Behavioral Health Integration subgroup

Tuesday, July 20
10:00 am – Noon

Agenda Items	Notes

Behavioral health integration at UW Kent-Des Moines	**Leslie Graham**, LICSW& **Doreen Kiss**, MD
	See page 4 for slides.
	Leslie:
	• Before the Behavioral Health Integration Program children were only referred out for treatment and pediatricians only saw small snapshot of the children's life but got no info on school, family, other agencies, community mental health, etc., related to the child/patient
	• Developing a pediatric behavioral health program
	  ○ Integrative Behavioral Health has to be a team process, there has to be collaboration between each provider to ensure complete care
	  ○ Psychiatrist role is only as consultant (90 min eval, recommendation to PCP) but provides great insight for the pediatrician in assisting to diagnose mental health issues.
	• Community networking
	  ○ Networking with school and community organizations is key. Leslie has school providers directly contacting her if the child is a patient. This allows for teachers to provide a viewpoint from school (where the child spends majority of their day) that parents, doctors, or other providers may not get otherwise.
	  ○ Get to know each other; allows for easier bridging of aspects of child's life and easier collaboration.
	Doreen:
	• After BHIP implementation
	  ○ Number 1 help is the care coordination piece to allow to hear from teachers about how students are in a classroom setting.
	  ○ Tracking: if they stop showing up for visits everyone knows, and the children are tracked down instead of just being lost in the wind.
	  ○ Having a psychiatrist allows pediatrician to feel more confident with diagnoses, medication prescription and help for other aspects of mental health.
	• State of Kid's mental health during COVID-19 pandemic
	  ○ Kids avoided coming in to therapy because of COVID. Now kids are coming forward with increased anxiety, depression, and suicidal ideation
	  ○ Key drivers: isolation, stress of parents losing income, jobs, housing, etc., kids losing their joy of social connections joys of being a child.
	  ▪ Virtual school had dropped grades for many students, dropped grades, and anxiety and depression increased.

	○ Children of specials needs found their needs to not be met with telehealth appointment; as well parents found it increasingly difficult to keep the child attentive and interacting during their appointment. ○ There are many struggles with access to mental health treatment: Families are struggling to find treatment centers with openings, therapists are flooded with case loads and many clinics are struggling to even return calls of potential patients.
Discussion/Q & A	• Regarding the Unite Us pilot, are you finding out if patients got help and what kind of help? Don't know yet as referrals just began last week. We'll get info if they get a referral, but don't know yet how much additional information we'll get. • How to deal with schools re-opening and increased depression and anxiety? As well with child abuse and domestic violence and how they can reach out too? • Population Health approach, outreaching to children for them to come into clinic and then go into next steps. • Schools even pre-covid were grateful to have this program and connection, when child gets referred, to actually deal with problems; worried about the fall and uptick in reports to CPS or kids scared to go back to school, afraid of grade changes during the online school year. • Is this an effective way to engage entire family to youth's needs ? (Libby Hein) • The program allows questions to be asked, including issues that weren't on the radar for the family; still have ways to go to engage entire family. More therapists and social workers would allow help. • Integrated BH makes sense – great care. If everyone does it, we will not have enough pediatric psychiatrists and therapists – workforce, access issues. • Bachelors' level clinicians can provide some components. • Child psychiatrists doing case load reviews with a counselor or care manager rather than direct counseling can spread resource further – an hour a week per practice. Bigger issues - # of therapists, fiscal issues in bringing up a model. • ARNP/Psychiatric MHNP– Can provide oversight, can use collaborative codes.
Chat comments	• I really appreciate hearing this work, as a BH clinician working with teen and young adults in direct service for years there were one or two physicians that would contact me back to coordinate care out of maaaanny…. Looking for ward to the continued evolution of partnersips for the care of our shared young people across disciplines! Nice paper from colleagues at Kaiser on cost of integrated care in primary care: Costs of using evidence-based implementation strategies for behavioral health integration in a large primary care system. https://doi.org/10.1111/1475-6773.13592 *Also attached; see page 26.* • Really appreciate theis presentation and the incredible work you are doing to support families. One of the challenges when working with youth has sometimes revolved around being able to engrage families since youth's mental health is so impacted by their family system and support. Have you found this to be an effective way to engage the entire family in supporting the youth's needs? • We use ANRPs.

Attendees

Rachel Burke, Health Care Authority (HCA)
Teresa Claycamp, HCA
Diana Cockrell, HCA
Christine Cole, HCA
Devon Connor-Green, representing ARNPs
Kahlie Dufresne, Molina Healthcare
Christal Eshelman Community Health Plan of Washington (CHPW)
Victoria Evans, Molina
Dr. Thatcher Felt, Yakima Valley Farmers Clinic
Leslie Graham LICSW, UW Neighborhood Clinic
Dr. Bob Hilt, Seattle Children's Hospital
Kristin Houser, Parent
Marissa Ingalls, Coordinated Care
Avreayl Jacobson, King County Behavioral Health and Recovery
Michelle Karnath, Clark County Juvenile Court, ParentDr. Doreen Kiss, UW Neighborhood Clinic
Sarah Kwaiatkoski, Premera, representing AWHP
Joan Miller, Washington Council for Behavioral Health
Connie Mom-Chhing
Sheryl Morelli, Seattle Children's Hospital
Liz Perez, CHPW
Deborah Pineda
Wendy Pringle, HopeSparks
Sarah Rafton, Washington Chapter of the American Academy of Pediatrics (WCAAP
Caitlin Safford, Amerigroup
Lucas Springstead, HCA
Beth Tinker, HCA
Jackie Yee, ESD 113
Cesar Zatarian, Jr., HCA

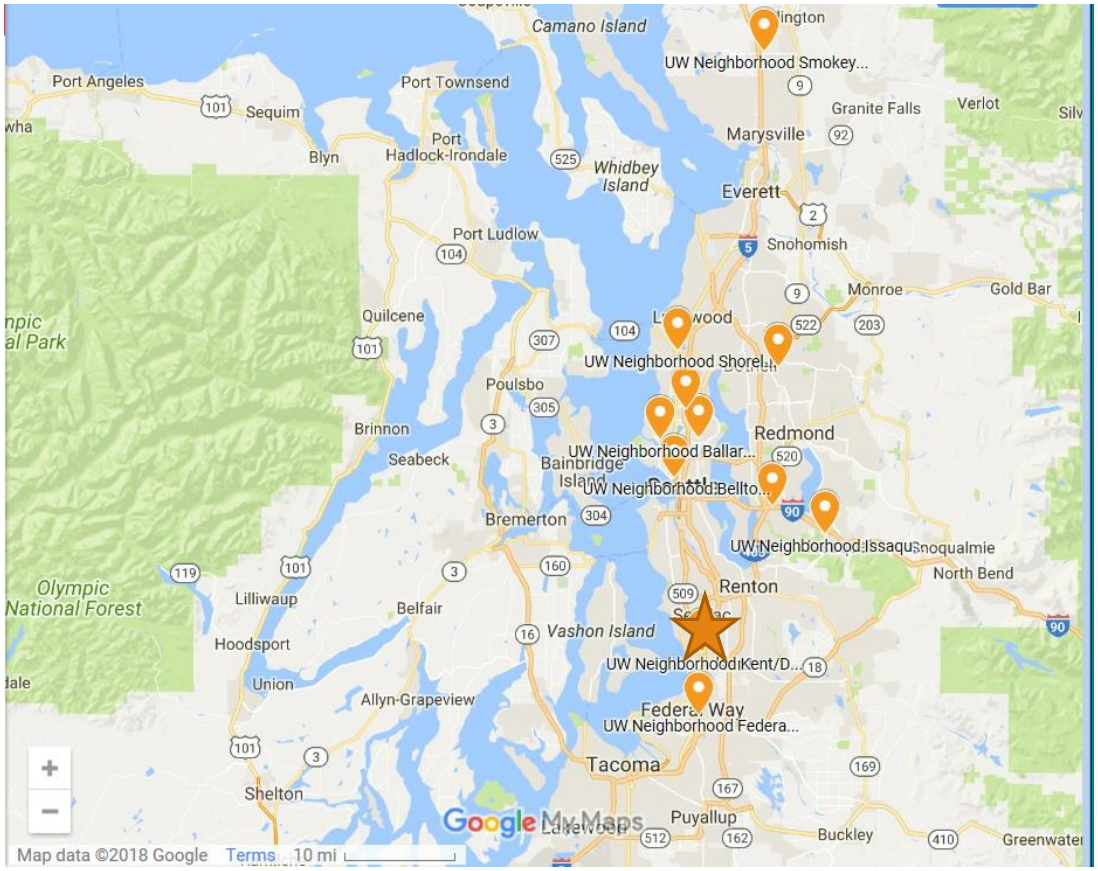
Integrated Pediatric Behavioral Health

LESLIE GRAHAM MSW,LICSW

DOREEN KISS, MD

UW KENT DESMOINES CLINIC

JULY 20, 2021



UW Neighborhood Clinic Kent/Des Moines

Location: South King Count

Population: ~150,000

Pediatric patients: ~ 5000 representing ~ 13,000 annual visits

Payor: 70% public, 30% private

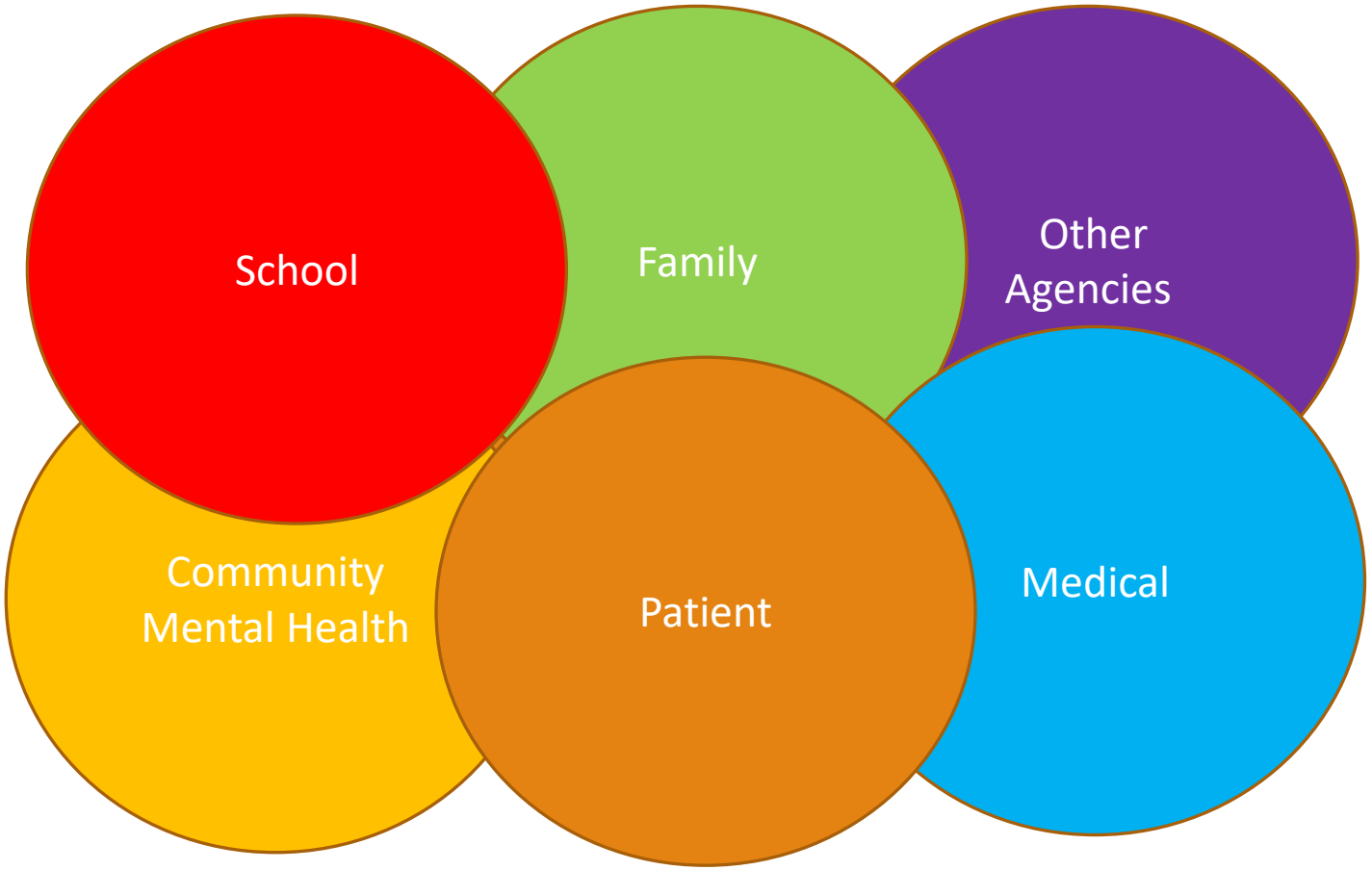
Race/ethnicity: White 30%, Black or African 25%, Hispanic 20%, Asian 10%, Pacific Islander 5%, Native American 1%

Preferred language: English, Spanish, Somali, Arabic, Vietnamese, French, Amharic, Ukrainian, Panjabi, Oromo, Farsi, Haitian Creole, Russian, Tagalog, Dari, Korean, Marshallese, Swahili, Cambodian, Cantonese, Tigrinya, Bambara, Romanian, Sign Language, Soninke, Bengali, Bulgarian, Chuukese, Hakha Chin, Lao, Mandarin, Pashto

UW Kent Des Moines Behavioral Health Team

Masters level Social Work 1.0 FTE
Pediatric Health Navigator 0.6 FTE
Pediatric Psychiatry 0.2 FTE
Pediatricians 5
Pediatric Residents +25
Pediatric Medical Assistants
Pediatric Nurse 0.6 FTE

Pediatric Care Management and Behavioral Health Integration



Developing a Pediatric Behavioral Health Program

It's a TEAM process.

Define the roles: Social worker, MD , Health Navigator, Psychiatrist, Nurse

Care management and monitoring – monthly group meetings

Psychiatrist role- consultant to MD (not ongoing care) and oversight of counseling.

Organization and communication with strong leadership is key

Network with community providers:

- Community mental health agencies/therapist
- School – teachers, counselors
- Group homes

Ongoing QI process, policy development and meeting expectations of insurance companies.

Team education - medication management and community resources

A Day in the Life of an MSW, LICSW at KDM

8am

- Care Management meeting with MD and CM team, review of cases, typically 35-50 on a list
- Charting and forecasting

- **9am-1pm (COCM, Collaborative Care Management and Social Work)**
- Community outreach and networking to include schools, community mental health programs
- Distributing referrals with Health Navigator (HN) (working the queue)
- Weekly meetings with psychiatry to review patients receiving BHIP services or on medication
- Consultation with medical team regarding social/behavioral/mental needs and team support Staff meetings with agency or visits to schools for IEP/504 planning
- Outreach calls for social determinants of health, social work, CPS (Child Protective Services)
- Anything else "as needed"*

These services are either free or billed collaborative care codes if meet minutes required

2pm-5pm: BHIP/counseling (BHIP Behavioral Health Program)

- to include 30-60 minute visits involving therapy such as, CBT, DBT, family consults, parenting education, psychotherapy.

These services are billed fee for service codes

*As needed is regarding emergency situations such as, child abuse referrals, domestic violence or sexual assault victims. Can also include issues such as: medically fragile patient needs, transportation, or social determinants of health such as, housing, food resources etc.

Community Networking

Schools

Pearl Clinic – Seattle Childrens ADHD clinic

UPower

Calma Clinic

Community Mental Health

FAST

Washington Autism Alliance

Private Therapists

Unite Us

Benefits of Community Networking

- Collaborating with Seattle Children's PEARL clinic
- Screening new parents for PPD, Post Partum Depression
- Autism diagnosis and resources in community such as DDA, Washington Autism Alliance, and ABA
- Short term counseling and SW services in longitudinal format. KDM is to be a medical home for patients.
- Seattle Children's FAST program
- CALMA clinic for Spanish speaking families in South end
- Schools

Increased communication and collaboration results in more resources, broader "team" approach and caring for the "whole" child

Patient story #1
Collaborative Care Example

- 16 year old Latino American male comes to WCC; makes no eye contact. Flags on PHQ. Warm Hand off in clinic by provider.
- PCP consents for COCM; MSW assesses for safety and gathers info from patient. ROI obtained.
- Phone consult with parent and develop plan with patient present
- Patient wants some privacy with parents re: mental health and prefers bilingual male provider
- Concern for learning disability
- MSW consult school psychologist and counselor
- Appointment with psychologist who is bilingual scheduled for patient and his mother.
- Patient interested in medication intervention and is scheduled with psychiatry for full evaluation and discussion of medication.

Outcome is reduced PHQ/GAD, improved mood, school support, parents informed and engaged, therapy initiated, and monitoring

Collaborative care codes billed for services provided by care management team

Pediatric BHIP Summary 2019

Mental Health: 309

- Anxiety/Depression/Oppositional Defiant Behavior/Autism/Post partum depression

ADHD: 98

School collaboration: 74

P**sychiatric evaluations completed:** 56

Psychotherapy : 22 patients

Child Protective Services (CPS): 60

Health navigator/social work (DDA/ABA/housing/Child Find/Act): 156

Other (legal/DV): 33

Pediatrician Perspective Before

BEFORE BHIP IMPLEMENTATION:

- Time - Complex mental/behavioral health concerns in short visits
- Lack of extensive training on mental health
- Probably missing diagnoses in complex kids with multiple psych diagnoses
- Referrals to community mental health – low chance they ever happen
- Kids get lost to follow up or return with same problem
- Not enough Pediatric Psychiatrists – Pediatricians asked to prescribe complex psychiatric medications
- Financial – only paid for face to face visit, not for care coordination
- Silos – schools, community mental health, clinics don't talk to each other

Pediatrician Perspective After

AFTER BHIP IMPLEMENTATION:

- Care coordination –BHIP team connects with school/therapist for insight on progress
- Care management – team tracking, kids don't get lost to follow up
- Higher percentage of kids engage in therapy
- Psychiatry consultations to help with complex/multiple mental health diagnoses
- Psychiatry overview of med management- prescribe with greater confidence and efficacy
- Significantly better mental health outcomes
- Increased use of evidence -based screening tools

The State of our Kids' Mental State During COVID 19 Pandemic

Very significant increase in anxiety/depression

Very significant increase in suicidal ideation

Frequently check ups are uncovering significant mental illness

Isolation and parental stress is key driver

Significant school failure in previously good students

IEP /Special Ed needs not met, virtual therapies inadequate

CPS referrals dropped by 50% - a lot of unrecognized abuse/neglect

Mental Health Access in WA State

Telehealth

Exploded in use and popularity during COVID 19 pandemic

Highly effective for mental health medication visits and frequent check ins

Highly effective for cognitive behavioral therapy visits

Great for families who have transportation difficulties and working parents

Useful but not perfect:

- Risk to miss physical exam findings – cutting, weight loss/eating disorder. Bring them in when something amiss or not responding to care
- Many adolescents and parents have voiced preference to see a mental health provider or psychiatrist in person vs telehealth

Patient Story #2
BHIP Therapy- Telehealth

- 16 year old White female with SI, PHQ 24, concerns for sexual identity/parents acceptance, school and social anxiety
- Referred by PCP to MSW for enrollment in BHIP program.
- 10 months in house psychotherapy
- One time psychiatry evaluation and ongoing consult with team
- PHQ reduced below 10, family and patient learn communication skills

Patient outcome: no SI, confidence in managing anxiety via CbT/DBT skills, improved family communication, completes Junior year

Collaboration with MD, psychiatry and MSW through entire year of care. Care billed FFS (fee for service codes)

Post Partum Depression Screening At Well Baby Checks?

Why at well baby checks?

- Mothers make their baby appointments, but not their own
- Most PPD identified > 6 mo after delivery

Impact on child when mom is depressed

- Affects physical growth and cognitive/social development
- Behavior issues

Our process:

- Screening mother at every well baby check age 2 weeks-12 mo
- Refer depressed mothers in to BHIP
- SW connects mother to community mental health or engages in therapy directly.

Community Referrals Pilot UniteUs

New pilot project to address Social Determinants of Health- Starting 6/2021

Software platform to connect/refer with community partners

Social factors have a huge impact on health outcomes

Your zip code can have more impact on your health than your genetic code

Health systems and social/community support systems are siloed

With UniteUs technology:

- Patients will be easily connected to the care and services they need, more quickly and more effectively.
- Panel Navigators will be able to track referrals to UniteUs Partnering organizations, and more effectively coordinate care.

Pediatric BHIP Key Take-Aways

* Collaborative Care leads to better understanding of a child's mental health care needs

* Primary care is whole person care, and mental health management really fits here- integrate with good sleep, social, and exercise habits

* Psychiatry support and mental health training is essential for a Pediatrician to successfully diagnose and treat complex mental health issues

* A Health Navigator provides efficient and cost-effective care coordination, offloads the MSW who can focus on therapy and more complex resource needs

* Pediatric BHIP often involves work with the family and the school

* Billing – billing codes for care coordination and therapy help, but do not completely cover the cost of staff needed for effective BHIP

Patient Story #3
Long Term Intervention

- 23 year old Asian female referred eight years ago dropping out of high school, depressed, suicidal, cutting, mother with severe illness, 1st generation immigrant, parents non-English speaking, some DV in family, high social/familial stressors
- Enrolled in BHip for short term CBT as well as intensive SW services
- Six months in house therapy; collaboration with outside resources
- Over next 7 years, stops by clinic during difficult times, resource needs, or just to "check in"

Most recent update was a BIG smile and PRIDE as she brings her phone to clinic to share her admittance to a 4 year university to become a health care worker

Integrated behavioral health = medical home

Future?

* Need FINANCIAL SUSTAINABILITY for an integrated behavioral health program. How? A second north Seattle Peds BHIP site for UW Medicine? Adding G Codes to existing COCM billing. Initiating group therapy via telemedicine

* Screening for SOCIAL DETERMINANTS OF HEALTH and easy access to community referrals such as UniteUs.

* Meeting patients where they are: SCHOOL BASED THERAPY options

* PARTNERSHIPS with Seattle Childrens PEARL clinic in research and clinical care

* Consider division of the role? social work vs therapist

* DATA? No easy way to study program outcomes

QUESTIONS?

Barriers to Increasing Access to Brief Pediatric Mental Health Treatment From Primary Care

Erin Schoenfelder Gonzalez, Ph.D., Nathaniel Jungbluth, Ph.D., Carolyn A. McCarty, Ph.D., Robert Hilt, M.D.

A quality improvement process targeted mental health care uptake and system capacity in an underserved region. The pediatric program created pathways for rapid referral from primary care and schools to four sessions of evidence-based treatments for disruptive behavior and depression with community clinicians. Of 250 referrals, 46 families enrolled in treatments for disruptive behavior and 21 for depression. Many families did not respond or required more intensive treatment. Acceptability of the program was high for participating families, referrers, and clinicians. Brief treatment met most participating families' needs. The process demonstrated barriers to mental health care access and delivery and the need for integrated and multitiered care delivery.

Psychiatric Services 2021; 00:1–4; doi: 10.1176/appi.ps.202000457

More than 25% of pediatric primary care patients present to care with a psychosocial problem (1), yet less than one-third of children referred to mental health treatment by their primary care provider (PCP) complete an outpatient visit (2, 3). Although most parents report interest in receiving child behavioral treatments through primary care (4), existing referral and handoff processes to mental health care are insufficient to engage the majority of families. Additionally, evidence-based treatments (EBTs) for pediatric mental health problems can be lengthy, cost-intensive, and burdensome. Common barriers to engagement include lack of trained providers, limited treatment capacity, and logistical and transportation problems among patients. Thus, there is a need to improve integration of mental health care with primary care through consultation or team-based processes and to develop briefer and more targeted EBTs to increase treatment uptake, retention, and reach (5).

In response to a state initiative to improve access to behavioral treatments in remote areas with minimal uptake of and demand for primary care–embedded mental health services, we conducted a quality improvement process to provide rapid access to brief behavioral treatment for children and adolescents in an underserved region of Washington State. The process created pathways from primary care clinics and schools to regional mental health clinicians trained in brief EBTs. We evaluated the feasibility of implementing the program, acceptability of the model, and preliminary clinical outcomes. We hypothesized that increasing availability of and access to brief EBTs would increase service uptake for pediatric primary care patients. The 2-year project period for working within existing community care systems provided opportunities to understand system barriers and to test solutions designed to improve care delivery and quality.

The state-funded quality improvement process was conducted in Benton and Franklin counties, located in South Central Washington State, with limited specialized health services and without integrated services in primary care. Over 29 months, we sought referrals from primary care (and later from schools) of children with disruptive behavior problems and adolescents with depression, all with Medicaid insurance.

We developed brief treatments to enhance system capacity and family engagement. Two four-session First Approach Skills Training (FAST) treatment manuals were adapted from full-length EBTs and reviewed by child clinical psychologists, psychiatrists, and community therapists. Both manuals are available for free (https://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/pal-plus). The programs were designed for

HIGHLIGHTS

- A pilot program targeted increased system capacity and rapid referrals from primary care and schools to brief pediatric mental health treatment.
- A direct referral pathway was insufficient to overcome barriers to treatment access.
- Embedded mental health care should remain a focus of efforts to reduce barriers to mental health care.

patients with mild-to-moderate acuity without immediate safety risks or with a different primary treatment need. We supported patients with higher acuity and needs in accessing other services through the same community mental health centers where FAST programs were delivered.

The FAST-Behavior (FAST-B) program was designed for children ages 4–12 with a primary disruptive behavior problem, including oppositional behavior, attention-deficit hyperactivity disorder, parent-child relational problems, and/or adjustment problems. Content was adapted from the *Defiant Children* manual (6) and included skills training for one-on-one play time, labeled praise, planned ignoring, incentives, and time-out. Children referred to more intensive community services included those with autism spectrum disorder, primary posttraumatic stress or depression, and open child welfare investigations.

The FAST-Depression (FAST-D) program was developed for adolescents ages 12–17 with mild-to-moderate depressive symptoms. The protocol was adapted from the *Behavioral Activation for Adolescent Depression* manual (7) and included psychoeducation on depression, sleep hygiene, goal setting, and activities planning. Adolescents with primary anxiety disorders, posttraumatic stress, substance abuse, eating disorders, bipolar disorder, ongoing self-injury, or active suicidality were referred to higher-intensity care.

We remotely trained three mental health clinicians from community mental health agencies to deliver the programs. Training was manual based and consisted of 4–6 hours of training, via videoconferencing, with clinical psychologists specializing in EBTs as well as weekly phone consultation.

To improve the referral and handoff process to behavioral treatment, we created a one-step phone or fax referral pipeline directly to clinicians. We advertised the program to PCPs through a regional medical conference, an e-mail registry, and recruitment visits to primary care offices. When program capacity remained after 14 months, we invited school-based referrals through phone calls and school staff trainings.

After being referred to the program, families received up to three outreach phone calls and one letter from the clinician within 2 weeks. Responding families were phone screened for eligibility and then invited to attend an in-person screening at the clinician's clinic. Enrolled families were offered four free 1-hour FAST treatment sessions. Clinicians sent "faxbacks" to PCPs describing the referral outcome and sent treatment summaries if the families had enrolled. Families that were ineligible or declined the programs were connected to other local services. Because FAST clinicians were located within community mental health centers, they could provide immediate access to full-length treatments in that setting and, in many cases, could provide the higher-level intervention themselves or offer a direct handoff to a colleague.

For FAST-B, we received 140 referrals (N=104 from PCPs), and 84 families responded to contact. Of these, 47 families attended the screening (34% of referred), 46 enrolled, and 26 completed the program. Mean±SD age was 7.3±2.27, and 77% (N=36) were male. Of those who attended the screening, 28% (N=13) identified as White, 9% (N=4) as mixed race, and 30% (N=14) as Hispanic; nine participants spoke primarily Spanish. The primary reasons for declining the program were caregiver's preference for individual child therapy and family scheduling barriers. Several children were screened out during the initial phone call because of a primary mood disorder, suicidality, high-risk aggression, or trauma-related problems and referred to traditional community mental health treatment services. Of those who attended the screening, 43% (N=20) completed all sessions.

For FAST-D, we received 80 referrals (N=45 from PCPs), and 58 families responded to contact. Of these, 38 adolescents attended screening (48% of referred), 21 initiated treatment, and 15 completed the program. Mean age was 13.6±1.53, and 55% (N=24) were female. Of those who attended the screening, 19% (N=7) identified as White, 5% (N=2) as mixed race, and 10% (N=4) as Hispanic; two participants spoke primarily Spanish. Notably, PCPs referred fewer patients to FAST-D than to FAST-B and tended to refer individuals with more severe and complex cases. We received nearly an equal number of referrals to FAST-D from schools as from PCPs and in only half the time. A majority of youths screened for the program showed severe depressive symptoms, suicidal ideation, or other risk factors necessitating more intensive community treatment, which was facilitated by the clinician. Of those who attended the screening, 71% (N=15) completed all sessions.

We administered family acceptability questionnaires adapted from existing surveys (8) privately after the final session. Questionnaires were completed by 23 FAST-B caregivers, 15 FAST-D caregivers, and 13 adolescents who attended FAST-D. All respondents reported that the program was helpful, that they would recommend it, and that they were satisfied overall. Most caregivers in both tracks reported that the program met most or all of their needs. Most FAST-B caregivers (N=20 of 23) agreed that there were enough sessions, whereas nine of 15 FAST-D caregivers and nine of 13 of adolescents agreed. Most adolescents (N=7 of 13) reported they would have been "not at all likely" to seek mental health treatment if not offered FAST-D.

Study clinicians completed an acceptability rating scale after seeing several patients and again after the project ended. Initial clinician acceptability for FAST-B (N=3 clinicians) was very high for ease of use and comfort with the manual; high for training, user-friendliness, consultation, and appropriateness of content; and moderate for flexibility and length of the program. FAST-D acceptability (N=2 clinicians) was very high for user-friendliness, ease of implementation, training, and consultation and high for flexibility, appropriateness, and length. After the pilot, FAST-B clinicians (N=2) rated all acceptability items highly, except for split responses (moderate/high) on fit of the program. The

FAST-D clinician (N=1) rated all aspects as highly acceptable.

PCPs referring at least two patients received a digital satisfaction questionnaire, and five of the 13 who completed it indicated that the program was easy to refer to, was a valuable additional service, and addressed patients' needs. Four of five reported that communication with the clinician was easy. PCPs were split (three agreeing, two disagreeing) on whether they could now better meet patients' mental health needs.

FAST-B parents rated child behavior problems on the Home Situations Questionnaire (HSQ) at each session. Adolescents attending FAST-D completed the Patient Health Questionnaire–9 at each session; their caregivers completed the Short Moods and Feelings Questionnaire at baseline and the final session. All caregivers completed select subscales of the Weiss Functional Impairment Rating Scale–Parent (WFIRS-P) at baseline and the final session. We estimated preliminary effect sizes of clinical outcomes for families who completed at least one treatment session by using paired t tests and the formula for Cohen's d_{av} (9). For FAST-B, there was significant improvement on the HSQ ($t=2.79$, $df=45$, $p=0.008$; $d_{av}=0.40$) and WFIRS-P ($t=4.39$, $df=17$, $p<0.001$; $d_{av}=0.81$). FAST-D had a smaller sample and small but nonsignificant effect size for adolescent-reported depressive symptoms and functional impairment and a moderate but nonsignificant effect size for parent-reported depressive symptoms.

We originally hypothesized that creating brief EBTs with direct referral pathways from primary care would increase pediatric mental health treatment uptake in an underserved region. However, our service model was insufficient to accomplish this goal and required improvements along the way. Our project succeeded in increasing availability of brief EBTs; acceptability was high for participating families, most of whose needs were met by brief treatment. Program completion rates were comparable to mental health care generally and better than therapy in community mental health settings (10). However, our approach did not substantially increase treatment uptake. Rates of in-person session attendance for referred patients (34% [N=47] for those with disruptive behavior and 48% [N=38] for those with depression) exceeded the 30% threshold observed in previous studies (2, 3), but most referrals still did not initiate treatment. Our program highlights continued service barriers and potential solutions to improve treatment access. The introduction of a novel provider and location outside of the familiar primary care environment and a time gap of several days since leaving clinic likely constituted barriers to access and engagement. Over time, not being colocated and integrated within the clinic likely also diminished our program's visibility to PCPs, who are notoriously busy. Inappropriate referrals received support in accessing alternative services, but nonenrollment in our program may have discouraged referrers. The lack of routine behavioral health screenings in local practices and PCP bandwidth for in-depth mental health assessment may have prevented milder cases from being identified. Relative to PCPs, school staff appeared better able to identify adolescents with depression, highlighting benefits of including schools in primary care and mental health care collaborations.

Our project demonstrated the need for integrated mental health care to provide a "warm handoff" in a comfortable and familiar primary care setting. Routine pediatric mental health screening measures allow PCPs to identify patients with mild-to-moderate acuity cases and make immediate treatment recommendations. After the initial project period, we transitioned to provide FAST training and weekly videoconferencing consultation to mental health clinicians integrated within pediatric primary care practices across Washington State and incorporated their feedback to improve FAST usability in collocated service settings. We have observed that referrals and handoffs are more effective in this context. By request from PCPs, we also developed a FAST pediatric anxiety manual. Additionally, telehealth delivery during the COVID-19 pandemic has facilitated program access and should remain a delivery format for brief treatments. We also learned that intensive community treatments are often unavailable, and our brief programs likely constitute an appropriate first step for families waiting to initiate additional care. Referring families with higher acuity to a separate program creates additional care barriers for them. One benefit of offering FAST in community mental health centers was that no additional contact was needed for most referred families to initiate more intensive treatment. However, integrated mental health care should incorporate stepped-care models, in which lower and higher acuity services are available with a single entry point or completion of a lower-intensity treatment leads directly to a higher level of care, when needed.

Our project was limited in scope. Only those who completed the program rated acceptability, and those who initiated the treatment reported clinical outcomes; families with more hardship and barriers were underrepresented by our data. A strength of the program was its deployment focus, meaning that our model could be replicated in other communities with traditional health care infrastructure. Our program could be appropriate for remote areas with insufficient demand for embedded mental health care because a single regional program can serve many clinics. Furthermore, implementing this project in a "real-world" setting allowed us to observe and respond flexibly to barriers, for example, by increasing communication with PCPs, adding school referrals, and partnering with primary care–embedded clinicians during a second phase. Our findings demonstrate that brief behavioral treatments can expand system capacity and meet the needs of lower-acuity families, but do not substantially increase service uptake. Rather than replicating our program model, future efforts should focus on integration with primary care, where families have greater access to and comfort with treatment and care teams can work collaboratively.

AUTHOR AND ARTICLE INFORMATION

Seattle Childrens Hospital, Seattle (all authors); Department of Psychiatry and Behavioral Medicine (Schoenfelder Gonzalez, Hilt) and Department of Pediatrics (McCarty), University of Washington School of Medicine, Seattle. Marcela Horvitz-Lennon, M.D., Kenneth Minkoff, M.D., and Esperanza Diaz, M.D., are editors of this column. Send correspondence to Dr. Schoenfelder Gonzalez (erin.gonzalez@seattlechildrens.org).

This work was funded by the Washington State Legislature and Washington State Health Care Authority.

The authors report no financial relationships with commercial interests.

Received June 18, 2020; revision received March 12, 2021; accepted April 15, 2021; published online June 15, 2021.

REFERENCES

1. Cunningham PJ: Beyond parity: primary care physicians' perspectives on access to mental health care: more PCPs have trouble obtaining mental health services for their patients than have problems getting other specialty services. Health Aff 2009; 28(suppl 1):w490–w501
2. Hacker KA, Penfold R, Arsenault L, et al: Screening for behavioral health issues in children enrolled in Massachusetts Medicaid. Pediatrics 2014; 133:46–54
3. Rushton J, Bruckman D, Kelleher K: Primary care referral of children with psychosocial problems. Arch Pediatr Adolesc Med 2002; 156:592–598
4. Riley AR, Walker BL, Wilson AC, et al: Parents' consumer preferences for early childhood behavioral intervention in primary care. J Dev Behav Pediatr 2019; 40:669–678
5. Rotheram-Borus MJ, Swendeman D, Chorpita BF: Disruptive innovations for designing and diffusing evidence-based interventions. Am Psychol 2012; 67:463–476
6. Barkley RA: Defiant Children: A Clinician's Manual for Assessment and Parent Training. New York, Guilford Press, 2013
7. McCauley E, Schloredt KA, Gudmundsen GR, et al: Behavioral Activation With Adolescents: A Clinician's Guide. New York, Guilford Publications, 2016
8. Crawley SA, Kendall PC, Benjamin CL, et al: Brief cognitive-behavioral therapy for anxious youth: feasibility and initial outcomes. Cognit Behav Pract 2013; 20:123–133
9. Lakens D: Calculating and reporting effect sizes to facilitate cumulative science: a practical primer for t-tests and ANOVAs. Front Psychol 2013; 4:863
10. Kim H, Munson MR, McKay MM: Engagement in mental health treatment among adolescents and young adults: a systematic review. Child Adolesc Social Work J 2012; 29:241–266