



# Where can we find hope during the epidemic of hopelessness facing our children?

*Opportunities for breakthrough progress in Washington's adolescent mental health crisis*

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By Reid Saaris | 2023



# A NOTE FROM OUR EXECUTIVE DIRECTOR

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Children's Alliance advocates to ensure that all kids in Washington - especially kids of color and children who have been historically left behind by our state's health care system – have access to the things they need to thrive. This includes quality and accessible behavioral health care.

The behavioral and mental health struggles currently faced by youth in Washington are undeniable. In 2022 Children's Alliance partnered with executive adviser Reid Saaris to convene a steering committee of youth behavioral health experts in Washington, conduct innovative new analyses of the youth behavioral health landscape, and connect with local and international experts and practitioners. Through this work we have identified solutions that we believe are both highly impactful and feasible for serving children across our state. In our analysis, we discovered the true nature of the current behavioral crisis facing our state's kids:

- **Over half (58%) of Washington adolescents experience anxiety and/or depression.**
- **114,000 of 633,000 (~20%) of Washington adolescents need clinical care for anxiety and depression.**
- **Multi-racial respondents have the highest self-reported rates of anxiety/depression symptoms.**
- **Female-identifying and LGBTQ+ youth report symptoms of depression and/or anxiety at double the rate of male-identifying and heterosexual youth, respectively. Non-binary youth experience depression or anxiety in 6 out of 7 cases.**

**"Washington can build on the hard work of local, state, and national leaders to develop a system that provides the care our youth deserve – a vision now within reach."**

In this report, we share the work of the steering committee by quantifying the existing gaps in Washington's behavioral health system with barriers to care related to care seeking, provider availability, affordability, and care effectiveness. Then, we focus on promising local and state solutions, projecting costs, and implementation timelines. It's crucial that we take immediate action to ensure all Washington students receive the care they deserve.

There is hope to effectively alleviate the burdens of our most affected adolescents across Washington. By expanding successful local initiatives, we estimate that **Washington could address the majority of its youth care gap within a year or so, at an estimated cost of \$25 million.** By integrating the best practices from these initiatives and adopting a multi-tiered system of support approach, Washington can improve access to care for its adolescents.

We want to recognize the U.S. Surgeon General's just-released report on the impact of social media technology on youth mental health. In it, Dr. Murthy details the early and emerging evidence of social media's contributions to the struggles of our youth. While it will be essential in the months ahead for us to apply the new guidance to Washington to further prevent anxiety and depression, in this paper we focus on near-term access to proven, effective care for those suffering now.

Making significant and needed near-term progress will undoubtedly take strong will, collaboration, and perseverance – but there may be no topic more worthy of our attention and effort. Washington can build on the hard work of local, state, and national leaders to develop a system that provides the care our youth deserve – a vision now within reach. Implementation of these proposed solutions has potential to create a brighter, more hopeful future for Washington's youth.

A handwritten signature in blue ink that reads "Dr. Stephan Blanford". The signature is fluid and cursive, with the first letters of "Stephan" and "Blanford" being capitalized and prominent.

*Dr. Stephan Blanford | Children's Alliance Executive Director*

## The crisis is severe and worsening

If you are a parent or caregiver of an adolescent in Washington state and your child has nine young people over to your house to celebrate their birthday this year, odds are that six of the children at the party would be experiencing symptoms of anxiety and/or depression—two at severe, clinically diagnosable levels. And—if that group of ten reflects the statewide pattern—one of them would be seriously considering suicide (Exhibit 1).

% of youth in Washington grades 8 – 12

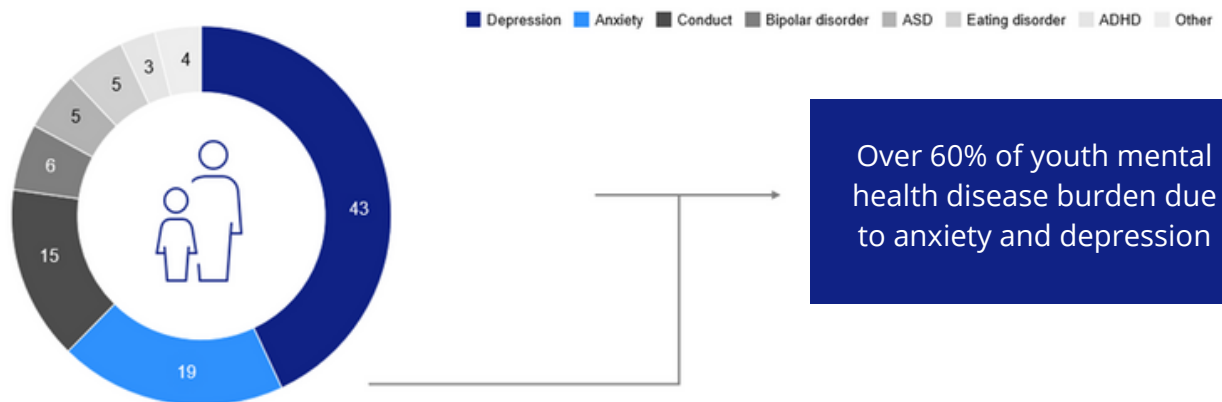


Exhibit 1

Whether from the U.S. Surgeon General’s advisory, the Washington Governor’s declaration of emergency, or what we see in our living rooms and classrooms—we all understand youth today are struggling with their mental health in new and often painful ways. Our analysis suggests that approximately 114,000 of Washington’s 633,000 adolescents<sup>4</sup> need clinical care for the biggest types of mental health struggles: anxiety and depression (Exhibit 2).<sup>5</sup>

### Relative disease burden of common mental disorders for youth aged 10-19 in WA

(% of total 10-19 y.o. mental health DALYs<sup>1</sup>)



Over 60% of youth mental health disease burden due to anxiety and depression

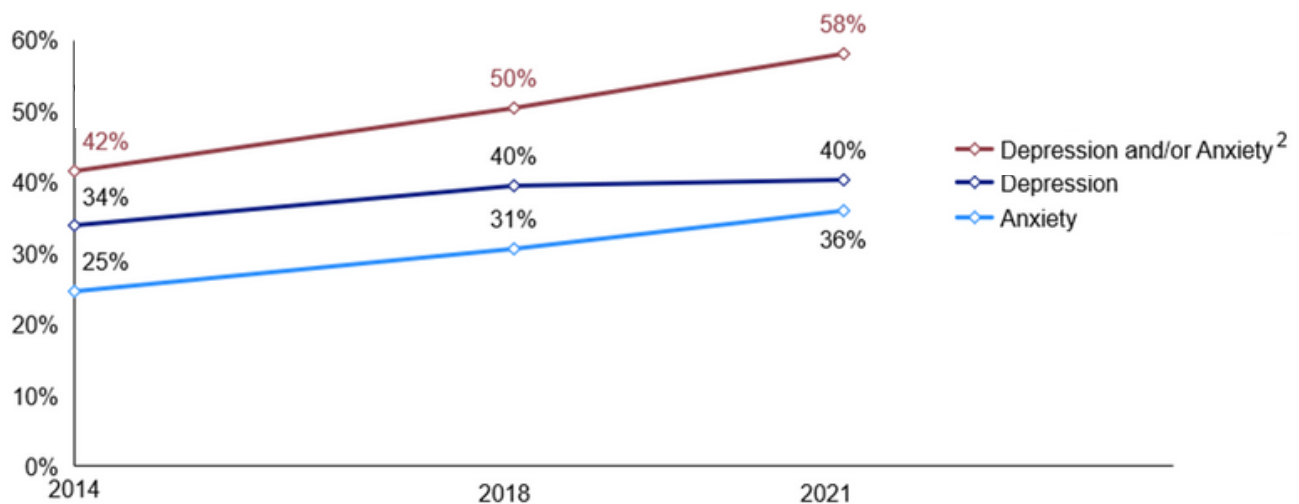
1. Diagnoses statistic drawn from UW’s Gaps Analysis of Research/Evidence-Based Treatment for Children’s Public Mental Health in Washington State (2014); Disease burden calculated from IHME % of total DALYs for anxiety and depression (2019)

Exhibit 2

Parents, teachers, and other caregivers who spend time with children will be aware that adolescent mental health challenges were a major issue before the COVID-19 pandemic, and that the ending of the pandemic does not make things all better (Exhibit 3).<sup>6</sup>

## Prevalence of at least one self-reported symptom of depression or anxiety

% adolescents aged 12-17 in WA<sup>1</sup>



1. Washington State Health Youth Survey 2014, 2018, and 2021

2. There is approximately a 50% comorbidity rate for depression and anxiety

*Exhibit 3*

Thankfully, there are new reasons for hope. Over the past several years, the hard work of parents, educators, mental health providers, and policymakers have yielded fresh examples of progress. From specific insights from each of the examples we'll present, an overriding theme emerges: **we could make a significant and meaningful difference in the lives of the rising generation now using strategies demonstrated to work surprisingly well.**

There are no silver bullets, and the work of scaling impactful solutions is not easy. But the local, national, and international examples that follow show that there are ways we could make substantial progress for Washington's children in the near term.

## The near-term pain and long-term consequences affect all groups, in all corners of the state

Over the past fifty years, the U.S. has reduced poverty, increased health and longevity, and improved housing, without a commensurate increase in life satisfaction. It turns out that life satisfaction is driven less by factors such as income, educational attainment, and employment than by emotional health.<sup>7</sup> A review of the evidence by Layard & Clark<sup>8</sup> shows that mental illness:

- Reduces life expectancy as much as smoking does (increases death rate by over 50%)
- Accounts for nearly half of people on disability, and nearly half of all sick days
- Is the biggest cause of misery in a given population, even more so than physical illness

During adolescence, mental health is more important to overall health than at any other time in life.<sup>9</sup> Adolescents' mental health is the biggest driver of their future life satisfaction.<sup>10</sup> And how we respond to the mental health challenges that our children are facing today will have major implications for the rest of their lives.

While there may well be differences in which groups of adolescents choose to self-report symptoms of mental illness, their self-reports are the best statewide data available, and show that mental illness is affecting all groups at high levels.

Geographically, the vast majority (93%) of Washington adolescents live in counties with between 50% and 60% of students reporting one or more symptoms of anxiety and/or depression.<sup>11</sup>

There is little variation in anxiety/depression symptoms reported by different racial groups, except that multi-racial respondents had the highest self-reported rates of anxiety/depression symptoms in WA.<sup>12</sup>

Demographic		WA youth breakdown, %	Self-reported rate of symptoms of depression or anxiety, % <sup>1</sup>
Race/ethnicity	White or Caucasian	48%	56
	Hispanic or Latino / Latina	17%	53
	More than one	16%	63
	Asian or Asian American	8%	51
	Black or African-American	3%	51
	American Indian or Alaskan native	2%	59
	Pacific Islander	1%	60
	Other	4%	55

1. Self-reported depressive symptoms defined as responding "Yes" to "During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?" Self-reported symptoms of anxiety defined by responses to the questions "How often over the last 2 weeks were you bothered by: Feeling nervous, anxious or on edge? Not being able to stop or control worrying.

*Exhibit 4*

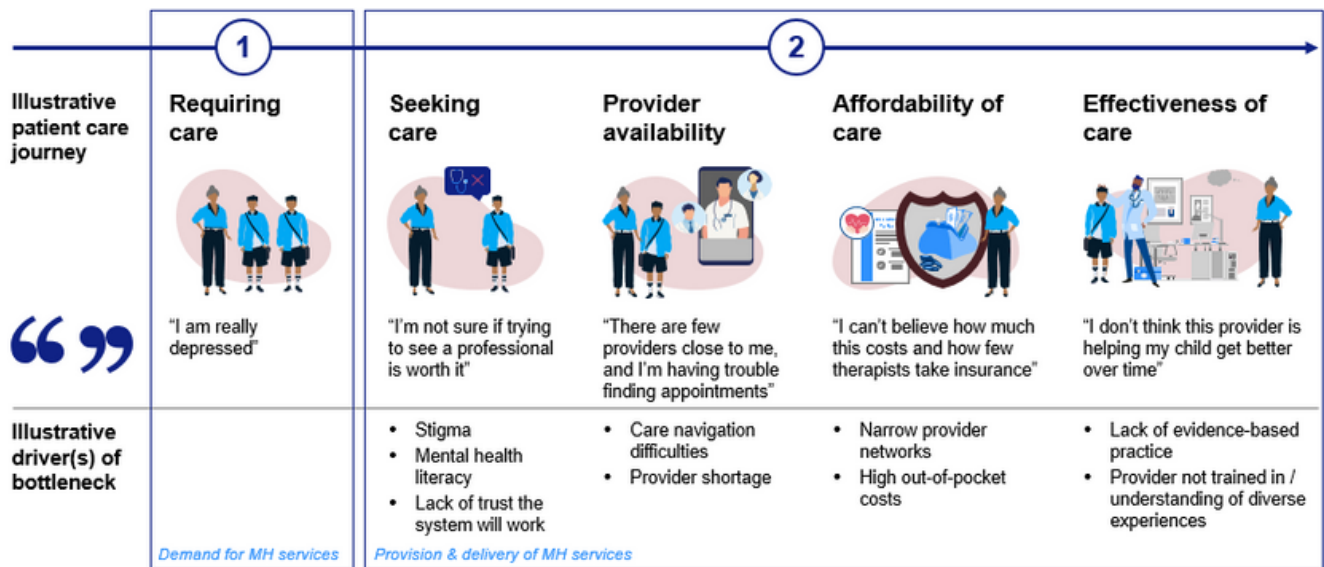
There is, however, significantly greater disparity by gender and sexual orientation, with cisgender girls and LGBTQ+ youth reporting symptoms at nearly double the rate as cisgender boys and heterosexual youth, respectively, and six out of seven non-binary youth suffering from 1+ symptoms of depression or anxiety.<sup>13</sup>

The recent increased general awareness of issues around youth mental health has led to important public investments, such as Washington's Mental Health Referral Services – a free service provided by Seattle Children's Hospital and funded by Washington State – that connected 1,864 families from 28 counties with mental and behavioral health resources in their communities in 2020.<sup>14</sup> Washington lawmakers also allocated \$600M over three years to hiring more school counselors, nurses, social workers and psychologists in March 2022<sup>15</sup> in part to address mental health concerns. Over the past several years, spending on mental health care and services has increased at about fifteen percent a year, rising to \$1 billion+ annually in Washington.<sup>16</sup>

Unfortunately, these investments and programs are not yet achieving the overall results that we are all seeking for Washington’s adolescents. During this period of increasing investments, we have slipped to 39th in Mental Health America’s rankings of youth mental health care. This is based on the fact that our youth are significantly more likely to suffer a major depressive episode than the U.S. average (18% locally v 15% nationally in 2022 makes WA third-worst in the nation) and the fact that about half of the ~100,000 youth experiencing those episodes are not receiving treatment.<sup>17</sup>

## The patient journey in Washington is riddled with gaps that deprive most adolescents of the care they need

To center the experiences of adolescents and their families, we considered a conceptual patient care journey—from first having symptoms to potentially receiving effective clinical care that would likely address and alleviate those symptoms (Exhibit 5).<sup>8</sup>



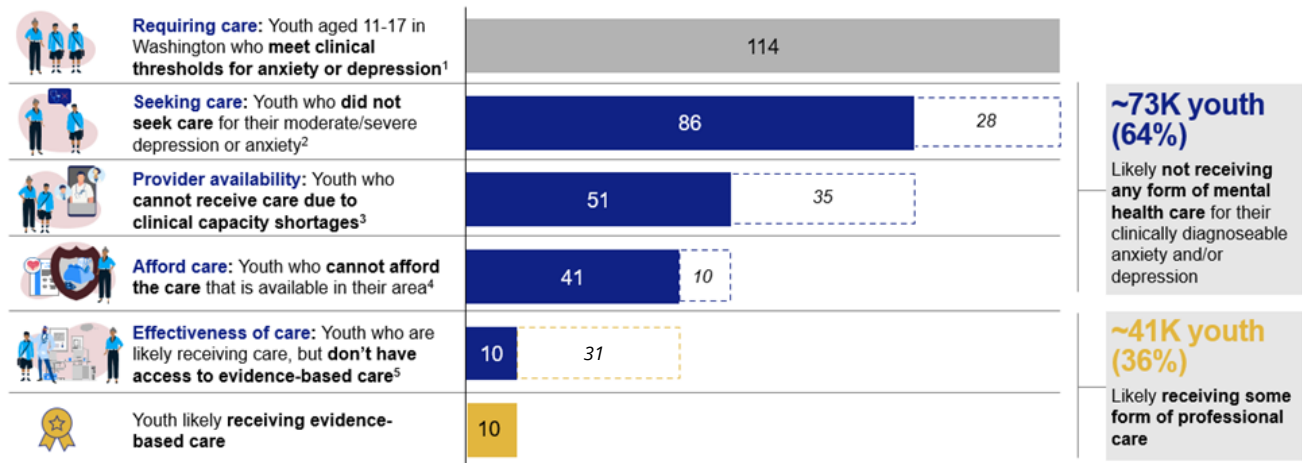
Source: Adapted from Levesque JF, Et al. Patient-centered access to health care. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3610159/>

Exhibit 5

We collected a wide variety of data for Washington from national reporting and databases, as well as from expert interviews, to estimate the number of Washington adolescents who are lost at each stage of the care journey. As families seek to address students’ symptoms and struggles, they may choose not to seek care (~28,000 WA adolescents); they may seek care and find no providers available (~35,000 WA adolescents); they may not be able to afford the care that is available (~10,000 WA adolescents); or they may receive care that does not meet Washington's evidence-based standards (~31,000 WA adolescents).

**Mental health care summary, # youth, '000s**

Not continuing in care journey    Not receiving evidence-based care



1. 2021 COVID-19 Student Survey and the 2018 Healthy Youth Survey of 633K youth aged 11-17;
2. WA COVID-19 Student Survey;
3. Department of Health Workforce Survey 2022;
4. Rowan K, Et al. Access and cost barriers to mental health care and <https://www.kff.org/other/state-indicator/children-0-18/>;
5. Evidence-based practice institute Fiscal Year 2021, Washington Annual Report

*Exhibit 6*

## Emerging solutions can address most gaps effectively and affordably

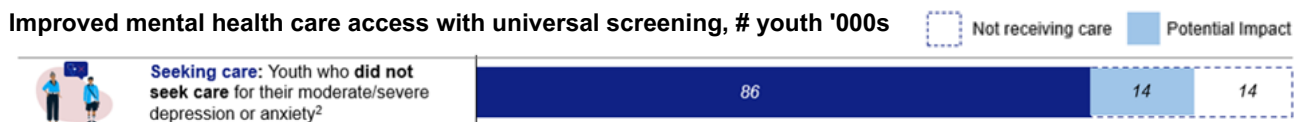
For each stage in the care journey where Washington families experience obstacles, we have found examples of solutions. In a time when the adolescent mental health crisis can feel intractably large and dire, these cases offer hope by expanding our sense of what could be—and how quickly it could be—achievable for Washington’s adolescents.<sup>19</sup>





## Seeking care

**WA could potentially cut the care-seeking gap in half at a cost of \$11/student, while generating savings of \$40+/student.**



2. WA COVID-19 Student Survey, BSK SBIRT 1.0 Cumulative Report

*Exhibit 7*

We estimate that one in four adolescents with clinical anxiety or depression are not seeking clinical care. Stigma is the main barrier to seeking mental health services,<sup>20</sup> with 18% of WA students feeling that it is not okay to seek help.<sup>21</sup> This feeling is epitomized by a middle school student from WA saying, “we don’t really use the resources because a lot of my peers don’t like opening up to people.”<sup>22</sup>

The COVID-19 pandemic has played a role in reducing mental health stigma, with many teens, educators, and providers working to change culture around mental health, and schools adopting policy changes to try to engage more youth in supportive services.<sup>23</sup>

Family beliefs and trust are an additional barrier – distrust being quite understandable in a system where patients who do seek effective care are very unlikely to receive it.<sup>24</sup> Lastly, mental health literacy – including poor recognition of mental health conditions and lack of awareness of available resources – can be a barrier to seeking care for youth and families.<sup>25</sup>

To make care seeking easier and address some of the barriers above with brief interventions, King County launched the Screening, Brief Intervention, and Referral for Treatment (SBIRT) program in 68 public middle schools across 13 school districts. Extending this program statewide could result in 14,000 additional students seeking care (Exhibit 7).<sup>26</sup> SBIRT has documented their processes and engaged in third-party evaluations, making it possible to learn from their model and implement such a program statewide in the near term.



Launched in 2018, the SBIRT program in King County provides tiered interventions tailored to student needs based on universal screening of adolescents in middle schools:

Current state	Potential statewide impact (with no other changes)
<p><b>Impact:</b></p> <ul style="list-style-type: none"> <li>• Universal screening ensures no one is overlooked, and everyone has a chance to share their struggles</li> <li>• SBIRT resulted in 47% of students receiving a brief intervention, and 16% of students referred to further mental health care;<sup>27</sup></li> <li>• 93% of students surveyed rated their interactions with an interventionist as “good”, “very good,” or “excellent”<sup>28</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Solution could address about half of the care-seeking gap, e.g., an additional 14,000 youth pursuing care<sup>29</sup></li> </ul>
<p><b>Timeline:</b></p> <ul style="list-style-type: none"> <li>• Can be implemented at a school within 1 academic year (3-9 months of planning and pilot stages)<sup>30</sup></li> <li>• ~25,000 students in 42 middle schools across King County completed the screening between 2019 and 2022</li> </ul>	<p><b>Possible timeline:</b></p> <ul style="list-style-type: none"> <li>• One academic year, where providers are available</li> <li>• Would require increased provider availability to implement in other areas of the state. See solutions on provider availability below</li> </ul>
<p><b>Funding:</b></p> <ul style="list-style-type: none"> <li>• Pilot funded by King County through the Best Start for Kids levy and a Mental Illness and Drug Dependency (MIDD) Sales Tax</li> <li>• King County allocated \$16.4M to SBIRT from 2019 – 2025<sup>31</sup></li> <li>• Cost per student: \$373<sup>32</sup> which includes the cost of clinical care that students are referred to in some cases</li> </ul>	<p><b>Funding required:</b></p> <ul style="list-style-type: none"> <li>• Estimated startup cost of \$2.1M to train brief interventionists<sup>33</sup></li> <li>• Estimated annual cost to screen all 633,000 WA youth of \$4.9M, consisting of \$2.6M to license screening tool plus \$2.3M to pay staff for interventions (if existing staff don't have capacity)<sup>34</sup></li> <li>• Total first-year cost of \$11 per student (excluding the cost of referrals to clinical care)</li> <li>• Potential to save \$28M+ in primary care healthcare costs<sup>35</sup></li> </ul>



# Finding an available provider

Although provider availability is the biggest and toughest challenge, research and case examples suggest that **most of the provider gap may be addressable for around \$10 per WA student.** After these training and administrative costs, total per-patient therapy expenses could decrease from current levels by up to two-thirds.



3. Department of Health Workforce Survey 2022

Exhibit 8

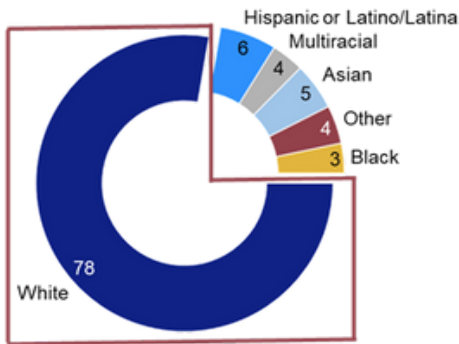
For a family seeking clinical care for their adolescent’s anxiety/depression, the first step is finding a therapist or provider. The availability of providers is the largest bottleneck in the care journey for families, with a Washington school mental health expert sharing: “I could double or triple my staff and still not really serve all the kids identified as in need”.<sup>36</sup> The “provider availability” bar (Exhibit 8)<sup>37</sup> shows that we only have enough clinical care providers available to serve around 51,000 Washington adolescents who suffer from anxiety and/or depression – or about 45% of those in need of care.<sup>38</sup> Patients seeking counseling sometimes wait 3-6 months, or even longer before their first appointment,<sup>39</sup> and waits for long-term beds for those with more serious conditions are also extensive (96 days in the first quarter of 2022 in WA).<sup>40</sup>

These long wait times are driven in part by a shortage of around 1,000 full-time mental health care providers – or 1.2 million hours of additional provider clinical time – needed per year.<sup>41</sup> Suburban and rural areas are more severely affected by the shortage. Suburban regions of WA have about half the youth-serving providers per thousand youth as urban areas, and rural areas have less than a third the providers per thousand youth as urban areas.<sup>42</sup> In fact, 18 of WA’s 39 counties do not have a single practicing psychiatrist.<sup>43</sup>

Many long-term proposals have sought to address this shortage by aiming to recruit and train around twice as many clinical therapists as currently practice in WA. Incentives to drive recruitment, such as loan forgiveness and new pathways to licensure, are estimated to cost \$100 million+ and take upwards of a decade to address the shortage of providers after they are designed and implemented.<sup>44</sup> Recruiting the next generation of providers—especially more diverse providers,<sup>45</sup> and providers trained to help adolescents address the disparate impacts of prejudice and discrimination—in Washington is critical, and there are key efforts underway. However, hundreds of thousands of children’s adolescences will end without access to needed clinical care unless we implement nearer-term solutions to address the shortage in therapist appointments and availability now.



### Breakdown of WA mental health providers by race/ethnicity<sup>1</sup>, %

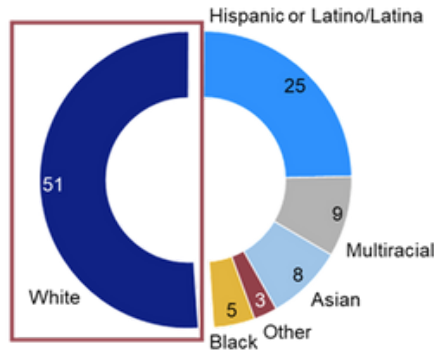


1.Source: WA Health Workforce Survey, 2022

2.Source: WA OSPI Enrollment reports, 2021

3.McKinsey.com, "Addressing the unprecedented behavioral-health challenges facing Generation Z", 2022

### Breakdown of WA youth by race/ethnicity<sup>2</sup>, %



+27pp

Difference between proportion of white mental health providers and proportion of white youth in WA

2-3x

Ethnic and racial minorities more likely to value the diversity of their MH providers vs. white youth<sup>3</sup>

Exhibit 9

We found four well-evidenced ways to help address the shortage of providers and appointments in the near term:

1. Brief interventions, like those offered by SBIRT, can help address symptoms early and prevent their progression to clinical levels requiring further treatment and therapy.
2. Collaborative care models work to make better use of existing clinical therapists' capacity. In these models, therapists support teams – whether pediatric teams in doctors' offices,<sup>46</sup> or school-based teams – by offering guidance and lighter case reviews, coaching existing teams of staff to provide support to students in need. The Washington Chapter of the American Academy of Pediatrics has supported the launch of collaborative care teams around the state, now serving several thousand behavioral health patients through their pediatricians' offices.<sup>47</sup> Some virtual therapy providers (see 'Making care affordable') provide both therapy for students, and support for school staff to be able to better serve students and address needs on campus with existing personnel.
3. Suburban and rural areas face some of the most acute shortages in therapists, while some urban centers like Seattle, Yakima, and Vancouver may actually have excess clinical capacity.<sup>48</sup> Online therapy or teletherapy has proven to be, on average, as effective as in-person therapy,<sup>49</sup> and could provide care to an additional 2+% of WA youth without other modifications in care delivery.<sup>50</sup>



4. Although every individual case is different, and care decisions will be made by providers and families, research shows that, on average, group-based cognitive behavioral therapy can be as effective for adolescents as individual therapy.<sup>51</sup> Teenagers often report increased confidence speaking to an adult in a group setting, and the realization that their situation is not uncommon can normalize mental health treatment.<sup>52</sup> The peer feedback that occurs in group settings is also a potential therapeutic benefit.<sup>53</sup> **If only 14% of providers statewide transitioned from individual to group-based therapy, we would theoretically have enough therapist capacity to address the unmet need for therapy among adolescents in WA today**<sup>54</sup> – a more significant impact on the biggest barrier to care than any other solution we’ve seen. At the same time, group therapy, which requires groups of six or more to be financially viable given lower reimbursement rates,<sup>55</sup> is logistically challenging (coordinating and aligning 6+ students’ and their caregivers’ schedules, additional administrative work for payment, etc.) and would require some providers to undertake new training.

Switching 14% of providers’ sessions from individual to group care would be complicated, but the case below shows that there are good examples we can learn from. Moreover, doubling reimbursement rates for group therapy could incentivize providers to switch to this modality, while the cost to payors would fall to around 30% of the individual rate for each patient. We didn’t find any better way to address the provider shortage and get care to the 63,000 youth without providers now than shifting some care to effective group-based sessions.

Tacoma Public Schools and the Capital Region Education Service District have deployed group care models during the school day – in some cases as clinical therapy, and in other cases as preventative care provided by non-therapists. Additionally, Seattle Children’s offers group-based clinical therapy for anxiety and depression.



Launched in 2018, G.R.O.W.T.H. (Gaining Resilience, Optimizing Wellness, Thinking Helpfully) at Tacoma Public Schools is a 6-session cognitive behavioral theory group conducted with 4-8 students:

Current state	Potential statewide impact (with no other changes)
<p><b>Impact:</b></p> <ul style="list-style-type: none"> <li>PSWQ-C<sup>56</sup>scores for anxiety reduced from 29 to 21 and CES-DC<sup>57</sup>scores from 28 to 20 for students participating in the program with school counselors, supported by clinical psychiatrists and therapists.<sup>58</sup></li> </ul>	<ul style="list-style-type: none"> <li>Approximately 2,500 additional youth could receive treatment for every 1% of providers that shift to group-based therapy.<sup>59</sup></li> <li>Could help 35,000+ additional youth in WA find mental health care if &lt;200 providers changed from individual to group therapy.</li> </ul>
<p><b>Timeline:</b></p> <ul style="list-style-type: none"> <li>Monthly coaching sessions for counselors, with 3-6 sessions before counselors are ready to employ techniques with children.</li> </ul>	<p><b>Possible timeline:</b></p> <ul style="list-style-type: none"> <li>12-18 months if sufficient capacity is found from trainers running professional learning sessions for providers.</li> </ul>
<p><b>Funding:</b></p> <ul style="list-style-type: none"> <li>\$300K over 3 years from City of Tacoma grant Elementary and Secondary School Emergency Relief (ESSER) funds,<sup>60</sup> covering additional payment to school counselors for sessions conducted outside of school hours and training for counselors led by external psychiatrist. ESSER funds were used to bring in clinical therapists from the community to provide additional care for students in need of longer-term support than that offered by the school counselor-led program.</li> </ul>	<p><b>Funding required:</b></p> <ul style="list-style-type: none"> <li>\$6.3M to roll out program to 63,000 youth without providers available to address care needs.<sup>61</sup> Beyond these startup, training, and administrative costs, smart policy could incentivize adoption with higher reimbursement rates, while lowering per-patient care costs by about two-thirds.</li> <li>To realistically address the full 63,000 youth gap, additional strategies would be needed in conjunction with group care, including geographic distribution of individual care to rural areas (e.g., by telehealth) and to those for whom group care is not appropriate or desired.</li> </ul>



## Making care affordable

**WA could potentially fully address therapy affordability at a cost of \$12.50 per student.**

### Improved mental health care access with Telehealth, # youth '000s

Not receiving care Potential Impact



**Afford care:** Youth who cannot afford the care that is available in their area<sup>4</sup>

4. Rowan K, Et al. Access and cost barriers to mental health care and <https://www.kff.org/other/state-indicator/children-0-18>

### Exhibit 10

Many families who find a care provider cannot afford their fees, and students are about twice as likely to need mental health care if financially distressed.<sup>62</sup> The affordability bar (Exhibit 10)<sup>63</sup> shows our estimate that currently another 10,000 adolescents do not receive care because it is too expensive. Therapy costs \$150 per session on average (or thousands of dollars for a course of treatment),<sup>64</sup> leading to 21% of WA youth experiencing difficulty affording mental health care for mild to severe anxiety or depression.<sup>65</sup> Moreover, 8.6% of WA youth have private insurance lacking coverage for mental or emotional difficulties,<sup>66</sup> and only five out of the nine WA educational service regions can bill Medicaid for school-based care. Select<sup>67</sup> Washington district leaders, and state leaders in Colorado and Hawaii, have decided to try to eliminate cost as a barrier for child mental health treatment by offering free therapy to students.

The states of Colorado<sup>68</sup> and Hawaii<sup>69</sup> offer free therapy online or in school at a cost to the state/schools of about ten dollars per enrolled student.<sup>70</sup> The Puyallup School District in WA funded free in-school or at-home clinical teletherapy, which became available to students in October 2021 at 34 elementary, junior high, and high schools. For Washington's 2,474 public, K-12 schools, there is potential to efficiently roll out similar telehealth initiatives in every school, using the lessons and successes from examples in other jurisdictions.



### Launched in October 2021, the Puyallup School District works with a telemedicine provider to bring mental health care to youth in schools:

Current state	Potential statewide impact (with no other changes)
<p><b>Accomplishment / Progress:</b></p> <ul style="list-style-type: none"> <li>• Approximately 2% of the 23,000 students in the district received care in the first year of program operation<sup>71</sup></li> <li>• Reduced waiting time to see a provider from months to approximately a week<sup>72</sup></li> <li>• Providers available 7am-7pm with about a 70%-30% split between services received at home and in-school during the ongoing 2022-23 academic year</li> </ul>	<ul style="list-style-type: none"> <li>• Universal free care has the potential to fully solve the affordability gap, through providers that bill MEDICAID, private insurance, and cover the difference w/ modest fees to the school<sup>73</sup></li> <li>• Increased flexibility through availability beyond school hours and potential for referral by school staff or self-referral by families</li> </ul>
<p><b>Timeline:</b></p> <ul style="list-style-type: none"> <li>• 3 months from establishment of partnership to official launch in 34 public schools<sup>74</sup></li> </ul>	<p><b>Predicted timeline:</b></p> <ul style="list-style-type: none"> <li>• Potential to launch state-wide within a year with school board approvals given provider commitment of 8 weeks for implementation<sup>75</sup></li> </ul>
<p><b>Funding:</b></p> <ul style="list-style-type: none"> <li>• \$15 annual cost per student currently covered by ESSER funds<sup>76</sup></li> <li>• No cost to students (provider bills Medicaid or private insurance where appropriate)</li> </ul>	<p><b>Funding required:</b></p> <ul style="list-style-type: none"> <li>• ~\$8 million to cover all 633k adolescents in WA<sup>77</sup></li> <li>• Need to find alternative funding sources after ESSER III expires in September 2024</li> </ul>

Colorado decided to offer teletherapy that students could access off campus, while other jurisdictions have provided the care on school campuses, and others like Puyallup offer a hybrid approach. On-campus care requires additional coordination, space, and supervision, but can help to solve internet access challenges. States and school districts can also draw from federal funding available to address the youth mental health crisis when creating programs, such as the \$1B+ committed through the Bipartisan Safer Communities Act of 2022<sup>78</sup> and \$1.85B allocated to Washington in the third round of the American Rescue Plan Act’s Elementary and Secondary School Emergency Relief (ESSER) Funds.<sup>79</sup> With the political will demonstrated in other states, the affordability gap could be quickly and effectively addressed in WA, providing options to adolescents who do not now receive care because it is too expensive.





# Receiving effective care

Improved mental health care access with evidence-based care, # youth '000s

Evidence-based care Not evidence-based care



5. Evidence-based practice institute Fiscal Year 2021, Washington Annual Report

Exhibit 11

Finally, if a family seeks, finds, and can afford care, they of course want that care to be effective in addressing the problems their child is experiencing. While our model suggests that 41,000 adolescents are currently receiving some form of clinical care for their anxiety/depression, the state estimates that only around a quarter of current youth mental health services meet Washington State Institute for Public Policy (WSIPP)'s criteria for evidence-based care (Exhibit 11). Though not all effective practices have necessarily been studied (especially indigenous and other culturally relevant practices), and practices not considered evidence-based could be effective, it is notable that 75% of care does not yet meet Washington's own standards for effectiveness.

Provider availability is a huge issue, but Washington behavioral health experts have suggested that transitioning to a more evidence-based care model could have an even bigger impact than adding provider capacity. As Elizabeth McCauley, child clinical psychologist and associate director of Seattle Children's Hospital, said, "The lack of evidence-based practice is the single biggest issue in the field. Yes, some people will improve with supportive therapy—but ultimately, it is not as effective" as evidence-based practices.

While we would like to provide similar analysis on effectiveness as we have provided on care seeking, provider availability, and affordability, it is more complicated. Some of the leading models – like Great Britain's, discussed below – are very different from the U.S. model, in terms of the overall design and administration of their healthcare systems. A theme that arose again and again in our interviews was that, here in Washington, we do not yet have a "system" for youth mental health. We have many disparate providers and approaches, which are not coming together to meet the needs of most children in the state.

Though we cannot take the example of Great Britain's program and conclude a certain level of improvement for Washington youth is attainable at a particular cost on a particular timeline, the example can help us think about what might become possible if we were to adopt a more systematic approach here. In building the Improving Access to Psychological Therapies (IAPT) program, the British made significant investments to ensure youth could access evidence-based resources to study on their own, and then also Cognitive Behavioral Therapy<sup>80</sup>—including individual in-person and teletherapy, and group-based therapy. Therapy under IAPT has clear



goals for addressing and resolving patients' symptoms, usually achieved in a structured, twelve-session sequence. For generalized anxiety disorder, the evidence-based therapies of Guided Self-help and Cognitive Behavioral Therapy employed in IAPT had relatively high recovery rates in 2015 and 2016 (61% and 57%, respectively).<sup>81</sup> The IAPT program assesses how patients are doing after every session, and consistently review that data for opportunities to systematically improve training and practice. And **they can now reliably resolve symptoms of anxiety/depression for most treated youth for a period of 9+ years.**<sup>82</sup> Knowing that such results are possible, we should aim at least as high for WA youth, and begin the work of consistently and systematically measuring and improving our progress.

**Launched in 2011, the Children and Young People's Improving Access to Psychological Therapies (CYP-IAPT) program is focused on the provision of effective mental health services for youth in England through the use of evidence-based psychological therapies:**

## Current state

### Impact:

- Rate of recovery or reliable improvement in the first five years grew from 49% to 59% based on child-reported measures<sup>83</sup>

### Timeline:

- Over 1,000 practitioners (equivalent to the estimated WA state shortage) trained in evidence-based CBT in the first five years of the program<sup>84</sup>

### Funding:

- Co-Funded by the UK Department of Health, the NHS and local authorities
- Funding of GBP 250MM per year from 2015-2020<sup>85</sup> (equivalent for WA population size would be \$74M annually)
- Cost per student: GBP 78 in 2015<sup>86</sup> (equivalent to \$118 per student in WA today)<sup>87</sup>

# CONCLUSION: TAKING ACTION TO GET CARE TO WASHINGTON ADOLESCENTS IN NEED NOW

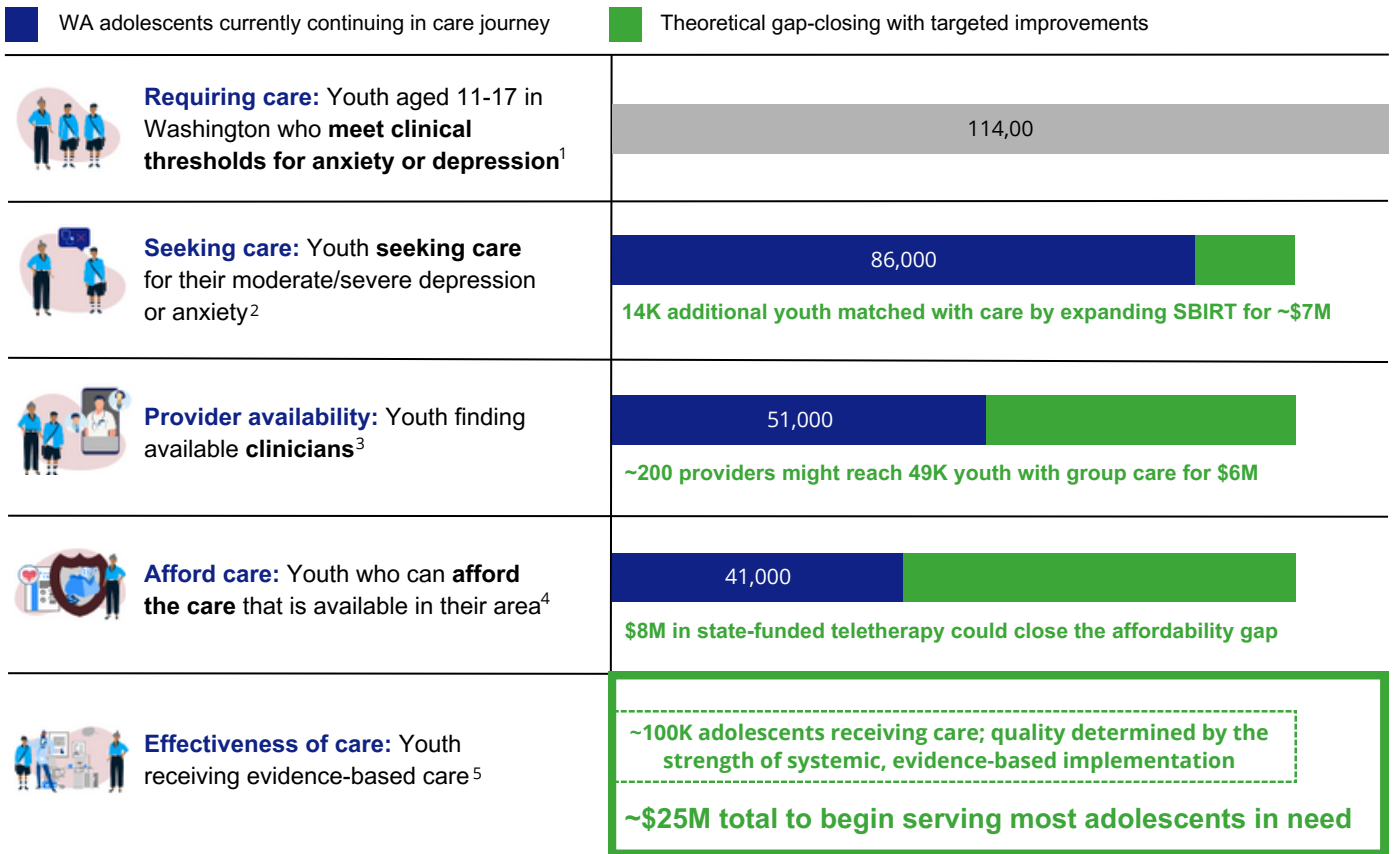
The pandemic brought us a deeply challenging period, where at times we all questioned what hope there might be for brighter days ahead. Now—from successful mental health efforts locally and globally—we know that there are good reasons for hope.

From the analysis presented in this paper and our work leading a steering committee of key school, practitioner, academic, and state leaders, we roughly estimate that a majority of the gap in care for Washington's youth could be addressed in the coming year or so, at an initial cost of around \$25M (less than \$40 per WA adolescent).<sup>88</sup> And the economic benefits could substantially exceed the costs of implementing these programs, even if viewed solely through the lens of near-term government savings.<sup>89</sup> Longer term, we could be losing tens of billions a year, if we don't invest a thousandth of those future losses in treatment and prevention now.<sup>90</sup> Spending even a few percent of WA's unspent \$800M in federal ESSER funds<sup>91</sup> on the most impactful mental health strategies would be enough to launch the key strategies, scaling up:

- Successful universal screening, brief intervention and referral treatment (SBIRT) efforts, like those in King County, to make sure every struggling student can be identified and connected with services;
- Group-based care models, like those in the Capital region and in Tacoma, and Seattle Children's Hospital, to implement proven group care approaches for those who would like and can benefit from such services;
- Fully funded virtual therapy and school-based integrated care models to ensure every student can afford care, like those used in Puyallup, Steilacoom, and Chief Leschi, as well as Hawaii,<sup>92</sup> Colorado,<sup>93</sup> and Los Angeles County;<sup>94</sup>
- Systems to support and resource such efforts based on the ongoing evaluation of rigorous evidence have reliably resolved persistent feelings of hopelessness and worry for hundreds of thousands of young people in Great Britain,<sup>95</sup> and more recently helped youth in Michigan.<sup>96</sup>

Washington can build on the work of local, state, and national leaders to develop a system that delivers the care we aspire to provide to our youth. And now we know such care could be provided in the near term. It is undoubtedly hard and complicated work – but there may be no work more important than helping to ensure the wellbeing of the rising generation. If a child fractured their arm, it would be inconceivable – abusive even – not to provide them with care right away. Let's make a lack of care for children who are feeling broken equally inconceivable by providing our adolescents the care they need and deserve now.

# SUMMARY CHART: ENVISIONING A MENTAL HEALTH SYSTEM IN WHICH ALL WA ADOLESCENTS SEEKING CARE WILL FIND IT



This is a conceptual illustration of the possible outcomes of these strategies. This paper cannot go into the complexity that implementing these strategies warrants. Our steering committee had extensive conversations about many challenges and possibilities, and sought highest impact and feasibility. We recommend an administrative focus on building a state-backed system using best practices and ongoing evidence review.

1. SAMSHA 2019 past-year prevalence of MDE for ages 12-17, CDC 2019 prevalence of high anxiety for ages 12-17 prevalence data, 50% comorbidity assumption between depression and anxiety (Kessler et al., Epidemiological Psychiatry Sci, 2015); US 2020 Census
2. Average of literature point-estimates (Oh et al., Int Journal of Mental Health Promotion, 2016; Mitchell et al., Mental health help-seeking behaviors in young adults, 2017)
3. Bottoms-up capacity estimation based on reported clinical hours from relevant license types within the Department of Health Workforce Survey 2022, an FTE assumption of ~1200 clinical hours (expert interviews), and a caseload assumption of ~60 youth per year (University of Behavioral Health Workforce Assessment 2017 validated by expert interviews)
4. Adapted from Rowan et al., Health Aff, 2013 and weighting by Washington State youth payer mix (KFF, 2019); triangulated with McKinsey Gen Z survey, 2022 and Sylwestrzak et al., Comm Mental Health Jour, 2015
5. State-sponsored Washington State Evidence Practice Institute (EBPI) Q2 2019 report

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- Washington Office of Superintendent of Public Instruction
- UW School Mental Health Assessment Research and Training (SMART) Center
- Puget Sound Educational Service District
- Educational Service District 113
- Association of Educational Service Districts

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- Tacoma Public Schools
- The Puyallup School District
- The Washington Chapter of the American Academy of Pediatrics
- Committee and sub-committee chairs of the Children and Youth Behavioral Health Work Group
- Dr. David Clark and Sir Richard Layard of the Increasing Access to Psychological Therapies programme
- King County's Screening, Brief Interventions, and Referral to Therapy program
- Seattle Children's Hospital
- State leaders in Colorado and program leaders in Hawaii
- The McKinsey Seattle Office for their collaboration, including offering support for the research and analysis that informed the calculation of the relative disease burden for youth in Washington state.

For more information please visit [childrensalliance.org](https://childrensalliance.org).

## Notes

1. Self-reported depressive symptoms from the 2018-2021 Healthy Youth Surveys defined as responding “Yes” to “During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?” Self-reported symptoms of anxiety defined by responses to the questions “How often over the last 2 weeks were you bothered by: Feeling nervous, anxious or on edge? Not being able to stop or control worrying?”
2. Based on ~15-20% range of MDE prevalence (SAMHSA), ~10% prevalence for anxiety (CDC) for ages 12-17, and assumption of 50% comorbidity. The DSM-5 defines clinical depression as experiencing at least 5 symptoms of depression over a two week-period and Generalized Anxiety Disorder for children as experiencing at least 1 of 6 listed symptoms more days than not over a 6 month period.
3. Based on self-reported responses from 2021 WA Healthy Youth Survey for grades 8 – 12
4. WA 2021 COVID-19 Student Survey and the 2018 Healthy Youth Survey of 633 thousand youth aged 11-17
5. Estimated comorbidity of 50% of youth experiencing depression also experiencing anxiety. Kessler et al., *Epidemiol Psychiatry Sci.* 2015; Diagnoses statistic drawn from UW’s Gaps Analysis of Research/Evidence-Based Treatment for Children’s Public Mental Health in Washington State (2014); Disease burden calculated from IMHE’s Global Burden of Disease report: % of total DALYs for anxiety and depression (2019)
6. Washington State Healthy Youth Survey 2014, 2018 and 2021
7. Obviously, physical health, economic well-being, and emotional health are all inter-related in complex ways and can affect one another. And yet, it is significant that Layard & Clark’s review of the evidence at the beginning of *Thrive* suggests that our progress on material wellbeing has not resulted in progress in life satisfaction, and that emotional health may be more important.
8. Layard & Clark, *Thrive: How Better Mental Health Care Transforms Lives and Saves Money*, Princeton University Press: 2015, pg. 94 – 95
9. “Global Burden of Disease” visualization of mental health disease burden in Washington State by age.
10. Layard & Clark, *Thrive*, Princeton University Press: 2015, pg. 114 – 116
11. Washington State Healthy Youth Survey, 2021; U.S. Census Bureau 2020 estimates
12. Multi-racial respondents had a 63% rate of reporting one or more symptoms of depression or anxiety compared to 60% for Native Hawaiian or other Pacific Islanders, 59% for American Indian or Alaska Natives, 56% for white students, 53% for Hispanic or Latinx, 51% for Asian/Asian-American and 51% for Black/African-American students; Healthy Youth Survey, 2018 – 2021 (average of responses from grades 8, 10, and 12)
13. 60% of Female identifying students reported one or more symptoms of depression or anxiety compared to 34% of male identifying students, 86% of transgender students, 87% of students questioning/not sure of their gender identity, 89% of students with “other” gender identity and 79% of students that checked off more than one gender identity box. 44% of heterosexual students reported one or more symptoms of depression or anxiety compared to 92% of bisexual students, 91% of gay or lesbian students, 78% of students questioning/not sure of their sexual orientation and 93% of students that checked “something else fits better”; Healthy Youth Survey, 2018 – 2021 (average of responses from grades 8, 10, and 12), U.S. Census Bureau, 2015 – 2019 American Community Survey 5-Year Estimates
14. “Mental Health Referral Service for Washington’s Children and Teens”, <https://www.seattlechildrens.org/globalassets/documents/clinics/how-to-get-mental-health-referrals/pal-mh-referral-infographic-2020.pdf>
15. House Bill 1664 <https://lawfilesexternal.wa.gov/biennium/2021-22/Pdf/Bills/House%20Passed%20Legislature/1664-S2.PL.pdf?q=20221208053350>
16. Analysis of data from the Truven Commercial and Medicaid Databases
17. From Mental Health America’s annual “State of Mental Health in America” report, 2022, and years previous. The 50% untreated percentage has improved from recent years past, when the rate hovered closer to 60% untreated.
18. Adapted from Levesque JF, Et al. Patient-centered access to health care. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3610159/>

19.
  1. SAMSHA 2019 past-year prevalence of MDE for ages 12-17, CDC 2019 prevalence of high anxiety for ages 12-17 prevalence data, 50% comorbidity assumption between depression and anxiety (Kessler et al., *Epidemiological Psychiatry Sci*, 2015); US 2020 Census
  2. Average of literature point-estimates (Oh et al., *Int Journal of Mental Health Promotion*, 2016; Mitchell et al., *Mental health help-seeking behaviors in young adults*, 2017)
  3. Bottoms-up capacity estimation based on reported clinical hours from relevant license types within the Department of Health Workforce Survey 2022, an FTE assumption of ~1200 clinical hours (expert interviews), and a caseload assumption of ~60 youth per year (University of Behavioral Health Workforce Assessment 2017 validated by expert interviews)
  4. Adapted from Rowan et al., *Health Aff*, 2013 and weighting by Washington State youth payer mix (KFF, 2019); triangulated with McKinsey Gen Z survey, 2022 and Sylwestrzak et al., *Comm Mental Health Jour*, 2015
  5. State-sponsored Washington State Evidence Practice Institute (EBPI) Q2 2019 report
20. BMC Psychiatry, "What are the barriers, facilitators and interventions targeting help-seeking behaviors for common mental health problems in adolescents?", 2020
21. WA COVID-19 report, High School and Middle School reports
22. 2022 WA COVID-19 report, High School and Middle School reports
23. WA House Bill 1834, which passed in June 2022, allows students to take an unlimited number of excused absences from school as mental health days without a medical diagnosis  
<https://lawfilesexternal.wa.gov/biennium/2021-22/Pdf/Bills/House%20Passed%20Legislature/1834.PL.pdf#page=1>
24. Per the above analysis, most patients will not find a provider, not be able to afford it, or receive care that is not evidence-based.
25. Aguirre Velasco et al. "What are the barriers, facilitators and interventions targeting help-seeking behaviours for common mental health problems in adolescents? A systematic review." *BMC Psychiatry* 20, 293 (2020). <https://doi.org/10.1186/s12888-020-02659-0>
26. WA COVID-19 Student Survey, BSK SBIRT 1.0 Cumulative Report
27. "School-Based SBIRT 1.0 Cumulative Report," Sep 2022
28. "School-Based SBIRT 1.0 Cumulative Report," Sep 2022
29. 12.5% of the 24,175 middle schoolers screened from 2018-2022 either connected to a resource or are in process of connecting to a resource based on a referral received through SBIRT. When this rate is applied to the entire 114K estimate of students requiring care in WA, we estimate 14,000 additional students seeking care. Students referred to a resource that the student or caregiver were not interested in connecting to are not included here, but those in process are because connection to a resource may be hindered by provider availability.
30. Interview with School-Based SBIRT Program Manager at King County, WA, Nov 2022
31. "King County Awards Funding to 11 School Districts to Extend Critical Program Addressing Youth Mental Health", May 2022
32. Assuming the \$16.4M allocated is spent evenly over the 6 years program funds were allocated for. Includes the cost of setting up the program.
33. Training in interventions estimated at \$900 per school based on 3-days of training per interview with School-Based SBIRT Program Manager at King County, WA.
34. Cost of access to the Check Yourself tool used in King County is \$1,100 per school adding up to \$2.6MM for all 2,342 middle and high schools in WA state. Cost of brief interventions estimated at 2.3MM, with each intervention taking 20 mins and 45% of students requiring an intervention assuming a wage of \$25/hour for interventionists.
35. SAMHSA, "SBIRT in Behavioral Healthcare," April 2011. Expected savings of \$3.81 for every dollar spent on SBIRT in primary care. If applied nationwide, SBIRT is estimated to potentially produce a net savings of \$1.82 billion annually. Savings come from a cost-benefit analysis, which was restricted to direct injury-related medical costs only so that it would be most meaningful to hospitals, insurers, and government agencies responsible for health care costs. Underlying assumptions used to arrive at future benefits, including costs, injury rates, and intervention effectiveness, were derived from published nationwide databases, epidemiologic, and clinical trial data (Gentilello 2005)

36. Healthy futures campaign, interview 2022.
37. Department of Health Workforce Survey 2022
38. Though each of these bars is not entirely discrete (e.g., with limited providers, the price of care increases, meaning that it may be possible to find a provider, but not one whom you can afford, or who will take your insurance), we have broken the steps out this way to focus on the biggest factors affecting children and families today.
39. Rachel Zimmerman, The Washington Post, "A psychiatry wait list had 880 patients; a hospital couldn't keep up", Oct 2022
40. Hannah Furfaro, "State's Mental Health Facilities for Children Are Strained," AP News, May 2022
41. Based off literature estimates (e.g., American Academy of Child & Adolescent Psychiatry) and validated with bottom-up analysis including data from Department of Health Workforce Survey 2022, UW 2018 Behavioral Health Workforce analysis, U.S. Census Bureau, and 2018 Healthy Youth Survey
42. There are 2.9 Mental Health Providers who see youth per 1K population aged 11-17 in urban areas of WA, 1.5 in suburban areas and 0.8 in rural areas with the percentage of youth population living in each 27%, 33% and 40%, respectively; US Census Bureau, National Center for Education Statistics, Department of Health Workforce Survey 2022
43. American Academy of Child & Adolescent Psychiatry: [https://www.aacap.org/aacap/Advocacy/Federal\\_and\\_State\\_Initiatives/Workforce\\_Maps/Home.aspx](https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx). Accessed 5/25/23
44. The Ballmer Group announced a \$38M grant to help build Washington's Behavioral Health Workforce in 2021 that is expected to help fund the graduate level clinical education for just 400 students over the following 5 years. Estimate based on an extrapolation of this number given the constraint from the number of educators available to train these new members of the mental health workforce.
45. Minority youth are more likely to use mental health services from providers of the same racial/ethnic group (Lu et al. Front. Public Health, 2021), but non-white providers are underrepresented in the provider workforce (17% of providers are non-white versus 40% of youth); "Diversity in the Mental Healthcare Profession: Then and Now," 2022
46. "How pediatricians can help mitigate the mental health crisis," Chawla & Rethy, March 2022
47. 2,728 patients seen across 8 clinics in 2022, with recent legislative approval to launch 10 more collaborations between pediatricians and behavioral health providers, to help address the fact that the majority of pediatric cases in WA today involve behavioral health issues, for which patients and doctors may need additional specialty support. Source: interviews with American Academy of Pediatrics Washington President Sarah Rafton and Collaborative Care CYBHWG sub-committee co-chair, Kristin Houser, 2023.
48. Bottom-up capacity estimation based on reported clinical hours from relevant license types within the Department of Health Workforce Survey 2022, an FTE assumption of ~1200 clinical hours, and a caseload assumption of ~60 youth per year (University of Behavioral Health Workforce Assessment 2017), validated by expert interviews
49. Lin, T., Heckman, T. G., & Anderson, T. (2021, December 30). The Efficacy of Synchronous Teletherapy Versus In-Person Therapy: A Meta-Analysis of Randomized Clinical Trials. *Clinical Psychology: Science and Practice*. Advance online publication. <http://dx.doi.org/10.1037/cps0000056>
50. Calculated based on I Matter and Hazel Health implementation data scaled to WA (1,208) using K – 12 students needing care (73,836), in comparison to the total number of youth blocked (58,711)
- 51.
1. O'Shea, Spence and Donovan, "Group versus Individual Interpersonal Psychotherapy for Depressed Adolescents," May 2014;
  2. Neary, Ginsburg & Cornish, "Comparing the effectiveness of individual and group therapy for students with symptoms of anxiety and depression: A randomized pilot study", March 2019;
  3. Sigurvinsdottir, Jensinudottir, Baldvinsdottir, Smarason & Skarphedinsson, "Effectiveness of cognitive behavioral therapy (CBT) for child and adolescent anxiety disorders across different CBT modalities and comparisons: a systematic review and meta-analysis", Nov 2019;
  4. Zhou, Shang, Furukawa, et al, "Different Types and Acceptability of Psychotherapies for Acute Anxiety Disorders in Children and Adolescents: A Network Meta-analysis" Jan 2019
52. Heindel C., "Group therapy with adolescent girls in foster care," 2011
53. Schechtman Z., "Group Counseling and Psychotherapy with Children and Adolescents," 2007



54. Internal Model assuming a treatment ratio of 6:1, 20 hours needed per youth for treatment (expert interviews), 1.23MM estimated provider hours for treatment of anxiety and depression for adolescents in WA from Workforce Survey and 50,375 youth that can access care in their area per zip code analysis of provider location.
55. Current reimbursement rates to providers are about 1/6th the individual rate in October 2022; Washington State Health Care Authority Provider Billing Guides and Fee Schedules, October 2022
56. The Penn State Worry Questionnaire for Children measures the tendency of youth to engage in excessive, generalized and uncontrollable worry
57. The Center for Epidemiological Studies Depression Scale for Children is a 20-item self-report depression inventory with possible scores ranging from 0 to 60
58. Interview with Director, Whole Child, at Tacoma Public Schools, 2022
59. Assuming the treatment ratio of patients to providers is 6:1 and the current rate of providers using group care is 0%. Interview with Executive Director for Integrated Student Support and Prevention, Intervention, and Treatment Services of ESD113. ESD113 does ~50% of clinical mental health care in groups.
60. Social Emotional Learning Curriculum, <https://www.tacomaschools.org/departments/businessandfinance/esser-funding/investments/investment-detail/~board/esser-investments/post/social-emotional-learning-curriculum>
61. Approximately 1,000 students referred to community mental health counselors in 2022 per interview with Director, Whole Child, at Tacoma Public Schools with annual funding to program of \$100,000 scaled up to 63,000 youth statewide
62. Goodrich DE, Kilbourne AM, Nord KM, Bauer MS, "Mental health collaborative care and its role in primary care settings," 2014
63. 4. Rowan K, Et al. Access and cost barriers to mental health care and <https://www.kff.org/other/state-indicator/children-0-18>; Interview with Puyallup School District Director of Equity & Social Emotional Wellness, Dec 2022
64. Ashley Laretta, "How Much Does Therapy Cost?," June 2022
65. KFF, "Health Insurance Coverage of Children 0-18", 2021
66. Mental Health America, The State of Mental Health in America 2023
67. Washington State Health Care Authority: Medicaid-funded school-based health care services and supports
68. Act signed on 06/18/2021, I Matter program announced and launched 10/27/2021, Colorado General Assembly, "Rapid Mental Health Response for Colorado Youth," Colorado Sun, "Colorado launches website to connect kids to free mental health sessions," 2021
69. Hawaii has a similar teletherapy program to Puyallup School District covering all students with no copays for care; "Hawaii K-12 Schools to Implement Telehealth Statewide," <https://www.govtech.com/education/k-12/hawaii-k-12-schools-to-implement-telehealth-statewide>.
70. "Year 1 cost will not exceed \$10.00 per student, for approximately 170,000 students" Hawaii RFT, DOE Form 7, 08/04/2021
71. Puyallup School District 2021-22 Academic Year Overview of Program Impact
72. Interview with Puyallup School District Director of Equity & Social Emotional Wellness, Dec 2022
73. Estimate based on the approximately 2.4% of students in grades 6-12 who availed of virtual care in Puyallup School District in School Year 2021-2022. If we were to see a similar rate of uptake statewide, this would mean ~15,200 additional adolescents availing of care at no cost to the user, effectively wiping out the affordability barrier.
74. Interview with Puyallup School District Director of Equity & Social Emotional Wellness, Dec 2022
75. Hazel Health Hawaii RFP
76. Interview with Puyallup School District Director of Equity & Social Emotional Wellness, Dec 2022

77. Average of the cost of \$15/person in Puyallup School District and \$10/person in Hawaii. Los Angeles County also recently announced coverage for 1.3M students at an annual cost of \$12M, or \$9.23 per student.
78. Bipartisan Safer Communities Act  
[https://www.murphy.senate.gov/imo/media/doc/bipartisan\\_safer\\_communities\\_act\\_text.pdf](https://www.murphy.senate.gov/imo/media/doc/bipartisan_safer_communities_act_text.pdf)
79. “Washington’s public K–12 schools will receive \$1.853 billion from ARP Act (on top of \$1.042 billion previously appropriated by Congress)” Emily Makings, Washington State Wire, March 2021
80. Distinct from “talk therapy”, cognitive behavioral therapy draws on specific, evidence-based practices and tasks focused on bringing about behavior change in the patient’s life, in addition to changes in thinking.
81. “Realising the Mass Public Benefit of Evidence-Based Psychological Therapies: The IAPT Program”, David M Clark, May 2018
82. Interview with David Clark and Richard Layard, 2022.
83. “Child- and Parent-reported Outcomes and Experience from Child and Young People’s Mental Health Services 2011–2015”, Wolpert, Jacob, Napoleone, Whale, Calderon and Edbrooke-Childs, December 2016. Recovery is defined here as “children that moved from being above threshold on at least one measure at the beginning of treatment, to being below threshold on all measures following treatment.” Reliable Improvement is defined as “where a score on at least one measure changed enough for it to be considered statistically reliable and no other score reliably deteriorated”
84. “Child- and Parent-reported Outcomes and Experience from Child and Young People’s Mental Health Services 2011–2015”, Wolpert, Jacob, Napoleone, Whale, Calderon and Edbrooke-Childs, December 2016.
85. “What next for Transformation Plans?” Kathryn Pugh, Peter Fonaghy, October 2015
86. “Children and Young People’s Mental Health Services Baseline Report Local Transformation Plans Review” 2015
87. At GBP/USD exchange rate of 1.20/1.00 and accounting for 25% CPI inflation from 2015 to 2022 for all 633k adolescents in WA, assuming a similar incidence rate of mental health illness; “Children and Young People’s Mental Health Services Baseline Report Local Transformation Plans Review” 2015
88. \$11 for universal screening and brief interventions; \$10 for training providers in group-based techniques; \$12.50 for universal access to teletherapy; and \$6 for administrative support, data collection, learning, and coordination costs.
89. Just the universal screening and brief interventions implementation at \$11 per student is estimated to return \$42 in savings, as cited above.
90. If individual mental health is not improved, it could reduce total GDP by 3.4%, largely through unemployment and absenteeism (Layard & Clark, Thrive, 2015, pg. 125 – 127). Furthermore, unaddressed mental health issues are estimated to increase taxpayer spending by 2%, through the added spending on mental and physical health care services, and other programs. (Layard & Clark, Thrive, 2015, pg. 84 – 85). With a \$725B economy that is one of the fastest-growing in the U.S., these costs to the economy could eas
91. Edunomics ESSER Spending Dashboard, accessed June 6, 2023: <https://edunomicslab.org/esser-spending/>
92. Hawaii has a similar teletherapy program to Puyallup School District covering all students with no copays for care; “Hawaii K-12 Schools to Implement Telehealth Statewide,” <https://www.govtech.com/education/k-12/hawaii-k-12-schools-to-implement-telehealth-statewide>.
93. Interviews with CO state leadership, 2022, and: “I Matter program gains momentum, addresses growing stress and anxiety facing youth.” <https://cdhs.colorado.gov/press-release/i-matter-program-gains-momentum-addresses-growing-stress-and-anxiety-facing-youth>
94. “Los Angeles County Addresses the Youth Mental Health Crisis Through a Groundbreaking, School-Based Telehealth Collaboration.” <https://www.lacoe.edu/Home/News-Announcements/ID/4766/Los-Angeles-County-Addresses-the-Youth-Mental-Health-Crisis-Through-a-Groundbreaking-School-Based-Telehealth-Collaboration>
95. Interviews with Richard Layard and David Clark, 2022.
96. <https://medicine.umich.edu/dept/psychiatry/news/archive/202201/michigan-docs-tackle-youth-mental-health-crisis-demand-psychiatric-support-u-m-program>