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From Crisis to Care: Innovative Care Models for Child and Adolescent Psychiatry

Integrating technology and partnerships to enhance child and adolescent psychiatry support

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Introduction

From Crisis to Care: Innovative Care Models for Child and Adolescent Psychiatry

Integrating technology and partnerships to enhance child and adolescent psychiatry support

The demand for child and adolescent behavioral health services is reaching critical levels, driven by increasing rates of anxiety, depression and behavioral challenges among younger populations. Meanwhile, the nationwide shortage of child and adolescent psychiatrists presents a significant barrier to timely, developmentally appropriate care. Health systems are under growing pressure to close these access gaps and ensure comprehensive support for children, adolescents and their families. This Knowledge Exchange e-book highlights how health care leaders are tackling youth behavioral health access challenges through virtual care and strategic partnerships to improve outcomes and build sustainable systems.

8 strategies to expand and strengthen behavioral health services for children and teens

1 | **Expand behavioral health access by integrating services into primary care and schools**, embedding clinicians across pediatric practices, campuses, mobile crisis units and virtual platforms. Equip school counselors, teachers and providers to identify early signs and refer promptly, while leveraging collaborative care models to extend psychiatric expertise through supervision and consultation.

2 | **Deploy telepsychiatry to bridge care gaps in rural and underserved areas**, supported by 24/7 tele-assessment services that streamline emergency department (ED) triage and reduce unnecessary admissions. Offer flexible scheduling, including evenings and weekends, and design child-friendly platforms that actively engage parents and other caregivers.

3 | **Mobilize crisis response and community collaboration.** Activate crisis stabilization units and mobile response teams to deliver timely care. Build partnerships with shelters, juvenile justice centers and community organizations for a coordinated outreach. Use tablets and virtual platforms to conduct rapid assessments and connect families to the appropriate support.

4 | **Streamline diagnostic and evaluation pathways.** Develop fast-track protocols for psychiatric, substance use and attention-deficit/hyperactivity disorder screenings. Advocate for insurance coverage of psychological testing and reduce reliance on cash-only services. Centralize intake and triage to reduce wait times and improve throughput.

5 | **Build and sustain a specialized workforce.** Partner with academic institutions and telepsychiatry organizations to train providers in pediatric psychiatry, psychology, counseling, social work and telehealth. Leverage programs like the National Health Service Corps and graduate medical education to offer incentives for clinicians serving high-need areas and populations with complex needs. Support ongoing professional development to strengthen clinical expertise and retention.

6 | **Strengthen care coordination and data sharing.** Implement shared electronic health record systems and artificial intelligence tools to improve communication and documentation across care teams. Facilitate regular case conferences among pediatricians, psychiatrists, therapists and educators. Track outcomes to identify gaps and continually improve service delivery.

7 | **Design financially viable models.** Quantify cost savings from reduced ED admissions and centralized care. Use philanthropic and grant funding to pilot programs and demonstrate return on investment. Advocate for sustainable reimbursement models that support integrated behavioral health.

8 | **Drive public awareness and policy change.** Share patient and family stories to build empathy and support. Engage with state policymakers to strengthen Medicaid, broaden coverage and improve post-18 care transitions. Promote behavioral health as essential to youth well-being.

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MODERATOR SUZANNA HOPPSZALLERN *(American Hospital Association):* **Access to child/adolescent behavioral health services remains one of the biggest care gaps in the country. How is your organization approaching these needs, and where do you still experience challenges?**

JESSELINA CURRY *(Luminis Health):* This is a real issue we're all facing; over the past year and a half, we've approached it in two key ways. First, we opened a behavioral health urgent care facility to provide timely support, especially for students who need to see someone before returning to the classroom. We've found that this model helps us meet kids where they are, in the moment they need it most. Second, we've placed clinicians directly in high schools. Through collaboration with county partners and a grant initiative, we've been able to work alongside school counselors to identify and support students in need.

Initially, our goal for the urgent care facility was to operate seven days a week but staffing and logistics made that difficult. Fortunately, this year we're on track to achieve that goal, including after-school and weekend hours. We know that kids are often the gateway to reaching families, so we're hopeful that by expanding access, we'll be able to support both students and their families more effectively.

MICHAEL JOHNSON *(Bethany Children's Health Center):* We're a pediatric specialty health center focused on caring for children with medical complexity and rehabilitation needs. Our inpatient program is uniquely positioned in the post-acute care space, offering a broad range of services. Many of our patients also face behavioral health challenges, often stemming from trauma or coexisting conditions. For years, we've provided inpatient behavioral health consultation services in psychiatry, psychology, neuropsychology and social services. Recently, we've set up our own dedicated team. We now have a physician assistant, working in child psychiatry, a neuropsychologist and a clinical psychologist, and we've expanded into outpatient care.

Demand was immediate. Internal referrals from our primary care, rehabilitation, neurology and newly launched medical genetics services quickly filled our behavioral health slots. We don't accept external referrals because we're already booked out months in advance.

To better serve our complex patient base, we're exploring integrated behavioral health and primary care models, and looking into support from the AIMS Center at the University of Washington, which offers consultation and training to help clinics implement this approach.

REBECCA CHICKEY *(American Hospital Association):* Michael, I can connect you with Dr. Jürgen Unützer, founder of the AIMS Center and international expert on innovative models of care that integrate behavioral health and physical health treatment. We did a podcast with a rural hospital CEO who shared how instrumental the AIMS Center's guidance, support and tele-access were in their efforts to integrate physical and behavioral health.

BARBARA WALCZYK JOERS *(Gillette Children's Specialty Healthcare):* I'm heartened to see growing recognition that children deserve dedicated behavioral health support. For our population, which includes children with such complex and rare conditions as musculoskeletal and neurological disorders, there has long been a harmful assumption that if a child can't speak or move,

BARBARA WALCZYK JOERS | GILLETTE CHILDREN'S SPECIALTY HEALTHCARE

// Our population, which includes children with such complex and rare conditions as musculoskeletal and neurological disorders, there has long been a harmful assumption that if a child can't speak or move, they must not feel pain or distress. But we know that's not true. Depression rates are high, especially as these children grow and undergo interventions. //

they must not feel pain or distress. But we know that's not true. Depression rates are high, especially as these children grow and undergo interventions.

One story that stays with us is of a child who underwent corrective surgery, Afterward, she wished she hadn't, because before the surgery her physical challenges were visible and understood. After surgery, she appeared simply awkward, and the bullying intensified. That's why we've worked to embed psychological safety and psychiatric care into our complex pediatric and child and family services programs. In our pain and palliative care program, psychiatry plays a key role in identifying and responding to pain triggers, whether physical or emotional, with immediate intervention.

We're committed to integrating behavioral health into our patients' care streams, not treating it as a separate silo. Yes, we face long wait times and workforce shortages like everyone else, but we're collaborating with community programs, schools and expanding virtual care to meet the need. Our goal is to embed support into the natural progression of each child's care journey.

THOMAS SAGGIO *(St. Louis Children's Hospital):* Over the last 10 years, our facility has seen a dramatic rise in behavioral health visits to the emergency department (ED), from roughly 400 annually to more than 2,000, with numbers continuing to grow each year. In response, we've taken a multipronged approach to meet the need.

We established a small acute care unit and partnered with KVC Health Systems to build a 77-bed behavioral health facility, which broke ground in April. In the meantime, we've enhanced ED services by integrating behavioral health advanced practice nurses who assess patients, initiate treatment immediately and discharge them to appropriate levels of care. Historically, we had no dedicated space and five years ago, 60% of these kids were admitted to medical units. Last year, that number dropped to 10%.

To further improve safety, we've retrofitted key rooms in our medical units to be behaviorally safe. We also launched a 24/7 tele-assessment system across BJC Health System, allowing remote evaluations, placement support and referrals when on-site capacity is limited.

Beyond the hospital, we're embedding counselors in schools throughout the community to address behavioral health needs proactively. It's a significant challenge in our region and we're committed to a comprehensive, integrated response.

WANDA FIGUEROA-PERALTA *(RiverValley Behavioral Health Hospital):* We're one of three psychiatric hospitals serving the entire commonwealth, specializing in pediatric psychiatry as a stand-alone facility. With 80 beds, we face the same challenges as others, especially recruiting child psychiatrists, which can feel harder than winning the lottery. Most of our referrals come directly from families or the Department of Community Based Services (DCBS), and we coordinate closely with local hospitals.

Last year, we opened a high-acuity unit for youth involved in the juvenile justice system, thanks to the support of state leadership. These are some of the most complex and intensive cases, requiring one-on-one care and significant resources. The unit has already made a meaningful impact, but many of these young people are wards of the state, and once they turn 18, they have almost nowhere to go. It becomes a revolv-

TOM MILAM | IRIS TELEHEALTH

// We started in community mental health and expanded into integrated care with pediatricians and family doctors. Today, we offer acute care support, telerounding for inpatient units, and 24/7 ED consults, often seeing patients within an hour to begin treatment and avoid unnecessary admissions. We also support post-acute transitions, addressing therapy, medication, housing and school needs. //

KALENA JONES | BAPTIST HEALTH

// We're beginning to build a stronger pediatric behavioral health focus. Through our participation in the state's psychiatry graduate medical education program and partnership with another health system, we've hired two child and adolescent psychiatrists who are now delivering telehealth to rural communities. We've launched a telesite program and are focusing on developing a sustainable strategy for a systemwide model. //

ing door. To make the unit sustainable, we had to secure a dedicated contract, something we had been advocating for years. Unfortunately, it took a public outcry over children sleeping in DCBS offices before this issue finally received the attention it deserved.

We've built strong partnerships with DCBS, the juvenile justice system, and the state Department of Behavioral Health, holding weekly clinical meetings and managing referrals through a specialized admissions committee. The unit has 10 beds for boys, and we're working to establish a similar unit for girls. But we're at capacity, and it's unsafe to take on more without additional support.

Public empathy is low for children with psychiatric needs and, unlike other medical conditions, families often can't share their stories. That makes it harder to communicate our impact and secure the support we need from government, philanthropy and the public.

WALCZYK JOERS: There's a persistent gap between short-term acute care treatment and long-term institutional support and, too often, children with complex needs are de-identified and dismissed. We need to shift the narrative — integrating care into family and community life — and rethink how we support them beyond the arbitrary cutoff at age 18.

BRITTANY EVANS *(Cincinnati Children's Hospital Medical Center):* In our psychiatric program, we operate 99 inpatient beds and a 24-bed residential unit, alongside robust upstream services. But as we strengthen early interventions, the strain on our inpatient and residential care has become more visible.

At any given time, up to 20% of our beds are occupied by children who can't be discharged due to their complex needs and lack of placement options. Many are females who are lower-functioning and present with high levels of aggression, a combination that most facilities won't accept. Our data demonstrate that after 18 days, even kids who previously have not exhibited aggressive episodes often become violent, putting immense pressure on staff. On any given day, as many as 20 employees may be out on restricted or light duty due to workplace injuries.

We're essentially functioning as Ohio's state hospital, supported by philanthropy and mission-driven leadership, but resources are finite. I regularly present patient stories to board members and donors, trying to convey the gravity of these cases. It's hard to generate empathy when the public often can't relate to these children's experiences.

We're doing well with upstream care for less complex cases, but we're falling short for the kids who need the most specialized support. The issue isn't a shortage of providers; it's a lack of incentives and training for professionals to sustainably work with these high-needs populations.

TOM MILAM *(Iris Telehealth):* As a psychiatrist for 25 years, I saw firsthand how overwhelmed practices were, especially when serving children with developmental disabilities, brain injuries and complex medical needs. Even with more staff, the demand always outpaced capacity. That led me back into academics and ultimately into telehealth, where I kept hearing the same thing: "We can't hire anyone. No one wants to work in our town, in our jail or with these kids."

It was disheartening to see communities and patients so marginalized. Iris was created to change that and to partner with organizations and ask, 'How can we support you?'

We started in community mental health and expanded into integrated care with pediatricians and family doctors. Today, we offer acute care support, telerounding for inpatient units, and 24/7 ED consults, often seeing patients within an hour to begin treatment and avoid unnecessary admissions. We also support post-acute transitions, addressing therapy, medication, housing and school needs.

One of our major health system partners had no ambulatory behavioral health services. We helped build its entire virtual system, now staffed by 30 providers.

Iris now has more than 500 providers across 44 states, working directly within health systems. We don't operate stand-alone clinics; we embed into your teams. Our mission is to bring care where it's needed most and, while it's encouraging to see progress, it's disheartening that many of these challenges persist. We're here to help tackle them, including the ongoing struggle around reimbursement and sustainability.

MODERATOR: Given the critical workforce shortages in child and adolescent psychiatry, how is your organization thinking creatively about leveraging technology, virtual care or collaborative care models to expand access to behavioral health services for younger populations?

KALENA JONES *(Baptist Health):* While we've traditionally focused on adult behavioral health and substance-use disorders, we're now recognizing a critical gap in pediatric and adolescent behavioral health. Children continue to present to our ED, but we lack the continuum of care to support them.

We're beginning to build a stronger pediatric behavioral health focus. Through our participation in the state's psychiatry graduate medical education program and partnership with another health system, we've hired two child and adolescent psychiatrists who are now delivering telehealth to rural communities. We've launched a telesite program and are focusing on developing a sustainable strategy for a system-wide model. With more than 200 access points across the state, half embedded in primary care, we have the infrastructure and the commitment to unify and scale these efforts.

One opportunity I'm advocating for is repurposing our mobile health units as mobile crisis units to help overcome Arkansas's transportation barriers. I'd also like to see us expand into schools and build a system that meets the needs of all children and/ or collaborate with a partnering health care organization to make it happen.

MATTHEW FRY *(Freeman Health System):* Ozark Center, our behavioral health arm with 600 staff, is launching a mobile health unit in three months, including play therapy for pediatric patients, to expand access and meet growing community needs.

MILAM: We partner with organizations and accept a wide range of insurance coverage, including Medicaid, while integrating directly into your electronic health record systems. Our team brings in providers and collaborates with your staff to deliver services through models like AIMS and collaborative care, where psychiatrists can supervise other clinicians. While we've implemented these approaches, many organizations still express the need for on-site prescribers, especially when patients are on multiple psychotropic medications alongside complex medical conditions.

While in-person care is still considered the gold standard, it's never been scalable in behavioral health, where provider shortages persist. That's why we're focused on leveraging telehealth and exploring artificial intelligence (AI)-driven solutions to improve efficiency and coordination. Right now, a child psychiatrist might see eight patients a day while dozens more wait. Communication across care teams — pediatricians, child psychiatrists, therapists, psychologists, teachers and counselors — is fragmented and chaotic. AI has the potential to streamline these interactions and unlock new levels of care coordination we haven't yet imagined.

JARED VAVROCH | CHILDREN'S MERCY KANSAS CITY

// At our children's hospital, we began by quantifying the fragmented resources already being used to manage complex behavioral health patients, such as one-to-one sitters scattered across medical-surgical units. Centralizing care helped demonstrate cost savings and made the financial case less daunting for leadership. The efficiencies and philanthropic momentum have helped bridge the gap and reduce perceived financial risk. //

MODERATOR: What does a financially sustainable pediatric behavioral health program look like in your organization?

CYNTHIA GRIMM *(East Tennessee Children's Hospital):* We've made significant changes to improve behavioral health care in our ED. After facing overcrowding and long stays, we created a dedicated unit for behavioral health patients, staffed with specialized nurses and social workers. Our social workers manage private insurance cases and coordinate inpatient referrals. In Tennessee, if it's a Medicaid patient in a behavioral health crisis, the Mobile Crisis services, which are state-funded and community-based, will perform the necessary assessments using tablets and provide stabilization services. High-acuity cases often face delays and denials, worsening patient outcomes.

With grant support, we added a case manager and milieu coordinator to improve care planning and de-escalation. We also benefited from a new pediatric psychiatric inpatient facility and a nearby center that now provides transportation, solving a major barrier. For psychiatry in our ED, we contract with a mental health agency, initially through a short-term grant, and have continued funding limited on-site coverage, though demand exceeds availability. We've also partnered to host a crisis stabilization unit for patients who don't meet inpatient criteria but still need structured support. These efforts reflect our commitment to collaborative, community-based solutions.

JARED VAVROCH *(Children's Mercy Kansas City):* Our mental health strategy is unified under the Illuminate initiative, which includes 20 comprehensive programs, including inpatient med-psych, ED crisis care and clinics for depression and anxiety. At our children's hospital, we began by quantifying the fragmented resources already being used to manage complex behavioral health patients, such as one-to-one sitters scattered across medical-surgical units. Centralizing care helped demonstrate cost savings and made the financial case less daunting for leadership. The efficiencies and philanthropic momentum have helped bridge the gap and reduce perceived financial risk.

JONES: Arkansas recently rolled out Life360s, a statewide initiative with three focus areas: maternal/infant health; mental health/substance use (Arkansas Rural Life 360 initiative), and chronic conditions in young adults. Under Rural 360, the goal is to place acute stabilization units in rural hospitals. We're working to implement this at our Heber Springs facility, where one ED room has been converted, but funding gaps remain, especially with the financial investment required to retrofit a second room.

Staffing is another challenge, as we must maintain readiness for crisis cases. While our senior leaders support the program, the up-front financial burden and per patient reimbursement model raise concerns, particularly given the projected low patient volume of one every nine to 10 days. Heber Springs is highly seasonal, so our system may consider launching in a different region. Still, we're evaluating investment now to build long-term capacity.

LIONEL PHELPS *(RiverValley Behavioral Health):* We've built a strong mobile crisis program, supported by an expansion grant and our status as a Certified Community Behavioral Health Clinic implementation state. While it doesn't address inpatient needs directly, it's

JESSELINA CURRY | LUMINIS HEALTH

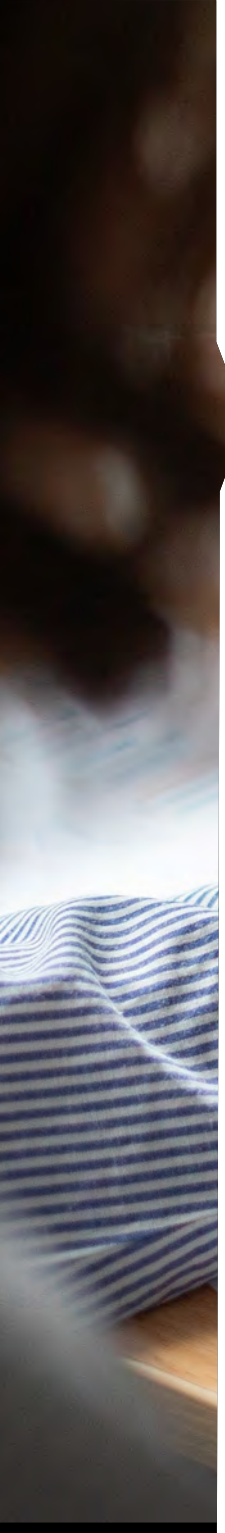
// After COVID-19, we've realized that it's essential to equip new providers with the skills to deliver care virtually and effectively. While in-person care remains the gold standard, telehealth has opened doors, especially in pediatric care, where engaging families, schools and children remotely can still build meaningful relationships. //

helped us create responsive teams that serve schools, law enforcement, shelters and domestic violence centers, often using tablets to connect individuals to care quickly and efficiently. It's a 24/7 service that's expanded our reach, though it requires highly dedicated clinicians willing to work after hours.

As a child and adolescent clinical psychologist, I can confirm that telehealth has limitations, especially for cognitive testing, which remains difficult to conduct remotely. Insurance reimbursement for psych testing is also a widespread challenge.

CURRY: The National Health Service Corps is a great resource for placing providers in underserved communities. There are people who genuinely want to serve. I also want to highlight Iris Telehealth and the broader shift toward telehealth training. After COVID-19, we've realized that it's essential to equip new providers with the skills to deliver care virtually and effectively. While in-person care remains the gold standard, telehealth has opened doors, especially in pediatric care, where engaging families, schools and children remotely can still build meaningful relationships.

ANDY FLANAGAN *(Iris Telehealth):* We're fortunate to collaborate with many of your peers, learning from their work and shaping solutions that fill gaps as part of the broader story. Our team includes more than 500 providers, with 70 child psychiatrists, and a growing demand for therapists after the pandemic subsided, as behavioral health needs surged. Our adaptable virtual clinic model uses licensed clinical social workers for initial assessments, triaging patients to therapy or medication management within three to seven days. This helps avoid long waitlists and ensures timely care while honoring each family's journey.



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Iris Telehealth helps health care organizations consistently increase access to high-quality behavioral health care for their patients by providing the care models, clinicians, analytics and expertise to build a sustainable behavioral health program. With clinical grounding and emphasis on human relationships, Iris Telehealth identifies best-fit providers for each unique organization and ensures long-term commitment to meeting their partner's needs, allowing them to provide the highest quality care to their patients and community.

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