systems & adjacent services	• Housing services • Child welfare & foster/kinship care systems • Early childhood services • Juvenile rehabilitation services • 211 services
Health insurance coverage systems	• Medicaid (Apple Health) • Managed Care Organizations (MCOs) – 5 • Private insurers

State committees, commissions, alliances, coalitions, networks, taskforces, workgroups, advisory groups, boards, and other related cohorts and bodies	• Joint Legislative and Executive Committee on Behavioral Health (JLEC-BH) • Crisis Response Improvement Strategy (CRIS) committees (HB1477) • Children and Youth Multisystem Care Project (HB1580) • State Commission on African American Affairs (CAAA) • State Commission on Asian American Pacific American Affairs (CAPAA) • State Commission on Hispanic Affairs (CHA) • State Women's Commission • State LGBT commission • Education Opportunity Gap Oversight and Accountability Committee • State Office of Equity • Governor's Office of Indian Affairs (GOIA) • Family Youth System Parter Roundtables (FYSPRTs) – 1 state & 10 regional • Accountable Communities of Health - 9 • Washington Communities for Children (WCFC) – 10 • Washington State Behavioral Health Advisory Council • Washington State Developmental Disabilities Council (DDC) • Washington State Health Care Cost Transparency Board (HCCT Board) • Washington State Liquor and Cannabis Board • Washington State Workforce Training & Education Board • Washington Student Achievement Council • SURSAC – Substance Use Recovery Services Advisory Committee • Washington Economic Justice Alliance (WEJA)
Related state-involved initiatives & strategies, services & supports	**Prevention** • Community Prevention and Wellness Initiative (CPWI) • Plan of Safe Care (DCYF) • Washington State Suicide Prevention Plan • It's About Respect: Sexual Violence Prevention block grant **Intensive & Inpatient Services** • Wraparound with Intensive Services (WISe) • Child's Long Term Inpatient Program (CLIP) • New Journeys • Evaluation and Treatment/Community Hospitalization (E&T) • Intensive Behavioral Health Treatment Facilities (IBHTF) **Child welfare** • Extended Foster Care Program • Independent Living Program **SUD** • Interagency Recovery Campus (King County) • Washington State Substance Use Disorder Prevention and Mental Health Promotion Five-Year Strategic Plan (2023-2027) • Secure Withdrawal Management & Stabilization Services (SWMS) **Early Childhood** • Infant and Early Childhood Mental Health Consultation (ICEMH-C)

- Early Childhood Education and Assistance Program (ECEAP) and Early ECEAP, Head Start
- Early Childhood Intervention Prevention Services (ECLIPSE)
- Mental Health Assessment for Young Children (MHAYC)

Young adults/TAY

- Statewide Youth Network (Youth Network)
- Healthy Transitions Project
- UW CoLab Youth Wellness Zones & Well-Being Approach to Care

Families

- Children's Behavioral Statewide Family Network (CBHSFN)
- Nurse-Family Partnership (NFP)
- Help Me Grow
- The Center of Parent Excellence (COPE) Project
- UW Parent-Child Assistance Program

Career

- Guided Pathways
- Start Your Path
- Career Connect Washington

Navigation / referral

- BH Navigation (previously BH360)
- Washington's Mental Health Referral Service for Children and Teens
- Washington State's Mental Health Referral Service for Children and Teens

School

- Project AWARE
- Muti-Tiered Support Systems (MTSS)

Community

- DOH Community Collaborative Network
- Mobile Response Stabilization Services (MRSS)
- Youth-Centered Environmental Shift Program (YES!)
- Clubhouse and peer-run programs
- Kids Mental Health Washington regional teams

Crisis

- 988 Crisis Line
- Mobile Rapid Response Crisis Team (MRRCT)
- HearMeWA
- Designated Crisis Responders (DCRs)
- 1580 Rapid Care Team

Maternal / pre/perinatal

- Maternal Mortality Review Panel
- Washington State Perinatal Collaborative
- Perinatal Support WA
- Centers of Excellence (COE) for Perinatal Substance Use

Housing

- Youth and Young Adult Housing Resource Team (YYAHRT) (HB1905)

	Equity • Blueprint for a Just & Equitable Future: the 10-Year Plan to Dismantle Poverty in WA (WEJA) • Birth Equity project **Behavioral Health Integration** • Pediatric Mental Health Care Access Initiative (PMHCA) • Community Health Workers in integrated Pediatric Care settings • Washington Partnership Access Line
Regional and local government initiatives, strategies, services, and supports	• County health boards, behavioral health offices, public health offices • Various local networks and efforts
Professional associations, committees, federations, coalitions, networks, workgroups, advisory groups, boards, and other related cohorts and bodies	• Washington Chapter of the American Academy of Pediatrics • Association of Washington Healthcare Plans • Association of Educational Service Districts (AESD) • WA State School Directors Association (WSSDA) • WA Association of School Administrators (WASA) • Association of Washington School Principals (AWSP) • Workforce Training & Education Coordinating Board • Tribal-Centric Behavioral Health Advisory Board • Washington Association of Addiction Professions • Washington Association of Counties • Washington Association of Community Health • Washington Association of Drug Courts • Washington Association of School Administrators (WASA) • Washington's Health Workforce Council & Sentinel Network initiative • Washington Chapter of American Academy of Pediatrics • Washington Mental Health Counselors Association • Washington State Association of Drug Court Professionals • Washington State Board of Community and Technical Colleges • Washington State Hospital Association • Washington State Medical Association • Washington State Nurses Association • Washington State Parent Teacher Association • Washington State School Directors Association (WSSDA) • Washington Association of Child and Adolescent Psychiatrists
Professional advocacy groups & coalitions	• Child Care Aware of Washington (CCA) • Children's Alliance • Washington Council for Behavioral Health • Washington Recovery Alliance • Washington State Community Action Partnership • Washington Communities for Children (WCFC) -10 • The ARC of Washington & Disability Rights Washington

Workforce development systems, higher education, and technical colleges	• American Indian Health Commission (AIHC) • Association of Educational Service Districts (AESD) • Association of Washington School Principles (AWSP) • Washington State Behavioral Health Workforce Development Initiative (WDI) • Washington Health Corps' loan repayment program • SEIU 1199 Training Fund "earn while you learn" • Health Care Apprenticeship Consortium • Career and Technical education infrastructure
Tribal organizations and governments	• 29 federally recognized tribal sovereigns in Washington State • Government-to-government coordinating mechanisms within Washington state government
Data and evaluators, state run dashboards, data projects	• RDA state-run dashboards • DOH Community Protective Factors Measurement Project
Recently published legislative and public-facing reports	• UW School Mental Health Assessment, Research, and Training (SMART) Center Landscape Analysis of Universal Social, Emotional, Behavioral and Mental Health (SEBMH) Screening in Washington State Schools and Districts • People Powered Workforce Initiative 2025 report • Digital Technologies to Support Youth and Young Adults in Behavioral Health – Report to Legislature from HCA • Enhancing Services for People with Co-Occurring Intellectual and Developmental Disabilities and Mental and/or Behavioral Health Supports in Washington by National Leadership Consortium on Developmental Disabilities and Washington State Developmental Disabilities Council • 2022 Behavioral Health Workforce Assessment: A report of the Behavioral Health Workforce Advisory Committee & Washington Workforce Training & Education Coordinating Board 2024 Annual Reports • Children's Alliance 2025 Kids Count Data book – State trends in child well-being • Healthy Youth Survey – 2023 • Children's Alliance Building the Mental Health System our Teens Need and Deserve Now • Washington's Statewide Early Learning Needs Assessment - DCYF 2020 • Transforming Washington's Children and Youth System of Care: Report on System Changes and Innovations to Legislature (HB1580) • State of Washington Homeless Housing Strategic Plan 2024-2029 • Washington State Maternal Mortality Review Panel Feb 2023 Report to Legislation • Washington State Early Learning Coordination Plan 2022

Appendix G. System of Care Definition

The excerpts below from the University of Maryland's School of Social Work's Institute for Innovation & Implementation's The Evolution of the System of Care Approach provide the academic definition of the System of Care, and provide a list of the types of services and supports that make up a comprehensive array.

"A system of care is a comprehensive spectrum of effective services and supports for children, youth, and young adults with or at risk for mental health or other challenges and their families that is organized into a coordinated network of care, builds meaningful partnerships with families and youth, and is culturally and linguistically responsive in order to help them to thrive at home, in school, in the community, and throughout life. A system of care incorporates behavioral health promotion, prevention, early identification, and early intervention in addition to treatment to *address the needs of all children, youth, and young adults".*

See next page for the **Array of Services and Supports** from The Evolution of the System of Care Approach.

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

Appendix H. Key Functions of Washington's System of Care

The following functions need responsible and accountable parties within the System of Care.

- **Governance and accountability:** sets direction, coordinates resources, connects systems, creates consistent standards, and advocates for Washington's young people and families
- **Administrative and operational support:** Cross-system coordination that eliminates duplicate processes
- **Regional and local implementation:** Connecting state direction and support to adaptive local delivery
- **System integration and interoperability:** Breaking down data and service silos
- **Technical assistance and support:** Ensuring consistent quality across regions and cross-cutting workforce supports
- **Shared learning and continuous improvement:** Systematic knowledge sharing, centers of excellence, implementation science, and other structures
- **Financial administration:** Unifying funding streams and aligning incentives
- **Advocacy:** Functions to ensure youth and families' priorities drive the policy and system changes
- **Independent service providers for key coordination functions:** Peer and family support organizations, care management and sequencing entities, and mechanisms for population-facing information and navigation supports

This list is illustrative, not comprehensive. The details of how Washington State should organize around these functions will be part of the first initiatives work for the next 12-24 months. The design will build from existing successful structures and past efforts in Washington, leverage best practices from other states, use lessons learned during the Washington Thriving planning process, and align with System of Care principles.

Appendix I: Measuring what matters

Throughout this journey, success is measured not by activities completed but by **lives improved**. The measurement framework captures four critical areas of system performance, each providing insight into different aspects of the transformation.

The system should measure the most important things **without adding to the administrative burden** that is already slowing down the system.

> **1: Access and equity measures** track whether services are truly available to all children who need them, no matter where they live or what their family situation is. These show if the system **is reducing disparities** between different communities, **inadvertently worsening disparities,** and **ensuring the system transformation benefits everyone**.
>
> **2: Service quality measures** examine whether the care provided meets professional standards and satisfies the families receiving it. These measures assess **whether providers are following proven methods** correctly, **whether services feel culturally appropriate** to families, and **both clinical effectiveness and family experience.**
>
> **3: System performance measures** evaluate how well the various parts work together. These measures track **coordination effectiveness**, **workforce stability, and effective resource use.**
>
> **4: Outcome measures** focus on the ultimate purpose of the entire effort: **improving the lives of children and families**. These measures track **functional improvements, emotional success, community engagement, and reduction of costly, restrictive interventions.**

Measurement should not be arbitrary, but should drive system improvement through:

> **1: Regular Review and Adaptation –** including predictable and reliable cadence of review of key measures with families, providers, and system leaders, annual comprehensive assessment of progress towards goals, and continuous refinement of measure based on what is learned.
>
> **2: Community Involvement –** including family and youth voice in deciding what gets measured and how, provider input on measures that help improve care delivery, and community feedback on whether measures reflect local priorities and values.
>
> **3: Action-Oriented Data Use** – including rapid cycle improvement when measures show problems, resource reallocation when data shows gaps or opportunities, and policy changes when measures reveal systemic barriers.

Appendix J. References

This plan relies primarily on Washington State data sources where available and credible; in cases where state-level data is unavailable or insufficient, we have drawn upon national data to support our analysis. The plan also places high importance on the qualitative insights of those with lived and living experience in the behavioral health system and needing behavioral health supports, balancing these perspectives with available quantitative insight.

[i] Mercer. (2025, June 27). *Washington thriving quantitative landscape and gap analysis report.* Washington State Health Care Authority. https://www.hca.wa.gov/assets/program/quantitative-landscape-and-gap-analysis-report.pdf

[ii] Reinert, M., Fritze, D., & Nguyen, T. (2024, July). *State of mental health in America: 2024 edition* [Report]. Mental Health America. https://mhanational.org/wp-content/uploads/2024/12/2024-State-of-Mental-Health-in-America-Report.pdf

[iii] Washington's Health Workforce Sentinel Network. (2024). *Washington's Health Workforce Sentinel Network findings brief: Behavioral/mental health, substance use disorder (SUD) clinics and related facilities*. https://wa.sentinelnetwork.org/wp-content/uploads/sites/2/2024/06/WASentinelNet_BehavioralHealth_Brief_2024Spring.pdf

[iv] Substance Abuse and Mental Health Services Administration. (2023, April 24). *Mental health: Get the facts*. https://www.samhsa.gov/mental-health/what-is-mental-health/facts

[v] Washington's Health Workforce Sentinel Network. (2024). *Washington's Health Workforce Sentinel Network findings brief: Behavioral/mental health, substance use disorder (SUD) clinics and related facilities*. https://wa.sentinelnetwork.org/wp-content/uploads/sites/2/2024/06/WASentinelNet_BehavioralHealth_Brief_2024Spring.pdf

[vi] McGorry, P. D., & Mei, C. (2018). Early intervention in youth mental health: progress and future directions. *Evidence-based mental health*, *21*(4), 182–184. https://doi.org/10.1136/ebmental-2018-300060

[vii] Arjun, L., Beers, M., & Ewart, H. (n.d.). *Funding, oversight, and administration of Washington's prenatal through age 25 behavioral health services.* https://www.hca.wa.gov/assets/program/prenatal-25-behavioral-health-funding-oversight-administration.pdf

[viii] Arjun, L., Beers, M., & Ewart, H. (n.d.). *Funding, oversight, and administration of Washington's prenatal through age 25 behavioral health services.* https://www.hca.wa.gov/assets/program/prenatal-25-behavioral-health-funding-oversight-administration.pdf

[Ix] Personal communication, Office of the Insurance Commissioner, September 2025.

[x] Arjun, L., Beers, M., & Ewart, H. (n.d.). *Funding, oversight, and administration of Washington's prenatal through age 25 behavioral health services.* https://www.hca.wa.gov/assets/program/prenatal-25-behavioral-health-funding-oversight-administration.pdf

[xi] Fabian, K., Rodriguez, F. I., Miller, K., Usrey, M., & Cole, C. (2023, January). *Behavioral health agencies serving infants, toddlers, and preschoolers in Washington State: Results from the 2022 Behavioral Health Provider Survey*. https://www.hca.wa.gov/assets/program/behavioral-health-agencies-serving-infants-toddlers-and-preschoolers-in-washington-state-2022.pdf

[xii] Mercer. (2025, June 27). *Washington thriving quantitative landscape and gap analysis report.* Washington State Health Care Authority. https://www.hca.wa.gov/assets/program/quantitative-landscape-and-gap-analysis-report.pdf

[xiii] Varela, V., Danielson, T., & Felver, B. (2025, August). *Homelessness among youth exiting systems of care in Washington State*. https://www.dshs.wa.gov/sites/default/files/rda/reports/research-11-254.pdf?ref=cascadepbs.org

[xiv] Centers for Disease Control and Prevention. (2025, July 15). *FASTSTATS - Adolescent Health*. https://www.cdc.gov/nchs/fastats/adolescent-health.htm

[xv] Reinert, M., Fritze, D., & Nguyen, T. (2024, July). *State of mental health in America: 2024 edition* [Report]. Mental Health America. https://mhanational.org/wp-content/uploads/2024/12/2024-State-of-Mental-Health-in-America-Report.pdf

[xvi] Mercer. (2025, June 27). *Washington thriving quantitative landscape and gap analysis report.* Washington State Health Care Authority. https://www.hca.wa.gov/assets/program/quantitative-landscape-and-gap-analysis-report.pdf

[xvii] Washington State Health Care Authority. (2023, December 1). *Access to behavioral health services for children, youth, and young adults* [Legislative report].https://www.hca.wa.gov/assets/program/access-bh-svcs-children-leg-report-20240206.pdf

[xviii] Bloom Works, LLC. (2024, August 13). *Washington state behavioral health during pregnancy discovery sprint: Research and recommendations*. https://www.hca.wa.gov/assets/program/wa-bh-pregnancy-report-20240813.pdf

[xix] Mercer. (2025, June 27). *Washington thriving quantitative landscape and gap analysis report.* Washington State Health Care Authority. https://www.hca.wa.gov/assets/program/quantitative-landscape-and-gap-analysis-report.pdf

[xx] Hong, G., Campbell, K., Glenn, S., Lucenko, B., Hughes, R., & Felver, B. E. M. (2019, February). *First episode psychosis.* https://www.dshs.wa.gov/sites/default/files/rda/reports/research-3.50.pdf

[xxi] Miller, C. (2023, August 25). *Early treatment for schizophrenia improves outcomes*. Child Mind Institute. https://childmind.org/article/first-episode-psychosis-early-treatment-critical/

[xxii] Mercer. (2025, June 27). *Washington thriving quantitative landscape and gap analysis report.* Washington State Health Care Authority. https://www.hca.wa.gov/assets/program/quantitative-landscape-and-gap-analysis-report.pdf

[xxiii] Personal communications, Washington Thriving Advisory Group System Partners, 2024.

[xxiv] Mercer. (2025, June 27). *Washington thriving quantitative landscape and gap analysis report.* Washington State Health Care Authority. https://www.hca.wa.gov/assets/program/quantitative-landscape-and-gap-analysis-report.pdf

[xxv] KFF. (n.d.). *Population distribution of children by Race/ethnicity: KFF State Health facts*. https://www.kff.org/other/state-indicator/children-by-raceethnicity/?currentTimeframe=0&selectedRows=%7B%22states%22%3A%7B%22washington%22%3A%7B%7D%7D%7D&sortModel=%7B%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D

[xxvi] Dicentra Consulting, LLC in consultation with the Health Care Research Center at OFM Forecasting and Research Division. (2024, September; revised January 2025). *Maternal health in Washington State, 2010–2022* [Report]. Washington State Office of Financial Management. https://ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/utilization_quality/maternal_health_WA_state.pdf

[xxvii] U.S. Department of Health and Human Services Office of Minority Health. (2025, September). *Mental and behavioral health in American Indians/Alaska Natives*. U.S. Department of Health and Human Services. https://minorityhealth.hhs.gov/mental-and-behavioral-health-american-indiansalaska-natives

[xxviii] Nath, R., Matthews, D., Hobaica, S., Eden, T. M., Taylor, A. B., DeChants, J. P., & Suffredini, K. (2025). *2024 survey on the mental health of LGBTQ+ young people in Washington*. The Trevor Project. https://www.thetrevorproject.org/wp-content/uploads/2025/02/2024-50-State-Report-Washington.pdf

[xxix] Dicentra Consulting, LLC (Mercer), in consultation with the Washington State Health Care Authority, Division of Behavioral Health and Recovery. (2023, December). *Rural access study: Accessing behavioral health services in rural Washington State counties* [Legislative report]. Washington State Health Care Authority. https://www.hca.wa.gov/assets/program/rural-access-study-legislative-report-2023.pdf

[xxx] Mercer. (2025, June 27). *Washington thriving quantitative landscape and gap analysis report.* Washington State Health Care Authority. https://www.hca.wa.gov/assets/program/quantitative-landscape-and-gap-analysis-report.pdf

[xxxi] Varela, V. & Danielson, T. (2025, May). *Apple Health enrollment and behavioral health status of youth and young adults exiting juvenile rehabilitation facilities: Calendar year 2023*. Washington State Department of Social and Health Services, Research and Data Analysis Division
[xxxii] Mercer. (2025, June 27). *Washington thriving quantitative landscape and gap analysis report.* Washington State Health Care Authority. https://www.hca.wa.gov/assets/program/quantitative-landscape-and-gap-analysis-report.pdf
[xxxiii] Washington Council for Behavioral Health. (2021, October). *The state of the community behavioral health system.*
https://app.leg.wa.gov/committeeschedules/Home/Document/236559#:~:text=Workforce%20shortages%20force%20behavioral%20health,our%20agencies%20instituted%20wait%20lists
[xxxiv] Washington State Department of Children, Youth, and Families. (2020, December 19). *Washington's statewide early learning needs assessment.*
https://www.dcyf.wa.gov/sites/default/files/pdf/2020StatewideNeedsAssessment.pdf
[xxxv] National Center for Health Workforce Analysis. (2024, November). *State of the behavioral health workforce 2024*. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/state-of-the-behavioral-health-workforce-report-2024.pdf
[xxxvi] Washington State Health Care Authority. (2023, December 1). *Access to behavioral health services for children, youth, and young adults* [Legislative report]. https://www.hca.wa.gov/assets/program/access-bh-svcs-children-leg-report-20240206.pdf
[xxxvii] Reist, C., Petiwala, I., Latimer, J., Raffaelli, S. B., Chiang, M., Eisenberg, D., & Campbell, S. (2022). Collaborative mental health care: A narrative review. *Medicine*, *101*(52), e32554. https://doi.org/10.1097/MD.0000000000032554
[xxxviii] Washington State Health Care Authority. (n.d.). *Crisis response improvement strategy (CRIS) committees.* https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/crisis-response-improvement-strategy-cris-committees
[xxxix] Burley, M. (2008, October). *Washington's public mental health system: Regional needs and approaches* (Document No. 08-10-3401) [Report]. Washington State Institute for Public Policy. https://www.wsipp.wa.gov/ReportFile/1025/Wsipp_Washingtons-Public-Mental-Health-System-Regional-Needs-and-Approaches_Full-Report.pdf
[xl] Center for Health Care Strategies. (2020, September). *Washington State's transition to integrated physical and behavioral health care* [Case study]. California Health Care Foundation. https://www.chcs.org/media/WA-BH-Integration-Case-Study_091620.pdf
[xli] ZERO TO THREE. (2017). *The basics of infant and early childhood mental health: A briefing paper*. https://www.zerotothree.org/resource/the-basics-of-infant-and-early-childhood-mental-health-a-briefing-paper
[xlii] Substance Abuse and Mental Health Services Administration. (2021). *Treatment considerations for youth and young adults with serious emotional disturbances/serious mental illnesses and co-occurring substance use* (Publication No. PEP20-06-02-001). https://library.samhsa.gov/sites/default/files/pep20-06-02-001.pdf
[xliii] U.S. Department of Health and Human Services. (2025, February 19). *Social media and youth mental health*. https://www.hhs.gov/surgeongeneral/reports-and-publications/youth-mental-health/social-media/index.html
[xliv] Washington State Health Care Authority. (n.d.). *Mobile rapid response crisis team enhancements* [Fact sheet]. https://www.hca.wa.gov/assets/program/fact-sheet-mobile-rapid-response-crisis-teams.pdf
[xlv] Weiss, B., Han, S., Harris, V., Catron, T., Ngo, V. K., Caron, A., Gallop, R., & Guth, C. (2013). An independent randomized clinical trial of multisystemic therapy with non-court-referred adolescents with serious conduct problems. *Journal of Consulting and Clinical Psychology, 81*(6), 1027–1039. https://doi.org/10.1037/a0033928
[xlvi] Barlow, A., Mullany, B., Neault, N., Goklish, N., Billy, T., Hastings, R., … Walkup, J. T. (2015). Paraprofessional-Delivered Home-Visiting Intervention for American Indian Teen Mothers and Children: 3-

Year Outcomes From a Randomized Controlled Trial. American Journal of Psychiatry, 172(2), 154–162. https://doi.org/10.1176/appi.ajp.2014.14030332
[xlvii] Wyman, P. A., Cero, I. J., Espelage, D. L., Reif, T., Mintz, S., LoMurray, S., Nickodem, K., Schmeelk-Cone, K. H., & Delgado, A. (2025). RCT of sources of strength testing impact on suicide attempts and tests of moderation by sexual violence victimization and perpetration. *American Journal of Preventive Medicine*, *68*(3), 465–474. https://doi.org/10.1016/j.amepre.2024.11.008
[xlviii] Hart, L. M., Morgan, A. J., Rossetto, A., Kelly, C. M., Gregg, K., Gross, M., Johnson, C., & Jorm, A. F. (2022). Teen Mental Health First Aid: 12-month outcomes from a cluster crossover randomized controlled trial evaluation of a universal program to help adolescents better support peers with a mental health problem. *BMC Public Health*, *22*(1). https://doi.org/10.1186/s12889-022-13554-6
[xlix] Pantin, H., Prado, G., Lopez, B., Huang, S., Tapia, M. I., Schwartz, S. J., Sabillon, E., Brown, C. H., & Branchini, J. (2009). A randomized controlled trial of Familias Unidas for Hispanic adolescents with behavior problems. *Psychosomatic Medicine*, *71*(9), 987–995. https://doi.org/10.1097/psy.0b013e3181bb2913
[l] Brody, G. H., Kogan, S. M., Chen, Y., & Murry, V. M. (2008). Long-term effects of the strong African American Families Program on Youths' conduct problems. *Journal of Adolescent Health*, *43*(5), 474–481. https://doi.org/10.1016/j.jadohealth.2008.04.016
[li] Brody, G. H., Chen, Y., Kogan, S. M., Yu, T., Molgaard, V. K., DiClemente, R. J., & Wingood, G. M. (2012). Family-centered program deters substance use, conduct problems, and depressive symptoms in black adolescents. *Pediatrics*, *129*(1), 108–115. https://doi.org/10.1542/peds.2011-0623
[lii] Zivin, K., Zhong, C., Rodríguez-Putnam, A., Spring, E., Cai, Q., Miller, A., Johns, L., Kalesnikava, V. A., Courant, A., & Mezuk, B. (2024). Suicide mortality during the perinatal period. *JAMA Network Open*, *7*(6). https://doi.org/10.1001/jamanetworkopen.2024.18887
[liii] Zhang, Q., Wang, J. & Neitzel, A. School-based Mental Health Interventions Targeting Depression or Anxiety: A Meta-analysis of Rigorous Randomized Controlled Trials for School-aged Children and Adolescents. *J Youth Adolescence* **52**, 195–217 (2023). https://doi.org/10.1007/s10964-022-01684-4
[liv] Treatment Advocacy Center. (n.d.). *Washington severe mental illness resources & helpful info*. https://www.tac.org/map_directory/washington/#:~:text=Prevalence%20of%20SMI%20in%20jails,Likelihood%20of%20incarceration%20versus%20hospitalization
[lv] Washington State Fetal Alcohol Syndrome Diagnostic & Prevention Network (FASDPN). (n.d.). *30th Annual Report*. https://depts.washington.edu/fasdpn/pdfs/FASDPN-HCA-30thAnnual-Report-2024-25.pdf
[lvi] Deng, G. (2023, July 5). *Why WA is taking a new approach to caring for newborns exposed to drugs*. Washington State Standard. https://washingtonstatestandard.com/2023/07/05/why-wa-is-taking-a-new-approach-to-caring-for-newborns-exposed-to-drugs/
[lvii] Washington State Department of Health. (2024, March). *Opioid use disorder in pregnancy and postpartum*. https://waportal.org/sites/default/files/2024-07/141-106_OPPE_Opioid%20Use%20Pregnancy%20Postpartum_03132024_web.pdf
[lviii] Washington State Health Care Authority. (2025, August 12). *Children and youth behavioral health work group* [Video]. TVW. https://tvw.org/video/children-and-youth-behavioral-health-work-group-2025081011/?eventID=2025081011
[lix] Washington State Office of Financial Management. (2024, December 12). *Kindergarten through grade 12 (K-12) enrollment*. https://ofm.wa.gov/washington-data-research/statewide-data/washington-trends/budget-drivers/kindergarten-through-grade-12-k-12-enrollment
[lx] Stroul, B. A., Blau, G. M., & Larson, J. (2021). *The evolution of the system of care approach for children, youth, and young adults with mental health conditions and their families*. The Institute for Innovation and Implementation, School of Social Work, University of Maryland. https://www.cmhnetwork.org/wp-content/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf

CALL-OUT BOX REFERENCES:

Box 1:
National Alliance on Mental Illness. (2024, December 3). *Mental health conditions*. https://www.nami.org/about-mental-illness/mental-health-conditions/

Substance Abuse and Mental Health Services Administration. (2025, July). *Key substance use and mental health indicators in the United States: Results from the 2024 National Survey on Drug Use and Health*. https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf

Box 2:
Personal communication, Children's Behavioral Health Statewide Family Network, Peggy Dolane, September 2025.

Box 3:
Washington State Health Care Authority. (2024, December 1). *Behavioral health access and network adequacy for children and youth (prenatal – age 25)* [Legislative report]. https://www.hca.wa.gov/assets/program/behavioral-health-access-apple-heath-children-youth-leg-report-2024.pdf

Box 4:
Mercer. (2025, June 27). *Washington thriving quantitative landscape and gap analysis report.* Washington State Health Care Authority. https://www.hca.wa.gov/assets/program/quantitative-landscape-and-gap-analysis-report.pdf

Box 5:
Social & Economic Sciences Research Center – Washington State University. (2024, August 9). *Languages spoken at behavioral health agencies serving children and youth in Washington state: Report from the 2022-2023 Behavioral Health Provider Survey*. https://www.hca.wa.gov/assets/program/behavioral-health-youth-children-language-report-202408.pdf.
Northwest Health Law Advocates, & Washington State Coalition For Language Access. (2012, December). *Language access in Washington State.* https://nohla.org/wordpress/img/pdf/Language_Access.pdf

Box 6: National Academies of Sciences, Engineering, and Medicine. 2025. *Blueprint for a National Prevention Infrastructure for Mental, Emotional, and Behavioral Disorders*. Washington, DC: The National Academies Press. https://doi.org/10.17226/28577.

Box 7:
Child Health and Development Institute. (2025, July 24). *Strengthening children's behavioral health systems of care: The essential role of infrastructure* [Issue brief]. https://www.chdi.org/resource-library/issue-briefs/strengthening-systems-of-care

Box 8:
Washington State Department of Social and Health Services. (2019, December 1). *Five-year plan to reduce intergenerational poverty and promote self-sufficiency* [Legislative report]. https://governor.wa.gov/sites/default/files/2023-01/Five-Year%20Plan%20to%20Reduce%20Intergenerational%20Poverty.pdf

Box 9:

Duff-Brown, B. (2018, July 18). *More racial diversity among physicians would lead to better health among black men, research shows*. Stanford Health Policy. https://healthpolicy.fsi.stanford.edu/news/more-african-american-doctors-would-lead-better-outcomes-black-men

Bespoke Surgical. (2025, October 13). *What LGBTQ+ patients reveal-and hide-from their doctors*. https://bespokesurgical.com/2025/10/12/lgbtq-healthcare-study/

Dawson, L., Frederiksen, B., Long, M., Ranji, U., & Kates, J. (2021, July 22). *LGBT+ People's health and experiences accessing care*. KFF. https://www.kff.org/womens-health-policy/lgbt-peoples-health-and-experiences-accessing-care/#97cb8247-8b33-4930-9c37-952474071284--sexual-and-reproductive-health

Box 10:

Wei, M. (2025, October 2). *Hidden mental health dangers of artificial intelligence chatbots*. Psychology Today. https://www.psychologytoday.com/us/blog/urban-survival/202509/hidden-mental-health-dangers-of-artificial-intelligence-chatbots?msockid=1a906fedaa1860ec27da7b52ab776133

Illinois.gov. (2025, August 4). Gov. Pritzker Signs Legislation Prohibiting AI Therapy in Illinois. *Illinois.Gov*. Retrieved from https://idfpr.illinois.gov/content/dam/soi/en/web/idfpr/news/2025/2025-08-04-idfpr-press-release-hb1806.pdf.

Protecting Washington children online. SB 5708, WA 2025-26. https://app.leg.wa.gov/billsummary/?billNumber=5708&year=2025&initiative=False

Box 11:

Gilmore, J. H., Shi, F., Woolson, S. L., Knickmeyer, R. C., Short, S. J., Lin, W., Zhu, H., Hamer, R. M., Styner, M., & Shen, D. (2012). Longitudinal development of cortical and subcortical gray matter from birth to 2 years. *Cerebral Cortex*, 22(11), 2478-2485. https://doi.org/10.1093/cercor/bhr327; Shonkoff, J. P., & Phillips, D. A. (Eds.). (2000). *From neurons to neighborhoods: The science of early childhood development*. National Academy Press.

Academic self-concept formation: Marsh, H. W., & Martin, A. J. (2011). Academic self-concept and academic achievement: Relations and causal ordering. *British Journal of Educational Psychology*, 81(1), 59-77. https://doi.org/10.1348/000709910X503501

Social skill development and peer relationships: Ladd, G. W., Kochenderfer-Ladd, B., Eggum, N. D., Kochel, K. P., & McConnell, E. M. (2011). Characterizing and comparing the friendships of anxious-solitary and unsociable preadolescents. *Child Development*, 82(5), 1434-1453. https://doi.org/10.1111/j.1467-8624.2011.01632.x

Erikson's developmental framework: Erikson, E. H. (1963). *Childhood and society* (2nd ed.). Norton. (Original work published 1950)

Prevention science and sensitive periods: Bronfenbrenner, U., & Morris, P. A. (2006). The bioecological model of human development. In R. M. Lerner & W. Damon (Eds.), *Handbook of child psychology: Theoretical models of human development* (6th ed., Vol. 1, pp. 793-828). Wiley.

School-age social-emotional development: Eccles, J. S. (1999). The development of children ages 6 to 14. *The Future of Children*, 9(2), 30-44. https://doi.org/10.2307/1602703

Simpson, R. (2018). *Brain changes*. Young Adult Development Project. https://hr.mit.edu/static/worklife/youngadult/brain.html#ya

Goler, N. C., Armstrong, M. A., Osejo, V. M., Hung, Y., Haimowitz, M., & Caughey, A. B. (2012, January). *Early Start: A cost-beneficial perinatal substance abuse program*. *Obstetrics & Gynecology, 119*(1), 102–110. https://doi.org/10.1097/AOG.0b013e31823d427d

Camacho, E. M., & Shields, G. E. (2018, August 10). *Cost-effectiveness of interventions for perinatal anxiety and/or depression: A systematic review*. *BMJ Open, 8*(8), e022022. https://doi.org/10.1136/bmjopen-2018-022022 (PMCID: PMC6089324)

Lipari, R. N., & Van Horn, S. L. (2013, August 24). *Children living with parents who have a substance use disorder*. In *The CBHSQ Report*. Substance Abuse and Mental Health Services Administration (US). Retrieved July 31, 2025, from https://www.ncbi.nlm.nih.gov/books/NBK464590
Chang, G. (2020, June 30). *Maternal substance use: Consequences, identification, and interventions*. *Alcohol Research, 40*(2), Article 06. https://doi.org/10.35946/arcr.v40.2.06 (PMCID: PMC7304408)
Coussons-Read, M. E. (2013, June). *Effects of prenatal stress on pregnancy and human development: mechanisms and pathways*. *Obstetric Medicine, 6*(2), 52–57. https://doi.org/10.1177/1753495X12473751
Huffman, L. R., & Speer, P. W. (2000). Academic performance among at-risk children: The role of developmentally appropriate practices. *Early Childhood Research Quarterly, 15*(2), 167–184. https://doi.org/10.1016/S0885-2006(00)00048-X

Box 12:

Mercer. (2025, June 27). *Washington thriving quantitative landscape and gap analysis report.* Washington State Health Care Authority. https://www.hca.wa.gov/assets/program/quantitative-landscape-and-gap-analysis-report.pdf

Box 13:

Center on the Developing Child at Harvard University. (2007, May 20). *InBrief: Early childhood program effectiveness* [PDF brief]. Harvard University. https://developingchild.harvard.edu/wp-content/uploads/2024/10/inbrief-programs-update-1.pdf
Bania, N., Kay, N., Aos, S., & Pennucci, A. (2014). *Outcome evaluation of Washington State's Early Childhood Education and Assistance Program*, (Document No. 14-12-2201). Washington State Institute for Public Policy. https://www.wsipp.wa.gov/ReportFile/1576/Wsipp_Outcome-Evaluation-of-Washington-States-Early-Childhood-Education-and-Assistance-Program_Report.pdf

Box 14:

Full Frame Initiative (FFI), & Health Management Associates (HMA). (n.d.). *Qualitative Perspectives on Washington's Prenatal–25 Behavioral Health System*. https://www.hca.wa.gov/assets/program/prenatal-25-behavioral-health-system-qualitative-perspectives.pdf

Box 15:

The U.S. Surgeon General. (2023). *Social media and youth mental health* [U.S. Surgeon General's advisory]. https://www.hhs.gov/sites/default/files/sg-youth-mental-health-social-media-advisory.pdf

Box 16:

Center on the Developing Child at Harvard University. (2007, May 20). *InBrief: Early childhood program effectiveness* [PDF brief]. Harvard University. https://developingchild.harvard.edu/wp-content/uploads/2024/10/inbrief-programs-update-1.pdf
Landa, R. J. (2018). Efficacy of early interventions for infants and young children with, and at risk for, autism spectrum disorders. *International Review of Psychiatry, 30*(1), 25–39. https://doi.org/10.1080/09540261.2018.1432574
Estes, A., Munson, J., Rogers, S. J., Greenson, J., Winter, J., & Dawson, G. (2015). Long-term outcomes of early intervention in 6-year-old children with autism spectrum disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 54*(7), 580–587. https://doi.org/10.1016/j.jaac.2015.04.005
Cidav, Z., Munson, J., Estes, A., Dawson, G., Rogers, S., & Mandell, D. (2017). *Cost offset associated with Early Start Denver Model for children with autism*. *Journal of the American Academy of Child & Adolescent Psychiatry*. Advance online publication. https://doi.org/10.1016/j.jaac.2017.06.007

Box 17:
Harper, K. (2017, December 12). *The school-to-prison pipeline: The intersections of students of color with disabilities* [Testimony delivered before the United States Commission on Civil Rights]. Child Trends. https://www.childtrends.org/publications/school-prison-pipeline-intersections-students-color-disabilities

Box 18:
Full Frame Initiative (FFI), & Health Management Associates (HMA). (n.d.). *Qualitative Perspectives on Washington's Prenatal–25 Behavioral Health System*. https://www.hca.wa.gov/assets/program/prenatal-25-behavioral-health-system-qualitative-perspectives.pdf

Box 19:
The Baker Center for Children and Families. (2023, September). *Community outreach and engagement: Toolkit for mental health-serving agencies*. https://bridges4mentalhealth.org/wp-content/uploads/2023/12/Community-Outreach-and-Engagement-Toolkit.pdf

Box 20:
Center on the Developing Child at Harvard University. (2007, May 20). *InBrief: Early childhood program effectiveness* [PDF brief]. Harvard University. https://developingchild.harvard.edu/wp-content/uploads/2024/10/inbrief-programs-update-1.pdf
Treatment Advocacy Center. (n.d.). *Washington severe mental illness resources & helpful info*. https://www.tac.org/map_directory/washington/#:~:text=Prevalence%20of%20SMI%20in%20jails,Likelihood%20of%20incarceration%20versus%20hospitalization

Box 21:
Aratani, Y., Veele, S., Klinman, D., Graham, J. C., Fox, A., Cummings, K., & Ybarra , V. (2022, July). *DCYF Family First Services needs assessment.* Washington State Department of Children, Youth & Families, Office of Innovation, Alignment, and Accountability. https://www.dcyf.wa.gov/sites/default/files/pdf/reports/FamilyFirstServicesNeedsAssessment2022.pdf

Box 2:
Full Frame Initiative (FFI), & Health Management Associates (HMA). (n.d.). *Qualitative Perspectives on Washington's Prenatal–25 Behavioral Health System*. https://www.hca.wa.gov/assets/program/prenatal-25-behavioral-health-system-qualitative-perspectives.pdf

Box 23:
Dismantle Poverty in Washington. (n.d.). *Blueprint for a just & equitable future*. https://dismantlepovertyinwa.com/wp-content/uploads/2020/12/Final10yearPlan.pdf

Box 24:
Mercer. (2025, June 27). *Washington thriving quantitative landscape and gap analysis report.* Washington State Health Care Authority. https://www.hca.wa.gov/assets/program/quantitative-landscape-and-gap-analysis-report.pdf
Personal Communication, Kashi Arora, Seattle Children's Hospital, 2025

Washington
Thriving