Physicians Committed to the Health and Wellbeing of Youth

California Department of Health Care Services
Substance Use Disorder Conference
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Welcome, Introductions & Inclusion Activity

Community Background - Wasted Documentary

Community Committed Initiatives (Parent, Merchant, Athlete & Physician)

Adolescent Substance Use Rate and Prevalence of Mental Health Issues

Physician Committed – why is this so important?

Overview of the Physician Committed Process & Toolkit

Questions
When it comes to caring for children and teens, checking their social and emotional development such as how they build relationships and respond to stress is just as important as checking their height and weight.
Butte County

Population of 229,294
1,640 rural, square miles
Poverty Rate- 21.8%
  - California Rate- 15.3%
  - United States Rate- 14.7%
Medi-Cal Beneficiaries: 36.5%
  - California- 33.4%

Butte County adults with 4 or more ACE’s: 30.0%
California: 15.9%

butte county population by race/ethnicity, united states census bureau, 2014

White (not Hispanic or Latino), 73.5%
Hispanic or Latino, 15.5%
Asian, 4.6%
American Indian/Alaska Native, 2.5%
African American/Black, 1.8%
Persons of multi-races, 4.2%

Chico Unified Demographic Data
White (not Hispanic or Latino), 60%
Hispanic or Latino, 25%
Persons of multi-races, 20%
Asian, 7%
American Indian, 3%
The Need
Butte County needs...

Identification and intervention of behavioral health issues among it’s youth.

Collaboration among our partners in behavioral health, physical health, and education to strengthen and expand our safety net for our youth.

Our primary care system to embrace and feel empowered to integrate behavioral health screenings as part of the overall youth’s care.

### National Data
- 13% of youth aged 8-15
- 21% of youth aged 13-18
- Live with mental illness
- 50% of all lifetime mental health cases begin by age 14
- 1 in 3 youth begin drinking alcohol by the end of the 8th grade.

### Butte County Data
- 29% of 7th graders
- 32% of 9th graders
- 33% of 11th graders
- Report feeling so sad and hopeless almost every day that they stopped doing some usual activities.
- 22% of 9th graders
- 17% of 11th graders
- 37% of non-traditional high school students
- Have seriously considered attempting suicide within the past 12 months.
- 21% of 11th graders
- 11% of 9th graders
- Report binge drinking (5 or more drinks in a row) during the past 30 days.

Sources for these data include National Institute on Alcohol Abuse & Alcoholism (NIAAA), National Institute of Health (NIH), American Academy of Pediatrics and the California Healthy Kids Survey Results for Butte County.
Great community...great concerns

- Chico is plagued by a drinking and party culture that dates back to the 80’s when Playboy ranked Chico the #1 Party School USA.

- The high risk drinking and binge drinking behavior has contributed to AT LEAST 12 deaths in the past six years.

- 1.5 million dollars of the Chico Police Department resources are funneled to alcohol related problems annually (specifically city blocks in downtown Chico and a south college campus neighborhood).

- 80% of high school students were reporting that alcohol is easy to get.

Underage Drinking A National Crisis – The Surgeon General issued a Call To Action to prevent underage drinking and reduce high risk drinking. “Every year in the US 5,000 youth under the age of 21 die as a result from underage drinking” NIH
Wasted Documentary
A bit about your community...

- How do youth access alcohol in your community?
- What are some of the strategies you are using to address youth access to alcohol?
- Does your coalition partner with physicians on your coalition strategies/initiatives? If so, how?
Butte Youth Now Coalition

- Formed in 2006
- Environmental Prevention focus (social host ordinance, DAO, CUP, tobacco ordinances, marijuana ordinances, prescription drug prescribing standards, safe disposal, etc.)
- Drug Free Communities Coalition
- Recipient of the CADCA Got Outcomes Coalition of the Year Award
- Diverse memberships with three sub-committees (prescription drug, tobacco, alcohol/marijuana)
- www.butteyouthnow.org
Underage Alcohol Use

Young people are drinking:

- **Too Early (Age of Onset)**
  - 9% report their first drink at the age of 10 or under
  - 9% report their first drink at the age of 11-12
  - 21% report their first drink at 13-14 and
  - 26% report their first drink at age 15-16

- **Too Often (Past 30 Day Use)**
  - 24% of 9th graders and 38% of 11th graders report at least one drink of alcohol in the past 30 days.

- **Too Much (Binge Drinking - 5 Drinks or More in One Sitting)**
  - 48% of 11th graders and 28% of 9th graders report binge drinking.

*California Healthy Kids Survey (Butte County Report)*
Adolescent Mental Health

- 13% of youth aged 8-15 live with mental illness. This figure jumps to 21% in youth ages 13-18.
- One half of all lifetime cases of mental illness begin by age 14.
- Homicide and suicide are the leading cause of death for ages 15-24.
- 29% of Butte County 7th graders, 32% of 9th graders and 33% of 11th graders report feeling so sad and hopeless almost everyday that they stopped doing some usual activities.
- 22% of Butte County 9th graders, 17% of 11th graders, and 37% of non-traditional high school students have seriously considered attempting suicide within the past 12 months.
Community Wide “Committed” Approach

- **Committed Chapters** on middle school and high school campuses - reducing substance use, fostering youth leaders, reduce mental health issues and promoting positive school culture
- **Merchant Committed** - reducing youth access to alcohol through commercial/retail environments
- **Parent Committed** - reducing youth access to alcohol through social environments (homes, parents, siblings)
- **Athlete Committed** - promoting health and wellness through education, policy and standards for participation in athletics
- **Physician Committed** - screening and early identification of adolescent health issues
Local high school students report high alcohol use rates, high binge drinking rates and low perception of harm.

In 2009, a local high school athlete died of alcohol poisoning (New Year’s Eve high school party).

**Athlete Committed** focuses on the impact of substance use, sleep, nutrition, training, recovery and stress - on all areas of performance (athletically, academically, personally)

**Athlete Committed** aims to debunk perceptions that use is acceptable through no-use policies and expectations for student athletes.

**Athlete Committed** is creating a culture shift - where athletes are holding each other accountable to higher expectations

**Athlete Committed** assists athletes in understanding the consequences of their use on athletic training and performance AND provides brief screening and intervention support for all substance use violations. The focus is to keep them on the team!
It Takes A Village

- Butte Glenn Medical Society - Physicians children were experiencing Athlete Committed in high school and the docs felt there was a role for them.
- Asked to partner on an initiative to bring the physicians into the program/process.
- Agreed to collaborate on screening adolescents for behavioral health issues.
- Physicians volunteer their time to complete the athlete physicals.
- Collaboration between Physicians, DBH, PH, CSU Nursing Dept.
Recognizing that adolescent mental health and substance issues often go undetected, are common, are risky and often a marker for other health issues, **this project poses a unique opportunity to engage the medical community in the solution - Behavioral Health Screenings integrated into physical health settings.**

If a young person is screened in for additional support, the intervention specialist meets with the youth within two days.

The follow up intervention consists of three sessions intended to:

1. Provide an experience for a young person to talk about their issues
2. Give accurate history and information
3. Identify related issues
4. Empower the young person to set goals and make informed choices
5. Assist the young person in accessing other services when appropriate
Physician Committed

Goals

Through comprehensive training, increased skill and capacity, physicians will effectively incorporate behavioral health screening into non-traditional health care settings, such as annual athletic physicals and comprehensive health screenings.

Using the success of the pilot phase of Physician Committed as a project model, this project will be successful on a County-wide scale.

Through comprehensive training and the implementation of a standardized tool and process, physicians will experience increased skill and comfort level in addressing behavioral health issues in adolescents.
Physician Committed To Screening and Early Identification of Health Issues

- Several Models - not reinvent the wheel, tested, evidence, reliable

- Alcohol Screening and Brief Intervention For Youth
  - National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institute of Health (NIH)

- Brief Mental Health Update - Mental Health Screening
  - Developed David S. Rosen, MD, MPH, Professor of Pediatrics - American Academy of Pediatrics

Special thank you to the Butte Glenn Medical Society & Rabobank
While early screening and detection for physical health issues in adolescents is common in medical practices, the early screening and detection for behavioral health is not common.

Research shows that early detection is key to helping people receive the support they need and keep the issue from becoming more severe.

It is also important that the screening is provided in a non-invasive and non-threatening way.

Research also demonstrates that mental health and substance issues are often underlying issues with other health concerns.
Why screen for underage drinking?

- It often goes undetected: Most adolescents visit a primary care practitioner every year or two (O’Connor et al., 1999), and many are willing to discuss alcohol use when they are assured of confidentiality.

- It’s common: Alcohol is by far the drug of choice among youth. It’s often the first one tried, and it’s used by the most kids (Johnston et al., 2010).
It’s risky: In the short term, adolescent drinking too often results in unintentional injuries and death; suicidality; aggression and victimization; infections and pregnancies from unplanned, unprotected sex; and academic and social problems. In the long term, drinking in adolescence is associated with increased risk for alcohol dependence later in life (Hingson et al., 2006; Grant & Dawson, 1997).

It’s a marker for other unhealthy behaviors: When adolescents screen positive for one risky behavior—whether drinking, smoking tobacco, using illicit drugs, or having unprotected sex—it’s generally a good marker for the others. For many youth, drinking alcohol is the first risky behavior tried.
Why choose this tool?

- **It can detect risk early:** This early detection tool aims to help you prevent alcohol-related problems in your patients before they start or address them at an early stage.

- **It’s empirically based:** The screening questions are powerful predictors of current and future negative consequences of alcohol use.

- **It’s fast and versatile:** The alcohol screen consists of just two questions that you can incorporate easily into patient interviews or pre-visit screening tools across the care spectrum, from annual exams to urgent care.

- **It’s the first tool to include friends’ drinking:** The “friends” question will help you identify patients at earlier stages of alcohol involvement and target advice to include the important risk factor of friends’ drinking.

- **It has been tested**
Athletic Physicals - Presented an Opportunity

- California Interscholastic Federation (CIF) requires all high school athletes to receive an annual health physical
- Current standard health physical has 49 questions - none address substance use or mental health issues
- Up to 80% of the high school students participate in high school athletics
- Exposure to a significant number of the adolescent population
- Low cost/no cost = access to diverse population regardless of insurance coverage
Five Simple Questions

Alcohol

1. In the past year, on how many days have you had more than a few sips of beer, wine, or any drink containing alcohol?

2. If your friends drink, how many drinks do they usually drink on an occasion?

Mental Health

3. In general, how do you think things have been going for you lately?

4. Many of my other patients your age often talk bout “stress” what are the things that are most stressful for you these days?

5. What changes have you noticed in your sleep lately?
For All Patients

Step 1: Ask the Two Screening Questions

Research indicates that the two age-specific screening questions (about friends’ and patient’s drinking) are powerful predictors of current and future alcohol problems in youth. Put them into your office practice in whatever way works best for you, whether by adding them to a previsit screening tool or weaving them into your clinical interview. In either case, take steps to protect patient privacy and, if at all possible, conduct an in-person alcohol screen when you are alone with your patient.

Guidelines for asking the screening questions: (1) For elementary and middle school patients, start with the friends question, a less threatening, side-door opener to the topic of drinking. (2) Because transitions to middle or high school increase risk, choose the question set that aligns with a patient’s school level, as opposed to age, for patients aged 11 or 14. (3) Exclude alcohol use for religious purposes.

Elementary School (ages 6–11) Ask the friends question first.

Friends: Any drinking? "Do you have any friends who drink beer, wine, or any drink containing alcohol in the past year?"

Any drinking by friends heightens concern.

Middle School (ages 11–14) Ask the friends question first.

Friends: Any drinking? "Do you have any friends who drink beer, wine, or any drink containing alcohol in the past year?"

Any drinking by friends heightens concern.

High School (ages 14–16) Ask the patient question first.

Patient: How many days? "In the past year, on how many days have you had more than a few sips of beer, wine, or any drink containing alcohol?"

Lower, Moderate, or Higher Risk

continued on page 4

For Patients Who Do Not Drink...

Step 2: Guide Patient

For patients who do NOT drink...

Neither patient nor patient’s friends drink

Praise choices of not drinking and of having nondrinking friends.

Patient does not drink, but friends do

Praise choice of not drinking.

Consider probing a little using a neutral tone: “When your friends were drinking, you didn’t drink. Tell me a little more about that.” If the patient admits to drinking, go to Step 2 for Patients Who Do Drink; otherwise, continue below.

• Reinforce healthy choices with praise and encouragement: “You’ve made a smart decision not to use alcohol.”

• Elicit and affirm reasons to stay alcohol free: “So, what led you to the decision to stay away from alcohol?” If friends drink, add, “…especially when your friends have chosen to drink.” Possible followup: “Those are great reasons and show you really care about yourself and your future.”

• Educate: If your patient is open to input, you may want to help him or her understand, for example, that (1) alcohol can affect brain development, which continues into a person’s twenties; and (2) drinking at an early age increases the risk for serious alcohol problems later in life.

• Rescreen next year at the latest.

• Explore how your patient plans to stay alcohol free when friends drink: Ask patients for their ideas on handling situations where they may feel pressure to drink. You can let them know that often the best response to a drink offer is a simple “No, thanks”; that, if pressured, an effective response is “I don’t want to”; and that they don’t have to give a reason.

• Advise against riding in a car with a driver who has been drinking or using other drugs.

• Rescreen at next visit.

Screening complete for nondrinkers.

Go to Step 2: Assess Risk.
STEP 2: ASSESS RISK
For patients who DO drink...

For a broad indicator of your patient’s level of risk, start with the chart below, which provides empirically derived population-based estimates. Then factor in what you know about your patient’s drinking and other risk factors, ask more questions as needed, and apply your clinical judgment to gauge the level of risk.

On how many DAYS in the past year did your patient drink?

<table>
<thead>
<tr>
<th>AGE</th>
<th>&lt; 11</th>
<th>12-15</th>
<th>16</th>
<th>17-18</th>
<th>19-24</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAYS</td>
<td>1-5</td>
<td>5-10</td>
<td>11-29</td>
<td>30-49</td>
<td>50-62</td>
</tr>
</tbody>
</table>

For elementary and middle school students: Having friends who drink heightens concern. Because having more friends who drink means more risk, ask how many friends drink, if your patient didn’t offer this detail when answering the screening question.

For high school students: Having friends who binge drink heightens concern. Recent research estimates that binge drinking levels for youths start at 3 to 5 drinks, depending on age and gender.

Include what you already know about the patient’s physical and psychosocial development in your risk evaluation, along with other relevant factors such as the level of family support, drinking and smoking habits of parents and siblings, school functioning, or trouble with authority figures.

For moderate and highest risk patients:

- Ask about their drinking patterns: “How much do you usually have? What’s the most you’ve had at any one time?” If the patient reports bingeing, ask, “How often do you drink that much?”
- Ask about problems experienced or risks taken: “Some people your age who drink have school problems like lower grades or missed classes. Some do things and feel bad about them later like damaging or stealing property, getting into fights, getting sexually involved, or driving while under the influence driven by someone who has been drinking. Others get injured, have memory blackouts, or pass out. What not-so-good things related to drinking, if any, have you experienced?”
- Ask about other substance use (“Have you used anything else to get high in the past year?”) and consider using other formal tools to help gauge risk. The majority of your lower risk patients will not have used illicit drugs (NIDA, 2011), but ask them, too, about past-year use, time permitting.

STEP 3: ADVISE AND ASSIST
For patients who DO drink...

In this step, conduct a brief intervention for your patients who drink, based on the risk levels identified during Step 2.

**LOWER RISK**
- Provide brief advice: “I recommend that you stop drinking, and now is the best time. Your brain is still developing, and alcohol can affect that. Alcohol can also keep you from making good decisions and make you do things you’d regret later. I would hate to see alcohol interfere with your future...”
- Notice the good: Reinforce any strengths and healthy decisions.
- Explore and troubleshoot the potential influence of friends who drink or binge drink.

**MODERATE RISK**
- Does the patient have alcohol-related problems?
  - If so, provide brief preparatory advice: Start with the brief advice for Lower Risk patients (at left) and add your concern about the frequency of drinking.
  - If yes, conduct brief motivational interviewing to elicit a decision and commitment to change.
- Ask if parents know: See suggestions for Highest Risk patients (at left).
- Arrange for follow up, ideally within a month.

**HIGHEST RISK**
- Conduct brief motivational interviewing to elicit a decision and commitment to change, whether or not you plan to refer.
- Ask if parents know: If so, ask parent permission to share recommendations with them. If not, take into account the patient’s age, the degree of acute risk posed, and other circumstances, and consider breaking confidentiality to engage parents in follow-through.
- Consider referral for further evaluation or treatment based on your estimate of severity.
- Arrange for follow up within a month.

If you observe signs of acute danger, such as drinking and driving, high intake levels per occasion, or use of alcohol with other drugs, take immediate steps to ensure safety.

FOR ALL PATIENTS WHO DRINK
- Collaborate on a personalized goal and action plan for your patient. For some patients, the goal will be accepting a referral to specialized treatment.
- Advise your patient not to drink and drive or ride in a car with an impaired driver.
- Plan a full psychosocial interview for the next visit if needed.

STEP 4: AT FOLLOWUP, CONTINUE SUPPORT
For patients who DID drink...

It may be uncommon for patients to return for an alcohol-specific follow up. Still, when patients with whom you’ve conducted an alcohol intervention return for any reason, you’ll have an opportunity to strengthen the effects of the previous visit. Start by asking about current alcohol use and any associated problems. Then review the patient’s goal(s) and assess whether he or she was able to meet and sustain them.

**Patient was able to meet and sustain goal(s):**
- Reassess the risk level (see Step 2 for drinkers).
- Acknowledge that change is difficult: that it’s normal not to succeed on the first try; and that reaching a goal is a learning process.
- Notice the good by:
  - Praising honesty and efforts.
  - Reinforcing strengths.
  - Supporting any positive change.
- Relate drinking to associated consequences or problems: to enhance motivation.
- Identity and address challenges and opportunities in reaching the goal.
- If the following measures are not already under way, consider:
  - Engaging the parents.
  - Referring the patient for further evaluation.
- Reinforce the importance of the goals and plan and renegotiate specific steps, as needed.
- Conduct, complete, or update the comprehensive psychosocial interview.

**Patient was not able to meet and sustain goal(s):**
- Reinforce and support continued adherence to recommendations.
- Notice the good: Praise progress and reinforce strengths and healthy decisions.
- Elicit future goal(s) to build on prior ones.
- Conduct, complete, or update the comprehensive psychosocial interview.
- Rescreen at least annually.
Mental Health Screening

- Research shows that early detection is key to helping people receive the support they need and keep the issue from becoming more severe.

- It is also important that the screening is provided in a non-invasive and non-threatening way.

- Research also demonstrates that mental health and substance issues are often underlying issues with other health concerns.

- Ask questions to begin an interactive discussion.

- Evaluate for other physical conditions that can mimic mental illness and rule these out.

- Evidence continues to support the link between untreated mental health issues and other negative physical health issues.

- Refer to mental health providers for further evaluation and services.
**WHY WE SCREEN FOR MENTAL HEALTH ISSUES?**
**THESE THREE QUESTIONS CAN TELL US A LOT...**

1. Tell me, in general, how do you think things have been going for you lately?
2. Many of my other patients your age often talk about “stress”; what are the things that are most stressful for you these days? How do you manage stress?
3. What changes, if any, have you noticed in your sleep lately (more, less, about the same as usual)?

<table>
<thead>
<tr>
<th>Physical Symptoms and Signs Suggestive of Mental Health and Substance Abuse Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sleep Problems</strong></td>
</tr>
<tr>
<td>• Excessive sleep</td>
</tr>
<tr>
<td>• Significant change in sleep patterns</td>
</tr>
<tr>
<td>• Difficulty falling or staying asleep</td>
</tr>
<tr>
<td>• Nightmares</td>
</tr>
<tr>
<td><strong>Chronic, Recurrent, or Unexplained Physical Symptoms</strong></td>
</tr>
<tr>
<td>• Abdominal pain</td>
</tr>
<tr>
<td>• Joint pain</td>
</tr>
<tr>
<td>• Headache</td>
</tr>
<tr>
<td>• Fatigue or low energy</td>
</tr>
<tr>
<td>• Loss of appetite</td>
</tr>
<tr>
<td>• Epigastric pain or gastritis (alcohol use)</td>
</tr>
<tr>
<td>• Chest pain or difficulty breathing (panic/anxiety attacks)</td>
</tr>
<tr>
<td>• Oligomenorrhea or amenorrhea, especially in women of low weight (anorexia, teen pregnancy)</td>
</tr>
<tr>
<td>• Irregular menses (anorexia, bulimia)</td>
</tr>
<tr>
<td><strong>Neurologic Symptoms</strong></td>
</tr>
<tr>
<td>• Legs weak</td>
</tr>
<tr>
<td>• Limb paralysis (conversion reaction)</td>
</tr>
<tr>
<td>• Pseudoseizures</td>
</tr>
<tr>
<td>• Non-physiologic neurologic symptoms</td>
</tr>
<tr>
<td>• Difficulty concentration, inattention in school</td>
</tr>
<tr>
<td>• Irritability, restlessness</td>
</tr>
<tr>
<td><strong>Physical Findings</strong></td>
</tr>
<tr>
<td>• Excess weight gain or loss</td>
</tr>
<tr>
<td>• Parotid gland enlargement, dental enamel erosion, calluses or erosions on knuckles (purging)</td>
</tr>
<tr>
<td>• Cigarette burns, multiple linear cuts or patterns (self-harm, maltreatment)</td>
</tr>
<tr>
<td>• Metabolic abnormalities such as hypochloremic metabolic alkalosis, low potassium, or elevated amylase (purging)</td>
</tr>
<tr>
<td>• Recurrent injuries (maltreatment, Self-harm)</td>
</tr>
<tr>
<td>• Isolated systolic hypertension (alcohol use)</td>
</tr>
<tr>
<td>• Chronic nasal congestion (cocaine use)</td>
</tr>
<tr>
<td>• Chronic red eyes (marijuana use)</td>
</tr>
<tr>
<td><strong>Other</strong></td>
</tr>
<tr>
<td>• Worsening symptoms of previously well-managed chronic illness</td>
</tr>
<tr>
<td>• School absences</td>
</tr>
</tbody>
</table>
Physician Training

- Although physicians, nurses and physician assistants are very well versed in how to screen for physical health issues, they were feeling less comfortable screening for behavioral health issues.

- Provide training on the research, algorithms and provide opportunities to role play.

Physician Reflection

- A post training survey has been developed and was administered to all attending doctors 30 days after the pilot training to assess level of implementation, comfort, efficiency and referrals made as a result of the substance use and mental health screenings.

- This survey helps guide areas of additional training, provide information on the amount of time needed for the additional screening questions, and track the type of issues being identified along with the follow up care plan.
The follow up intervention consists of three sessions intended to:

- provide a forum for a young person to talk about their issues,
- give accurate history and information,
- identify related issues,
- empower the young person to set goals and make informed choices,
- assist the young person in accessing other services.

The brief intervention sessions infuse Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI) approaches. CBT is a technique used to change perceptions, thoughts and feelings about behavior and the role social environments have in influencing these behaviors. MI is “a person-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence” (Miller and Rollnick - developers of MI).
Physician Committed

Journey from pilot project to MHSA Innovation Project

**Pilot Project**
- 67 physicians, nurses and medical staff trained
- High school physicals provided perfect testing sites (low cost/no cost)
- Approx. 500 youth screened in 2016
  - 12 MH and 6 SUD referrals for further screening/assessment
- Approx. 500 youth screened in 2017
  - 18 MH and 12 SUD referrals for further screening/assessment
  - One youth was referred to crisis services

**Expansion**
- Intervention Team
  - 2.0 FTE Intervention Specialists
  - .5 FTE youth peer provider
- Expansion of the model to
  - surrounding counties (Glenn)
  - additional school districts throughout the county
  - primary health care providers, pediatricians, acute care clinics and other health care settings (orthodontists, orthopedists, etc.)
- Training, consultation and technical assistance provided to the medical providers/staff
School Athletic Physical

- Non-traditional setting
- Access to diverse population
- Low cost/no cost screening

Reduce Stigma
- Physicians
- Adolescents

Intervention
- Trauma Informed
- Physician hotline

Expansion
- School Districts
- Primary care settings
- Opportunity for regionalization

Collaboration
- Butte Glenn Medical Society
- Chico Unified School District
- Butte County Public Health
- Chico State Nursing
**Evaluation Design**

**Outcome Data & Deliverables**

<table>
<thead>
<tr>
<th>Outcome Question</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will physicians experience increased comfort level screening adolescents for behavioral health issues?</td>
<td>• Pre/post-training surveys, 30-day follow up surveys</td>
</tr>
<tr>
<td>Can behavioral health screenings be effectively and efficiently integrated into the comprehensive adolescent health physical?</td>
<td>• Pre/post-training surveys, 30-day follow up surveys</td>
</tr>
<tr>
<td>Will adolescents feel more capable of managing early symptoms as a result of the intervention received (motivational interviewing and cognitive behavioral therapy techniques)?</td>
<td>• Post-intervention survey</td>
</tr>
<tr>
<td>Will adolescents coping skills increase as a result of the intervention received?</td>
<td>• Post-intervention survey</td>
</tr>
</tbody>
</table>
| Will adolescents’ mental health symptoms, such as depression, anxiety, and stress be reduced? | • Initial screening and post-intervention survey  
• CANS outcome data                                                        |
| Was the interagency collaboration between BCBH, BGMS, pediatric offices, and local school districts a success? | • Survey feedback from the staff  
• Number of physicians trained  
• Number of physicians actively using the screening tool  
• Number of youth screened                                                   |

- **Demographic and cultural distribution**
- **Count and type of clinical services**
- **Total number of**
  - Screenings by primary care
  - Physicians trained
  - Adolescents identified at-risk
  - Referrals to behavioral health
  - Participating agencies
  - Connected referrals
Community Voices
Tess Juarez, Butte County Youth

“Real depression isn’t being sad when everything is going wrong... real depression is being sad when everything is going right.”
Kevin Breel
High school all-star athlete

NAMI What Families Want From Primary Care
“Primary care physicians who can help identify potential mental illness can save a child and parent years of pain”
Parent, Chapin, S.C.

“This screening is far more important that any of the physical health screening questions currently asked during the physical.”
Local pilot program physician
Contact Information

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