Behavioral Health in the Emergency Department: Managing Risk, Complexity, and Moral Distress at the Bedside

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Objectives

At the end of the webinar, the participant should be able to:

1. **Recognize the clinical, operational, and ethical complexities of managing behavioral health patients in the emergency department, including prolonged boarding, limited resources, and competing priorities.**
2. **Analyze real-world patient scenarios to identify key safety risks, including suicide, self-harm, elopement, violence, and deterioration while awaiting placement.**
3. **Evaluate areas where implicit bias can influence emergency department care behavioral health care.**

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The Landscape aka The Pitt

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Emergency Care

Immediate

Stabilization

Urgent or life-threatening illnesses or injuries

Multidisciplinary team: Physician, nurse, technician, consultant

24/7

Rapid assessment, diagnosis, intervention

Goal: Preserve life

Goal: Prevent complication

Goal: Relieve Suffering

Goal: Appropriate disposition: DC, Admit, Surgery, or Transfer to higher level of care

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Emergency Psychiatric Care ??

Immediate

Stabilization

Urgent or life-threatening illnesses or injuries

Multidisciplinary team: Physician, nurse, technician

24/7

Rapid assessment, diagnosis, intervention

Goal: Preserve life

Goal: Prevent complication

Goal: Relieve Suffering

Goal: Appropriate disposition: DC, Admit, Surgery, or Transfer to higher level of care

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Why?

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What it feels like

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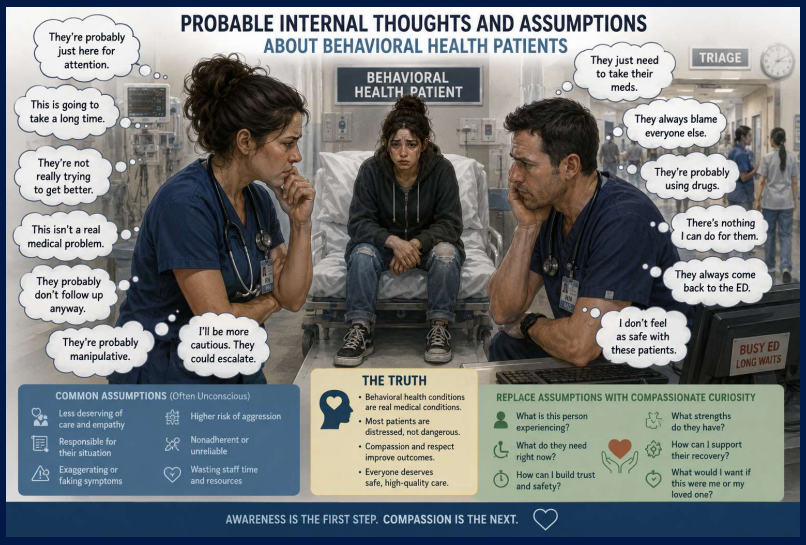
Stigma



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Pitfalls

Care beyond 4 hours is difficult for all ED patients

- Changing ED Physicians
- Changing ED Nurses

Different medication comfort by physicians – standard guideline like trauma, stroke, etc..

1:1 Observation is difficult at best

Environment traumatizing (physically and mentally)

Coordination of care when in the hospital

Insurance (commercial, partnership, medi-cal, medicare)

Definitive Care ?? Trauma/Heart attack

Least restrictive – voluntary??

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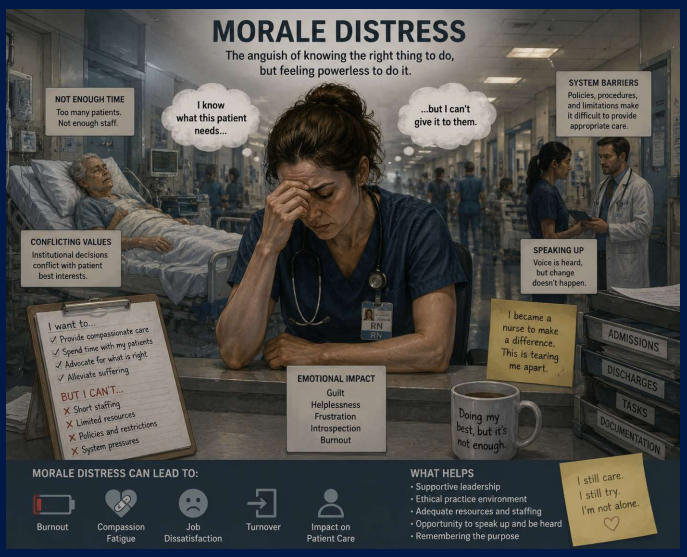
Moral Distress



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Medical Behavioral Health

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SUD Behavioral Health

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Geriatric Behavioral Health

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Special Needs Behavioral Health

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Adolescent Behavioral Health

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California Behavioral Health Changes

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Pitfalls of California Behavioral Health Changes

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Learned Helplessness? NO!

Care beyond 4 hours is difficult for all patients – standardizing protocols with the RN and CAN driving the care

- Changing ED Physicians
- Changing ED Nurses

1:1 Observation behaviors – engagement – training to develop rapport – own ADLs and observations

Constant reprioritization – try to put these patients together with one RN

Medication comfort – getting psychiatrist to develop PMGs for all physicians

Solitary – OUTSIDE!!

Coordination of care – we can be the glue that makes everyone talk

Definitive Care – receivers can say no – leverage partnerships

PADs – execute psychiatric advanced directives

Relationships BHAB – be apart of the greater conversation

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Questions?

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