families responded to the telephone survey. Respondents were more likely to have a child who was female and slightly younger compared to non-respondents. 98% of respondents reported some virtual schooling for their child, with 77% reporting virtual schooling for the majority of the three months prior to their child, first hospital admission. 61% indicated their child was exclusively in virtual school. No significant relationships were observed between virtual schooling and any outcome measures relating to mental health.

**Conclusions:** Pediatric mental health emergencies and hospitalizations have grown and evolved since the start of the COVID-19 pandemic. This study characterizes some of the changes in patient demographics and experience with virtual schooling prior to and following the pandemic. Our results do not support any correlation between virtual schooling and mental illness requiring emergent care or hospitalization. However, this study has many significant limitations. Respondents were not representative of all admitted patients, and survey data were gathered for only one-third of families whose children were admitted at one site. Very few respondents remained in school in person throughout the pandemic, complicating efforts to make meaningful comparisons. Future work should attempt to capture a broader subject pool and obtain prospective data regarding the effects of school modality on mental health.

## 8 The Utility of the Columbia-Suicide Severity Rating Scale in Determining a Patient, Imminent Risk for Suicide in the Emergency Department

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**Background:** In response to a 2019 Joint Commission report highlighting new suicide screening requirements, many hospitals have initiated universal screens for suicidal ideation for all patients. A common algorithm is to screen patients upon their entrance to a hospital with a tool such as the Columbia-Suicide Severity Rating Scale (C-SSRS). When a patient enters our institution, Emergency Department (ED), they are screened by a Registered Nurse (RN), who is either a psychiatric RN or a non-psychiatric ED RN, with the C-SSRS to assess their level of imminent risk for suicide. Patients scoring a 4 or 5 on the C-SSRS are considered high-risk, and one-to-one constant visual observation via a safety assistant is automatically assigned. All of these patients must then be formally assessed by the psychiatric consultation team, who then recommend whether to continue or discontinue the safety assistant. Existing literature on the C-SSRS measures either chronic risk over time (six months) or evaluates patients already admitted to an inpatient psychiatric unit, thereby selecting for an already known high-risk population. There is limited data on the validity of the C-SSRS in determining a patient, imminent risk for suicide upon presentation to the ED. Assignments of safety assistants may impose a psychological toll upon patients due to the resulting infringement upon the patient, independence and privacy, and this toll may sometimes result in further acute psychiatric decompensation. In addition, safety assistants are a limited resource, and their overutilization may present a financial and personnel concern for hospitals. It is thus pertinent for hospitals to assign safety assistants judiciously.

**Objective:** To evaluate the utility of the C-SSRS in assessing a patient, imminent risk for suicide compared to a psychiatrist, evaluation, and to determine whether the C-SSRS more accurately assesses imminent risk for suicide when administered by a psychiatric RN as opposed to a non-psychiatric ED RN.

**Method:** We examined patient encounters for which a safety assistant was ordered for suicidality based on a C-SSRS score of 4 or 5 (n = 164). For each encounter, we recorded the psychiatry team, recommendation for continuation or discontinuation of the safety assistant, title of the RN who administered the C-SSRS, and total duration of the safety assistant assignment. Data was analyzed via a multivariate logistic regression analysis.

**Results:** The psychiatry team aligned with the C-SSRS in assessing a patient as high-risk for imminent suicide in the ED 22.6% of the time. Administration of the C-SSRS by a psychiatric RN was not associated with increased C-SSRS accuracy in capturing high-risk patients compared to administration by a non-psychiatric ED RN. The average duration of unnecessary safety assistant assignments was 6.8 hours.

**Conclusion:** The data supports that the C-SSRS is of limited utility when determining a patient to be of high-risk for imminent suicide in the ED and may result in prolonged care due to unnecessary assignments of safety assistants. We propose that the C-SSRS should not be relied upon as the sole method for assessment of risk for imminent suicide in the ED.

## 9 Rare Disease Masked Behind Common Presentation: Toxic Leukoencephalopathy Up Close

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Toxic leukoencephalopathy refers to a structural alteration of the white matter, generally affecting myelinated structures. It is caused by environmental toxins, substance use, or chemotherapeutic agents. The clinical presentation is extremely variable, ranging from minor cognitive impairment to severe neurologic dysfunction, and is often mistaken for primary psychiatric illness. A 51-year-old man presented involuntarily to the ED for bizarre behavior and disordered mentation. His initial cognitive evaluation showed orientation to person but neither place nor time. He was unable to state how he arrived