Pediatric Readiness Program Education Session

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Legacy Health and Oregon Emergency Medical Services for Children.

Legacy Health designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Pediatric Behavioral Health in the ED:

Big Picture and Practical Guidance

November 20, 2025. Ajit Jetmalani MD Professor and Director, Child and Adolescent Psychiatry
Liz Marx, MSW, LCSW. Social Worker, Child and Adolescent Psychiatry

CME DISCLOSURE

None of the planners and faculty for this educational activity have relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, reselling, or distributing healthcare products used by or on patients.

OBJECTIVES

- Understand current pediatric behavioral health system developments
- Bring quality improvement ideas to your ED that may reduce aggression and suicide risk in your patients

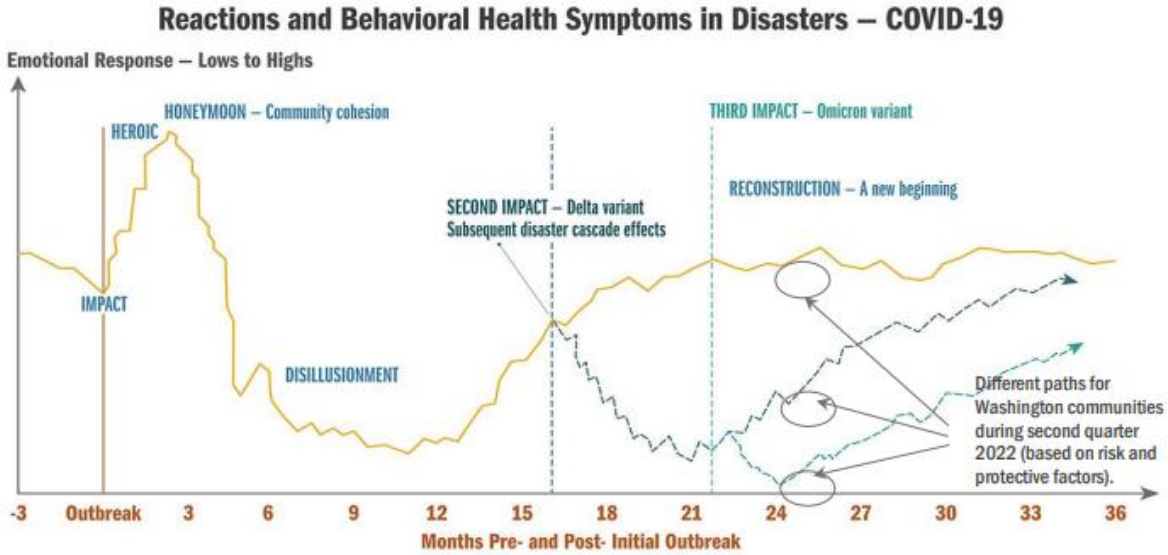
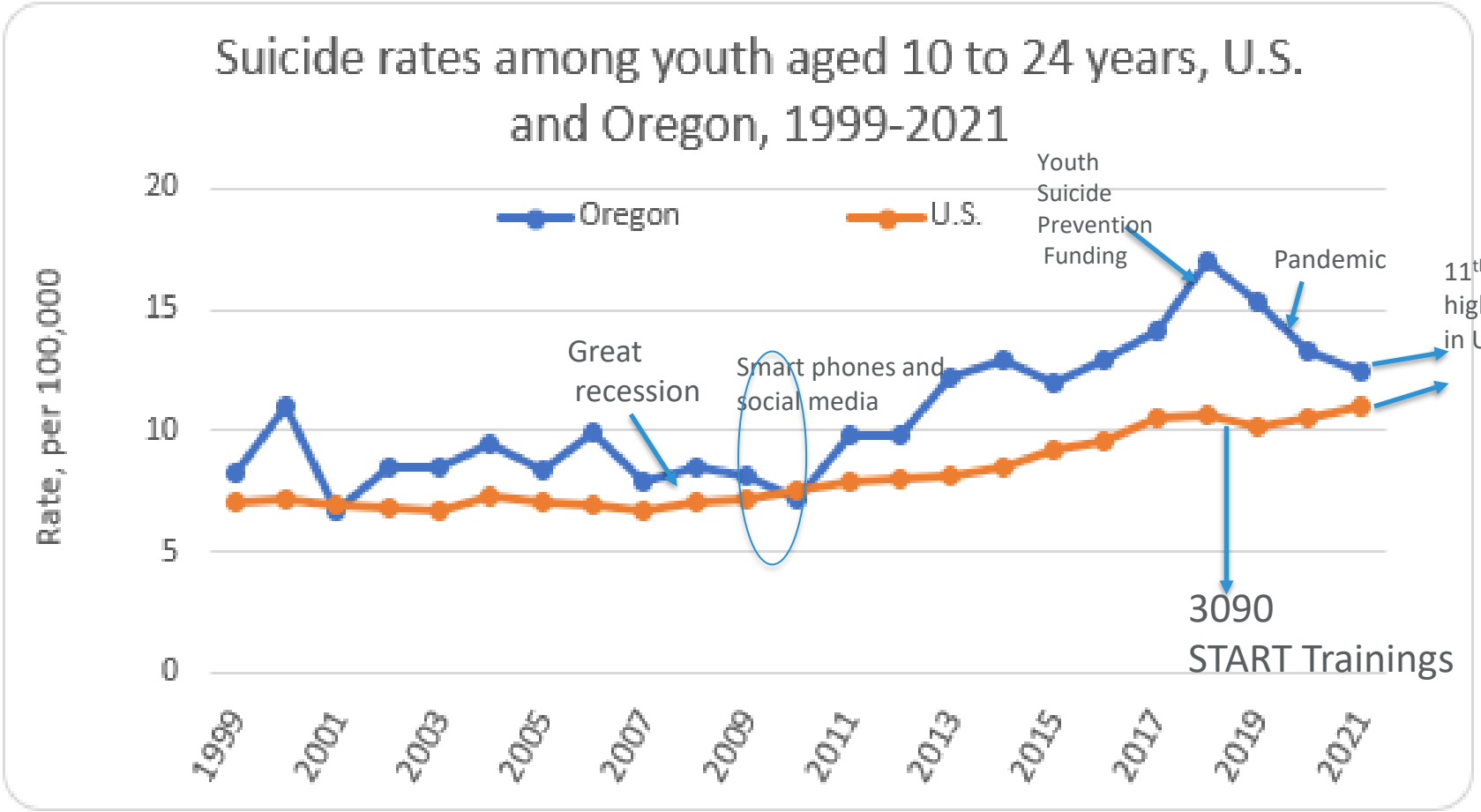


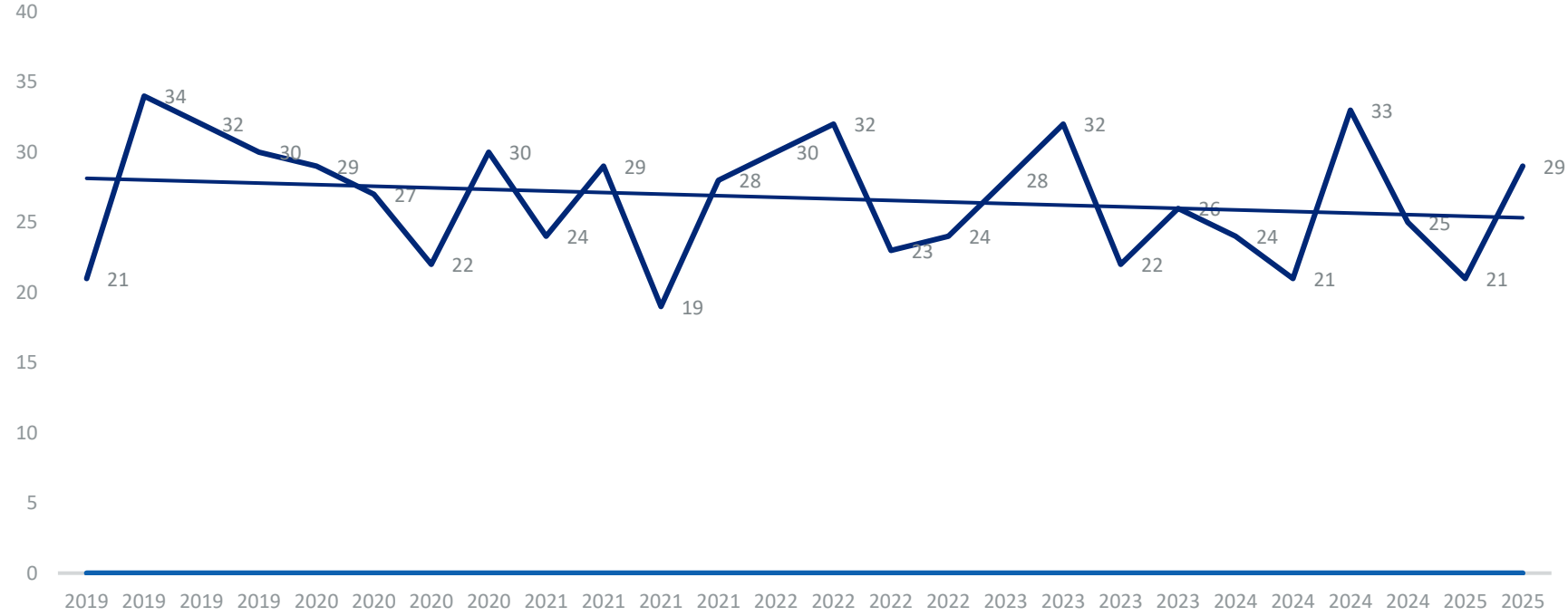
Figure 1: Phases of reactions and behavioral health symptoms in disasters. *The dotted graph line represents the response and recovery pattern that may occur if the full force of a disaster cascade is experienced by a majority of the population (i.e., the disaster cascade pathway). Protective factors are characteristics, conditions, or behaviors that reduce the effects of stressful life events. They also increase a person's ability to avoid risks or hazards, recover, and grow stronger. Adapted from the Substance Abuse and Mental Health Services Administration (SAMHSA).*[14]

Acknowledgements

This document was developed by the Washington State Department of Health's Behavioral Health Strike Team for the COVID-19 response. The strike team is a group of clinical psychologists, psychiatrists, and therapists who are professionals in disaster relief and behavioral health. Lead authors from the Behavioral Health Strike Team are Kira Mauseth, Ph.D., Tona McGuire, Ph.D., and Stacy Cecchet, Ph.D., ABPP. Research support for this report was provided by undergraduate psychology students at Seattle University.

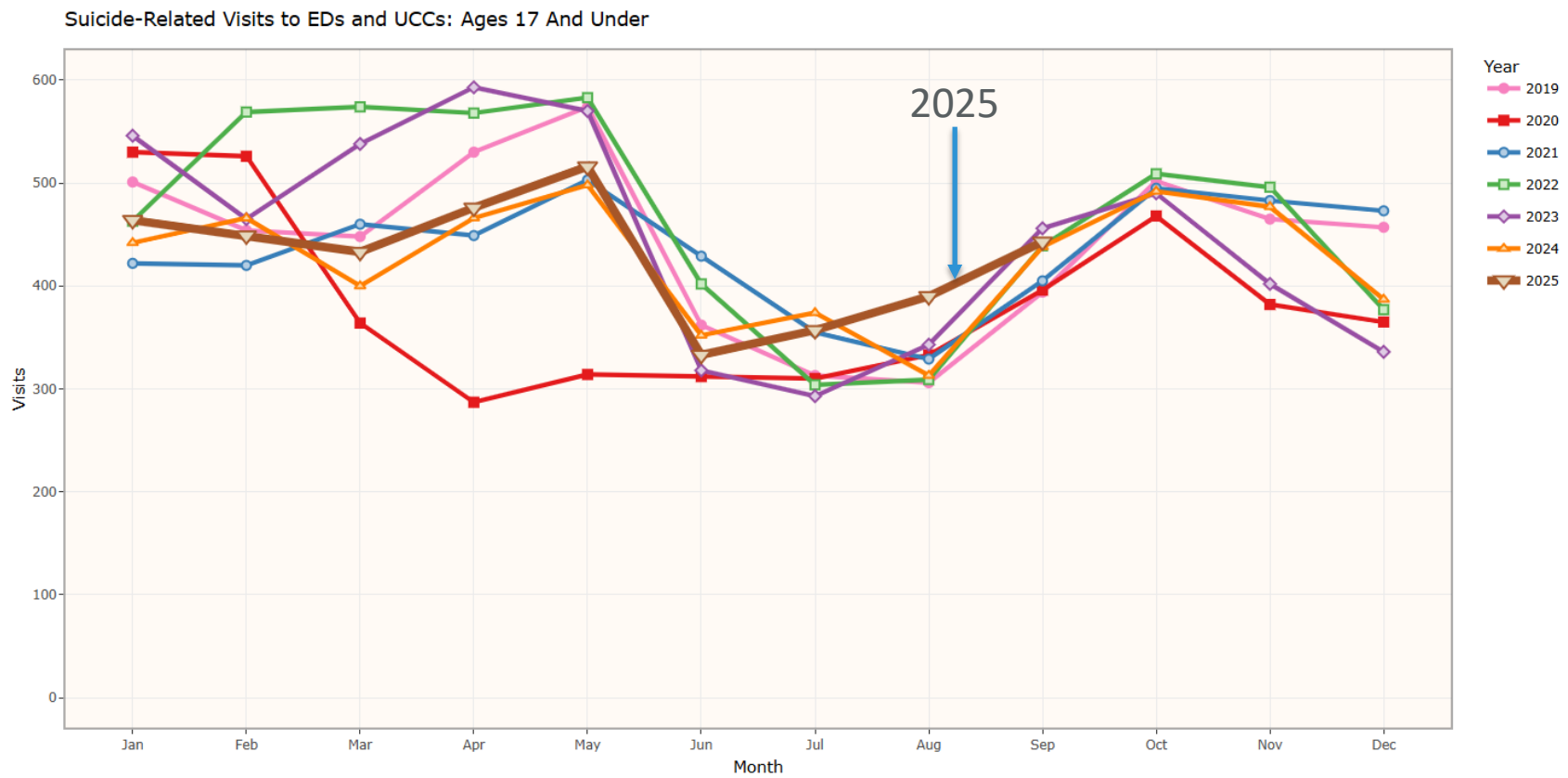

Suicide rates among youth aged 10 to 24 years, U.S. and Oregon, 1999-2021
Rate, per 100,000
20
15
10
5
0
Oregon
U.S.
Youth Suicide Prevention Funding
Pandemic
11th highest in US
Great recession
Smart phones and social media
3090 START Trainings
1999
2001
2003
2005
2007
2009
2011
2013
2015
2017
2019
2021

QUARTERLY NUMBER OF COMPLETED SUICIDES AGE 5-25



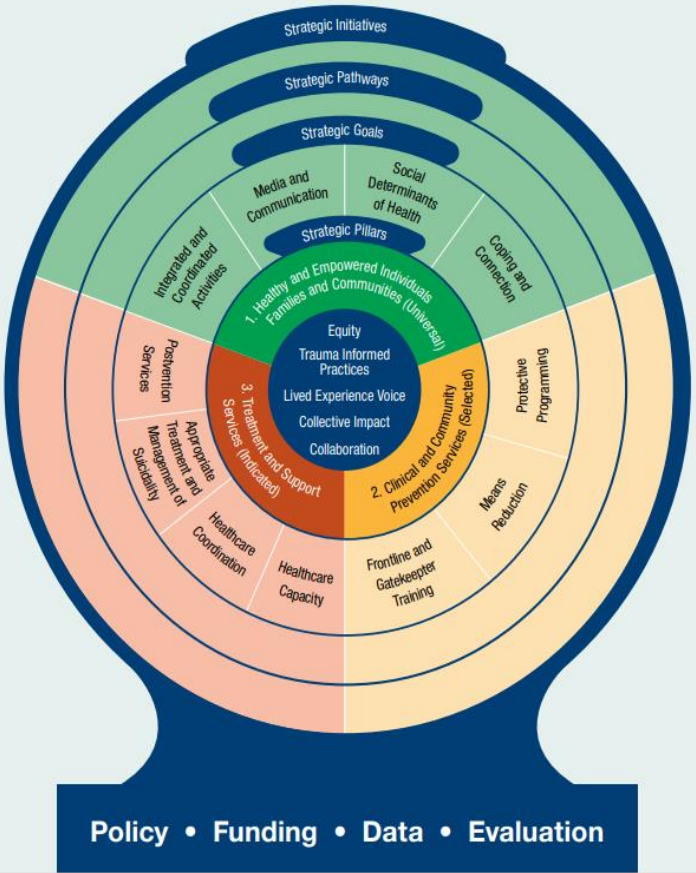
https://oregoninjurydata.shinyapps.io/suicide_updates/

Accessed 11/11/2025



https://oregoninjurydata.shinyapps.io/suicide_updates/

Oregon Suicide Prevention Framework



https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le8874a_24.pdf

HB 3090 2017

- Requirement for people with suicidal ideation prior to release:
  - Mental Health Evaluation
  - Risk Assessment
  - Safety Planning
    - Lethal Means Counseling
    - Caring Support Person
  - Caring Contact
  - Follow up Services

Psychiatric Emergency Department Boarding among Youth

K. John McConnell, PhD
October 1, 2025

Accessible research. Healthier health care.

OHSU Center for HEALTH SYSTEMS EFFECTIVENESS

1 in 8 visits results in boarding event

Oregon slightly above national average

Large variations across states

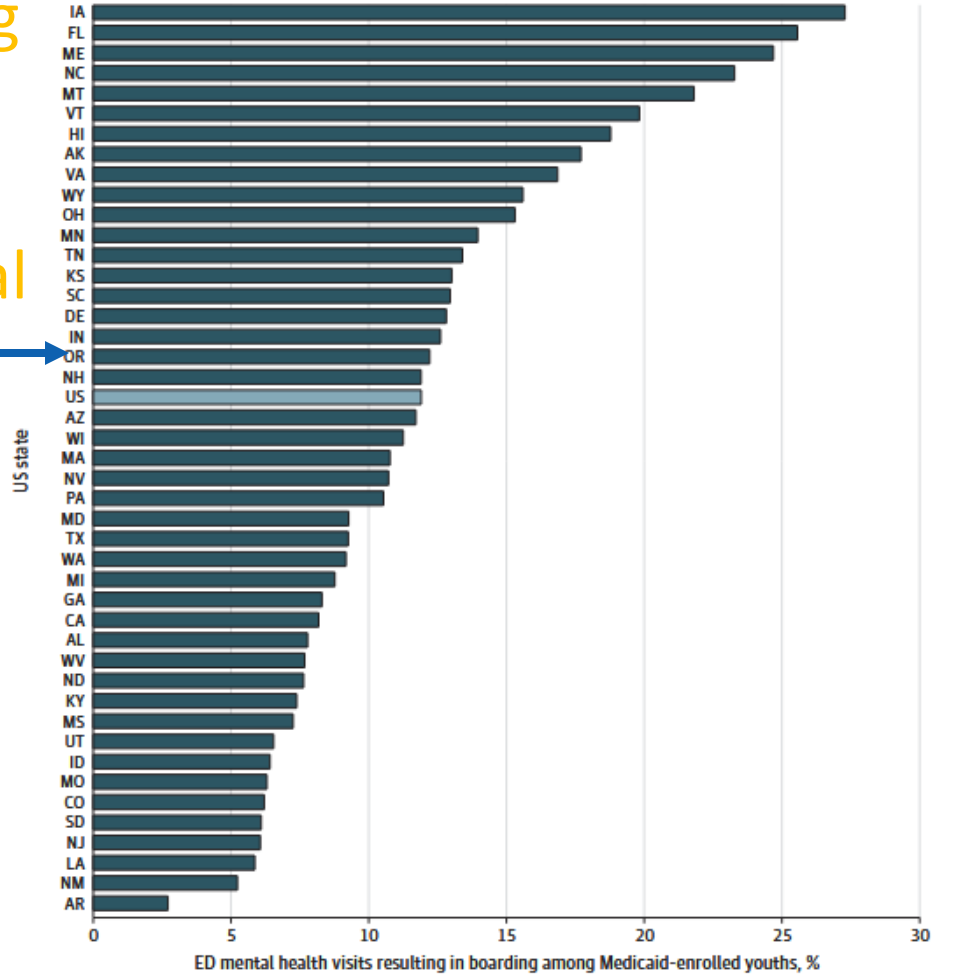
JAMA Health Forum™

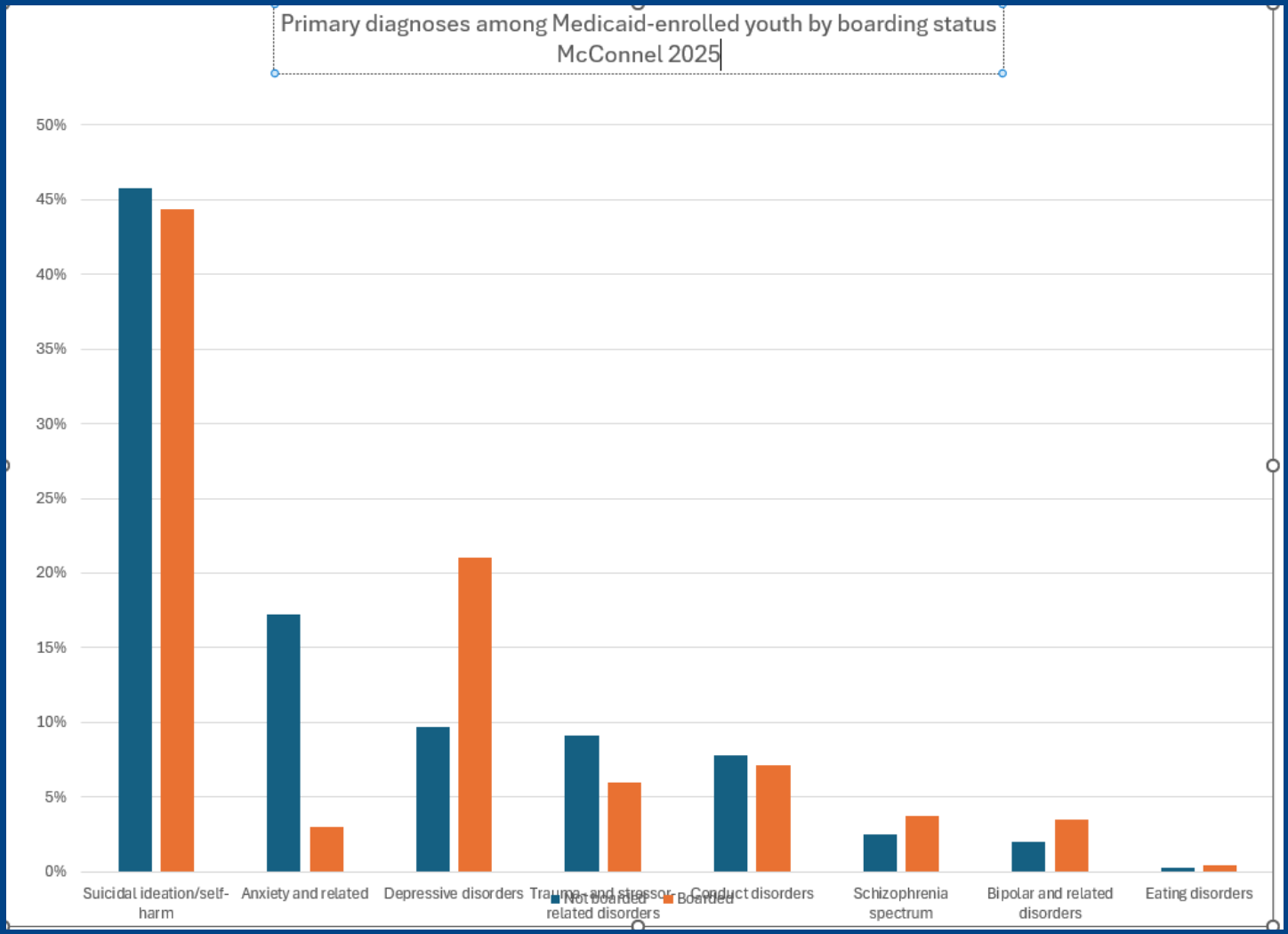
Research Letter

Variations in Psychiatric Emergency Department Boardin for Medicaid-Enrolled Youths

K. John McConnell, PhD; Thomas H. A. Meath, MPH; Lindsay N. Overhage, BA

Figure. Share of Emergency Department (ED) Mental Health Visits Resulting in Boarding Among Medicaid-Enrolled Youths, 2022



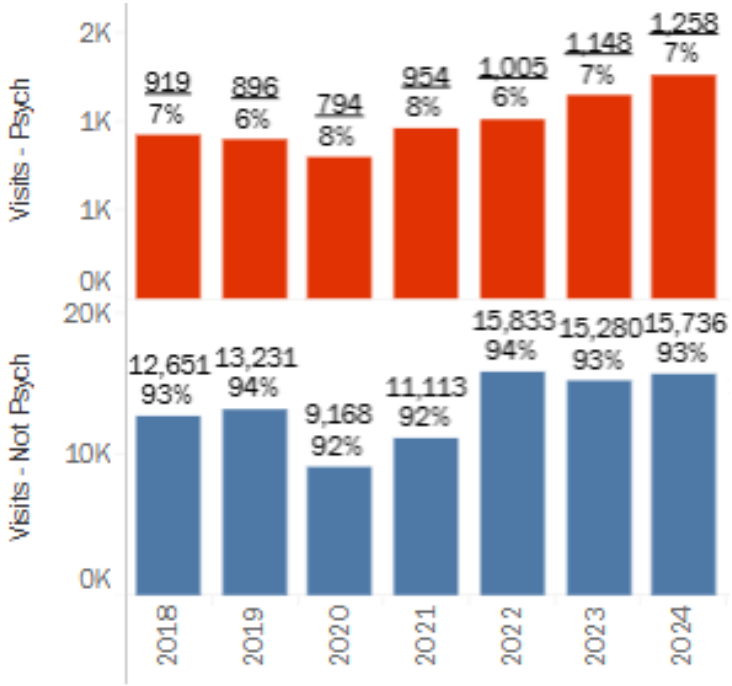

Primary diagnoses among Medicaid-enrolled youth by boarding status
McConnel 2025
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Suicidal ideation/self-harm
Anxiety and related
Depressive disorders
Trauma- and stressor-related disorders
Conduct disorders
Schizophrenia spectrum
Bipolar and related disorders
Eating disorders
Not boarded
Boarded

OHSU

OHSU CAP Inpatient Consultation Liaison Program

October 2025

Total Behavioral Health Visits and Non-Behavioral Health Visits (OHSU ED)



Pediatric behavioral health visits

- Since 2020, # of annual visits has steadily increased
- 58% increase in volume between 2020-2024

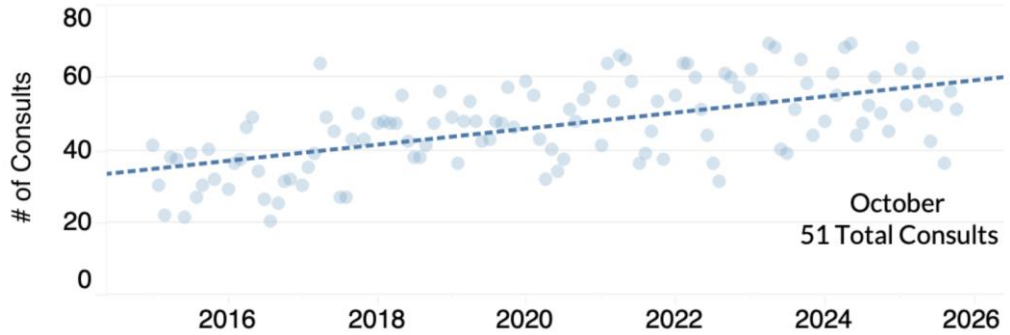
Pediatric non behavioral health visits

- # has been steady since the pandemic

OHSU

Total CAP Consults over Time

2015 – 2025 YTD



Who’ s Most Likely to Board

Youth with behavioral health needs and:

- aggression
- Intellectual / developmental disabilities (I/DD)
- medical complexity (eating disorders, diabetes, etc.)
- in the foster care system or with high social/family complexity
- with substance use disorder

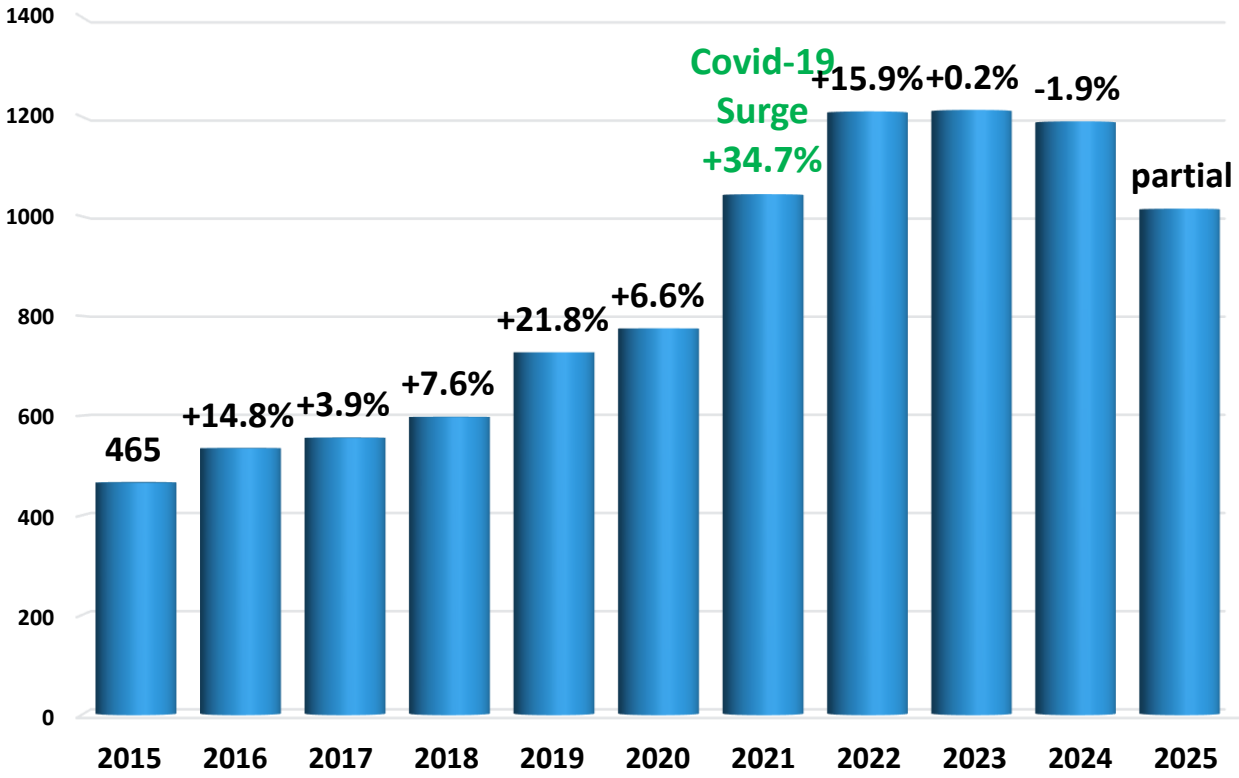
These youth are often unable to get the care they need because of systemic limitations.

OPAL-K & DBP

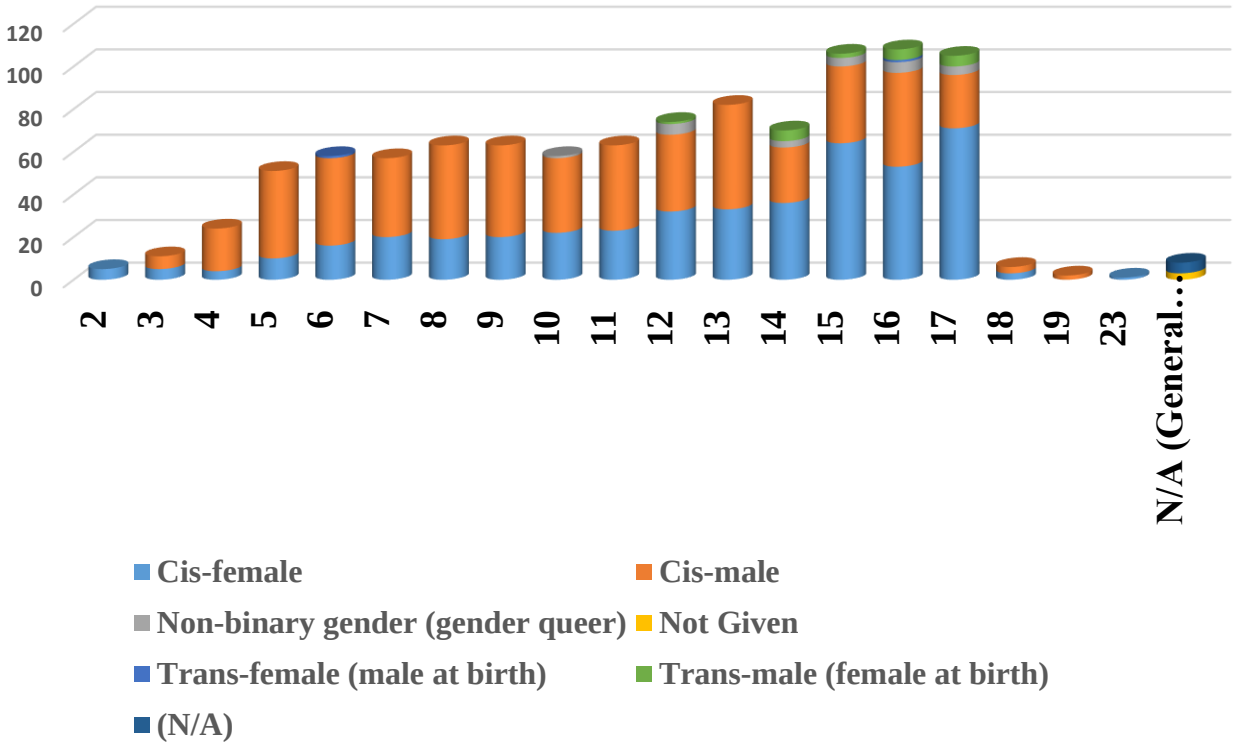
CAP Meeting

DATE: November 5,2025

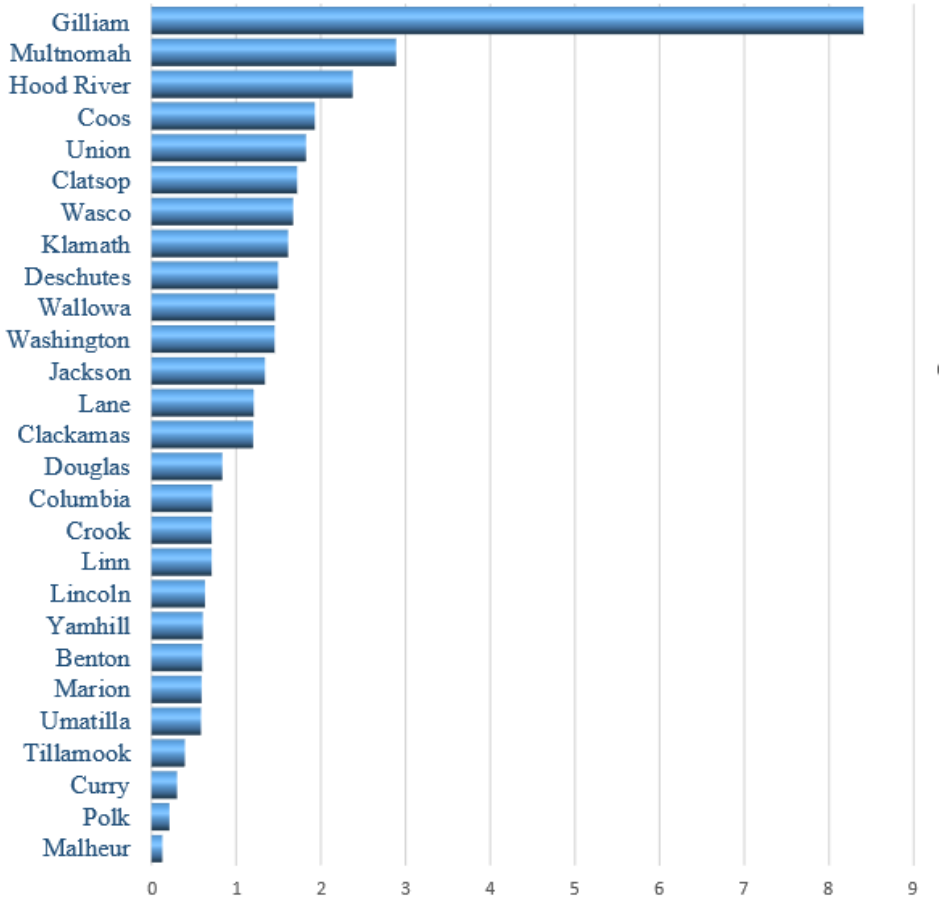
OPAL-K Call Trend
Fiscal Year 2015-2025



OPAL-K Age Distribution
Fiscal 2025
n=1,029



OPAL-K Consult Calls by County
Fiscal Year 2024 – 2025
(Per 1000 Population Age 0-17)
n= 1,015



JAMA Network™

From: **Pediatric Inpatient Psychiatric Capacity in the US, 2017 to 2020**

JAMA Pediatr. 2024;178(10):1080-1082. doi:10.1001/jamapediatrics.2024.2888

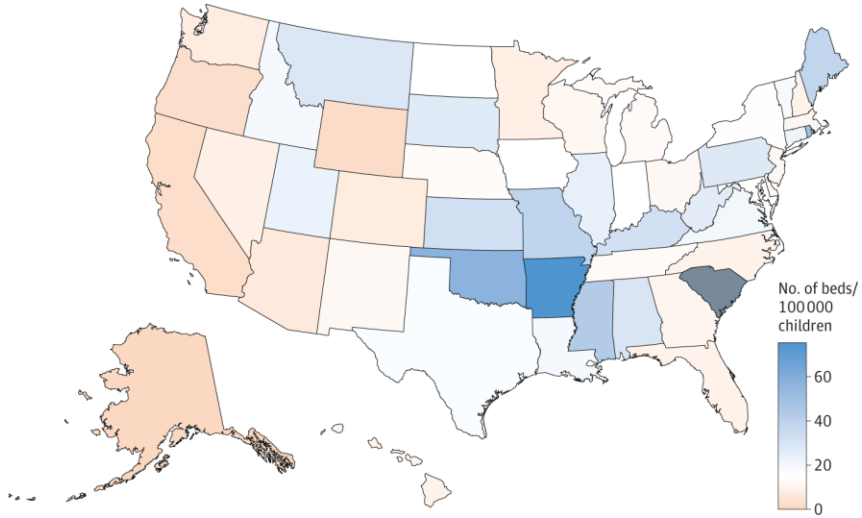


Figure Legend:

Pediatric Inpatient Psychiatric Beds per 100 000 US Children in 2020States in blue have greater than the national median number of beds (>15). States in tan have fewer than the national median number of beds (<15). South Carolina (gray) did not have any hospitals with available bed counts.


Youth Crisis Continuum
SAMHSA
Substance Abuse and Mental Health Services Administration
Self-Defined Crisis
YOUTH
FAMILY
988
SOMEONE TO TALK TO
SOMEONE TO RESPOND
A SAFE PLACE TO BE

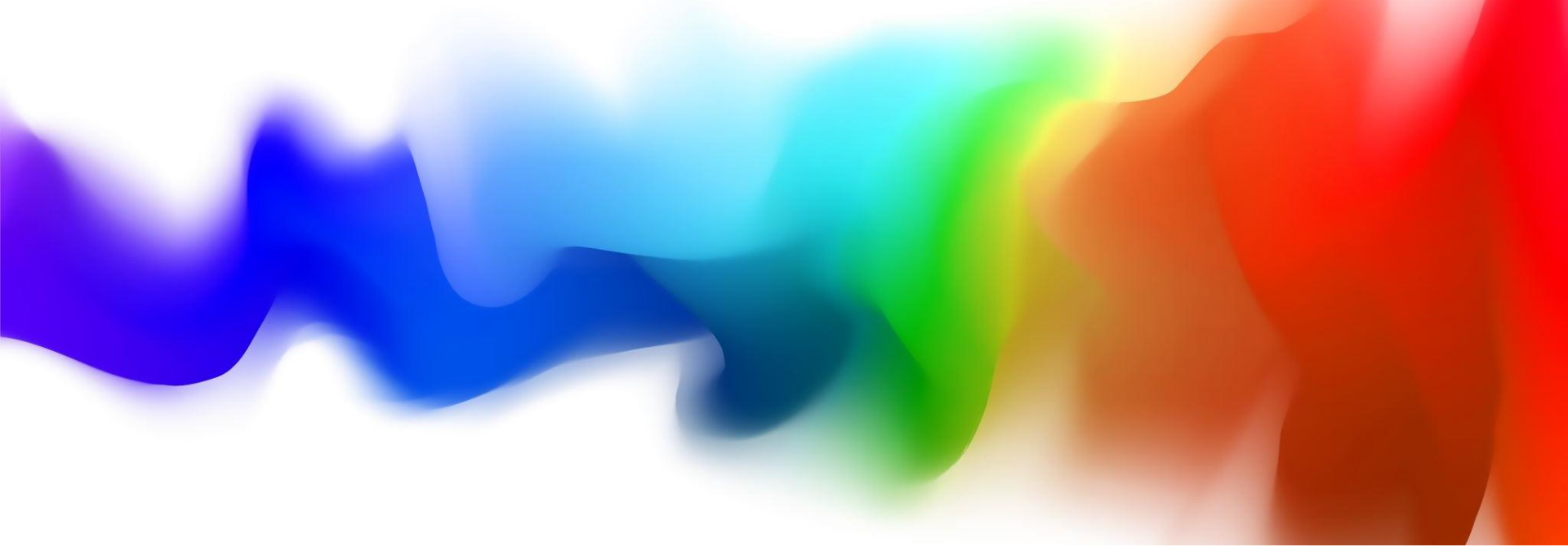
☑ ☑ ☒

Overall System Recommendations

Rebecca Marshall, MD OHSU DAETA team

1. Continue to invest in preventive, early-intervention services
2. Expand and specialize community-based crisis and intensive outpatient services.
3. Implement Regional Crisis stabilization units and systems (see below).
4. Increase residential and inpatient beds (residential expansion in process).
5. Med-psych unit for youth.
6. Specialized intensive residential center and community-based group homes for youth with I/DD and BH needs (combining Behavioral Health Care and Informed behavior management and supports).

OHSU



Emergency Behavioral Health Resources for Children/Adolescents

Regional Child Psychiatric Stabilization Centers

NAMI Oregon Collaborative

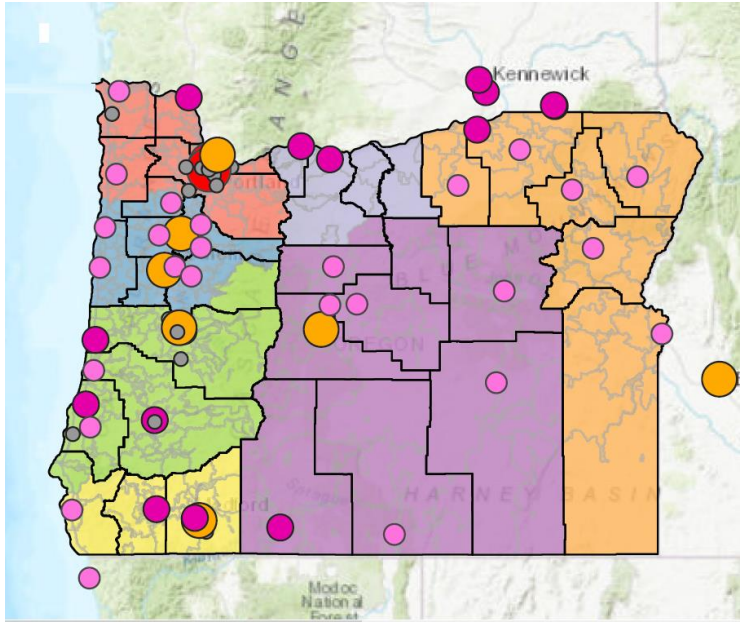
Model developers:

Robin Henderson PhD
Providence Health System

Ajit Jetmalani, MD
OHSU

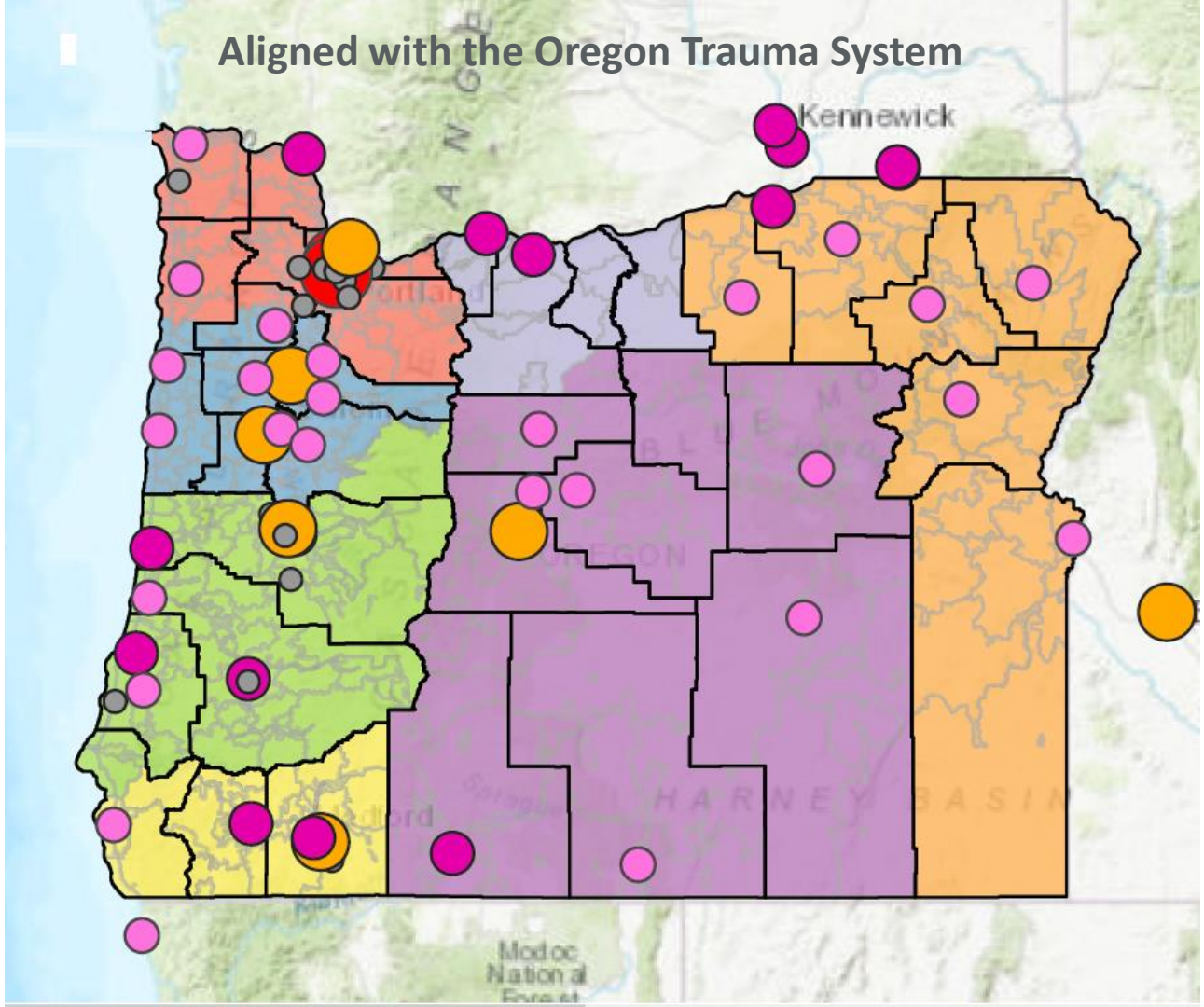
- Association of Community Mental Health Providers
- Care Oregon
- Child & Adolescent Provider Group (CAP)
- Lara Smith & Betsy Jones, Lobbyists extraordinaire
- Lines for Life
- Options
- Oregon Council for Behavioral Health
- Oregon Family Support Network
- Oregon Health Sciences University, Division of Child Psychiatry
- Peace Health
- Providence
- Representative Tawna Sanchez
- Trillium Family Services
- Unity
- Youth Villages
- Diana Bianco, our fearless facilitator
  - Youth and Family Focus Groups

Stabilization Centers ????



Regional Child Psychiatric Stabilization Centers

Aligned with the Oregon Trauma System



1

2

3

4

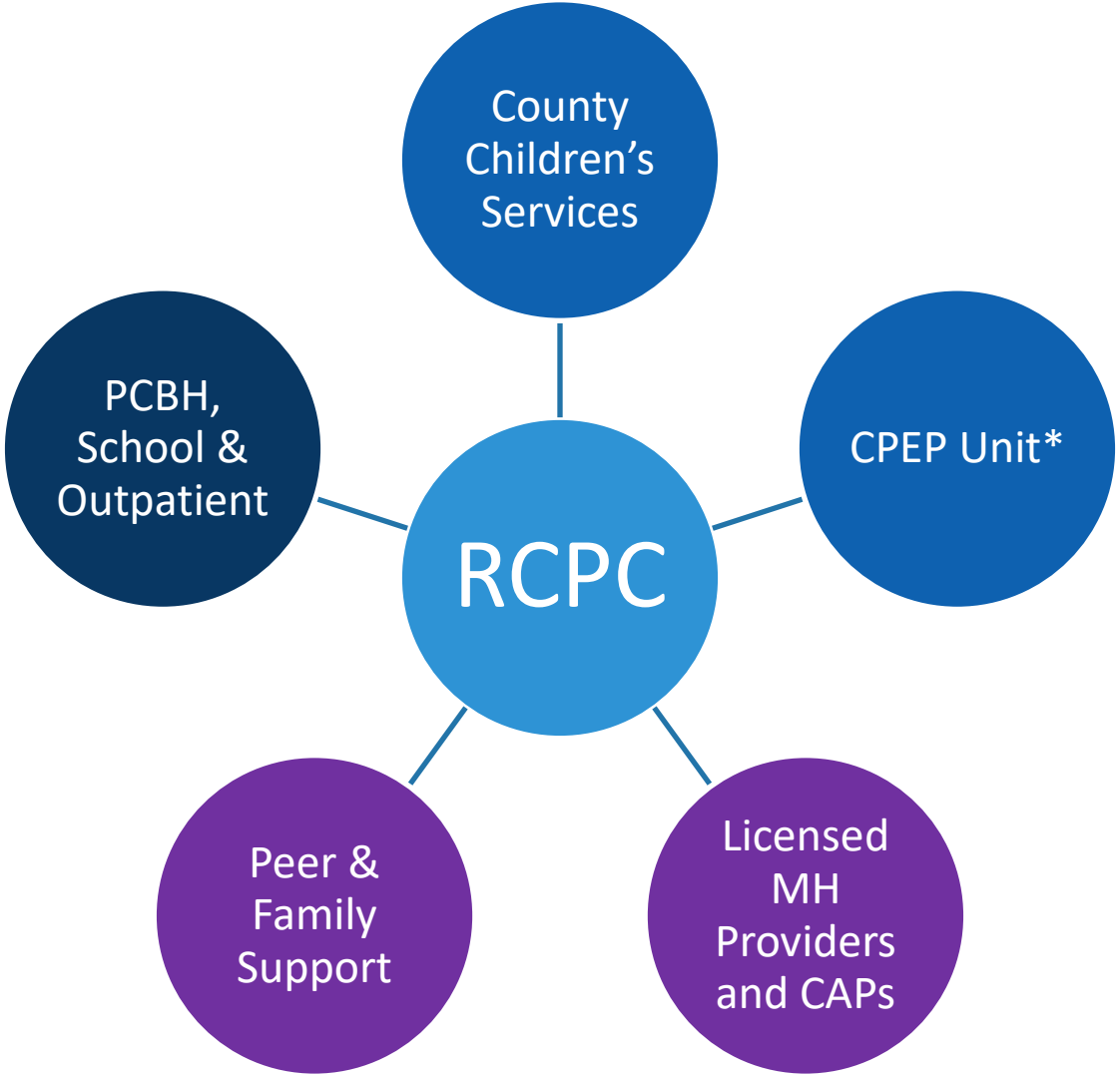
Not Trauma

Proposal for Regional Child Psychiatric Centers

- **Utilizing the existing Physical Trauma regions, create a similar structure for hospitals responding to a mental health crisis**
  - Each region would have a Regional Child Psychiatric Center including a Child/ Adolescent Psychiatric Emergency program (CPEP)
  - Other hospitals within each region would have an MOU with the Regional Child Psychiatric Center for consultation services
- **Regions would identify their individual response plans based on their existing resources, processes, services and supports**
  - County gap analyses identify future funding needs
  - Data gathered supports future investments
- **Hospitals will no longer be separated from the continuum of care**

Needs Assessment

- Determine services and gaps in each County
- Develop response plan for each region based on County level resources
- Hospitals within each defined region will decide who serves as the Regional Child Psychiatric Center


County Children's Services
PCBH, School & Outpatient
CPEP Unit*
RCPC
Peer & Family Support
Licensed MH Providers and CAPs

- **An Emergency Evaluation Area**
  - Over 60% of the youth evaluated can be stabilized, connected with outpatient treatment and discharged that same day.
- **A Pediatric Observation Unit**
  - 24/7 staffing
- **Outpatient Bridging Services**
  - Connection to next level of care
- **Mobile Crisis and Stabilization Services (MRSS)**
  - responding to youth and family where they are

Success is predicated on:

Robust community services CONNECTED to hospital services	• Identified by County needs assessments • Tight coordination leading up to, during, and after hospital services
Peer and family services and supports	• Fully funded to support regional services
Seamless transitions between levels of care	• Biggest risk point happens when youth leave the hospital • Navigation between levels of care
Successful implementation of Call Center/MRSS/CATS/IIBHT	• Embedded community services enable individuals and families to receive care in the least restrictive manner. • Public is socialized to use 988 before the ED

Bringing Quality Improvement to the ED

Behavioral Health Best Practice Committee

11 years of interdisciplinary efforts to address Behavioral Health Care in our Pediatric ED and Hospital.

Zero Suicide and the IMPWR Project

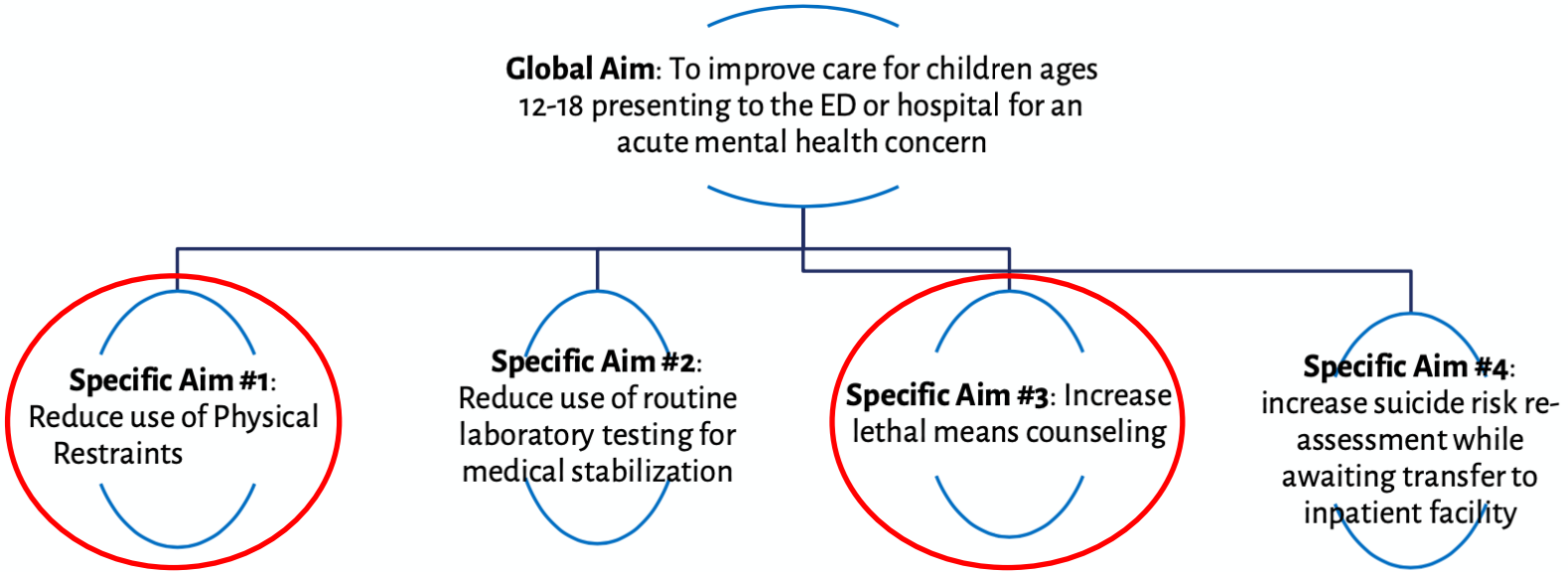
IMPWR

Improving Mental Health Processes, **W**orkflows, and Resources

(AAP initiative)

OHSU

PROJECT AIMS



American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Restraint Reduction Aim

Primary intervention:

Implement use of the *De-escalation Checklist* to promote consistent, trauma-informed early intervention and reduce behavioral escalation.

Checklist Component	Purpose
Agitation Pathway	Tools that aid in classification and guides response intensity
Behavioral Health Support Plan	Preventive, patient centered plan
Early PO Meds	Reduce escalation and restraint use
Debrief	Reinforce learning and safety

Recognizing and Responding to Agitation

Supporting Safety Through Tiered, Trauma-Informed Strategies

Considerations in assessment of agitation	Remember to call for security/support staff as needed
Past History	Review Medical & Behavioral History; Current Medications
Reasons for agitation	Identify the Reason for Behaviors; Identify Triggers & Interests
Environment	Implement Safety & Therapeutic Interventions
Social	Review Caregiver Supports, Consents
Severity	Assess Severity & Plan Response

Severity of Agitation (consider baseline and developmental level)

MILD	MODERATE	SEVERE
Subtle behaviors such as fidgeting, pacing, irritability, fixed state	Raising voice, yelling, non-redirectable, defensive stance	Combative, imminent risk to self or others, speech pressured or rambling

Agitation de-escalation strategies

Verbal Strategies	Language
Ask patient & caregiver what helps.	"What has worked in the past?"
Set expectations and consequences	"If you are having a hard time being safe, we will..."
Offer forced choices	"Would you like to do X or Y?"
Redirection/Distractions	"What else could we do?"
Listening to their perception of the problem	"Tell me if I have this right..."
Build empathy: validate their experience	"What you are going through is difficult
Behavioral Strategies	**Tips**
Use one voice & give simple instructions	Ensure the team is on the same page
Reward cooperation and praise	Catch and reward when displaying expected behaviors
Maintain space & consider body language	At least two arms-length distance. Calm demeanor.
Minimize stimulation	Dim lights, reduce noise. Minimize staff (1-2)
Consider soothing sensory tools	Child life consult. offer food/items of comfort

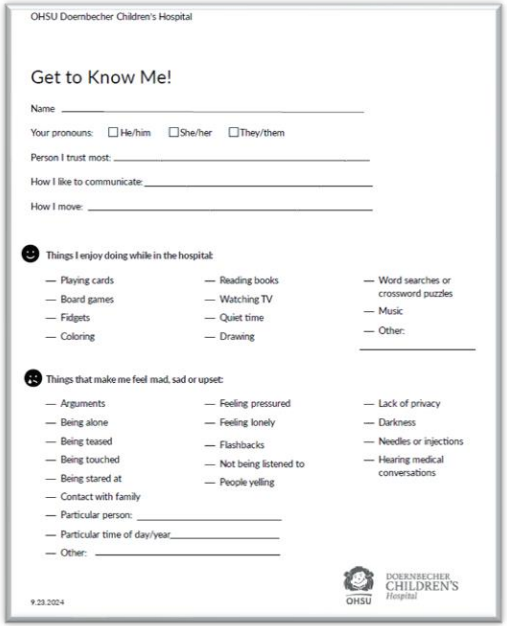
Implementation of “Get to Know Me” Card:
A Trauma-Informed Strategy

Purpose:

To promote partnership with patients and families as the ***experts in their own lives*** and to serve as a preventive and supportive tool during moments of escalation

Overview:

- Brief form completed by patients and/or families
- Captures personal preferences, communication needs, and calming strategies
- Accessible to **all staff** to ensure consistent, person-centered care
- Helps **reduce fatigue** from repeatedly sharing information with multiple team members
- Supports a **trauma-informed culture of collaboration, empathy, and empowerment** across care team



OHSU Doernbecher Children's Hospital

Get to Know Me!

Name _____

Your pronouns: ☐ He/him ☐ She/her ☐ They/them

Person I trust most: _____

How I like to communicate: _____

How I move: _____

Things I enjoy doing while in the hospital:

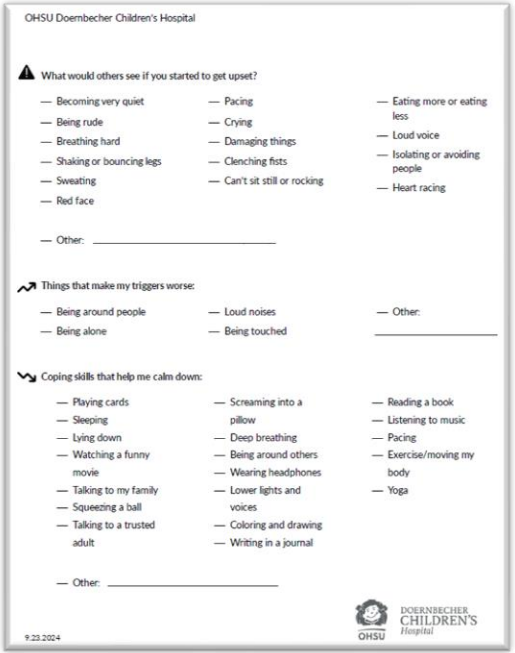
— Playing cards
— Board games
— Fidgets
— Coloring
— Reading books
— Watching TV
— Quiet time
— Drawing
— Word searches or crossword puzzles
— Music
— Other: _____

Things that make me feel mad, sad or upset:

— Arguments
— Being alone
— Being teased
— Being touched
— Being stared at
— Contact with family
— Particular person: _____
— Particular time of day/year _____
— Other: _____
— Feeling pressured
— Feeling lonely
— Flashbacks
— Not being listened to
— People yelling
— Lack of privacy
— Darkness
— Needles or injections
— Hearing medical conversations

9.23.2024

OHSU DOERNBECHER CHILDREN'S Hospital



OHSU Doernbecher Children's Hospital

What would others see if you started to get upset?

— Becoming very quiet
— Being rude
— Breathing hard
— Shaking or bouncing legs
— Sweating
— Red face
— Pacing
— Crying
— Damaging things
— Clenching fists
— Can't sit still or rocking
— Eating more or eating less
— Loud voice
— Isolating or avoiding people
— Heart racing
— Other: _____

Things that make my triggers worse:

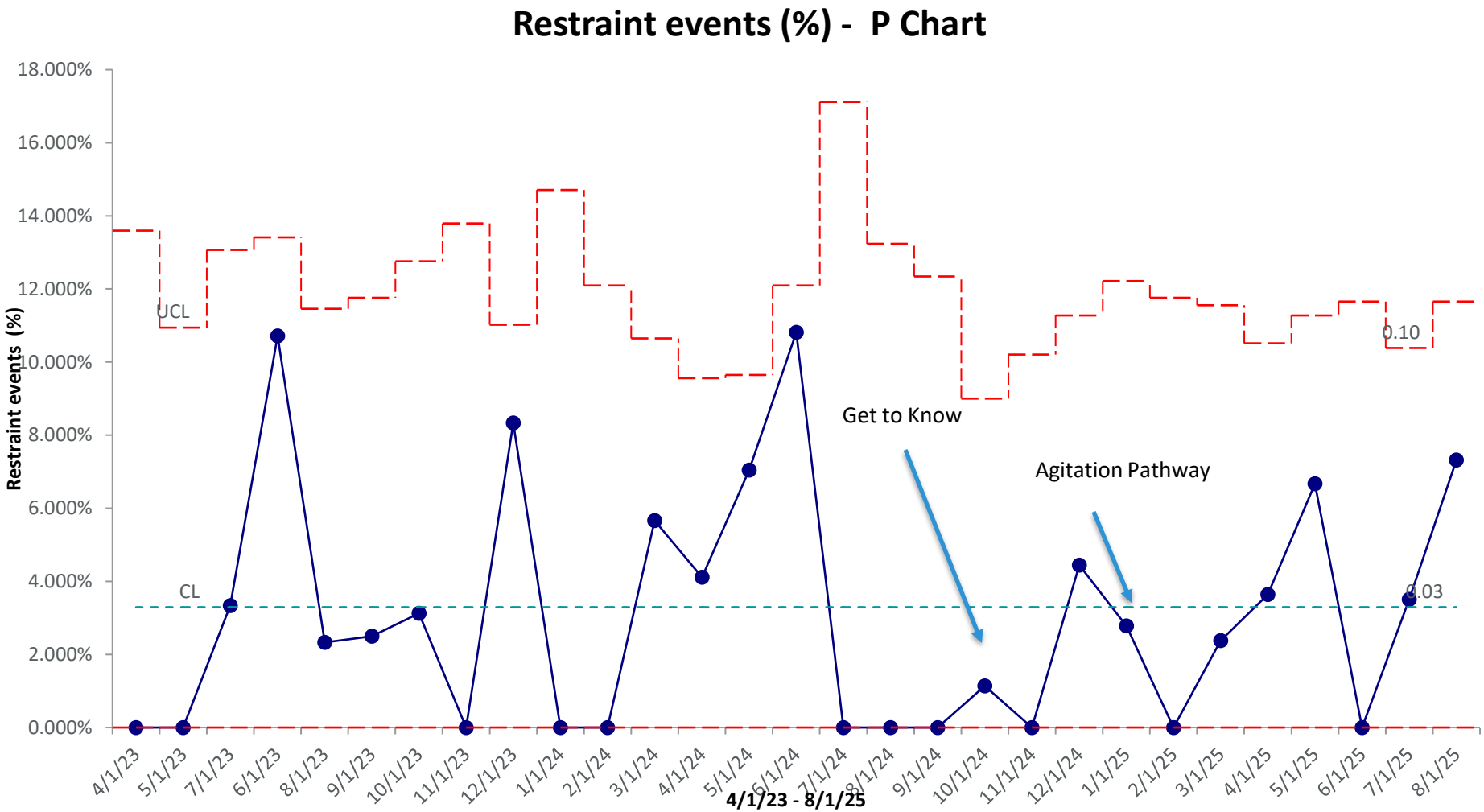
— Being around people
— Being alone
— Loud noises
— Being touched
— Other: _____

Coping skills that help me calm down:

— Playing cards
— Sleeping
— Lying down
— Watching a funny movie
— Talking to my family
— Squeezing a ball
— Talking to a trusted adult
— Screaming into a pillow
— Deep breathing
— Being around others
— Wearing headphones
— Lower lights and voices
— Coloring and drawing
— Writing in a journal
— Reading a book
— Listening to music
— Pacing
— Exercise/moving my body
— Yoga
— Other: _____

9.23.2024

OHSU DOERNBECHER CHILDREN'S Hospital


Restraint events (%) - P Chart
18.000%
16.000%
14.000%
12.000%
10.000%
8.000%
6.000%
4.000%
2.000%
0.000%
Restraint events (%)
UCL
CL
0.10
0.03
Get to Know
Agitation Pathway
4/1/23
5/1/23
7/1/23
6/1/23
8/1/23
9/1/23
10/1/23
11/1/23
12/1/23
1/1/24
2/1/24
3/1/24
4/1/24
5/1/24
6/1/24
7/1/24
8/1/24
9/1/24
10/1/24
11/1/24
12/1/24
1/1/25
2/1/25
3/1/25
4/1/25
5/1/25
6/1/25
7/1/25
8/1/25
4/1/23 - 8/1/25

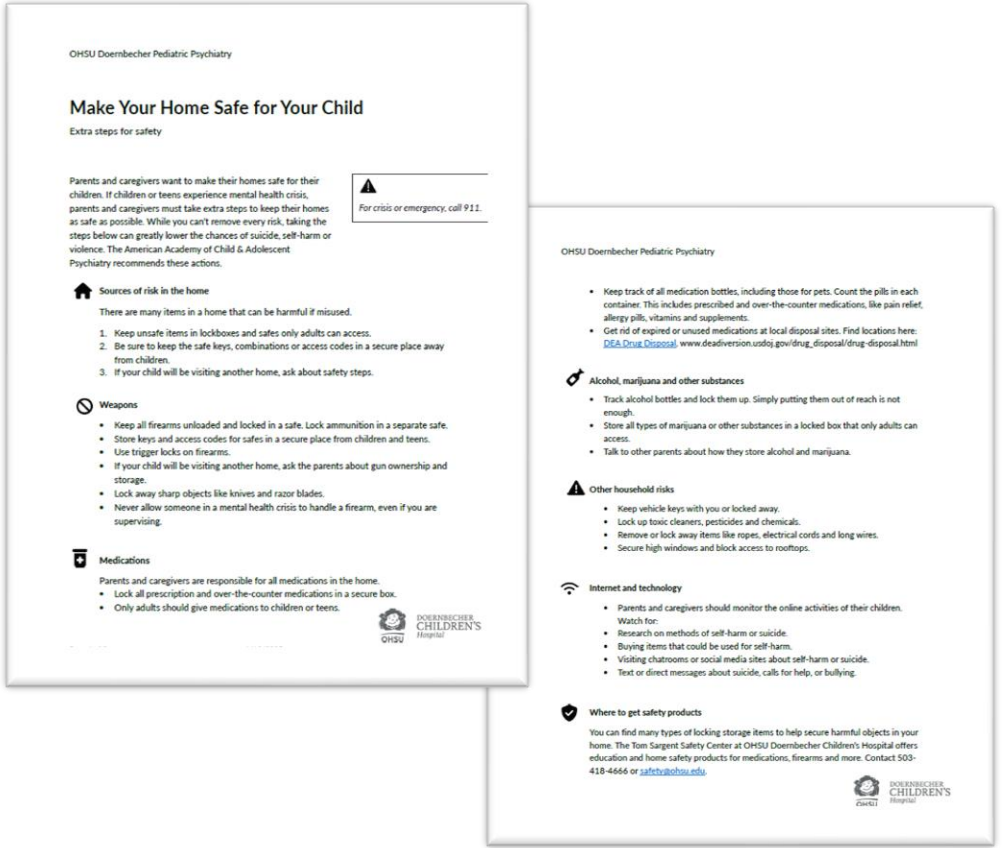
Increasing Lethal Means Aim

Purpose:

Increase consistency and frequency of ***lethal means counseling*** through standardization and family engagement

Implementation Strategies:

- Standard Dotphrase Created:
  - Added to all social work note templates to prompt and document lethal means counseling.
- Educational Handout Developed:
  - Distributed to patients and families to support safe storage and awareness of community resources.



OHSU Doernbecher Pediatric Psychiatry

Make Your Home Safe for Your Child

Extra steps for safety

Parents and caregivers want to make their homes safe for their children. If children or teens experience mental health crisis, parents and caregivers must take extra steps to keep their homes as safe as possible. While you can't remove every risk, taking the steps below can greatly lower the chances of suicide, self-harm or violence. The American Academy of Child & Adolescent Psychiatry recommends these actions.

For crisis or emergency, call 911.

Sources of risk in the home

There are many items in a home that can be harmful if misused.

1. Keep unsafe items in lockboxes and safes only adults can access.
2. Be sure to keep the safe keys, combinations or access codes in a secure place away from children.
3. If your child will be visiting another home, ask about safety steps.

Weapons

- Keep all firearms unloaded and locked in a safe. Lock ammunition in a separate safe.
- Store keys and access codes for safes in a secure place from children and teens.
- Use trigger locks on firearms.
- If your child will be visiting another home, ask the parents about gun ownership and storage.
- Lock away sharp objects like knives and razor blades.
- Never allow someone in a mental health crisis to handle a firearm, even if you are supervising.

Medications

Parents and caregivers are responsible for all medications in the home.

- Lock all prescription and over-the-counter medications in a secure box.
- Only adults should give medications to children or teens.
- Keep track of all medication bottles, including those for pets. Count the pills in each container. This includes prescribed and over-the-counter medications, like pain relief, allergy pills, vitamins and supplements.
- Get rid of expired or unused medications at local disposal sites. Find locations here: DEA Drug Disposal, www.deadiversion.usdoj.gov/drug_disposal/drug-disposal.html

Alcohol, marijuana and other substances

- Track alcohol bottles and lock them up. Simply putting them out of reach is not enough.
- Store all types of marijuana or other substances in a locked box that only adults can access.
- Talk to other parents about how they store alcohol and marijuana.

Other household risks

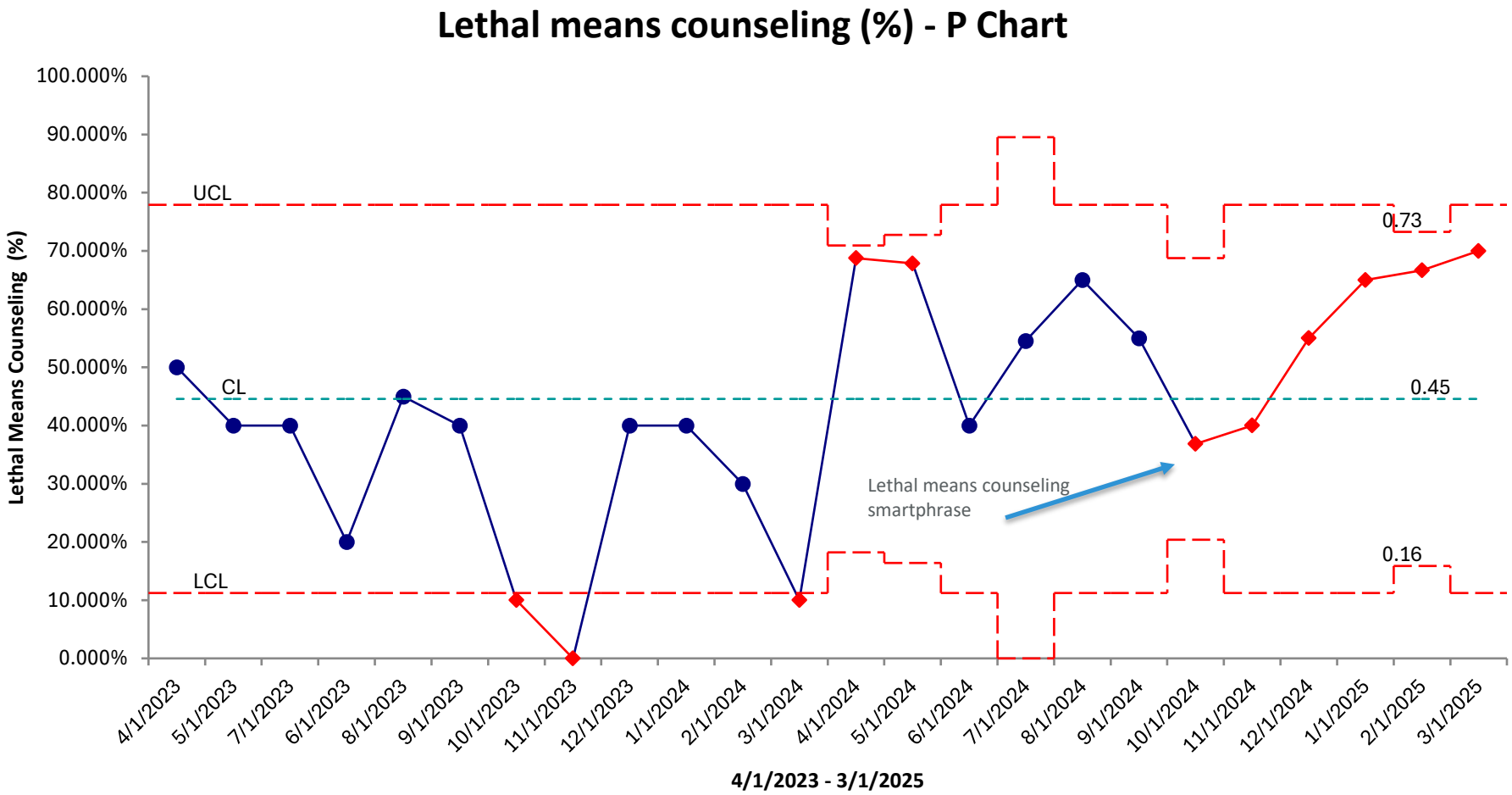
- Keep vehicle keys with you or locked away.
- Lock up toxic cleaners, pesticides and chemicals.
- Remove or lock away items like ropes, electrical cords and long wires.
- Secure high windows and block access to rooftops.

Internet and technology

- Parents and caregivers should monitor the online activities of their children. Watch for:
- Research on methods of self-harm or suicide.
- Buying items that could be used for self-harm.
- Visiting chatrooms or social media sites about self-harm or suicide.
- Text or direct messages about suicide, calls for help, or bullying.

Where to get safety products

You can find many types of locking storage items to help secure harmful objects in your home. The Tom Sargent Safety Center at OHSU Doernbecher Children's Hospital offers education and home safety products for medications, firearms and more. Contact 503-418-4666 or safety@ohsu.edu.


Lethal means counseling (%) - P Chart
100.000%
90.000%
80.000%
70.000%
60.000%
50.000%
40.000%
30.000%
20.000%
10.000%
0.000%
Lethal Means Counseling (%)
UCL
CL
LCL
0.73
0.45
0.16
Lethal means counseling smartphrase
4/1/2023
5/1/2023
7/1/2023
6/1/2023
8/1/2023
9/1/2023
10/1/2023
11/1/2023
12/1/2023
1/1/2024
2/1/2024
3/1/2024
4/1/2024
5/1/2024
6/1/2024
7/1/2024
8/1/2024
9/1/2024
10/1/2024
11/1/2024
12/1/2024
1/1/2025
2/1/2025
3/1/2025
4/1/2023 - 3/1/2025

Other Best Practices in Behavioral Support

Purpose: To promote consistent, trauma-informed approaches that reduce distress and support regulation for patients in behavioral crisis.

- **Establish a Predictable Schedule/Routine** – Helps patients anticipate transitions and reduces anxiety.
- **Use Visual Supports (if appropriate)** – Clarifies expectations and reinforces structure.
- **Partner with Family** – Collaborate with caregivers as experts in the child's needs and preferences.
- **Offer Sensory & Coping Kits** – Provide tools to promote regulation and self-soothing.
- **Incorporate Enriching Activities** – Support engagement, mastery, and positive distraction.
- **Maintain Clear Boundaries** – Communicate limits calmly and consistently.
- **Encourage Creativity & Flexibility** – Adapt interventions to individual needs and developmental level.

References

- Chun, T. H., Mace, S. E., Katz, E. R., American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, & American College of Emergency Physicians, Pediatric Emergency Medicine Committee. (2016). *Evaluation and management of children and adolescents with acute mental health or behavioral problems. Part 1: Common clinical challenges of patients with mental health and/or behavioral emergencies*. *Pediatrics*, *138*(3).
- Dalton, E. M., Herndon, A. C., Cundiff, A., Fuchs, D. C., Hart, S., Hughie, A., Kreth, H. L., Morgan, K., Ried, A., Williams, D. J., & Johnson, D. P. (2021). *Decreasing the use of restraints on children admitted for behavioral health conditions. Pediatrics*, *148*(1)
- CHOC Children's. (2019). *Best practices for hospitalized pediatric patients with autism spectrum disorder* [PDF]. CHOC Children's Hospital.

Thank you

PRP
PEDIATRIC READINESS PROGRAM
SERVING OREGON & SW WASHINGTON

Remember to claim credit for this event!

1. Go to https://cmetracker.net/LHS
2. Click on the claim credit button
3. Log in and claim your credit
4. To claim credit up to 30 days after date of presentation, contact CMERequests@lhs.org for assistance

Scan this QR code with your phone →

For more information visit
www.legacyhealth.org/pedinet