

Glossary

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

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

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



Background

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

Co-occurring mental health concerns are common in children. Almost 3 out of every 4 youth with depression also experience anxiety, and childhood anxiety is a risk factor for developing depression.^{vii} Youth with attention-deficit/hyperactivity disorder (ADHD) often have other concerns or conditions including disruptive behavior, learning disorders, anxiety and depression^{viii}; many individuals with diagnosed disruptive behavior disorders have underlying comorbid ADHD. Individuals with post-traumatic stress disorder (PTSD) often experience co-occurring substance use disorders.^{ix} Almost 10% of children under 18 will be diagnosed with PTSD, and girls are 4 times more likely than boys to develop it.^x In addition, many youth with mental health concerns are not receiving adequate treatment for their symptoms. Over 1 in 3 youth have a documented need for mental health treatment.^{xi}

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

Substance use can negatively impact the physical, mental, and social development of youth, as well as increase the risk of developing mental health conditions, such as depression, anxiety, and psychosis.^{xiii} In 2021, 13.5% of young adults (18-25 years old) had both a substance use disorder and any mental illness.^{xiv} Substance use can also impair academic performance, increase school dropout rates, and contribute to involvement in the criminal justice system, creating lifelong impact.^{xv}

Given the increasing prevalence and serious impact on the health of Washington's youth and families, improving early identification and intervention of behavioral health concerns is vital. Early intervention aims to identify and address behavioral health concerns as early as possible, before symptoms worsen or conditions become more severe; intervening early can prevent or reduce the severity of symptoms, improve functioning and development, enhance protective factors and resilience, and lower the risk of negative consequences, such as academic failure, substance use, or suicide.^{xvixvii} It can also reduce the



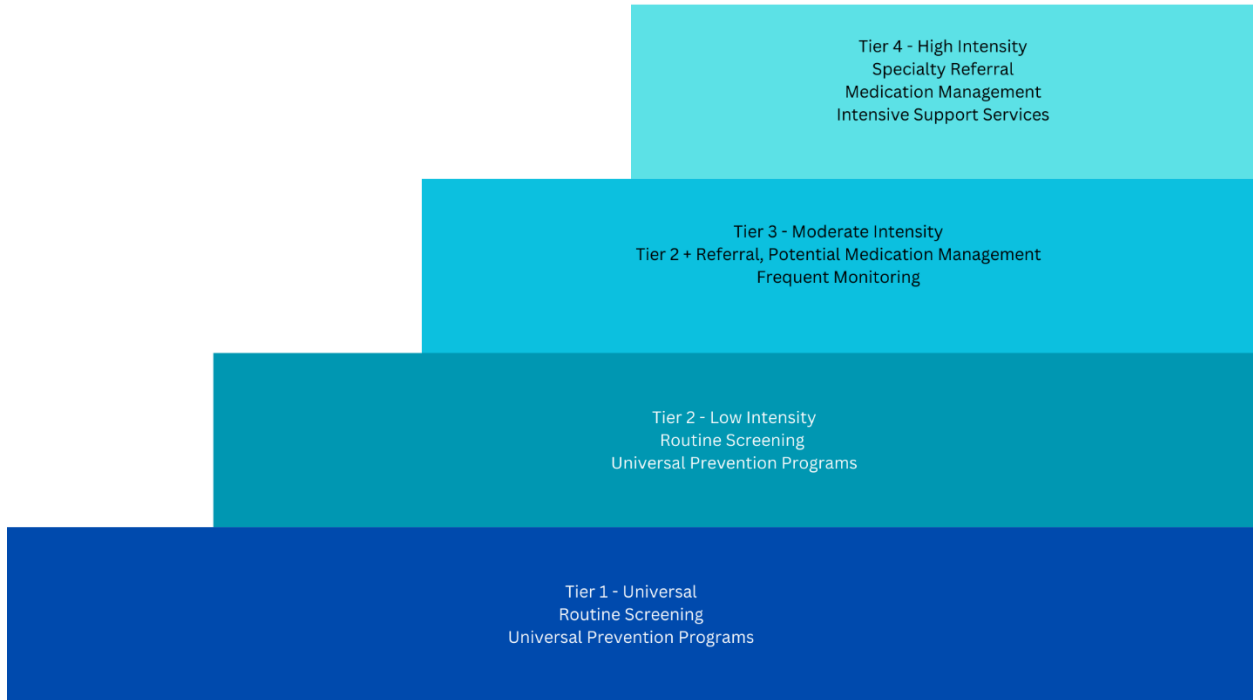
economic costs for youth, families and healthcare systems associated with untreated or poorly treated behavioral health conditions, such as increased health care utilization, increased disability, unemployment, experiencing homelessness, or incarceration.^{xviii}

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

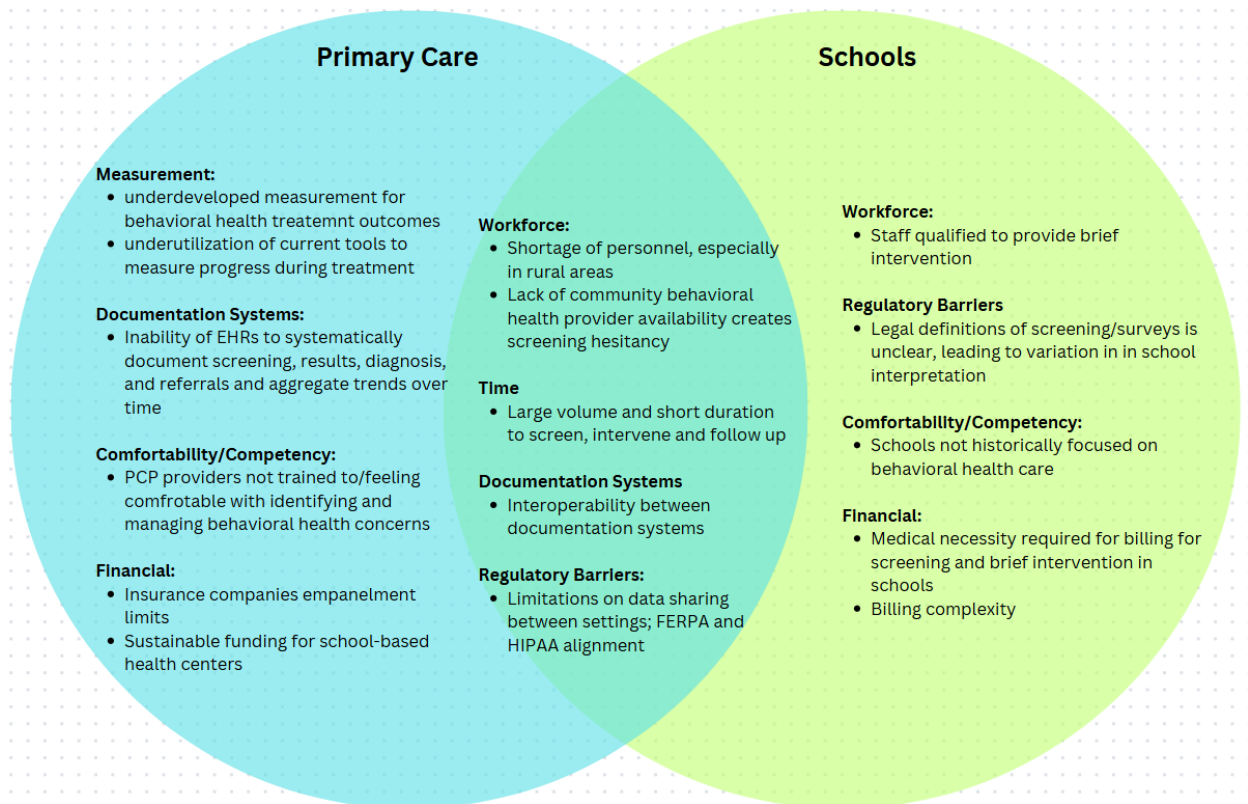
To narrow the focus of this report and guidelines, the workgroup decided to prioritize writing guidelines for the specific concerns for which there is the highest lifetime prevalence, mature bodies of literature on evidence-based treatments, and availability of low-cost trainings for providers in Washington state. Estimated adolescent prevalence of anxiety, depression, substance use, and behavioral disorders is approximately 32%, 14%, 11% and 19% respectively.^{xix} When it comes to evidence-based treatments, anxiety, PTSD, depression, behavioral problems and substance use all have several well-supported evidence-based therapies and have low-cost or free training for providers in Washington state. Therefore, the group chose to focus on **selected mental health (anxiety, depression, trauma and disruptive behavior) and substance use concerns**.

While the group is focusing mainly on these previously mentioned concerns, the workgroup recognizes that many individuals with behavioral health concerns often have multiple co-occurring conditions and concerns, and different people may experience these conditions differently with a wide range of symptoms and signs. This means services should be thoughtfully co-designed with youth and families, allow for no or low barrier to entry of services, based in community and provided in ways and spaces where youth and their families/caregivers feel there's trust and comfort. To meet the needs of youth experiencing a range of severity in symptoms and concerns, systems can implement tiered systems of services to ensure all youth and families are receiving universal support, and targeted increased interventions when symptoms appear or worsen.

Tiered Approach to Behavioral Health



Key Barriers to Optimal Behavioral Health and Healthcare





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

Focus Areas

Patient, Caregiver and Provider Education and Capacity Building	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• Universal systematic screening for behavioral health concerns• Same-day evidence-based brief intervention for mental health and substance use• Holistic assessment and treatment planning to identify risk factors, co-occurring conditions and develop person-centered goals• Expanding access to evidence-based treatments
Coordinated Management of Behavioral Health	<ul style="list-style-type: none">• Monitoring and measurement-based behavioral healthcare in primary care• Coordinated care planning between pediatric primary care, behavioral health, patients and caregivers, and school-based clinicians
Coordination & Data Sharing	<ul style="list-style-type: none">• Data sharing systems to support coordination of care• Population level tracking of children and youth with behavioral health concerns

Future innovations in payment should move away from diagnostically tied and volume-based reimbursement towards value-based, holistic and low-barrier models that are stratified by demographics to identify and solve inequities in access to care and outcomes.



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, such as the home, school primary care clinic or other community-based setting
- **Culturally and linguistically inclusive:** Prioritize adapting agencies, services, and supports to the cultural, racial, ethnic, and linguistic diversity of the young people and families they serve to provide care that meets individual needs, including those shaped by culture and language, and to ensure equity in access, quality, and effectiveness of services. (e.g., using linguistically appropriate screening tools for families who do not speak English)

Align with the Washington HCA's [children's behavioral health principles](#)

The workgroup recognizes the importance of providing comprehensive and evidence-informed care for youth behavioral health in schools, as well as the challenges and barriers that may limit access to such care. The workgroup proposes a set of core components that can be adapted to different contexts and resources, and that can support the implementation of screening, brief intervention and referrals to treatment or support services. The core components are listed below as guidelines:

Pediatric Primary Care Providers

Pediatric primary care providers are key touchpoints for youth and families who need support with mental health or substance use. Mild to moderate behavioral health concerns can be managed effectively in the primary care setting.

1. **Be aware of risk factors for behavioral health concerns or substance use in children and adolescents.** The best treatment is prevention of mental health and substance use concerns, and early identification of symptoms is key. Risk factors for behavioral health concerns include adverse childhood experiences,^{xx} family behavioral health concerns, racial disparities, social isolation, food and housing insecurity, and low income.^{xxi}
2. **Involve caregivers in discussions around mental health and substance use as supported by the patient.** Some patients may wish to not involve their caregivers, and individualized plans should be made based on the patients concerns and potential impact of involving their caregivers. Many psychotherapy interventions are more effective when caregivers are involved.
1. **Collaborate with behavioral health professionals as able and refer to them, when necessary.** Mild to moderate mental health concerns can be managed primarily in the primary care setting.
 - a. **Ensure warm handoffs to specialists** (e.g. speaking to specialist on the phone or in person about the patient) When referring to specialists, close the loop with the patient and/or caregiver.



- b. Consult with behavioral health specialists if needed either onsite or virtually.** The Washington [Partnership Access Line \(PAL\)](#) is a free consult service available during business hours to support pediatric primary care providers with diagnostic clarification, medication adjustment or treatment planning for pediatric patients.^{xxii}
- 3. Ongoing monitoring.** Document screening results, brief intervention and monitoring plan in medical record. Ensure all patients with an indicated concern for behavioral health receive follow up (e.g., phone call, direct message) within 6 weeks.

The following steps should be taken during any health visit.

- 2. For youth with a positive screening result, presenting with a behavioral health related complaint, or for which there is strong clinical suspicion of a behavioral health concern despite a negative screen, perform a comprehensive assessment as able.**
- 3. Assess suicidal ideation, self-harm or substance use that poses immediate danger. Use appropriate crisis intervention protocols, including referral to emergency services if necessary.** See the Bree Collaborative's report on [Suicide Care](#) for more details.
- 4. At a minimum, provide coaching support to patient and caregiver, and consider providing brief intervention during visit (or refer to in-house behavioral health professional to provide brief intervention).** During the visit, if a concern is identified, Brief interventions should include psychoeducation about symptoms, treatment options and monitoring for worsening symptoms as needed.
- 5. If indicated, consider pharmacological management for moderate to severe depression, anxiety, ADHD or certain substance use disorders**
 - a. Medications for Opioid Use Disorder (MOUD) can be effective for patients under 18.

Primary Care Settings

If a pediatric primary care provider owns their own clinic or is a standalone provider, they should follow both the pediatric provider guidelines and the primary care settings guidelines. 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, care team assessment and individualized patient and caregiver needs and preferences.

- 1. Make health information and processes youth-friendly and culturally inclusive.** In health information materials, include straightforward and evidence-based information on how to recognize symptoms of suicide risk, substance use risk, unhealthy behaviors, how to support their peers and how and where to get help when necessary.^{xxiii}
- 2. Interdisciplinary team.** Teams should consist of the primary care provider and other healthcare professionals such as nurses, pharmacists, behavioral health professionals and community health workers to provide comprehensive care.
 - a. **Consider incorporating community health workers as part of the interdisciplinary team.** Community health workers placed in clinic settings can provide services that prevent disease, disability or other health conditions, prolong life, promote physical and mental health and efficiency. Their services will be reimbursable by Washington state Medicaid.



- b. **Consider incorporating Behavioral Health Support Specialists with appropriate training and experience to provide care for children and adolescents specifically to support delivery of behavioral health services.** BHSS are bachelor's prepared professionals that are trained specifically to provide brief evidence-based intervention, apply measurement-based care strategies to track progress and facilitate referral to specialty services.
- 3. **Training.** Primary care staff (providers and other healthcare workers as applicable) should be trained on the signs and symptoms of behavioral health concerns in youth, evidence-based interventions for these concerns and appropriate treatment protocols. Example protocol for depression [here](#).
 - a. **Train staff on the essentials of youth-friendly care.** Youth and adolescents have unique needs in healthcare environments which include creating a positive and welcoming culture. See University of Michigan's [Spark Training](#) for an example of Youth Friendly Care training.
- 4. **Telehealth.** Incorporate telehealth/telemedicine capabilities into clinics. Telehealth is effective for providing behavioral healthcare services and is covered by insurance.
- 5. **Implement a stepped or tiered approach to youth behavioral health concerns with levels of intervention based on severity of symptoms or concerns and individualized patient and caregiver needs.**

Tiers	Guidelines
Universal – No symptoms or at risk for behavioral health concerns	<ol style="list-style-type: none">1. Universally screen annually for youth behavioral health concerns for which there is a validated screening instrument according to most updated evidence-based guidelines (Bright Futures). Practices can combine core elements of screening tools into one questionnaire to reduce documentation burden.<ol style="list-style-type: none">a. Depression (PHQ-A, PHQ2, PHQ9)b. Anxiety (GAD-2, GAD-7)c. Substance Use (CAGE-AID, CRAFFT)2. Education and Support - Provide universal psychoeducation regarding common childhood behavioral health concerns, prevention strategies and parenting strategies. Youth who identify as a racial minority, female or LGBTQ+ are at higher risk of developing behavioral health symptoms and conditions.
Targeted Intervention – Mild to Moderate Symptoms	<ol style="list-style-type: none">1. For youth with a positive screening result, presenting with a behavioral health related complaint, or for which there is strong clinical suspicion of a behavioral health concern despite a negative screen, perform a comprehensive assessment.^{xxiv} The comprehensive assessment does not need to be completed all in the same visit.<ol style="list-style-type: none">a. Assess for comorbid behavioral health concerns. (e.g., co-occurring anxiety and depression, ADHD and behavioral concerns, history of trauma and substance use, disordered eating, etc.)b. Routine screening for adverse childhood experiences is not recommended, but screening for traumatic stress symptoms in patients who have experienced a trauma may help identify



	<p>individuals that would benefit from evidence-based trauma treatment.^{xv} Consider using validated symptom screening tools such as the Child Trauma Screen (CTS) and provide brief intervention in office aimed at specific symptoms (e.g., sleep problems). See an example of an algorithm for screening for and treating trauma here.</p> <ul style="list-style-type: none">c. If a patient presents with academic or behavioral problems and show inattention, hyperactivity, or impulsivity, consider evaluating for ADHD using symptom rating scales and reports from caregivers or other relevant adults. (e.g., Connors Rating Scale). See AAP’s Clinical Practice Guideline for ADHDd. When evaluating for disruptive behavior disorders (DBD) consider using validated assessment tools such as the Pediatric Symptom Checklist (PSC) or Strengths and Difficulties Questionnaire (SDQ).e. Consider other symptoms not included on all validated screening tools, such as social isolation and loneliness, when assessing behavioral health concerns. These symptoms are not always recognized using validated instruments.f. As part of the comprehensive assessment, identify youth and caregivers’ strengths and resilience factors (social support, coping skills, etc) that can support reaching their treatment goals. See American Academy of Pediatrics Resource on strengths and resilience factors here. <p>2. During the visit, provide evidence-based educational materials to patients and their caregivers during the visit. Consider providing a brief intervention as appropriate. See Table X for elements of brief interventions for common childhood behavioral health concerns.</p> <ul style="list-style-type: none">a. First Approach Skills Training (FAST) Program provides evidence-based training and resources for children, families and providers for common behavioral health concerns in children (anxiety, depression, behaviors, trauma, parenting skills)b. If a patient is identified with substance use, brief interventions should follow evidence-based SBIRT protocols. See Seattle Children’s resource here. <p>3. Consider referral to behavioral health and provide a warm handoff.</p>
Specialized Care – Moderate to Severe Symptoms	<ul style="list-style-type: none">1. In addition to brief intervention, refer to appropriate behavioral health specialists and provide a warm handoff.2. If clinically appropriate, develop a safety plan with caregivers (e.g., patient experiencing depressive symptoms) See Bree Collaborative’s Suicide Care report for further details on safety planning.

- 4. **Develop a treatment plan in partnership with patients and caregivers, and incorporate family or patient strengths.** Consider medication management when appropriate and determine appropriate follow up for Family-based interventions include (e.g., home, peer, and school settings) that follows current clinical practice guidelines (American Academy of Child & Adolescent Psychiatry, American Academy of Pediatrics, etc.) and individualizes goals and approach for improvement and incorporate addressing the social determinants of health.



- a. **Develop a safety plan with family when clinically appropriate** (e.g., patient experiencing depressive symptoms) See Bree Collaborative's [Suicide Care](#) report for further details on safety planning.
- I. **Monitor patient response to treatment plan** following [principles of measurement-based care](#) (MBC). Behavioral health concerns can be effectively managed in the primary care setting with adequate training, consultative support and coordination with specialty providers including behavioral health. MBC involves a process of routinely and systematically collecting patient-reported outcomes, sharing feedback in a timely manner with patients and families about their reported progress scores and trends over time, and acting on the scores using clinical judgment in partnership with patients to guide course of care.
 - a. **Establish a clear plan for follow-up after a positive screen. Consider a telephone follow up within 1 week that can be completed by any qualified healthcare worker and a face-to-face follow up within 2-4 weeks, especially if medication started or dose adjusted.** This can be fulfilled either by connection to care (e.g., follow up office visit or visit with a behavioral health provider) or a phone call depending on individualized care plan.
- II. **Establish and train staff on safety protocols for patients at risk for suicide.** Refer to [Bree Collaborative Suicide Care report](#) or more updated evidence for patients at risk for suicide. As clinically appropriate, establish a safety plan that includes limiting access to lethal means and developing emergency communication mechanisms should the patient deteriorate.
- III. **Provide practice enhancements that support delivery of behavioral health services in primary care.**
 - a. **Have a directory of mental health and substance use disorder referral sources easily accessible;** Washington's [Mental Health Referral Services for Children and Teens \(MHRS\) through](#) Seattle Children's offers to connect patients and families to evidence-based outpatient mental health services in their community.
 - b. **Screen for the social determinants of health** according to the Foundation for Health Care Quality's [Social Needs Screening Report and Guidelines](#) or most updated guidance. Integrate screening and results into care planning for all patients.
 - c. **Review auto-populated educational materials for culturally and linguistic appropriateness.** Seek out resources for specific populations served in your community.
 - d. **Build referral capacity for behavioral health professionals.**
 - e. **Identify or provide guides** for coding and billing for behavioral health related service.
- IV. **Evaluation.** Set quality improvement goals for relevant measures to your practice, such as depression, anxiety and substance use screening rates and connection to care after a positive screen. Stratify any measures relevant to

Health Plans

- I. **Cover all reasonable and necessary costs for the provision of behavioral health services.** This includes coverage of a nurse or other individual responsible for care coordination for youth and families identified with behavioral health concerns without significant cost sharing to members.
 - o **Remove copays or coinsurance** for behavioral health screening, assessment and brief intervention codes. (e.g., codes such as CPT 96127/96160.)



- II. **Incent delivery of screening, brief intervention and referral to treatment** in primary care practices by increasing reimbursement rates, equalizing reimbursement between different clinicians and expanding types of professionals that can be reimbursed for screening, assessment and brief intervention.
- III. **Consider alternative population-based payment models linked to quality metrics** that support integration of behavioral health into pediatric primary care and prioritize child and adolescent behavioral health tracking and outcomes. (e.g., APMS with shared savings + downside risk, condition specific population-based payment such as per member per month payments linked to quality metrics)
 - **Prioritize screening, assessment and brief intervention in contracts.** Consider designing key performance indicators around improved uptake of universal screening and follow up after a positive screen.
- IV. **Support clinics by internally tracking screening, brief intervention, referral to treatment and follow-up** rates by organization and if possible, at the provider level. Share findings with clinical sites to use for quality improvement for delivering screening and brief interventions.
- V. **Support patients and caregivers in attending well-child visits and connecting to follow up care** by tracking annual well-child visits rates and referral to healthcare services and providing outreach and navigation services. Include value-added benefits for annual well-child visits.
 - **Develop a system to identify when a child or adolescent patient has screened positive for a concern and automatically flags them for follow up** by a care navigator or other professional offering coordination services.
- VI. **Increase accessibility of telemedicine/telehealth services.** Offer parity on reimbursement for in person and telehealth visits for well-checks, screening and assessment of behavioral health concerns, and behavioral health related visits (e.g., psychotherapy, etc.)
- VII. **Evaluate provider networks for adequacy** and expand when able to form robust network of primary care and behavioral health professionals
- VIII. **Cover services to support health-related social needs** for youth and their caregivers (e.g., transportation to appointments, food access)
- IX. **Develop the capability to measure and track a set of performance measures** for behavioral health for youth and families. Measures should be stratified by race, ethnicity, language, SOGI data, and disability as able. Included but not limited to:
 - [HEDIS measures](#)
 - Diagnosed Mental Health Disorder (DMH)
 - Diagnosed Substance Use Disorders (DSU)
 - **Child and Adolescent Well-Care Visits (WCV)**
 - **Depression Screening and Follow up for adolescents and adults (DSF-E)**
 - Utilization of PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)
 - Depression Remission and or Response for Adolescents and Adults (DRR-E)
 - Social Need Screening and Intervention (SNS-E)
 - **Follow-up after ED Visit for Substance Use Disorder (FUA)**
 - **Follow-up after hospitalization for mental illness (FUH)**



Employer Purchasers

- I. **Offer comprehensive employee assistance programs (EAPs)** that include behavioral health services, such as counseling and therapy for children and adolescents.
- II. **Review benefit design to remove financial barriers to behavioral health services** (e.g., copays or coinsurance for behavioral health screening) **and consider value-based arrangements that incent performance in behavioral health screening and follow up.**
- III. **Consider benefits like flexible working arrangements and paid time off for caregivers** to care for their children's health.
- IV. **Educate employees on common youth behavioral health concerns**, such as depression, anxiety, trauma/PTSD, disruptive behaviors, ADHD and substance use.

Washington State HCA

- V. **Consider removing the requirement for diagnosis to bill for psychotherapy services under the EPSDT benefit in primary care.** When youth begin to experience symptoms of behavioral health concerns, they may not meet standards for particular diagnoses. This can delay their access to treatment that would prevent progression of symptoms. Examples from [California](#) and [Colorado](#)
- VI. **Integrate screening, assessment, brief intervention and referral into primary care payments.** Consider shared savings models that incorporate non-provider provision of SBI, reducing burden on providers to screen and provide brief intervention. Support primary care offices in setting up coding and billing practices for screening, brief intervention and referral by providing technical assistance, outreach and other needed methods
- VII. Include annual screening metrics in value-based contracts to drive universal annual screening
- VIII. Support educational service districts or school districts to hire their own behavioral health staff

Department of Health

- Work with OSPI to develop a standardized referral form for use between schools and healthcare providers for concerns identified through school-based screening, such as behavioral health concerns.

Schools

1. **Prepare to implement screening, brief intervention and referrals to treatment or support.**
 - a. **Engage community stakeholders**, including parents and guardians, **in the design of school-based behavioral health standards, processes and protocols.**
 - b. **As able, establish partnerships with primary care providers and behavioral health providers** to facilitate referrals for more intensive services. Consider incorporating [Mental Health Referral Service](#) network through the state of Washington. Develop partnerships with community social service providers and public health departments to meet other needs.
 - c. **Consider incorporating telehealth-based services** available on campus through partnerships with local community providers to address transportation barriers. If youth



- 12+ are using telehealth to regularly access behavioral health services, consider complementary regular in-person visits to support engagement.
- d. **Develop a system to track behavioral health screening**, results and referrals with the ability to monitor follow-up and connection to care.
 - e. **Ensure appropriate staff are trained** in screening, providing brief intervention and referrals, youth behavioral health, and **how to talk to youth about involving their caregivers and primary care with next steps**.
 - f. **Identify a dedicated space for meetings between students and staff and/or students and behavioral health/health care professionals** to facilitate brief interventions and delivery of behavioral health services onsite as available. (e.g., psychotherapy)
2. **Screening. Systematically screen annually for common childhood and adolescence behavioral health concerns** (anxiety, depression, ADHD, trauma, substance use) according to most updated guidelines (Bright Futures, AAP, School Mental Health) using a validated instrument(s). Screening can combine core elements of other screening tools to ensure coverage of all concerns without the need to screen to use multiple screening tools. A list of screening tools is available on Washington OSPI's website.
- a. Choose a systematic way to screen (e.g., all 6th and 8th graders annually) and follow a timely process for assessing and responding to screening results.
 - b. **Consider diverse cultural values and attitudes as they relate to behavioral health concerns in your setting**. Different cultures have different views on mental health and substance use disorders, help-seeking and treatment preferences. Provide culturally sensitive and responsive screening tools based on the student population you serve, and interventions that are flexible to student and caregivers' specific context and needs.
3. **Brief Intervention. For those who screen positive, assess severity of concern to determine the level of support necessary** (e.g., brief intervention and follow up versus referral to primary care and/or behavioral healthcare) and provide brief intervention using evidence-based core components as appropriate.
4. **Referral to Treatment or Support. Refer to school-based or community-based primary care and/or behavioral health professionals**. Track and close the loop on referrals to ensure timely connection to care.
- a. **Sharing information**. Establish a protocol for when concerns are identified, onsite school-based staff connect and share information with the youth's caregivers (as appropriate and with student's consent) and their primary care provider to encourage follow-up with healthcare providers after a positive screen.
5. **Monitoring and Evaluation**. Collect data on outcomes of screenings, delivery and content of brief interventions, referrals made and linkage to care.
- a. Stratify data collected by relevant demographics (e.g., race, ethnicity, English as a second language, sexual orientation and gender identity (SOGI), disability status, social needs) to identify and resolve inequities in access to care.

Student Based Health Centers

School-Based Health Centers (SBHCs) play a crucial role in providing accessible healthcare to students. As such, establishing comprehensive guidelines for behavioral health services within these centers is essential to ensure the wellbeing of all students. These guidelines aim to outline best practices for

delivering equitable and effective behavioral health care in SBHCs. School based health centers can follow the guidelines for pediatric primary care as closely as possible, and the following guidelines:

1. **Engage school staff as applicable in plans for youth with behavioral health concerns.** Many care plans are more effective with involvement from multidisciplinary teams (school professionals, behavioral health, primary care and the patient and caregivers)
2. **If counseling services are provided onsite, consider offering group counseling.**
3. **Share information with the patient’s primary care provider if applicable.** Share relevant information with the patient’s PCP directly as able, do not rely on patient and caregiver to relay information to their primary care office.

Washington State Legislature

1. Consider funding [RCW.28A.320.127](#) to support staff for implementing school-based SBIRT.
2. Designate a lead agency to support school-based SBIRT and school-based behavioral health services.

Health Services Academic Training Programs

- I. Train students in primary care provider tracks (MD, DO, NP, PA, etc.) in behavioral health care as a core competency for primary care.

Progression Towards the Ideal State

Achieving early identification and intervention for youth behavioral health concerns will not happen overnight. The workgroup recognizes every step towards addressing behavioral health symptoms for youth and families is a step in the right direction, and the same ideal state may not be achievable for all institutions and organizations. Therefore, the workgroup chose to describe the ideal state stratified by setting to provide realistic expectations for systems based on their level of available resources and location.

Current State	Intermediate Steps	Ideal State
Small and/or Rural Clinics		
<ul style="list-style-type: none"> • High variation in screening and connection to treatment • Geographical distance and clinician capacity limits accessibility of behavioral health services 	<ul style="list-style-type: none"> • Establish partnerships with local behavioral health providers and agencies to increase access to referrals, consultations, and telehealth services. • Implement screening tools and protocols for identifying and addressing behavioral 	<ul style="list-style-type: none"> • All youth have reliable access to high quality, evidence0based and culturally responsive behavioral healthcare services. • Primary care providers (PCPs) are trained and supported to screen, assess, treat, and refer youth with behavioral

	<p>health needs of patients in primary care settings.</p> <ul style="list-style-type: none"> • Provide training and supervision for primary care staff on how to conduct brief interventions, motivational interviewing, and other evidence-based practices for behavioral health. • Develop and monitor quality indicators and outcome measures for behavioral health integration and improvement. • Engage patients and families in shared decision making and care planning for behavioral health issues. 	<p>health needs, using a collaborative care model that involves behavioral health consultants, care managers, and psychiatrists</p> <ul style="list-style-type: none"> • PCPs and behavioral health specialists coordinate care across settings and systems, using telehealth and other technologies to enhance access and communication. • Behavioral health outcomes are routinely measured and used to inform and improve care quality and effectiveness
<p>Large Clinic Systems/Urban Clinics</p>		
	<ul style="list-style-type: none"> • Establish multidisciplinary teams that include PCPs, BHPs, care managers, and specialists responsible for providing comprehensive and coordinated care. • Train PCPs and behavioral health providers in identification, assessment and treatment of behavioral health conditions. • Introduce standardized tools and protocols for screening and assessing youth behavioral health needs. This ensures consistency and 	<ul style="list-style-type: none"> • All youth in large primary care clinics with integrated or onsite behavioral health providers have access to high-quality, evidence-based, and culturally responsive behavioral health services that are coordinated with their primary care. • Primary care providers (PCPs) and behavioral health providers (BHPs) work as a team to screen, assess, treat, and refer youth with behavioral health needs, using a stepped care model that matches the level and intensity of services to



	<p>accuracy in identifying and addressing issues.</p> <ul style="list-style-type: none">• Implement electronic health record (EHR) systems that facilitate real-time communication and information sharing between PCPs, BHPs, and external partners.• Promote shared decision-making practices that involve youth and their families in the care process.• Establish a system for routinely measuring behavioral health symptoms. Use this data to monitor progress, inform care plans, and continuously improve the quality and effectiveness of services.• Secure funding and resources to support the integration of behavioral health services. Develop strategies for sustaining these efforts in the long term.	<p>the severity and complexity of the condition.</p> <ul style="list-style-type: none">• Youth and their families are engaged and empowered to participate in shared decision-making and self-management of their behavioral health.• PCPs and BHPs collaborate with each other and with external partners, using electronic health records and other technologies to enhance access and communication.• Behavioral health outcomes are routinely measured and used to inform and improve care quality and effectiveness.
Schools		
<ul style="list-style-type: none">• High variation in screening and connection to treatment in schools• Youth with mild-moderate behavioral health symptoms may be overlooked and not receive help they and their families need• Schools may not see their role in addressing behavioral health or not	<ul style="list-style-type: none">• Establish partnerships with local mental health agencies, clinics, and practitioners to expand the range of services available to students.• Professional development: provide ongoing professional development opportunities for school staff in school-based	<ul style="list-style-type: none">• Providers should be easily accessible to students within the school setting. This may involve having dedicated space on campus to ensure privacy and confidentiality.• School-based staff collaborate with community-based providers to support at-

<p>be able to navigate regulatory barriers to screening, brief intervention and connection to care</p>	<p>behavioral health support.</p> <ul style="list-style-type: none"> • Develop strategies to increase caregiver involvement in supporting students' behavioral health. Provide evidence-based resources on how to recognize and respond to signs of distress in children and adolescents. • Review and update school policies related to behavioral health and confidentiality to ensure they are aligned with best practices and legal standards. 	<p>risk students and implement strategies to support wellbeing.</p> <ul style="list-style-type: none"> • School-based staff and providers take a holistic approach to student wellness, health, social, emotional, and academic factors that may impact a student's well-being. • Implement services across the multi-tiered systems of support, including preventative programs that promote mental health. • Providers and school-based staff should be sensitive to needs of their unique community, as many cultures have different views on mental health, help-seeking and treatment. • Parents and caregivers are engaged appropriately as safe and per consent of the student. Family involvement in interventions to support behavioral health has shown to be more effective, but may not be appropriate based on individual students' circumstances. • Robust support network with both healthcare and other related resources (transportation, food assistance, etc).
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Appendix A. First Approach Skills Training Evidence-Based Brief Interventions

First Approach Skills Training (FAST) is a brief intervention that aims to help students cope with common mental health challenges, such as depression, anxiety, stress, or substance use. FAST consists of four core components: psychoeducation, motivational interviewing, cognitive-behavioral skills, and referral to further services if needed. FAST can be delivered by school counselors, nurses, psychologists, or social workers in one or two sessions of 15 to 30 minutes each.

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

Concern	Brief Intervention Components
Depression	<ul style="list-style-type: none">• Motivational interviewing to enhance engagement and readiness for change• psychoeducation about depression and coping skills• behavioral activation to increase positive activities and social interactions• problem-solving therapy to help identify and resolve stressors
Anxiety	<ul style="list-style-type: none">• Motivational interviewing to enhance engagement and readiness for change• psychoeducation about anxiety and coping skills• exposure therapy to gradually confront feared situations or stimuli• problem-solving therapy to help identify and resolve stressors
Trauma	<ul style="list-style-type: none">• Motivational interviewing to enhance engagement and readiness for change• psychoeducation about trauma and coping skills• trauma-focused cognitive behavioral therapy to process traumatic memories and reduce avoidance• eye movement desensitization and reprocessing to help integrate traumatic information and reduce distress• stress inoculation training to increase coping skills and resilience
Disruptive behaviors (age 4-11)	<ul style="list-style-type: none">• psychoeducation about disruptive behaviors and coping skills• behavioral management to reinforce positive behaviors and reduce negative behaviors• problem-solving skills training to improve conflict resolution and communication• social skills training to improve peer relationships and empathy• parent training to increase consistency and support
Substance use	<ul style="list-style-type: none">• Motivational interviewing to enhance engagement and readiness for change• psychoeducation about substance use and coping skills

- | | |
|--|---|
| | <ul style="list-style-type: none">• brief negotiated interview to elicit pros and cons of substance use and set goals |
|--|---|



Appendix X 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.² 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)^{xxvi}

	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. 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.^{xxvii}

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.

Appendix Social Media Use

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.^{xxviii} 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.^{xxix}

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

For more resources, visit the American Academy of Pediatrics [Center of Excellence on Social Media and Youth Mental Health](#).



Other Initiatives

[Medicaid School-Based Behavioral Health Services and Billing Toolkit](#)

The purpose of the toolkit is to provide guidance on how ESDs and SDs access Medicaid funding for non-IEP school-based behavioral health services through Medicaid MCOs and fee-for-service programs. The toolkit provides considerations for determining the best options for expanding behavioral health services, including directions on becoming a behavioral health agency and guidance on best practices for billing Medicaid.

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](#).

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 right 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. 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 claim 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 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.

Figure 7: Aligning Quality Measures Across the Delivery System to Address Population-Level Goals

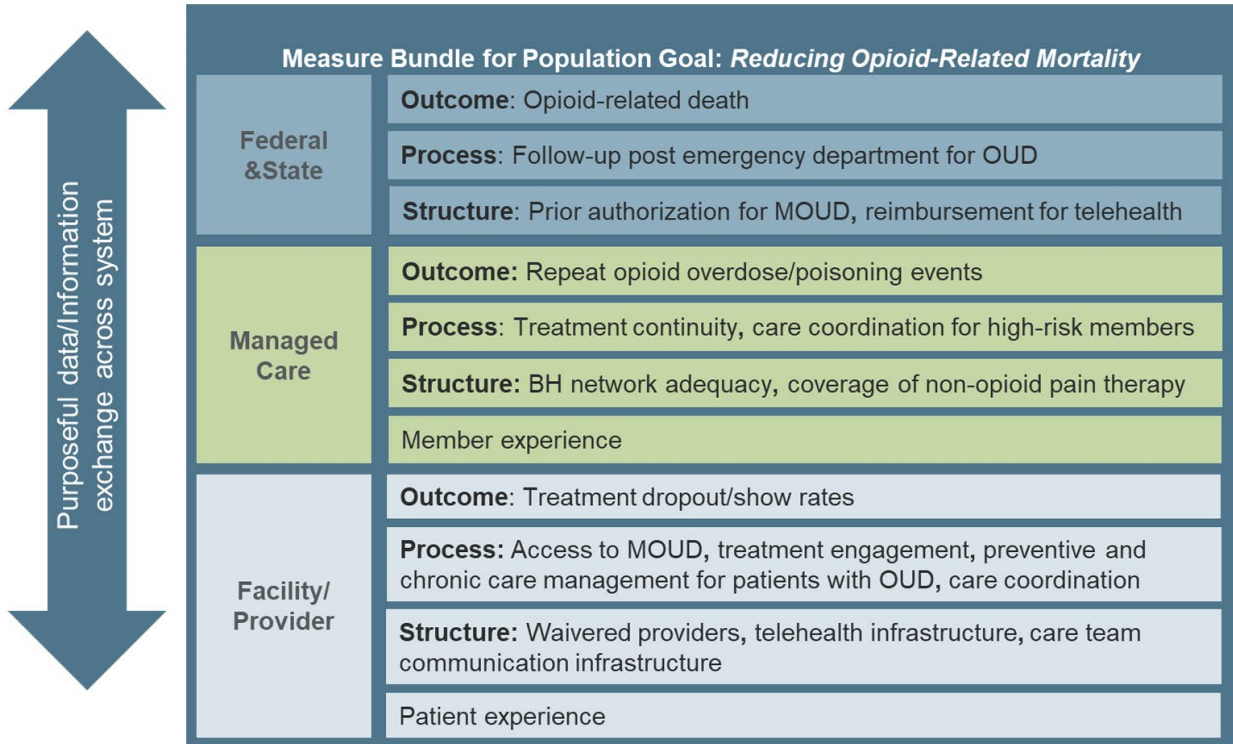


TABLE 1
Proposed Core Quality Measure Set to Assess Behavioral Health Care

Measure Title	Measure
Outcome Measures	
Depression Response	Patients with depression and a 50% reduction of PHQ-9 score at six months
Depression Remission	Patients with depression and a PHQ-9 score < 5 at six months
PTSD Response	Patients with PTSD and a ≥ 10-point reduction of PCL-5 score at six months
PTSD Remission	Patients with PTSD and a PCL-5 score < 23 at six months
Anxiety Response	Patients with anxiety and a 25% reduction of GAD-7 score at six months
Process Measures	
Symptom Assessment	Patients with depression, PTSD, or anxiety with a symptom assessment during a four-month measurement period
Minimal Initial Psychotherapy	Patients with depression, PTSD, or anxiety with at least four psychotherapy visits in eight weeks
Minimal Initial Care	Patients with depression, PTSD, or anxiety with at least four psychotherapy visits or two E&M or medication management visits in eight weeks
Structure Measure	
Average Days to Appointment	Average days from intake to first appointment with BH care provider is ≤ 15 days

NOTE: E&M = Evaluation and management; PCL-5 = PTSD Check List for Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; GAD-7 = General Anxiety Disorder-7 item.

Billing Guides

Payment of School-based BH Services

Washington Medicaid covers school based healthcare services through

Provider Billing Guide

CPT Code		
96127 and 96160	Depression Screening	Every well-child checkup
96127 and 96160	General Behavioral Health Screening	12 years and older
96127 and 96160	Tobacco, Alcohol and Drug Screening	11 years and older

Other Bree Collaborative Reports and Guidelines

LGBTQ+ Care

Behavioral Health Integration

Addiction and Dependence

ⁱ [Measurement-based care \(apaservices.org\)](https://www.apaservices.org/)

ⁱⁱ [SAMHSA Announces National Survey on Drug Use and Health \(NSDUH\) Results Detailing Mental Illness and Substance Use Levels in 2021 | HHS.gov](https://www.samhsa.gov/newsroom/2021/05/12-nsduh-2021)

ⁱⁱⁱ [Youth Risk Behavior Survey Data Summary & Trends Report: 2013-2023 \(cdc.gov\)](https://www.cdc.gov/youthrisk/youth-risk-behavior-survey-data-summary-trends-report-2013-2023)

^{iv} <https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/adolescent-health>

^v [Youth Suicide Rates | Washington State Department of Children, Youth, and Families](https://www.wa.gov/youth/youth-suicide-rates)

^{vi} [Youth Risk Behavior Survey Data Summary & Trends Report: 2013-2023 \(cdc.gov\)](https://www.cdc.gov/youthrisk/youth-risk-behavior-survey-data-summary-trends-report-2013-2023)

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^{viii} [Other Concerns and Conditions with ADHD | Attention-Deficit / Hyperactivity Disorder \(ADHD\) | CDC](https://www.cdc.gov/ncbddd/adhd/publications/other-concerns-conditions-with-adhd)

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^x <https://www.ncbi.nlm.nih.gov/books/NBK559140/>

^{xi} [CHILDRENS BH DASHBOARD 2023NOV.pdf \(wa.gov\)](https://www.wa.gov/childrens-bh-dashboards)

^{xii}] Substance Abuse and Mental Health Services Administration. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from [URL]/.

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^{xiv} <https://www.hhs.gov/about/news/2023/01/04/samhsa-announces-national-survey-drug-use-health-results-detailing-mental-illness-substance-use-levels-2021.html#:~:text=13.5%20percent%20of%20young%20adults%20aged%2018%20to,a%20substance%20use%20disorder%20or%20any%20mental%20illness.>

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^{xxi} [2023 CAMH Principles.pdf \(aap.org\)](#)

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^{xxiii} [Adolescent and Young Adult Health Youth Advisory Council Report - 2022 Cohort - Washington State Department of Health 0.pdf \(waportal.org\)](#)

^{xxiv} Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Part I. Practice Preparation, Identification, Assessment, and Initial Management ; 2018

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