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

MEMBERS PRESENT VIRTUAL

Terry Lee, MD, Community Health Plan of Washington (Chair)
Diana Cockrell, MA, SUDP, HCA
Katie Eilers, MPH, MSN, RN, DOH
Brittany Weiner, MS, LMFT, CPPS, Washington State Hospital Association
Santi Wibawantini, LMFT, CMHS, Kaiser Permanente (KP)
Delaney Knottnerus, LICSW SUDP, King County
McKenna F Parnes, PhD, UW Department of Psychiatry and Behavioral Sciences
Libby Hein, LMHC, Molina
Margaret Soukup
Sara Ellsworth
Jeffery Greene, MD, Seattle Children's
Thatcher Felt, MD, Seattle Children's

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative
Karie Nicholas, MA, GC, Bree Collaborative
Gina Cabiddu, Kids Mental Health Washington
Sarah Michelle Leonard, King County

WELCOME

Beth Bojkov, Bree Collaborative, welcomed everyone to the Behavioral Health Early Intervention for Youth and provided an overview of for the meeting. Minutes were approved at the end of the meeting.
Motion to approve June meeting minutes: motion approved.

PRESENTATION: KING COUNTY SB-SBIRT

Delaney Knottnerus, LICSW SUDP, King County presented on the school-based SBIRT program in King County.

- Best Starts for Kids approach grounded in promotion, prevention, early intervention and policy & systems change. Overall strengths-based approach.
- Components of screening – asking a series of questions; brief intervention – connection with the individual around behaviors; refer – connect with resources as the person is willing and as needed
    - Screening is self directed, digital, universal and using the Check Yourself tool developed with Seattle Children's
    - Brief Intervention with a school intereventionist using motivational interviewing principles
    - Referral – students with identified needs for support may be referred to resources internally and externally
- Currently in 11 districts, some grants sunsetted December 2021.
- Funded through the Best Starts for Kids levy and MIDD Behavioral Health Sales Tax (4.5 million to sustain current level, budget is getting reduced soon)
- Schools have to develop response protocols, referral networks, and coordination of care

    - Schools are variable in level of preparation. SBIRT has been helpful with formalizing what's happening around behavioral health and mental health in schools.
- Key assumptions
    - Systems level change: Clear, coordinated and integrated system of tier 1, 2 and 3 emotional/behavioral supports, strategic partnerships between districts, schools, and CBOs that result in equitable policies and systems to promote student wellbeing
    - Student level change: increase connectedness between students, caregivers, trusted adults and staff; address unmet needs; decrease health risk behaviors and delay onset of substance use.
- Timeline
    - Before screener, ensure process is voluntary
    - During screener, get confidentiality notice, student consent, staff answer questions, resources and follow up
    - After screener, specific staff review data, staff meet 1x1 with students, loop in caregivers (as needed per district policies)
- Check Yourself
    - Provides interactive feedback based on responses, and encourages healthy behaviors
- SBIRT Tiers by Type of School
    - 2022-2023 school year, where students fall on the tiers
        - Tier 1: ~50%
        - Tier 2: ~35%
        - Tier 3: ~15% - safety risk, endorsing suicidal thoughts/behaviors, harms, needs follow up immediately or before the end of the school day
    - If you're a teacher in the classroom and start to implement screener, about half of students are probably going to have something they endorsed on the tool and need follow up – use this to talk about staffing.
    - For high school, tier 2 is often related to anxiety
- Brief intervention: school staff trained motivational interviewing
- Challenges
    - Most of our funding goes to FTE, people in the building, or community providers to be the "referral"
    - Schools continue to lose funding and are forced to cut positions, most often BH providers
    - Legal
        - All districts interpret legal language differently (FERPA and HIPAA)
        - Who is qualified or not qualified to respond to needs of students? Screening is not an assessment; schools are asked to fill this role. Most are not clinicians, and there are not enough clinicians to fill those roles.
- Cost & Options
    - Consult OSPI guide for screeners, but most are independent tools
    - Check yourself tool is intellectual property of Seattle Children's
- Cost & Options
    - King County using Reclaiming Futures – motivational interviewing
    - Alternatives – UW SMART Center BRISC, FAST, SBIRT NORC, TRAILS
    - Who is doing the work? School based clinicians, school social workers, primary care/health centers
- Expanding to King County

    - SB SBIRT is being implemented in 13 of 19 school districts and does not have funding to expand further at this moment
    - Struggles with finding time to train staff, building buy in from admin, finding referral options once they are screened
- What would expanding statewide look like?
    - There are free screeners using available, although there is not on that covers most needs/issues of students, many already doing assessments and surveys about school culture and climate, either created by counseling teams or through companies like Panorama
    - Following up with students would require dedicated staff, training, and support in administration of screeners
    - Districts are slowly putting in place policies and procedures around responding to mental health, substance use, etc. need to be in place before screening and responding to students. MTSS is slowly being adapted across Washington state
    - Due to current workforce issues, limited referral spaces, there is a challenge in many places with accessing culturally relevant care and even affording care
- **Questions/Discussion**
    - Gina: Kids Mental Health Pierce County – expanding statewide, who are some of the top navigator programs that you're collaborating with and what does that look like?
        - Delaney: mostly been us working with school districts directly, different across districts, more than happy to connect with you later.
    - Thatcher: primary care pediatrician in Yakima area – curious about at what point and if so how does this model loop in primary care providers when there is a concern on how a child/teen is doing? Never see any referrals pr information that families are bringing in, generally it's the school raising concerns needing further intervention based on school-based assessments. Usually, it's the parent that is bringing in concerns.
        - Delaney: it's usually schools with SBHCs that are most connected. Sometimes physical symptoms of behavioral health concerns (e.g., stomachaches) can lead to asking about connecting to primary care. In screening tool we don't have any physical symptom based, but in brief intervention, hope is that folks think about looping in their provider. Disordered eating can be a bridge between physical and behavioral health in these conversations. We hear a lot that professionals would not recognize the youth that need help, which is why we are doing universal screening.
        - Thatcher: what's challenging for us in primary care is when there is a need identified in schools, it's not communicated with the parent, so when the parent and kid comes to a checkup there's not information about what the concern was that needs to be addressed.
    - Beth: seems like data sharing between primary care and schools is key issue, are there any intermediate steps we could recommend are taken?
    - Terry: we should highlight recommendations to communicate between schools and primary care. Almost all parents and kids that I know want me to talk with primary care providers, think we should highlight this piece in the report.
        - Delaney: also think that sometimes youth don't want parents involved, so schools are also navigating that. That will happen depending on the age of the young person. We have to respect their autonomy and understand their fear with their caregivers knowing.

        - Terry: often encounter youth that say they don't want their parents involved, and their can be good reasons. However, most solutions are family based, and work better with family involvement, especially if they can get to the doctor. There often needs to be limited disclosure to caregivers to involve them in getting them to follow up.
        - Delaney: Agree, and that's a lot to put on a school counselor with 5 minutes with a child. Often times they will take whatever the youth's wishes are.
        - Terry: That's an issue too, because without involving family we don't get anywhere.
    - Denise: we often have a lot of issues with both youth not wanting parents involved, or parents not willing to pay for primary care provider visits. We have started including primary care referral as part of our assessment process; also, not every ESD now has a behavioral health navigator, which are required to help set up distress plans. ESDs are now working on embedding system and policy pieces.
    - Sara Ellsworth: one of the challenges we've had is that through the theory, MTSS directs to embed tier 1 before tier 2 and so on, which leaves youth with severe needs without resources.
    - Delaney: During COVID, some school lawyers said they could not continue screening virtually since it's a liability, and was struck with the fact that kids are now struggling even moreso and without resources. Anecdotally before the pandemic people were hesitant on universal screening, but now its not like that.
    - Sara Ellsworth: theory is MTSS is using some sort of fidelity tool and you move through tiers. Pushback from schools because their tier 1 and tier 2 ready to go.
    - Delaney: we haven't experienced that, but our model aligns well with MTSS, but we're also funders and giving money to do it.
        - Margaret: we put out RFPs, districts self-select. We did planning grants before they were implementing. They had to have implementation plan and respond to MTSS plans as well, saying they need to build that out first. We don't ask people to start universal screening right away, but to roll it out over a period of time.

DISCUSSION ON SCHOOL-BASED SBIRT DRAFT GUIDELINES

Beth transitioned the group to begin reviewing the draft school-based guidelines. The draft guidelines are meant to be core components/actions that we want schools (or other audiences) to act on. We also have scope within this group to identify an ideal state (e.g., every school in Washington has a school-based health center) that would be the ideal way for youth and families to get access to early intervention and behavioral health services.

- Thatcher: on the bullet point "establishing partnerships with community behavioral health providers…" agree with that, but there is a challenge in data sharing between school behavioral health and primary care. In order to have a resource for referring tier 1 kids an teens, primary care has partnership with community based BH providers – accessibility is a problem, sometimes it's better to refer to primary care. BH staff in primary care are much more accessible. If the primary care provider is involved, they could get connected much easier. We should consider expanding to primary care because there is mental health service in primary care.
    - Terry: agree, and think we need to call this out to improve the link between schools and primary care, recognizing there are confidentiality issues. Thatcher happens to be part of a primary care organization that has an excellent youth behavioral health program.

Not all primary care organizations have the same resources, but it shows what is possible.

- Terry: do people think we will ever get to the point where every middle or high school will have a health center? See some people shaking their heads.
    - Denise: Think it is difficult to start school-based health center in a rural community, we've been struggling at white salmon since before the pandemic, getting services started and staffing like a PCP. We are looking at changing to a mobile health center, especially for community where schools are super far apart from each other. Works well in the cities, but not working so well in rural communities.
    - Sara E: they are started under grant funding, and most are not able to sustain services when they have to bill, it's really challenging because the services are not billable.
    - Beth: thoughts from partners who are with plans?
        - Terry: part of it is financial sustainability, also personnel issue, workforce issue, I like the idea of a mobile clinic. Economy of scale doesn't lend itself to doing SBHC in each school.
        - Thatcher: it is difficult enough to just staff a clinic in a rural area, to think sustainably staffing a SBHC in every rural area, it's unattainable.
        - Denise: out in White Salmon we are trying to add dental health to our mobile clinic, we're hoping to combine all services so students can receive everything from the mobile clinic
    - Libby: the language that support staff use in trying to engaging parents in the treatment planning for youth and families is not really taught in healthcare training programs.
        - Terry: training staff whether they are mental health clinicians or not on how to talk with youth to encourage caregiver/parent and primary care providers.
    - Sarah L: a lot of people making referrals are not clinical staff, so having to create my own referral form without clinical training is a huge lift. Having a plug and play form to send to PCPs would be super helpful.
        - Thatcher: that would be wonderful, highly support.
        - Terry: could offer a model or recommend a creation of a model, because each school district interprets legal language a bit differently, so each district would want to adapt that themselves.

PRESENTATION: EVIDENCE-BASED PRACTICES FOR MILD-MODERATE YBH

McKenna F Parnes , PhD, UW Department of Psychiatry and Behavioral Sciences presented on the evidence-based practice for youth mental health.

- Evidence-based practice is the "integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences" (APA 2008)
- Core components
    - Skill building
    - Specific problem focus
    - Assessment of progress
    - Brief treatment
    - Additional elements to consider for children and youth
        - Family and caregiver involvement
        - Behavioral and cognitive targets
        - Environment/skill translation (doing well in certain contexts but not others)
- Adopting empirically supported treatments versus incorporating core components

    - Empirically supported treatmetns – come with treatment manual, high quality experimental research demonstrates effectiveness requires fidelity to adhere to approach
    - Core components – features, attributes, characteristics of program that promote positive outcomes, identified through meta-analysis of studies
- Treatment approaches for anxiety, depression, trauma
    - Usually a combination of cognitive and behavioral with interpersonal elements
    - Examples:
        - CBT/coping cat
        - Interpersonal psychotherapy
        - Caregiver based treatment
        - Trauma focused CBT/attachment frameworks
- Treatments for ADHD/disruptive behaviors
    - Examples
        - Parent management training
        - School-/home-based reward system
        - Executive function/behavior coaching
        - Play therapy
- Treatments for Substance use disorder
    - Examples
        - Family based therapy
        - Cognitive behavioral therapy
        - Motivational interviewing
        - Contingency management
    - More and more folks are looking to harm reduction
- Limitations
    - Lack of cultural responsiveness and gaps in adaptation/effectiveness studies
    - Language barriers to delivering to non-English speaking communities
    - Limited capacity for training/supervision/support and time constraints in delivering care
    - Belief that manualized treatments are rigid/inflexible and skepticism
    - Concern that despite demonstrated efficacy in controlled settings, not effective in community context
    - No infrastructure to support tracking outcomes
- Common elements treatment approach
    - Modular, community-based treatment approach to address various mental, behavioral and social problems together
    - Adaptable to meet the needs and situations of childnre/youth and families
    - Treatment elements, sequence and dosage can be customized
    - Able to be implemented by lay providers in the community
- CBT+ is a common elements treatment approach – CETA
- Questions/Discussions
    - Terry: both CBT+ and FAST are free trainings for professionals
    - Libby: Sarah Walker is looking at this for wellness specialists, she's been doing some work around the workforce, adding this on for possible certification for peer support or community health workers for them to help
        - Terry: there is a general trend to lowering barriers to provide effective treatments, even from other countries. By hiring community health workers and

workers from the community, it creates more effective treatment and helps engagement
    - Delaney: something to consider is who is doing this work, we have a lot of school staff asking us for clinical and treatment intervention skills. Some of it is outside their wheelhouse, what we struggle with is getting them helpful training that is within their scope.
    - Terry: we should consider commenting in the report this movement towards non-clinicians and their role in supporting a solution.

ACTION ITEMS

- Send school-based guidelines for first round of feedback
- Expanding workforce capacity through additional roles

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 review expanding workforce roles

The workgroup's next meeting will be on **Wednesday, August 14th, 2024 from 8-9:30AM**.