

Working together to improve health care quality, outcomes, and affordability in Washington State.

**Early Intervention for Youth Behavioral Health Report and Guidelines**

**2024**

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# Executive Summary

This report and guidelines focus on strategies in primary care and school settings for advancing the early identification and connection of youth to services and interventions for the most common youth behavioral health needs for which training for effective treatments are most reasonable accessible in Washington state. For this report, **“early” refers to the stage of progress of a behavioral health concern, not chronological age.** Using a public health framework, described below, the scope concentrates on universal identification and targeted supports and interventions.

The workgroup endorses and public health prevention approach to behavioral health for youth, blending primary, secondary and tertiary prevention[[1]](#endnote-2) with the socioecological model.[[2]](#endnote-3) In a prevention framework, primary prevention consists of measures aimed at preventing disease or health concerns altogether – for behavioral health, this constitutes health promotion activities for wellbeing and emotional health. Secondary prevention emphasizes early detection, even in subclinical forms of concerns, such as universal screening for mental health and substance use concerns. Tertiary prevention aims to mitigate or reduce severity of a condition or concern, commonly rehabilitative efforts. These levels of prevention can also be seen through the lens of the socioecological model, which recognizes the complex interplay between any individual and their environment at the macro (policy, natural environment, built environment), interpersonal and individual level. The workgroup has created guidelines directed at both interpersonal and macro socioecological levels.

The workgroup recognizes the full spectrum of evidence-based behavioral health services should be readily and equitably accessible for all youth and their caregivers. However, several topics were identified as being out of scope for this report and set of guidelines. These include specific strategies for other places where youth may often frequent including community, cultural and spiritual based settings; universal wellbeing and emotional health promotion activities, detailed instructions on implementing evidence-based effective interventions for the identified most common behavioral health concerns, interventions for less common conditions, and conditions for which effective interventions and/or training are not readily available. A brief summary of the guidelines is included below:

## Summary

1. Identification and treatment of behavioral health concerns early in the course of symptom development can improve prognosis and youth wellbeing and functioning and reduce further complications and suffering.
2. Primary care settings should be ready and able to identify, provide brief intervention and referral to BH services for all youth.
3. School-based providers should be ready to identify and refer appropriate providers on or off-site for intervention.
4. Standardized tools to measure behavioral health symptoms should be required and reimbursed for in healthcare visits and schools.
5. Targeted supports for youth with risk factors and/or pre- or sub-clinical symptoms but do not meet criteria for a BH diagnosis should be reimbursed and provided.
6. Activities associated with connecting youth to needed behavioral health services should be required and reimbursed for.
7. Services should be culturally and linguistically appropriate ([CLAS](https://cccm.thinkculturalhealth.hhs.gov/PDF_Docs/CLASStandards.pdf))
8. Alternative roles should be reimbursed for providing services to youth and families who come from or have knowledge of the communities being served (e.g., peer support workers, community health workers, promotores/as, etc)
9. Technical solutions are necessary to facilitate communication and information exchange between primary care, behavioral health and school clinical and non-clinical personnel.
10. Agencies should invest in infrastructure to assess impact of policy and systems changes, training and supervision efforts, and clinical and functional outcomes for prevention and intervention activities

# Glossary

**Behavioral Health Support Specialist (BHSS):** a trained professional who works as part of a team to provide behavioral health services to children and youth with mental health or substance use disorders, as well as their families and caregivers. BHSSs have knowledge and skills in areas such as screening, assessment, care coordination, crisis intervention, psychoeducation, peer support, and referral to appropriate resources. BHSSs collaborate with other service providers and systems involved in the care of the child or youth, such as primary care, education, child welfare, juvenile justice, and community-based organizations. BHSSs adhere to ethical standards and practice within their scope of competence (SAMHSA, 2013; NAMI, 2017).

**Measurement-based care**: evidence-based practice of using systematic and routine assessment of the patient’s perspective through patient-reported progress and outcomes, such as symptoms and functioning, throughout the course of mental and behavioral care, to inform treatment decisions and engage patients in their treatment (Scott & Lewis, 2015) Key components include (1) routinely collecting patient-reported outcomes throughout the course of treatment, (2) sharing timely feedback with the patient about their reported progress scores and trends over time, and (3) acting on these data in the context of the provider’s clinical judgment and the patient’s experiences to guide the course of care (i.e., shared-decision making regarding treatment; Lewis et al., 2018; Oslin et al., 2019; Resnick & Hoff, 2019)0F0F[[3]](#endnote-4)

**Strength & Protective Factors:** [here](https://downloads.aap.org/DOCHW/LTSAE_PediatriciansGuide.pdf)

**Warm Handoff**: a process of transferring care from one provider or service to another in a coordinated and respectful manner, with the goal of ensuring continuity and quality of care for the patient. A warm handoff involves direct communication between the providers, either in person or by phone, as well as the involvement of the patient and their family or caregivers in the transition plan. A warm handoff can facilitate the establishment of trust and rapport between the new provider and the patient, reduce barriers to accessing care, and prevent gaps or delays in service delivery. (AHRQ, 2017; SAMHSA, 2019).

**Youth:** Unless specifically stated, this report will use the term “youth” to refer to young people of all ages under 18 years old.

# Bree Collaborative Background

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 “…to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State.” The Bree Collaborative was named in memory of Dr. Robert Bree, a leader in the imaging field and a key member of previous health care quality improvement collaborative projects.

Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying health care services annually with substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each health care service, the Bree Collaborative identifies and recommends best-practice, evidence-based approaches that build upon existing efforts and quality improvement activities to decrease variation. In the bill, the legislature does not authorize agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private health care purchasers or carriers.

See **Appendix**  for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State’s largest health care purchasers, Medicaid, and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, health care service quality, and the affordability of health care for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: [www.breecollaborative.org](http://www.breecollaborative.org).

Bree Collaborative members identified diabetes care as a priority improvement area and convened a workgroup to develop evidence-informed standards. The workgroup met from January 2024 to January 2025.

See **Appendix** for the workgroup charter and a list of members.

# Background

Behavioral health encompasses both mental health and substance use disorders, which affect the emotional, psychological, and social well-being of individuals and communities. Nationally, poor mental health and suicidality have worsened over the past decade. In 2021, 1 of every 5 adolescents experienced an episode of major depression within the past year, and 75% of them experienced severe impairment with home, school and family life.1F1F[[4]](#endnote-5) In 2023, 40% of high school students reported feeling sad or hopeless almost every day for 2 or more weeks in a row; female students and students who identified as LGBTQ+ were more likely than their peers to report persistent feelings of sadness or hopelessness.2F2F[[5]](#endnote-6) 1 in every 5 high school students reported seriously considering attempting suicide during the past year, both nationally and in Washington state.3F3F[[6]](#endnote-7); Between 2013 to 2021, rates of youth suicide and attempted suicide in Washington have risen by over 600%.4F4F[[7]](#endnote-8) Not all youth are equally as likely to attempt suicide; youth who identify as female, American Indian or Alaska Native, Black, Hispanic, Native Hawaiian or Pacific Islander, or LGBTQ+ are more likely to have attempted suicide in the past year.5F5F[[8]](#endnote-9)

Co-occurring mental health concerns are common in children. Almost 3 out of every 4 youth with depression also experience anxiety, and childhood anxiety is a risk factor for developing depression.6F6F[[9]](#endnote-10) Youth with attention-deficit/hyperactivity disorder (ADHD) often have other concerns or conditions including disruptive behavior, learning disorders, anxiety and depression7F7F[[10]](#endnote-11); many individuals with diagnosed disruptive behavior disorders have underlying comorbid ADHD. Individuals with post-traumatic stress disorder (PTSD) often experience co-occurring substance use disorders.8F8F[[11]](#endnote-12) Almost 10% of children under 18 will be diagnosed with PTSD, and girls are 4 times more likely than boys to develop it.9F9F[[12]](#endnote-13) In addition, many youth with mental health concerns are not receiving adequate treatment for their symptoms. Over 1 in 3 youth have a documented need for mental health treatment.10F10F[[13]](#endnote-14)

Substance use often goes hand in hand with mental health concerns. In 2019, about 4.1 million adolescents (12-17) had a substance use disorder (SUD). The most common SUDs among adolescents were alcohol use disorder (AUD) (12.4% of adolescents) and marijuana use (7.8%); almost 1 million adolescents in the U.S. had both alcohol and marijuana use disorders.11F11F[[14]](#endnote-15) In Washington state in 2023, Almost 40% of 10th graders reported using alcohol at some point in their lifetime, and use was disproportionately higher for American Indian/Alaska Native students (45%). Also, 1.3% of Washington 8th graders reported using drugs other than alcohol, tobacco or marijuana, while American Indian/Alaska Native youth and Black youth reported use over twice as often (2.7%).

Substance use can negatively impact the physical, mental, and social development of youth, as well as increase the risk of developing mental health conditions, such as depression, anxiety, and psychosis.12F12F[[15]](#endnote-16) In 2021, 13.5% of young adults (18-25 years old) had both a substance use disorder and any mental illness.13F13F[[16]](#endnote-17) Substance use can also impair academic performance, increase school dropout rates, and contribute to involvement in the criminal legal system, creating lifelong impact.14F14F[[17]](#endnote-18)

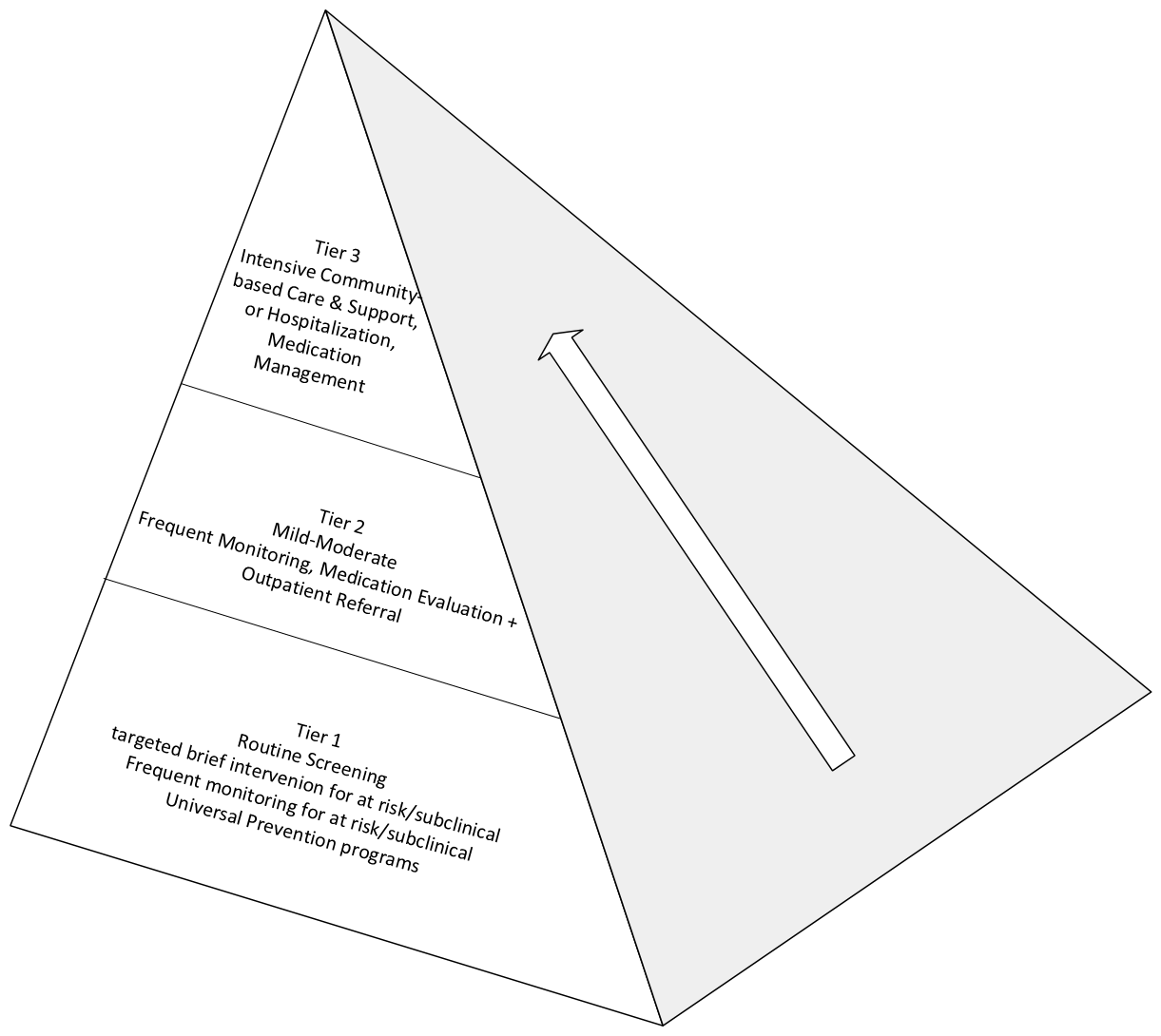
Given the increasing prevalence and serious impact on the health of Washington’s youth and families, improving early identification and intervention of behavioral health concerns is vital. Early intervention aims to identify and address behavioral health concerns as early as possible, before symptoms worsen or conditions become more severe; intervening early can prevent or reduce the severity of symptoms, improve functioning and development, enhance protective factors and resilience, and lower the risk of negative consequences, such as academic issues, substance use, or suicide.15F15F[[18]](#endnote-19)16F16F[[19]](#endnote-20) It can also reduce the social and economic costs for youth, families and healthcare systems associated with untreated or poorly treated behavioral health conditions, including increased health care utilization, increased disability, unemployment, homelessness, or incarceration.17F17F[[20]](#endnote-21)

While early intervention can take place in various settings, pediatric primary care and schools both have important roles in providing early intervention because these settings offer opportunities to reach large numbers of youth and can serve as first points of contact for children and youth with behavioral health concerns. Primary care providers can screen, assess, diagnose, treat and/or refer children and youth with behavioral health concerns, and provide prevention and wellness promotion activities. Schools can also identify and intervene to support or refer students experiencing behavioral health concerns, and provide safe and positive learning environments to support emotional development. Some schools in Washington also bring health services to their students through partnerships with local organizations called [School-Based Health Centers](https://wasbha.org/sbhcs-in-washington/), provide behavioral health services directly to their students by becoming a licensed Behavioral Health Agency in Washington state, or partner with licensed treatment centers to offer group-based recovery onsite for students struggling with varying levels of substance use. Early intervention can involve many kinds of interventions, ranging from psychoeducation and peer support to counseling and medication; however, it is based on the principles of family-centered, youth-driven and culturally responsive evidence-informed care and requires collaboration and coordination across multiple systems and stakeholders.

To narrow the focus of this report and guidelines, the workgroup decided to prioritize writing guidelines for the specific concerns for which there is the highest lifetime prevalence, mature bodies of literature on evidence-based treatments, and availability of low-cost trainings for providers in Washington state. Estimated adolescent prevalence of anxiety, depression, substance use, and behavioral disorders is approximately 32%, 14%, 11% and 19% respectively.18F18F[[21]](#endnote-22) When it comes to evidence-based treatments, anxiety, PTSD, depression, behavioral problems and substance use all have several well-supported evidence-based therapies and have low-cost or free training for providers in Washington state. In addition, evidence-based primary and secondary substance use prevention strategies provide opportunities for earlier intervention. Therefore, the group chose to focus on **selected** **mental health (anxiety, depression, trauma and disruptive behavior) and substance use** **concerns**.

While the group is focusing mainly on these previously mentioned concerns, the workgroup recognizes that many individuals with behavioral health concerns often have multiple co-occurring conditions and concerns, and different people may experience these conditions differently with a wide range of symptoms and signs. This means services should be thoughtfully co-designed with youth and families, allow for no or low barrier to entry of services, based in community and provided in ways and spaces where youth and their families/caregivers feel there’s trust and comfort. To meet the needs of youth experiencing a range of severity in symptoms and concerns, systems can implement tiered systems of services to ensure all youth and families are receiving universal support, and targeted increased interventions when symptoms appear or worsen. Future innovations in payment should move away from diagnostically tied and volume-based reimbursement towards value-based, holistic and low-barrier models that are stratified by demographics to identify and solve inequities in access to care and outcomes

## Tiered Approach to Behavioral Health

  
The workgroup endorses and public health prevention approach to behavioral health for youth, blending primary, secondary and tertiary prevention[[22]](#endnote-23) with the socioecological model.[[23]](#endnote-24) In a prevention framework, primary prevention consists of measures aimed at preventing disease or health concerns altogether – for behavioral health, this constitutes health promotion activities for wellbeing and emotional health. Secondary prevention emphasizes early detection, even in subclinical forms of concerns, such as universal screening for mental health and substance use concerns. Tertiary prevention aims to mitigate or reduce severity of a condition or concern, commonly rehabilitative efforts. These levels of prevention can also be seen through the lens of the socioecological model, which recognizes the complex interplay between any individual and their environment at the macro (policy, natural environment, built environment), interpersonal and individual level. The workgroup has created guidelines directed at both interpersonal and macro socioecological levels and designated specific activities/interventions that line up with the three tiers of prevention.

The workgroup chose the following focus areas as being the most relevant to improving early intervention for children and youth in Washington state.

## Focus Areas

|  |  |
| --- | --- |
| Patient, Caregiver and Provider Education and Capacity Building | * Patient and family education on behavioral health signs and symptoms * Pediatric and school-based providers training on screening, brief intervention, referral and management |
| Screening, Brief Intervention & Referral to Treatment | * Universal systematic screening for behavioral health concerns * Same-day evidence-based brief intervention for mental health and substance use * Holistic assessment and treatment planning to identify risk factors, co-occurring conditions and develop person-centered goals * Expanding access to evidence-based treatments |
| Coordinated Management of Behavioral Health | * Measurement-based behavioral healthcare in primary care * Coordinated care planning between pediatric primary care, behavioral health, patients and caregivers, and school-based clinicians |
| Monitoring & Data Sharing | * Data sharing systems to support coordination of care * Population level tracking of children and youth with behavioral health concerns |
| Incentives & Investments | * Value-based purchasing for outcome-based car * Reimbursement for behavioral health screening and early intervention for subclinical/preclinical symptoms * Funding for home and community-based programs |

## 

# Stakeholder Guidelines

## All Organizations that Provide Services to Children, Youth and Families

* **Family & Youth Driven**
  + Engage families and youth as active partners in decision-making whenever possible.
  + Seek community feedback on changes in service delivery and payment.
* **Home- and Community-based**:
  + Services are provided in the least restrictive setting
* **Culturally and linguistically inclusive**:
  + Prioritize providing agencies, services, and supports the cultural, racial, ethnic, and linguistic diversity of the young people and families they serve.
  + Provide care that meets individual needs, including those shaped by culture and language.
  + Ensure equity in access, quality, and effectiveness of services.

Align with the Washington HCA’s [children’s behavioral health principles](https://www.hca.wa.gov/assets/program/washington-state-childrens-behavioral-health-principles.pdf)

## Pediatric Primary Care Providers

Mild to moderate behavioral health concerns can be managed effectively in the primary care setting with adequate training, infrastructure for screening and follow-up and consultatory support from behavioral health professionals and psychiatric specialists.

#### Education & Capacity Building

1. **Understand risk factors for behavioral health concerns or substance use in children and adolescents** (e.g., adverse childhood experiences, family behavioral health concerns, racism and discrimination, social drivers of health, neurodevelopmental disorders, involvement in foster care, etc)
2. **Know national and local crisis resources, including crisis lines.** (Resource: [Youth Suicide Prevention Resources | Washington State Department of Health](https://doh.wa.gov/you-and-your-family/injury-and-violence-prevention/suicide-prevention/youth-suicide-prevention/youth-resources))
3. **Understand and engage in continuing education opportunities** around the following:
   1. risk factors for youth behavioral health concerns
   2. improved identification of youth behavioral health concerns in primary care
   3. common co-occurring behavioral health concerns in youth
   4. evidence-based interventions for behavioral health concerns in youth
   5. Consider for care for youth with neurodevelopmental disabilities.

#### Screening, Brief Intervention & Referral to Treatment

1. **Whenever a patient is identified with a potential behavioral health concern, assess for common co-occurring conditions,** including but not limited to trauma, ADHD, anxiety, depression.
   1. Consider other symptoms not included in all validated screening tools, such as social isolation and loneliness.
   2. Identify youth and caregivers’ risks, strengths and protective factors (e.g., social support, coping skills) that can support reaching their treatment goals.
   3. Use validated tools to screen/assess for common co-occurring conditions
      1. Traumatic stress (e.g., Child Trauma Screen)
      2. ADHD (e.g, Connors Rating Scale)
      3. Disruptive behavior disorders (e.g, Pediatric Symptom Checklist, Strengths and Difficulties Questionnaire)
2. **Refer to specialists for evaluation** of co-occurring conditions as necessary
3. **Refer patients to behavioral health providers** best suited to address inequities (e.g., LGBTQIA+, marginalized youth, youth involved in foster care, etc**)**
4. **Use warm handoffs** during referrals

#### Co-management

1. **Collaborate** with multidisciplinary team and behavioral health professionals as able to manage behavioral health care
2. **Consult with behavioral health professionals as needed.** (free insurance-agnostic resource: [Partnership Access Line (PAL)](https://www.seattlechildrens.org/healthcare-professionals/community-providers/pal/wa-pal/))
3. **Ensure all patients receive 30-day virtual follow-up** if behavioral health concern identified**.** (e.g., phone call, direct message)
4. **When suicidal ideation is present, ensure follow-up within 24 hours** (e.g., phone call, direct message)
5. **Involve caregivers** in discussions around and interventions for behavioral health (with permission from the patient and as per state statute)

The following steps at a minimum should be taken during any visit

#### Screening, Brief Intervention & Referral to Treatment

1. **For youth with a positive screening result, presenting with a behavioral health related complaint, or for which there is strong clinical suspicion of a behavioral health concern despite a negative screen,** perform an assessment. (resource: [Washington Care Guides – Seattle Children’s](https://www.seattlechildrens.org/healthcare-professionals/community-providers/pal/resources/))
   1. Assess for suicidal ideation, self-harm or substance use that poses immediate danger in confidence without caregiver present (involve caregiver if positive per WA statute).
   2. Use appropriate crisis intervention protocols, including referral to emergency services and/or crisis line if necessary ([**988**](https://www.samhsa.gov/find-help/988)). (Resource: Bree Collaborative’s [Suicide Care](https://www.qualityhealth.org/bree/our-guidelines/suicide-care/) Report)
2. **Provide or refer onsite to receive a brief intervention during visit.** 
   1. Tailor to specific identified concerns
   2. Include psychoeducation about symptoms, treatment options and monitoring for worsening symptoms
   3. Delegate to appropriately trained team member as available (e.g., CHW)
3. **Routinely address behavioral health concerns in confidence** (involve parental input as per state statute)

#### Co-management

1. **If indicated, consider pharmacological management for depression, anxiety, ADHD or substance use disorders** based on most updated clinical practice guidelines. (Resource: [Washington Care Guides – Seattle Children’s](https://www.seattlechildrens.org/healthcare-professionals/community-providers/pal/resources/))
   1. Medications for Opioid Use Disorder (MOUD) is effective to reduce risk of overdose and death for patients under 18. (Resource **Bree Collaborative’s Treatment for Opioid Use Disorder Guidelines** ) page xx and [learnabouttreatment.org.](https://www.learnabouttreatment.org/for-professionals/youth-treatment/)

## Primary Care Clinics

The workgroup recommends primary care settings implement a tiered approachto behavioral health concerns for children and youth that seeks to provide the appropriate level of support and intervention based on screening results, assessment and individualized patient and caregiver preferences and goals.

#### Education & Capacity Building

1. **Provide health information materials on**:
   * recognizing behavioral health signs and symptoms,
   * unhealthy behaviors,
   * how to support peers,
   * how/where to get help when necessary.
2. **Validate that patient facing material is youth-friendly and culturally inclusive**. (Resource: [Teen Health Hub](https://doh.wa.gov/teenhealthhub#:~:text=Find%20credible%20health%20information%20on%20topics))
3. **Ensure primary care healthcare workers are understand the following:**
   * Signs and symptoms of behavioral health concerns in youth
   * Common co-occurring concerns in youth behavioral health
   * Special considerations for populations at higher risk for BH concerns
   * Evidence-based treatment
   * Essentials of youth friendly care
   * Bias and stigma towards people with behavioral health concerns (mental health/substance use)
4. **Offer resources to providers on brief intervention**
5. **Ideally have dedicated staff person** to manage referral process
6. **Establish and train staff on safety protocols for patients at risk of suicide.** Resource: [Bree Collaborative Suicide Care report](https://www.qualityhealth.org/bree/our-guidelines/suicide-care/)
7. **Hire and retain providers and staff** that identify with the communities they serve.
   * Encourage providers to share their identities with youth and caregivers as comfortable.
8. **Consider hiring** [**community health workers**](https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules)**/promotoras, peer support workers** and others with lived experience as part of the multidisciplinary team.
9. **Incorporate telehealth/telemedicine capabilities for visits.**
10. **Have a** **directory** of mental health and substance use disorder referral sources easily accessible (see Washington’s [Mental Health Referral Services for Children and Teens (MHRS) through](https://www.seattlechildrens.org/healthcare-professionals/community-providers/pal/mental-health-referral/))
11. **Build partnerships with community based organizations (CBOs)** that provide support for social drivers of health, including parent support groups.

#### Screening, Brief Intervention and Referral to Treatment

1. **Universally screen annually for youth behavioral health concerns for which there is a validated screening instrument** according to most updated evidence-based guidelines ([Bright Futures](https://publications.aap.org/toolkits/resources/15625/Bright-Futures-Toolkit-Links-to-Commonly-Used), [USPSTF-depression](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-children-adolescents)[, USPSTF-anxiety](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-anxiety-children-adolescents))
   * **Depression** (PHQ2, PHQ9, PHQ-A)
   * **Anxiety** (GAD-2, GAD-7)
   * **Alcohol & Other Substances** (CAGE-AID, CRAFFT)
2. **For youth with a positive screening result, presenting with a behavioral health related complaint, or for which there is strong clinical suspicion of a behavioral health concern despite a negative screen, perform a comprehensive assessment including for common co-occurring conditions.** 
   * Systematically include evaluation for other symptoms not included on all validated screening tools, such as social isolation and loneliness.
   * Assess for suicidal ideation, self-harm or substance use that poses immediate danger in confidence without caregiver present (involve caregiver if positive per WA statute).
   * Use appropriate crisis intervention protocols, including referral to emergency services and/or crisis line if necessary ([**988**](https://www.samhsa.gov/find-help/988)). (Resource: Bree Collaborative’s [Suicide Care](https://www.qualityhealth.org/bree/our-guidelines/suicide-care/) Report)
   * Ask patient for consent to include support system (e.g., caregivers) when discussing screening results.
3. **Identify youth and caregivers’ risks, strengths and protective factors** (e.g., social support, coping skills) that can support reaching their treatment goals.
4. **Provide a brief intervention tailored to identified concern**. (resources: [FAST](https://www.seattlechildrens.org/healthcare-professionals/community-providers/fast/), [Children’s care guides)](https://www.seattlechildrens.org/healthcare-professionals/community-providers/pal/resources/)
   * See[**First Approach Skills Training (FAST) Program**](https://www.seattlechildrens.org/healthcare-professionals/community-providers/fast/) for evidence-based training and brief intervention resources.
5. **Refer to behavioral health professionals as appropriate** through warm handoff.

#### Coordinated Management

1. **Establish a clear plan for follow-up** based on screening results.
   * Suicidal ideation: within 24 hours.
   * Mild: consider telephonic/direct message follow-up within 7 days and face-to-face follow-up within 2-4 weeks.
   * Moderate-Severe: Face-to-Follow up within 7 days
2. **Develop a treatment plan** in partnership with patients, caregivers, and behavioral health professionals
3. **Consider medication management** (including for mild-moderate behavioral health concerns).
4. **Follow patient medication management** closely(e.g., every 3 months)
5. **At follow-ups, use repeated screening with validated tools to measure progress toward symptom reduction**
6. **Use repeated screening results to inform treatment plan adjustments**
7. **With consent, share relevant treatment plan information** with the patient’s school support system directly as able.
8. **Offer group psychotherapy onsite** if behavioral health integrated

#### Data & Measurement

1. **Integrate screening tools into the EHR.** (behavioral health and social determinants of health)
   * Screening can be performed by any qualified member of the care team or completed online ahead of the appointment. (screening tool for SODH example [here](https://prapare.org/what-is-prapare/))
2. **Use a registry to track patients** at risk and with identified behavioral health concerns.
3. **Flag patients for follow-up** from a predetermined care team member
4. **Identify gaps in care** (e.g., missed appointments) and reach out
5. **Stratify registry** by race, ethnicity, language, sexual orientation and gender identity data, and other relevant factors to identify and address inequities
6. When able, **incorporate EHR functionalities that can confirm closed loop referrals** to external providers and CBOs and receive information back.
7. Ensure that outgoing referrals use **interoperable language**

## School Based Health Centers

School-Based Health Centers (SBHCs) play a crucial role in providing accessible healthcare to students. Most SBHCs are primary care clinics that provide care within the school setting. While they are a critical access point for youth in Washington state, most schools in Washington State do not contain health centers. School-based health centers can follow the guidelines for pediatric primary care as closely as possible, and the following guidelines:

* **Engage school staff** as applicable and with patient consent in plans for youth with behavioral health concern.
* Offer **group counseling** onsite to expand accessibility to services**.**
* **Share information** with the community-based providers as applicable.

## Health Plans

#### Financial

1. **Consider alternative population-based payment models** linked to quality metrics that support integration of behavioral health into pediatric primary care and prioritize tracking youth screening for behavioral health, follow-up and outcomes (e.g., [HEDIS DRE](https://www.ahrq.gov/sites/default/files/wysiwyg/pqmp/measures/chronic/chipra-244-fullreport.pdf#:~:text=The%20Depression%20Remission%20or%20Response%20for%20Adolescents%20and,to%208%20months%20of%20the%20elevated%20PHQ-9%20score.)).
2. **Cover (increase rates?)** for [CPT codes](https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/behavioral-health-integration-coding.html#:~:text=Current%20Procedural%20Terminology%20%28CPT%29%20code%2099484%3A%20care%20management,other%20qualified%20health%20care%20professional%2C%20per%20calendar%20month) related to behavioral health in primary care (e.g, CPT 99484, CoCM codes CPT 99492, 99493, 99494, HCPCS G2214)
3. **Include a value-added benefit** for annual well-child visits.
4. **Consider implementing enhanced rates** for location-based codes for school-based health centers to account for lower visit counts
5. **Expand types** **of healthcare professionals** (e.g., CHWs) that can bill for screening for BH
6. **Partner with accountable communities of health** (ACHs) to for social need referrals and to track closed loop referrals.

#### Education/Capacity Building

1. **Educate members in separate pamphlet on available behavioral health services** available at enrollment and annually
2. **Inform in-network clinicians/clinics and members**:
   1. Lack of that there is no increase in cost-sharing for behavioral health screening in primary care
   2. privacy protocols for billing statements
3. **Train staff on HIPAA regulations** and any additional state-specific privacy laws pertaining to healthcare records for individuals under 18.
4. **Train member-facing staff** annually on the following:
   1. Stigma and bias towards people with behavioral health concerns
   2. Special considerations for communities at risk for behavioral health concerns
5. **Ensure disclosure of benefit statements** are compliant with state-specific privacy laws referenced above.
6. **Explore ways for school-based health center providers** can bill for services without being assigned to specific dependents or members

#### Co-management

1. Evaluate and expand provider networks when able to form robust network of primary care and behavioral health professionals both in person and through telehealth.
2. Encourage in-network providers to provide their identities if comfortable for members to review.
3. Work to improve network adequacy for providers trained in foundations of neurodevelopmental diversity
4. Incentivize integration of behavioral health in pediatric primary care.

#### Data & Measurement

1. **Implement privacy protocols and secure EHR systems** that restrict access to sensitive information based on consent parameters aligned with state-specific privacy laws to protect youth information.
2. **Develop the capability to measure and track a set of performance measures** for behavioral health for youth.
3. **Stratify measures** by race, ethnicity, language, SOGI data, and disability as able to identify and intervene to address disparities. See the Bree Collaborative’s **Youth Behavioral Health** **Evaluation Report and Framework**.

## Employer Purchasers

#### Financial

1. Lower total cost of care for behavioral health services for members and their dependents
2. Consider value-based arrangements that incent performance in behavioral health screening and completed follow-up appointments
3. Offer paid parental, medical and sick leave for employees to attend to medical and behavioral health needs.
4. Incorporate flexible working arrangements]] whenever possible (e.g., working remotely) and access to on-site or subsidized childcare.
5. Offer comprehensive employee assistance programs (EAPs) that include behavioral health services, such as counseling and therapy for youth.
6. Communicate the availability of behavioral health services, employee assistance programs and wellness programs to employees.

## Washington State Agencies

### HCA

#### Education & Capacity Building

1. Support educational service districts or school districts to become behavioral health agencies to be able to hire their own behavioral health staff. ([billing guidance](https://www.hca.wa.gov/assets/billers-and-providers/82-0404-medicaid-school-based-behavioral-health-billing-toolkit.pdf))

#### Screening, Brief Intervention & Referral to Treatment

1. **Set standards for screening for behavioral health concerns in youth statewide (e.g., PHQ-9 annually, GAD-7 annually,)** and standardize required follow-up screens after a positive screen. (Example here and )
   1. **Consider incentives for providers to complete screening** (payment per screen,payment for extended visit)
   2. Develop system to monitor delivery of screening as part of quality measurement

#### Financial

1. Enhance rates for family-based interventions and group counseling
2. Prioritize screening and follow-up for youth behavioral health in value-based contracting, and as able, include outcomes-based measures (e.g., HEDIS DRE)
3. ~~Explore pathways to fund tier 1 and 2 services behavioral health prevention services.~~
4. Aid providers to understand what they can bill for behavioral health prevention services
5. In alignment with recent [CMS guidance](https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf), consider allowing billing for skill building and support to address early signs and symptoms of behavioral health concerns (e.g., under the EPSDT benefit). Examples from [California](https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf) and [Colorado](https://hcpf.colorado.gov/sites/hcpf/files/Short-term%20Behavioral%20Health%20Services%20in%20Primary%20Care%20Fact%20Sheet%20Jan%202019.pdf)
6. Align coverage of screening for youth behavioral health concerns with evidence-based guidelines (e.g., Bright Futures).
7. Expand billing capabilities of screening and brief intervention to appropriately trained non-providers

#### Data & Measurement

1. **Facilitate a community information exchange** that allows for electronic closed loop referrals for social and financial needs.
2. Encourage use of electronic health records with interoperability and data sharing capabilities at behavioral health agencies and primary care to support coordinated behavioral and physical healthcare.

### Department of Health

* Explore partnership with other state agencies (e.g., OSPI) to develop a standardized referral form for use between schools and healthcare providers for concerns identified through school-based screening, such as behavioral health concerns.
* Incorporate Bree Collaborative Guidelines in school-based health center and behavioral health services investments.
* Include in the Community Health Worker Core Curriculum a module that captures best practices in youth friendly behavioral health services.
  + Seek opportunities to build the CHW workforce (e.g., [apprenticeship programs](https://www.wacommunityhealth.org/inreach-ma-apprenticeship-da-program))
* Consider development of excellence in youth behavioral health services for clinical practices

The Behavioral Health Early Interventions for Youth workgroup also wishes to address School systems. While these stakeholders are not typically within the purview of the Bree Collaborative, the scope of youth behavioral health necessitates their inclusion.

## Schools

* **Prepare to implement screening, brief intervention and referrals to treatment or support.** 
  + **Engage community stakeholders**, including parents and guardians, **in the design of school-based behavioral health standards, processes and protocols.**
  + **As able, establish partnerships with primary care providers and behavioral health providers** to facilitate referrals for more intensive services. Consider incorporating [Mental Health Referral Service](https://www.seattlechildrens.org/healthcare-professionals/community-providers/pal/mental-health-referral/) network through the state of Washington. Develop partnerships with community social service providers and public health departments to meet other needs.
  + **Consider incorporating telehealth-based services** available on campus through partnerships with local community providers to address transportation barriers. If youth are using telehealth to regularly access behavioral health services, consider complementary regular in-person visits to support engagement and for all youth.
  + **Develop a system to track behavioral health screening**, results and referrals with the ability to monitor follow-up and connection to care.
  + **Ensure appropriate staff are trained** in screening, providing brief intervention and referrals, youth behavioral health, and how to talk to youth about involving their caregivers and primary care with next steps.
  + **Identify a dedicated space for meetings between students and staff and/or students and behavioral health/health care professionals** to facilitate brief interventions and delivery of behavioral health services onsite as available. (e.g., psychotherapy)
* **Screening. Appropriately trained professionals should systematically screen students annually for common childhood and adolescent behavioral health concerns** (anxiety, depression, ADHD, trauma, substance use) according to most updated guidelines (Bright Futures, AAP, National Center for School Mental Health) using a validated instrument(s). A list of screening tools is available on Washington OSPI’s website.
  + Choose a systematic way to screen (e.g., all 6th and 8th graders annually) and follow a timely process for assessing and responding to screening results.
  + **Consider diverse cultural values and attitudes as they relate to behavioral health concerns in your setting.** Different cultures have different views on mental health and substance use disorders, help-seeking and treatment preferences. Provide culturally sensitive and responsive screening tools based on the student population you serve, and interventions that are flexible to student and caregivers’ specific context and needs.
* **Brief Intervention. For those who screen positive, assess severity of concern to determine the level of support necessary** (e.g., brief intervention and follow up versus referral to primary care, outpatient behavioral healthcare and/or immediate referrals for crisis support) and provide brief intervention using evidence-based core components as appropriate.
* **Referral to Treatment or Support. Refer to school-based or community-based primary care and/or behavioral health professionals.** Track and close the loop on referrals to ensure timely connection to care, including immediate crisis response if appropriate.
  + **Sharing information.** Establish a protocol for when concerns are identified, onsite school-based staff connect and share information with the youth’s caregivers (as appropriate and with student’s consent) and their primary care provider to encourage follow-up with healthcare providers after a positive screen.
* **Monitoring and Evaluation.** Collect data on outcomes of screenings, delivery and content of brief interventions, referrals made and linkage to care.
* **Have away to know which students have had referrals** to behavioral health at the population level (without patient level information**)**
  + Stratify data collected by relevant demographics(e.g., race, ethnicity, English as a second language, sexual orientation and gender identity (SOGI), disability status, social needs) to identify and resolve inequities in access to care.

## Washington State Legislature

* Consider funding [RCW.28A.320.127](https://app.leg.wa.gov/RCW/default.aspx?cite=28A.320.127) to support staff for implementing school-based SBIRT.
* Designate a lead agency to support school-based SBIRT and school-based behavioral health services.

# Measurement

While behavioral health conditions are a leading cause of disease burden and cost in the United States, many individuals with substance use disorders or mental health concerns do not receive services to address their needs. Access and engagement disparities disproportionately impact communities that have been intentionally marginalized. To make significant improvements in the healthcare system, quality measures provide information and can be used to evaluate and inform policies and service delivery initiatives. Picking the appropriate quality measures and transparently reporting them across systems can create accountability and drive quality improvement in care. Quality measures are also used to inform payment innovation, fueling the movement towards paying for quality over volume of services.

It is also important to align quality measures across systems and organizations to drive collective action toward common goals. In an environmental scan by the NCQF in 2019, they found across 39 Federal Reporting Programs and their 1,410 measures and metrics, only 48% were standardized quality measures.30F[[24]](#endnote-25) These standardized quality measures focus narrowly on evidence-based treatment for specific conditions or processes and are misaligned and used variably across programs and used administrative claims data. The most frequently used being the following, notably all process measures:

* Follow up After Hospitalization for Mental Illness
* Screening for Depression and Follow-up Plan
* Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
* Preventative Care and Screening – Tobacco Use: Screening and Cessation Intervention

Notably, organizations with various funding streams at facility level lends itself to use of multiple various reporting requirements and use of quality measures. This can cause overburdening of delivery systems at all levels which can cut into staff time and reduce the ability to deliver services in a field already struggling to maintain workforce capacity. In addition, existing behavioral health measures have been described as limited and insufficient to improve quality of care for patients. F31F[[25]](#endnote-26)

See more in our **Evaluation Framework** for more details

# Technology and Social Media

Social media use has become an integral part of many people’s lives, offering opportunities for communication, learning, entertainment, and civic engagement. Media use has skyrocketed for both youth and adults, with the invention of the internet, streaming services and almost all teenagers owning a smartphone.27F28F[[26]](#endnote-27) Social media and the internet are tools that can connect people, share information, and provide opportunities for engagement and more. However, it’s important to recognize when unhealthy use is occurring or damaging mental and/or physical health. Risks with use include impacts on sleep, learning, exposure to substances like alcohol and tobacco products, cyberbullying and online solicitation.

The American Academy of Pediatrics has recommended several steps for both pediatricians and caregivers, including understanding both the benefits and risks of media, consider creating a family media use plan that includes components like daily physical activity and creating boundaries around bedtime, and developing a network of trusted adults who can support if youth and children are experiencing challenges with media use.

The following recommendations were written by the American Academy of Pediatrics to help pediatricians guide conversations about media and device usage for children and youth.28F29F[[27]](#endnote-28)

* Start the conversation early. Ask parents of infants and young children about family media use, their children’s use habits, and media use locations.
* Help families develop a Family Media Use Plan ([www.healthychildren.org](http://www.healthychildren.org)/MediaUsePlan) with specific guidelines for each child and parent.
* Educate parents about brain development in the early years and the importance of hands-on, unstructured, and social play to build language, cognitive, and social-emotional skills.
* **For children younger than 18 months, discourage use of screen media other than video-chatting**.
* **For parents of children 18 to 24 months of age who want to introduce digital media, advise that they choose high-quality programming/apps and use them together with children**, because this is how toddlers learn best. Letting children use media by themselves should be avoided.
* Guide parents to resources for finding quality products (eg, Common Sense Media, PBS Kids, Sesame Workshop).
* **In children older than 2 years, limit media to 1 hour or less per day of high-quality programming**. Recommend shared use between parent and child to promote enhanced learning, greater interaction, and limit setting.
* Recommend no screens during meals and for 1 hour before bedtime.
* Problem-solve with parents facing challenges, such as setting limits, finding alternate activities, and calming children.

For more resources, visit the American Academy of Pediatrics [Center of Excellence on Social Media and Youth Mental Health](https://www.aap.org/en/patient-care/media-and-children/center-of-excellence-on-social-media-and-youth-mental-health/).



# Appendix A. Clinical Guidelines and Systematic Reviews

|  |  |
| --- | --- |
| Source | Guidelines and Reviews |
| AHRQ | [ADHD Diagnosis and Treatment in Children and Adolescents | Effective Health Care (EHC) Program](https://effectivehealthcare.ahrq.gov/products/attention-deficit-hyperactivity-disorder/research)  [Interventions for Substance Use Disorders in Adolescents: A Systematic Review | Effective Health Care (EHC) Program](https://effectivehealthcare.ahrq.gov/products/substance-use-disorders-adolescents/research)  [Treatment of Depression in Children and Adolescents | Effective Health Care (EHC) Program](https://effectivehealthcare.ahrq.gov/products/childhood-depression/research) |
| Cochrane | [Family‐based prevention programmes for alcohol use in young people - Gilligan, C - 2019 | Cochrane Library](https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD012287.pub2/full?highlightAbstract=health%7Cmental%7Cyouth) |
| United States Preventive Services Task Force | [Recommendation: Depression and Suicide Risk in Children and Adolescents: Screening | United States Preventive Services Taskforce](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-children-adolescents)  [Recommendation: Unhealthy Drug Use: Screening | United States Preventive Services Taskforce](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening)  [Recommendation: Anxiety in Children and Adolescents: Screening | United States Preventive Services Taskforce](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-anxiety-children-adolescents) |
| Professional Associations/National Organizations | [Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management | Pediatrics | American Academy of Pediatrics](https://publications.aap.org/pediatrics/article/141/3/e20174081/37626/Guidelines-for-Adolescent-Depression-in-Primary?autologincheck=redirected)  [Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part II. Treatment and Ongoing Management | Pediatrics | American Academy of Pediatrics](https://publications.aap.org/pediatrics/article/141/3/e20174082/37654/Guidelines-for-Adolescent-Depression-in-Primary?autologincheck=redirected)  [Media Use in School-Aged Children and Adolescents | Pediatrics | American Academy of Pediatrics](https://publications.aap.org/pediatrics/article/138/5/e20162592/60321/Media-Use-in-School-Aged-Children-and-Adolescents)  [Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Major and Persistent Depressive Disorders - Journal of the American Academy of Child & Adolescent Psychiatry](https://www.jaacap.org/article/S0890-8567(22)01852-4/abstract)  [Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders](https://www.jaacap.org/action/showPdf?pii=S0890-8567%2820%2930280-X)  [Clinical Update: Child and Adolescent Behavioral Health Care in Community Systems of Care](https://www.jaacap.org/action/showPdf?pii=S0890-8567%2822%2900291-X)  [Recommended Standard Care | National Action Alliance for Suicide Prevention](https://theactionalliance.org/resource/recommended-standard-care) |
| PubMed | [Juwariah T, Suhariadi F, Soedirham O, Priyanto A, Setiyorini E, Siskaningrum A, Adhianata H, Fernandes ADC. Childhood adversities and mental health problems: A systematic review. J Public Health Res. 2022 Aug 28;11(3):22799036221106613. doi: 10.1177/22799036221106613. PMID: 36052096; PMCID: PMC9425896.](https://journals.sagepub.com/doi/full/10.1177/22799036221106613?rfr_dat=cr_pub++0pubmed&url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org)  [Carrillo de Albornoz S, Sia KL, Harris A. The effectiveness of teleconsultations in primary care: systematic review. Fam Pract. 2022 Jan 19;39(1):168-182. doi: 10.1093/fampra/cmab077. PMID: 34278421; PMCID: PMC8344904.](https://pubmed.ncbi.nlm.nih.gov/34278421/)  [Keeshin B, Byrne K, Thorn B, Shepard L. Screening for Trauma in Pediatric Primary Care. Curr Psychiatry Rep. 2020 Sep 5;22(11):60. doi: 10.1007/s11920-020-01183-y. PMID: 32889642; PMCID: PMC7474707.](https://pubmed.ncbi.nlm.nih.gov/32889642/)  [Duong, M. T., Bruns, E. J., Lee, K., Cox, S., Coifman, J., Mayworm, A., & Lyon, A. R. (2021). Rates of Mental Health Service Utilization by Children and Adolescents in Schools and Other Common Service Settings: A Systematic Review and Meta-Analysis. Administration and policy in mental health, 48(3), 420–439. https://doi.org/10.1007/s10488-020-01080-9](https://pubmed.ncbi.nlm.nih.gov/32940884/)  [Koreshe E, Paxton S, Miskovic-Wheatley J, Bryant E, Le A, Maloney D; National Eating Disorder Research Consortium; Touyz S, Maguire S. Prevention and early intervention in eating disorders: findings from a rapid review. J Eat Disord. 2023 Mar 10;11(1):38. doi: 10.1186/s40337-023-00758-3. PMID: 36899428; PMCID: PMC9999654.](https://pmc.ncbi.nlm.nih.gov/articles/PMC9999654/)  [Viduani, A., Arenas, D. L., Benetti, S., Wahid, S. S., Kohrt, B. A., & Kieling, C. (2024). Systematic Review and Meta-Synthesis: How Is Depression Experienced by Adolescents? A Synthesis of the Qualitative Literature. Journal of the American Academy of Child and Adolescent Psychiatry, 63(10), 970–990. https://doi.org/10.1016/j.jaac.2023.11.013](https://pubmed.ncbi.nlm.nih.gov/38340896/)  [Lewis FJ, Rappleyea D, Didericksen K, Sira N, Byrd J, Buton A. Bringing Inclusion Into Pediatric Primary Health Care: A Systematic Review of the Behavioral Health Treatment of Racial and Ethnic Minority Youth. J Pediatr Health Care. 2021 Nov-Dec;35(6):e32-e42. doi: 10.1016/j.pedhc.2021.04.002. Epub 2021 Jun 1. PMID: 34083102.](https://pubmed.ncbi.nlm.nih.gov/34083102/)  [Becker, T. D., Castañeda Ramirez, S., Bruges Boude, A., Leong, A., Ivanov, I., & Rice, T. R. (2023). Interventions for prevention and treatment of substance use in youth with traumatic childhood experiences: a systematic review and synthesis of the literature. European child & adolescent psychiatry, 10.1007/s00787-023-02265-x. Advance online publication. https://doi.org/10.1007/s00787-023-02265-x](https://pubmed.ncbi.nlm.nih.gov/37480386/)  [Family-based treatments for disruptive behavior problems in children and adolescents: An updated review of rigorous studies (2014–April 2020) Ashli J. Sheidow PhD, Michael R. McCart PhD, Tess K. Drazdowski PhD](https://pubmed.ncbi.nlm.nih.gov/34723395/) |

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# Appendix B. First Approach Skills Training Evidence-Based Brief Interventions

[First Approach Skills Training (FAST)](https://www.seattlechildrens.org/healthcare-professionals/community-providers/fast/) programs are designed to provide brief, evidence-based behavioral therapy for youth and families with common mental health concerns, in settings such as primary care clinics or schools where longer-term treatment is not typically provided. FAST programs are designed for clinicians and parents/caregivers to use with their youth.

Evidence-based brief interventions are short-term, focused, and structured treatments that target specific problems or behaviors related to mental health. They are usually based on cognitive-behavioral principles and incorporate techniques such as problem-solving, goal-setting, coping skills, relaxation, or mindfulness. Evidence-based brief interventions can be effective for reducing symptoms, improving functioning, and increasing well-being among students with mild to moderate mental health concerns. FAST created the following resources for several common youth behavioral health concerns:

* Anxiety problems
* Depression problems
* Traumatic events
* Challenging behavior (child and teen)

They also include resources on other topics:

* Early childhood (1-4)
* Sleep tips for teens
* Teens and technology
* Racism & discrimination
* LGBTQ+ mental health

See [provider resources](https://www.seattlechildrens.org/healthcare-professionals/community-providers/fast/primary-care-providers/) and [parent and caregiver resources](https://www.seattlechildrens.org/healthcare-professionals/community-providers/fast/parents-caregivers/).

# Appendix C. Child Serving Systems of Care

Child serving systems of care are coordinated networks of services and supports that are organized to meet the physical, mental, social, emotional, educational, and developmental needs of children and their families. Traditionally these systems have been more provider driven, delivering services through the lens of the professionals and agencies in charge of coordinating them. However, this approach created gaps in meeting the needs of families and children and as such systems have started to shift toward a more family-driven paradigm. Family-driven systems aim to provide individualized, strength-based, culturally and linguistically competent, and family-driven care across multiple settings and domains. The workgroup endorses this as the ideal state for all systems that provide services for youth and families.

**Paradigm Shift in Service Delivery Systems for Children and Youth** (From American Academy of Child and Adolescent Psychiatry)25F26F[[28]](#endnote-29)

|  |  |  |
| --- | --- | --- |
|  | **Provider Driven** | **Family-Driven** |
| Source of Solutions | Professionals and agencies | Child, family and their support team |
| Relationship | Child and family viewed as dependent, and client expected to carry out instructions | Partner/collaborator in decision-making, service provision and accountability |
| Orientation | Isolating and “fixing” a problem viewed as residing in the child or family | [Ecological](https://psycnet.apa.org/record/2018-59956-009) approach enabling child and family to do better in the community |
| Assessment | Deficit-oriented | [Strengths-based](https://www.jpedhc.org/article/S0891-5245(16)30281-4/fulltext) |
| Expectations | Low to modest | High |
| Planning | Agency resource based | Individualized for each child and family |
| Access to Services | Limited by agency’s menus, funding streams, staffing | Comprehensive and provided when and where the child and family require |
| Outcomes | Based on agency function and symptom relief | Based on quality of life and desires of child and family |

# Appendix D. School-based Health Centers

School-based health centers are partnerships between communities, schools and community health providers. health care facilities that are located within or near a school campus and serve the health needs of students and sometimes staff, families, and community members. The purpose of school-based health centers is to improve access to safe, comprehensive, youth-friendly, affordable care that reduces health disparities. These centers work in collaboration with school staff, parents, and community partners to provide coordinated and comprehensive care for students. Studies have found students are more likely to use mental health services in school-based health centers than in community primary care or community behavioral health clinics.26F27F[[29]](#endnote-30)

There are currently over 70 SBHCs in Washington state across different education levels and

Some of the strengths of school-based health centers in Washington state are:

* providing access to quality and comprehensive health care services for students and families who may face barriers to health care, such as lack of insurance or transportation.
* promoting positive health behaviors and outcomes among students, such as increased attendance, academic achievement, self-esteem, and resilience.
* collaborating with school staff, families, and community partners to address the social determinants of health and create supportive and safe school environments.

Some of the challenges of school-based health centers in Washington state are:

* funding constraints and sustainability issues, especially in rural and underserved areas, where the need for health care services may be greater but the resources may be scarcer.
* encountering regulatory and administrative barriers, such as credentialing, billing, reporting, and confidentiality requirements, that may limit their scope of practice and service delivery.
* struggling to recruit and retain qualified and diverse health care providers and staff, who can meet the needs and preferences of the student population and the school community.
* difficulty engaging and retaining students in their services, especially those who are at higher risk of dropping out, experiencing stigma, or facing cultural or linguistic barriers.

# Other Initiatives

[**Children and Youth Behavioral Health Workgroup:**](https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/children-and-youth-behavioral-health-work-group-cybhwg)

This workgroup provides recommendations to the Governor and Legislature to improve behavioral health services and strategies for children, youth and young adults and their families. The larger group is broken up into five sub-groups: behavioral health integration, prenatal to age five relational health, school-based behavioral health and suicide prevention, youth and young adult continuum of care, and workforce and rates. There is also a strategic plan advisory group. Read more about their work [here](https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/children-and-youth-behavioral-health-work-group-cybhwg#vision-and-mission).

[**Seattle Children’s Care Guides**](https://www.seattlechildrens.org/healthcare-professionals/community-providers/pal/resources/)**:**

The Seattle Children’s Care Guides are focused practical points for primary care physicians based on current evidence and literature around mental health treatment. It is based on current evidence in the litreature around mental health treatment for children. They are authored primarily by Dr. Hilt from the Partnership Access Line, a child psychiatric consultation program for primary care providers in Washington state.

[**Youth Advisory Council (YAC)**](https://waportal.org/partners/adolescent-health/youth-engagement-and-youth-advisory-council)**:**

The YAC is *“a community engagement group of diverse young people from around Washington. This group helps the Washington State Department of Health (DOH) learn about the public health topics that are important to young people.”* Participants in the YAC are youth aged 13-22 from all across the state with a variety of different cultural, racial, ethnic and economic backgrounds and identities. Applicants were prioritized from communities most affected by inequities. Read their report and recommendations [here](https://waportal.org/sites/default/files/2024-02/Adolescent%20and%20Young%20Adult%20Health%20Youth%20Advisory%20Council%20Report%20-%202022%20Cohort%20-%20Washington%20State%20Department%20of%20Health_0.pdf).

**ESD Behavioral Health Navigators**: Every ESD has a behavioral health navigator to provide a network of support for school districts to develop and implement comprehensive suicide prevention and behavioral health supports for students. Read more [here](https://www.k12.wa.us/student-success/health-safety/mental-social-behavioral-health/youth-suicide-prevention-intervention-postvention).

[**Kids Mental Health Washington:**](https://kidsmentalhealthwa.org/)

Kids Mental Health Washington is a partnership between the Health Care Authority, Kids mental Health Pierce County and the Developmental Disabilities Administration (DDA) to stand up youth regional behavioral health navigation teams in every region of the state. These teams will focus on improving collaborative communication, service connection processes and deploying multidisciplinary teams (MDTs) designed to improve access to and coordination of services for children and youth with behavioral health challenges. They prioritize young people needing more intensive services. Read more [here](https://kidsmentalhealthwa.org/about/).

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