Bree Collaborative | Behavioral Health Early Interventions for Youth
April 10th, 2024| 8-9:30AM
Hybrid

MEMBERS PRESENT VIRTUAL

Terry Lee, MD, Community Health Plan of Washington (Chair)
Thatcher Felt, DO, Yakima Valley Farmworkers Clinic
Denise Dishongh, LMHC, SUDP, ESD 112
Diana Cockrell, MA, SUDP, HCA
Katie Eilers, MPH, MSN, RN, DOH
Brittany Weiner, MS, LMFT, CPPS, Washington State Hospital Association
Linda Coombs, LICSW, United Healthcare
Kevin Mangat, MHA, MS, LMHCA, SUDPT, Navos
Jennifer Wyatt, LMHC, MAC, SUDP, Kind County BH and Recovery Division
Santi Wibawantini, LMFT, CMHS, Kaiser Permanente (KP)
McKenna Parnes , PhD, UW CoLab
Jeffery Greene, MD, Seattle Children's
Angela Cruze, National Foster Youth Institute
Erin Wick, MBA, ESD 113
Sarah Rafton, MSW, WCAAP

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative
Karie Nicholas, MA, GC, Bree Collaborative
Ginny Weir, MPH, Foundation for Health Care Quality CEO
Terrence Capiendo
Cora Espina, NP, CDES
Colleen McCarty, MPH

WELCOME

Beth Bojkov, Bree Collaborative, welcomed everyone to the Behavioral Health Early Intervention for Youth and provided an overview of for the meeting.

Motion to approve March meeting minutes: motion approved.

SCOPING CONVERSATION: FUNCTIONAL IMPAIRMENT AND DIAGNOSES – DR. TERRY LEE, CHPW

Beth turned the meeting over to Dr. Terry Lee from CHPW and our workgroup chair. Dr. Lee provided an overview of a Functional Impairment rating scale (DLA-20) to elaborate on the meaning of functional impairment. Dr. Lee provided an example from the DSM-5 describing conduct disorder severity, including mild, moderate and severe.

- Question: Are these universal tools or can they be used across different audiences?
    - A lot of people use these tools, but they are just examples. DLA-20 can be used to measure progress by clinicians, and there are trainings that go along with it, but it is also a self-assessment. We could find tools used for different audiences.
    - There are tools that are meant to be scored by non-trained people, but often when the tools are used in some analytic or clinical way.
    - Diana: through the Medicaid state plan, there are some services through primary care side, and there are mental health and SUD services under the rehab part of the state plan, sometimes community based mental health. I wanted to mention that we want to make sure the broadest audience possible can use our guidelines.

        - In the Washington Administrative Code, States services requires the GAIN-SS to be used on just the community part of the state plan to look for co-occurring conditions.
            - GAIN-SS is paid for currently, easy to train on, and free to use.
        - Terry: would like to think that outside a healthcare setting, we want to be flexible and not worry administratively where the screening is occurring, and that people can get connected to care wherever they are screened. It would be useful to use one tool across different systems to compare prevalence and need across different settings.
        - Jennifer: maybe we should look at the GAIN-SS in the group, might be really helpful to review what's in the literature and
        - Karie: if different settings are using different measurements, it might be more difficult to develop a metric to track that across settings
    - Thatcher: appreciate the flexibility of the DLA-20 to the levels but have never seen it in practice.
    - Terry: Some states require it being used, but it's just an example. There are cons such as the number of items.
    - Jeffery: in the clinical setting, these are not very familiar – trying to keep it simple in primary care generally the **GAD-7** and **PHQ-9** is most often used. Using the mild-moderate-severe scores helps determine treatment including medication use. ASQ is used to further assess suicide risk.
    - Brittany: all experience with DLA-20 was in community health settings, population often comes in with pretty significant impairment. It was helpful to determine the domains to drive where to intervene; while this tool has lots of items, think it's useful to drive this conversation. The audience is both clinical and nonclinical. If the document is for a large audience where functional impairment may be difficult to understand or scary, we might want to develop that a bit more.
    - Denise: ASAM guides substance use assessment and where to place students. The DLA-20 is very similar to threat assessment. A lot of tools we've been discussing we've already been using in schools.
    - Terry: we might want to consider what screening tools have been validated in different cultural groups

Action: consider highlighting tools commonly used in different settings to screen

Dr. Terry Lee continued by highlighting findings from the National Comorbidity Study – Adolescent Supplement on lifetime prevalence of different behavioral health areas of concern. The highest prevalence was anxiety (31.9%) followed by behavior concerns (19.1%) then mood/depression (14.3%) and substance use (11.4%).

- Karie: Is there any information on the cost of treatment for these conditions?
    - Terry: the Washington State Institute of Public Policy creates reports on the cost to taxpayers on these conditions. There are some cost-benefit analyses that demonstrate savings to taxpayers.
- Thatcher: behavior is pretty broad – assuming that includes ADHD? Is that enmeshed with behavior as an area of concern?
    - Terry: would have to go back and check the study
- Diana: Thoughts on the cost-benefit discussion: roughly 25-30% symptomology shows up by adolescent and 75% by age of 25 – the cost of a young person not getting a diploma, ending up

in criminal system, etc. We might not be able to articulate all of that in this particular report, but we will have a difficult time getting people to care about behavioral health for young people until we connect the costs.
    - WSIPP does publish their model and includes studies that look at cost.
- Jeffery: Want to raise that traditionally, eating disorders have mostly been understood as anorexia nervosa and bulimia, but would argue that obesity could be included in that and people with disordered eating that leads to obesity can lead to depression. That feeds into the increased cost such as metabolic syndromes, hypertension, diabetes etc when we could have intervened earlier to prevent that.
    - Terry: agree that obesity has lots of implications for both mental and physical health. It is not a traditional behavioral health disorder, there is more attention being devoted to intervening in the behavioral health side. It is a good point, and it might be a good area to independently look at.
- Beth: obesity and weight health would be out of scope for this workgroup.

Terry showed the California Evidence-based Clearinghouse for Child Welfare, which deals with the foster care system and child protective services. There are many websites like these, but Dr. Terry Lee wanted to highlight this one because it rates the number of programs for different problems and rates those practice based on the strength of evidence. Then Terry displayed the number of evidence-based treatments and level of support for anxiety, PTSD, behavior, mood, substance use, eating disorder, autism/intellectual disability and attachment. For anxiety, PTSD, behavior, mood/depression, and substance use there are several well supported and/or supported evidence-based treatments.

- Diana: do you happen to know if they look at efficacy in the same way for family preservation and behavioral health treatments?
    - Terry: Family First Preservation Act – federal act that opened up dollars outside the Medicaid system (4E waiver) for child abuse prevention, states can apply for those dollars – this clearinghouse looked at behavioral outcomes and family preservation outcomes, and staying in the community
- Diana from chat: “Will share the youth/ young adult ASAM version coming out sometime next year has framework for co-occurring capable care and home and community-based services at its core, so the nat'l group will be calling for shifts that will support innovation for adolescents and young adult SUD care too.”

Terry combined the information we’ve been discussing, highlighting areas of concern such as anxiety, PTSD, behavior, mood/depression and substance use, which have higher lifetime prevalence, a mature body of evidence and available low-cost or free trainings for providers. That is why we aim to focus on these areas of concern. A lot of things that divert substance use overlap with early interventions for behaviors. Some things like parent monitoring, attachment to schools and peers, if we do these things, we can divert substance use as well.

- Karie: question about highlighting substance use as part of the scope of this – the Bree is currently updating our OUD Treatment report, should we exclude substance use from this report?
- Beth: Bree Treatment for OUD report will address adolescents with OUD, which is not a common condition.
- Brittany: would recommend we focus on early substance use, which does not commonly overlap with OUD. Think it would be reasonable to refer to the OUD Treatment group for their guidelines on adolescents with OUD.
- Denise: been doing substance use with youth for 25 years, it’s usually a symptom of other issues. It will become a problem if we don’t intervene early.

- Erin: Agree with Denise, having done behavioral health with children and adolescents for 25 years, and a lot of times you have to address both. We are trying to prevent kids from using opioids, so anything we can do early and often is critical.
- Thatcher: Support clinically keeping substance use in the report and want to stress the early intervention component.
- Sarah from chat: "I think we should model integrating SUD and MH treatment. We are in denial if we think kids with MH needs in middle and high school are not using substances. They deserve integrated care."
- Diana from chat: "I hope this group holds SUD and MH together for kids - a continued bifurcated system and reccs are keeping the field from being able to serve people first - diagnosis second."

Beth then provided some speaker updates, including:

- First Approach Skills Training (FAST) Program
    - Colleen McCarty – brought FAST B curriculum for elementary schools in Oak Harbor, great feedback from parents.
    - Sarah from chat: "This outreach and support to 2 elementary schools was funded with a one-time tiny DOH rural health grant ($10K.) We would love to see it scaled and spread. It was a 6-week in person training in the evening for parents and they LOVED it."
- Kids Mental Health Washington: statewide partnership between Kids Mental Health Pierce County, Washington HCA and DDA. They are planning to expand to all regions in the state and provide care coordination and multidisciplinary team meetings when necessary to support youth with complex needs.

Sarah shared that Champions for Youth is a group of primary care clinicians and school leaders working on behavioral healthcare. Sarah pointed out that getting care is super challenging because providers are not available, so it is important to keep in mind that we have to help families/caregivers manage in the interim until they can get care.

PRESENT AND DISCUSS: EVIDENCE REVIEW

Beth provided insight into how evidence was identified and prioritized and introduced the first resources the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Practice Preparation, Identification, Assessment and Initial Management. The recommendations in these guidelines are as follows:

- Preparation of PC Practice
    - **Recommendation 1**: PC clinicians are encouraged to seek training in depression assessment, identification, diagnosis, and treatment if they are not previously trained (grade of evidence: 5; strength of recommendation: very strong).
    - **Recommendation 2:** PC clinicians should establish relevant referral and collaborations with mental health resources in the community, which may include patients and families who have dealt with adolescent depression and are willing to serve as a resource for other affected adolescents and their family members. Consultations should be pursued whenever available in initial cases until the PC clinician acquires confidence and skills and when challenging cases arise. In addition, whenever available, these resources may also include state-wide or regional child and adolescent psychiatry consultation programs (grade of evidence: 5; strength of recommendation: very strong).
- Identification and Surveillance

    - **Recommendation 1:** Adolescent patients ages 12 years and older should be screened annually for depression (MDD or depressive disorders) with a formal self-report screening tool either on paper or electronically (universal screening) (grade of evidence: 2; strength of recommendation: very strong).
    - **Recommendation 2**: Patients with depression risk factors (eg, a history of previous depressive episodes, a family history, other psychiatric disorders, substance use, trauma, psychosocial adversity, frequent somatic complaints, previous high-scoring screens without a depression diagnosis, etc) should be identified (grade of evidence: 2; strength of recommendation: very strong) and systematically monitored over time for the development of a depressive disorder by using a formal depression instrument or tool (targeted screening) (grade of evidence: 2; strength of recommendation: very strong).
- Assessment and/or Diagnosis
    - **Recommendation 1**: PC clinicians should evaluate for depression in those who screen positive on the formal screening tool (whether it is used as part of universal or targeted screening), in those who present with any emotional problem as the chief complaint, and in those in whom depression is highly suspected despite a negative screen result. Clinicians should assess for depressive symptoms on the basis of the diagnostic criteria established in theDSM-5 or the International Classification of Diseases, 10th Revision(grade of evidence: 3; strength of recommendation: very strong) and should use standardized depression tools to aid in the assessment (if they are not already used as part of the screening process) (grade of evidence: 1; strength of recommendation: very strong).
    - **Recommendation 2**: Assessment for depression should include direct interviews with the patients and families and/or caregivers (grade of evidence: 2; strength of recommendation: very strong) and should include the assessment of functional impairment in different domains (grade of evidence: 1; strength of recommendation: very strong) and other existing psychiatric conditions (grade of evidence: 1; strength of recommendation: very strong). Clinicians should remember to interview an adolescent alone.
- Initial Management
    - **Recommendation 1:** Clinicians should educate and counsel families and patients about depression and options for the management of the disorder (grade of evidence: 5; strength of recommendation: very strong). Clinicians should also discuss the limits of confidentiality with the adolescent and family (grade of evidence: 5; strength of recommendation: very strong).
    - **Recommendation 2:** After appropriate training, PC clinicians should develop a treatment plan with patients and families (grade of evidence: 5; strength of recommendation: very strong) and set specific treatment goals in key areas of functioning, including home, peer, and school settings (grade of evidence: 5; strength of recommendation: very strong).
    - **Recommendation 3**: All management should include the establishment of a safety plan, which includes restricting lethal means, engaging a concerned third party, and developing an emergency communication mechanism should the patient deteriorate, become actively suicidal or dangerous to others, or experience an acute crisis associated with psychosocial stressors, especially during the period of initial treatment, when safety concerns are the highest (grade of evidence: 3; strength of recommendation: very

strong). The establishment and development of a safety plan within the home environment is another important management step.

Beth then asked the group to identify if these guidelines would be something the group would want to endorse, and invited comments/questions.

- Brittany: When we think about adopting these guidelines, we want to make sure that we highlight priority actions without discouraging primary care practices from trying some and not all of the guidelines if they can't adopt all of them.
- Sarah: primary care is hungry for doing this work, I don't think it's a huge lift to get to a point where primary care has a better system in place. Most places in primary care are super interested in doing this work but the resources.
- Thatcher in chat: "Everything just presented is great. I do my very best to implement all the steps outlined with teens. The challenge is time limitations. Doing all this in 20min is difficult at best."

Action: revisit these general steps in the recommendations to identify priorities and outline the gaps to implementing them in full.

PUBLIC COMMENT AND GOOD OF THE ORDER

Ms. Bojkov invited final comments or public comments, then thanked all for attending. At the next workgroup, the group will hear from the program directors at the First Approach Skills Training and continue our discussion of our first focus area identification and assessment.
The workgroup's next meeting will be on **Wednesday, May 8th, 2024 from 8-9:30AM**.