TeleBehavioral Health 2025 Training Series

Behavioral Health Institute (BHI)
Harborview Medical Center
Website: https://bhinstitute.uw.edu
Email: bhinstitute@uw.edu

Northwest Regional
Telehealth Resource Center (NRTRC)
Website: https://nrtrc.org
Email: info@nrtrc.org

July 18, 2025

Behavioral Health Institute (BHI)

Training, Workforce and Policy Innovation Center

The Behavioral Health Institute is a Center of Excellence where innovation, research and clinical practice come together to improve mental health and addiction treatment.

The BHI brings the expertise of Harborview Medical Center/University of Washington Medicine and other university partners together to address the challenges facing Washington's behavioral health system through:

- Clinical Innovation
- Research and Evaluation
- Workforce Development and Training
- Expanded Digital and Telehealth Services and Training

The BHI serves as a regional resource for the advancement of behavioral health outcomes and policy, and to support sustainable system change.

Northwest Regional Telehealth Resource Center (NRTRC)

Telehealth Technical Assistance Center

The NRTRC delivers telehealth technical assistance and shares expertise through individual consults, trainings, webinars, conference presentations and the web.

Their mission is to advance telehealth programs' development, implementation and integration in rural and medically underserved communities.

The NRTRC aims to assist healthcare providers, organizations and networks in implementing cost-effective telehealth programs to increase access and equity in rural and medically underserved areas and populations.

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Speaker Disclosures

None of the series speakers have any relevant conflicts of interest to disclose.

Planner disclosures

The following series planners and team have no relevant conflicts of interest to disclose:

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DISCLAIMER

Please be aware that policy changes may take place after the original date of this presentation.

Any information provided in today's talk is not to be regarded as legal advice. Today's talk is purely for informational purposes.

Please consult with legal counsel, billing & coding experts, and compliance professionals, as well as current legislative and regulatory sources, for accurate and up-to-date information.

We gratefully acknowledge the support from

Washington State Health Care Authority

NRTRC NORTHWEST REGIONAL TELEHEALTH RESOURCE CENTER

AHEC WW
AREA HEALTH EDUCATION CENTER
FOR WESTERN WASHINGTON AT WHATCOM COMMUNITY COLLEGE

TeleBehavioral Health 501

TELEBEHAVIORAL HEALTH WITH YOUTH & FAMILIES: BEST ETHICAL PRACTICES

EVE-LYNN NELSON, PHD, LP, FATA

PROFESSOR, KU PEDIATRICS

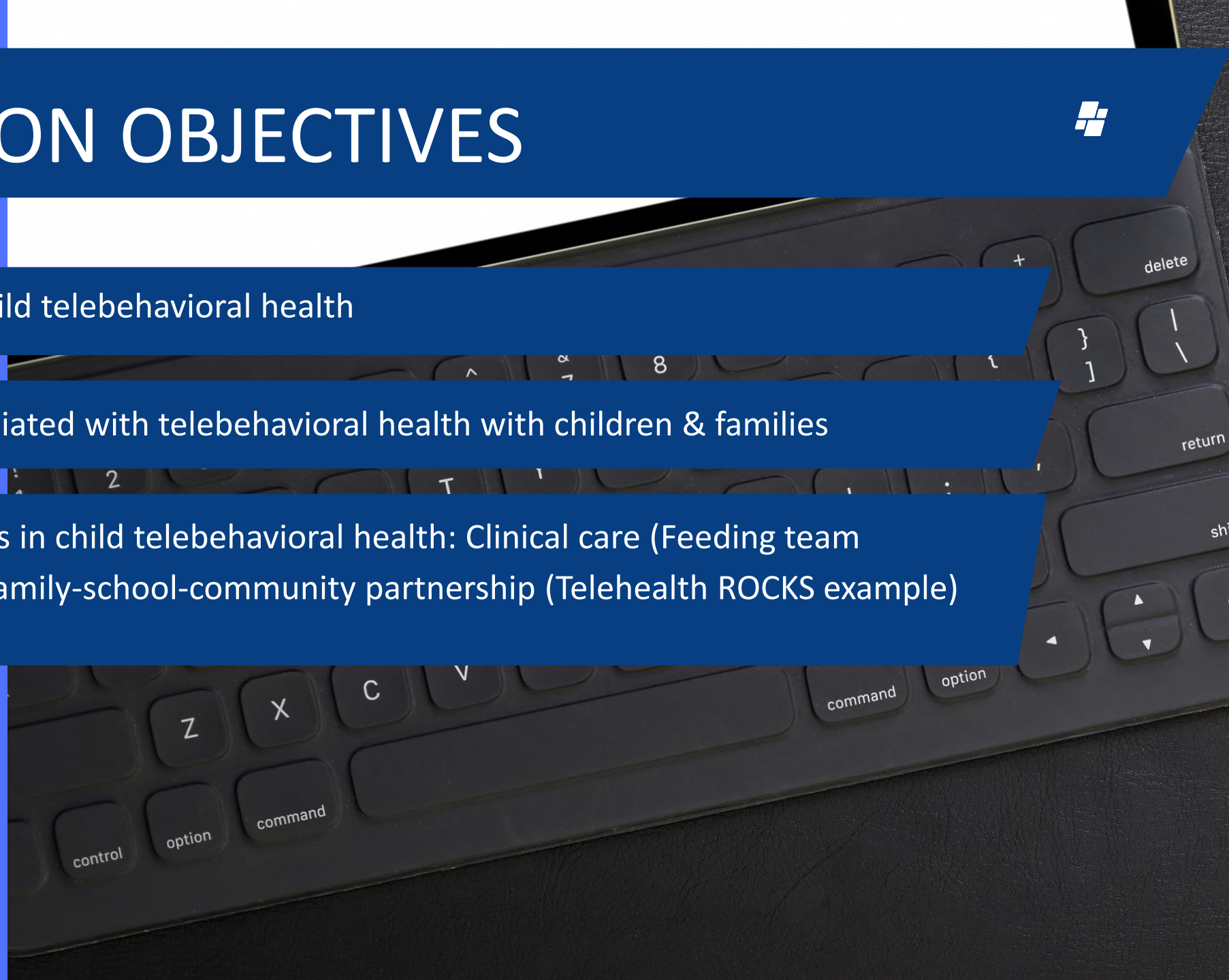
UNIVERSITY OF KANSAS MEDICAL CENTER

ENELSON2@KUMC.EDU

JULY 18, 2025

With admiration and appreciation to my team and contributions from participating families, community partners, academic collaborators, and funders

PRESENTATION OBJECTIVES



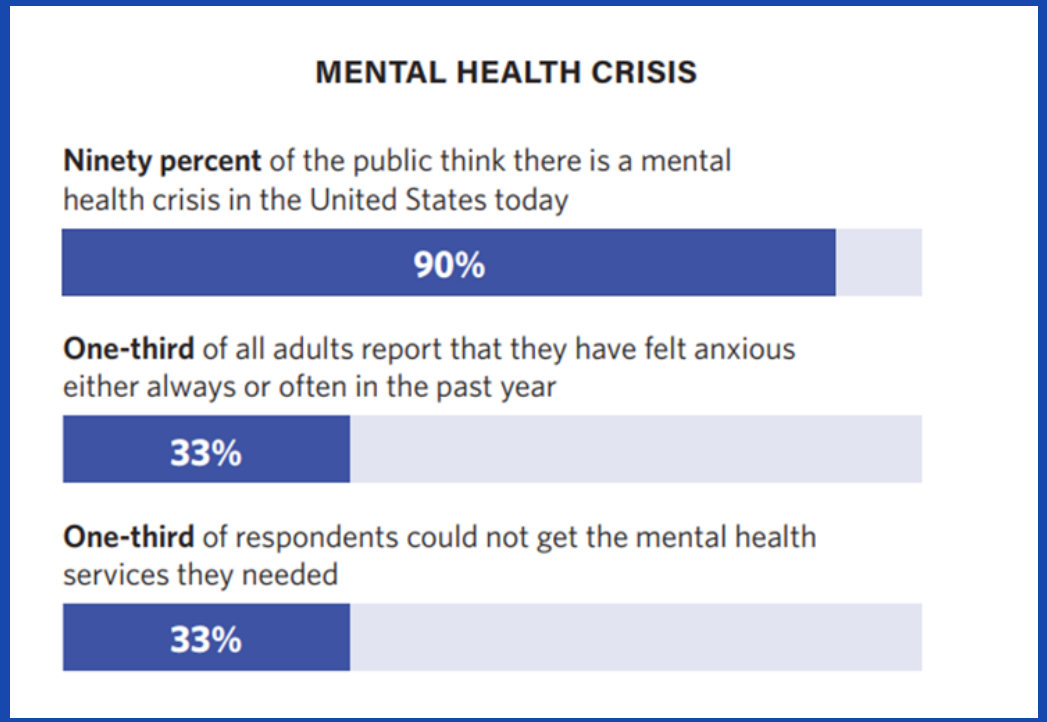
Review the rationale for child telebehavioral health

Discuss competencies associated with telebehavioral health with children & families

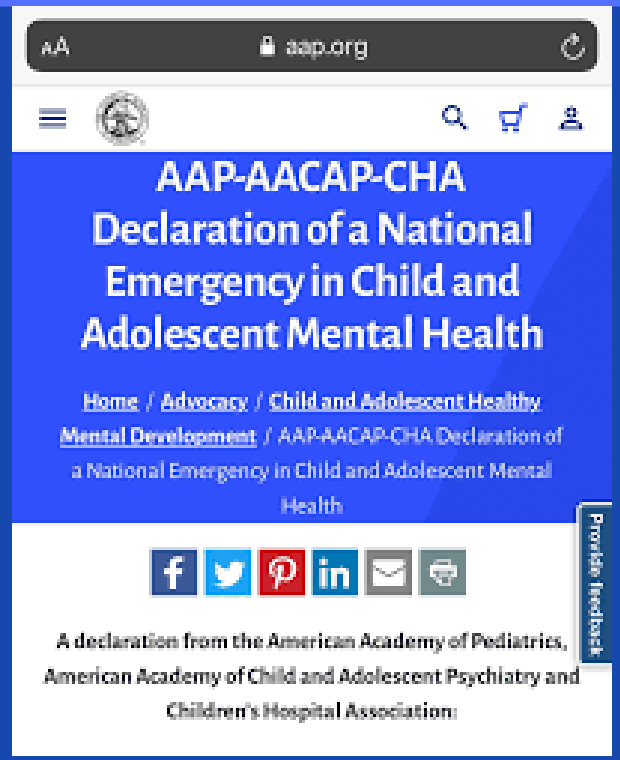
Share ethical best practices in child telebehavioral health: Clinical care (Feeding team example) and as part of a family-school-community partnership (Telehealth ROCKS example)

RATIONALE

APA Monitor 2024 Trends in Psychology



Academy of American Pediatrics



https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/

Rural child health: Compared with urban peers

CCCHS Ylink Chapter Award

- Rurality is associated with an increased risk for **overall morbidity and mortality** including infants, children, and adolescents.
- Increased rural risks for **child injuries** and delays in treatment, as well as risks of poor physical environments/**living situations and environmental risks** associated with poor health outcomes.
- Higher frequency of **adverse childhood experiences (ACEs)** & more likely to be exposed to **parental separation/divorce, parental death, family economic hardship, violence in the household, incarceration of a household member, mental illness & sub abuse in a household member.**
- Rural youth have Increased rates for **disability, obesity, poor oral health, and alcohol and illicit drug use**, as well as higher rates of **adolescent pregnancy and sexually transmitted infections**.
- Rural children had **a slightly higher incidence** of mental, behavioral, and developmental disabilities and were **significantly less likely to have access and use MBDD services**

https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/2020-NRHA-Policy-Document-Overview-of-Rural-Child-Health.pdf

Strengths in rural communities (Werth et al., 2010)

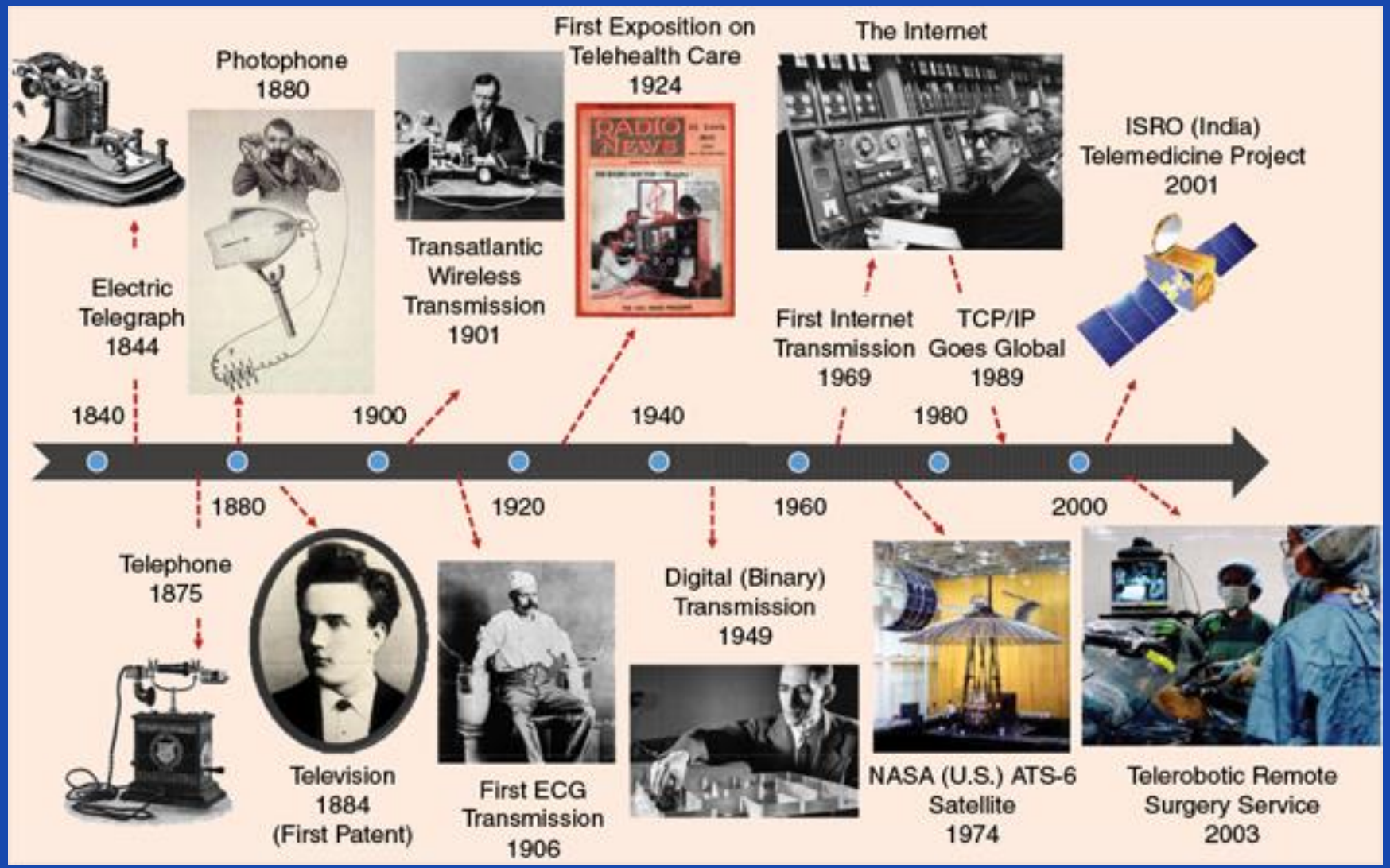
- **Individual variability greater than group variability**

Rural

  - Trust and value community
  - Ingenuity, hardiness, and adaptation
  - Stoicism

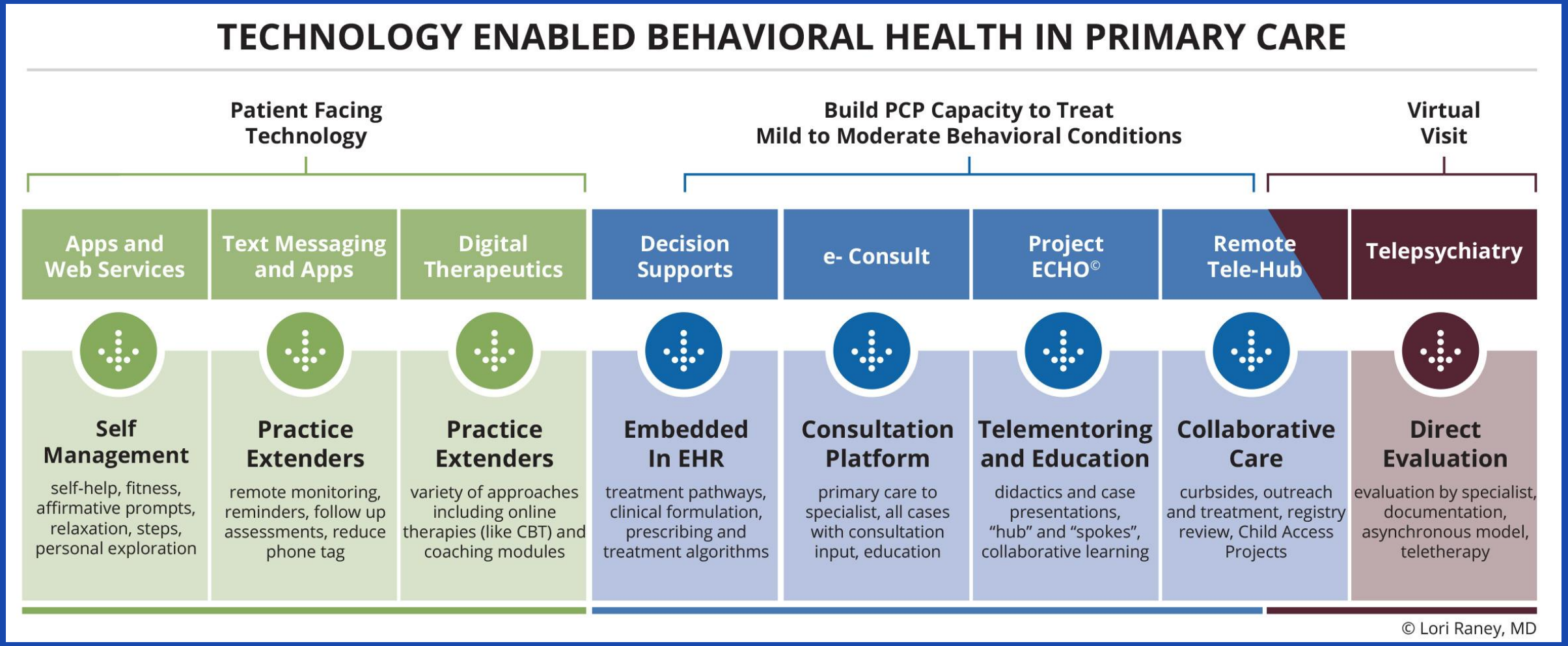
- **Resilience**
  - Local access to role models and peers
  - Culture of local support to survive

- **Social capital**
  - Relationships are highly valued
  - People working in different community systems know each other
  - Schools and related activities often as heart of communities
  - Higher religious involvement



Potential for care anyplace, anytime, anyone

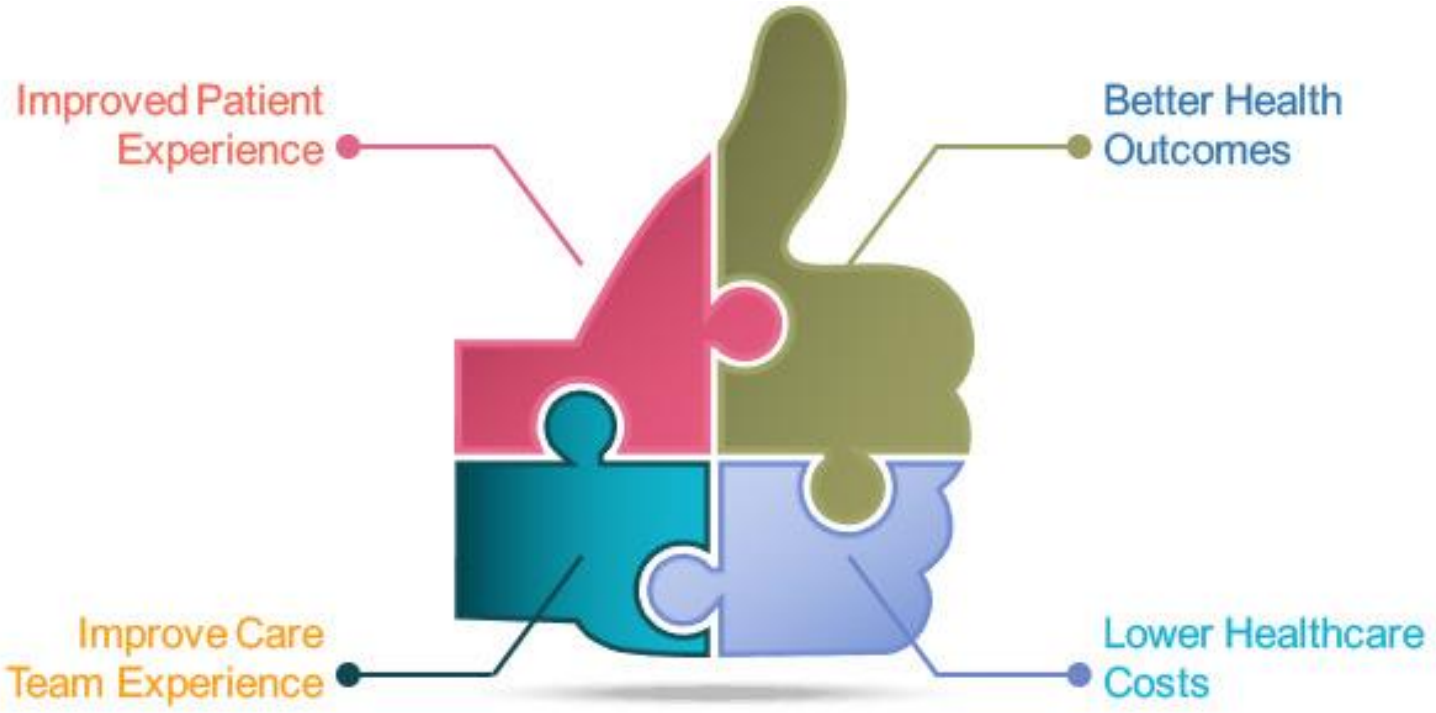
https://www.embs.org/pulse/articles/making-health-care-universally-accessible/



Raney, L., Bergman, D., Torous, J. *et al.* Digitally Driven Integrated Primary Care and Behavioral Health: How Technology Can Expand Access to Effective Treatment. *Curr Psychiatry Rep* **19,** 86 (2017). https://doi.org/10.1007/s11920-017-0838-y

The Potential of Telebehavioral Health

- RESEARCH: Compared to in-person care, telepsychiatry and telebehavioral health appear equal or better (Hilty DM, et al. 2013; McCord et al., 2022; Zhang, Nelson, et al., 2025)



Videoconferencing-based Child Behavioral Health Assessment and Interventions: A Systematic Review

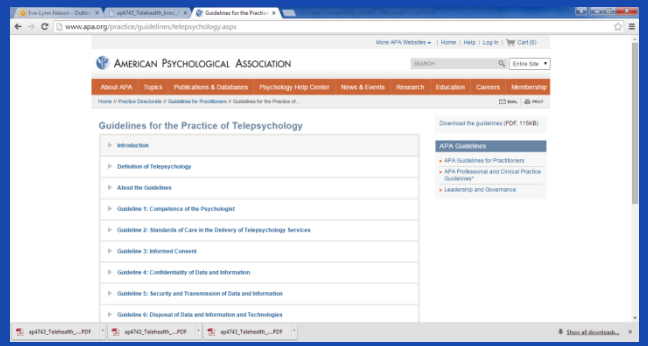
(Zhang, Giovanneti, Punt, Hilty, Nelson, 2025 SEARCH presentation)

- **INCLUSION**: STUDIES ON CHILDREN (0-18), VIDEOCONFERENCING-BASED INTERVENTIONS, RCTS, JANUARY 2000 TO SEPTEMBER 2023
- **EXCLUSION:** NON-BH FOCUS, ASYNCHRONOUS INTERVENTIONS, NON-VIDEO TECHNOLOGY, NO CHILD OUTCOME
- **4,265 references** identified, removed 285 duplicates
- **361 full-text reviews**
- **34 unique RCTs analyzed**
- **Mental Health:** Anxiety, OCD, depression, social anxiety; **Developmental Disorders:** Autism, Fragile X, tic disorders; **Pediatric Psychology/chronic Conditions:** Epilepsy, TBI, diabetes, obesity, neurofibromatosis
- **Across telehealth settings, geographies, and demographics**
- **Comparable or superior outcomes overall, benefits adherence/engagement**
- **Limitations**: Lack of long-term outcome data, Heterogeneity in interventions and outcome measures, Reliance on self-reported outcomes introduces bias

Four (of MANY) Telebehavioral Health Professional Guidelines & Competencies

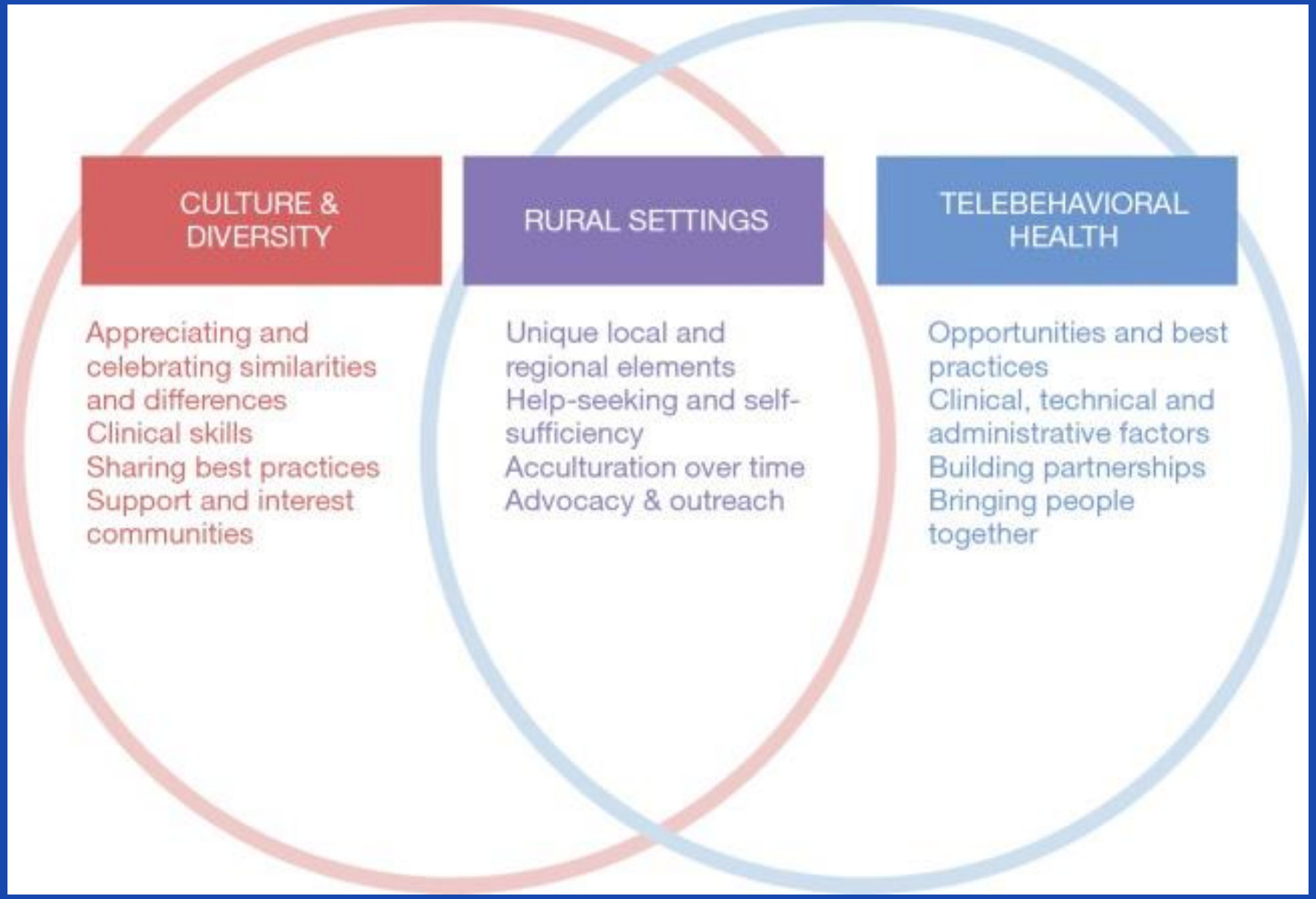
American Academy of Child and Adolescent Psychiatry (AACAP) practice parameter (2018)

American Psychological Association (2013; Updated 2024)



American Psychiatric Association/American Telemedicine Association (2018)

American Telemedicine Association – ATA (2009; 2013; 2017)



Hilty DM, et al. Telehealth for rural diverse populations: telebehavioral and cultural competencies, clinical outcomes and administrative approaches. Mhealth. 2020 Apr 5;6:20. doi: 10.21037/mhealth.2019.10.04.

Domain/competency (From Hilty et al., 2022)	Psychology	Psychiatry	ATA
Patient care (e.g., informed consent)	✓✓	✓✓	✓✓
Cultural issues		✓✓	
Language interpreting		✓✓	
Communication, Cultural issues	✓	✓✓✓✓	✓✓
Knowledge	✓✓	✓✓✓	✓✓
Professionalism	✓✓	✓✓✓	✓✓
Practice-based learning (e.g., QI)	✓	✓✓✓	✓✓
Systems-based practice (e.g., legal/reg. issues)	✓✓	✓✓✓	✓✓
Technology (e.g., technical skills)	✓✓	✓✓	✓✓
Training (e.g., methods, evaluation)	✓	✓✓✓	✓
Other technology (in general)	✓	✓✓✓	✓
Social media		✓✓✓	
Mobile health & apps			
Telepresence (including cultural factors)			

Competencies from the Guideline for the Practice of Telepsychology (American Psychological Association, 2013; Updated 2024)

1. **Maintain competence of psychology using technology:** competence with the technologies used and the potential impact of the technologies on clients/patients, supervisees, or other professionals

2. **Ensure compliance with ethical standards**: meet the standards of care and practice

3. **Provide informed consent:** obtain and document informed consent that specifically addresses the unique concerns, laws and regulations related to the services

4. **Protect confidentiality:** inform, protect and maintain the confidentiality of the data and information related to the use of the telecommunication technologies

5. **Maintain security measures:** protect data and information from unintended access or disclosure

6. **Dispose data:** dispose of data and information and the technologies used in a manner that facilitates protection from unauthorized access and accounts

7. **Adjust testing practices:** consider the unique issues that may arise with test instruments and assessment approaches when used via telepsychology

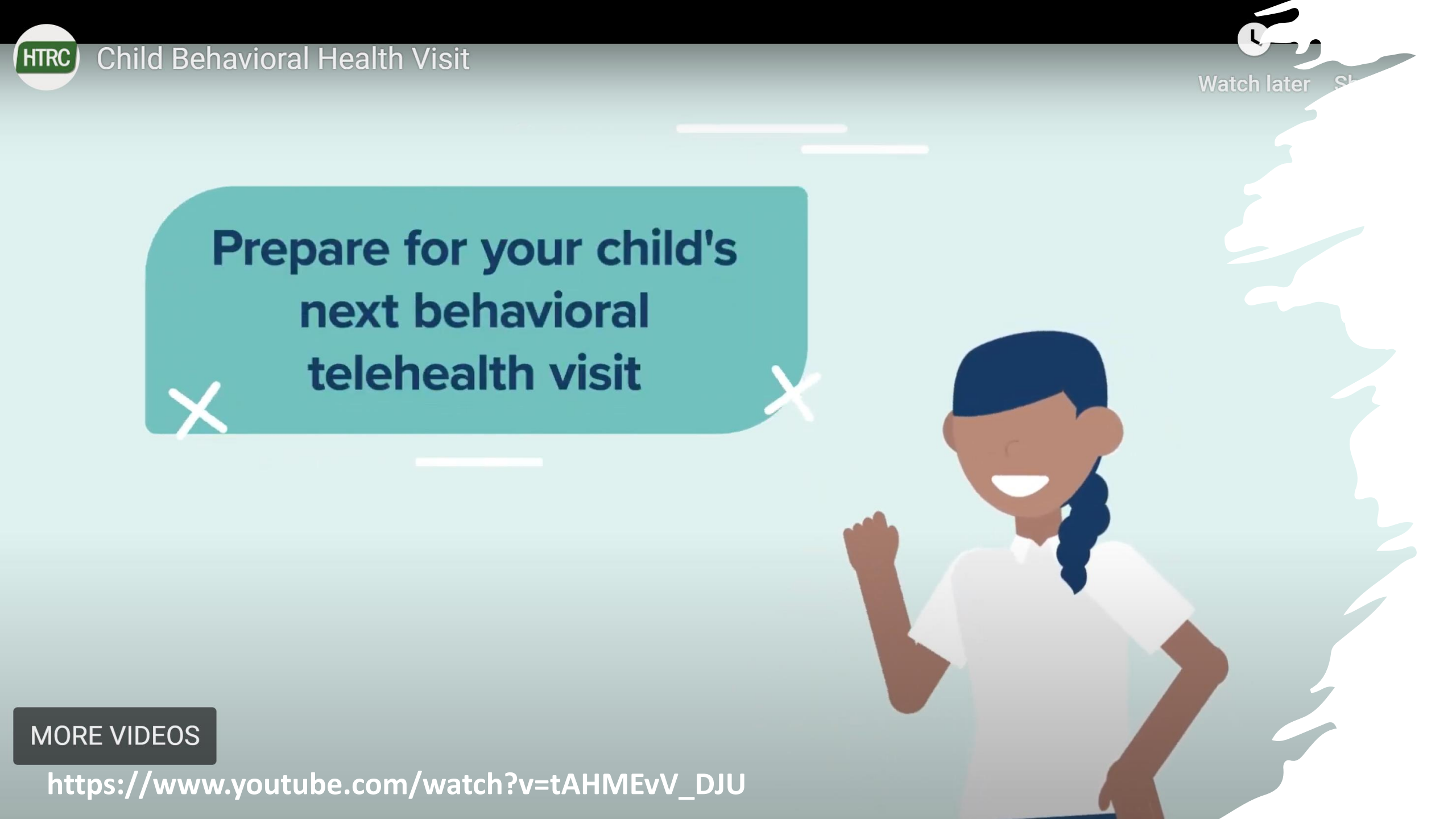
8. **Comply with laws of the local jurisdiction:** comply with all relevant laws and regulations of the clients/patients' jurisdictions and across international borders, as applicable

- **Individualized child telepsychology decisions with consideration**(Luxton, Nelson, & Maheu, 2023):
  - developmental considerations
  - parent/guardian preferences
  - resources at the child's site
  - behavioral health provider comfort
- **Please type one child telebehavioral health advantage (A) and one challenge (C) in the chat:**
  - –ADVANTAGES
  - –CHALLENGES

- **When considering telehealth, weigh:**
  - –ADVANTAGES such as a safe environment during public health emergencies, a convenient environment from home, school, primary care, and other places children are at everyday and with fewer transportation difficulties; consider advantages of the lived environment in getting a picture of the family and building rapport
  - –CHALLENGES of less control of the environment and need to plan for behavioral & medical emergencies, potential for less formality and more distractions

Telebehavioral Health & Relationship (Hilty et al., 2019)

- ✓ **Compared to in-person care, telebehavioral health appears at least equal in relationship and trust**
- ✓ **Telepresense:** "The use of technology to establish a sense of shared presence or space among geographically separated members of a group." (Buxton , 1991)
- ✓ Provider **skill and confidence with telehealth & population** are important, driven by training and ongoing mentorship.
- ✓ **Good seating** (e.g., ergonomic support) and consideration of comfort for a child with chronic health conditions
- ✓ Ensure it is **clinically conducive environment** (e.g., others not around, avoid interruptions), with consideration of child and family needs in the population served.
- ✓ A sign signifying the need for relative quiet, avoiding interruptions
- ✓ Consider **medical interpreting** needs following CLAS standards
- ✓ **Grandma's Rule**—Overall, good manners and associated best communication practices go a long way, just as onsite services.


HTRC
Child Behavioral Health Visit
Watch later
Prepare for your child's next behavioral telehealth visit
MORE VIDEOS
https://www.youtube.com/watch?v=tAHMEvV_DJU

KUMC Feeding Team (Adapted from Davis, 2024)

- Types:
  - Inappropriate developmental appropriateness of foods eaten: Texture, Variety
  - Inappropriate quantity consumed (typically underconsumption)
  - Inappropriate mealtime behaviors
  - Delays in self-feeding skills
- TEAM-FOCUSED TELEHEALTH:
  - Psychologist, Occupational Therapist, Dietitian, Others
- Visit:
  - Parent interview, 60 minutes new, 30 minute return
  - Observe eating
  - All providers simultaneously
  - Clinical Interview
  - Diet History/Record
  - Behavioral Pediatrics Feeding Assessment Scale (BPFAS)
- Patient/family Choice – in person or telehealth

Advantages of Tele-feeding Team (adapted from Davis, 2024)

- Patients/families
  - Convenience
    - Other children
    - Children with developmental issues
    - Children scared of medical providers
  - Weather
  - Easier to prepare food
  - Other parent can join from other location

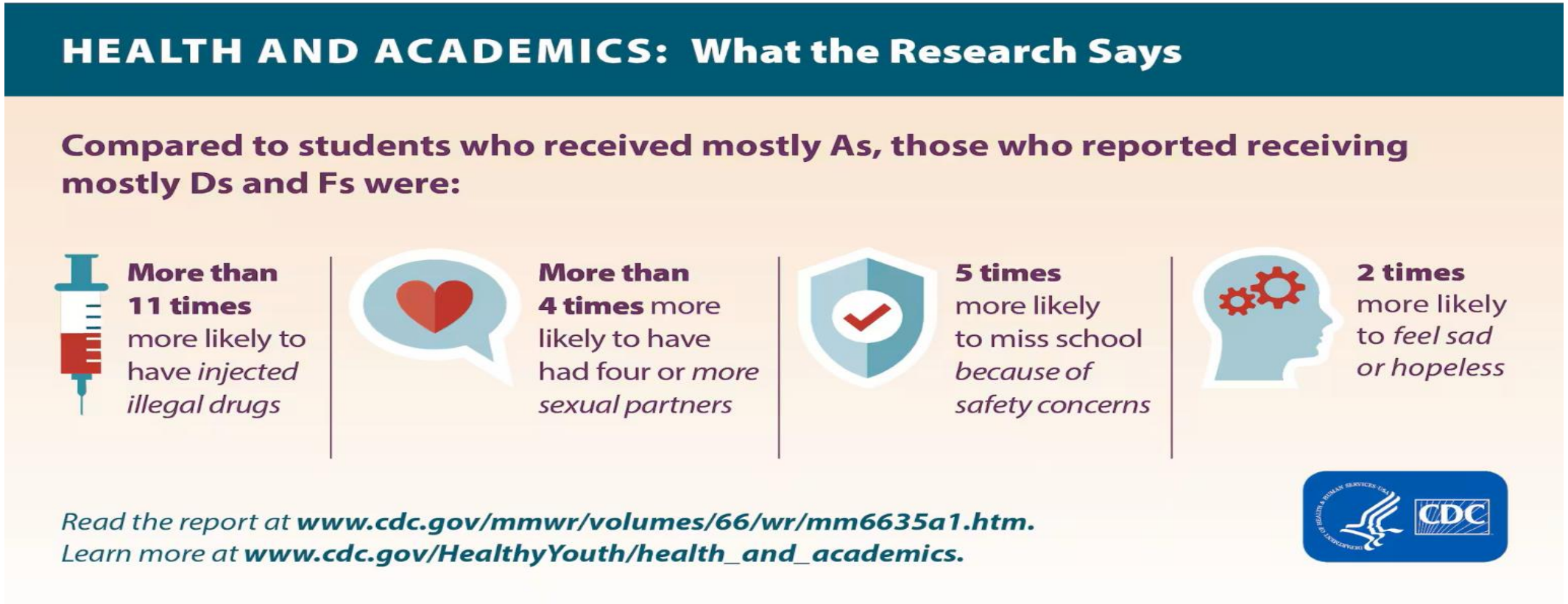
- Providers
  - Convenience
    - Generally do telehealth from campus
      - Weather
      - Medical issues
        - Medical procedures
        - Different abilities
  - Can better see a “typical” meal
  - Easier to link in school and/or other providers
  - New perspective
    - Cats! Dogs! Brothers! Sisters!

Challenges with Tele-feeding Team (Adapted from Davis, 2024)

- Patient/family
  - Technology
    - Must have EMR app
    - Sometimes sound/image can require adjusting
    - Improving over time
  - Team can't help with other children/ behavioral issues
  - Ask them to gather height and weight
- Provider
  - Can be hard for OT to see oral motor skills
  - Extra steps IN EMR
    - Different billing codes
    - Must enter location of patient and provider
    - Should enter in note that visit was telehealth
  - Sometimes join without patient present

Telebehavioral Health & Schools

- **Eldon District is a partner in the Telehealth ROCKS network that has informed the HERE approach. It was among the first school districts in the country to implement school-based CHW in 2016, in collaboration with the broader school health team and rural community.**
- **Eldon R-1 Demographics**: Appx. 1,900 students, Four schools plus Career Center, Approximately 50% free/reduced, 90% graduation rate; **City of Eldon:** Approximately 5,000 population, 2 factories, bedroom community for Lake of the Ozarks and Jefferson City
- **2008:** 450th out of 550 school districts academically, Two factories and a car dealership leave, Large teacher turnover numbers, Little support in the community

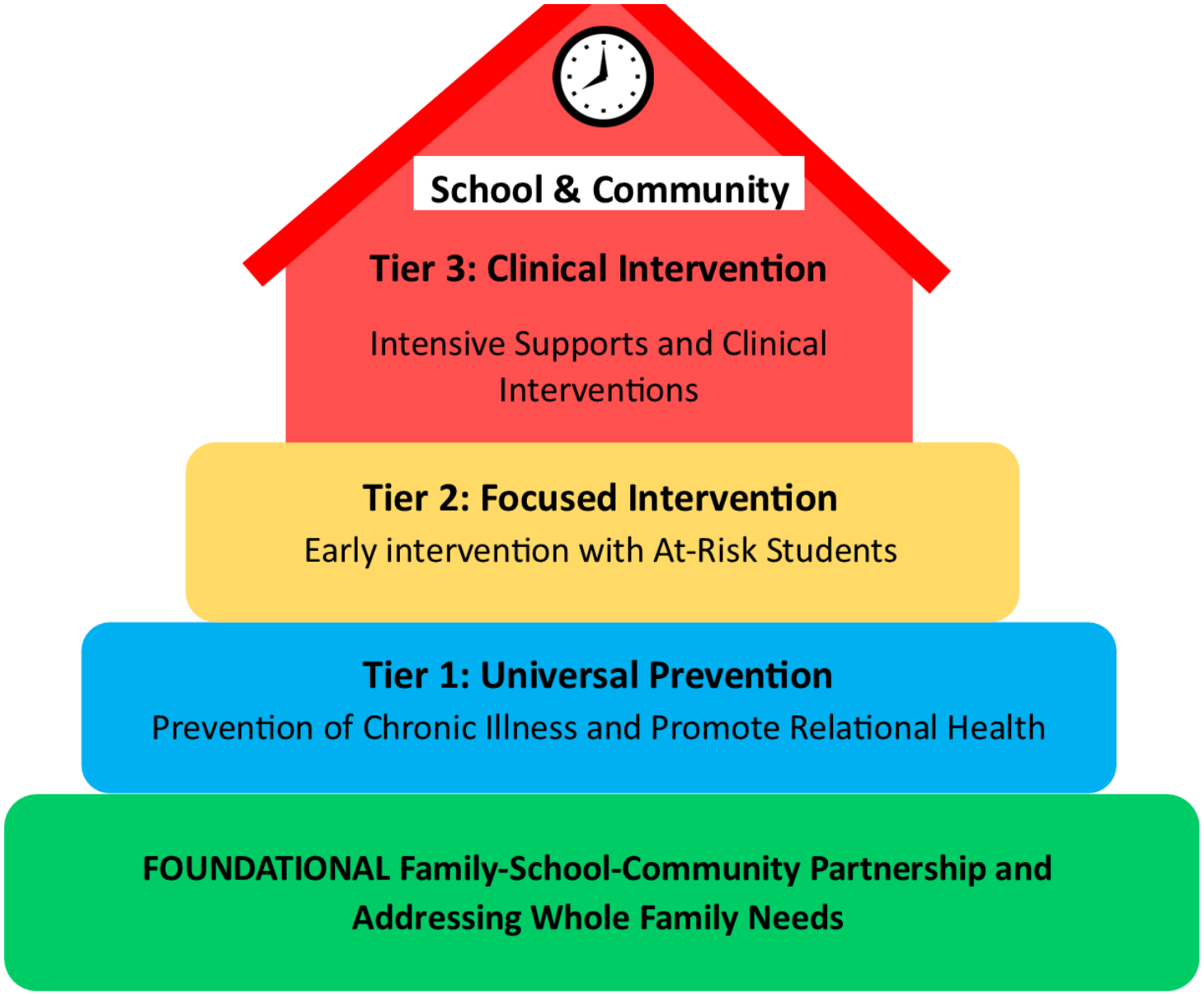


Higher educational attainment is associated with better health outcomes in **almost every health condition**.

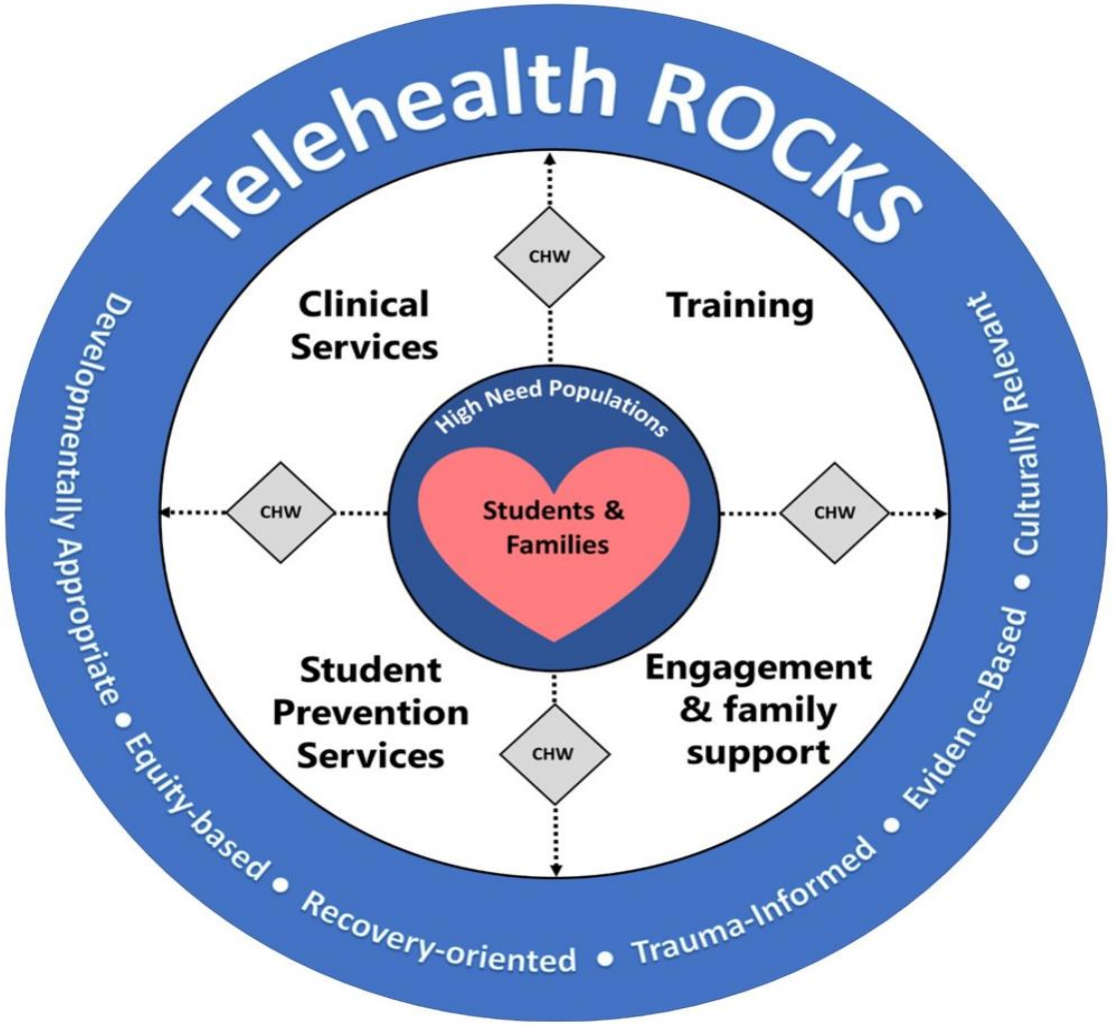
Education shows a **dose–response** relationship with all-cause adult mortality (IHME-CHAIN Collaborators, 2024).

The quality and length of one's education impacts an individual's **future well-being, employment, and economic factors** (McGill, 2016).

- **Telehealth ROCKS** is a family-school-community partnership that has expanded to a holistic health focus. It aims is to meet student and whole family health and behavioral health needs and increase access for families across foundational, prevention, and clinical health needs.



Schools and communities where every child and family has the resources and skills they need to have the exact same opportunity for success in school and in life.



COLLECTIVE VISION

Telehealth ROCKS
Regional Outreach for Communities, Kids and Schools

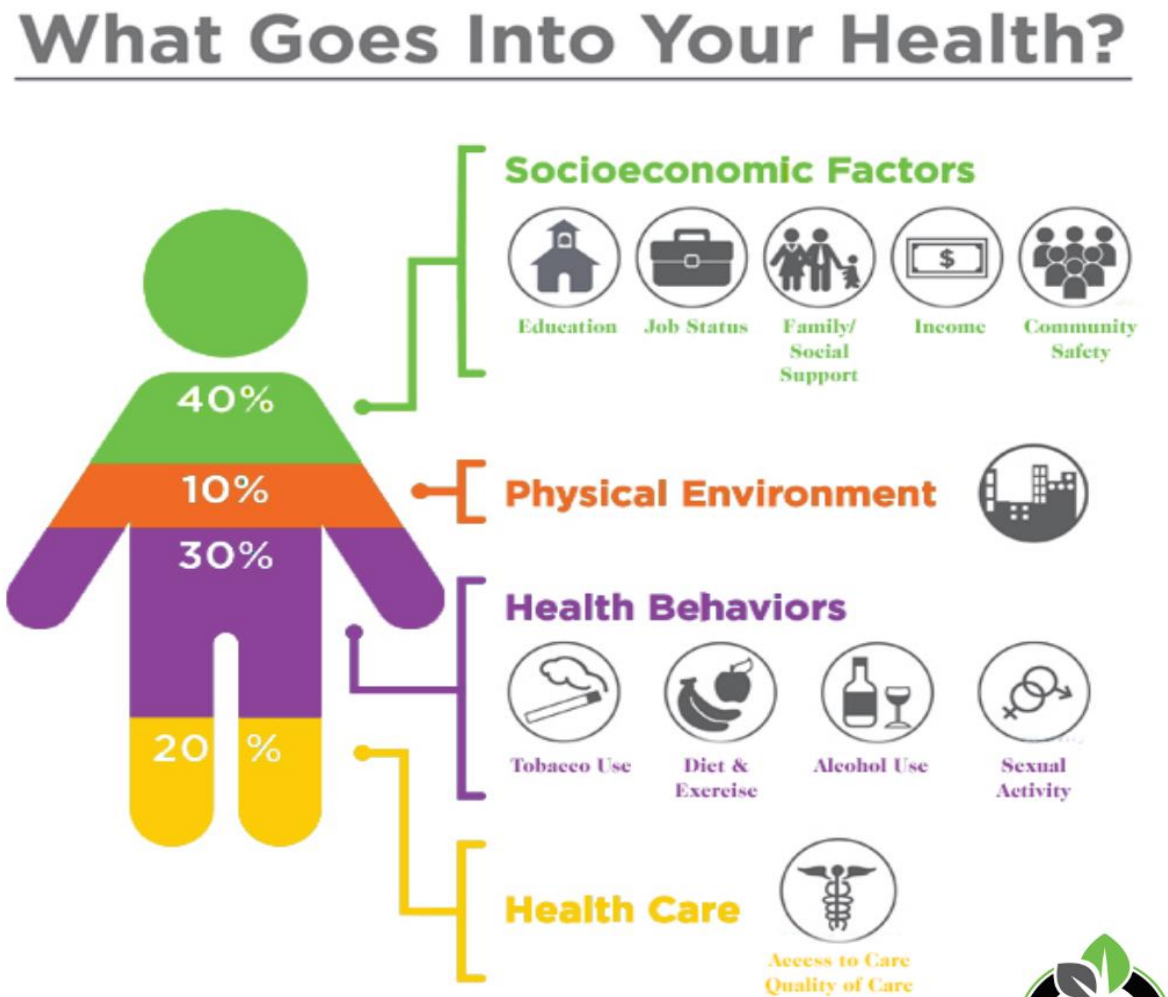
Telehealth ROCKS Family-Community-School Partnership

NadoFest Family Event 2025

- **Over 80 organizations in the rural health network working with Families and Students**
- **Education**—Missouri-Eldon, Kennett, South Callaway School Districts; Kansas-Greenbush, Caney Valley, Chautauqua County, Coffeyville, Fort Scott, Iola, Labette County, Neodesha, and Pittsburg School Districts.
- **Advocacy**— DCCCA, Headquarters, Families Together, Communities Honoring Adolescent Success in Education (CHASE), FosterAdopt Connect
- **Health Care**— Community Health Center of Southeast Kansas, Four County Mental Health Center, University of Kansas Medical Center, KSDE MHIT Program
- **Local Entities**— Restorative Justice Authority, Southeast Kansas DCF, Southeast Kansas FosterAdopt Connect, Crossover Youth Practice Model, Stepping UP Juvenile Justice TA Center.
- **State Government-** Missouri-DESE, DHSS; Kansas-KSDE, KDADS, DCF, KDHE, Corrections, Attorney General, Commerce
- **Others**

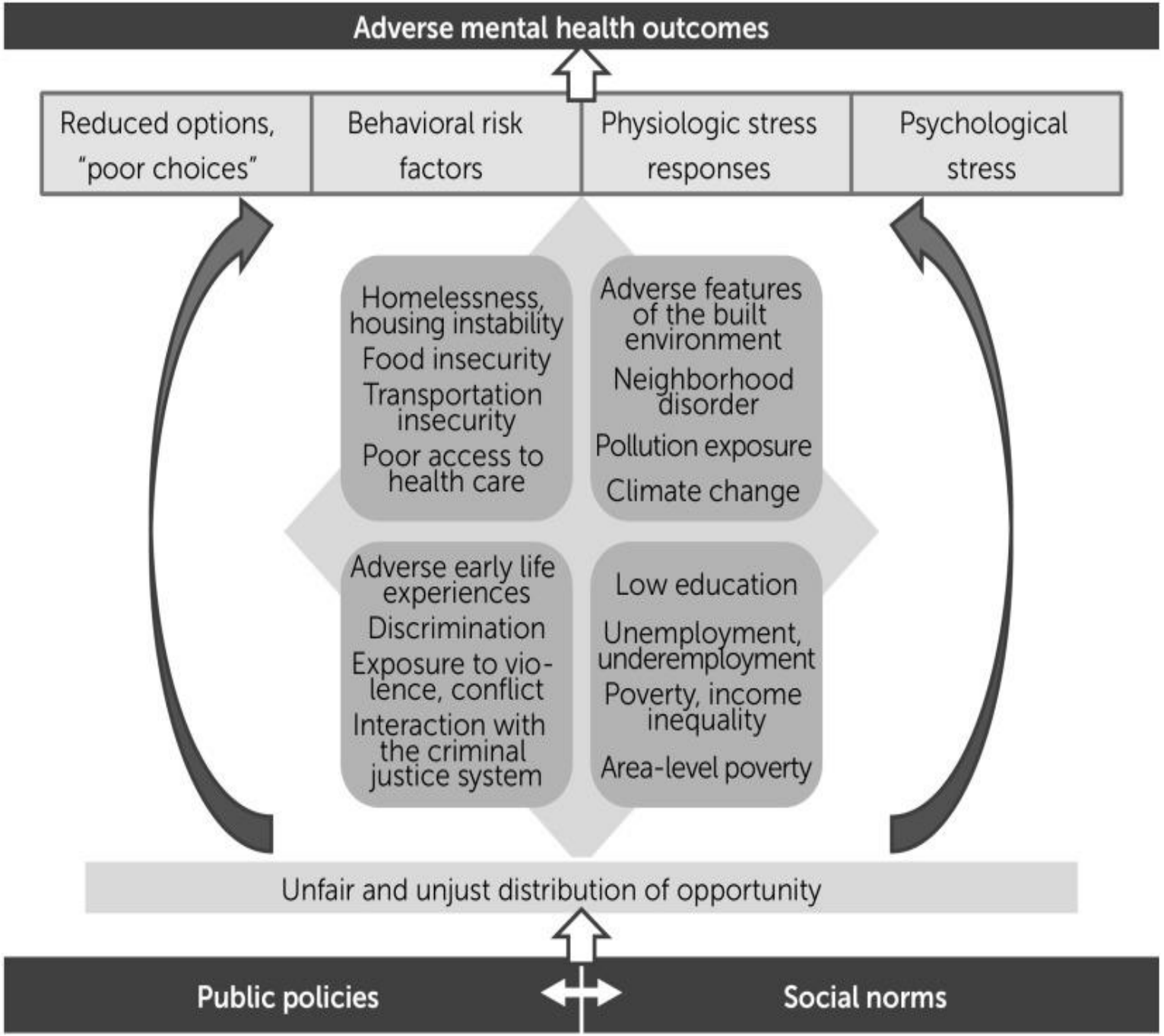
Why do we need to transform our communities?

Because 50 percent of our health is related to our community,
and it has a direct relationship to the remaining 50 percent.



Source: Healthy Baton Rouge
https://healthybr.com/community-health/what-are-the-social-determinants-of-health

Model of Social Determinants of Mental Health (Shim & Compton, 2020)



Video:
https://youtu.be/6ddsZ6kakDw?si=TqvQIA1v9LVhWmdA

CHW are the “Swiss Army knife of school staff”

“For our staff to know they don't have to shoulder all of the burden of worrying about their students’ unmet needs helps them not feel alone, helping to reduce burnout and increase staff morale. A CHW in our school frees up the administration, counselor, and teacher to help all kids focus on the work in front of them and not the roadblocks that get in the way. The question isn't how CHWs fit into the broader school team. The question districts should be asking themselves is what need do we have, and how could a frontline staff member like a CHW help resolve it?” –School District Director of Special Education

Telehealth ROCKS Communities: Community Health Worker Role

Telehealth Care Partners

KUMC Specialists

FQHC Therapists

School Therapists

Patient referral

Coordinate services

Advocate for patient/families

Community Health Worker

Health education

Care navigation

Informal counseling

Support with social determinants of health

Community

Patients And Families

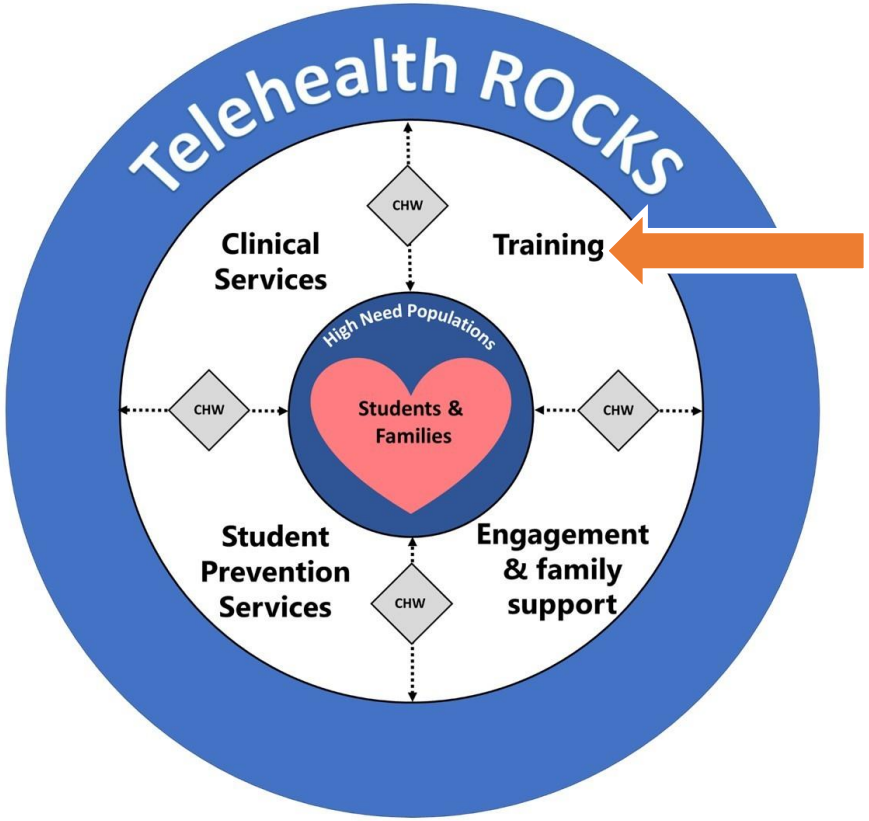
Community Care Link

Community Care Link

Telehealth Tablet

Vetted app & behavioral health resources

Social media & podcast



2024 Telehealth ROCKS ECHO Series/Webinars

- Impacting Health with Communities
- Keeping Kids Safe
- School-Based Community Health Workers
- Early Childhood Wellness
- Innovative Approaches to School Success
- BrainWorks
- Behavior Checker: Parenting is Healthcare

Supporting partner trainings

- Greenbush Early Childhood Education Training
- CHCSEK School Health Conference
- NadoFest Social Media parent presentation

2024—6 series, 29 presenters
1600+ training hours provided
19 training sessions
765 registrants

Resources focused on the Mind-Body Connection

Take a Brain Break

See four ideas for taking a break and incorporating mindfulness into your day. This works in the classroom and for yourself. Try one today.

QUICK CHECK IN

15 Second Check-In

Take 15 seconds to check in with yourself. How are you doing in this moment? Try this short breathing exercise.

MAKE A LIST

Make a List

Making a list (e.g., to-do list, grocery list) can help reduce stress and improve our cognitive functioning. View 5 Smarter Ways to Organize Your To-do list

GROUNDING

Grounding

By observing and describing what is around us, we can decrease our perception of feeling overwhelmed. Try this guided meditation for grounding.

GUIDED MEDITATIONS

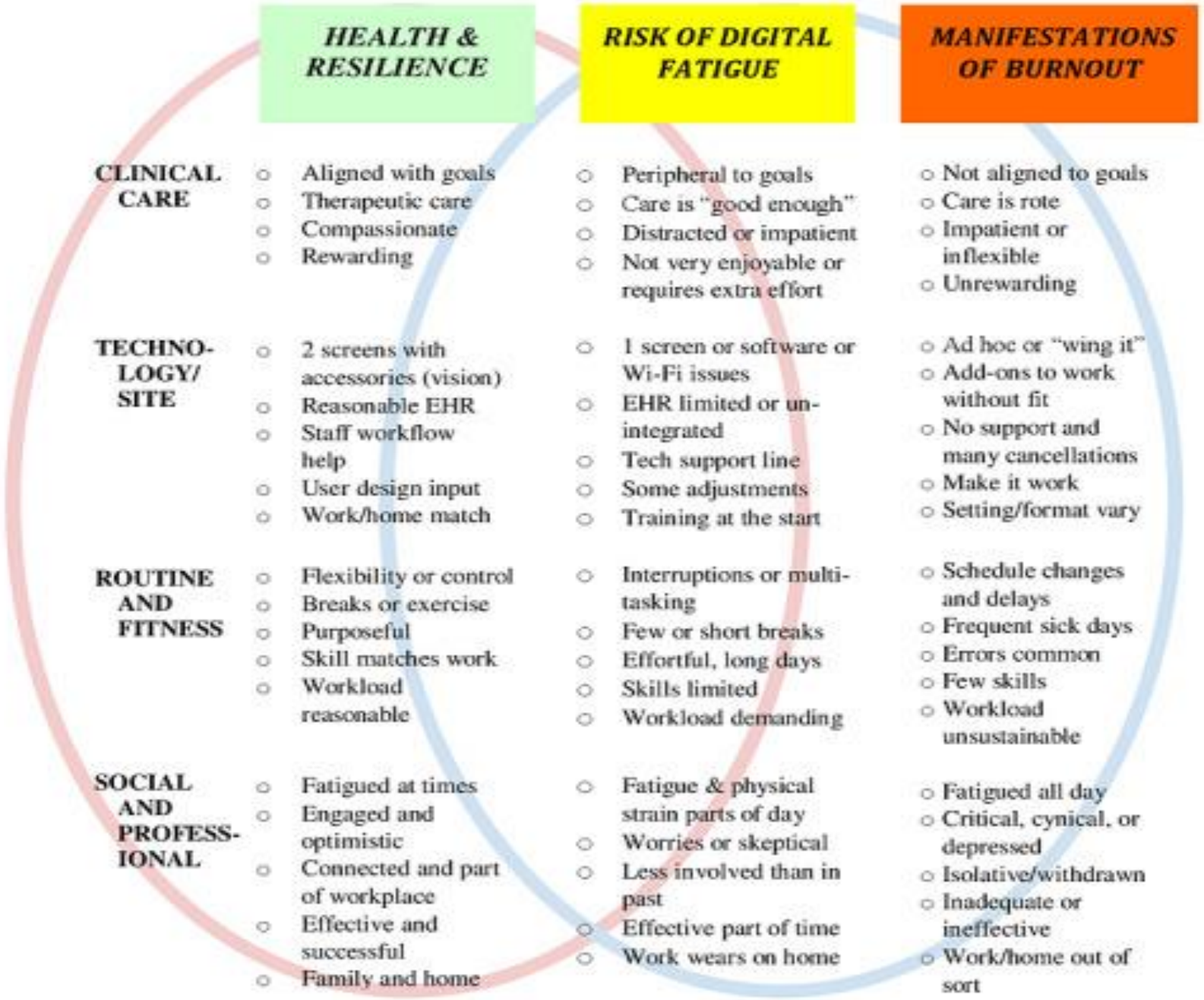
Guided Meditations

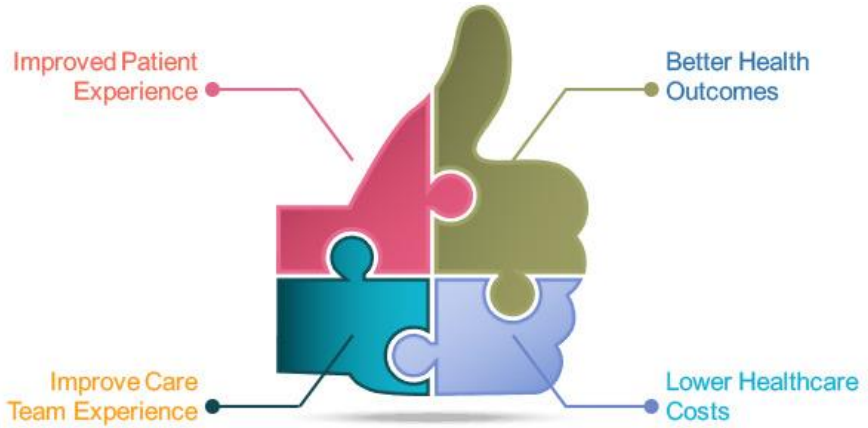
Taking a moment to non-judgmentally be in the present, helps us practice being in the "here and the now." This helps us manage our stress. Free app with guided meditations.

Self-Care = Ethics Care

- We can't pour from an empty glass
- It is important to take time for ourselves in order to promote our own physical and mental health (McEwen, 2017).
- Stress can negatively impact our cognition (Sandi, 2013) and thus make ethical decision making even more of a difficult task

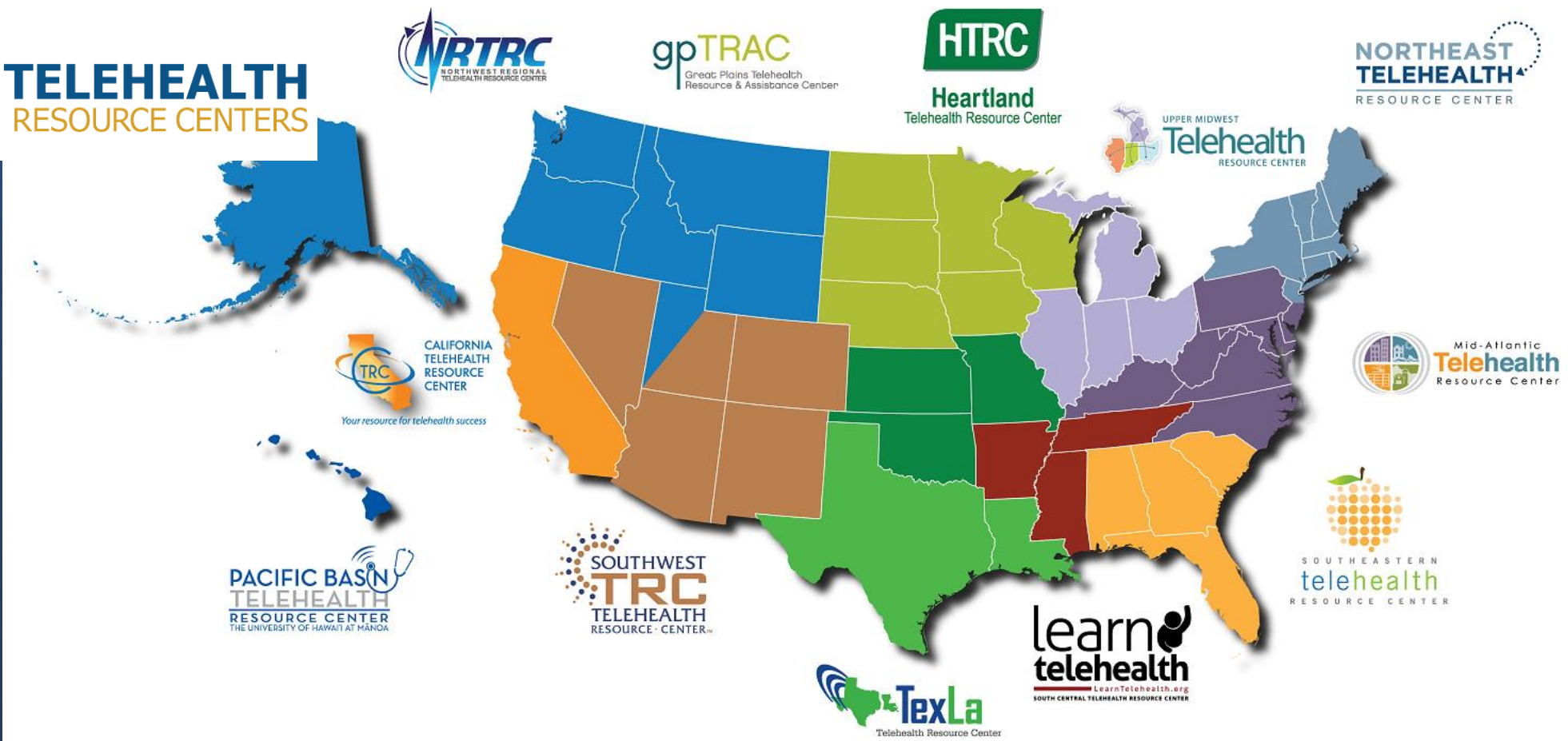
Figure 2 A comparison of health and resilience, risk to well-being, and manifestations of technology-based fatigue and burnout. EHR: electronic health record. Hilty, Armstrong, et al. (2022) JMIR.





- **2024**: 24th in the state in most recent MSIP data- Consistently top 100 in state academically, Industry is back (new factory with a goal of over 1,000 employees), Very low teacher turnover
- **Community-wide approach including CHWs is at the heart of our turnaround.**
  - SB-CHW ingrained in school and community
  - Able to go beyond the walls of the school, Home visits, Wrap around practices
  - Problem solving mindset
  - Free up Administrator's time, Help reduce teacher burnout
  - Support onsite behavioral and telebehavioral health interventions across prevention and clinical care
- **"Rocking chair days"**

TELEHEALTH RESOURCE CENTERS



TTAC
TelehealthTechnology.org
National Telehealth Technology Assessment Resource Center

Center for Connected Health Policy
The National Telehealth Policy Resource Center

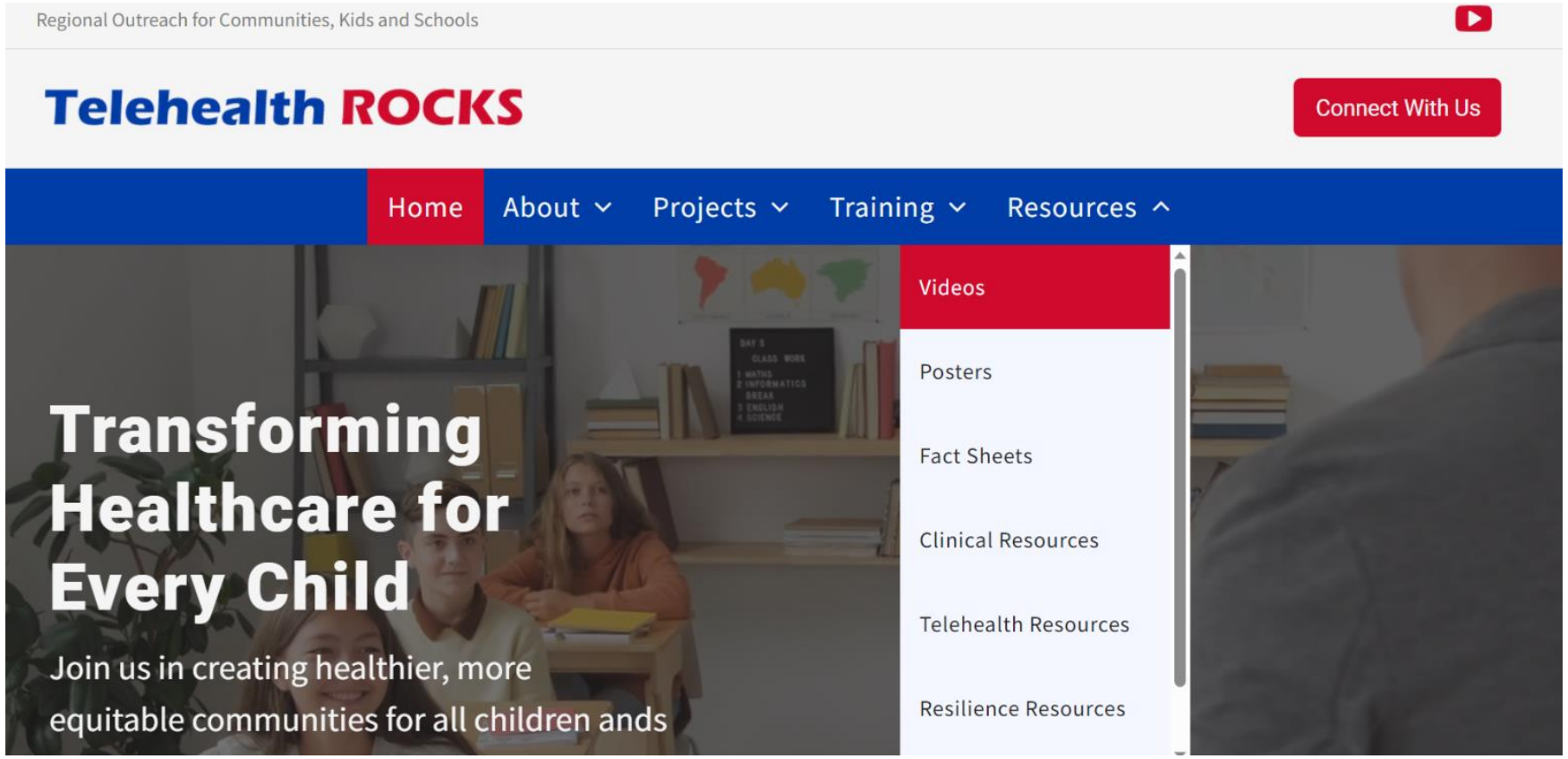
2 National Resource Centers

NRTRC	gpTRAC	NETRC
CTRC	HTRC	UMTRC
SWTRC	SCTRC	MATRC
PBTRC	TexLa	SETRC

12 Regional Resource Centers

We welcome you to join Telehealth ROCKS no cost child behavioral health ECHOs/trainings

telehealthrocks@kumc.edu Telehealthrocks.org



THANKS!

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www.telehealthrocks.org
www.heartlandtrc.org

Looking for Health Equity & Ethics Training?

Cultural Humility In Behavioral Health Care

- Free two-hour module
- On-demand & self-paced
- Meets **Health Equity** training requirements in WA State

Empowering Recovery: Ethics & Collaborative Decision-Making in Behavioral Health

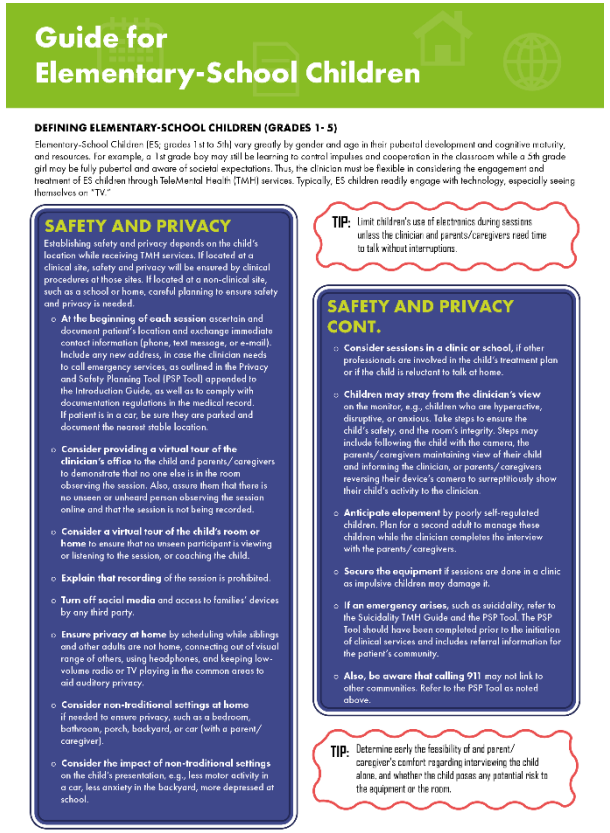
- Free two-hour module
- On-demand & self-paced
- Meets **Law & Ethics** training requirements in WA State

Learn more at: https://bhinstitute.uw.edu/learn-online

TeleMental Health Guides for Infancy to Young Adults

Guides (8)

- Infancy and Toddlers
- Pre-schoolers
- Elementary School Children
- Middle School Youth
- High School Teens
- Young Adults
- Neuropsychological Testing
- Suicidality



Guide for Elementary-School Children

DEFINING ELEMENTARY-SCHOOL CHILDREN (GRADES 1- 5)

Elementary-School Children (ES; grades 1st to 5th) vary greatly by gender and age in their pubertal development and cognitive maturity, and resources. For example, a 1st grade boy may still be learning to control impulses and cooperation in the classroom while a 5th grade girl may be fully pubertal and aware of societal expectations. Thus, the clinician must be flexible in considering the engagement and treatment of ES children through TeleMental Health (TMH) services. Typically, ES children readily engage with technology, especially seeing themselves on "TV."

SAFETY AND PRIVACY

Establishing safety and privacy depends on the child's location while receiving TMH services. If located at a clinical site, safety and privacy will be ensured by clinical procedures at those sites. If located at a non-clinical site, such as a school or home, careful planning to ensure safety and privacy is needed.

- **At the beginning of each session** ascertain and document patient's location and exchange immediate contact information (phone, text message, or e-mail). Include any new address, in case the clinician needs to call emergency services, as outlined in the Privacy and Safety Planning Tool (PSP Tool) appended to the Introduction Guide, as well as to comply with documentation regulations in the medical record. If patient is in a car, be sure they are parked and document the nearest stable location.
- **Consider providing a virtual tour of the clinician's office** to the child and parents/caregivers to demonstrate that no one else is in the room observing the session. Also, ensure them that there is no unseen or unheard person observing the session online and that the session is not being recorded.
- **Consider a virtual tour of the child's room or home** to ensure that no unseen participant is viewing or listening to the session, or coaching the child.
- **Explain that recording** of the session is prohibited.
- **Turn off social media** and access to families' devices by any third party.
- **Ensure privacy at home** by scheduling while siblings and other adults are not home, connecting out of visual range of others, using headphones, and keeping low-volume radio or TV playing in the common areas to aid auditory privacy.
- **Consider non-traditional settings at home** if needed to ensure privacy, such as a bedroom, bathroom, porch, backyard, or car (with a parent/caregiver).
- **Consider the impact of non-traditional settings** on the child's presentation, e.g., less motor activity in a car, less anxiety in the backyard, more depressed at school.

TIP: Limit children's use of electronics during sessions unless the clinician and parents/caregivers need time to talk without interruptions.

SAFETY AND PRIVACY CONT.

- **Consider sessions in a clinic or school,** if other professionals are involved in the child's treatment plan or if the child is reluctant to talk at home.
- **Children may stray from the clinician's view** on the monitor, e.g., children who are hyperactive, disruptive, or anxious. Take steps to ensure the child's safety, and the room's integrity. Steps may include following the child with the camera, the parents/caregivers maintaining view of their child and informing the clinician, or parents/caregivers reversing their device's camera to surreptitiously show their child's activity to the clinician.
- **Anticipate elopement** by poorly self-regulated children. Plan for a second adult to manage these children while the clinician completes the interview with the parents/caregivers.
- **Secure the equipment** if sessions are done in a clinic as impulsive children may damage it.
- **If an emergency arises,** such as suicidality, refer to the Suicidality TMH Guide and the PSP Tool. The PSP Tool should have been completed prior to the initiation of clinical services and includes referral information for the patient's community.
- **Also, be aware that calling 911** may not link to other communities. Refer to the PSP Tool as noted above.

TIP: Determine early the feasibility of and parent/caregiver's comfort regarding interviewing the child alone, and whether the child poses any potential risk to the equipment or the room.

TELEMENTAL HEALTH GUIDE FOR ELEMENTARY-SCHOOL CHILDREN

Case Example

Abdul is a 10 y/o Afghani refugee boy who presented with his mother due to the school's concern with his inattention and distractibility in class, restlessness and difficulty staying seated, yelling out answers impulsively, and falling behind academically. The Mother noted similar difficulties in the home, especially regarding homework. Both parents worked and lived in an urban neighborhood with poor transportation options, so they agreed to home-based TMH. The family used their smartphone for the sessions, with adequate, but not optimal, cell reception. Sessions were held in the parent's bedroom, for privacy. An older sister watched the siblings in another room or took them for a walk.

Abdul was readily engaged over the smartphone and told of his favorite videogame, his love of Legos, and his best friend at school, as well as the injustices of his siblings. The clinician conducted the interview by alternating between the mother's history and the child's input.

Even with the spotty connectivity, the clinician appreciated Abdul's good verbal skills, intellect, charming personality, as well his impulsive intrusiveness and mild mid-facial and guttural tic. To assess his gross motor skills, the clinician asked Abdul to do some movements, including some dance movements. He was awkward and had difficulty cooling down once wound up. To assess his fine motor skills, and to keep him occupied in order to obtain the mother's history, Abdul was asked to draw a picture of his favorite animal. He impulsively scribbled something and quickly returned to the smartphone to show his artwork: not an animal, but he enthusiastically told of its meaning, demonstrating his creativity and knowledge.

The clinician then asked Abdul to play with his Hot Wheels in front of his mother, allowing more time with the mother while monitoring Abdul. He did so, fairly quietly for a while, then became increasingly louder, and then disruptive. At various times, Abdul's mother quietly flipped the smartphone's camera to allow observation of Abdul's play without his knowledge. He did show symbolic play, although somewhat aggressive with the Hot Wheels breaking off some wheels.

Then, the clinician sent an ADHD rating scale and an anxiety rating scale to the older daughter's tablet so that the mother could complete these behavior reports in another room while the clinician spent some individual time with Abdul. The mother also logged into the school's website to check Abdul's grades, missing assignments, and the teacher's recent comments. Meanwhile, the clinician observed Abdul's play and engaged him verbally regarding his Hot Wheels. The clinician asked Abdul to trace his favorite Hot Wheel car and write the name of it along with his name on top of the paper. He showed some difficulties with tracing and penmanship but had correct spelling. He showed increased tic movements while engaged in this task.

The clinician made a diagnosis of ADHD with a concern about a fine motor disability and tics. They wrote a treatment plan on the "White Board" that included: a) the clinician requesting completion of behavior rating scales from selected teachers, to be uploaded into the clinician's website portal; b) making the child a "Focus of Concern" under Public Law 94-142 for further school evaluation and possibly special education services, and c) developing a structured plan for homework including turning it in reliably; and d) the mother reviewing the treatment plan on the website and reading information about ADHD treatment, including using behavior charts. As the family did not have a printer, the clinician also sent a hard copy of the treatment plan and readings. They made a plan for the mother to meet alone with the clinician in a week to set up a behavior program and discuss the relevance of a medication trial, consistent with evidence-based treatment for ADHD.

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Additional Free Resources for Washington State Behavioral Health Providers

EDUCATIONAL SERIES:

- UW Traumatic Brain Injury – Behavioral Health ECHO
- UW Psychiatry & Addictions Case Conference ECHO
- **UW TelePain series**

PROVIDER CONSULTATION LINES

- **UW Pain & Opioid Provider Consultation Hotline**
- Psychiatry Consultation Line
- Partnership Access Line (pediatric psychiatry)
- Perinatal Psychiatry Consultation Line

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