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

Behavioral Health Early Intervention for Youth Report and Guidelines 2024

Table of Contents

Executive Summary

This report and guidelines focus on strategies for early identification (i.e., stage of disease progress not chronological age), interventions, and referral to treatment for common behavioral health conditions impacting youth under 18 years of age that have effective, accessible treatment. Behavioral health encompasses "mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms,"[i] which significantly impact the well-being of individuals and communities. Behavioral health concerns for youth are driven by a combination of physical, biological, psychological and social factors, and are significantly influenced by growth and development stages. Identification and treatment of behavioral health concerns early in the course of symptom development can improve prognosis, wellbeing, and functioning. These guidelines focus on primary care with a secondary focus on school-based health care settings. Other settings (e.g., community settings), developmental, neurotype assessment (e.g., autism), and physical diagnoses (e.g., vision, sleep) are out of scope of this guideline.

This guideline builds on the Bree Collaborative's 2017 Behavioral Health Integration guideline. While not all systems will be able to provide fully integrated behavioral health currently, progress toward this high-quality care delivery model should be prioritized. Integrated behavioral health is the most effective mechanism to increase access. The guideline also calls for appropriate funding for the components of integrated care and for State agencies to 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. These guidelines also build on a public health framework of universal identification with targeted supports and interventions, blending primary (preventing disease), secondary (early disease identification), and tertiary (reducing disease severity) prevention[ii] with the socioecological model.[iii]

The workgroup developed the following focus areas to provide a framework for the guidelines, highlighting areas of opportunity and change for delivery systems, health care plans, health care purchasers, state agencies as purchasers and regulatory bodies, and others.

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 • Evidence-based brief intervention for mental health and substance use as soon as possible • 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 • Monitoring time to treatment
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 and coordinated care

The Bree Collaborative's goal is to improve the overall health for people within Washington State by impacting care delivery, payment, experience, quality, affordability, and equity. These guidelines are intended to be actionable for those across the health care ecosystem. On the following pages are action items for each partner group by type. Most other relevant information can be found in the appendices, as follows:

See **Appendix A** for a summary of reviewed evidence.
See **Appendix B** for a background on the Bree Collaborative and list of members.
See **Appendix C** for the workgroup charter and a list of members.
See **Appendix D** for a more detailed background on youth behavioral health.
See **Appendix E** for a glossary of commonly used terms.

See further appendices for additional information.

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 as they evolve

Primary Care Clinics serving Pediatric Patients

The workgroup recommends primary care settings implement a tiered approach to 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. These guidelines serve as minimum standards for primary care clinics, and are designed to be model agnostic. *These settings include pediatric primary care offices, family medicine offices, and other outpatient clinics settings where children and adolescents receive primary care.*

Education & Capacity Building

- **Prioritize further integrating behavioral health into the clinic** (e.g., Pediatric Collaborative Care Model) consider resources available (e.g., UW AIMS Center), making sure that care is developmentally appropriate.
- **Offer teen-friendly and culturally inclusive health information materials on**: (Resource: Teen Health Hub)
  - Recognizing behavioral health signs and symptoms
  - Unhealthy behaviors
  - How to support peers
  - How/where to get help when necessary
- **Ensure staff know national and local crisis resources, including crisis lines.** (Resource: Youth Suicide Prevention Resources | Washington State Department of Health)
- **Ensure primary care healthcare workers understand/receive training on including but not limited to:**
  - How to discuss family involvement in care with youth
  - Risk, strength and protective factors for youth
  - 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
    - Bias and stigma towards people with behavioral health concerns (mental health/substance use)
- **Offer resources to providers** on brief intervention
- **Ideally, have dedicated staff person** to manage referral process
- **Establish and train staff on safety protocols for patients at risk of suicide.** Resource: Bree Collaborative Suicide Care report
- **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.
- **Consider hiring community health workers/promotoras, peer support workers,** and others with lived experience as part of the multidisciplinary team.
- **Incorporate telehealth/telemedicine capabilities for visits.**
- **Have a directory with provider demographic data** of BH referral sources easily accessible (see Washington's Mental Health Referral Services for Children and Teens (MHRS) through)
- **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

- **Universally screen annually for youth behavioral health concerns for which there is an age appropriate validated screening instrument** according to most updated evidence-based guidelines (Bright Futures, USPSTF-depression, USPSTF-anxiety)
    - **Depression** (PHQ2, PHQ9, PHQ-A)
    - **Anxiety** (GAD-2, GAD-7)
    - **Alcohol & Other Substances** (CAGE-AID, CRAFFT)
    - Consider screening tools for younger ages (e.g., SCARED, Vanderbilt, SMQ, PROMIS)
- **Enter screening results** into the medical record
- **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**.
    - ~~o~~ 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). (resource: Supporting Adolescent Patients in Crisis)
    - Use appropriate crisis intervention protocols, including referral to emergency services and/or crisis line if necessary (**988**). (Resource: Bree Collaborative's Suicide Care Report)
    - Ask patient for consent to include support system (e.g., caregivers) when discussing screening results.
- **Use validated tools when assessing for common co-occurring conditions** (E.g., Child Trauma Screen, Connors Rating Scale, Pediatric Symptom Checklist, Strengths and Difficulties Questionnaire, Vanderbilt Assessment Scales (ADHD))
- **Consult with behavioral health professionals as needed.** (free insurance-agnostic resource: Partnership Access Line (PAL)

- **Routinely address behavioral health concerns in confidence,** but involve caregivers with permission and per statute
- **Identify youth and caregivers' risks, strengths and protective factors** (e.g., social support, coping skills) that can support reaching their treatment goals.
- **Provide or refer for a brief intervention** tailored to identified concern when indicated. (resources: FAST, Children's care guides)
    - See **First Approach Skills Training (FAST) Program** for evidence-based training and brief intervention resources.
    - Provides may delegate to appropriately trained team member as available (e.g., CHW)
- **Refer to specialists for evaluation** of co-occurring conditions as necessary
- **Refer patients and families to behavioral health providers,** especially those who share characteristics (race, ethnicity, sexual orientation) with youth and family as possible.
- **Ideally, use warm handoffs** when referral is necessary

Coordinated Management

- **If indicated, consider pharmacological management for depression, anxiety, ADHD or substance use disorders** based on most updated clinical practice guidelines. (e.g.,: Washington Care Guides – Seattle Children's)
    - Consider non-pharmacological methods to accompany medication and in collaboration with youth and families
    - 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**), learnabouttreatment.org., and Adolescent Learning Collaborative
- **Follow up at a time that is appropriate to the acuity of the need.** (e.g., youth with suicidal ideation may need to be held for evaluation and potential escalation of care – Supporting Adolescent Patients in Crisis)
- **Develop a treatment plan** in partnership with patients, caregivers, and behavioral health professionals. Consider inquiring about school-based assessments and psychological educational assessments as appropriate.
- **Follow patient medication management** closely (e.g., every 3 months)
- **At follow-ups, use repeated screening with validated tools to measure progress toward symptom reduction**
- **Use repeated screening results to inform treatment plan adjustments**
- **With consent, share relevant treatment plan information** with the patient's school support system directly as able.
- **Share care plans** with professionals involved in youth and their support system's care, including inquiring about and integrating with educational plans (e.g., IEPs, Section 504 plans)
- **Consider how to make steps towards providing integrated behavioral health in your delivery system.** Integrated models such as the Pediatric Collaborative Care model have shown to improve mental health outcomes above regular practice
- **Offer group psychotherapy onsite** if behavioral health integrated.

Data & Measurement.

- **Integrate behavioral health screening tools into the EHR when able**

    - 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)
- **Use a registry to track patients** with a history of a positive screen.
- **Flag patients for follow-up** from a predetermined care team member
- **Identify gaps in care** (e.g., missed appointments) and reach out
- **Stratify registry** by race, ethnicity, language, sexual orientation and gender identity data, and other relevant factors to identify and address inequities
- When able, **incorporate EHR functionalities that can confirm closed loop referrals** to external providers and CBOs and receive information back.
- Provide electronic referrals **interoperable language**

School Based Health Centers

School-Based Health Centers (SBHCs) play a crucial role in providing accessible healthcare to students and preventing substance use and/or worsening mental health concerns. 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.
- **Use clear guidelines regarding release of information** and use privacy protocols to protect student and family information

Health Plans

Financial

- **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).
- **Consider ways to incentivize delivery systems to integrate behavioral and primary health care services and when able, use of** CPT codes related to behavioral health in primary care (e.g, CPT 99484, CoCM codes CPT 99492, 99493, 99494, HCPCS G2214)
    a. **Consider evidence-based integrated models of care** (e.g, Pediatric Collaborative Care Model)
- **Include a value-added benefit** for annual well-child visits including with BH screening
- **Explore alternative payment models** for school-based health center-based providers to account for lower visit counts.
- **Expand types of healthcare professionals** (e.g., CHWs) that can bill for screening for behavioral health symptoms as available
- **Partner with accountable communities of health** (ACHs) to for social need referrals and to track closed loop referrals.

Education/Capacity Building

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

Co-management

- Evaluate and expand provider networks when able to form robust network of primary care and behavioral health professionals both in person and through telehealth.
- **Encourage in-network providers** to provide demographic, cultural, and linguistic information accessible by members
- Incentivize integration of behavioral health in pediatric primary care.

Data & Measurement

- **Utilize privacy protocols and secure systems** that restrict access to sensitive information based on state-specific privacy laws
- **Develop the capability to measure and track a set of performance measures** for behavioral health for youth.
- **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

- Minimize out-of-pocket cost of BH care for employees and dependents as able
- Consider value-based arrangements that incent performance in behavioral health screening, completed follow-up appointments, and improved outcomes
- As able, incentivize integration of behavioral health with primary care
- Offer paid parental, medical, and sick leave for employees to attend to medical and behavioral health needs.
- Incorporate flexible working arrangements whenever possible (e.g., working remotely) and access to on-site or subsidized childcare.
- Provide BH services as part of the EAPs (youth-focused counseling)
- Communicate the availability of behavioral health services, employee assistance programs, and wellness programs to employees.

Washington State Agencies

HCA

Education & Capacity Building

- **Drive state-wide efforts** to incentivize mental health promotion and early intervention services
- **Support educational service districts or school districts to become behavioral health agencies** to be able to hire their own behavioral health staff.
- **Seek and include feedback from communities** you serve in design and execution of services, especially those historically marginalized
- **Support, promote and align the Multi-Tiered Systems of Supports (MTSS) Model** for Services

Screening, Brief Intervention & Referral to Treatment

- **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 consider UW CoLab resources (e.g., Value-Based Care Models in Pediatric Mental/Behavioral Health Care)

Financial

- Consider incentives to increase use of family-based interventions and group counseling
- Prioritize screening and follow-up for youth behavioral health in value-based contracting, and as able, include outcomes-based measures (e.g., HEDIS DRE)
- Aid providers to understand what they can bill for behavioral health prevention services
- **In alignment with recent** CMS guidance, **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 and Colorado
- **Consider reimbursement for all EPSDT services,** including prevention services, health screenings and appropriate child find screening and assessments

- **As able, provide reimbursement for school-based applied behavioral analysis (ABA) and behavioral interventions**
- Align coverage of screening for youth behavioral health concerns with evidence-based guidelines (e.g., Bright Futures).
- **Expand the types of school-based services practitioners** to include master's level providers who are licensed by OSPI ESA certification exclusively for the school setting
    a) Expand and clarify billing capabilities of screening and brief intervention to **appropriately trained non-providers under a supervising licensed provider**

Data & Measurement

- **Facilitate a community information exchange (CIE)** encourage for electronic closed loop referrals for social and financial needs.
- **Encourage and support electronic health record interoperability** and data sharing capabilities at behavioral health agencies and primary care.
- **Evaluate Options for Statewide SBS Electronic Health Records (EHR)**

Department of Health

- **Explore partnership with other state agencies** (e.g., OSPI) to develop a standardized referral form for use among primary care and BH providers and schools
- 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 teen-friendly behavioral health services** and other provider types overseen by DOH curriculum.
    - Seek opportunities to build the CHW workforce (e.g., apprenticeship programs)
- **Consider development of Center 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

Education & Capacity Building

- **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. Resource: Mental Health Referral Service network through the state of Washington.
- **Consider incorporating telehealth-based services** available on campus through partnerships with local community providers to address transportation barriers.
- **Develop a system to track** behavioral health screening, results and referrals with the ability to monitor follow-up and connection to care.
- **Consider hiring staff with adequate training** to screen and provide brief intervention and referral
- **Identify a dedicated private space for meetings** between students and staff and/or students and behavioral health/health care professionals

Screening, Brief Intervention & Referral

- **Systematically screen students annually for common youth behavioral health concerns using validated tools** (see OSPI) following evidence-based guidelines (e.g., Bright Futures)
    - 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.
- For those who screen positive, **provide follow up** according to acuity of need.
- **Inform caregivers** with permission of youth and as per state statute
- **Support referral to and shared planning with** school- or community-based providers when indicated
- **Collect data** on outcomes of screenings, brief interventions delivered and ideally closed-loop referrals completed.
- **Stratify data** collected by relevant demographics to identify and intervene to address inequities in screening and access to care

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.[iv] 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.[v]

Recently, progress has been made toward prioritizing reduction of symptoms in measuring outcomes. For example, the HEDIS measure for **Depression Remission or Response for Adolescents and Adults (DRR)** is a measure of the percentage of members in a health plan 12 years or older with a diagnosis of depression and an elevated PHQ-9 score who had evidence of response or remission within 4-8 months of the elevated score.

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.[vi] 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. [vii]

- 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/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.

Other Initiatives

This is a non-exhaustive list of other initiatives in Washington state supporting youth behavioral health. Please refer to their resources for additional information.

Children and Youth Behavioral Health Workgroup:

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.

Seattle Children's Care Guides:

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.

Pediatric Collaborative Care Implementation Guide: The Pediatric Collaborative Care Implementation Guide created by the University of Washington's AIMS Center aims to help primary care teams improve access to behavioral health care and outcomes for children and adolescents. It provides a comprehensive roadmap for implementing and sustaining Collaborative Care programs, emphasizing culturally responsive and evidence-based practices. The guide highlights the importance of team roles, patient engagement, measurement-based treatment, and accountability to ensure effective and sustainable care.

Bree Collaborative Behavioral Health Integration Report and Recommendations: This Report and Recommendations is focused on integrating behavioral health care services into primary care for those with behavioral health concerns and diagnoses for whom accessing services through primary care would be appropriate. The workgroup defined integrated behavioral health care in order to create a common vocabulary and focused on using available evidence and existing models to develop eight common elements that outline a minimum standard of integrated care. These eight elements are meant to bridge the different models used throughout Washington State and across the country and include:

1. Integrated Care Team
2. Patient Access to Behavioral Health as a Routine Part of Care
3. Accessibility and Sharing of Patient Information
4. Practice Access to Psychiatric Services
5. Operational Systems and Workflows to Support Population-Based Care
6. Evidence-Based Treatments
7. Patient Involvement in Care
8. Data for Quality Improvement

Washington Integrated Care Assessment: The Health Care Authority (HCA), in partnership with Washington's Accountable Communities of Health (ACHs) and Medicaid managed care organizations

(MCOs) recommends the use of this standardized assessment, called the Washington Integrated Care Assessment (WA-ICA), across the state to advance clinical integration for outpatient primary care and behavioral health settings. The WA-ICA is a continuum-based integration assessment tool meant to:

1. Develop an improvement roadmap for clinical practices to advance integration and whole-person care.
2. Reduce provider administrative burden by minimizing duplicative assessments.
3. Understand the level of and progress towards clinical integration within primary care and behavioral health outpatient practices.
4. Improve patient outcomes.
5. Publish practice-level data to support quality improvement efforts.

While this report does not discuss primary care integration in behavioral health settings, previous Bree Collaborative work on primary care and behavioral health integration has been integrated into work at the Washington Health Care Authority.

Youth Advisory Council (YAC): 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.

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.

Kids Mental Health Washington:

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

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 Interventions for Substance Use Disorders in Adolescents: A Systematic Review | Effective Health Care (EHC) Program Treatment of Depression in Children and Adolescents | Effective Health Care (EHC) Program
Cochrane	Family-based prevention programmes for alcohol use in young people - Gilligan, C - 2019 | Cochrane Library
United States Preventive Services Task Force	Recommendation: Depression and Suicide Risk in Children and Adolescents: Screening | United States Preventive Services Taskforce Recommendation: Unhealthy Drug Use: Screening | United States Preventive Services Taskforce Recommendation: Anxiety in Children and Adolescents: Screening | United States Preventive Services Taskforce
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 Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part II. Treatment and Ongoing Management | Pediatrics | American Academy of Pediatrics Media Use in School-Aged Children and Adolescents | Pediatrics | American Academy of Pediatrics 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 $ ÄÄÑ ; ìJNNX+§ÄXÄXZçì ö X îîXîä XãöJãT AìXJöä XãöçZ$| ÄTìXã JãT Tç XìNXãöî ß Ä ã®ÄXö©&ÄçìTXîî $ ÄÄÑ CêTJöX↑$| ÄTJãT Tç XìNXãö#X J¶ÄìJ , XJ ö $JìXÄ $çä ä §ãÄ© ?©îöXä î çZ$JìX >XNçä ä XãTXT ?öJãTJìT $JìX |6 Jfçã J Nfçã ˜˜ ÄãNXZçì ?§ÑÄTX ; ìX¶Xãfçã
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. 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. 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. 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 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. 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 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. 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 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

Appendix B: Bree Collaborative Background and Members

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.

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.

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.

Member	Title	Organization
June Altaras, MN, NEA-BC, RN	Executive Vice President, Chief Quality, Safety and Nursing Officer	MultiCare Health System
Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
Colin Fields, MD, AAHIVS	Medical Director, Government Relations & Public Policy	Kaiser Permanente
Dary Jaffe, MN, ARNP, NE-BC, FACHE	Senior Vice President Safety and Quality	Washington State Hospital Association
Sharon Eloranta, MD	Medical Director, Performance Measurement and Care Transformation	Washington Health Alliance

Norifumi Kamo, MD, MPP	Internal Medicine	Virginia Mason Franciscan Health
Kristina Petsas, MD, MBS, MLS	Market Chief Medical Officer – WA, OR, MT, AK, and HI	UnitedHealthcare, Employer & Individual
Greg Marchand	Director, Benefits, Policy and Strategy	The Boeing Company
Kimberly Moore, MD	Associate Chief Medical Officer	Franciscan Health System
Carl Olden, MD	Family Physician	Pacific Crest Family Medicine, Yakima
Nicole Saint Clair, MD	Executive Medical Director	Regence BlueShield
Mary Kay O'Neill, MD, MBA	Partner	Mercer
Kevin Pieper, MD	Chief Medical Officer	Kadlac Medical Center
Susanne Quistgaard, MD	Medical Director, Provider Strategies	Premera Blue Cross
Colleen Daly, PhD	Director, Occupational Health, Safety and Research	Microsoft
Emily Transue, MD (Chair)	Chief Clinical Officer	Comagine Health
Judy Zerzan-Thul, MD	Medical Director	Washington State Health Care Authority
Jake Berman, MD, MPH	Medical Director for Population Health Integration	UW Medicine and UWM Primary Care and Population Health

Appendix C. Behavioral Health Early Intervention for Youth Charter and Roster

Problem Statement

In 2021, 35% of 8 graders in Washington reported depressive symptoms for 2 weeks straight within the past year, almost 16% had a plan to commit suicide and about 1 in 10 had previously attempted suicide.1 Instead of waiting for a crisis to arise and overwhelming the already limited psychiatric crisis support, Washington state youth require support and treatment in addressing a short-term behavioral health condition; however, support is difficult to find, receive, and afford. Youth need to receive high-quality timely interventions to promote their mental health and well-being, learn skills to build resiliency to manage mental health symptoms as they arise and health promotion interventions involving children, youth and families to support their growth into healthy adults.

Aim

To develop and/or promote a preventative, universal and responsive behavioral health system for children, youth and families/caregivers.

Purpose

To propose evidence-informed guidelines to the full Bree Collaborative on preventative, universal and responsive behavioral health strategies, including:

- Defining topic area and scope
- Evidence-informed and culturally consistent early identification and treatment for behavioral health concerns across healthcare, school and community settings to prevent youth behavioral health crisis
- Strategies to increase equitable access to evidence-informed and best practices, especially for vulnerable populations
- Health promotion strategies to empower children, youth and families to support their own behavioral health
- Identify areas for promoting and expanding upon other relevant Bree reports (Behavioral Health Integration, Telehealth, Suicide Care, etc.)
- Funding mechanisms for and barriers to high-quality behavioral health care for youth

Duties & Functions

The workgroup will:

- Research evidence-informed and expert-opinion informed guidelines and best practices (emerging and established).
- Identify current barriers and future opportunities for implementing interventions.
- Consult relevant professional associations and other stakeholder organizations and subject matter experts for feedback, as appropriate.
- Meet for approximately nine months, as needed.
- Provide updates at Bree Collaborative meetings.
- Post draft report(s) on the Bree Collaborative website for public comment prior to sending report to the Bree Collaborative for approval and adoption.

- Present findings and recommendations in a report.
- Recommend data-driven and practical implementation strategies including metrics or a process for measurement.
- Revise this charter as necessary based on scope of work.
- Identifying measures and metrics that are meaningful to understanding the effectiveness of guidelines

Structure

The workgroup will consist of individuals confirmed by Bree Collaborative members or appointed by the chair of the Bree Collaborative. The Bree Collaborative director and program coordinator will staff and provide management and support services for the workgroup.

Less than the full workgroup may convene to: gather and discuss information; conduct research; analyze relevant issues and facts; or draft recommendations for the deliberation of the full workgroup. A quorum shall be a simple majority and shall be required to accept and approve recommendations to send to the Bree Collaborative.

Meetings

The workgroup will hold meetings as necessary. Bree Collaborative staff will conduct meetings, arrange for the recording of each meeting, and distribute meeting agendas and other materials prior to each meeting. Additional workgroup members may be added at the discretion of the Bree Collaborative director.

Roster

Name	Title	Organization
Terry Lee, MD (chair)	Senior Behavioral Health Medical Director	CHPW
Linda Coombs, MSW, LCIS	Behavioral Health Clinical Director	UnitedHealth Community
Jennifer Wyatt, LMHC, MAC, SUDP	SBIRT Coordinator	King County
Delaney Knottnerus LICSW, MSW	School Based SBIRT Manager	King County
Brittany Weiner	Director, Opioid Stewardship and Behavioral Health	WSHA
Libby Hein, LMHC	Director of Behavioral Health	Molina Healthcare
Santi Wibawantini, MA, LMFT, CMHS	Child Therapist	KP, Everett Medical Center
Sarah Rafton	Executive Director	WCAAP
Kevin Mangat	Manager Child & Family Team	Multicare/Navos
Sally McDaniel	Clinical Manager/Child & Family Services	Greater Lakes Mental Healthcare

Thatcher Felt, MD	Pediatrician	Yakima Valley Farm Workers Clinic
Jeffery Greene, MD	Pediatrician	Seattle Children's
Nicole Hamberger	Community Engagement Specialist	Southwest Washington Accountable Community of Health
Erin Wick	Executive Director	Integrated Student Supports (ESD 113)
Katie Eilers	Director of Office of Family and Community Health Improvement	DOH
McKenna Parnes, PhD	Postdoctoral Research Fellow	UW CoLab
Sarah Danzo, PhD	Clinical Psychologist/Assistant Professor	UW CoLab/Seattle Children's
Diana Cockrell	Section Manager Prenatal to 25 Lifespan; Mental Health and Substance Use Disorders	Washington HCA
Denise Dishongh	Director of Behavioral Health	ESD 112

Appendix D: Behavioral Health for Youth Background

Behavioral health encompasses "mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms,"[viii] which significantly impact the well-being of individuals and communities. Behavioral health concerns for youth are driven by a combination of physical, biological, psychological and social factors, and are significantly influenced by growth and development stages. Behavioral health should be approached holistically, whether or not concerns or symptoms reach a threshold of needing treatment by medical and/or behavioral health professionals; professionals should always consider a person's living and built environment when developing care plans through shared decision making. Early intervention is crucial to address concerns before they symptoms worsen. Nationally, poor mental health and suicidality have worsened over the past decade, affecting youth disproportionately.

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 difficulties, substance use, or suicide.[ix x] In Washington state, early intervention can occur in a variety of settings, including primary care and schools, which offer opportunities to reach many youths at risk. Primary care providers can screen, assess, diagnose, treat, and refer children with mild-moderate behavioral health concerns. Behavioral health care should be integrated with physical health care. This guideline is agnostic as to the specific type of integrated behavioral health care as some models may not be feasible to deliver in all settings.[xi] Integrated care models have shown improved mental health outcomes above care as usual, and potentially reduced costs per individual.[xii xiii xiv]

The workgroup endorses a public health prevention approach to behavioral health for youth, blending primary, secondary and tertiary prevention[xv] with the socioecological model.[xvi] 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.

Below is the framework for primary care integration developed by the Bree Collaborative's 2017 Behavioral Health Integration workgroup. While this workgroup recognizes that not all systems will be able to provide fully integrated behavioral health currently, progress toward this high-quality care delivery model should be prioritized.

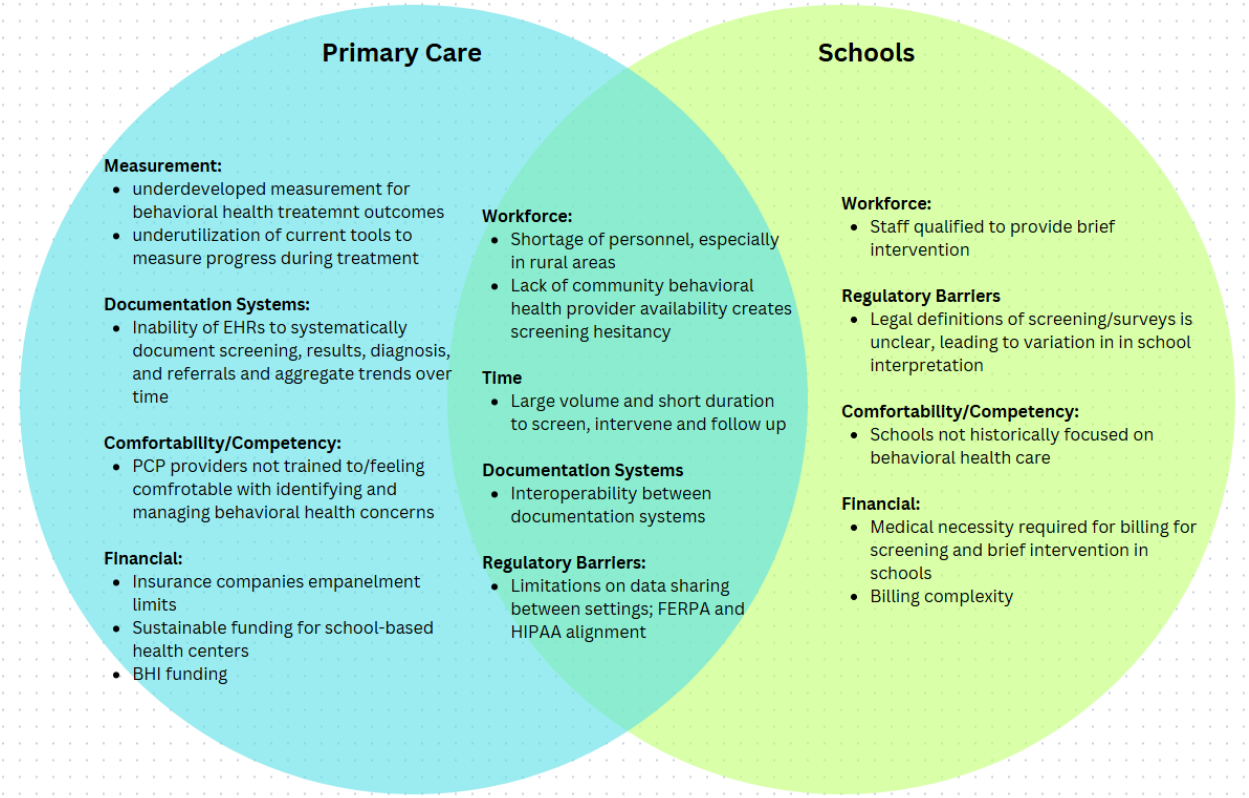
Figure 1: Levels of Primary Care Integration

Schools can provide supportive environments for healthy development, and serve as a significant opportunity to identify, refer to and provide direct behavioral health care services.

The Bree Collaborative workgroup chose to focus on anxiety, depression, trauma, disruptive behavior, and substance use due to their high prevalence, availability of evidence-based treatments and availability of trainings for youth-serving providers. The workgroup emphasizes the need for family-centered, youth-driven, and culturally responsive care, advocating for low-barrier access and system-wide coordination and integration as possible. Professionals that care for youth and families should also follow evidence-based screening guidance at developmental milestones throughout the life course (e.g., Bright Futures Toolkit)

While the group is focusing mainly on these previously mentioned concerns, the workgroup recognizes that not all people experiencing behavioral health concerns may require treatment by a medical or behavioral health professional, 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. 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. Behavioral health concerns should be approached holistically by considering underlying causes, stressors, and contributing factors and working collaboratively with youth and their support systems to support their overall well-being. Providers and professionals serving children and families should provide guidance and support overall healthy development, including nutrition, exercise, stress, sleep, education, relationships, and else.

Key Barriers to Optimal Behavioral Health and Healthcare



The workgroup identified the key barriers to providing optimal behavioral healthcare for youth in Washington state. These barriers were broken out into different categories of workforce, measurement, documentation systems, time, regulatory barriers, comfortability/competency, and financial incentives or reimbursement. Not all of these barriers are within scope of this report, or the scope of the Bree Collaborative workgroup. However, they do impact on the environment and systems in which patients and their support systems seek and receive care.

Appendix E: 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).~~

Collaborative Care Model: a specific type of integrated care developed at the University of Washington to treat common mental health conditions in medical settings like primary care. Behavioral health conditions such as depression, anxiety, PTSD, alcohol or substance use disorders are among the most common and disabling health conditions worldwide. Based on principles of effective chronic illness care, CoCM focuses on defined patient populations who are tracked in a registry to monitor treatment progression. The treatment plan focuses on measurement-based treatment to target, to ensure the patient's goals and clinical outcomes are met.[xvii]

Integrated Care: Team-based care provided to individuals of all ages, families, and their caregivers in a whole-person oriented setting or settings by licensed primary care providers, behavioral health clinicians, and other care team members working together to address one or more of the following: mental illness, substance use disorders, health behaviors that contribute to chronic illness, life stressors and crises, developmental risks/conditions, stress-related physical symptoms, preventative care, and ineffective patterns of health care utilization**. (BHI Report Bree Collaborative)**

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) [xviii]

Referral: a request from one physician to another to assume responsibility for management of one or more of a patient's specific conditions. This represents a temporary or partial transfer of care to another physician for a specific time until resolved, or on an ongoing basis. It is the responsibility of the physician accepting the referral to maintain appropriate and timely communication with the referring physician and to seek approval from the referring physician for treating or referring the patient for any other condition that is not part of the original referral.[xix]

Shared Care Plan: patient-centered health record designed to facilitate communication among members of the care team, including the patient and providers. Rather than relying on separate medical and behavioral health care (treatment) plans, a shared plan of care combines both aspects to encourage a team approach to care.[xx]

Strength & Protective Factors: strengths for a child or family may include a variety of qualities, strategies or resources such as: parental resilience, social connections, knowledge of parenting and child development, community support, positive childhood experiences, and social and emotional competence. Protective factors are characteristics that are associated with lower likelihood of negative outcomes or that reduce a risk factor's impact. Protective factors may be seen as positive countering events. Examples include: conflict management, commitment, quality time together, etc[xxi].

Team-based care: Team-based care is a transformative method of delivering care that emphasizes teamwork. It includes many elements, such as: A care team that works collaboratively with the patient and family. The care team may include a provider, registered nurse, care team coordinator (medical assistant or licensed practical nurse); patient access coordinator, and even pharmacist, educator, or case manager; daily huddles and regular care team meetings; Team documentation to allow the provider to spend more time in direct patient contact; Co-location of the care team in a space that fosters collaboration; Expanded standard rooming processes that may include functional and behavioral health screenings, agenda setting, coaching, and medication reconciliation. These processes help build relationships between the care team and the patient; Planned care principles, such as previsit planning, previsit labs, and advanced access to care; Warm handoffs, which are handoffs conducted in the patient's presence.[xxii]

Warm Handoff: a transfer of care between two members of the health care team, where the handoff occurs in front of the patient and family. This transparent handoff of care allows patients and families to hear what is said and engages patients and families in communication, giving them the opportunity to clarify or correct information or ask questions about their care.[xxiii]

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

Appendix F. Pediatric Integrated Models of Care

Pediatric integrated models of care for behavioral health are designed to provide comprehensive and coordinated care that addresses both physical and mental health needs within primary care settings. These models integrate behavioral health services directly into pediatric primary care, allowing for early identification, intervention, and continuous management of mental health concerns.[xxiv xxv] The design of these models often includes a multidisciplinary team approach, incorporating pediatricians, behavioral health specialists, and other healthcare providers who work collaboratively to deliver holistic care to children and adolescents.

Evidence supports the effectiveness of pediatric integrated models of care in improving mental health outcomes among youth. Studies have shown that these models can lead to increased access to mental health services, early detection and treatment of behavioral health issues, and improved overall health outcomes.[xxvi] Integrated behavioral health provides significant benefits for racial and ethnically marginalized youth and their families.[xxvii] The **Collaborative Care model** is designed to provide comprehensive and coordinated care that addresses both physical and mental health needs within primary care settings. This model is based on five core principles that differentiate it:

- **Patient-centered care team**: a multidisciplinary care team involving a primary care provider, behaviorla health care manager and a psychiatric consultant.
- **Population-based**: the practice uses systematic screening and identification, longitudinal measurement of outcomes, and a stepped approach to care with referral options for patients who need higher levels of care.
- **Measurement-based Treatment to Target**: Longitudinal measurement of treatment response, caseload reviews by the behavioral health care manager and psychiatric consultant, and timely adjustment to treatment plans
- **Evidence-based Treatments**: individualized structured treatment plans including evidence-based medications and/or brief behavioral interventions
- **Accountable**: Longitudinal measurement of provider- and practice-level performance metrics, use of metrics to drive quality improvement, and program sustainment.
-

The Advancing Integrated Mental Health Solutions (AIMS) center at the University of Washington created a Pediatric Collaborative Care Model Implementation Guide to support primary care providers and practices in preparing for and implementing the model specifically for youth and their families. Please see their website for more resources.

Appendix G. First Approach Skills Training Evidence-Based Brief Interventions

First Approach Skills Training (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 exposure, behavioral activation, and parenting skills. 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 and parent and caregiver resources.

Appendix H. Instruments for Recommended Universal Screening and Specific Bright Futures Visits

Recommended Visit	Recommended Screening	Tool by Author/Owner
Newborn Through 21 Years	Behavioral/Social/Emotional	Ages & Stages Questionnaires®: Social-Emotional, Second Edition (ASQ®:SE-2) Age range: 1–72 months
		Baby Pediatric Symptom Checklist Age range: under 18 months
		Preschool Pediatric Symptom Checklist Age range: 18–65 months
		Pediatric Symptom Checklist (PSC) • Translations Age range: 4–16 years
		Strengths & Difficulties Questionnaires (SDQ) • Translations Age range: 2–17 years
18 Month **2 Year**	Autism Spectrum Disorder	Modified Checklist for Autism in Toddlers, Revised, with Follow-Up (M-CHAT-R/F) • Translations
		Survey of Well-being of Young Children (SWYC) (Parent's Observations of Social Interactions)
11 Through 14 Year **15 Through 17 Year** **18 Through 21 Year**	Depression and Suicide Risk	PHQ-9 Modified for Teens (PHQ-A)[a] A version of the PHQ-9 Modified for Teens is available in the *Guidelines for Adolescent Depression in Primary Care Toolkit* (in multiple languages). Another sample of the PHQ-9 Modified for Teens is available through the Community Care of North Carolina.
		PHQ-2[a] • Bright Futures sample form Instructions
		Ask Suicide-Screening Questions (ASQ)
		Columbia-Suicide Severity Rating Scale (C-SSRS)
		Patient Safety Screener (PSS-3)
11 Through 14 Year **15 Through 17 Year** **18 Through 21 Year**	Tobacco, Alcohol, or Drug Use	*Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide*
		Brief Screener for Alcohol, Tobacco, and other Drugs (BSTAD)
		Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT)
		Screening to Brief Intervention (S2BI)

Appendix I. 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) [xxviii]

	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 approach enabling child and family to do better in the community
Assessment	Deficit-oriented	Strengths-based
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 J. 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. [xxix]

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.

References

[i] American Medical Association. (2022.). What is behavioral health? Retrieved January 6, 2025, from https://www.ama-assn.org/delivering-care/public-health/what-behavioral-health

[ii] National Center for Biotechnology Information. (2019). *Neuroinflammation: New insights into neurodegenerative diseases*. https://www.ncbi.nlm.nih.gov/books/NBK537222/

[iii] National Academy of Medicine. (2023). *Figure 1* [Image]. https://nam.edu/wp-content/uploads/2023/08/Figure-1-web.png

[iv] HealthMeasures. (2020). *NQF PROs: Approaches and challenges in selection and data collection*. https://www.healthmeasures.net/images/Implement_HealthMeasures/NQF_PROs_Approaches_and_Challenges_in_Selection_and_Data_Collection.pdf

[v] RAND Corporation. (2022). Using quality measures and measurement-based care to improve behavioral health care for veterans and service members. https://www.rand.org/content/dam/rand/pubs/research_reports/RRA2500/RRA2522-1/RAND_RRA2522-1.pdf

[vi] AAP Council on Communications and Media. Media. Use in School-Aged Children and Adolescents. Pediatrics. 2016;138(5):e20162592

[vii] AAP COUNCIL ON COMMUNICATIONS AND MEDIA. Media and Young Minds. Pediatrics. 2016;138(5):e20162591

[viii] American Medical Association. (2022.). What is behavioral health? Retrieved January 6, 2025, from https://www.ama-assn.org/delivering-care/public-health/what-behavioral-health

[ix] Burns, B. J., & Hoagwood, K. (2002). Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders. Oxford University Press.

[x] Carney, T., Myers, B. Effectiveness of early interventions for substance-using adolescents: findings from a systematic review and meta-analysis. *Subst Abuse Treat Prev Policy* **7**, 25 (2012). https://doi.org/10.1186/1747-597X-7-25

[xi] Burkhart K, Asogwa K, Muzaffar N, Gabriel M. Pediatric Integrated Care Models: A Systematic Review. Clin Pediatr (Phila). 2020 Feb;59(2):148-153. doi: 10.1177/0009922819890004. Epub 2019 Nov 24. PMID: 31762297.

[xii] Yonek J, Lee CM, Harrison A, Mangurian C, Tolou-Shams M. Key Components of Effective Pediatric Integrated Mental Health Care Models: A Systematic Review. JAMA Pediatr. 2020 May 1;174(5):487-498. doi: 10.1001/jamapediatrics.2020.0023. PMID: 32150257; PMCID: PMC7483725

[xiii] Yu H, Kolko DJ, Torres E. Collaborative mental health care for pediatric behavior disorders in primary care: Does it reduce mental health care costs? Fam Syst Health. 2017 Mar;35(1):46-57. doi: 10.1037/fsh0000251. PMID: 28333516; PMCID: PMC5364816

[xiv] Richardson LP, Ludman E, McCauley E, Lindenbaum J, Larison C, Zhou C, Clarke G, Brent D, Katon W. Collaborative care for adolescents with depression in primary care: a randomized clinical trial. JAMA. 2014 Aug 27;312(8):809-16. doi: 10.1001/jama.2014.9259. PMID: 25157724; PMCID: PMC4492537.

[xv] National Center for Biotechnology Information. (2019). *Neuroinflammation: New insights into neurodegenerative diseases*. https://www.ncbi.nlm.nih.gov/books/NBK537222/

[xvi] National Academy of Medicine. (2023). *Figure 1* [Image]. https://nam.edu/wp-content/uploads/2023/08/Figure-1-web.png

[xvii] Advancing Integrated Mental Health Solutions (AIMS) Center. (n.d.). *Collaborative care*. University of Washington. Retrieved from https://aims.uw.edu/collaborative-care/

[xviii] American Psychological Association. (n.d.). Measurement-based care. APA Services. Retrieved November 19, 2024, from https://www.apaservices.org/practice/measurement-based-care

[xix] American Academy of Family Physicians (AAFP). (n.d.). *Consultations, referrals, and transfers of care*. Retrieved from https://www.aafp.org/about/policies/all/consultations-referrals-transfers-of-care.html

[xx] Agency for Healthcare Research and Quality. (n.d.). Develop a shared care plan. U.S. Department of Health and Human Services. Retrieved November 19, 2024, from https://integrationacademy.ahrq.gov/products/playbooks/behavioral-health-and-primary-care/implementing-plan/develop-shared-care-plan#:~:text=A%20shared%20care%20plan%20is%20a%20patient-centered%20health,the%20care%20team%2C%20including%20the%20patient%20and%20providers.

[xxi] American Academy of Pediatrics. (n.d.). A pediatrician's guide to working with families of children with special health care needs. Retrieved November 19, 2024, from https://downloads.aap.org/DOCHW/LTSAE_PediatriciansGuide.pdf

[xxii] Agency for Healthcare Research and Quality. (n.d.). Team-based care: A key component of patient- and family-centered care. U.S. Department of Health and Human Services. Retrieved November 19, 2024, from https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/teambased-2.pdf

[xxiii] Agency for Healthcare Research and Quality. (n.d.). Warm handoff: A strategy for improving patient safety. U.S. Department of Health and Human Services. Retrieved November 19, 2024, from https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html

[xxiv] 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.

[xxv] 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

[xxvi] 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

[xxvii] 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.

[xxviii] h - Systems Based Practice Module - Family Driven Care For Web.pdf (aacap.org)

[xxix] 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