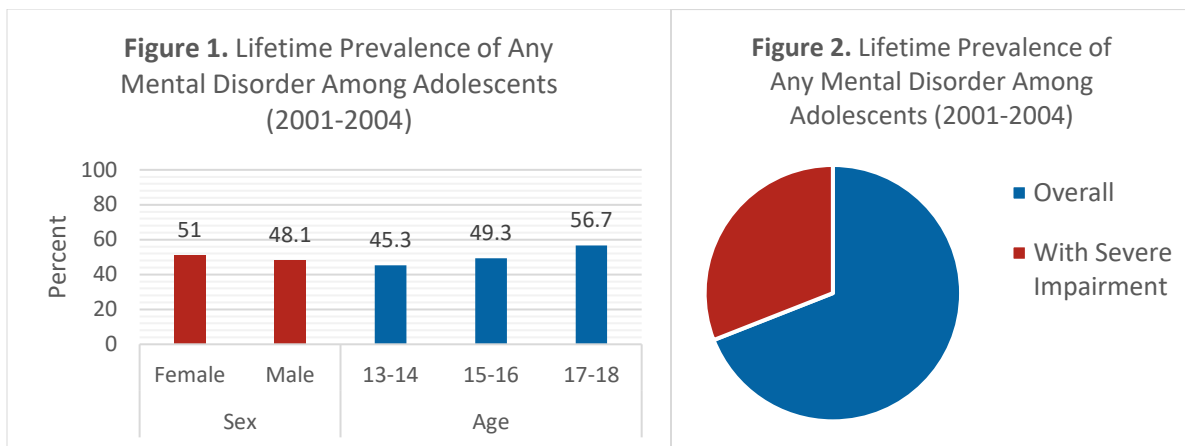


## VOA Alaska and Providence

### Behavioral Health Services in the Anchorage School District

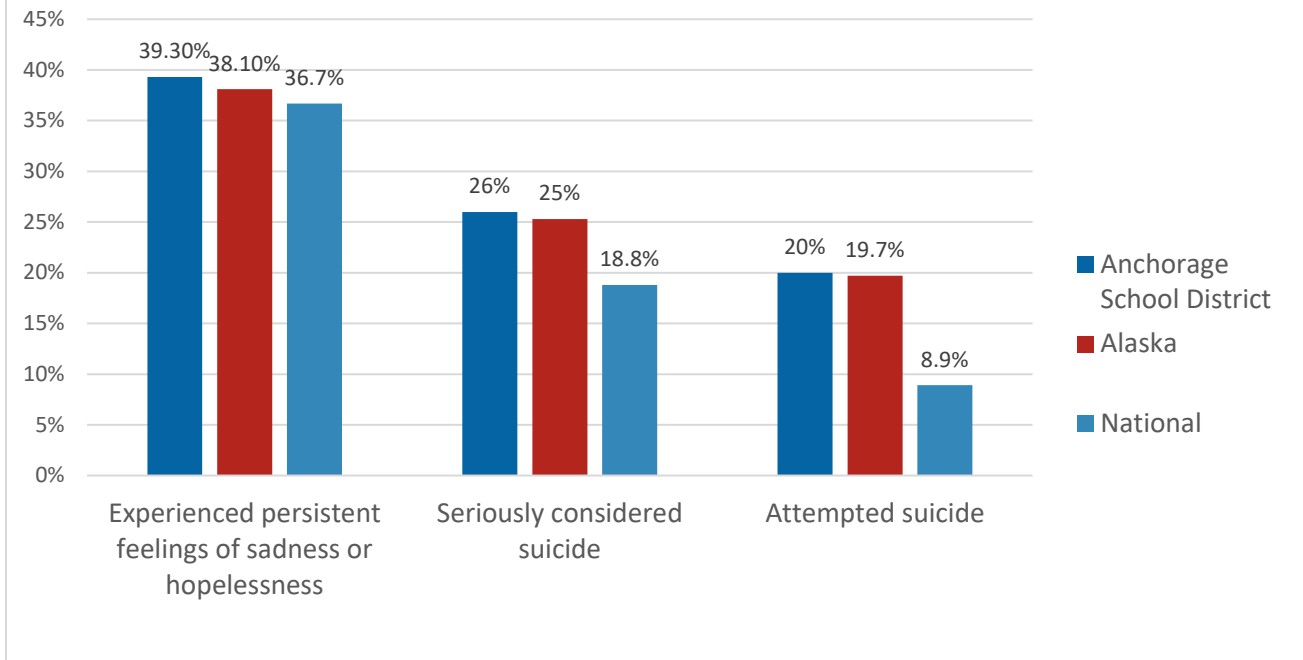
Before the unprecedented social disruption of the COVID-19 pandemic, it was estimated that nearly 1 in every 4-5 U.S. children met the criteria for a mental disorder with severe impairment across their lifetime. Diagnostic interview data published in the National Comorbidity Survey Adolescent Supplement (NCS-A) estimated that the lifetime prevalence of any mental disorder for adolescents was 49.5%, and of those adolescents, an estimated 22.2% experienced severe impairment and/or distress.<sup>i</sup> The Substance Abuse and Mental Health Services Administration’s (SAMHSA) 2021 National Survey on Drug Use and Health report provided further insight into the pattern of lifetime prevalence of adolescent mental health disorders, showing a steady increase as adolescents grow up. This data is shown below in Figures 1 and 2.



Despite the overwhelming prevalence and lifelong impacts of mental illness, youth mental health needs are often unidentified or treated in a timely manner. Estimates show that up to 75% of students suffering from poor mental health receive insufficient treatment or are not treated at all.<sup>ii,iii,iv,v</sup> Untreated mental health symptoms may worsen over time and manifest in adulthood.<sup>vi,vii</sup> This presents our community with an opportunity to significantly impact public health, as many youth experience mild or moderate symptoms initially.<sup>viii</sup> Therefore, prevention, early identification, and treatment are beneficial for youth, families, and the overall population.<sup>vi,ix,ix</sup>

Mental health disorders are among the most prevalent health conditions children and youth face,<sup>x</sup> including anxiety (7.1%), behavioral or conduct disorder (7.4%), and depression (3.2%).<sup>xi</sup> Rates of suicide are the most alarming indicators of a growing youth mental health crisis, and suicide is the second leading cause of death in youth ages 10 – 24, and rates have been increasing.<sup>xii</sup> In Alaska, the rates of youth depression and suicide are increasing, and youth experience some of the nation’s highest substance misuse rates in the nation.<sup>xiii</sup> According to the Center for Disease Control & Prevention 2019 Youth Risk Behavior Survey, Anchorage students are more than twice as likely to report attempting suicide compared to national rates (see details in Figure 3 below).<sup>xiv,xv</sup>

**Figure 3. Youth Mental Health and Suicide Indicators (YRBS, 2019)**



The highest unmet need is found among low-income youth and communities of color.<sup>xvi</sup> The issues fueling this are varied and complex, including barriers to screening and diagnosis, stigma associated with mental health care or limited awareness, high cost of care or lack of insurance, lack of mental health services and providers in the community, and racial barriers and disparities. Untreated mental health conditions affect a student’s performance and ability to learn and grow, and they are preventable barriers to their health and future well-being.

The pandemic only increased the need for behavioral health support. It is estimated that youth experiences with mental health difficulties have doubled during the pandemic.<sup>xvii</sup> There has been a 33% increase in the rate of students reporting depression and anxiety since 2010. The most alarming trends are seen for students of color: suicide rates among Black youth, for example, have doubled since 2014.<sup>xviii</sup>

These statistics do not capture the innate potential and capacity for resilience among Alaska youth, and their potential for recovery, wellness, and leadership. We have the opportunity to address gaps in the systems of care through collaboration and trauma-informed delivery of services. Our community is ready to address these behavioral health needs before they become disruptive to student health, academics, and school climate.

### **Current State: Integrated Multi-Tiered Behavioral Health Model**

There are various models of behavioral health service delivery in schools. However, the integrated multi-tiered approach has emerged as the most effective model in promoting wellness, supporting behavioral health needs, and contributing to academic success.<sup>xix</sup> In this approach, behavioral health and wellness are integrated into the school climate, not seen as separate, and are supported through a collaborative partnership between school staff and community service providers.

In the integrated approach, the school clinician is a fully integrated member of the school team. Formalized agreements allow for open communication and ease of accessibility for students and school staff. This integration enables school clinicians to infuse wellness and behavioral health strategies throughout the school environment allowing all students to receive a broad set of wellness and prevention-based services, a smaller subset with more targeted interventions, and a limited number of youth with high-needs receiving intensive treatment services on-site at school.

Key components of the VOA Alaska and Providence partnership integrated multi-tiered approach within the Anchorage School District include:

- A strong collaborative relationship with principals and school staff to address the school's unique needs,
- Open communication between partners,
- Shared understanding that behavioral health and wellness is integral to academic success,
- A strength-based and trauma-informed lens,
- Alignment with research and best practices,
- Minimizing barriers to accessing mental health services,
- Alignment with 2021-26 School Board Goals and Guardrails, and
- Partnerships to provide additional services as part of a coordinated service delivery system.

## Three Tiers of Support

The core services provided by VOA Alaska and Providence are provided across three tiers of support: school-wide, targeted, and intensive. These are the critical activities that directly contribute to improvements in student health, well-being, and project success. Activities in all tiers are aligned with the Anchorage School District's implementation of the Positive Behavior Interventions and Supports and Interconnected Systems Framework. This approach empowers all students and school staff toward wellness, regardless of their level of behavioral or emotional symptoms. (See Appendix A)

### Tier One: School-Wide Services

School clinicians support existing school resources with universal initiatives to support students, families, and staff with developing wellness practices to maintain mental health. Services may include education, wellness support, and outreach within the school environment and with referral agencies or partners.

### Tier Two: Targeted Services

School clinicians provide support and services that include on-site, real-time resources for students, families, and school staff focus on individuals identified as "at risk" for a mental health concern or issue. Targeted support includes individual or group student support such as drop-in, psychoeducation, or coping skill development; caregiver support; resource navigation; staff consultation and support; referrals to intensive services; and crisis intervention.

### Tier Three: Intensive Services

Intensive services include behavioral health treatment for students experiencing a significant stressor and/or mental health condition. Services include mental health and/or substance use assessment, individual therapy, family therapy, group therapy, treatment planning, and case management.

## Benefits of School-Based Behavioral Health Services

Mental health services for youth exist outside of the school setting. However, services are underutilized and unavailable to many youth and their families due to limited outpatient mental health providers accepting Medicaid, leaving significant gaps in access to mental health care in our community. Currently, 60% of Alaskans 18 years and younger rely on Medicaid for their care coverage.<sup>xx</sup> Research has shown that significant numbers of youth do not receive help to address mental health challenges, and even when delivered this support is often ended prematurely.<sup>xxi,xxii</sup>

Data suggests that school-based behavioral health services may resolve known barriers to accessing mental health services for children and adolescents, including lack of insurance, mental health stigma, and lack of transportation.<sup>xxiii</sup> Across the country, research has documented that **schools are communities' primary sites for providing consistent and accessible behavioral health and well-being services to children and adolescents**. For most children who receive mental health services, schools are their point of entry – and providing culturally responsive, community-reflective services within schools improves education outcomes.<sup>xxiv</sup>

The benefits of school-based services include:

- increase in attendance,
- improved academic performance,
- decrease in disruptive behaviors,
- increase in student autonomy,
- improved resilience and mental wellness,
- addressing the needs of children affected by trauma,
- improved children's health by preventing the onset of mental illness,
- cost savings associated with earlier interventions,
- access to screening and referrals, and
- decrease in stigma associated with behavioral health services.

## National Trends, Best Practices, and Case Studies

Partnerships between schools and community-based providers are a vital, time-tested antidote to the gap between youth health needs and community capacity for service delivery. As is more starkly visible now than ever, our schools are the most central and consistent delivery point of resources across the well-being spectrum for youth and families.

***Delivering behavioral health services within a school setting allows providers to combat barriers to care such as providing appointments on site for low or no cost [to families], continuity of care, reduction of stigma, and, most importantly, allowing for a greater number of students in need of care to access it (Bains & Diallo, 2015). Further, behavioral health issues largely manifest during school-age and providing support for youth in a school setting allows for a greater chance of behavioral health care usage for them where they spend much of their time (Forman, Ward & Fixsen, 2017). Including schools in the partnership to promote health***

*development for children and adolescents **simplifies the delivery of accessible, effective, integrated prevention and intervention supports to students who need them most** (Price, 2016). ... Assessments of School-Based Health Centers providing behavioral health services, including those from off-site partner organizations, indicate that they **help to support mental, behavioral, and social-emotional health of students, promote success in learning, and improve attendance and behavior** (Center for School Mental Health, 2014).*

*“Behavioral Health Services in School-Based Settings”  
University of Michigan Behavioral Health Workforce Research Center, 2018.*

School-based behavioral health services vary widely in structure and approach and are sometimes called Comprehensive School Mental Health or Expanded School Mental Health (ESMH). In their best forms, they are highly responsive to the needs, goals, and populations of each location. This may look like a coordinated training and referral framework among school nurses or a system of fully operational School-Based Health Centers providing one-stop physical and mental health care to children and families. Partnerships between schools and community-based providers are highly recommended at every level of school-based care to ensure appropriate referrals, continuity of care during school breaks, and sustainability of programming.

## School-Based Behavioral Health: Range of Services

In 2018, the University of Michigan Behavioral Health Workforce Research Center conducted a survey of school-based behavioral health providers,<sup>xxv</sup> concluding that these programs “fill a critical role in providing a range of behavioral health services for students of all ages.” Among those surveyed, most settings (over 75%) provided social-emotional counseling, and prevention of violence, bullying, and self-harm/suicide were the most consistently provided prevention-based services, followed by prevention of drug and alcohol use. The most common behavioral health service providers reported delivering within school settings was crisis intervention. A majority served only students in their roles, but over a third reported that they serve other populations as well, particularly focusing on families of students, school personnel, and out of school youth.

## Best Practices: Site-Specific Multi-Tiered Support Systems

While many different site- or population-specific versions of the tiered framework for school-based behavioral health service exist, they follow a consistent format. All students receive a broad set of prevention-based and/or school climate-focused services, a smaller subset receive more targeted interventions and assessments as warranted, and a limited number of youth with higher needs receive direct treatment onsite and/or through community referral.

### **CASE STUDY – EXPANDED SCHOOL MENTAL HEALTH IN WEST VIRGINIA**

Presented at the 2016 KidStrong Conference, this three-tiered system “emphasizes services and supports for ALL students, a critical link between mental health and academic success, shared responsibility between schools and community providers, meaningful involvement of parents and youth, evidence-based/best practices and programs, [and] continuous quality improvement.”

In this system, **Tier One: Universal** includes services to all students. Depending on the school, these may include the ABC Early Warning System (Attendance, Behavior, Course failure), suicide prevention,

substance use prevention, universal screening and referral, positive school climate/culture interventions, trauma-informed care, Mental Health First Aid training for school staff, a Mental Health Crisis Prevention plan, etc. Evidence-based practices in use at this tier can include PATHS Promoting Alternative Thinking Strategies, Positive Action Climate, Signs of Suicide, and STEP UP Strategies & Tools to Embrace Prevention with Upstream Programs, among others.

**Tier Two: Targeted** serves an estimated 5%-15% of students deemed “at-risk,” such as through behavioral need assessments, development of student support and behavior plans, Individual Education Plans (IEPs), peer support programs, and conflict mediation, comprehensive school counseling programs, and specialized skill-building groups (social skills, anger management, substance abuse, etc.). Evidence-based practices in use at this tier can include Coping Cat, Early Risers Skills for Success, Incredible Years, Seeking Safety, and the Positive Parenting Program.

**Tier Three: Intensive** provides 1-5% of students identified as “high risk” through screening, assessment, and other interventions at the lower tier with services such as individualized counseling/therapy and treatment, tele-health services as needed, specialized services, and support for behavior plans, through evidence-based practices including CBT and Trauma-Focused CBT.

#### **CASE STUDY – COMPREHENSIVE SCHOOL MENTAL HEALTH FOR OSHS GRANTEES**

Similarly, the U.S. Department of Education Office of Safe and Healthy Students recommends a full array of services delivered at three tiers, a foundation of “planned, purposeful partnerships between schools and community systems” and an emphasis on evidence-based practices and continuous quality improvement.

This model’s **Tier One: Universal** includes mental health promotion and prevention services for the entire student population, focused on promoting social/emotional understanding and skills, using tools and curricula such as Second Step, Project ALERT, Project ACHIEVE, Life Skills Training, and the Good Behavior Game.

**Tier Two: Selective** provides “services for students identified as at risk for a mental health concern or problem,” focusing on reducing risky or problematic behaviors and building social/emotional skills enabling healthier functioning, using Strengthening Families, Coping Power, Positive Action, Guiding Good Choices, and others.

Finally, **Tier Three: Indicated** provides individualized services to students who already display a mental health concern, specifically “serious problem behaviors and emotions,” using interventions such as Aggression Replacement Training, New Beginnings, Adolescents Coping with Depression, and CBT for Trauma in Schools.

In both cases, the multi-tier approach aims to serve the behavioral health needs and overall wellbeing of all students – not just students experiencing mental health struggles with externalizing or disruptive symptoms. The importance of collaboration and coordination is emphasized, including through establishing strong and consistent referral pathways, developing mental health crisis plans before they are needed, consultation with caregivers and teachers, as well as other school staff as appropriate, and collaboration wherever possible with capable community partners.

#### **Best Practices: Evidenced-Based Models, Stakeholder Buy-In, & Universal Screening**

Working with providers who are trained in fidelity to **evidence-based practices** and treatment models and ensuring that school-based staff have or receive training as needed is crucial. In addition to those in use by schools and districts in the case studies above, the Substance Abuse & Mental Health Services Administration’s [National Registry of Evidence-based Programs and Practices](#), [Institute of Education Sciences’ What Works Clearinghouse](#), and Annie E. Casey Foundation’s [Blueprints for Healthy Development](#) are significant resources for identifying the best suite of tools for any given school context.

**Stakeholder buy-in** among educational professionals and the caregivers of students is another critical condition for the success of school-based behavioral health services.

**Universal screening** is also highly recommended as a first step for schools to identify unique needs and goals.

*Traditional mental health services in the school setting have largely operated under a refer-test-place model that focuses primarily on the assessment of individual students to determine their eligibility for special education services or referrals for other supports (Dowdy et al., 2010). This service model emphasizes assessment and treatment services for students at the highest levels of risk. Similarly, under the ‘wait-to-fail’ model (Glover & Albers, 2007), students are referred for services in response to emotional or behavioral difficulties that are apparent and have become a cause for concern. Given the reactive nature of these traditional approaches, 12 students with unmet mental health needs may be overlooked or their need for services may not be recognized until after their symptoms have intensified and early intervention services are no longer likely to be beneficial (Dvorsky et al., 2014). Further, because these approaches focus on emotional and behavioral health concerns at the level of the individual student, they are unlikely to have a meaningful impact at the population level.*

*“Universal Behavioral/Emotional Health Screening in Schools: Overview and Feasibility”  
Report on Emotional & Behavioral Disorders in Youth, 2017*

While universal screening of students provides unparalleled data both about the needs of individuals and school-level functioning from which to make decisions about resource allocation, it also presents a number of challenges – which is likely why fewer than 15% of U.S. schools systematically evaluate students’ mental health needs.<sup>xxvi</sup> The fiscal and capacity costs to “systematically evaluate, identify, and monitor the mental health needs of an entire student population” are often prohibitive, as is the requirement to maintain the resulting mass of health data.

If a system can conduct universal screening, the potential benefits are clear. Identifying a validated screening tool that genuinely works for the school staff who will be utilizing it, isn’t excessively long or detailed, and doesn’t present the school with unrealistic costs is key. Tools the U.S. Department of Education Office of Safe and Healthy Students recommends for this undertaking include the [Center for School Mental Health’s Summary of Free Assessment Measures](#), the [American Institutes for Research Center on Response to Intervention Screening Briefs](#), the 2013 book *Depression in Children and Adolescents: Guidelines for School Practice*, particularly Handout H: *Mental Health Screening in Schools*, and the UCLA Center for Mental Health in Schools’ [Analysis Brief on Screening Mental Health Problems in Schools](#).

As noted in a 2017 Report on Emotional & Behavioral Disorders in Youth, “families may perceive mental health screening as an intrusive over-reach of the government or a violation of their right to privacy.”

This may be more true for communities of color such as the Alaska Native community, who have had more negative experiences with the school and/or healthcare systems. Caregivers may understandably have concerns about “possible stigmatization ... as a result of the problem-focused approach that is typical in mental health screening and the possible consequences of being identified as at-risk (Williams, 2013).”

Caregiver concerns are best addressed through authentic participatory information sharing, such as making space for constituents to voice their concerns and help resolve them, as well as partnering with culturally specific community organizations where possible. Opt-out or “passive” consent protocols for universal screening permissions have been used in some cases (such as the [University of South Carolina’s Project to Learn about Youth](#)), however, this approach requires intensive, active efforts to inform caregivers of their ability to opt-out well ahead of data collection – such as by mailing the opt-out form directly as well as passing it out within classrooms.

Educator concerns often revolve around the additional burden and time requirements associated with completing student screenings, attending training, and learning new protocols for discipline, referral, and other behavioral health interactions. Once again, authentic and early involvement of school staff input, clear communication about the long-term goals and benefits of school-based behavioral health on school climate and classroom experience, and – perhaps particularly within the Anchorage School District – an emphasis on Second Order Change and adult affect as a critical component of any program will be key to program success.

## **Conclusion**

The youth mental health crisis in Alaska will increase without interventions that effectively address youth mental health symptoms and illness. The integrated model of support implemented by VOA Alaska, Providence, Alaska Behavioral Health, and the Anchorage School District can effectively reach entire school populations, as well as the youth with the most impairment due to mental health symptoms. However, the most significant barrier to implementation is sustainable funding infrastructure for schools and community-based providers to sustain this critical service in our community.

Alaska lacks a funding mechanism to support and sustain school-based mental health services. For each school site, VOA Alaska and Providence must identify and secure funding for approximately 70% of total costs, which is roughly \$130,000 per site, due to the gap between billable revenue of reimbursable services and the actual cost of delivering care. While these services are currently supported through a mix of public and private grants, this model is unsustainable in the long term. We cannot grow the integrated, multi-tiered approach until there is a sustainable way to maintain it in the future.

To bridge this gap, a funding mechanism is urgently required to reimburse community behavioral health providers for the total cost of school-based mental health services, including a mechanism for the combination of prevention, early intervention, and intensive mental health services deployed within evidence-based frameworks like the Multi-Tiered System of Support (MTSS) mentioned earlier. (See Appendix A)

In recent guidance for delivering services in school-based settings, The Centers for Medicare and Medicaid Services (CMS) offered flexibility in implementing services within schools. <sup>vii</sup> One option

presented in the report, “Fee Schedule Rates that Exceed Community Rate,” would fit well with Alaska’s fee-for-service model of Medicaid reimbursement. For example, enhanced clinical psychotherapy for master’s level clinic service (psychotherapy) and enhanced rehab rate (therapeutic behavioral health service) could offer a mix of credentialed staff to provide MTSS within schools across the state. With this concept it could lay the groundwork to develop an encounter rate for a service that encompasses all necessary services being provided in a school setting (universal services, targeted services, intense services).

**A solution such as this would promote partnerships between school districts and community-based providers to combat the youth mental health crisis across Alaska.**

Expanding Medicaid to cover school-based services and creating opportunities for behavioral health providers to deliver them will significantly reduce the burden on school districts. During the 2023 Alaska Superintendent Association conference, VOA Alaska participated in a youth mental health panel discussion, and we heard clearly that school districts lack the capacity to provide mental health services themselves.

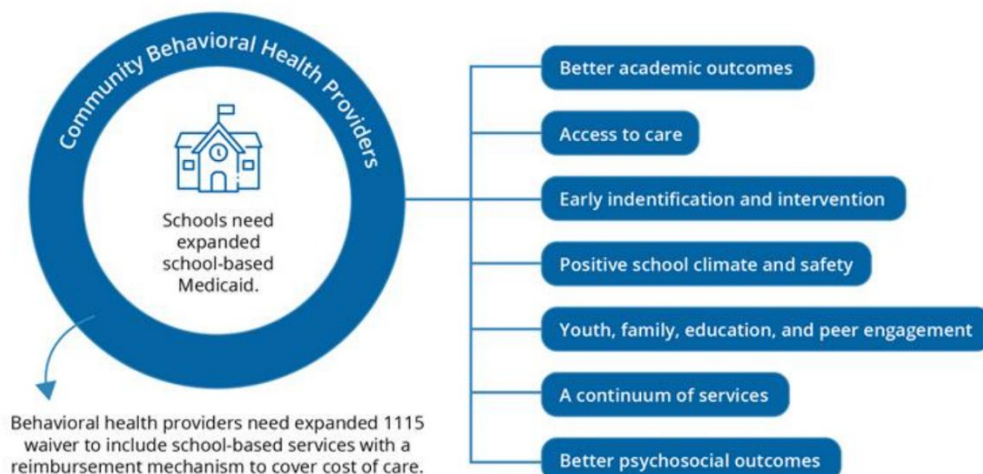
One superintendent shared how overwhelming it is to support their students and staff alone:

*One of the things that we're finding lately, that's really making it difficult for some of what we have to do, is the sheer volume of students and others needing mental health services and supports and the availability of services.*

As another superintendent put it, this is a “we” effort:

*There’s an expectation among some that say, “Oh, the schools have these kids; why can’t they provide services?” ... This is a “we” effort. The school plays one part of it, but it can’t be the only part of the support or the solution.*

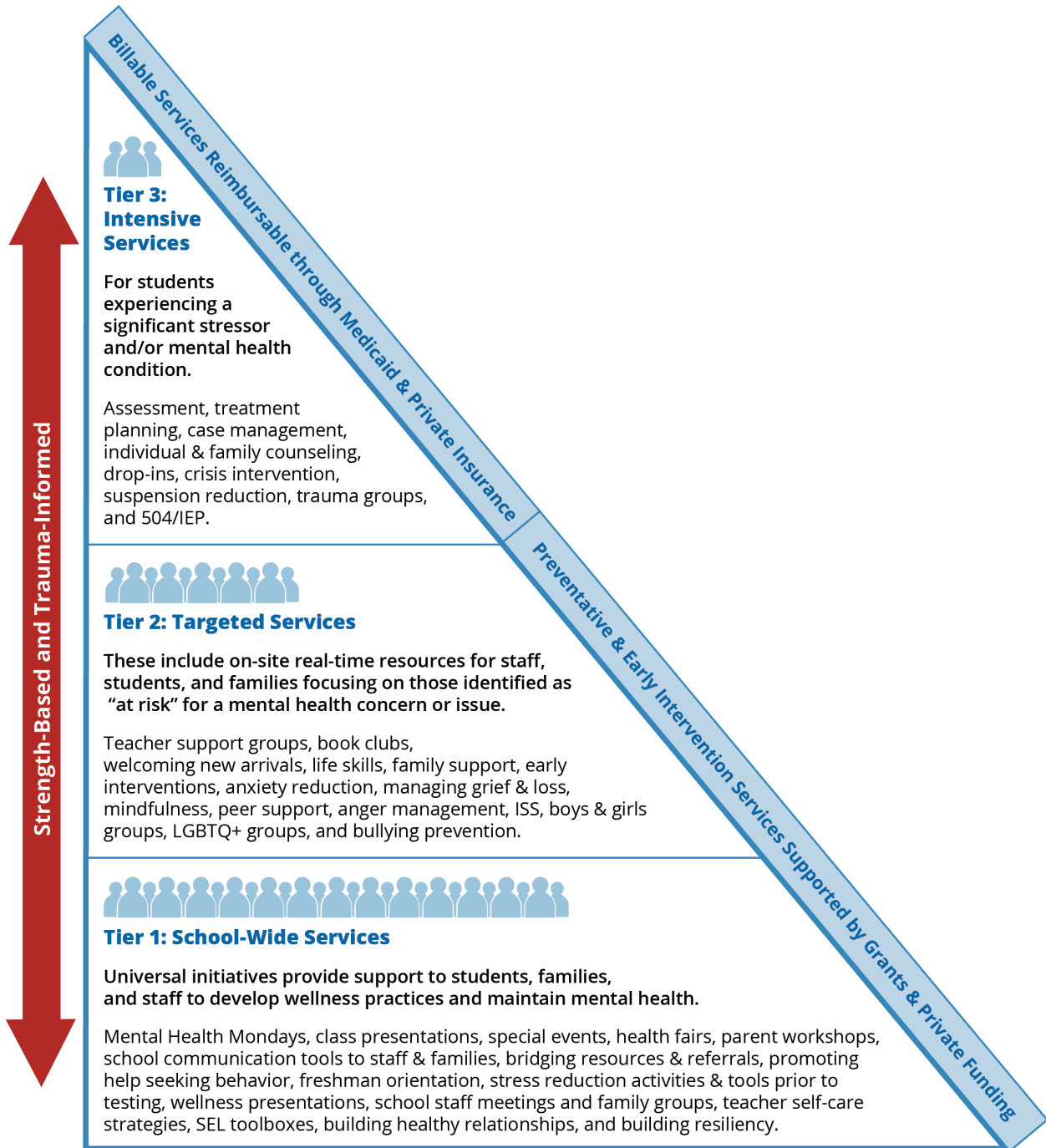
**The Value of Comprehensive School Mental Health Systems: Positive Outcomes**



This is a “we” effort, and it needs investment in multiple sectors (Education, Public Health & Behavioral Health) to develop and sustain a comprehensive school mental health system. These investments will improve the lives of students, families, teachers, and school administrators and reduce the long-term financial burden on communities and states. Research has demonstrated that for every \$1 invested in prevention and early intervention, savings ranging from \$2 to \$10 can be realized in other costs related to health care, legal issues, and educational impacts.<sup>viii</sup> Investment in evidenced-based social-emotional learning returns \$11 for every \$1 invested.

If mechanisms existed to cover the cost of school-based services (such as an Encounter Rate), more providers from across Alaska would come to the table. **It will take all of us** to meet the overwhelming need, working alongside schools to help alleviate the challenges on the front lines of the youth mental health crisis in every corner of Alaska.

**Appendix A: The Multi-Tiered System of Support for School-Based Services**



## References

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- <sup>i</sup> Merikangas, K.R., He J.P., Burstein, M., Swanson, S.A., Avenevoli, S., Cui L., Benjet, C., Georgiades, K., Swendsen, J. Lifetime prevalence of mental disorders in U. S. adolescents: Results from the National Comorbidity Survey Replication – Adolescent Supplement (NCS-A). *Journal of the American Academy of Adolescent Psychiatry*. 2010 October; 49(10): pgs 980-989. PMID: 20855043
- <sup>ii</sup> Merikangas, K.R., He, J.P., Burstein, M., Swanson, S.A., Avenevoli, S., Cui, K., Benjet, C., Georgiades, K. & Swendsen, J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication – Adolescent Supplement (NCS – A). *Journal of American Child and Adolescent Psychiatry*, 49(10), 980-989.
- Olfson, M., Druss, B.G. & Marcus, S. C. (2015). Trends in mental health care among children and adolescents. *New England Journal of Medicine*, 372(21) 2029-2038
- <sup>iii</sup> Olfson, Druss & Marcus, 2015
- <sup>iv</sup> Lean, D.S., Colucci, V.A. *Barriers to Learning: The Case for Integrated Mental Health Services in Schools*. Rowman Littlefield Education: Washington, WA, USA, 2010.
- <sup>v</sup> Stallard, P. Promoting Children’s Well-Being. In *Child Psychology and Psychiatry: Frameworks for Practice*, 2<sup>nd</sup> ed., Skuse, D., Bruce, H., Dowdney, L., Mrazek, D., Eds., John Wiley & Sons: Hoboken, NJ, USA, 2011, pp.72-77
- <sup>vi</sup> Rutter, M., Moffitt, T.E., Caspi, A. (2006) Gene-environment interplay and psychopathology: Multiple variants but real effects. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 47, 226-261.
- <sup>vii</sup> Kim-Cohen, J., Caspi, A., Moffitt, T.E., Harrington, H., Milne, B.J., & Poulton, R. (2003). Prior juvenile diagnoses in adults with mental disorder: Developmental follow-back of a prospective-longitudinal cohort. *Archives of General Psychiatry*, 60, 709-717
- <sup>viii</sup> Kessler, R.C., Avenevoli, S., Costello, J., Green, J.G., Gruber, M.J., McLaughlin, K.A., Petukhova, M., Sampson, N.A., Zaslavsky, A.M., Merikangas, K.R. (2012) Severity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry*, 69, pp 381-389.
- <sup>ix</sup> National Research Council. *Preventing Mental, Emotional and Behavioral Disorders Among Young People; Progress and Possibilities*; O’Connell, M.E., Boat, T., Warner, K.E., Eds. National Research Council: Washington, WA, USA, 2009.
- <sup>x</sup> Perou, R., Bitsko, R.H., Blumberg, S.J., Pastor, P., Ghandour, R.M., Gfroerer, J.C., Hedden, S.L., Crosby, A.E., Visser, S.N., Schieve, L.A., Parks, S.E., Hall, J.E., Brody, D., Simile, C.M., Thompson, W.W., Baio, J., Avenevoli, S., Kogan, M.D., Huang, L.N., Centers for Disease Control and Prevention (2013). Mental health surveillance among children – United States, 2005-2013. *Morbidity and Mortality Weekly Report Suppl.* 2013, 62(2), 10-35.
- <sup>xi</sup> Ghandour, R.M., Sherman, L.J., Vladutiu, C.J., Lynch, S.E., Bitsko, R.H., Blumberg, S.J. (2019). Prevalence and treatment of depression, anxiety, and conduct problems in US children. *The Journal of Pediatrics*, vol 206, 256-267.
- <sup>xii</sup> Curtin, S.C. & Heron, M. (2019) Death Rates Due to Suicide and Homicide among Persons Aged 10-24: United States, 2000-2017, NCHS Data Brief No. 352, October 2019.
- <sup>xiii</sup> Alaska Department of Health and Social Services (2020). Youth Risk Behavior Survey, Statewide Traditional High School Data Dashboard. Retrieved from <http://dhss.alaska.gov/dph/Chronic/Pages/yrbs/yrbs19.aspx>
- <sup>xiv</sup> Alaska Department of Health, Division of Public Health. 2019 Anchorage School District Traditional High School YRBS Results: Depression and Suicide Indicators.
- <sup>xv</sup> Centers for Disease Control and Prevention. Youth Risk Behavior Survey Data Summar & Trends Report 2011-2021.
- <sup>xvi</sup> Costello, E.J., He, J.P., Sampson, N.A., Kessler, R.C. & Merikangas (2015). Services for adolescents with psychiatric disorders: 12-month data from the National Comorbidity Survey – Adolescent. *Psychiatric Services*, 65(3), 359-366.

- 
- <sup>xvii</sup> Racine, N., McArthur, B.A., Cooke, J.E., Eirich, R., Zhu, J. & Madigan, S. (2021). Global prevalence of depressive and anxiety symptoms in children and adolescents during COVID-19, A meta-analysis. *JAMA Pediatrics*, doi:10.1001/jamapediatrics.2021.2482
- <sup>xviii</sup> Ramchand, R., Gordon, J.A. & Pearson, J.L. (2021). Trends in suicide rates by race and ethnicity in the United States. *JAMA Network Open*, May; 4(5): e2111563
- <sup>xix</sup> Motes, P.S., Melton, G. & Waithe Simmons, W.E. (1999). Ecologically oriented school based mental health services: implications for service system reform. *Psychology in the Schools*, 36(5), 391-401
- Weist, M.D., Youngstrom, E.A., Stephan, S., Lever, N., Fowler, J., Taylor, L., McDaniel, H., Chappelle, L., Paggeot, S. & Hoagwood, K. (2014). Challenges and ideas from a research program on high-quality, evidence-based practice in school mental health. *Journal of Child & Adolescent Psychology*, 43(2), 244-255
- Kang-Yi, C.D., Wolk, C.B., Lock, J., Beidas, R.S., Lareef, I., Piciella, A.E., Lim, S., Evans, A.C. & Mandell, D.S. (2017). Impact of school-based and out-of-school mental health services on reducing school absence and school suspension among children with psychiatric disorders. *Evaluation and Program Planning*, 67, 105-112
- <sup>xx</sup> Alaska Hospital and Healthcare Association, Child and Adolescent Behavioral Healthcare Improvement Project, 2022.
- <sup>xxi</sup> Armbruster, P., Fallon, T. (1994) Clinical, sociodemographic, and systems risk factors for attrition in a children's mental health clinic. *American Journal of Orthopsychiatry*, 64, 577-585
- <sup>xxii</sup> McKay, M.M., Pennington, J., Lynn, C.J., McCadam, K., (2001) Understanding urban child mental health service use: Two studies of child, family, and environmental correlates. *Journal of Behavioral Health Services & Research*, 28, 475-483
- <sup>xxiii</sup> Committee on School Health. School-Based Mental Health Services. *Pediatrics*. (2004), 113, 1839-1845.
- <sup>xxiv</sup> Salvador, J., Goodkind, J. & Ewing, S.F. (2016). Perceptions and use of community and school based behavioral health services among urban American Indian/Alaska Native youth and families. *American Indian and Alaska Native Mental Health Research*, 23(3), 221-247
- <sup>xxv</sup> University of Michigan Behavioral Health Workforce Research Center. Behavioral Health Services in School-Based Settings. Ann Arbor, MI: UMSPH; 2018.
- <sup>xxvi</sup> Bulanda, J.J., Bruhn, C., Byro-Johnson, T. & Zentmyer, M. (2014). Addressing mental health stigma among young adolescents: evaluation of a youth-led approach, *Health & Social Work*, 39(2): 73-80