

Telehealth Webinar Series:

Pediatric Behavioral Health Emergencies in the Field

Presented by:

Jeremiah D. Simmons, PhD

Christoph Isbjorn, DO

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Presenters



Jeremiah D. Simmons, PhD

Jeremiah D. Simmons, PhD, (Navajo/Yankton Sioux), is a licensed clinical psychologist and Assistant Professor in the Division of Community Behavioral Health, within the Department of Psychiatry and Behavioral Sciences, at the University of New Mexico Health Sciences Center. Dr. Simmons' clinical, teaching, and research efforts focus on improving behavioral health outcomes for Native American communities, with an emphasis on youth and school-based mental health systems. Dr. Simmons specializes in culturally responsive adaptations of evidence-based practices, integrating community-based participatory approaches to enhance engagement, access, and effectiveness of care. His work spans direct clinical service delivery in tribal communities, supervision and training of interdisciplinary behavioral health providers, and the development of community-informed prevention and intervention models. He has contributed to state and federal initiatives focused on suicide prevention, systems of care development, and behavioral health workforce capacity building. His long-term goal is to advance culturally grounded behavioral health systems that reduce disparities and promote resilience among American Indian and Alaska Native populations.

EMS Content Matter Contributor



Christoph Isbjorn, DO, MPH

Dr. Christoph Isbjorn brings a multidisciplinary background in emergency medicine, public health, psychiatry, and nonprofit leadership. He spent 10 years as an EMT, including 911 ALS ambulance service in Denver and several years in Iraq. He earned his MPH from St. George's University and his DO from Rocky Vista University. He founded Vital Start, creating healthcare pathways for at-risk youth, and served as CEO of House Lucky Bear, supporting migrant women. He is currently completing his psychiatry residency, with interests in trauma prevention and recovery, Child and Adolescent Psychiatry, justice-involved youth, and interpersonal relationships following traumatic experiences.

Training Purpose & Learning Objectives

Purpose of Session:

Review common pediatric behavioral health presentations in prehospital care and practical approaches to assessment, risk stratification, and scene safety. Examine age-appropriate communication, trauma-informed de-escalation, transport decisions, and coordination with emergency departments and behavioral health providers.

Learning Objectives:

1. Identify common pediatric behavioral health presentations and associated risk indicators.
2. Apply age-appropriate, trauma-informed de-escalation and communication techniques.
3. Determine transport considerations and interagency coordination strategies.

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Scope & Shared Roles

- Field priorities are safety, medical stability, calm engagement, focused risk assessment, and a clear handoff.
- Behavioral health responders contribute communication, suicide risk formulation, coping support, and culturally responsive coordination.
- EMS clinicians contribute medical assessment, physiologic monitoring, treatment within protocol, and destination decisions.
- CHAs, CPSWs, BHAs, school responders, and tribal providers work within local scope, policy, supervision, and law.

Pediatric Behavioral Health in EMS

- Behavioral health concerns accounted for 11.3% of 2.74 million pediatric EMS encounters in a national 2019 to 2020 analysis.
- Most patients were adolescents, but younger children and youth with developmental or communication disabilities need adapted approaches.
- Sedating medication and physical restraint were uncommon, which supports early use of environmental and verbal strategies.
- Field presentations may reflect psychiatric illness, substance effects, medical illness, trauma, developmental needs, or several factors at once.

(Wnorowska et al., 2024; Boland et al., 2023)

Case 1

NSSI in School-Based Setting

- Composite case: A 15-year-old is found in a school restroom with several superficial forearm cuts.
- Bleeding is controlled. The student says, "I was trying to calm down. I did not want to die."
- A breakup, online conflict, and poor sleep occurred this week. The student used cannabis last night.
- A counselor is present. A caregiver is 35 minutes away. The nearest pediatric emergency department is 70 miles away.
- Discussion: What must be assessed before deciding whether and where to transport?

NSSI & Suicidal Behavior

- Nonsuicidal self-injury, or NSSI, is intentional damage to body tissue without intent to die.
- A suicide attempt includes at least some intent to die, even when the injury appears medically minor.
- Intent may be mixed, uncertain, or change quickly. Ask about the purpose of the act and what the youth expected would happen.
- NSSI is non-suicidal by definition, but repeated NSSI is associated with later suicidal behavior. Assess both every time.

(Grandclerc et al., 2016; Valencia-Agudo et al., 2018)

Functions of NSSI

- Emotion regulation is the most commonly reported function, including relief from intense distress or numbness.
- Other functions include self-punishment, interrupting dissociation, communicating distress, or changing an interpersonal situation.
- The same youth may report several functions, and the function may change across episodes.
- Ask with curiosity: "What did the injury do for you in that moment?" Avoid labels such as attention-seeking.

(Taylor et al., 2018)

Direct Suicide Questions

- Ask plainly about a wish to die, suicidal thoughts, a plan, current intent, past attempts, and access to the proposed method.
- Whenever feasible, speak with the youth privately, then obtain caregiver or collateral information.
- Asking about suicide does not increase suicidal thoughts or self-harm in available meta-analytic evidence.
- The four-item ASQ has high sensitivity in pediatric emergency settings, but a positive screen requires further assessment.

(Horowitz et al., 2012; Polihronis et al., 2022; NIMH, n.d.)

Field Risk Formulation

- **Current state:** suicidal intent, plan, agitation, psychosis, intoxication, severe hopelessness, or inability to collaborate with safety.
- **History:** prior attempts, recent NSSI, psychiatric care, substance use, violence, trauma exposure, and recent loss or humiliation.
- **Environment:** supervision, access to firearms or medications, caregiver capacity, distance, weather, and reliable follow-up.
- **Protection:** trusted adults, cultural and family connections, reasons for living, willingness to accept help, and an actionable care pathway.
- A checklist supports judgment. No single item determines risk or disposition.

Age-appropriate Communication

- Begin with name, role, and what will happen next. Use one calm speaker whenever possible.
- Use short sentences and one question at a time. Match language to developmental and communication needs.
- Offer limited choices that preserve safety, such as where to sit or which supportive adult remains nearby.
- Validate the emotion without agreeing with unsafe behavior or a delusional belief.
- Tell the youth what information must be shared for safety and who will receive it.

(Gerson et al., 2019; Saidinejad et al., 2024)

De-escalation Sequence

- Reduce noise, crowding, lights, and visible equipment when clinically safe.
- Create physical space, maintain an exit route, and remove bystanders who increase distress.
- Identify triggers, pain, hunger, sensory needs, communication barriers, and preferred calming strategies.
- Use respectful repetition, concrete choices, and time. Avoid arguing, sudden touch, threats, or rapid commands.
- Escalate to medication or restraint only when less restrictive measures cannot maintain safety.

(Gerson et al., 2019; Foster et al., 2024)

Brief Coping Skills

- Paced or box breathing: invite a slow, comfortable rhythm. Stop if breath holding increases panic, dizziness, or distress.
- 5-4-3-2-1 grounding: identify five things seen, four felt, three heard, two smelled, and one tasted or appreciated.
- Use sensory grounding only with consent and adapt it for disability, trauma history, culture, and the environment.
- These skills may lower arousal. They do not replace suicide assessment, medical evaluation, or transport when indicated.
- DBT for adolescents reduces self-harm and suicidal ideation, although evidence for a single field skill is limited.

(Kothgassner et al., 2021)

Case 1

Next Steps

- Treat the wound and assess for other injuries, ingestion, intoxication, or medical instability.
 - Call Poison Control if known ingestion
 - 1-800-222-1222
- Ask directly about suicide, prior attempts, NSSI pattern, access to means, current intent, and ability to stay safe.
- Obtain collateral information and identify the adult who can assume continuous supervision.
- Follow local protocol for transport or urgent evaluation. NSSI alone does not establish either transport or non-transport.
- Provide a concise handoff that separates reported intent, observed behavior, medical findings, and responder judgment.

Case 2

Cannabis and Psychosis

- Composite case: A 16-year-old becomes frightened and paranoid after repeated high-potency cannabis vaping.
- The youth has slept about three hours across two nights and says people outside are monitoring the home.
- A caregiver reports recent trauma and an uncle with schizophrenia. The youth is pacing and refuses transport.
- Discussion: Which findings suggest intoxication, delirium, mania, trauma, or a first psychotic episode?
- What would make this encounter medically or behaviorally unsafe to manage in place?

Cannabis and Psychosis Evidence

- Adolescent cannabis use was associated with later psychosis in a meta-analysis of 18 studies, with pooled relative risk 1.71.
- Heavier use shows a dose-response relationship. The heaviest-use group had about four times the odds of psychotic outcomes compared with non-users.
- Cannabis-associated psychosis can resolve, but a meta-analysis found substantial later transition to schizophrenia after cannabis-induced psychosis.
- Association does not mean certainty. Most youth who use cannabis do not develop psychosis.

(Kiburi et al., 2021; Marconi et al., 2016; Murrie et al., 2020)

Psychosis Risk Modifiers

- Higher concern: younger onset of use, frequent use, high-potency products, and use of several substances.
- Childhood trauma and recent adversity may add vulnerability, but they do not determine diagnosis.
- Family history of schizophrenia-spectrum or bipolar disorder increases concern and should prompt careful follow-up.
- Clarify abbreviations. Bipolar disorder and borderline personality disorder are not interchangeable when a family reports "BPD."
- Avoid causal certainty. Assess the whole pattern, including sleep, mood, functioning, medical findings, and time course.

(Kiburi et al., 2021; Varese et al., 2012; Kendler et al., 2024)

Field Response to Psychosis

- Reduce stimulation and use one primary communicator. Ask permission before moving closer or touching.
- Do not argue about hallucinations or delusions. Acknowledge the fear and focus on immediate safety.
- Use concrete language, extra processing time, and simple choices. Avoid rapid questioning.
- **Ask about content of hallucinations**, screen for commands, suicidal or violent thoughts, access to weapons, and the ability to resist unsafe commands.
- Treat first-episode psychosis, severe functional change, or inability to care for basic needs as requiring urgent evaluation.

(Gerson et al., 2019; Saidinejad et al., 2024)

Medical and Toxicologic Assessment

- Complete primary and secondary surveys. Be sure to assess vitals, pupil size and reaction to light, blood glucose, orientation, and the 3F's that effect the brain: Force (Trauma), Flow (Cardiovascular), Fuel (Oxygen/Glucose)
- Look for fluctuating attention, abnormal vital signs, fever, hypoxia, seizure, head trauma, severe headache, rigidity, or focal findings.
- Ask what was used, how much, when, by which route, and whether products could contain other substances.
- Consider intoxication, withdrawal, medication effects, endocrine or metabolic illness, infection, neurologic illness, and delirium.
- Assessment and de-escalation occur together. Do not assume a psychiatric cause before medical threats are addressed.

(Gottlieb et al., 2018; Gerson et al., 2019)

Transport and Destination

- Urgent transport is indicated for medical instability, significant injury or ingestion, current suicidal intent, severe agitation, first-episode psychosis, or inability to maintain safety.
- Caregiver availability, means restriction, distance, weather, and reliable follow-up affect the safety of any non-transport pathway.
- Use a pediatric-capable emergency department, if available, when medical evaluation is needed or eligibility for a psychiatric destination is uncertain. However, a non-pediatric specific emergency room is an appropriate alternative if required.
- Direct psychiatric transport can be safe when an approved protocol defines eligibility, exclusions, and re-transport procedures.
- Use local policy, medical control, and applicable tribal, state, and federal requirements.

(Glomb et al., 2023; NIMH, n.d.)

Medication and Restraint Guardrails

- Use medication only for a clinical indication and according to age, weight, likely cause, local protocol, and medical direction.
 - What agitation medications are you using?
 - Paradoxical reactions (1%-2%) = Stop the drug
- Offer oral first vs. IM. Aim for calm and safe assessment, not punishment or unnecessary deep sedation.
- Physical restraint is a last resort. Use the least restrictive method for the shortest possible time.
- Never transport prone or use a position that compromises the airway, ventilation, circulation, head, or neck.
- Any medication or restraint requires continuous observation, physiologic monitoring, frequent reassessment, and detailed documentation.

(Kupas et al., 2021; Gerson et al., 2019)

Tribal and Reservation Contexts

- Tribal Nations and communities are distinct. Ask what local practices, roles, language, and supports the youth and family want involved.
- Honor tribal sovereignty and local response pathways. Coordinate with tribal programs rather than assuming an outside pathway fits.
- Historical and ongoing harms can shape trust. Explain each action, request consent when possible, and avoid unnecessary law-enforcement presence.
- Protect privacy in small communities. Share only what is necessary for safety and continuity within applicable policy and law.
- Offer traditional or cultural supports when requested and available. Do not assume that every family wants the same supports.

(Gone & Trimble, 2012; Allen et al., 2022; Grande et al., 2022)

Strengths and Protective Factors

- Family, peer, school, community, and cultural connectedness are documented protective domains for many AI/AN youth.
- Cultural identity and continuity can support resilience when they are defined and led by the community.
- Ask, "Who helps you remember who you are and what matters to you?"
- Activate strengths in the immediate plan: a named adult, a safe place, transportation, follow-up, and culturally meaningful support.
- The intervention evidence remains limited, but culture-centered community engagement is a consistent feature of promising programs.

(Henson et al., 2017; Allen et al., 2022; Grande et al., 2022)

Rural and Frontier Operations

- Long distance, weather, limited staffing, and lack of pediatric behavioral health destinations change the risk of every plan.
- IHS and tribal EMS agencies report pediatric training and medical-direction gaps similar to other rural systems.
- Rural EMS behavioral encounters can require more time where child psychiatry and hospital resources are limited.
- Plan before the call: eligibility criteria, receiving contacts, teleconsultation, backup transport, and who owns follow-up.
- A warm handoff may include EMS, the receiving facility, caregiver, school or CPSW, and a tribal or community crisis contact.

(Genovesi et al., 2014; Fische & Lynch, 2019)

Interagency Coordination

- Identify one operational lead and one primary communicator for the youth.
- State what each agency needs to know, what each can do, and who has authority for medical and safety decisions.
- Confirm the destination before departure when feasible, especially during long-distance transport. Attempt to contact family to inform where the child will go.
- Use closed-loop communication for supervision, belongings, medications, caregiver travel, and follow-up.
- Avoid parallel plans that leave the youth or family repeating the same story to several teams.

Structured Handoff

- ID statement: age/sex, past medical hx, past psych hx, current meds, medication allergies, substance use hx, and reason for transport or consultation.
- Subjective of current situation: Why was 911 called and by who? was this an attempted suicide/violence/NSSI, any hallucinations/delusions, recent stressors/intoxication, trauma?
- Objective: Vital signs, physical assessment, Mental Status Exam
- Assessment/Plan: Primary diagnoses, interventions/response, transport plan?
 - Parents/guardians aware and how to contact?

Integrated Reservation Case

- Composite case: A 14-year-old at home reports cutting, hears a threatening voice, and used an unknown THC concentrate.
- The youth is calm now, denies wanting to die, and asks to speak with an aunt and a traditional helper.
- The caregiver reports a firearm in the home. The nearest pediatric-capable emergency department is 95 minutes away.
- Decision points: intoxication, medical threats, suicide and violence risk, means safety, preferred supports, transport, destination, and handoff.
- A calm moment creates an assessment opportunity. It does not erase the earlier risk picture.

Documentation that Supports Care

- Use the youth's own words for suicidal intent, NSSI function, hallucinations, threats, and requests for help.
- Separate observed behavior from interpretation. Describe actions, speech, orientation, attention, and change over time.
- Record collateral sources, access to means, supervision capacity, and barriers created by distance or weather.
- Document alternatives attempted before medication or restraint, plus monitoring and reassessment afterward.
- Record consultation, receiving acceptance, caregiver communication, and the exact transfer of responsibility.

Field Response Algorithm

- BSI Scene Safety: Weapons contained? Safe environment? Patient showing aggression? Gloves at a minimum.
- Medical stability: ABCs, vital signs, glucose when available, injury, ingestion, and delirium red flags.
- Calm engagement: reduce stimulation, one speaker, caregiver input, developmentally matched language, and real choices.
- Focused risk assessment: suicide, NSSI function, psychosis, violence, substance use, prior history, means, and current supports.
- Disposition: apply local protocol, medical control, caregiver capacity, distance, destination capability, and cultural preferences.
- Handoff and continuity: objective documentation, closed-loop transfer, with parent/guardian contact information

Key Takeaways

- NSSI is defined by absent suicidal intent, but it still requires direct suicide assessment and thoughtful follow-up.
- Cannabis can precipitate acute psychotic symptoms and is associated with later psychosis, especially with earlier and heavier use.
- Calm, developmentally appropriate communication and environmental modification are first-line responses to agitation.
- Medical causes, intoxication, and delirium remain part of the differential throughout the encounter.
- Culturally responsive care respects tribal sovereignty, local pathways, family and community strengths, and the youth's preferences.

Questions and Discussion

Thank you for the work you do with youth, families, and communities.

References

- Boland, L. L., Anderson, M. K., Powell, J. R., Patock, M. T., & Panchal, A. R. (2023). EMS responses for pediatric behavioral health emergencies in the United States. *Prehospital and Disaster Medicine*, 38(6), 784-791. doi:10.1017/S1049023X2300657X
- Fishe, J. N., & Lynch, S. (2019). Pediatric behavioral health-related EMS encounters: A statewide analysis. *Prehospital Emergency Care*, 23(5), 654-662. doi:10.1080/10903127.2019.1566423
- Wnorowska, J. H., Naik, V., Ramgopal, S., Watkins, K., & Hoffmann, J. A. (2024). Characteristics of pediatric behavioral health emergencies in the prehospital setting. *Academic Emergency Medicine*, 31(2), 129-139. doi:10.1111/acem.14833
- Glomb, N. W., Trivedi, T., Grupp-Phelan, J., Schriger, D. L., & Sporer, K. (2023). Safety of a prehospital EMS protocol for an alternative destination for pediatric behavioral emergencies. *JACEP Open*, 4, e12930. doi:10.1002/emp2.12930
- Genovesi, A. L., Hastings, B., Edgerton, E. A., & Olson, L. M. (2014). Pediatric emergency care capabilities of IHS EMS agencies in rural and frontier areas. *Rural and Remote Health*, 14(2), 2688. doi:10.22605/RRH2688
- Gerson, R., Malas, N., Feuer, V., Silver, G. H., Prasad, R., & Mroczkowski, M. M. (2019). Best practices for evaluation and treatment of agitated children and adolescents in the emergency department. *Western Journal of Emergency Medicine*, 20(2), 409-418. doi:10.5811/westjem.2019.1.41344

References

- Saidinejad, M., Foster, A. A., Santillanes, G., et al. (2024). Strategies for optimal management of pediatric acute agitation in emergency settings. JACEP Open, 5(4), e13255. doi:10.1002/emp2.13255
- Foster, A. A., Saidinejad, M., & Li, J. (2024). Approach to acute agitation in the pediatric emergency department. Current Opinion in Pediatrics, 36(3), 245-250. doi:10.1097/MOP.0000000000001337
- Gottlieb, M., Long, B., & Koyfman, A. (2018). Approach to the agitated emergency department patient. Journal of Emergency Medicine, 54(4), 447-457. doi:10.1016/j.jemermed.2017.12.049
- Kupas, D. F., Wydro, G. C., Tan, D. K., Kamin, R., Harrell, A. J., IV, & Wang, A. (2021). Clinical care and restraint of agitated or combative patients by EMS practitioners. Prehospital Emergency Care, 25(5), 721-723. doi:10.1080/10903127.2021.1917736
- Horowitz, L. M., Bridge, J. A., Teach, S. J., et al. (2012). Ask Suicide-Screening Questions: A brief instrument for the pediatric emergency department. Archives of Pediatrics & Adolescent Medicine, 166(12), 1170-1176. doi:10.1001/archpediatrics.2012.1276
- National Institute of Mental Health. (n.d.). Youth ASQ Toolkit.

References

- Polihronis, C., Cloutier, P., Kaur, J., Skinner, R., & Cappelli, M. (2022). What's the harm in asking? Archives of Suicide Research, 26(2), 325-347. doi:10.1080/13811118.2020.1793857
- Grandclerc, S., De Labrouhe, D., Spodenkiewicz, M., Lachal, J., & Moro, M. R. (2016). Relations between nonsuicidal self-injury and suicidal behavior in adolescence: A systematic review. PLOS ONE, 11(4), e0153760. doi:10.1371/journal.pone.0153760
- Valencia-Agudo, F., Corbet Burcher, G., Ezpeleta, L., & Kramer, T. (2018). Nonsuicidal self-injury in community adolescents: A systematic review of prospective predictors. Journal of Adolescence, 65, 25-38. doi:10.1016/j.adolescence.2018.02.012
- Taylor, P. J., Jomar, K., Dhingra, K., Forrester, R., Shahmalak, U., & Dickson, J. M. (2018). A meta-analysis of the prevalence of different functions of non-suicidal self-injury. Journal of Affective Disorders, 227, 759-769. doi:10.1016/j.jad.2017.11.073
- Kothgassner, O. D., Goreis, A., Robinson, K., Huscsava, M. M., Schmahl, C., & Plener, P. L. (2021). Efficacy of dialectical behavior therapy for adolescent self-harm and suicidal ideation. Psychological Medicine, 51(7), 1057-1067. doi:10.1017/S0033291721001355
- Kiburi, S. K., Molebatsi, K., Ntlantsana, V., & Lynskey, M. T. (2021). Cannabis use in adolescence and risk of psychosis: A systematic review and meta-analysis. Substance Abuse, 42(4), 527-542. doi:10.1080/08897077.2021.1876200

References

- Marconi, A., Di Forti, M., Lewis, C. M., Murray, R. M., & Vassos, E. (2016). Meta-analysis of the association between the level of cannabis use and risk of psychosis. *Schizophrenia Bulletin*, 42(5), 1262-1269. doi:10.1093/schbul/sbw003
- Murrie, B., Lappin, J., Large, M., & Sara, G. (2020). Transition of substance-induced, brief, and atypical psychoses to schizophrenia. *Schizophrenia Bulletin*, 46(3), 505-516. doi:10.1093/schbul/sbz102
- Varese, F., Smeets, F., Drukker, M., et al. (2012). Childhood adversities increase the risk of psychosis: A meta-analysis. *Schizophrenia Bulletin*, 38(4), 661-671. doi:10.1093/schbul/sbs050
- Kendler, K. S., Abrahamsson, L., Sundquist, J., & Sundquist, K. (2024). The nature of the familial risk for psychosis in bipolar disorder. *Schizophrenia Bulletin*, 50(1), 157-165. doi:10.1093/schbul/sbad097
- Henson, M., Sabo, S., Trujillo, A., & Teufel-Shone, N. (2017). Identifying protective factors to promote health in American Indian and Alaska Native adolescents. *Journal of Primary Prevention*, 38(1-2), 5-26. doi:10.1007/s10935-016-0455-2
- Allen, J., Wexler, L., & Rasmus, S. (2022). Protective factors as a unifying framework for culturally responsive AI and AN suicide prevention. *Prevention Science*, 23(1), 59-72. doi:10.1007/s11121-021-01265-0

References

- Grande, A. J., Elia, C., Peixoto, C., et al. (2022). Mental health interventions for suicide prevention among Indigenous adolescents: A systematic review. *Sao Paulo Medical Journal*, 140(3), 486-498. doi:10.1590/1516-3180.2021.0292.R1.22102021
- Gone, J. P., & Trimble, J. E. (2012). American Indian and Alaska Native mental health: Diverse perspectives on enduring disparities. *Annual Review of Clinical Psychology*, 8, 131-160. doi:10.1146/annurev-clinpsy-032511-143127