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Title
NUBE Abstract Issue

Permalink
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Journal
Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health, 25(2.1)

ISSN
1936-900X

Author
Saucedo, Cassandra

Publication Date
2024-02-06

DOI
10.5811/westjem.19410

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Volume 25, Supplement, February 2024 Open Access at WestJEM.com ISSN 1936-900X

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Supplement to

Western Journal of Emergency Medicine:
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The American Association for Emergency Psychiatry (AAEP) is proud to have presented the 13th Annual National Update on Behavioral Emergencies (NUBE) Conference December 6-8, 2023 in Las Vegas, NV. This conference was the first and only conference focused entirely on state-of-the-art behavioral emergencies. As the care of these patients is frequently interdisciplinary, emergency psychiatrists, psychologists, nurses, nurse practitioners, mental health workers, social workers, physician assistants and emergency physicians are invited participants. The conference includes two preconference programs, a scientific session, and opportunities for networking with your colleagues. For further information for next year's conference go to: https://www.emergencypsychiatry.org/nube-conference.

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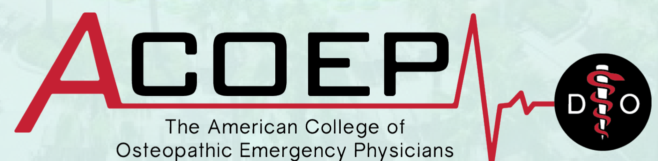

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Western Journal of *Emergency Medicine*:

Integrating Emergency Care with Population Health

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1 988 One Year Later: National Trends in Crisis Care and Pre-Hospital Behavioral Health Emergency Response

Margie Balfour MD, PhD, Richard T. McKeon PhD, MPH, Michael H. Allen MD, Jason Winsky Sgt

The new 988 National Suicide and Crisis Lifeline went live in July 2022, providing an alternative to 911 for people experiencing behavioral health emergencies. This compounded with bipartisan support for increasing behavioral health funding and policing reform movements focused on creating non-law enforcement responses to behavioral emergencies is catalyzing a once-in-a-lifetime expansion in behavioral health crisis services. It is important for AAEP membership to be aware of these developments as they provide new opportunities for funding emergency behavioral health care, creating alternatives that lessen the need for ED utilization, and better care for the individuals we serve. Furthermore, AAEP members can shape the development of these new services via policy advocacy and as local medical leaders. The presenters include SAMHSA leadership, national experts in suicide prevention and crisis systems, a police sergeant and a peer services director. The session will begin with an overview of SAMHSA's vision for crisis care in which everyone has "someone to call, someone to respond, and a safe place to go." Next we provide an overview of 988, data and lessons learned from the first year of implementation, and future plans. Then we outline trends, best practices, and funding opportunities for mobile crisis and facility-based crisis care. SAMHSA has a goal that peers will be involved in crisis care. A director of peer services at a 988 center will describe the uniquely effective way that peers can help develop safety plans in acute care settings and provide ongoing care to individuals in crisis after a hospital visit. Next, we will discuss the role of law enforcement in BH emergency response and highlight best practices for collaborations between law enforcement and care providers. Then we describe tools that communities can use to help plan and coordinate the development of their crisis systems and highlight opportunities for clinical leadership and policy advocacy at both the national and state legislative levels. The session will conclude with a panel discussion and audience Q&A.

2 Preventing Firearm Injury and Death - What Clinicians Can Do

Amy Barnhorst, MD

Clinicians in emergency mental health settings often conduct suicide and violence risk assessments, and firearms are a major contributor to injury and death from both. Evidence suggests that the majority of clinicians feel that preventing firearm injury is within the scope of their practice. However, survey research shows that most don't routinely counsel at-risk patients, often citing lack of education on how to do so as a primary barrier. Many clinicians also report not knowing how to identify risk, not knowing how to open a conversation about firearms, and not knowing what interventions are available to them. Although the CMA, the AMA, the ACP, the APHA, the AAFP, and other major medical societies have endorsed clinicians' role in reducing firearm injury, the topic remains largely absent from curricula to train medical and mental health care clinicians. Through this presentation of the BulletPoints 3A's framework, learners will learn how to identify risk for firearm-related harm, ask about access to firearms in a culturally appropriate manner, and based on the level and type of risk, work with their patients and their families to reduce that risk. The presentation includes various clinical scenarios where the presence of a firearm increases the risk of harm and explores ways mental health providers can put time and space between dangerous people and their firearms.

3 The Road Not Taken: Collaboration Between Health Experts and Firearm Trainers to Reduce Firearm-Related Injuries

Christopher Barsotti, MD

Across America, individuals and communities live with a potent fear of being hurt by a gun. Efforts to confront this health crisis have stalled for decades, even though most Americans view firearm injury as a major problem. A primary culprit for the lack of progress is the absence of collaborative partnerships between essential stakeholders in medicine, public health, law enforcement, and the community of firearm owners, trainers, and retailers. Widely accepted, carefully evaluated effective, community-based firearm injury prevention programs are essentially non-existent. Few evidence-based tools are currently available to reduce the risk of people harming themselves or others with firearms, or to alert families and communities about the warning signs of danger and how to respond appropriately. While many well-intentioned programs have been developed by advocacy groups, few have been designed with input from public health experts, medical providers, or the firearm sector and there is little rigorous data to support their value. The exception is interventions used by healthcare providers, which have shown that the right training can increase their capacity to discuss firearms with high-risk groups, many of whom are brought to medical care through the awareness of their families, friends, and other communities' members. There are an estimated 393 million civilian-owned firearms in the United States and more than 80 million US adults own firearms. At the same time, many public health and medical professionals

own or use guns. Indeed, the percentage of physicians with guns (55%) may actually be slightly higher than that of the overall population. Concern about firearm misuse is high among firearm owners and industry groups, and numerous firearm industry organizations address the health issues that influence firearm use in their publications, such as stopping mass shooters, protecting mental health in the COVID-19 era, recognizing intimate partner violence, preventing suicide in veterans, and taking action to ensure gun safety among the elderly to name a few. These data suggest that a diverse array of stakeholders agree that the mental, physical, and social health of gun users play major roles in the proper use of firearms. What is needed to comprehensively address firearm injury at the community level is an on-demand, scalable educational model built on a health framework that capitalizes on a common vision of health, safety, and responsible firearm ownership. Such education would help individuals anticipate, recognize, and lessen the risk of firearm misuse and injury. Myriad precedents for this type of education already exist within both health and firearm training pedagogies. Developing an integrated curriculum would require cross-sector relationships between health and firearm community stakeholders and also serve as an exemplary model for building consensus on a traditionally divisive topic, influencing the national discourse and social norms concerning firearm ownership and its fundamental relationship with health.

4 Overcoming Deception in Suicide Assessment

Erin H. Gallagher, Sayde King, MS

How an examination of my son's lies before his death can lead us to the truth about deception in suicide assessment, the vital importance of our work at This Is My Brave, and how to eliminate stigma and save lives. Three weeks before he took his own life, my son was asked by his school counselor if he was suicidal. Jay said, "no," and never got the help he needed. Later we learned that he had told a friend that he wanted help but didn't know how to ask for it. If that were the case, why did he lie when the truth would surely have yielded the help he needed? In this piece I examine his lie and the school counselor's acceptance of it to reveal a path towards more accurate suicide assessments.

AI as a Valuable Assessment Tool

What safeguards can we implement to assist in recognizing when a patient who is suffering is being dishonest about their well-being? Research shows that trained professionals (e.g., police officers and mental health counselors) are not significantly better than chance at detecting deception. To bridge this gap, artificial intelligence has been leveraged in recent work to detect deception Ñ using non-verbal behaviors like body language or facial expressions as measures of deceptive behavior. In this talk, we discuss our findings from 20 qualitative interviews conducted with mental health professionals to better understand their experiences with patient deception, how they approach deception as it occurs, and their perceptions of using artificial intelligence as a tool to detect deception in therapeutic settings. These findings are compared with trends in the research literature surrounding deception in clinical and therapeutic settings.

5 Any Given Monday

Debbie Hapenny Ciavola, PhD

On any given Monday throughout the U.S., emergency departments struggle with an overwhelming number of patients presenting with mental health crisis. The reliance on emergency departments (EDs) to provide psychiatric care has led to nationwide boarding and overcrowding bringing throughput to a near standstill as medical emergencies are forced to compete for ED resources. Collaboration between psychiatry and emergency medicine has emerged as a pivotal approach to address the complex and diverse needs of patients presenting with mental health crises in emergency settings. This presentation illustrates just how the synergy between these two specialties has proven to be highly effective in treating patients with psychiatric emergencies. It further explores the impact of collaborative practice to foster knowledge exchange and skill-sharing. Evidence demonstrates that emergency department staff gain valuable insights into psychiatric conditions and psychiatrists develop a deeper understanding of medical conditions as well as exposure to the challenges of emergency care. In 2014, a successful implementation of an emergency psychiatric team was launched in the second busiest emergency department in Massachusetts, focusing on innovative interventions, and collaborative approaches that provide timely and effective treatment and psychiatric stabilization. These services reduced the need for ED boarding by 32% and reallocated valuable resources to patients experiencing medical emergencies. Given the potential for self-harm or violence within the ED, the need for well-trained professionals capable of rapid assessment, de-escalation, and intervention in these critical situations to determine appropriate clinical pathways will also be discussed. Specific strategies and protocols will be outlined for optimizing emergency psychiatric care including the use of 'Psychiatric Observation Status' for psychiatric emergencies within an ED setting, implementing ED psychiatric consultation services, applying the use of Psychiatric ESI protocols, and 2023 CPT professional codes

for Observation and consults in an ED setting. Psychiatric observation serves four functions. It allows for the timely assessment and diagnosis of mental health conditions, as well as the initiation of appropriate interventions and treatments. Overall, psychiatric observation plays a crucial role in ensuring the safety, assessment, and initial management of individuals experiencing acute psychiatric symptoms. More importantly, it significantly reduces the need for admissions to psychiatric facilities, thereby preserving beds for the more acutely ill. Since observation is classified as a status, it can be implemented in any ED setting. Explicit steps to set up psychiatric observation status will be presented and include assessment, stabilization, and determination of appropriate disposition. The presentation will further describe implementing standardized protocols and facilitating timely psychiatric consultations. It will also examine the challenges associated with psychiatric observation, including staffing, resource allocation, and the need for efficient patient flow and coordination. In conclusion, collaborative psychiatry and emergency medicine represent a promising and dynamic approach to effectively address the complex needs of patients experiencing mental health crises as well as allow ED providers and staff to focus on care of medical emergencies. By fostering interdisciplinary cooperation and integrating psychiatric expertise into emergency care, healthcare systems can improve patient outcomes, reduce psychiatric boarding, reallocate ED resources, and positively impact revenue.

6 Then, venom, to thy work! The Neurobiological and Behavioral Impact of Early Trauma

Christopher W. Miller MD, Sarah Van Remmen, MD

Early trauma and adversity are highly prevalent. Childhood environments have a pronounced influence on how neural development is shaped, with an enduring effect on establishing default modes of responding to stimuli (including other people). During the sensitive period of brain development, our brains are very susceptible to the modulating effect of our surround. This becomes "locked in" and can be difficult to change with later experience. When a sense of safety is provided through benign caregiving, there is consolidation of pathways that can modulate emotional reactivity and establish nuanced, flexible modes of relating. However, when adversity if prominent, neural pathway development may be "accelerated" and incomplete, with responses to situations being driven primarily by emotions, with difficulty "thinking through" matters. Given the oftentimes confusing and distressing nature of the early environment, what is consolidated is a default of anxiety, suspiciousness, and expectation of hostility. This is accompanied by a magnification of risk assessment and an exaggerated neuroendocrine response Ñ the release of stress hormones thus prepares the individual to deal with a threatening situation, even in the absence of an objective danger. Individuals with early adversity are often in "as if" situations, recasting their current circumstances in accordance with what has been laid down on a neural level during childhood. This increases the risk of psychiatric conditions such as anxiety, depression, post-traumatic stress disorder, personality disorders, and impulse control disorders. In addition, the threshold for experiencing a situation as menacing may be decreased, leading to increased reactivity and the potential to feel threatened by others, possibly responding with defense strategies. This is relevant for management of aggression and agitation in emergency room settings. The approaches to care by clinicians should take the potential role of trauma in our patients' lives into account, as we as trying to establish rapport and provide a healing experience, as opposed to a retraumatizing one. This presentation will contrast how neural development unfolds in benign versus adverse environments, with a particular focus on the role of attuned caregiving in facilitating activity in areas of the brain associated with empathy and regulation of areas involved with emotional reactivity (e.g., the amygdala and insula). We will discuss the neurobiological changes associated with different psychiatric conditions, mapping the influence of trauma on neural pathways. We will also link the neuroendocrine and neural activation patterns with early encoding of adversity, and how the expectation of harmful interpersonal interactions can inform patients' strong reactions to providers in settings that are overwhelming or perceived as hostile, as can be the case in emergency rooms. Finally, we will discuss how pharmacological and non-pharmacological interventions can help to manage agitation in psychiatric emergency settings, keeping this neurobiological backdrop in mind. The recovery model is one that maintains a trauma-informed care framework in mind when interacting with patients at all stages and levels of treatment.

7 Managing Behavioral Crisis in Special Populations: NONVERBAL POPULATIONS

Dwayne Narayan, MD, Susan A. Waterman, MD, Taniya Pradhan, MD

Patients with neurodevelopmental disorders can exhibit agitation/challenging behaviors (A/CBs) that frequently present in the emergency room and are distressing both for the caregivers and the patients themselves. These behavioral crises are more frequent in nonverbal individuals with intellectual disability and autism spectrum disorders and usually during the transition period from late childhood to young adulthood. This presentation will take a deep look into multiple factors in managing behavioral health crises in special populations, including:

High incidence of co-occurrent trauma, therefore

behavioral interventions are Gold Standard
Consideration of medical/proximate and reversible causes
Recognizing true psychosis using criteria that are part of standard diagnostic procedure
Consideration of antipsychotics/mood stabilizers; avoiding drugs that can cause paradoxical agitation

Consideration of rare causes:
Causes are extremely diverse, but include comorbid medical conditions, either organic or psychiatric. Look at developmental, environmental, medical, and psychiatric causes precipitating a behavioral crisis.

Discuss Psychosis:
Persons with intellectual disabilities and/or developmental disabilities such as autism are vulnerable to the same psychiatric conditions as anyone else. However, recognition of psychosis (hallucinations, delusions, or paranoia) requires the examiner to try to ascertain the internal perceptual experiences of persons who do not use the same primary spoken language as the examiner.

Discuss non-pharmacologic therapeutic approaches, including:
Maintaining a low-stimulus environment
Avoiding retraumatization
Allowing self-soothing
Minimizing distress by performing all relevant investigations together
Note that the patient may have an existing Behavioral Management Plan with advice on how to manage acute distress

Discuss pharmacologic approaches, including:
Observing if there has been an acute change in sleep habits or patterns
Were new meds started? Specifically AED: levetiracetam; Antihistamine; selective serotonin reuptake inhibitors (SSRIs), or neuroleptic malignant syndrome (NMS)
Were medications suddenly discontinued or doses missed?
ÐIs there further regression of neurologic baseline?
Is there akathisia?
FDA-approved medications, with associated limitation considerations and monitoring needs

Discuss rare situations, including:
Is there marked vital sign change with paroxysmal sympathetic hyperactivity (PSH), otherwise known as autonomic storming?
Is there Status dystonicus, or “dystonic storm,” as has been described in patients with dystonic cerebral palsy and other underlying dystonic conditions
Postictal/interictal psychosis and forced normalization
Autoimmune encephalitis

8 Identifying credible threats of targeted school violence in school-aged children in the emergency setting

Micah Park, MD, Meghan Schott, DO, Jordan Pizzarro, BS

In 2020, nearly 44,000 people died from gun related injuries. Of these, 164 deaths have been from 40 active shooting incidents. Fewer still are the casualties from violence targeted in schools. Recent high-profile cases of targeted school violence, especially those with firearms, have elevated fears of the next possible incidence. These factors have shifted the tolerance for speech or activities suspicious for violence in schools. And for the students who have endorsed homicidal ideations, their angry outburst may involve intervention with law enforcement, or in many cases involving school-aged children with behavioral problems, a visit to the emergency room. Parents, schools, primary and other community providers present to the emergency department (ED) seeking help, often insisting on immediate admission or solutions. Emergency departments are not structured to board such patients long term, nor is a several-day stay in inpatient psychiatric hospitals a guaranteed solution for such multifactorial problem. Many behavioral problems such as anger and homicidal ideations are not suitable for admission, and instead require coordinated care within the community, involving not only psychiatrists, but also school administration, parents, and even law enforcement. This session aims to share key findings from government publications regarding targeted school violence in order to educate the front-line workers about some of the key features that should raise alarm for serious threats of school violence. The data will demonstrate the importance of identifying leakages, as well as exhibit personal, family, academic, and social dynamics of individuals who pose a serious threat. data will also highlight the limitations and challenges of accurately identifying credible threats. Perspectives on implementing gun violence education and disseminating information within the ED will be shared, as well as perspectives from the point of learners when gun violence education becomes integrated into the part of their curricula. Finally, a closing discussion period will offer participants a chance to share their experiences of working within or without established protocol for identifying homicidal threats.

9 Detecting the Undetectable: Training Healthcare Providers in Identifying Victims of Human Trafficking

Jinal R. Patel MBBS, Erica Cohenmehr, MD

Human trafficking is a tragic global enterprise that has enslaved over 20 million citizens of the world. In 2014, a study showed that 88% of victims of sex trafficking in the US reported some contact with healthcare providers while being exploited. Moreover, 68% of all encounters of a victim with a healthcare provider were in the emergency room (ER) setting. For this reason, it is imperative that healthcare providers in various disciplines, and especially emergency medicine physicians, are skilled at identifying victims of human trafficking. Psychiatrists and other mental health professionals working in the ER, in particular, could play a pivotal role in making sure such screenings and assessments are appropriate and trauma-informed, given the extensive challenges faced by this patient population. Moreover, many of the victims meet the criteria for PTSD, substance use disorders, mood disorders, and so on, and do not have access to mental health services in a safe setting. We have developed a training workshop for healthcare providers in our community to educate them on key aspects of human trafficking. We have also created a screening tool to identify victims of trafficking and developed a protocol to triage and support potential victims in an ER setting. Our training is designed for psychiatry residents, attendings, social workers, and psychologists. We have administered our training in various clinical and academic settings with good responses. In this resident-run workshop, we hope to share some of our experiences and help the audience become more comfortable with screening for human trafficking victims, understanding how to support victims, providing trauma-informed care, and helping link these victims to appropriate resources.

10 Practitioner Vitality: Finding Meaning and Vibrancy at Work

Jeffrey Ring, PhD

The US Surgeon General issued a report on Workplace Mental Health in 2022 that reminds us of the many challenges to vibrancy at work. This is ever more true today in the shadows of the pandemic and for those on the front lines assisting patients in our current mental health tsunami. This interactive and experiential presentation provides an opportunity to think about the unique challenges in emergency behavioral medicine and to learn about and practice ways to find meaning in our work, to celebrate successes, and to strengthen our connection to our individual calling and institutional mission.

11 Careful Whispers: Information Sharing, Emergency Psychiatry, and Threat Management

Jack Rozel, MD, MSL

Increasingly PES professionals are expected to assist in evaluations of people who may be at risk for serious violence including targeted violence and mass violence. Some of these clinical scenarios are initiated by our partners in criminal justice, some originate in the clinical sphere. Neither law enforcement nor behavioral health professionals alone can reasonably evaluate people at risk for violence. One evidence-based approach to handling these high risk cases is called Behavioral Threat Assessment and Management (BTAM). BTAM is an interdisciplinary approach involving behavioral science, law, law enforcement, and intelligence professionals. Suffice it to say that not all of these disciplines adhere to clinical ethics Ñ thus working in threat management can create ethical and legal challenges for PES professionals. This presentation will help attendees understand the limits and allowances of major privacy rules under HIPAA and FERPA and explain how they can apply in interdisciplinary efforts to prevent serious acts of violence, including on guidance for receiving information from law enforcement authorities for use in clinical settings. Basic considerations for ethical analysis of ambiguous situations will be discussed. The primary aim of this presentation is to help the PES clinician successfully navigate interactions with law enforcement in terms of information sharing in ways which are ethical, legal, and clinically useful, understanding that some scenarios will be relatively straightforward, and others will be proverbial wicked problems.

12 Building an Adolescent Behavioral Health Roadmap in a Rural State

Laura Russell, JD, Anne Zink, MD, FACEP

Adolescent behavioral health needs are at an all-time high across the nation. Rural states in particular are faced with finding solutions to a growing behavioral health crisis while simultaneously defending against an increasing number of investigations and lawsuits brought by the federal government. Alaska’s acute workforce shortages combined with extreme geographical and infrastructure challenges have led to creation of unique strategies to increase access to behavioral health. In this session, Alaska will:

1. Educate providers on the landscape of current investigations into state behavioral health systems, especially those in rural states.
2. Share success stories and unique strategies to enhance

access to behavioral health in rural states, including Alaska's Behavioral Health Aide and Community Health Aide programs which train individuals to respond to behavioral health crisis and provide therapeutic services in rural and Tribal communities (recognized in SAMHSA's 2023 National Guidelines for Child and Youth Behavioral Crisis Care report). Other initiatives include mobile crisis teams in rural areas, telehealth, and psychiatric consulting for providers through a grant funded partnership with Seattle Children's Hospital.

3. Share Alaska's Behavioral Health Roadmap for Youth, an intensive effort to structure a region-focused, iterative approach to improving the continuum of care for Alaskan youth with behavioral health disabilities. This Roadmap includes a process for meaningful stakeholder engagement, tribal partnerships, and building out care in unique geographic environments. The intent is that this roadmap will provide a focused path to:

1) create a shared vision for behavioral health services in Alaska;

2) align funding opportunities and requests with service delivery needs;

3) identify barriers including regulatory, fiscal, technology, or other issues not fully addressed; and

4) ensure unique regional and cultural needs are cared for and local solutions leveraged as much as possible.

When complete, the plan will provide a framework with specific, phased approaches to statewide and regional service building, including an implementation timeline and measurable results. The plan will be shared with the legislature and other governmental agencies. In this session, Alaska will provide an overview of this project along with next steps and opportunities for interstate collaboration.

13 Academic Emergency Psychiatry: A New Future of Scholarship, Teaching, and Crisis Care

Scott A. Simpson, MD, MPH, Katherine Camfield, MD, MPH, Ben Lee, MD, Michael Wilson, MD, PhD;

Academic medicine has long promised to bring cutting edge science and teaching practices to the care of patients. However, emergency and crisis psychiatry has not always benefitted from this promise. Meanwhile, emergency psychiatry programs have grown to include a broad workforce Ñ of physicians, nurses, social workers, and other mental health professionals Ñ with different skillsets and come to represent health systems with law enforcement agencies and patient advocates who have important but varied priorities in addressing patients in crisis. What then is the future of academic emergency psychiatry? This session features a diverse panel of academic physicians who will discuss the challenges and opportunities for traditional academic medicine in this specialty Ñ and pose a promising future in which academic medicine engages diverse communities and professional partners to improve patient care, scholarship, and health education. Panel discussion will be led by an active moderator, who will also incorporate live feedback from the audience in guiding discussion. To start, each panelist will briefly discuss a specific facet of academic emergency psychiatry. Dr. Wilson will discuss the state of research in emergency psychiatry; the direction of behavioral health services within emergency medicine; and opportunities to build learning health systems in which scientific knowledge informs iterative, outcomes-driven improvements in clinical care. Drs. Simpson and Camfield will discuss the challenges of physician and provider training in this field; academic emergency psychiatrists in the future will play key roles in complex care coordination, integrated care, and the career development of non-physician providers. Finally, Dr. Lee will discuss faculty and program development in this field including challenges of professional growth and clinical operations to support academic mission. Thereafter, the Chair will lead a conversation on these issues with guidance from audience members. Crisis behavioral health involves not only by counselors, social workers, and psychologists but also law enforcement, paramedics, social service providers, and families. How will academic medicine include these other fields in training and research? How will physicians train in this specialty, and what will they do? How can we advance the field while remaining grounded in the underserved and diverse patients we serve? The relationship among traditional medicine, community mental health providers, and our patients is often characterized by clashes of cultures and priorities. This panel imagines how emergency psychiatry can bring together the best practices of all fields to create a new future of evidence-based, compassionate, patient-centered care. Our patients in crisis deserve no less.

14 Hospital Crisis Assessment and Intervention Teams: Addressing Pediatric Psychiatric Emergencies Before (and Beyond) the Emergency Room

Monica T. vonAhlefeld, LISW, Jennifer M. Wallsteadt, LISW-S

Across the United States, there is a crisis with accessing mental health services. The volume of children in need surpasses the capacity for urgent psychiatric services. As a result, many children utilize the Emergency Department to meet their needs. Mental health safety nets are inadequate and non-existent at times, which can lead to psychiatric admissions. Children awaiting bed placement may linger in the Emergency Department for days or

weeks. Generally, during this time, mental health treatment is not specific to their needs, but solely focuses on safety. This pediatric mental health crisis requires unique solutions. At Cincinnati Children's Hospital Medical Center (CCHMC), the number one ranked pediatric hospital in the country, a team of over 70 emergency department psychiatry employees manage the growing mental health system dilemma. At CCHMC Psychiatric Intake Response Center (PIRC), we created a designated point of access for families and/or providers to call when they are experiencing a crisis. This provides an alternative psychiatric assessment option outside of an ED setting. Our Crisis Assessment Team is available to respond to crisis calls from patients, caregivers, schools, and community agencies. Master's level clinicians use standardized tools to assess risk and to provide treatment recommendations. Approximately 70% of the callers are directed to outpatient resources including our Bridge Clinic, mental health urgent care sites, or alternative levels of care. The entire community benefits with the Crisis Assessment Team as the access point. The PIRC at Cincinnati Children's Hospital identified the lack of psychiatric treatment options for at-risk children evaluated in the Emergency Department. Children are evaluated and discharged with referrals, but there is no guarantee of their ability to access therapy and/or medication evaluation in a timely manner. In addition, some of the children evaluated can be better served by receiving a psychiatric evaluation outside of the Emergency Department. The Bridge Clinic was created in 2017 to provide an alternative psychiatric assessment and stabilization option for children presenting in crisis and who need assistance coordinating ongoing mental health treatment. The Bridge objectives are:

to minimize unnecessary Emergency Department visits.

to provide an alternative level of care to support Emergency Department discharge.

to provide crisis management interventions for safety and stabilization.

to support transition to ongoing mental health treatment. In summary, the Bridge Clinic partners with families to help them navigate through their mental health crisis to support them in their next steps towards mental health wellness.

The collaborative efforts of our Crisis Assessment Team and Bridge Clinic offer unique solutions to mitigate the pediatric mental health crisis. Our programs work conjunctively to quickly assess the child's crisis and to refer them to the appropriate level of care and treatment. These initiatives improve family and hospital system outcomes by decreasing strain on an already overwhelmed Emergency Department.

15 Applying Structured Approaches to Implementing Change in a Behavioral Health Emergency Service

Heather M. Wobbe, DO, MB, PMP

Behavioral health emergencies exist at the intersection between complex community dynamics and complex healthcare systems. If one seeks to implement positive changes in the management of behavioral health emergencies, adopting a structured approach to the analysis of both the community one serves and the healthcare system in which one operates can clarify challenges and inform the development of a realistic approach. This session will begin by introducing the Quality Implementation Framework (Meyers, et al) to provide a four-phase roadmap for implementing change. Next, several conceptual frameworks will be discussed; including Andersen's behavioral framework, Donabedian's structure-process-outcome framework, Nadler/Tushman and others' organizational design framework, and Gittell's relational coordination framework; that may inform participants about where opportunities for improvement in the delivery of behavioral health emergency care may exist (McDonald, et al). Using this newfound understanding, participants will learn to draw upon the Project Management Body of Knowledge (PMBOK) published by the Project Management Institute, to develop a realistic plan to address the challenges they have identified. Finally, participants will examine why efforts to improve healthcare delivery might fail (Kotter) to empower participants to anticipate and navigate hurdles they may encounter on their journey of change.

16 "May I Have Your Attention Please, Code Correct": Tips to Accurately Code for Psychiatric Services in the ED

David Yankura, MD, Junji Takeshita, MD

Provision of psychiatric services in the ED setting allows for several options for coding and billing, depending on the specialty/discipline of the provider. Familiarity with how your setting is licensed (outpatient, ED, observation unit, etc.) can also be essential when choosing between these options. Options for coding and billing for psychiatric services include outpatient E/M codes, psychiatry family codes for psychiatric evaluation, emergency services E/M codes, consult E/M codes, and interprofessional consult E/M codes. Over the past few years, there have been significant changes to requirements for E/M codes. These E/M services are now billed either on medical decision making or on time. We

will review tips related to the following areas: 1) Changes in requirements for E/M codes 2) Explanation of requirements for medical decision making and time when using E/M codes 3) Use of psychiatry family codes (90792/90791) 4) Use of emergency services E/M codes 5) Use of consult services E/M codes 6) Use of interprofessional consult E/M codes 7) Billing for follow-up services in the ED 8) Coding for services provided with involvement of a resident physician

17 Pediatrics-Law Enforcement Alliance for Youth: a Collaborative Approach to Caring for Patients with Law Enforcement Involvement

Jennifer A. Zaspel MD

Intro: Both psychiatric and medical emergency providers may interact with law enforcement personnel (LEP) when treating pediatric patients for a variety of reasons, including caring for patients who are in custody, on involuntary psychiatric holds, or involved in cases of suspected abuse or neglect. The relationship between LEP and the medical team is important to maintain but is secondary to the relationship between the medical team and patient. This distinction is particularly important to consider when caring for youth, who lack legal and frequently developmental agency to advocate for themselves. The role of advocate is often taken up by the medical team, who must then navigate what is often a gray area for individuals who feel a need to protect their patient but have varying degrees of understanding of the law and varying degrees of comfort with interacting with LEP. Methods: A multidisciplinary team, Pediatrics-Law Enforcement Alliance for Youth (PLAY), was developed to review and create evidence-based, patient-centered, ethically sound hospital policies and procedures for patients whose medical encounter involves law enforcement. The team is comprised of physicians and APPs from various specialties, social work, security, hospital leadership, risk management and legal, on-campus law enforcement, and more. PLAY is tasked with evaluating and implementing organizational improvements in the process and care of patients with LEP involvement at Children's Wisconsin (CW) in Milwaukee, WI, focusing primarily on Emergency Department and Hospital care. Results: Five areas of improvement have been identified: resource development, policy, education, scholarship, and engagement. The first resources developed have been focused on event reporting and incident review. The hospital policy has been revised and expanded to include language specific to involuntary psychiatric holds, the rights of both patients and guardians when a youth is in custody, and best practices regarding any kind of investigation by LEP related to patients and families. There has been considerable education and outreach both internally and externally regarding LEP and PLAY's overall mission. Finally, we have begun collecting current state data on perceptions and experiences with LEP as well as patient data for individuals who interact with LEP during their care encounters. Discussion: In pediatric emergency psychiatric care, interactions with LEP are inevitable. PLAY has made considerable progress towards ensuring our hospital policies and practices support patients' rights and promoting effective collaboration between CW healthcare workers and local LEP. While some interventions are specific to our hospital system and community, by approaching our challenges with an intent of patient-centered collaboration, we feel the spirit of our work can provide other systems with a framework for improving their own understanding of and interactions with LEP in the care of this vulnerable patient population."

18 An Analysis of all Behavioral Codes at a VA Medical Center During a Five-Year Period

Muahmmet Celik, MD, Brian Fuehrlein, MD, PhD

Background: An emergency behavioral code is generally defined as an individual who poses a threat to the safety of patients, visitors, or staff. These events pose a challenge for healthcare workers and hospital administration. In a recent study, the prevalence of agitation among emergency department (ED) patients was 2.6% and the literature indicates that the prevalence of seclusion among ED patients is around 25%. Interdisciplinary behavioral emergency response teams (BERTs) are often utilized in response to behavioral codes. At VA Connecticut, the behavioral code responders include psychiatric registered nurses, mental health technicians, a psychiatrist, a nursing supervisor, the primary team (where applicable) and the VA police. Despite the significant safety risks posed to patients and staff, the current literature on behavioral emergencies and BERTs is limited. Decisions surrounding security interventions, restraint use, and involuntary medication administration can present challenges. The use of restraints in various healthcare settings differs between studies, with rates ranging from 2.2% to 51.3%. A study that examined patients who had been restrained revealed that being restrained had long-term consequences on their relationship with the healthcare system. Additionally, it has been reported that injuries can occur in situations where attempts are made to restrain individuals experiencing agitation. Furthermore, the presence of implicit bias among healthcare professionals can further exacerbate disparities in healthcare for patients with different demographics.

Methods: This study analyzed the characteristics and prevalence of behavioral codes among veterans at a VA medical center. In this descriptive study, 751 behavioral emergency codes that occurred between fiscal years 2018 and

2022 were reviewed. The demographics, diagnoses, causes, interventions used, and outcomes were analyzed and will be presented in detail in the poster.

Results: In summary, the prevalence of behavioral codes among all hospital admissions and presentations to either the medical emergency room or the psychiatric emergency room was 1.8%. 370 patients accounted for the 751 total behavioral codes, and the average number of codes per patient was 1.9 (SD=3.1). Eight patients accounted for 16.1% of all behavioral codes with a maximum of 23 codes for a single patient. The mean age of patients involved was 62.0 years with 96.5% male, and 64.8% white. Diagnostic categories contributing to the codes were: substance use disorders (38.0%), psychiatric diagnoses (24.1%), medical diagnoses (20.1%), and dementia (12.0%). In 50.1% of codes, only verbal de-escalation was utilized, and in 48.8% chemical sedation was required. Physical restraints were used in 28% of codes, and 2.1% of all codes resulted in injuries to an involved party. The poster will expand upon these data and present suggestions for reducing the incidence of codes and improving outcomes.

19 A Case of Catatonia Responsive to Lorazepam Following Methamphetamine Use in A Patient with No Formal Psychiatric Diagnosis

Erica Cohenmehr, MD

Background: Methamphetamine is an addictive synthetic central nervous system stimulant abused for its euphoric and energizing effects. Acute methamphetamine use has been linked to acute and chronic neurotoxic effects via both dopamine depletion and excessive NMDA-receptor activity. Catatonia is a neuropsychiatric syndrome characterized by psychomotor abnormalities, likely mediated by similar pathways including disturbances in dopaminergic, glutamatergic, and GABA-ergic activity. While catatonia has been noted to be provoked by drug exposures, only one case report links acute methamphetamine use to catatonia.

Case: The patient is a 48-year-old man with a past medical history of diabetes, hypertension, and HIV on ART, without any formal past psychiatric diagnoses but with a longstanding history of methamphetamine use and one prior psychiatric ER visit with transient paranoia following methamphetamine use and a family history of schizophrenia in a first-degree relative, who presented to the ER reporting anxiety. On initial evaluation, Bush Francis Catatonia Rating Scale (BFCRS) score was 15 for mutism, staring, posturing, rigidity, automatic obedience, and negativism. After administration of IM lorazepam 2mg, symptoms showed marked improvement but returned in hours. Urine toxicology was positive for amphetamines only. The patient was admitted to medicine for rhabdomyolysis with CPK = 815, followed by consultation liaison psychiatry, and started on IV lorazepam 1mg TID. On re-evaluation the next morning, patient was again in a hypokinetic catatonic state with a BFCRS of 20, and IV lorazepam was increased to 2mg IV TID. Subsequently, patient remained significantly improved with a BFCRS of <5 with residual intermittent staring, psychomotor slowing, and prolonged speech latency. Lorazepam was transitioned from IV to PO and tapered down to 1mg PO BID. Subsequently, catatonic symptoms completely resolved with BFCRS = 0. On interview, the patient presented calm, linear, and euthymic and firmly denied all mood and psychotic symptoms on interview and prior to presentation. He was discharged to outpatient level of care.

Discussion: Given patient's euthymic presentation with lack of reported or observed psychotic, depressive, or manic symptoms following treatment with lorazepam, the most likely etiology for his acute catatonia is methamphetamine use. His family history of schizophrenia and personal history of substance-induced psychotic symptoms may contribute to a vulnerability to the neurotoxic effects of methamphetamine or may be additional markers for an underlying psychotic spectrum illness.

Conclusion: While there is limited research on a connection between methamphetamine use and catatonia, the present case demonstrates a temporal association between methamphetamine use and acute catatonia responsive to lorazepam.

20 Management of Agitation in Pregnancy: Collaborative Education to Improve Safety and Care

Christine N. DeCaire, MD

Background: Management of behavioral health emergencies such as acute agitation in pregnant patients requires knowledge of general agitation management as well as special considerations for this unique population. The growing shortage of psychiatrists places a significant burden on other specialties, who may have to manage complex psychiatric conditions or behavioral health emergencies without the support of in-house psychiatry. Data from a cross-sectional study of Obstetrics and Gynecology (OB-GYN) program directors in the US indicates an overwhelming shortage of psychiatric education throughout OB-GYN residency training attributed primarily to a lack of integration between OB-GYN and Psychiatry. This quality improvement project aims to improve the knowledge and skills of OB-GYN residents in managing agitation in pregnant patients, both in the inpatient and emergency room setting. Method: We have distributed a baseline survey of

all OB-GYN residents to assess their comfort level. The psychiatry residents and faculty involved will design and deliver the educational component. We have provided the educational component with case-based examples to all OB-GYN trainees, demonstrating basic verbal de-escalation techniques, which are targeted to the pregnant population. We have distributed a post-survey of all OB-GYN residents to assess their comfort level after this educational exercise. This type of simulation quality improvement project has been performed in psychiatry at our hospital, as well as in other departments/institutions, and it has been shown to improve de-escalation skills.

Results: Collaborative education with psychiatry for OB-GYN trainees is expected to improve the confidence of trainees in managing agitation in pregnant patients and thereby improve patient safety. We are currently pending survey results. Conclusion: Collaborative education with psychiatry for OB-GYN trainees is expected to improve the confidence of trainees in managing acute agitation in pregnant patients and thereby improve patient safety in both the inpatient and emergency room setting.

21 Co-Responder Programs in the US: Overview of First Responder/Mental Health Field Teams

Thom Dunn, PhD

There is a growing interest in utilizing combinations of first responder and mental health provider "co-responder" programs as a prehospital intervention for behavioral emergencies. Some communities use a social worker and a police officer. In others, an EMT or paramedic is paired with mental health worker. Yet a third configuration involves EMS, law enforcement, and social worker. This presentation by a clinical psychologist and paramedic reviews such teams, the literature about their efficacy, and proposes best practices.

22 Transition of Psychiatric Care: From PES to Community with Peer Support

Ryan Felton, Bryan J. Griffin, DO, MHA

Introduction: Psychiatric emergency services are used by individuals undergoing mental health crisis, but many patients fail to transition to outpatient care. Instead, many of these patients return to the emergency settings for additional care. Barriers such as the patients' own psychiatric symptoms as well as navigating the complex mental health care system often prevent patients from receiving ongoing psychiatric care outside of the emergency department. Data from the University of Cincinnati's (UC) Psychiatric Emergency Services (PES) reported a 17.4% patient recidivism rate within 30 days between March and April 2023.

Aim: The primary aims of this project are to 1) initiate a peer support programs' follow-up call system that is intended to transition patients from PES to community outpatient care, 2) target discharged psychiatric patients that do not meet inpatient admission criteria and 3) evaluate patients' use of peer services for future targeted interventions. Intervention: Using the Plan-Do-Study-Act (PDSA) Model of Improvement, peer specialists made follow-up calls for PES patients within 24 hours of the patient's discharge. Peer specialists consist of a team of non-clinical individuals who have experience in either mental health or substance abuse recovery. They are trained to guide, support, and advocate for patients through the adherence of the Substance Abuse and Mental Health Administration (SAMHA) guidelines. During these follow-up calls, peer specialists asked patients if they needed assistance with connecting to outpatient mental health services. Only patients that were discharged into the community from UC Health's Ridgeway PES that did not meet criteria for in-patient psych admission nor were transferred to another medical facility were qualified for the follow-up calls. For this project peer specialists documented who they called, the number of calls attempted to contact patient, who answered call, if peer services were used, and if patient scheduled a future outpatient appointment with mental health services. Patients' psychiatric history, demographics, emergency department encounters, and clinician notes from the designated PES visit were collected from the patient's medical recorder via EPIC Systems. Data

Collection and Analysis: Between June 25th through July 2nd, 2023, approximately 10 discharged patients from the previous day were randomly selected to receive follow-up calls from a peer specialist to offer help with discharge instructions and connecting to outpatient mental health services. Only patients that were discharged into the community from UC Health's Ridgeway PES that did not meet criteria for in-patient psych admission nor were transferred to another medical facility were qualified for the follow-up calls. For this project peer specialists documented who they called, the number of calls attempted to contact patient, who answered call, if peer services were used, and if patient scheduled a future outpatient appointment with mental health services. Patients' psychiatric history, demographics, emergency department encounters, and clinician notes from the designated PES visit were collected from the patient's medical recorder via EPIC Systems.

Discussion: This project was preformed to analyze the preliminary stages of the peer program and establish the groundwork for carrying out the Plan-Do-Study-Act (PDSA) Model of Improvement to target patients with 1) high psychiatric symptom burden and 2) a pattern of not connecting with

outpatient services. The results of this project showed that phone calls were an effective method to follow up with discharged patients. This information is aligned with a similar study that did follow up calls after ED discharges in which they reported 66.7% of discharged patients were able to be reach via telephone within one phone call. However, in the current project, only a third of patients utilized their peer services to connect with outpatient mental health resources. even though a majority of the patients were not connected with outpatient mental health services. The low number of patients using the peers service could be due to the fact that data was collected a week after services were first launched; therefore, patients may not have been aware of the new program. Therefore, the Plan-Do-Study-Act (PDSA) Model of Improvement will be used in the future to not only continue monitoring peers support progress but also to target patient populations that would most benefit from follow-up calls by transitioning from randomly selected discharge patients to clinician- selected discharged patients.

23 Emergency Department De-escalation Team to Manage the Acute Agitated Patient

Trish Hendricks, RN

Background: Regions Emergency Department has had recent events with severe patient escalation and increased restraint usage. The ED team intervenes though a code purple response which can put employees and patients at risk. There are existing standards for a code purple response that require updates and role clarity to enhance safety. We sought to explore best practice and improve the care of the agitated patient.

Methods: Multidisciplinary team engaged a two part design event followed by a build of role clarity, safety huddle framework and electronic display of patient status

Results: YTD data shows a reduction from from 1.63 events per day to 0.64 events per day; 75% of staff surveyed feel the safety huddle has kept patients out of restraints. Conclusion: The implementation of a safety huddle as a result of a multidisciplinary project improvement process has resulted in less restraint usage and a reduction in work place violence. Front line staff engagement in the project improvement process has contributed the most to the sustainment of results.

24 Phenobarbital in the ED When Medical Detox is a Resource of the Past: A Case Series

RuDonna Hernandez, MPH, James Hardy, MD

Introduction: Medical detoxification (detox) programs are widely known to have medical staff close by to aid with patients who demonstrate symptoms of alcohol withdrawal. When medical detox programs are a limited resource, Phenobarbital can be the solution in an ED. Phenobarbital is a medication used to manage alcohol withdrawal symptoms and has a long half-life, but outcomes are not well studied among patients who receive Phenobarbital in the ED, and discharged from the hospital to a social detox program. The objective of this case series was to 1) develop a protocol in the ED with AUD (alcohol use disorder) patients, 2) reduce withdrawal symptoms while at a social detox program, and 3) to make prescribing AUD medication at discharge, obsolete.

Methods: The case series was conducted at a research and teaching hospital Emergency Department (ED) in California. Patients who arrived at the ED suspected of heavy alcohol consumption, concerned about withdrawal, and wanted to be discharged to a substance use treatment program (a community partner), were administered Phenobarbital. A combination of criteria determined the Phenobarbital dose, including, triage vital signs, seizure history, daily alcohol consumption, and The Clinical Institute Withdrawal Assessment Alcohol Scale Revised (CIWA-AR) score. There were weekly updates between the ED provider champion, substance use navigator (SUN), and a community partner liaison, to monitor if patients had alcohol withdrawal complications throughout participation.

Results: Between January 2022 to June 2023, the ED referred 85 patients to Salvation Army's Harbor Light social detox program, a 30-day or longer residential treatment program, and community partner, located in San Francisco, CA. Some 20% (n=17) met the criteria to be administered phenobarbital, a medication used to treat alcohol withdrawal symptoms, in the ED. Most (82%) identified as male, and majority (65%) identified as White/Caucasian. The preferred alcohol type was liquor (59%), most (65%) consumed more than 6 drinks per day, and majority (76%) stayed at Harbor Light longer than 72 hours (about 3 days).

Conclusions: Patients who arrived at the ED suspected of heavy alcohol consumption, received Phenobarbital, and were discharged to the social detox program had zero alcohol withdrawal complications, and did not return the ED within the crucial 72-hour period. It is within the 72-hour period when alcohol withdrawal symptoms would be expected to develop and be seen. Our case series has a promising approach and deserves further research.

25 The Boarding Battle A Journey with Light at the End of the Tunnel

Diane E. Hindman, MD, PharmD, BScPhm, FAAP, LeeAnn Kuang, MA, Licensed Professional Counsellor, Tracy Kouns, MA, MSN

Pediatric mental health remains a national emergency with disorders beginning in early childhood, impacting

children and adolescents across diverse sociodemographic categories, and experiencing escalating incidence in psychiatric diagnoses alone and with co-occurring medical conditions. Emergency departments are becoming the initial and, in many cases, only point of access for essential pediatric psychiatric care. This is less than ideal as emergency departments struggle with bed capacity, extended lengths of stay, access to providers skilled in necessary psychiatric care, patient safety and quality of care, difficulty with ultimate care coordination, and limitations in definitive disposition options. This session aims to share the experiences of Arizona's largest tertiary care pediatric academic center in addressing pediatric mental health emergency visits and boarding over the past five years. The speakers will highlight successes in partnerships and modifications implemented. Participants will close with a discussion of ongoing efforts and opportunities to enhance pediatric mental health care, education and research.

26 Treatment and Economic Challenges when Treating Patients with Agitation Associated with Schizophrenia or Bipolar Disorder in the Emergency Department

Sonja Hokett, PharmD, MS

Objective: Episodes of acute agitation associated with schizophrenia (SCZ) or bipolar disorder (BPD) pose treatment and economic challenges for patients and staff. Occurrence of staff injuries, physical restraint use, extended inpatient admissions, and increased emergency department (ED) boarding create a complex clinical environment. Identifying and quantifying the impact of these treatment challenges and economic drivers is critical to effective patient management strategies.

Methods: Two separate analyses of medical and pharmacy claims data [Clarivate Real World Data between 9/2015 and 4/2022 and Healthcare Cost and Utilization Project (HCUP) Nationwide Emergency Department Sample (NEDS) from 2018] quantified prevalence and direct medical costs from ED and inpatient visits. These data were combined with a multicenter retrospective chart review and published data to provide a comprehensive overview of the clinical and economic burden of acute agitation episodes in patients with SCZ and BPD.

Results: Within this population, high utilizers of healthcare resources comprise 12% of patients but account for 54% of agitation episodes. This subset of high-utilizing patients had 5 times the mortality risk and nearly double the 30-day hospital readmission rate (65% vs 37%) versus the lower-utilizing group. When treated in the ED, 27% of patients with agitation associated with SCZ or BPD were physically restrained contributing to additional direct medical costs of $1,511 (SCZ) and $1,233 (BPD). Components of these additional costs of physically restraining patients in the ED included 4.2 additional hours in the ED, 8% higher inpatient admission rate, 1.45 days longer inpatient stays, and 22% staff injury incidence. Total inpatient admission costs were $11,000 (SCZ) and $7,600 (BPD). Hospital staff injury Workman's Compensation claims were an average of $15,860 between 2006 and 2011. Additional challenges around ED patient boarding cost $ 3,400 and denied care of 2.2 patients.

Conclusion: Treatment of agitation associated with SCZ and BPD is challenging and results in higher healthcare utilization and higher patient mortality risk. Direct medical costs are increased from ED and inpatient admission incidence rates and length of stays, increased patient physical restraint use, increased staff injuries, and ED boarding. Detailing and quantifying these clinical and economic patient treatment challenges can assist in evaluating the current therapeutic paradigms and selecting effective and safe treatment options which may improve patient outcomes and lower staff burden.

27 Improving Behavioral Health Infrastructure in Michigan: Filling Gaps and Finding Solutions

Lauren LaPine, MPH, Laura Appel, MS

The COVID-19 Pandemic exacerbated existing behavioral and mental health challenges across the United States. Each state is facing challenges, unique to the populations and communities of each state. Historically, in the 1980s during the time of deinstitutionalization, Michigan, like other states, dramatically decreased the number of state forensic hospital beds. Today, an additional set of state forensic beds have been taken offline due to workforce shortages. This has created a significant backlog in patients that are waiting for critical inpatient psychiatric care. The Michigan Health and Hospital Association (MHA) secured funding and designed a competitive grant process for hospitals and health systems to add capacity statewide for pediatric inpatient psychiatric services through a funding amount of $50 million dollars. This presentation will highlight the proposals that were received and awarded and will provide an overview of what innovative programs were implemented with the funding. Additionally, the MHA launched a state-wide survey to understand from a quantitative perspective the number of patients that are waiting in emergency departments (ED) with inpatient psychiatric needs, or public behavioral health services to gain a better understanding of the problem. This data helps identify the existing gaps in capacity, and the need for increased services and supports to address the need. This presentation will cover the longitudinal data that's been collected, and will be broken down by pediatric, adult,

and geriatric cases. Lastly, we know that addressing such systemic challenges require collaborations and partnerships with various partners. This presentation will detail the various policy and legislative efforts that the MHA has launched to improve the behavioral health landscape across the state. Presenters will detail efforts to secure reimbursement for peer recovery coaches/specialists, policies to implement Pediatric Residential Treatment Facilities (PRTFs), and legislation to expand treatment for opioid use disorder through Medication Assisted Treatment in the emergency department, and other substance use disorder legislation to make it easier to get treatment for addiction and dependencies.

28 Evaluating The Response to Patient Agitation and Workplace Violence in An Acute Care Hospital

Nicole Lincoln, DNP, RN, APRN-BC, Sabine Clasen, PhD, RN

Background: Workplace violence is an increasingly serious problem that negatively affects healthcare workers in acute care hospitals, which has been well documented. It also adds to the overall financial burden through staff injuries and turnover. In 2022, Boston Medical Center identified that frontline staff get injured on the job at alarming rates, with 1 -2 reported assaults daily, and have expressed fears for their safety and well-being. Four major categories of patients at risk for agitation and escalation were identified, including those with psychiatric and substance use disorders, cognitive impairment, and neuro-diversity. The historical procedure for responding to an agitated patient was reactive and missed the opportunity to prevent a crisis. However, not much was known about the contributing factors and gaps in preventing and reacting to patient agitation.

Quality Improvement Methods: A stakeholder workgroup that included frontline workers, clinicians, and leadership was convened to evaluate the current state of agitation and patient on healthcare worker violence management and to make recommendations for a future ideal state. A systematic quality improvement process was used to understand the etiology of patient agitation, current processes, and resources used to manage workplace violence. Information collection included individual and group stakeholder interviews to conduct comprehensive root cause analyses and map out the current state. A scoping literature review of best practices and a gap analysis were used to identify and understand unmet needs, themes, and possible solutions.

Solutions: Based on our findings, the following solutions were proposed: Implementation of a proactive agitation screening for all adult inpatients using the Behavioral Agitation Rating Scale (BARS) embedded in the electronic health record. A team response to behavioral escalation led by behavioral response nurses and proactive rounding on patients at risk for agitation or withdrawal is in the process of implementation. Documentation and debriefing tools were built for the behavioral response nurses.

Proposed outcome measures: The proactive agitation assessment and team response are expected to close current gaps in staff education and real-time clinical response and better address unmet patient needs. Initial outcome measures will include staff skills and an anonymous survey for staff to rate their self-efficacy in the proactive management and response to patient agitation. Additionally, the percentage of patients who experience agitation is measured with the BARS score and the use of violent and non-violent restraints. The number of workplace incidences will be trended over time, and early nurse retention data will be presented. The return on investment will be discussed to describe the financial impact of using a team to address workplace violence.

Conclusion: A rigorous quality improvement process was used to investigate the current state, root causes, and contributing factors of patient on healthcare worker violence. Participants will benefit from understanding how quality improvement methods can lead to a system-wide proactive approach that addresses patient agitation and escalation to reduce workplace violence.

29 Disparities in the Care of Youth with Agitation or Aggression in the Emergency Department: A Systematic Review and Clinical Guidance

Megan M. Mroczkowski, MD

Objective: This systematic review aims to summarize the current state of research literature on disparities in the care of youth with agitation and aggression in the Emergency Department (ED), including referral, assessment, diagnosis, use of pharmacologic interventions, and utilization of restraint and seclusion.

Method: This study used the preferred reporting items for systematic reviews and meta-analyses (PRISMA) 2020 checklist searching PubMed and PsycINFO databases (May 1, 2013-May 5, 2023) for studies that reported disparities in the care of youth with agitation or aggression in the Pediatric ED

Results: Disparities in the care of youth with agitation or aggression in the ED have been documented for race, sex, age, developmental status, and insurance status. There is no data on disparities in ED-based care of youth with agitation or aggression based on gender identity and/or presentation, sexual orientation, socioeconomic status (SES), systems-involvement (including child welfare, foster care, juvenile justice), or language proficiency.

Conclusions: While there is some data on disparities in the care of youth with agitation or aggression the ED documented for race, sex, age, developmental status, and insurance status, further work in this area is needed. Actionable steps to address mental health disparities in the pediatric ED are discussed.

30 Crisis Care Design: Prototyping Community Crisis Centers Nationwide

Stephen N. Parker, M. Arch, NCARB

There has been explosive growth in the design and development of crisis stabilization centers Ñ some prototyped and prefabbed Ñ that divert mental health patients from law enforcement or overburdened hospital emergency departments. In this poster session, he will share how the right expertise, partnerships & resources can align to meet the nation's growing demand for crisis stabilization units. Our designers have been applying evidenced-based behavioral health practices that lead to better outcomes and shorter lengths of stay for crisis stabilization. Increasingly, designers and planners employ Trauma-Informed design principles to create spaces for patients that have a sense of dignity and a connection to their community. These trends have become manifested in FGI 2022 guidelines for behavioral health crisis units following the EmPATH model. This dovetails with the use of subacute inpatient settings for crisis stabilization, which is often driven by the 16- bed count threshold. Often the intake suite for ''warm hand-off with first responders is a critical space to ensure patients in crisis being brought into these facilities can transition as smoothly as possible. This includes the correct flow into assessment rooms and that staff feel safe during this intake period while reassuring patients during this critical moment in their continuum of care. Spatial considerations for families and loved ones are increasingly of interest to crisis care providers. In this way, our Dignity-Driven Design approach seeks to humanize mental health environments for patients, harmonize staff safety and enhance the comfort of visiting family and friends for the communities we serve.

31 Protocolized Management of Acute Agitation in ASD and ID in a Pediatric Emergency Department

Samia Taoulost, MD

Introduction: There is a scarcity of research on the optimal method for delivering care to individuals with autism spectrum disorders (ASD) and Intellectual Disorders (ID) who experience sudden agitation and seek emergency medical attention. At the same time, ED personnel identify clear guidelines as one of the most important resources for improving their self-perceived competence in managing patients with neurodevelopmental disorders (NDD). Current study draws upon the available evidence-based approaches to create a training session for Montefiore psychiatry residents, summarize the key points in a pre-written sequence of steps to be uploaded into the electronic medical record (EMR), and a Health Passport that promotes collaboration with patients' families and caregivers to provide a safe and therapeutic ED experience. Additionally, there is a paucity of published assessments of psychiatry residents' level of competence in treating agitated patients with NDD. Given that psychiatric providers are frequently the ones treating acute agitation in the ED, this study seeks to explore self-perceived competency of Montefiore psychiatry residents and strategies to address competency gaps.

Method: This is an interventional prospective study to implement and evaluate evidence-based interventions to improve the management of acute agitation in a pediatric emergency department. The interventions include, 1) a training module for psychiatric residents in evidence-based approach to agitation in pediatric patients with neurodevelopmental disorders (NDD); 2) an Epic dot phrase outlining pharmacologic and non-pharmacologic interventions for the studied patient population; and a Health Passport to be completed by patients' caregivers to inform the psychiatric ED care team about potential warning signs, calming techniques, and any additional needs the patient may have. Evaluation will be done through retrospective chart review and resident surveys pre and post the training session. Descriptive statistics will be computed to describe the characteristics of the residents of the analysis groups: the post-training group and the historical control group. Patterns of PRN and seclusion orders identified through a retrospective chart review will also be characterized and presented.

Results: Study is ongoing and preliminary results of both surveys and retrospective chart analysis are expected to be available in September 2023. Interventions such as the Epic dot phrase which summarizes evidence-based guidelines, training module and health passport have already been designed and ready for implementation.

Conclusion: Management of acute agitation in patients with NDD within emergency settings can be challenging and potentially pose a safety risk for both residents and nursing staff. Characterizing use patterns of PRN medications and restrictive methods such as seclusion may allow for the identification of gaps in evidence, and opportunities for improvement. Targeted interventions such as staff training, implementing a health passport and evidence-based guidelines can help guide clinical staff in their management of acute agitation and create a safer environment for both staff and patients.

32 Discrepancies in Care for Psychiatric Patients in the Emergency Department

Joy Yang BA

Despite increasing numbers of psychiatric patients being boarded in the emergency department (ED) for extended periods of time, studies show that these patients rarely receive optimal therapeutic treatment, resulting in decreased bed turnover and increased costs for hospital systems. This study aims to quantify disparities in variables denoting length of stay (LOS) for psychiatric patients and nonpsychiatric patients in EDs. The authors used retrospective chart review to evaluated psychiatric and nonpsychiatric adult admissions in several EDs in Connecticut, considering different measures of LOS. 779 psychiatric patients and 57,949 nonpsychiatric patients were considered. Time to be seen by Physician (37.69 minutes vs 28.65 minutes, P<0.001) and time between arrival and discharge (1174.78 minutes vs 332.87 minutes, P<0.001) were both significantly longer for patients housed in psychiatric sites. Time in waiting room is notably significantly shorter for psychiatric patients (9.46 minutes vs 15.93 minutes, P<0.001). All disparities are found to be highly statistically significant and the time between arrival and discharge is clinically significant as well, amounting to about a 14-hour difference between psychiatric and nonpsychiatric patients.

33 They Said It Couldn't Be Done: Lessons Learned from Launching an ED Telepsychiatry Program at an Academic Medical Institution

David Yankura, MD, Margaret Ealy, CPA, MA

For over 10 years, an ED Telepsychiatry program had been considered, but was never moved forward due to concerns for cost, logistics, staffing, feasibility, etc. After a rapid shift to providing telemedicine services across the country as a result of the COVID-19 pandemic, our academic medical institution finally launched an ED Telepsychiatry program in 2021. Given needs of the system, the program was first launched at 4 emergency departments in hospitals that are located in a different market than the primary site. About one year later, the program was expanded to include 3 emergency departments in hospitals in the same market as the primary site. We are currently in the process of expanding to an additional 3 emergency departments that are located in another different market than the primary site. The development and implementation of this new ED Telepsychiatry program presented several challenges. Lessons learned during this process include: 1) While ED's operate 24/7, ED Telepsychiatry coverage can operate effectively with around 12 hours of coverage. 2) APP's with additional training in psychiatry can be successfully utilized as part of the ED Telepsychiatry team. 3) Consider clinical risk tolerance when making hiring decisions. 4) Planning and coordination with existing clinical services is necessary to avoid poaching physician/APP resources. 5) While the goal of an ED Telepsychiatry program is not to replicate a behavioral health unit with daily visits and medication changes while patients are awaiting bed search, medications can be started to target acute manic/psychotic symptoms in an effort to improve patient experience and to help reduce utilization of ED resources. 6) Dedicated equipment in the ED for Telepsychiatry services is essential. 7) Coordination between various stakeholders (IT, HR, revenue cycle, credentialing, legal, physician services, local hospital and ED leadership, etc.) is crucial. Having the ED Telepsychiatry leadership team visit the local ED sites to meet ED and hospital leadership can help to build a relationship and improve coordination among stakeholders. 8) Hospital privileging is a rate limiting step in initiating the service at new ED locations. 9) A financial model that includes a monthly fee based on expected monthly consult volumes has allowed our ED Telepsychiatry program to remain viable. In conclusion, an ED Telepsychiatry program can be effectively implemented at an academic medical institution. The program has allowed us to successfully bring behavioral health expertise into emergency departments in the system that could not individually sustain the cost of providing these services.

34 Threat AID (Assessing Imminent Dangerousness) for Clinicians: What to Do If There Is Concern for a Mass Shooting Event

Amy Barnhorst MD

Mental health practitioners working in acute and emergency settings occasionally evaluate patients who have made threats of or appear to be at risk of perpetrating a mass shooting. Fortunately, these events are rare, though their infrequency can lead to attrition of clinical skill and knowledge of best practices when they do arise. Such encounters confer an elevated risk for patients and their communities, and a standardized protocol for clinicians based on the best evidence and expert consensus can mitigate the risk of both violence and medicolegal liability. This session will introduce a novel clinical tool to guide clinicians through such encounters, based on the paper "Evaluating threats of mass shootings in the psychiatric setting. It will include: a) special considerations for mental health evaluations b) indications for psychiatric hospitalization c) engagement and information sharing with law enforcement and other relevant

parties who can help mitigate threats d) how HIPAA and the Duties to Warn and/or Protect (“Tarasoff duties may apply e) civil protective orders for firearm removal, including Extreme Risk Protection Orders or “red flag laws f) institutional and individual risk management.

35 Resident Education in Emergency Psychiatry

Annelise Bederman, MD, MSC, Christina Terrell, MD

Psychiatric emergencies present unique challenges and require specialized knowledge and skills. Education plays a pivotal role in preparing residents to assess, stabilize and manage these emergencies. The ACGME requires that all general Psychiatry residents have experience in psychiatric emergencies. Beyond specifying that this competency should not be counted as part of the outpatient psychiatry requirement, and that on-call shifts alone cannot satisfy this requirement, there is very limited guidance. This presentation will highlight the importance of education (formal and informal), identify critical competencies, and review different approaches to emergency psychiatric and crisis care. This presentation will examine tools to enhance experiential learning opportunities. Discussion will include models of care and the various roles of residents in and outside of psychiatry and emergency medicine. As interest grows in emergency psychiatry and crisis care a leader is needed to establish best practices for the education of residents in psychiatric emergencies. We believe AAEP is that leader and this will become a roadmap for the education of residents.

36 The Treasure and the Quicksand: Emergency Psychiatry as a Dialectic of Psychiatry and Emergency Medicine

Jon S. Berlin, MD

I present this lecture from the biopsychosocial perspective. As always, the points are mostly based on clinical examples, and I attempt to make audience learning experiential, with participants having the feel of being in the room with a patient. The talk is two things: 1) a brief meditation on the identity, achievements, and perils of emergency psychiatry as a discipline; and 2) a brand-new installment in the ongoing task of improving our understanding of hard-to-engage and hard-to-read crisis patients and improving our ability to work with them. What is emergency psychiatry? It’s the offspring of two parent disciplines, emergency medicine (EM) and psychiatry, but it’s also a unique discipline in its own right, sometimes reflecting the ethos and concepts of one parent, sometimes the other. Neither one mindset nor set of skills is sufficient. This idea is developed using the examples of agitation/de-escalation and suicide risk assessment and management. For example, EM teaches us how to act immediately and decisively, authoritatively, and what the bedrock principle is that justifies this, while psychiatry teaches us to engage the patient as we help him de-escalate himself. But what is really taking place on a micro level? How do we shift gears without slowing down? How do we defend ourselves against the criticism of treating without evaluating? We review and re-examine this classic material and discover new insights. Current practice, as well as the limits of our knowledge, are illuminated. Similarly, in the case of suicide assessment, our ever-pragmatic EM background teaches us to make important level-of-care decisions in a relatively short period of time with often a limited amount of hard information. But psychiatry teaches us to tease out the subtleties, caveats, and the potential drawbacks of this style of practice. A number of these are explored. For example, should the goal be to amass ever-larger quantities of data for an algorithm to synthesize into a level of risk, or should we find a way to work with the patient and develop a small amount of choice data that forms the basis of a collaborative assessment? This talk delves more deeply than any of my past talks into what is commonly thought of as intuition, i.e., the thing that “can’t be taught”. Audience members are given the opportunity to (privately) examine their own internal reactions to a patient. The idea of the interpersonal field is introduced. Our feelings can be very specific co-creations of contrasting states within the patient, feelings which can tip us off to a piece of the individual that wants to engage. The profound implications of this are explored. Finally, what do we do when patients we have seen before and referred out return in a partially treated state and fill up our PES’s and ED’s? One answer: return to a classic EM paper, that the ED is a “room with a view.” Again, EM is a crucial bedrock for emergency psychiatry.

37 Connected and Strong: Medical considerations for Crisis Care

Charles Browning, MD, Deborah Pinals, MD

Implementing the new 988 three-digit number for individuals experiencing mental health crises has immense potential to significantly improve access to crisis care and establish equal care standards for mental health and substance use emergencies. Crisis care encompasses a 24/7 call center, crisis mobile response teams, and services to receive and stabilize patients. Addressing issues with medication, medical stabilization, and coordinating care with other emergency medical services can effectively overcome barriers to emergency care, particularly for marginalized populations. This presentation will provide a summary of the

recommendations and highlights from the 2023 NASMHPD publication on medical considerations in crisis care, including how medications can be used in crisis situations, as well as topics related to medical stabilization that can create barriers to treatment, leading patients to undergo unnecessary medical clearance in emergency departments. This paper also includes recommendations on providing this care in a recovery-oriented, trauma-informed, collaborative way with design from those with lived experience receiving crisis care. Finally, it highlights multiple tools in the guidelines of the paper to consider for use including AIDET, guidelines from SMI Advisor, project Beta from AAEP, SMART tool from AACP (American Association of Emergency Psychiatry), and MI-SMART tool.

[Soon to be published 2023 NASMHPD paper "Crisis Services: General Medical and Psychiatric Approaches to Care Delivery."]

38 How to Create a Diagnosis-Based Model Curriculum for Psychiatric Emergency Department Residency Training

Gerald I. Busch, MD, MPH

1. Presentation of current gold standard model curriculum for ED psychiatry residency training: "Residency Training in Emergency Psychiatry: A Model Curriculum Developed by the Education Committee of the American Association for Emergency Psychiatry" by Brasch et al. The strengths of this structure are reviewed. The question is then posed, how can this general approach be adapted to the unique aspects of any residency training program?
2. An alternative approach to the ED Resident Curriculum is then suggested. In this model, the most common psychiatric diagnosis in the ED is identified. For our ED, the most commonly occurring presenting diagnosis in our ED is F15.259, Amphetamine-induced Psychotic Disorder, which constitutes almost 30% of all cases.
3. The curriculum is then rebuilt around this diagnosis. This approach allows resident education, reaction, and disposition to become streamlined by emphasizing its prevalence. As this is the most prominent diagnosis, the residents become most familiar with the presentation, diagnosis, management, and disposition.
4. Familiarity and elevated competence in the most prevalent diagnosis allow more efficient evaluation and care, allowing residents more time to spend on less prevalent ED presentations. This diagnosis-centered approach can be applied to any ED at any site, using its own unique pattern of diagnostic prevalence to shape the curriculum. For our program, it led to additional educational and quality improvement efforts. For example, a grand rounds was prepared to orient the residents to this approach, entitled "F15.259." The walls of the ED cubicle were decorated with the diagnostic nomenclature "F15.259." A quality improvement project involving the quality metric of the ED, length of stay, was implemented, using best pharmacologic practices from the ED literature to manage agitation from F15.259. As the residents developed more expertise in this realm, they were able to spend more time on cases that fell outside this diagnosis. Methods of determining educational effectiveness of this model are discussed in conclusion.

39 Pediatrics and Opioids

Anthony Cirillo, MD, FACEP, Christopher S. Kang, MBBS, MD, FACEP

Emergency departments (EDs) are grappling with the effects of the opioid overdose crisis and pediatrics are a special population affected by it. Approximately 3.6% of adolescents under 18 years of age misuse opioids annually, and in recent estimates, it is reported that 14% of high school seniors have misused prescription opioids. In 2016, over 150,000 adolescents met criteria for an opioid use disorder (OUD) and given the pervasiveness of opioid use among adolescents along with the associated risks, it is imperative emergency physicians are knowledgeable in caring for adolescents with OUD. Additionally, acute opioid overdose in children represents a complex presentation, and requires efficient and evidence-based management as well as a comprehensive understanding of immediate and long-term implications.

40 Unveiling Inequities: Racial Disparities in Involuntary Mental Health Commitment

Isaiah T. Crum, MD

In the current United States landscape, addressing racial disparities in law enforcement and healthcare is of utmost importance. This research sheds light on the involuntary mental health commitment process, considering its potential impact on civil liberties and life preservation. Balancing the need to prevent the weaponization of the behavioral emergency system with the urgency to provide life-saving treatment for patients of color is a critical challenge faced by emergency clinicians. Certain mental illnesses impair insight, sometimes leading to life-threatening psychiatric emergencies necessitating involuntary treatment. However, initiating such treatment in the back of a police car presents significant obstacles to perceiving providers as therapeutic. Furthermore, data supports the alarming underdiagnosis and undertreatment of mental illness in the Black community, while suggesting a disproportionate reliance on law enforcement involvement

and involuntary commitment for Black individuals compared to nonminority white individuals. Emergency psychiatry must grapple with these opposing realities to ethically and compassionately care for those in need. Failure to do so risks increased violence at the hands of the police for patients in mental health crises, alongside a growing reluctance among individuals to seek commitment for their loved ones, fearing that risks outweigh potential benefits. Our research team delved into data from the Greater Pittsburgh/Allegheny County area, focusing on the involuntary commitment process and the race/ethnicity of individuals receiving care. This presentation will explore the findings, exposing racial disparities within the commitment processes. By bringing attention to these issues, this research contributes to a much-needed dialogue on achieving equitable and just mental healthcare for all. Finally, the presentation will close with a brief discussion of what steps Psychiatric Emergency Services and systems can do to reduce discriminatory impact and access to care.

41 The Connection Between Schizophrenia and Autism Spectrum Disease and the Importance of Gaining Collateral

Jacob C. Diaz, Meghan Schott, DO

It has been established that schizophrenia and autism spectrum disorder (ASD) share many symptoms, with the Diagnostic and Statistical Manual of Mental Disorders (DSM) requiring only a month of active hallucinations to diagnose someone with schizophrenia if they have a history of ASD. ASD is characterized by a level of social dysfunction that can include; deficits in social communication, reciprocity and maintaining relationships. These symptoms can classified as negative symptoms in the setting of evaluating for schizophrenia. It is important to know the diagnostic criteria for schizophrenia when a patient already has a history of ASD due to the significant overlap of symptoms and the possible distress that can occur due to delay in treatment. It also shows the importance of gathering collateral of a patient's baseline level of functioning in order to judge whether they are experiencing an increase in dysfunction or not. This is especially important in the emergency department where boarding rates for people with ASD are significantly higher than neurotypical individuals. While research has been done to show a connection between the two diseases, it has not been conclusively shown. Some research has shown that rates of schizophrenia are increased among those with a previous history of ASD. This presentation will use case-based discussion to serve as an illustration to highlight some of the important aspects needed while evaluating a patient with ASD, including obtaining collateral, understanding nuanced DSM criteria for both ASD and schizophrenia, and the need for appropriate medical clearance.

42 Alternatives to Sending the Police to Behavioral Emergencies: Denver's STAR Program

Thom Dunn, PhD, Leigh Foster, BS, David Edwards, MS

In 2020, Denver created an alternative service to respond to 911 calls for behavior emergencies and other concerns to prevent underrepresented groups from having contact with law enforcement. STAR (Support Team Assisted Response) is based in the Denver Health Paramedic Division and pairs and EMT or paramedic with a masters-level behavioral health provider. In 2022, STAR responded to over 4,700 calls. Most common calls were for "welfare checks," followed by providing other types of assistance. Services can range from deescalating agitation, assessing for suicide risk, arranging for follow up care, or providing transportation to shelters. Since the in nearly three years, no STAR staff have been assaulted nor have they had to call for the police for help. In 2022, Senator Michael Bennett introduced federal legislation proposed making STAR a model for the rest of the nation to follow. This session with be an overview of the STAR program, a discussion of the partnership of various agencies that support STAR, and presentation of data from the inception of the program.

43 Death by Suicide During Interfacility Transport

Thom Dunn, PhD, NRP

In many parts of the US, patients presenting with a behavioral emergency are often first worked up in a general hospital emergency department. If inpatient admission is indicated, typically these patients need to be transferred to a specialty center for definitive care. After the doc-to-doc" and the "nurse-to-nurse" is done, who is communicating with the transport team? Should the patient be restrained for transport? Should the ambulance be staffed with a paramedic who can manage agitation with medication? Would you be surprised to learn that regularly patients living with mental illness die by jumping from moving ambulances? This session is designed to address these and other common issues that may arise between emergency departments and EMS providers who often transport these patients to definitive care. A case will be presented.

44 Clinical Predictors of Psychiatric Admission Vs. Discharge After Observation in a Psychiatric Emergency Room

James J. Graham, DO

The Crisis Response Center (CRC) of Temple University

sees the highest number of patients of any Psychiatric Emergency Service (PES) in the city of Philadelphia, PA. Due in part to the high rates of comorbid substance use and other clinical unknowns, some patients are placed into a 23-hour observation status before a final clinical decision is made.

Our study evaluated the charts of observation patients over a 3-month period in 2019 (pre-COVID) to determine if there are any clinical factors associated with psychiatric admission at the conclusion of the observation period. Being able to better predict which patients will ultimately need psychiatric admission, we can eliminate the need for observation and get them to the appropriate level of care more promptly. Our research team developed a list of 41 clinical variables, from literature and chart reviews, that might have influence psychiatric admission rates. These variables include, but were not limited to, demographics, symptoms at presentation, commitment status, urine drug screen (UDS) results, and history from previous CRC presentations.

After obtaining IRB approval from the Temple IRB, a total of 320 patient records were evaluated. Patient records were first anonymized. Each observation encounter was reviewed by study physicians looking at all 41 variables. Data was then entered into a REDcap database. Descriptive, univariate, and, multivariate analyses were used to determine if any variables were significantly associated with subsequent acute psychiatric hospitalization.

Our analysis demonstrated that several variables appear to have a significant association with psychiatric admission versus referral to a lower level of care (inpatient drug and alcohol, outpatient, etc). Clinical features strongly linked with subsequent psychiatric admission after observation include the presence of delusions (OR-2.7), symptoms of mania (OR-5.04), an inability to perform a breathalyzer analysis (OR-3.11), and an involuntary commitment status (OR-2.31). Conversely, some variables were found to be associated with lower rates of admission. These include acute intoxication (OR-0.39), reported recent substance use (OR-0.43), and multiple previous discharges after CRC observation periods (OR-0.27).

Interestingly, neither a positive breathalyzer nor any particular UDS result were found to have a significant effect on disposition. Reported synthetic cannabinoid use however, does appear to be linked with a lower likelihood of admission (OR-0.43).

This research is the first step to possibly developing a predictive clinical tool that may aid in preventing unnecessary observation in those patients that will require acute psychiatric admission. This could help ensure that delay to appropriate treatment for these patients is reduced. Our future directions with this project are two-fold. The first is to evaluate the data to ascertain if there are any combinations of variables that are linked with a certain clinical outcome. Additionally, we plan to further investigate ways to add specificity to the variables (ex: the quality of delusions) that might be improve the accuracy of the data. A comparison of data from more recent months would also help us determine what, if any, effect COVID has had on post-observation dispositions.

45 A Novel Approach to Addressing Neuropsychiatric Symptoms in Older Adults with Dementia and Delirium in the Emergency Department: Code DICE

James C. Hardy, MD, Stephanie E. Rogers, MD, MPH

Has this ever happened to you? You respond to an overhead call for help with an agitated patient in the emergency department. Physicians, nurses, ED techs and security staff rush to help. When you arrive at the scene, you find an exasperated nurse trying to stop an angry patient from leaving the department. The patient is 89 years old with a history of dementia. What now? A take-down? Medications? The crowd and noise only seem to make things worse. Is there a better way? Neuropsychiatric symptoms (NPS) of dementia and delirium (including confusion, disorientation, refusal of care, and agitation) frequently occur in older adults presenting to the emergency department. An outpatient method called "The DICE Approach(TM)" (Describe, Investigate, Create, Evaluate), has been developed to help caregivers and clinicians address NPS. However, we could not identify established behavioral approaches for NPS in the acute-care setting. To address this pressing need, we adapted the DICE Approach to combine behavioral and pharmaceutical interventions to address NPS in acute-care settings. Our framework draws from best practices in our ACEP Level 1 accredited Geriatric Emergency Department (GED) as well as our medical center's delirium-reduction program. Older adults presenting to the emergency department have different needs, and a one-size-fits-all approach to agitation may not be appropriate in many cases. This lecture aims to help acute-care practitioners improve care for older adults exhibiting neuropsychiatric symptoms of dementia and delirium.

46 Improving Youth Mental Health Crisis Response in Rural Hawaii Through Interagency Collaboration

Geniel Hernandez Armstrong, PhD, Stephanie Campbell, PhD

When crisis care is inadequate, a greater financial burden is created due to an overdependence on hospital use and law enforcement, as well as the immense cost of human tragedies that occur due to a lack of access to care. There are specific

barriers present in rural settings (e.g., lack of resources, understaffing, transportation difficulties) that exacerbate challenges in mental health crisis response. Structural barriers and uncoordinated systems of care result in fragmented, inadequate care. This fragmentation was apparent in Hawaii, especially in rural areas, prior to 2016. Community members and providers alike were not confident about whom to contact in a mental health crisis, and services were often unreliable. Documentation of these crisis encounters were irregular, posing ethical challenges and difficulties providing follow-up care. To address these challenges, several child-serving state agencies on Hawaii Island came together in September 2016 for a Cross-Systems Crisis Response Summit. The summit was designed to bring together professionals from various agencies and organizations to learn about crisis response plans and to collaboratively work towards a seamless crisis response system for children and youth on the island. The summit included a panel of professionals from different systems as well as several activities focusing on specific aspects of crisis response management. Action plans arose from the Cross-Systems Crisis Response Summit. One primary development was the formation of a statewide, multiagency, mental health crisis response taskforce that includes the department of education, emergency departments across the state, department of health, law enforcement, and others. Thanks to the collaborative work of this taskforce, Crisis Mobile Outreach (CMO) has become more appropriately used in multiple settings, and a feedback mechanism regarding the functioning of CMO was developed to support ongoing improvements in care. These changes, along with the release of 988 nationwide, have resulted in CMO utilization for youth being higher than ever before. Additionally, state legislation was passed in 2023 that supports longer follow-up care (i.e., six to eight weeks) for youth after mental health crisis events. This rapid fire presentation will overview the development of youth mental health crisis response across the state of Hawaii from 2016 through present day. Presenters will explain how and why inter-agency collaboration was crucial for progress, and they will describe barriers faced working with rural communities spread across multiple islands. Presenters will share data that highlights systemic changes in crisis services and in attitude shifts about responding to mental health crises, including pre- and post-data gathered at the Cross-Systems Crisis Response Summit. They plan to share this information in comparison with 2023 data about the same topics after seven years of work by the crisis response taskforce. Finally, presenters will incorporate SAMHSA guidelines to make suggestions regarding improvement for youth crisis response in rural settings.

47 When The Medical/Psychiatric Divide Is Not So Clear: The Clinical and Forensic Challenges of a Case of MS Induced Psychosis

Michael Higbee, PA-C

In this session, we will discuss a challenging case of a 35 year old female with a history of MS and normal premorbid functioning, who presented with new onset psychosis. During the course of this patient's hospital visits, many challenging forensic and medical dilemmas faced our team: 1) Where does the primary treatment belong? Neurology, psychiatry or both? And what is the standard of care? 2) What aspects of this patient's presentation argued against a primary psychiatric disorder i.e. age of onset, normal premorbid functioning, atypical presentation. 3) If the etiology was found to be fully attributable to, or at least partially, to MS, can treatment of MS be considered on an involuntary basis due resultant danger to others?

48 Emergency Department Management of Suicidal Ideation

Christopher S. Kang, MD, FACEP, Anthony Cirillo, MD, FACEP

Suicide is a major and growing public health concern in the United States (US), ranking among the top 10 leading causes of death and the second leading cause of death for youth and young adults. Each year in the US, more than 500,000 people present to emergency departments (EDs) with deliberate self-harm, and many more people present with suicidal ideation. Suicidal ideation is associated with increased risk of death by suicide and EDs offer potentially serve as an important window of opportunity in which to intervene, deliver suicide prevention services, ensure patient safety, and save lives. In our presentation we will review ED management of suicidal ideation and review current resources available through ACEP.

49 ECG Interpretation Matters in Mental Health An Algorithmic Approach

Paul Kivela, MD, MBA, FACEP, FAAEM

Patients with mental health disorders have excessive all-cause mortality compared to the general population even when accounting for tobacco and lifestyle differences. Cardiac deaths are significantly above predicted numbers. Psychiatrists, internal medicine physicians, and even emergency physicians often interpret ECGs for acute ischemia or obvious arrhythmias.

Drugs of abuse and many medicines frequently prescribed by psychiatrists and physicians can put patients at increased risk of cardiac ischemia and arrhythmias potentially leading to sudden cardiac death. This presentation will introduce a simple algorithmic way to interpret the ECG and discuss of some of the drugs of abuse and commonly prescribed medications that may put patients at increased risk of arrhythmias and sudden cardiac death. This may lead to introducing certain considerations and cautions in prescribing certain medications.

50 Updates in Pediatric Boarding: A Review of Recently Published National Pediatric Boarding Consensus Panel Recommendations

Nasuh Malas, MD, MPH, Megan Mroczkowski, MD

Pediatric mental health visits to the Emergency Department (ED) rose 60% from 2007 to 2016 with many youths presenting with worsening acuity and severity of presentation. Boarding, defined as the practice of holding patients in the ED after the decision to psychiatrically admit has been made, has become a consequence of the rise in patient volumes and complex mental health needs, coupled by limited access to inpatient psychiatric beds and other safe dispositions. Psychiatric boarding is complicated by variability in care practices, ED overcrowding, limited training and clinical expertise to support this population, safety concerns, as well as significant healthcare utilization. A National Pediatric Boarding Consensus Panel was convened given the rise of boarding and the lack of standardization of care for this population. During the boarding period, there are often missed opportunities to stabilize and potentially avoid inpatient psychiatric hospitalization altogether. Boarding also creates significant challenges for health system by impacting ED and hospital workflow, creating inefficiencies in care, causing increased risk for patient escalation and decompensation, as well as delays in needed mental health treatment. However, the boarding period can also be utilized to provide active and iterative education, evaluation and management to utilize the time optimally and stabilize the patient, while mitigating worsening disease, reducing unnecessary healthcare utilization and improving outcomes. The consensus panel recommended identifying and addressing several factors encountered during the ED boarding stay, including: environmental modification, improved staffing models, enhanced and clear workflows and policies, integrating early intervention, screening and prevention, use of evidence-based evaluation and management practices, promoting health equity, mitigating risk of violence and behavioral escalation, providing iterative evaluation and modification of intervention, ongoing disposition review, as well as pathways to escalate interprofessional communications with a goal of supporting the least restrictive environment for care and improving patient outcomes. The findings of the National Pediatric Boarding Consensus Panel provide guidance on universal and best practices for the care of youth boarding in the ED. Those items that received unanimous consensus provide a baseline standard to support safe, timely, and equitable care for the boarding patient. During the presentation we will review the recommendations universally recommended in the care of the boarding pediatric patient. We will also describe principles that were universally adopted by the consensus panel yet were considered to be flexible so that application could be tailored to the unique circumstances of a given locality, health system, or hospital. The findings of the Consensus Panel are intended to spur health systems to develop working groups on pediatric boarding with interprofessional input to build an infrastructure of care that addresses the key recommendations outline in the panel's recommendations. Challenges for adoption will include access to mental health staffing, the demands on the ED more globally, limited access to outpatient and inpatient care, and limited pediatric mental health subspecialty care settings. However, the Consensus Panel recommendations provide a foundation to critically review the issue of boarding, adopt universal and best practices, customize the experience to the circumstances of a given health system, employ initiatives to address particular barriers or challenges to care for this population, as well as spur local and national research, innovation and ongoing discussion on this topic.

51 Retrospective Evaluation of Violence Risk Assessment in Youth Utilizing the Fordham Risk Screening Tool (FRST)

Anna P. McLean, DO

The increasing volume of children and adolescents presenting to emergency departments (ED) with mental health complaints presents a national crisis. A decade-long longitudinal study revealed that such presentations are trending upward, with an annual rise of 6-10%. This trend will continue to have cumulative effects that challenge our current systems of care. In an effort to inform disposition in situations where aggression and violence are relevant, it is important that emergency medicine providers be informed regarding how to effectively assess the risk for violence in youth. Youth demonstrating aggressive behavior can present a unique challenge to the ED setting, particularly if they are awaiting inpatient psychiatric treatment and/or possess psychosocial challenges that yield disposition planning difficulties. These situations are not unique to pediatric EDs or academic centers that may have integrated pediatric providers. Community hospitals that may have limited mental health resources might benefit from the implementation

of evidence-based violence risk screening that can be applied by a variety of clinical staff to inform risk, treatment disposition, and safety planning. While the ED presents a uniquely restrictive environment for all persons, some children are more likely to manage related distress through externalized behaviors when compared to adults. Intervention by ED staff who have not received de-escalation training specific to children and youth may subsequently escalate young patients further, thus contributing to the risk of injury for both patients and staff. There are several widely known youth-specific violence risk assessment tools, such as SAVRY, which has moderate validity for those aged 12-18 years old and is well known to the juvenile justice system. Similar well-validated violence risk assessment tools have useful applications but can be time intensive and difficult to translate to the ED setting as they require specialized training programs. ED providers often have limited time to assess patients who present with psychosocially complex complaints. Therefore, there is a practical necessity to validate a violence risk assessment tool that balances reliability and brevity. The Fordham Risk Screening Tool (FRST) has a growing body of data to support its utility in the ED and civil inpatient settings. Recently, the FRST has been integrated as a standard portion of the assessment of patients who present in behavioral or mental health crisis at Maine Medical Center's (MMC) ED. All patients seen by MMC's Emergency Psychiatry team have been asked FRST screening questions and a subset of these patients are youth who present to the ED seeking crisis evaluation. Therefore, we aim to retrospectively evaluate the utility of the FRST as a clinical tool for evaluating and assessing the risk of violence in children and adolescents. Increasing objectivity of violence risk assessment will allow more thoughtful approaches to patient management in ED settings, and ideally reduce the length of stay and the necessity for pharmacologic interventions, while informing future risk of violence as predicted by an objective screening tool. This work will also inform whether it is possible to streamline risk assessment to a single tool for all ages.

52 Implementing Observation Care Pathways for Behavioral Health Patients in NYC Emergency Departments

Jonathan Merson, MD, Rachel Bruce, MD, Kate O'Neill, MSN, RN, Kayla Perro MSW

Increasing behavioral health patient volume, severity of illness, and decreased inpatient care resources have resulted in extended emergency department (ED) length of stay. Observation care has been a standard within emergency medicine for treating patients with diagnostic uncertainty or those who may benefit from protocol-based interventions to avoid admission. Historically in New York State, Behavioral Health patients have been excluded from observation care within medical Emergency Departments, instead being either rapidly admitted to inpatient Psychiatry or transferred to specialized CPEPs (Comprehensive Psychiatric Emergency Programs).Through close collaboration between Emergency Medicine, Psychiatry, Nursing, Social Work, and hospital leadership, BH Observation pathways were implemented in high-throughput space-constrained Medical Emergency Departments. The aim was to create a standard for short-term treatment, assessment, and re-assessment of behavioral health patients for whom diagnosis and determination concerning inpatient admission, discharge, or transfer was expected to take greater than 8 hours e.g., substance metabolism, dearth of disposition-determining collateral, extended medical workup, etc. In the pilot phase, patients treated without any increase in expense yielded a significant increase in facility and professional revenue, which could be re-invested in architectural and staffing enhancements for BH patients. An expanded program would have the potential to reduce avoidable brief psychiatry admissions, creating inpatient capacity for higher-acuity ED BH patients throughout the system.

53 Use of A Behavioral Emergency Response Team to Reduce Restraint Use and Healthcare Costs

Monica Miner, BSN, MSN, Christopher Sampson, MD, FACEP

There currently exists very little data on the use of behavioral emergency response teams (BERT) in the inpatient or emergency hospital setting. Given the rise in workplace violence and injuries among staff and patients, the use of a BERT program at our large academic institution was found to reduce physical restraint use through early intervention. Implementation of the program was also found to be associated with significant healthcare cost savings. The cost savings were a 31% reduction in workplace injuries associated with violent patient events which translates to a financial savings of almost half a million dollars over a single fiscal year. This session will discuss current literature surrounding restraints and possible social and racial biases. Next it will follow by how to set up a BERT program in your institution and important stakeholders. This will include how to train staff and reportable metrics to show success.

54 Level 1 Trauma Emergency Department Workplace Violence Mitigation Strategy

Jen Moberg, MPA, BSN, RN, CPPS, NE-BC

Workplace violence reports comprise 25% of our reported safety events, with the emergency department (ED) having the highest reported events in the hospital. In addition, the annual employee engagement survey reported

workplace violence as a top concern since 2016. We had a 28% turnover in the last two years and was attributed to burnout due to the increased incidence of workplace violence communicated at exit interviews. Our ED team is well known in the community for its mission of head and heart together. The culture is rare; the last few years have taken a toll on the team, and our leading goal is to reignite purpose and revive the team's spirit. Moving out of pandemic operations, we realize the long waits for care in the ED due to increased medical boarding and high hospital census impacted patient access to care resulting in lower patient experience scores. In addition, health equity needs, and case management demands outpaced resource availability. According to OSHA, psychological and physical harm related to workplace violence make it difficult for employees to perform job duties. The economic impact of workplace violence is seen mainly in high turnover, increased staffing costs, decreased morale, and poor productivity and patient outcomes. Nursing leaders navigate challenging times with competitive staffing markets and stressful work environments that ultimately impact healthcare costs and patient experience. Workplace violence and bullying impede compassionate, high-quality care impacting patient quality and safety outcomes. The effects of workplace violence physically and psychologically result in lost time and potential long-term manifestations of anxiety, depression, and post-traumatic stress disorder. The chronic toll on nursing creates burnout and compassion fatigue resulting in potential medication errors, lack of engagement with patients and families, and decreased vigilance leading to patient harm recommend the support of employee assistance and debrief support as the "unaddressed mental anguish" of the team decreases engagement putting quality and safety outcomes at risk. We are realigning department goals with a workplace violence mitigation strategy that includes four quadrants including culture of safety, trauma support, community violence intervention and risk mitigation. The culture of safety spans the design of psychological and physically safe space for coworkers, a culture of respect with collegial interactions, and communicate and demonstrate safe environments to receive care for patients, families, and communities. The mitigation of risk includes a thorough assessment of campus access and work environments along with a commitment to education and updated work standards for patient care staff. Violence intervention community collaboration with county partners encompasses gun violence prevention programs and extreme temperature van and shelter coordination. Finally secondary trauma support for staff with onsite assistance, commitment to real-time debriefs and critical stress debriefings along with ongoing team morale buildings some of which include coffee shop chalkboard themes, raffles, family dinners, sports outings and rounding with leaders. We are making a difference! We have decreased our workplace violence events, increased safety huddles, committed to diversity, equity, and inclusion committees, and are building social and cultural tools to support the teams' provision of safe and effective care.

55 Defining Child Emergency Psychiatry: Lessons Learned from a National Survey of Current State Practices and Service Delivery Models

Megan M. Mroczkowski, MD, Nasuh Malas, MD, MPH

Objectives: The field of child and adolescent emergency psychiatry has been minimally characterized with a lack of clarity of current models of care, services offered, staffing approaches and care delivery. In light of the significant rise in pediatric mental health emergencies, we sought to characterize the current models of care and service delivery models of care through an international survey of health systems and their approaches to Child and Adolescent Emergency Psychiatry.

Methods: A 42-item survey, modeled on surveys developed by Shaw et. al. in 2006 and 2016, assessed best practices and service delivery in Child and Adolescent Emergency Psychiatry. Participants were elicited from 11/8/2022-11/18/2022 via emails sent to the professional listservs of the American Academy of Child and Adolescent Psychiatry, the Academy of Consultation-Liaison Psychiatry, and the American Association for Emergency Psychiatry. This survey will be described in depth.

Results: Seventy-three participants volunteered to complete the survey representing sixty-one sites. The majority of respondents identified as child psychiatrists (51%), followed by child emergency psychiatrists (33%), pediatric emergency physicians (16%), and emergency psychiatrists (12%) with the remaining 14% of respondents either being general psychiatrists or having other specialty roles in child psychiatry such as consultation-liaison psychiatry or inpatient psychiatry. Geographic representation included the United States, United Kingdom, Canada, and Switzerland. A majority of respondents were urban (N=44, 90%) and in an academic center with a dedicated Children's Hospital (N=33, 67%). Twenty-eight respondents (57.1%) had direct access to inpatient psychiatric care, while 21 respondents (43%) did not have access. Thirteen respondents (50%) responded that access to inpatient psychiatric beds impacted the ED/hospital length of stay and boarding.

Conclusions: Survey findings will provide an opportunity, empowered by data, to make more informed decisions about service models and care delivery related to child and adolescent psychiatric emergencies. This study will also inform and guide future research, quality improvement and program development related to the nascent yet rapidly growing field of child and adolescent emergency psychiatry.

56 Assessing Return to School After Safety Concerns Are Raised

Dwayne Narayan, MD

A common presentation to the pediatric emergency room is that of a return to school evaluation. A child is commonly sent to the ER after a statement is made that they are going to hurt themselves or others and the consultant is tasked with answering whether there is an acute risk, or not, i.e., can they go back to school, or not? With mental health-related pediatric emergency room visits increasing by 8% annually between 2011 and 2020 (accounting for more than 13% of all emergency room visits among youth), and the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declaring a national emergency in child and adolescent mental health in the fall of 20212, physicians will be faced with these types of evaluations more often, and discussion around how to best evaluate and treat these cases is key to helping children and adolescents facing mental health crises. A child can present to the emergency room with a request from the school for a physician to comment on whether they can return to school or not. This is asking for a consultant to evaluate chronic vs acute risk and often what was the mitigating factor, and if it can be changed. One must ask a series of questions to begin to evaluate the risk such as: What was said? To whom was it said? Have there been other times when this has been said? It is helpful to know who the audience was and what was the setting when the comment was made. Did the child have a goal in mind when the statement was made? For this question, particularly looking at any history of tardiness, school refusal, or truancy. Chronic risk factors are also evaluated such as, do they have a history of self-harm, suicidal ideation, or attempts, and are weapons in the home, or do they have access to them at all? We would also look at any history of violence or aggression. Substance use, and whether they were under the influence is also an important point in a comprehensive assessment. The evaluation does not stop with the child, but often includes parents (or legal guardians) and their involvement. At times one must also involve law enforcement or Child Protective Services. Typically, once the child arrives in the emergency room, their presentation is vastly different, and it helps to ask, "What has potentially changed since this behavior took place?" During this session we will look at these questions, how to decide if a psychiatric consult is needed, and potential dispositions through brief case reviews. Our goal in these scenarios is to assess for general safety, discuss when it is necessary to involve psychiatry, potential outcomes, and dispositions, as well as highlight needs for reporting/considerations for reporting. We will also look at challenges in evaluation, particularly in those with intellectual disabilities or on the autism spectrum.

57 In A World of Rising Deltas, Review of Clinical Implication of Delta 8, 9 And 10 THC In Emergency Psychiatry

Thersilla Oberbarnscheidt, MD, PhD

Along with the legalization of marijuana throughout the U.S., there is an increase in use of delta products as well. While these delta-THCs are widely available and advertised, little information about the effects and possible risks are broadcast to the public. Marijuana is federally classified as a Schedule 1 substance; however, the Delta drugs are not regulated. According to the Farm Bill from 2018, hemp products with less than 0.3% THC can legally be bought, sold, and grown in most states in the U.S., creating a loophole for marketing of these products. For the user this means that there is no assurance of content of the purchased product, and they bear the risk of potentially containing harmful byproducts. Delta-9-THC is one of the primary psychoactive cannabinoids of marijuana. Delta-9 is hemp derived and binds to the same cannabinoid receptors as marijuana. It can induce the same psychoactive effects which are euphoria, feeling "stoned", anxiety or paranoia as well as aggression. Delta-8-THC is commonly called "marijuana lite" or "diet weed". Marijuana contains Delta-8 THC only in a small percentage. The sold Delta 8 product is typically made by synthetically converting CBD or Delta 9 THC into Delta 8. Delta 8 binds to the same receptors as Delta 9; Little research is available on Delta 8, but available studies are showing side effects that are comparable to marijuana ranging from paranoia, difficulties with concentration, memory, perception of time to sedation and euphoria. Concerning are reports of accidental severe intoxication, resulting in more than 2000 calls to poison control centers between January 2021 and February 2022. Several states have started to ban the recreational sales of delta-8-THC. Delta-10-THC, however, is often reported to cause more euphoria and energy rather than sedation. Little research is available regarding its benefits and side effects, but the novelty of this substance makes it especially attractive to users. The delta-drugs are available in various forms: edibles, vaped concentrates as well as smoking bud or flower or in topical ointments. About 50% of consumers of delta-drugs also reported in surveys to use marijuana as well. It is important for emergency psychiatrist to know and understand these substances in order to be able to assess the clinical presentation correctly and to provide the effective clinical care for acute and ongoing stabilization. This presentation is a systematic review of literature looking at the available data for Delta 8,9,10 for psychiatric and medical use. Utilized sources were PubMed, Ovid, Medline, Psych Info, EMBASE.

58 Effectively Integrating Management of Acute Severe Agitation into Resident Didactics and Staff Training

Jinal R. Patel, MBBS, Jessica Poster, MD, Simran Ailani MBBS

Management of agitated patients is central to clinical practice in the emergency room (ER) and in psychiatry training is a core objective per Accreditation Council for Graduate Medical Education (ACGME) guidelines. The potential for unmanaged agitation to escalate to aggressive behaviors can harm patients, staff, and others, which makes it imperative to address quickly and efficiently. Rapid, systematic, and standardized implementation of de-escalation strategies, and behavioral interventions reduces the need for calming medications and physical restraints, which are associated with various adverse outcomes.The Best Practices in Evaluation and Treatment of Agitation (BETA) project guidelines are currently the standard of care and detail methods for a non-coercive, patient-centered, and collaborative approach to managing acutely agitated patients. They are nationally adopted in numerous psychiatric clinical centers across the US. Many institutions also now utilize highly trained and dedicated intervention teams who are paged instantly when there is an agitated patient. This strategy, "Code White", is currently implemented at Maimonides Health, a community hospital and academic training center in Brooklyn, NY. Code White is a departmental alert in the ER to mobilize a multidisciplinary team of staff, led primarily by psychiatry residents and attendings. It is activated in order to safely care for all patients with acute agitation. The hospital-specific Code White protocol was first designed and implemented in 2019 and has drawn heavily from BETA project guidelines. The design was informed by frontline clinical staff identifying key obstacles to the management of agitation. The protocol has evolved significantly in response to staff and patient feedback and has been integrated at various levels into resident didactics and staff training. We have developed a multi-level strategy to equip residency training programs in community hospital settings with the information and tools required to integrate effective agitation management into resident didactics and staff training. Our workshop is designed for psychiatry and emergency medicine residents, attendings, program directors, and psychologists. We aim to share our efforts towards the development of an effective resident didactic curriculum on agitation, the creation of inter and intra-departmental Code White simulation trainings, and the formation of an agitation management task force. The trainings and task force interventions are designed for all staff, including nurses, mental health workers, social workers, and psychologists, as well as physicians. We have administered our training in various clinical and academic settings with good responses. Through this workshop, we aim to highlight the importance of translating national and local policies and guidelines on agitation management into practical teaching and training sessions for residents and other staff and hope to share our experiences of this endeavor at a community hospital.

59 When There's No Where Else to Go

David A. Pepper, MD, Emily Brown LCSW

When we think of behavioral health emergencies, most people think of suicidal ideation mania or psychosis, but there is a population that presents its own unique challenge. Patients with an Autism Spectrum Disorder and patients with Intellectual Disability commonly present in crisis and require a specialized assessment and management. These patients have moments of emotional dysregulation, sensory overload, self-injurious behavior that require medication intervention, period of respite, evaluation or de-escalation by staff out of the home. At times the behaviors make them unsafe in their current living situation but do not rise to the level of requiring inpatient psychiatric admission. This can result very long lengths of stay in Emergency Departments. This is a unique situation for us as providers and we must consider the ethical ways to treat and accommodate these patients within the limitations of the walls of our hospitals. In this presentation we will consider what causes these patients to end up in our care for such an extended period of time, including the systemic implications and barriers, ways to advocate for patients with their providers and families, and how to best serve them while they are residents of a hospital emergency department. We will look at considerations to ensure these patients have their needs met in a very basic way (clothing, food, shelter) and higher needs like emotional support, comfort, social interaction, boredom. Explorations of sensory considerations, medications, and restraints will also be considered.

60 How Can We Engage Patients with Substance Use Disorders?

David A. Pepper, MD

Patients with Substance Use disorders (SUD) present to Emergency Department and Crisis center with regularity, but many do not find the experience helpful, or do not utilize the visit as an opportunity for starting treatment. The National Survey on Drug Use and Health from 2019 found that only 1.5% of patients with SUD had received any treatment in

the last year, and roughly 1/3 of those patients received their treatment in emergency departments. Recently the American Psychiatric Association (APA), the American College of Emergency Physician (ACEP) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have focused on enhancing care and offering evidence-based treatment in the emergency department. The challenging remains, how can we engage patients in crisis, and successfully get them into treatment? I will explore the current evidence-based models around patient engagement and some challenges unique to substance use disorders. I will examine the use of motivational interviewing as a way to but understand the patients needs and get them to the right level of care. I will explore the use of people with lived experience (peer supports, recovery support specialist, recovery coaches) as a way to improve engagement. I will also look at the need for the ED or Crisis center to adequately assess and understand the culture, and socio-economic influences in their SUD patients. I will discuss some useful lessons in community engagement and ways to expand diversity, equity, inclusion and belonging into the treatment of patients with Substance Use Disorders.

61 Sensing the Invisible: Implicit Bias and Clinical Practice

Jeffrey Ring, PhD

Health inequities and disparities are a searing symptom of institutional and historical racism. While there are many contributors to health inequities, the role of clinicians cannot be underestimated. This interactive and experiential presentation invites participants to explore biases and stereotypes and the ways they can unfold in clinical care through micro-aggressions, suboptimal communication, and problematic decision-making. Participants will leave with tangible tools for diminishing the impacts of bias in care provision and perhaps recommit to tangible advocacy for health justice.

62 Improving Cultural Competence in Emergency Psychiatry

Monica Sadhu, MD, MPH, Muna Telsem, MD, MBA

A 13-year-old female with a history of Leber Congenital Amaurosis presents to the ED for acute behavior and mental status changes. The patient and her family are refugees who came to the US 1 year ago. The patient is struggling with visual impairment and difficulty learning English and Braille and is only partially responding to questions on interview. How can we best provide culturally competent care with the limited time and resources we have in the ED? The cultural beliefs and attitudes of patients directly influence their utilization of emergency psychiatry services. In an increasingly diverse and globalized world, cultural differences in the emergency setting are becoming more and more common. Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that help systems or professionals work effectively in the context of cultural differences. It bridges the gap between the intersection of the patient's culture, the clinician's culture, and the medical culture of the place where clinical work is being performed. Culturally sensitive assessments are critical to patient-centered care and have been noted to improve clinical rapport, patient participation in care, and the efficacy of clinical therapies. The Cultural Formulation Interview, or CFI in the DSM-5, is an internationally validated tool that contains questions that elicit patients' experiences and identify subtle sociocultural factors that impact diagnosis formulation. Through this case-based discussion, we will illustrate how to incorporate elements of the CFI into a culturally sensitive interview in the context of cultural differences in EP settings. Our talk will also highlight how to 1) best utilize language interpreters and cultural informants to provide effective patient care, 2) gain a better sense of awareness of nonverbal components of communication and 3) integrate patients' cultural values and perspectives into their diagnoses to formulate comprehensive treatment plans.

63 If you Build It? Addressing the Pediatric Substance Abuse Crisis

Meghan M. Schott, DO

Although addiction has been the bread and butter of emergency physicians it is becoming an emerging area that pediatric emergency medicine (PEMs) physicians are now encountering. Pediatricians often get little to no training in substance abuse and treatment options for substance abuse. In 2016, the American Academy of Pediatrics (AAP) advised pediatric residency programs to teach the Substance use screening, brief intervention, and referral to treatment (SBIRT) model. However, little is taught on how to treat substance use disorders and generally focuses on alcohol, cannabis, and tobacco. Psychiatrists on the other hand have been trained to treat substance use disorders. Substance use disorders is one of the required medical knowledge milestones created by the American College of Graduate Medical Education (ACGME). Psychiatry residents are also a required to have 1 month of clinical rotation in addiction in order to graduate from psychiatric residency. Although child and adolescent psychiatry (CAP) fellowship programs are required to show how substances impact mental health, there is no clinical rotation requirement for understanding

and utilizing treatment. Since COVID-19, children's hospitals are seeing an increase in the number of patients presenting with substance abuse complaints. In the DC-Maryland-Virginia (DMV) region, the hospitals and community clinics have seen an increase in pediatric opioid use disorder by 600 percent in the past 6 months. With this vast increase in substance use presentations, PEMs are being forced to identify and treat substance use complaints will minimal clinical training. Consequently, psychiatrists become the de-facto content experts despite having limited formalized training about substance use during their fellowship. With both CAPs and PEMs feeling ill prepared to take on the growing opioid overdose epidemic, children's hospitals are being pressed to essentially start from scratch to find novel ways to undertake the pediatric substance use epidemic. This presentation will focus on four aspects of developing a substance abuse program in pediatric emergency departments. Part 1 will discuss the current epidemiology of substance use in children. While highlighting the trends of current substance use, it will also accentuate why children's hospitals need to start their own plan for developing substance abuse programs. Part 2 will focus pediatric substance abuse screeners and withdrawal power plans and how to implement them into electronic medical records. Part 3 will focus on the need for naloxone distribution and the stigma that needs to be broken to help with implementation. Part 4 will focus on training and education of pediatric physicians and nurses and creating substance abuse champions to help disseminate information.

64 Streamlining the Care Received by Patients with Mental Health and IDD Concerns in Emergency Medicine

Shawna E. Scully, DO

This session will provide an overview of the performance improvement projects Emergence Health Network is conducting in the dynamic border metroplex of El Paso, Texas, to optimize the care received by patients with mental health (MH) concerns and/or intellectual and developmental disabilities (IDD) when they need emergency medical attention: 1) An overview of the approaches typically taken by emergency medical providers in response to patients with MH and IDD diagnoses: review of the literature along with a case presentation 2) Summarized results of our local public health review regarding ER encounters involving patients with MH and IDD diagnoses. 2) An overview of our "warm and informed' process that ensures a solid understanding of the client's medical background and functional baseline. 3) A clear line of communication between health care staff who know the client well and emergency room staff trying to develop an informed differential diagnosis and treatment plan 4) Establishment of standardized ER workups for patients needing transfer to regional inpatient behavioral health facilities 5) Establishment of standardized admission and exclusion criteria for regional inpatient behavioral health facilities 6) Plans to assess the impact of performance improvement initiatives, build on success, and sustain the gains.

65 The Evolution A BERT - New Opportunities In A New Environment

David Seigler, MD, FAPA

In 2021, we presented on the creation of a Behavioral Emergency Response Team (BERT) at a large Psychiatric hospital that caters to Medicaid patients and its utility in fostering culture change in both staff and providers. With the success of the pilot program, the hospital team tasked us with an expansion project Ñ rolling out a dedicated BERT team beyond the walls of the Behavioral Health units and into the 456 bed medical center. During this roll out, significant time has been spent providing in-service education on the Behavioral Activity Rating scale (BARs), as well as providing demonstration on how a BERT is called, how it is preformed, and the importance of a proper debrief afterward. While working on this, multiple opportunities for improvement were found, leading to the rollout of new tools to aid in deescalation in the general hospital setting.

66 PES Case Conference

Ahmad Shobassy, MD

Residents rotate in PES and encounter variety of behavioral emergency cases. However, many unique findings or interventions during patients' interviews will be only experienced by the specific trainee that happen to be rotating at that time. Some of these findings/interventions are unique and are particularly helpful for skills building. The goal of this activity is to share these specific interventions with other trainees. PGY-2 residents meet for an hour per month in a case conference format to discuss PES-focused cases. The conference is led by a core PES faculty discussant who would work with the PES day shift resident to identify cases appropriate for the conference. The resident will be presenting 4-6 short cases Ñ as explained below Ñ and then will zoom in into very specific areas in the interviews or specific interventions that made uniquely significant contributions to the decision-making in these cases. This faculty discussant then will lead an interactive discussion about the case for the group. Here are a few examples about areas of focus:1- A specific word or phrase a patient said that was particularly helpful for risk assessment or made a shift in the assessment. 2- A unique way by which a clinician

(nurse, social worker, student, resident, NP, attending, etc) was able to get a more accurate version of the history that allowed better assessment and interventions. 3- A phrase or an intervention made by the interviewer that allowed the interview to move more smoothly with a patient that was otherwise difficult to interview.4- A specific clinical information because of which a certain medication was preferred to address an emergency such as agitation over other agents. Or retrospectively, why a certain medication was not a good option or led to an adverse event in a particular case.5- A situation in which a misread of a patient or the way by which certain information was delivered to the patient led to a negative outcome such as an assault. What could have been done differently?6- A particularly challenging case for risk assessment, what made this case difficult, what else can be done to better estimate the risk. 7- A case in which unusual actions were taken (family not allowed to take their child out of PES, low enforcement involvement, ..etc)

67 Seeing Parades After PNES: A Delirium-Like Presentation of A Conversion Disorder In A Pediatric Patient

Victoria N. Smith, Meghan M. Schott, DO

Background: Psychiatric disorders are common in children and adults with functional neurologic disorders (FND). Adults with FND often have comorbid depression, generalized anxiety disorder, and PTSD, while children with FND more commonly carry diagnoses of adjustment disorders, somatic symptoms and related disorders, and neurodevelopmental disorders (Patron, 2022). Researchers have long hypothesized a link between conversion disorders and trauma and studies have shown that stressful life events and maltreatment, especially emotional neglect, are more common in people with FND than healthy controls with a stronger association for childhood onset FND (Ludwig, 2018).

Case: A 12-year-old girl with major depressive disorder (MDD) and PTSD initially presented with acute onset seizures, altered mental status (AMS), and visual hallucinations concerning for encephalitis. Structural and infectious etiologies was ruled out with CT, MRI, and LP. She was briefly treated for autoimmune encephalitis with IVIG and corticosteroids, which were discontinued when urine toxicology returned positive for Ecstasy, a known cross reactant of Wellbutrin and explanation for her seizures and AMS. She eventually admitted to intentional ingestion and was transferred to inpatient psychiatry. Three days after discharge from inpatient psychiatry, she re-presented after an episode concerning for psychogenic nonepileptic seizures (PNES) at school. While in the ED, she developed acute confusion, agitation, vivid visual and auditory hallucinations concerning for delirium. Vitals and CBC were normal, and toxicology was negative. She was discharged 24 hours later after delirium had resolved. She then re-presented three weeks later with increased sleepiness and making nonsensical statements but was otherwise cognitively intact. Overall, this presentation is consistent with a FND including PNES and delirium-like symptoms in the setting of PTSD.

Discussion: Conversion disorders can present with a variety of neurologic symptoms. When our patient presented with AMS following a PNES episode, we had to evaluate whether her symptoms were likely due to another intentional ingestion of Wellbutrin or delirium from an unknown cause. We felt comfortable ruling out ingestion after speaking with the patient and family. However, we struggled to make sense of the cause of acute delirium. When the patient re-presented again with behavioral changes, we concluded that her previous delirium was likely part of a conversion disorder. This case suggests that delirium-like presentations can be a component of FND symptoms in patients with underlying MDD and PTSD. Psychiatrists should consider conversion disorders in their differential of causes of delirium, especially in pediatric patients with other comorbid psychiatric diagnoses.

Conclusions: Conversion disorders may also include delirium-like presentations. When evaluating patients with delirium and known PTSD, psychiatrists should consider the possibility of a conversion disorder.

68 Code 99 & 100: A Team-Focused Approach to Behavioral Emergencies Grounded in Design-Thinking

Nicholas R. Stark, MD, MBA, James Hardy, MD

With behavioral health diagnoses accounting for an increasing number of Emergency Department (ED) visits - over 2 million in 2021 in California alone - our California-based, academic ED has continued to experience a growing number of behavioral emergencies. Although our team developed a semi-structured approach to these acute events several years ago, over the past year it became clear that we needed to refine our process and more clearly-define roles to keep our staff and patients safe. The academic ED environment, with its regularly rotating groups of trainees, can complicate this process by making consistency difficult to achieve. To address the complex problem of managing behavioral emergencies in a coordinated, compassionate way in an academic ED environment, we engaged a multidisciplinary team of emergency physicians and trainees, psychiatry APPs and staff, emergency nurses and technicians, security, and department leadership. By utilizing the design-thinking process, which began with asking stakeholders probing questions about the current process and their

needs, we were able to better understand and define the problems surrounding our existing response to behavioral emergencies. After refining our understanding, we ideated around potential solutions, which ultimately led to the creation of a two-tiered process for behavioral emergencies: Code 100 for immediate threats that are unresponsive to verbal de-escalation and tension reduction strategies, and Code 99 for escalating situations that have not yet become immediate threats. Based on stakeholder interviews, our team also developed a "post-code huddle" process and checklist to ensure each team member is on the same page following a behavioral emergency event. Given the relatively transient nature of many stakeholders due to our academic setting, our team opted for a multi-pronged implementation strategy. We began with in-person presentations at meetings and educational conferences, which included de-escalation training in many cases. In addition, we used technology to our advantage by creating streamlined workflow flyers that we uploaded on our ED's online information hub, as well as email communication, printed flyers, and on-shift education at huddles. Due to the constant rotation of trainees in our academic environment, we have implemented regular "pulses" of re-education to improve awareness, while also relying more heavily on nurses and attending physicians who are more longitudinal team members in our ED structure. Since implementing this two-tiered behavioral emergency response process and post-event huddle earlier this year, we have experienced significantly reduced chaos and confusion surrounding many of our behavioral emergencies. While the academic ED environment brings unique challenges, particularly for implementing long-term, sustainable change for critical situations such as behavioral emergencies, it also provides an opportunity to implement innovative approaches - such as design-thinking in this case - and test creative culture-change strategies.

69 Current Challenges of Dosing, Management, And Precipitated Withdrawal with Suboxone For Opiate Use Disorder

Annika Strand, MD, Brad Gordon, MD, Jenna Wilkinson, MD

Opiate Use Disorder is a significant public health issue, with substantial implications for individuals, families, and communities. The emergency department often serves as a critical first point of care for individuals struggling with opiate use disorder (OUD). The utilization of suboxone as a medication-assisted treatment (MAT) has quickly become standard of care for patients with OUD presenting to the emergency department. However, since the initial ED dosing for suboxone was introduced, complexities have arisen and potential complications associated with this treatment have come to the fore, including the risk of precipitated withdrawal and the possible requirement for higher doses than are currently FDA-recommended. Understanding the efficacy and potential challenges associated with MAT using suboxone is critical for emergency care providers. Suboxone, a combination of buprenorphine and naloxone, has demonstrated effectiveness in MAT for OUD. However, its use presents specific challenges, including the risk of precipitated withdrawal. This occurs when a patient dependent on full opioid agonists is administered suboxone, causing withdrawal symptoms to occur more rapidly and severely. The published rate of precipitated withdrawal is less than 1%, but that rate may be changing with the advent of fentanyls. We present data from a series of cases across our metropolitan area in this regard. This presentation will provide an in-depth analysis of precipitated withdrawal, its recognition, management, and the steps that can be taken to prevent it when initiating suboxone therapy in the emergency department. The ubiquity of fentanyls has brought about challenges and the potential need for higher doses of suboxone than are currently recommended by the FDA for treating OUD. Buprenorphine, the primary active ingredient in Suboxone, has unique pharmacology and a ceiling effect on respiratory depression, suggesting that higher doses may be safe. In addition, its partial agonist property may render the standard FDA-approved doses less effective, particularly for individuals with severe OUD. The presentation will explore current research, clinical experiences, and ongoing debates regarding this issue, providing attendees with a comprehensive understanding of the topic.- Healthcare professionals need to be able to navigate the complexities of using safely, appropriately, and effectively using suboxone for OUD to improve patient outcomes and reduce the public health burden of OUD.

70 Not the Same Old Workplace Violence (WPV) Intervention: Implementing a Quality Review Process for WPV Events in a Level 1 Trauma Emergency Department

Leslie Strugnell, BSN, RN, Erin Seguin, BSN, RN

Without question, emergency departments around the world have been witnessing an increased number of workplace violence incidents. It is known that these incidents lead to physical injury, psychological injury, decreased work performance, and increased turnover rate amongst staff. Current "best practice" interventions found in the literature include high level/high-cost system interventions such as de-escalation training, environmental safety assessments, use of safety duress badges, increased security presence, and flagging of patient charts in the electronic medical record (EMR). However, there remains a gap in the literature about

how to mitigate workplace violence in a proactive, timely, and effective manner at a departmental level. We have developed a process that has led to quick improvements to increase safety, but also, one which we believe can be easily duplicated in other departments, to yield similar positive results. To be proactive in mitigating workplace violence, real time knowledge is critical. At our level 1 trauma emergency department in the Midwest, a group of interdisciplinary team members have developed a "just in time" WPV quality review process. Our intervention utilizes a collaborative approach, bringing together emergency department physicians, behavioral health experts, and emergency department nursing management to review every event which occurs each month in our ED in a mini-root cause analysis". Each event is fed into a database with pre-designed questions based on the literature regarding risks for WPV and intradepartmental processes. Once each discipline reviews the case, all recommendations are formatted into a 2-page document which includes basic information about the event, patient care/context/team factors that can provide opportunities for increased safety/education, "take away" education that can be immediately given back to staff, and administrative actions which may be needed. Once these events are summarized by the interdisciplinary team, this information and knowledge is disseminated to all emergency department staff through emails, huddles, staff meetings, resident meetings, and quality newsletters. Like any quality event, we believe it is important to dive deep into each specific incidence of violence to focus on the why as not every event has the same root cause. The triggers and response to a patient with autism versus a patient with schizophrenia versus an intoxicated patient are different. While these 3 groups are at risk for violent behavior, the proper approach and care differ; our intervention not only helps to narrow the root causes down, while being nimble enough that we can make quick changes or longer policy changes based specifically on our department's needs. Our rapid-fire presentation will describe the creation of this intervention, the criteria we use to assess each event, some of the data we have been able to collect and monitor because we now use a standardized approach, and examples of some of the action changes which have been implemented since this process was started.

71 Interventions To Address Pregnancy-Associated Deaths Due to Overdoses

Muna S. Telsem, MD, MBA, Monica Sadhu, MD, MPH

Pregnancy-associated deaths due to overdoses have significantly increased over the past decade, and there has been a progressive increase in pregnancy-associated mortality due to psychostimulants and synthetic opioids including fentanyl. A study on pregnancy-associated deaths from 2017-2020 revealed that 16.3% of these deaths were overdose related and associated with a mortality rate of 8.35 per 100,000. Pregnancy-associated overdose mortality gradually increased over the study period, with increases in overdose mortality in 2020 being more pronounced than increases in any previous year. For countless women with substance use disorders, the ED is the first point of care. Clinicians play a key role in impacting outcomes in this maternal health crisis. There are several factors that contribute to the increase in pregnancy-associated overdoses including disparities that lead to challenges in accessing drug treatment services and difficulties in achieving timely harm reduction. These disparities disproportionately affect BIPOC and have persisted despite advancements in medical care. Treatment strategies require a multidisciplinary coordinated approach that focuses on not only the mother but also the infant.
In our talk, we will discuss time-sensitive ways through which clinicians can address pregnancy-associated overdose mortality in the EP setting. We will discuss the importance of early universal screening, brief interventions, counseling and education in the ED, and referral to support services. We will also discuss identifying withdrawal symptoms in the mother and infant, pain control strategies, and modifying elements of prenatal care for women with OUD.

72 Turning Grievances into Gold: The Skilled Handling of Dissatisfied Patients

Tony Thrasher, DO, MBA, CPE, DFAPA

Have you ever been working with a patient who was not pleased with your decisions? How about a patient's family? How about a law enforcement officer and/or an outside emergency department? If you work in emergency psychiatry or emergency medicine, chances are you have experienced this frequently! The goal of this quick talk is to turn this from a dreaded interaction to one where a skilled team member can increase satisfaction, decrease fear, and increase the engagement and trust in the moment. We will examine different types of scenarios where this dissatisfaction may emerge as well as many different approaches to resolving said conflict. There will be components that address what line staff may do in the moment, as well as what managers/administrators may find to be core competencies in their subsequent reviews. Lastly, we will look at how this can be addressed systemically (even before said grievance emerges) to increase the quality of care in your organization and diminish bias and discrimination that can confound the dissatisfaction.

73 Review Of Current Practice Habits: Antipsychotic Use in The Emergency Department

Sarah Van Remmen, MD

Psychotic illness causes significant burdens of disease both domestically and globally. Antipsychotic medication is a cornerstone of treatment for psychosis. Long term adherence to these medications has been shown to have a host of benefits to patients. One practice setting where the effect of scheduled antipsychotics has not been thoroughly explored is in the emergency department (ED). Antipsychotic medication administration in the ED has shown great promise both in terms of safety and patient outcomes. Unfortunately, they have only been utilized in the acute management of agitation and for treatment of somatic symptoms such as nausea and migraine. The use of antipsychotic medication for the management of acute agitation in the ED has been extensively studied. Literature review shows Droperidol and olanzapine appear to be more efficacious than other antipsychotic medications, however they have similar efficacy to midazolam and ketamine. Antipsychotic use in the ED decreases the risk of violent events but is linked to increased lengths of stay. Scheduled, long term use of antipsychotic medication has, so far, not been studied in this setting. Determining whether initiating scheduled antipsychotic medication in the ED provides any benefit to patients is critical to determining how to provide optimal care for this patient population. Our review of the current antipsychotic practice habits described in emergency medicine and emergency psychiatry literature shows that even intermittent antipsychotic dosing for acute agitation improves patient outcomes. This suggests that purposeful scheduling of standing antipsychotic medication could be just as beneficial, if not more so to helping treat patients with psychosis sooner and more effectively. Unfortunately, there is scant literature exploring the topic of initiating routine, scheduled antipsychotic medication for non-agitated patients in the ED. This represents a critical knowledge gap that both emergency medicine and psychiatric physicians should work to remedy.

74 How To Better Gauge Intentionality as A Potential Measure Of Future Safety In The Context Of A Suicidal Gesture Or Attempt

Susan A. Waterman, MD

Intentionality can be defined as “the act of being deliberate or purposive.” Although a crucial element reflective of a patient’s current mental health state and the degree of desire to end their life, it can be challenging for clinicians working in an emergency setting with people who may be at risk of harming themselves to determine the level of intentionality behind self-harm and suicide gestures/attempts, varying from impulsive to pre-meditated. How can we best get to the Who, What, Where, When, How, and Why? How can we determine what the patient thought might happen? What has potentially changed in the patient’s life since this behavior took place? Once assessed/determined, what are the implications for clinical practice in an emergency room setting? Through an overview of operational criteria, three brief case examples (breaking down the behaviors, potential motives, and potential for disposition) and thoughtful discussion, this presentation seeks to widen the optic by exploring patient behavior in the context of the environment, coping skills, level of maturation, degree of impulsivity, presence of Axis 1 psychiatric and substance use disorders, potential lethality of actions, intentionality, and wished outcome of events by the patient. We can take a quick look into a few examples of screening tools that can be used to help assess suicidal intentionality, including:- Patient Health Questionnaire-9 (PHQ-9) a nine-item questionnaire used in primary care and other clinical settings to screen for depression. Ask-Suicide Screening Questions (ASQ) tool four questions that can be used in any setting to screen for suicidal ideation and behavior over the previous month. Columbia-Suicide Severity Rating Scale (C-SSRS) comprehensive instrument consisting of six subscales to assess the full spectrum of suicidal ideation and behavior. Scale for Suicide Ideation (SSI) a 19-item scale, covering three domains, used to measure the current intensity of a person’s specific attitudes, behaviors, and plans to commit suicide. Beyond these tools, how can we continue to advance our understanding and clinical judgment in assessing self-harm in an emergency setting? Suicidal ideation and behavior can change over time and across situations, so how can we best account for these factors in an emergency room where action may be needed quickly and without the ability to have assessed a patient’s patterns over an ongoing period of time? Additionally, patients may have more than one intention for their behavior(s) and thoroughly assessing intentionality can help differentiate NSSI from suicidal behavior, because while they share numerous clinical characteristics, the best treatment course between them can vary and the co-existence of both behaviors can be a useful indicator for additional diagnoses such as borderline personality disorder and other impulsive personality disorders. Measuring suicidal intentionality can help to identify the level of risk, the need for intervention, overall patient care plans, and the potential outcomes of suicidal behavior. It is key to continually broaden our line of questioning around self-harming behaviors to assist us in providing safer and higher-quality patient care, resulting in increased positive patient outcomes.

75 Outcomes and Treatments for Those Involuntary Hospitalized - A Deep Dive of Allegheny County

Pim Welle, PhD, Erika Montana, MS

In this study we analyze the involuntary hospitalization program in Allegheny County using high quality administrative data. We find that individuals who are hospitalized have very poor outcomes upon release - within 5 years of their first hospitalization fully 20% of the population has died, a rate that is higher than that for the jail, shelter, and SNAP receiving populations as well as that for folks with severe mental illness (SMI). Mortality rates are elevated in the first two years (especially the first year), producing a "crisis window" where adverse outcomes are especially likely to occur. We see especially poor outcomes among individuals with a pre-existing substance use disorder - 6% of those with SUD 18-50 years of age die within two years of release, compared to 4% of the 18-50-year-olds without SUD, largely of drug overdose. When we look at other outcomes besides mortality, we also find similar poor outcomes. Over 23% have been charged with a crime within 5 years of release, and 60% use an emergency room within one year of release. Not only are base rates high among the population, but statistical methods can distinguish between riskier and less risky portions of those hospitalized with high accuracy, meaning that there is potential for targeting of step-down programs to high acuity populations. Individuals who are involuntarily hospitalized are well known to the system before their first hospitalization. Fully 50% bill mental / behavioral health services in the month before their hospitalization, and 72% in the year prior. Seven in ten have pre-existing SMI diagnoses. After their hospitalization, they are frequent users of services. This cohort accounts for 23% of mental / behavioral Medicaid spending in Allegheny County, despite accounting for just 8% of folks who bill through Medicaid and 1.5% of all Medicaid enrollees. We analyze petition upheld rates among different demographic groups and see no significant differences, though those petitioned to get a 302 are much more African American and much less Caucasian than the county as a whole. Involuntary hospitalizations are common, with a rate of 305 per 100k in Allegheny County. This is somewhat shy of an estimated 357 per 100k nationally. Taken together, this study paints a rich tapestry of information regarding outcomes and service utilization among those involved in involuntary hospitalization and suggests changes to the system to ultimately improve outcomes.

76 Risk Assessment of Concurrent Stimulants and Benzodiazepines

Paul Zarkowski, MD

The use of amphetamine has increased steadily over the past couple decades, with total use in the United States increasing 2.5 times between 2006 and 2016. Since then, use of amphetamine has continued to increase, particularly in the last few years with relaxation of rules for prescribing controlled substances during the pandemic. Although the number of prescriptions for Adderall has stayed constant with pre pandemic levels for those younger than 21 years or older than 45, the number of prescriptions for those ages between 22 and 44 has increased 58% from 2018 to 2022, outpacing the number of ADHD diagnoses in that age group. Insomnia and anxiety are common side effects of stimulants. 30.8% of patients receiving a prescription for a stimulant also received prescriptions for anxiety/sedative/hypnotic medication. The original FDA approval data on amphetamine for attention disorders did not evaluate efficacy or safety of concurrent use with any other medication including benzodiazepines, except acetaminophen. Subsequent efficacy trials of amphetamine for ADHD excluded all other psychoactive medications, including benzodiazepines. One prospective study found that amphetamine reversed the sedative effects of a benzodiazepine, but left substantial deficits in balance, reaction time, memory and insight to impairment. In contrast to the dearth of prospective studies on the efficacy of concurrent amphetamine and benzodiazepines is the wealth of epidemiological studies showing an increased risk of negative outcomes. The combination of amphetamine and a benzodiazepine yielded the highest odds ratio, over 300, for an accident or arrest for erratic driving, higher than any substance alone. Once alprazolam was detected in the blood of an impaired driver, the mostly likely additional substance was amphetamine. If a person combines a sedative with another sedative, they are uncoordinated but also likely to fall asleep. But if a stimulant is combined with a benzodiazepine, subjects are still uncoordinated, but they are wide awake and active, leading to a synergistically greater risk of accidents. The prescription of concurrent amphetamine and alprazolam varies with socioeconomic factors. The prevalence of the combination in each zip code is positively correlated with the fraction of high-income households according to data from the Washington State Prescription Monitoring Program (PMP). The total prescription of amphetamine increased with both the fraction of high- and low-income households. In contrast, the total prescription of alprazolam decreased with the fraction of high-income households. The Substance

Abuse and Mental Health Data Archive includes surveys on the use of controlled substances during the past year, defined as use prescribed by a physician but also misuse including use of diverted substances. The number of people reporting misuse of both amphetamine and alprazolam exceeds the number prescribed both by a physician for all income brackets. Regardless of source, patients taking this combination are at a synergistically greater risk of a variety of different accidents. This information could be useful in an improved risk assessment in patients presenting with psychiatric emergencies with toxicology screens positive for both amphetamine and benzodiazepines.

77 Where Does "Crisis Care" End and Emergency Psychiatry Begin?

Scott L. Zeller, MD

As nationwide recognition grows of the post-pandemic surge in serious behavioral health issues, there has been an unprecedented level of attention and support for creating acute behavioral healthcare intervention options. 988 is now well established and handling tens of millions of calls per year. States, counties, and communities are developing call centers, mobile crisis teams, peer-run facilities and crisis receiving centers. Simultaneously, many hospitals have been initiating emergency psychiatry units, telepsychiatry, improved staff training, and other adaptations, to improve the care for behavioral emergencies, which now number one in every seven patients in emergency departments in the USA as well as working to eliminate the long-standing problem of psychiatric patients boarding for long hours or days, untreated, in emergency departments, awaiting admission to an elusive behavioral health inpatient bed. Yet with all this promising movement, a surprising dichotomy has emerged. Community-focused crisis planning often completely ignores hospital-based programs, or even refers to hospitals solely as places individuals in crisis should go only when medical clearance and inpatient psychiatric hospitalization are warranted. While Emergency Psychiatry clinicians are investigating new treatment modalities or novel agents for calming agitation, the Community Crisis professionals may see their roles very differently as one recently said, "Crisis Stabilization to me consists of a cup of tea and a sympathetic ear". Meanwhile, "Crisis Stabilization" as a term itself can have wildly different meanings depending on where you are; in some parts of the country, crisis stabilization is a 23-hour observation, in others it's a weeks-long subacute stay, while in still other places crisis stabilization is defined as a six-month residential substance abuse program. Not only has this confusing variation been noticed by behavioral health professionals, but it has now become a subject of debate among healthcare architects. Is it finally time for standardized, clearly defined nomenclature for all these? And should "crisis" and "emergency psychiatry" even be categorized together? As the three main models of hospital based 'crisis' programs- PES, CPEP, EmPATH- all have 'emergency psychiatry' as part of their names, but not 'crisis', should we think of Emergency Psychiatry and Crisis Care as two separates, though related, entities? Is an Emergency and a Crisis two different things, or different levels of acuity of the same thing? Or is there enough in common that Emergency Psychiatry and Crisis Care should still be considered part of the same spectrum or continuum? The presenter will share these concepts and propose a new set of definitions and hierarchies which could, if implemented, might better standardize this arena in the future. It is expected that these ideas may be controversial to some in the audience, so questions and a robust conversation with the audience will be encouraged.

78 Race/Ethnicity and Involuntary Psychiatric Admission Among Veterans: A Retrospective Chart Review

Sahana Malik, MD

Background: Involuntary psychiatric hospitalization is based upon a patient's risk of harm or inability to care for themselves and plays an important role in stabilizing patients. However, how "harm" and "inability for self-care" are particularly defined varies by state and is influenced by governmental policy. These discrepancies in definitions increase the risk for differing interpretations by and consequently, inequalities in treatment. Current literature has shown that disparities in involuntary psychiatric care exist amongst minority ethnic groups specifically, minorities tend to be involuntarily hospitalized at higher rates than their White peers. The purpose of this study was to determine if similar pattern exists within the Veteran Health Administration (VHA) system.

Methods: This study was a retrospective chart review querying all inpatient psychiatric admissions, voluntary and involuntary, at a large VA teaching hospital from January 1, 2021 to January 1, 2022. In addition to legal status on admission (voluntary or involuntary), we extracted patient-level data on self-reported race/ethnicity, age, sex, marital status, admitting diagnosis, and length of stay.

Results: Of the 792 admissions, 569 patients were identified, with average age of 51.4 years and length of stay of 11.8 days. The rate of involuntary admissions among Asian (67.5%) and Black (61.0%) patients was statistically higher than that of White patients (50.3%), with p-values of 0.035 and 0.025, respectively.

Conclusions: Involuntary psychiatric admissions have been associated with stigma, stress and reduced quality of life. The reason for the racial disparities observed may be

rooted in individual clinician bias, and the level of perceived "threat" a patient has can be subjective. Standardization of risk assessments and definitions can help to combat bias and the risk of unequal treatment. Additionally, contrasting to community hospitals and civilian patients, nearly all patients involved in this study were eligible for VHA outpatient mental health coverage, suggesting that access does not necessarily equate to higher utilization. Furthermore, higher utilization in turn does not necessarily equate to lower rates of involuntary psychiatric hospitalizations, as Black adults were the most likely to use mental health services. This further highlights the role individual bias may be playing when compared to systemic inequalities.

79 Factors Associated with Prolonged Time Awaiting Psychiatric Hospitalization In The Emergency Department

Jin Hong Park, MD, MS

Background: Limited access to mental health resources, particularly inpatient beds, can lead to prolonged time awaiting psychiatric hospitalization in emergency departments (ED). There is limited research exploring factors that influence this prolonged wait time for psychiatric patients. Our study aimed to investigate sociodemographic and clinical variables associated with the time spent awaiting psychiatric admission for patients in the ED at a large academic tertiary care center.

Methods: We conducted a retrospective chart review focusing on adults admitted to an acute inpatient psychiatric unit through an academic tertiary care center ED over the span of one year. Sociodemographic data including age, sex, marital status, race, and insurance type, were collected. Clinical variables, such as primary diagnosis, current suicide attempt, current self-injurious behaviors, history of a suicide attempt, history of psychiatric hospitalization, involuntary status, use of acute intramuscular injections, and use of physical restraints, were also extracted. Temporal factors such as timing of presentation within the day of the week and the season of the calendar year were also included. Multiple regression modeling was employed to identify factors associated with prolonged time awaiting psychiatric admission in the ED.

Results: A total of 498 patients were included in the study (mean age: 34.3±11.1) with a female-to-male ratio of 0.83. 77% were Caucasian and 16% were African American. The mean time awaiting psychiatric admission in the ED was 29.6±25.1 hours. Visits during fall months (September, October, and November) ($p=0.004$), weekends ($p=0.001$), involuntary status ($p< 0.001$), and use of acute intramuscular injections ($p< 0.001$) were significantly associated with a prolonged time awaiting admission in the ED. Primary psychiatric diagnosis of major depressive disorder ($p=0.024$) was associated with a shorter time awaiting psychiatric admission in the ED. Current self-injurious behaviors ($p=0.050$) and African American race ($p=0.096$) showed a non-significant trend towards longer stays.

Conclusions: The use of acute intramuscular injections was the most significant factor associated with longer time awaiting psychiatric hospitalization in the ED, followed by involuntary status, and ED visit during the weekend or fall season. A diagnosis of major depressive disorder was associated with shorter time awaiting psychiatric admission in the ED. Recognizing these factors and implementing strategies to address barriers to admission (e.g. staff verbal de-escalation training, acute intramuscular injections stewardship considerations, increasing inpatient staffing to accommodate for high acuity patients, etc.) may play a role in addressing the multifactorial issue of prolonged time awaiting psychiatric hospitalization in the ED.

80 Development of a Behavioral Emergency Response Team (BERT) at a Large Safety-Net Hospital and Trauma Center in Oakland, CA

Tushara Surapaneni, MD, Claire Lamneck, MD, MPH

Background: Agitation and behavioral related emergencies stemming from psychosis, delirium, substance use, or psychological trauma are common in emergency departments (EDs), and frequently place patients and staff at risk of violence, abuse, and traumatization.[1] Similar to how a Rapid Response Team responds to patients in medical crises, a Behavioral Emergency Response Team (BERT) is a multidisciplinary group of healthcare professionals with psychiatric and behavioral healthcare experience who respond to patients in behavioral crises to prevent harm.[2] Research published from BERT programs show significant decrease in assaults, security involvement, and restraint use on patients.[3,4,5,6] The purpose of this work is to demonstrate a framework and research protocol for the development of a BERT program at a safety-net hospital while fostering an understanding about the efficacy of BERT programs and their need for violence prevention in EDs.

Methods: A multidisciplinary team at Highland Hospital in Oakland, CA, led by emergency medicine physicians, in collaboration with hospital administration, nursing, and security have created a framework for a BERT consultant program. In this framework, BERT can be activated emergently in the ED as a "Code BERT" for behavioral emergencies to provide immediate de-escalation. "Code BERT" may prevent the activation of a "Code Grey" in the hospital, which is an established rapid response led by security and law enforcement. BERT can also be consulted non-emergently for patients, including patients on a psychiatric

hold, to develop individualized plans to prevent behavioral escalation. Similar to BERT programs at other hospitals, our program will be staffed by nurses, social workers, and psychiatric technologists. Medical providers may easily consult with BERT and review BERT encounters via our electronic medical record (EMR). Evaluation of program efficacy will include structured interviews with patients and staff as well as data extracted from the EMR.
Results: Program efficacy will be based on quantitative and qualitative data. Qualitative data will include patient and staff interviews on perceived safety and satisfaction prior to and six months after implementation of BERT. Quantitative data will focus on metrics including number of BERT consults, comparison of number of Code BERTs vs Code Greys, and use of chemical and physical restraints on patients. These metrics will be used to assess utilization of the BERT team, security and law enforcement services, and patient restraints.
Conclusions: BERT programs increase patient and staff safety, improve staff satisfaction, and decrease behavioral related emergencies while promoting a culture of patient-centered care. In this work, we show the development of a BERT program at our safety-net, county hospital initiated by emergency medicine residents and attendings. We hope our framework and research methods may be helpful to other programs and look forward to discussing and collaborating on best practices for violence prevention in behavioral emergencies.

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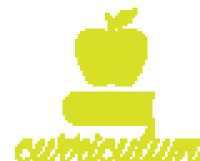

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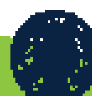
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