Behavioral Health: Early Intervention for Youth Guideline Checklist

Primary Care Clinics serving Pediatric Patients

Level 1

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The current state of the issue

Behavioral health encompasses both mental health and substance use disorders. In 2023, 40% of high school students reported feeling sad or hopeless almost every day for 2 or more weeks in a row.[i] Between 2013 to 2021, rates of youth suicide and attempted suicide in Washington have risen by over 600%.[ii] Not all youth are equally as likely to attempt suicide; youth who identify as female, BIPOC, or LGBTQ+ are more likely to have attempted suicide in the past year.[iii]Co-occurring mental health concerns are common in children. Almost 3 out of every 4 youth with depression also experience anxiety. [iv] Over 1 in 3 youth have a documented need for mental health treatment.[v] Substance use can negatively impact youth development, as well as increase the risk of developing mental health conditions, such as depression, anxiety, and psychosis.[vi] Given the increasing prevalence and serious impact on the health of youth, improving early identification and intervention of behavioral health concerns is vital.

Education & Capacity Building

- ☐ **Offer teen-friendly and culturally inclusive health information materials on**: (Resource: Teen Health Hub)
  - ☐ Health information and privacy
  - ☐ 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 (see FAST, Seattle Children's Care Guides)

- [ ] **Establish and train staff on safety protocols for patients at risk of suicide**. Resource: Bree Collaborative Suicide Care report, WCAAP)
- [ ] Encourage providers to **share their identities** with youth and caregivers to the extent that they are comfortable
- [ ] **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 Seattle Children's)

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, Children's care guides). Also see Appendix H
  - [ ] **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, SMQF, 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 further 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 and/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); Bree Collaborative's Suicide Care Report)
  - [ ] Ask paent 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)

- [ ] **Consult with behavioral health professionals as needed**. (free insurance-agnos◆c 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., community health worker)
- [ ] **Refer to specialists for evaluation** of co-occurring conditions as necessary, or if possible, collaborate through shared care planning.
- [ ] **Refer patients and families to behavioral health providers**, especially those who share characteristics (race, ethnicity, sexual orientation) with youth and family as possible, and/or collaborate through shared care planning when possible. (Mental Health Referral Service)
- [ ] **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 – Seatle Children's)
  - [ ] Consider, in collaboration with youth and families, non-pharmacological methods to accompany, instead of, or prior to medication.
  - [ ] Medications for Opioid Use Disorder (MOUD) is effective to reduce risk of overdose and death for patients under 18. (Resources: **Bree Collaborative's** Treatment for Opioid Use Disorder Guidelines, learnaboutreatment.org., UW ADAI Adolescent Learning Collaborative.)
  - [ ] Naloxone should be prescribed or provided per guidelines (see above resources)
- [ ] **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 and incorporate that into care planning as appropriate.
- [ ] **Follow patient medication management** appropriate to the clinical need (e.g. more frequently while titrating medication, less frequently when maintenance dose is established)
- [ ] **At follow-ups, use repeated screening with validated tools to measure progress toward symptom reduction**
- [ ] **Use repeated screening results to inform treatment plan adjustments**

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, FHCQ Social Determinants of Health and Health Equity Report)

Resources

- The Bree Report is meant to supplement these resources.
- Full Bree Report: https://www.qualityhealth.org/bree/wp-content/uploads/sites/8/2025/01/BH-Youth-Repot-Final-0127.pdf
- Seattle Children's First Approach Skills Training (FAST) Program: https://www.seattlechildrens.org/healthcare-professionals/community-providers/fast/
- WCAAP Supporting Adolescent Patients in Crisis: https://wcaap.org/wp-content/uploads/2021/10/Crisis-toolkit_final56497.pdf
- UW CoLab Value-Based Care Models in Pediatric Mental/Behavioral Health Care Report: Microsoft Word - VBC100322.docx
- Washington's Mental Health Referral Service for Children and Teens: https://www.seattlechildrens.org/healthcare-professionals/community-providers/pal/mental-health-referral/
- SAMHSA Student Assistance: https://library.samhsa.gov/sites/default/files/d7/priv/pep19-03-01-001.pdf

Read the full Bree Report on Behavioral Health Early Intervention for Youth online by scanning the QR code:

Connect with the Bree Collaborative at bree@qualityhealth.org

References: [i] Youth Risk Behavior Survey Data Summary & Trends Report: 2013-2023 (cdc.gov) [ii] Youth Suicide Rates | Washington State Department of Children, Youth, and Families [iii] Youth Risk Behavior Survey Data Summary & Trends Report: 2013-2023 (cdc.gov) [iv] Ghandour RM, Sherman LJ, Vladutiu CJ, Ali MM, Lynch SE, Bitsko RH, Blumberg SJ. Prevalence and Treatment of Depression, Anxiety, and Conduct Problems in US Children. J Pediatr. 2019 Mar;206:256-267.e3. doi: 10.1016/j.jpeds.2018.09.021. Epub 2018 Oct 12. PMID: 30322701; PMCID: PMC6673640. [v] CHILDRENS_BH_DASHBOARD_2023NOV.pdf (wa.gov) [vi] National Institute on Drug Abuse. (2020). Common Comorbidities with Substance Use Disorders Research Report. Retrieved from [URL].

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