Testimony in Support of 3835

Ajit Jetmalani, M.D.

May 12, 2025

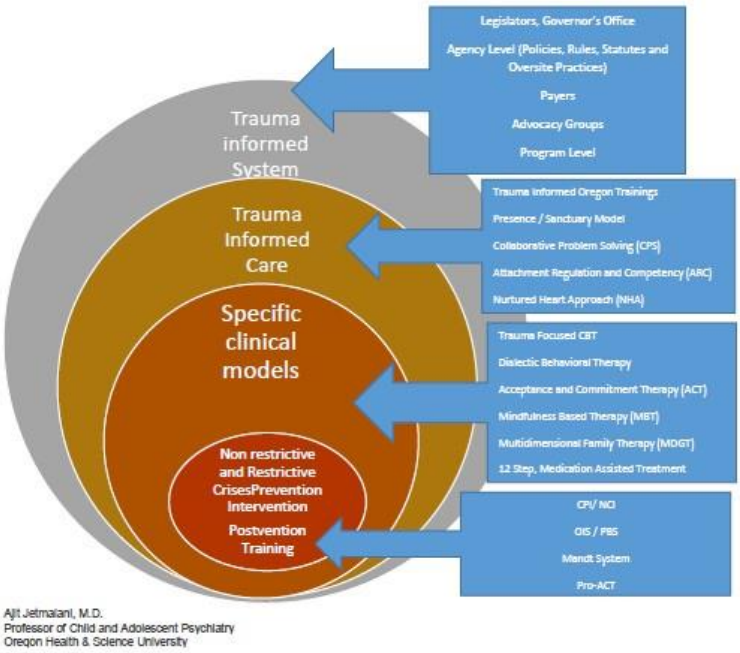
Dear Chair Bowman, Vice-Chair Drazan. Vice Chair Pham and Members of the Committee:

My name is Ajit Jetmalani. I am a professor of psychiatry and director of the division of child psychiatry at OHSU. I am past president of Oregon Council of Child and Adolescent Psychiatry, and I was the psychiatric consultant to Oregon Health Authority and Child Welfare from 2008 to 2024. I was appointed to Governor Browns child welfare oversight board and children's cabinet and participated in SOCACs safety committee as psychiatric consultant. This written testimony is my own and not necessarily representative of OHSU or other entities I am associated with. I support 3835. While it is a very large bill with many parts, much of it is a focused on simplifying language and creating consistency across many elements of our laws and rules to make it clearer for providers staff and oversight bodies what constitutes reportable abuse or neglect and what circumstances warrant hands on intervention for youth who are at acute risk of injuring themselves or others.

It was painful to hear the harms people have felt in systems over the decades during testimony during Monday's hearing. I have participated in many gatherings where youth and families shared experiences of harm and it's important to never forget our past to prevent repeating errors in the future. It was also painful to hear personalized attacks and aggressive accusations during the hearing directed towards leadership and therefore the entire child welfare agency. It may feel powerful or cathartic to rage at others in a public forum and privately as well, but this makes all of us smaller, less effective and vulnerable to the contagion of hate and fear that is so pervasive everywhere in our society. We will never solve problems this way and the contagion effect is real…it trickles or moves like waves through our bodies and minds and speech and create a toxic landscape where solutions are impossible. Doing what is best for children in Oregon means we as adults have to put our fears and anger aside and believe in the best intentions of each other.

I would apply the same lens to our current regulatory environment. 1515 was in response to the debacle of "Give us this Day" BRS program and the discovery of what was happening in some for-profit out of state residential facilities and 710 focused on concerns about other system elements. Both were implemented with the intent of preventing bad things happening to children in care; however, I do not believe that 1515 and 710 considered how the regulations might adversely influence the therapeutic elements that are prerequisites to healing in therapeutic residential or family environments. Below you will find a diagram

which emphasizes how practices up and down the system influences each other. This can be a virtuous improvement cycle when all participants are trauma informed or a deteriorating punishment cycle when trauma is enacted at each level up and down:



I believe we are trapped in a fear based spiral that we must disrupt to be successful. Youth who have behavioral health challenges, trauma and sometimes developmental delays may over respond to environmental or internal stress in unexpected ways or at unexpected levels. Care givers must alter communication (verbal and non-verbal) to combine developmentally appropriate expectations with a supportive and curious frame for growth to occur (an example of this is the Collaborative Problem Solving approach https://thinkkids.org/ which is common in many programs in Oregon). In addition, if communication and behavior are not going well, de-escalation strategies and nonviolent Crisis intervention as well as specialized safe restraint training are sometimes needed (see NCI training at cpihttps://www.crisisprevention.com/).

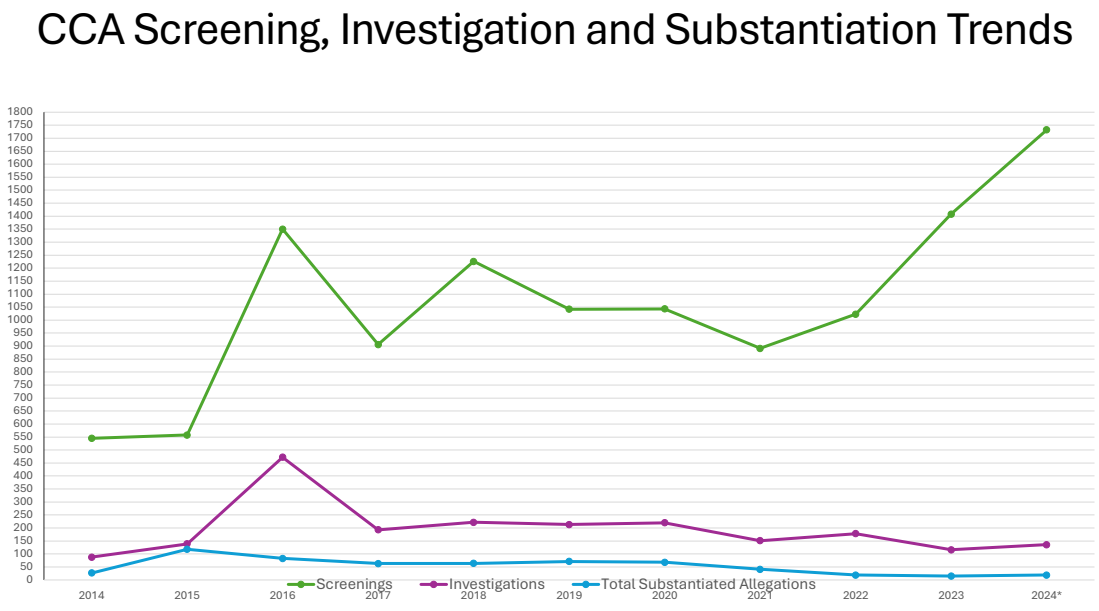
Collaborative Problem Solving and NCI training both depend on staff being well trained, confident, curious learners who get ongoing coaching consultation and refresher training to be effective. Mistakes happen in acute crises situations and staff must learn from mistakes to keep developing skills. This is what medicine has learned and practiced for decades (sometimes called just culture which is part of continuous quality improvement).

In our current regulatory environment, however, the space for learning occupied by abuse and neglect screenings. Adults feel less confident or calm during crises as there are

external risks of adverse findings…youth with trauma can feel this doubt and fear and this can cause an escalation rather than de-escalation cycles. The tools one learns in training become confused by unclear language and guidance in our rules…imagine you are witnessing a child losing control of their emotions and you feel fear and the need to act…"do I only act if I feel afraid that someone will die or have a life-threatening outcome before I intervene, how about a broken arm or facial fractures, how about bruising, back strains or bite wounds? If I use my evidence-based training in NCI but that is in conflict with Oregon's definitions what might happen? Am I neglectful if I intervene too late or abusive if I intervene too early according to Oregon law?

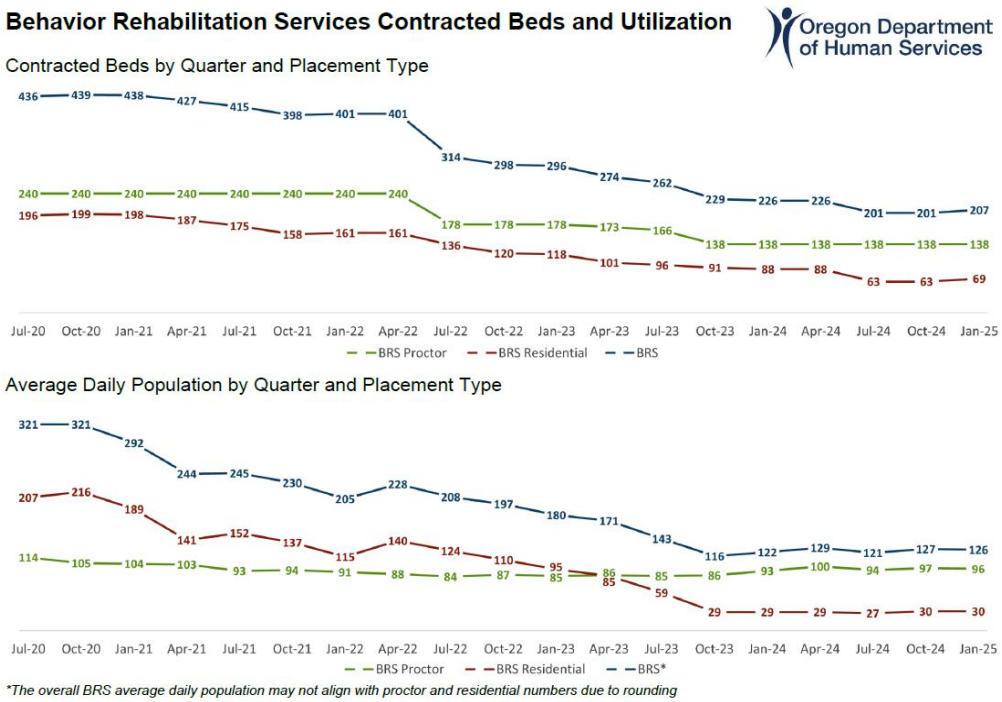
The cascading impact of this confusion and fear is demoralization of staff and staff turnover, disrupted care for youth, closing of programs, and for those who are left, avoiding youth who have aggression as a symptom.

Here are some data slides as well as a brief "day in the emergency room at Doernbecher" story:

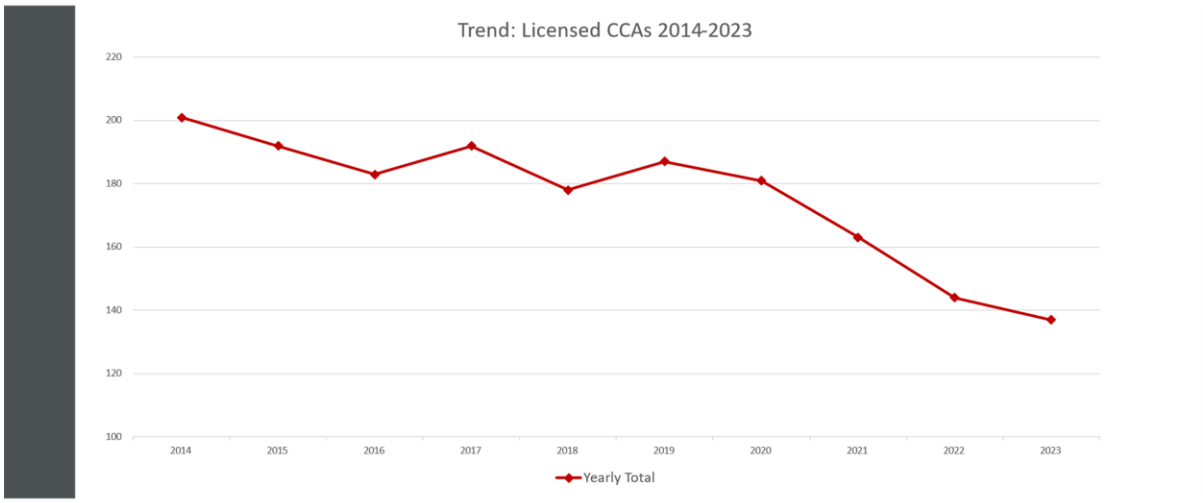


As you can see, there were dramatic increases in abuse and neglect screenings starting with legislation in 2016 and again in 2022. Every provider or staff member knows that a screening or investigation may be the end of one's career and livelihood. Out of more than 1750 screenings in 2024, less than 20 were substantiated yet there is a significant emotional and administrative burden that occurs with each of these screenings.

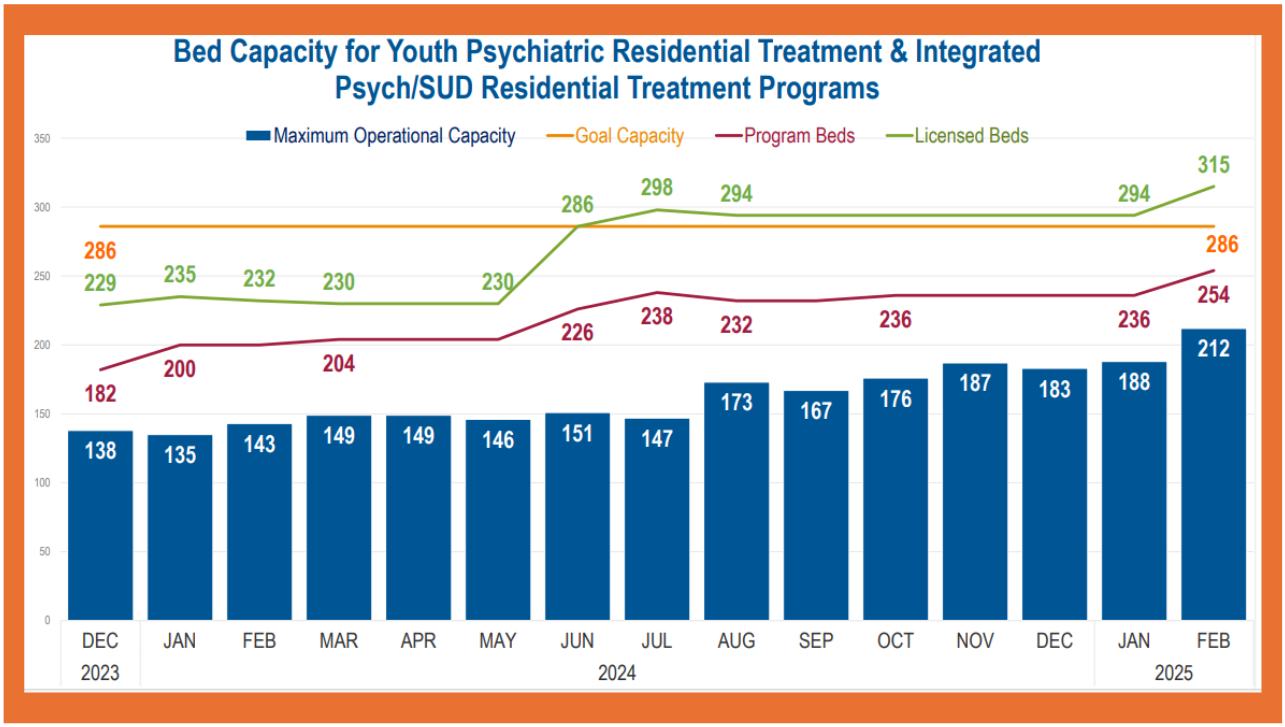
In parallel to these changes in oversight practices, we have lost capacity in the system. While there are several factors that drive loss of programming (funding, pay, overly aggressive utilization review by insurers, aging infrastructure the pandemic) providers *universally agree* that our regulatory environment is a major driver on top of an already weakened system. I believe the word of these providers as I have worked with many of them for decades.



BRS programs were hardest hit by far. BRS programs are not treatment facilities; they are places that youth who have struggled for long periods of time in the community might benefit from longer stays than a month or two ideally to attend school, learn social and life skills, experience positive mentorship and successes and rebuild relationships with potential forever homes. By October of 2023 we only had 30 residential BRS beds occupied compared to a peak of 236 in October of 2020.



The graph above shows the total number of licensed facilities (not beds) by year from 2014 to 2023. Many small and some large Residential, BRS homes, proctor homes and day treatment programs were lost for good during this period.

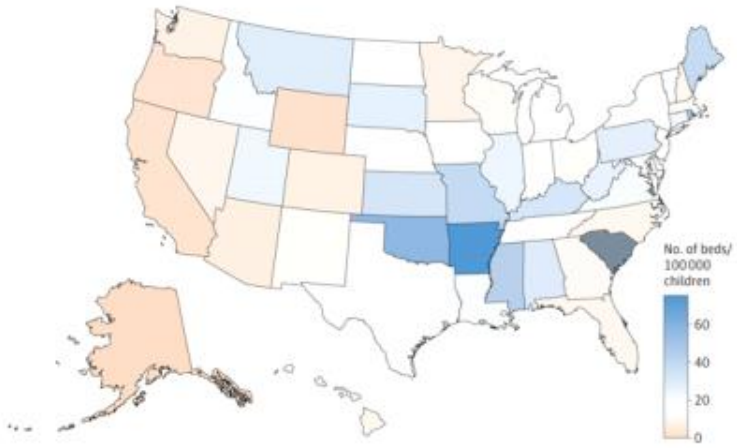


This is our residential capacity. Our estimated need based on our current population is 286 beds in this category. You will see that we have recovered from our low point of 135 to now having @ 212 functioning beds…still well short of our goal but an improvement. Despite this increase in beds, the average wait time for admission is well over two months. In addition, youth with aggression are the highest reason for referral and many are denied admission often for the reasons discussed above.

By the way, Oregon has zero locked SUD programs in the state. Especially when fentanyl is involved the risk of death in a person unable to consent to care is extremely high.

Another headwind in Oregon is that we are one of four states with the lowest number of acute pediatric psychiatric inpatient beds in the country. This means that we frequently do not have access to this level of service for youth in crises when lower intensity programs refuse them. In addition when hospitals are ready to discharge youth, lower levels of care may not accept them due to a history of aggress in the hospital. A vicious cycle that prolongs hospital lengths of stay and then decreases access. The theme you can see is children do not end up at the right level of service and the right time.

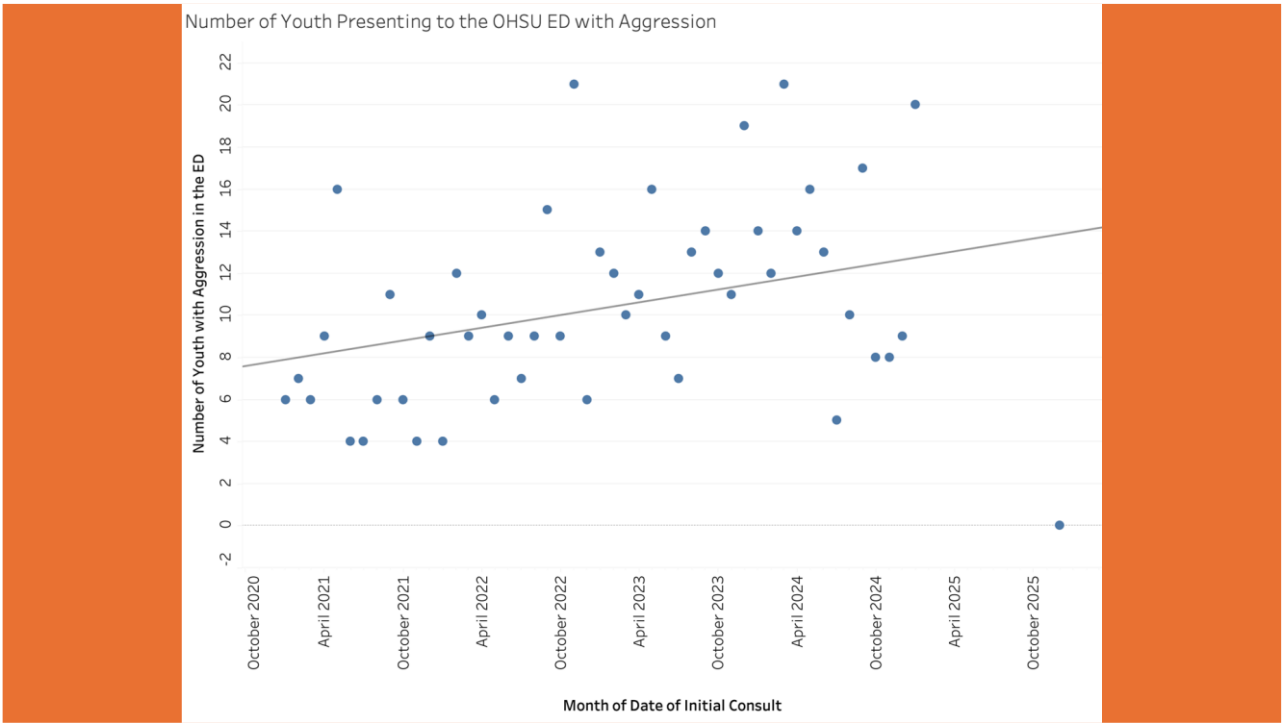
Figure. Pediatric Inpatient Psychiatric Beds per 100 000 US Children in 2020



From: **Pediatric Inpatient Psychiatric Capacity in the US, 2017 to 2020**
JAMA Pediatr. 2024;178(10):1080-1082. doi:10.1001/jamapediatrics.2024.2888

Emergency rooms reflect the overall health of a community. I oversee acute care behavioral health services at Doernbecher and Randall Childrens Hospital. Both hospitals are frequently overwhelmed with young people presenting with behavioral health challenges.

The next slide shows the continuous increase of youth with a primary challenge with aggressive behavior (the total number of youth coming to Doernbecher monthly is much higher…this is just youth for whom aggression is a major driver)



Why is this happening? Due to our deteriorated continuum and fear of accepting youth with aggression, families and even intensive community-based service providers have no recourse other than to bring youth in crises to emergency rooms or when a child hurts someone, juvenile justice pathways.

Following a crisis, some children board for days in EDs or they and their families begin a revolving door of visits to various EDs in the region. In this context, OHSU has the second longest emergency room lengths of stay among 21 major academic pediatric medical centers across the country.

ED LOS – OHSU vs 20 Other University Children's Hospitals

(length of stay in hours reflects many youth who stay for days)

2

MN

		ED THROUGHPUT			
		Avg LOS BH - Dschg	Median LOS BH - Dschg	Avg LOS BH - Admit	Median LOS BH - Admit
	Min	5.4	3.4	3.8	2.9
	25th	7.7	4.9	16.7	10.4
	Median	11.5	6.5	23.0	15.5
	75th	14.6	8.4	47.2	28.7
	Max	42.4	23.5	79.1	52.3
	Mean	14.4	7.7	30.7	20.6
	Median	11.5	6.5	23.0	15.5
	N	15	15	16	16
University	ED				
Brown University	Hasbro Children's Hospita	8.34	6.50	29.32	22.85
Columbia University	NewYork-Presbyterian Morgan Stanley Children's Hospital				
Denver Health	Denver Health Medical Ce	5.41	4.03	3.75	2.93
East Carolina Universit	Vidant Medical Center Chi	42.40	7.57	46.69	27.05
Hackensack University	Hackensack University Medical Center				
Icahn School of Medici	Mount Sinai Hospital Chil	10.97	8.75	10.97	8.75
Indiana University	IUSM-Riley Hospital for Children				
Johns Hopkins Univers	Johns Hopkins Hospital Ch	12.56	3.40	59.64	33.68
Loma Linda University	Loma Linda University Chil	8.57	7.50	23.09	20.04
Oregon Health and Sci	Doernbecher Children's Ho	33.66	23.47	56.19	42.50
Penn State University	Penn State Hershey Childre	12.73	5.33	48.80	34.78
SUNY Upstate	Upstate University Hospital Childrens ED				
Texas A&M University	Baylor Scott & White McLar	13.78	10.91	17.32	15.40
University of California	Benioff Children's Hospita	20.11	9.43	28.26	10.68
University of Massachu	Baystate Medical Center Ch	11.54	8.09	79.13	52.31
University of Michigan	CS Mott Children's Hospita	6.99	6.39	16.84	12.61
University of New Mexi	University of New Mexico Hospital Childrens	14.63	9.52		
University of Rochester	Strong Memorial Hospital Childrens ED				
University of Texas Hea	University Hospital Childre	6.60	3.63	17.01	11.65
Virginia Commonwealt	VCU Medical Center Childr	6.52	4.39	16.26	9.09
Virginia Tech Universit	Carilion Roanoke Memoria	15.36	6.33	22.81	15.68

A Day at Doernbecher Hospital Emergency Room:

I want to finish by sharing the story of one day a few months ago at Doernbecher Hospital. 7 of our 11 beds were filled with youth struggling with behavioral health challenges. Our waiting room was full of children with respiratory and gastrointestinal illnesses waiting to be seen. One child in the ED had level three autism and was head banging screaming and urinating in the hallway, two young women with severe trauma histories aggression toward family and chronic suicidal thinking were turned down by all community and residential resources and were waiting for a psychiatric hospital bed that was days out. One of the young women tried to elope from the ED and threatened to harm a CNA who was trying to talk her out of leaving. Another youth was sexually trafficked and had injured multiple DHS case workers in temporary lodging but was declined by residential and BRS programs due to her aggression. The hospitals and subacute programs (one step below hospital and one step above residential) denied admission because her condition was chronic and would not respond to the two-week average length of stay. Keep in mind, hospitals can't find places for youth who are ready for a lower level of care so access is then diminished. As a result, hospitals decline youth with chronic challenges as well as they are unlikely to have sustained responses to a short few days in a hospital setting. The emergency room never considers residential care referrals as the wait times are well over two months as noted.

The consequences for staff were significant direct emotional trauma, vicarious trauma, moral injury, physical injury all contributing to eventual burn out and loss of employees over the long run. For the youth, a feeling that no one can help, that they must be truly unlovable and awful, another episode to add to a myriad of traumatic experiences, hopelessness and a loss of trust in adults and the system. For care givers in the community (DHS staff, parents, foster parents, intensive service providers) the feeling is frustration, anger, fear, hopelessness and burnout compounding the traumatic experience of trying to support a youth in the community at extreme risk for long periods of time.

These stories repeat nearly every day in our two hospitals and emergency rooms across the state. **As we argue and mistrust each other about this bill, keep in mind the suffering and impact on the hundreds of youth and concentric circles of community around them who are negatively impacted by not having access.**

HB 3835 was the result of years of effort with methodical analysis of the drivers of our struggles, engagement of myriad stakeholders and multiple amendments who care deeply and have decades of collective knowledge and experience in the field. The state created SOCAC for just this purpose…to collaboratively find solutions to make Oregon a better place for children with behavioral health challenges:

- It will realign regulatory practices with the science of caring for highly reactive and traumatized youth who are at risk of aggressive behavior. Programs, providers and staff who feel supported, valued and are well-trained stay in their jobs longer and deliver better care. Children will feel the difference when their care givers are well trained and not afraid
- It will bring back full access to medically necessary care for youth in foster care out of state if needed services are not available in Oregon. Youth in foster care should have the same access to care as any other child in Oregon; it's a form of stigma and discrimination to not have equal access. The errors of the past must be acknowledged and understood but the future is determined by new practices as described in this bill.
- I would add one element no one has mentioned in hearings, but you should understand. This bill funds the position of medical director for Child Welfare. A child psychiatrist will participate in policy and clincal oversight in Oregon aligning with many other states who have found this is an important element in supporting the success of other agencies across the country.

Please move 3835 out of committee. Many people will be focused on implementing and monitoring the outcome of this bill. If Oregonians approach this with optimism and

collaboration, we can be successful! Thank you for your deep investment in time to understand these complicated issues.

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Child Adolescent and Adult Psychiatrist