

9th Annual National Update on Behavioral Emergencies Conference (NUBE) in Las Vegas, Nevada (December 12-14, 2018)

The American Association for Emergency Psychiatry held the 9th Annual National Update on Behavioral Emergencies on December 12-14, 2018 in Las Vegas. We had a robust set of abstract presentations that the *Western Journal of Emergency Medicine* was gracious enough to publish in this issue. Please join us next year for the 10th Annual National Update on Behavioral Emergencies in Scottsdale, Arizona December 11-13, 2019. A call for speakers and abstracts will be out shortly on our website: <https://www.emergencypsychiatry.org/>

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1 Management of Pediatric Agitation and Aggression: Lessons Learned from the National Consensus Pediatric BETA Guidelines

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Introduction: Agitation in pediatric acute care settings is common and disruptive. We begin with a case example of an agitated patient on a pediatric medical unit. Using data from a survey of 38 North American children's hospitals we will outline the prevalence, screening methods, clinical guidelines, and physician training in the management of agitation. We will describe hospital practice in the comprehensive evaluation and management of pediatric agitation and aggression at one institution, followed by a summary of the literature on medications for agitation. We conclude with the National Consensus Pediatric BETA Guidelines for the management of pediatric agitation and aggression in emergent settings.

Methods: A case presentation will be followed by data from a national survey of pediatric hospitalists and consultation/liaison psychiatrists. A clinical pathway for management of agitation will be described. Using a *Medline and PsycINFO* search from 01/01/1996-01/01/2017, we will summarize the literature on psychopharmacological management of agitation in pediatric patients. Using the Delphi method for consensus guideline development, a team of emergency department-based child and adolescent psychiatrists from across the United States created the Consensus Guidelines.

Results: Results of the survey of 38 North American academic children's hospitals revealed 85.5% of the respondents encountered agitation in pediatric patients at least once a month. Most viewed agitation in pediatric patients as highly important, yet 55.1% do not screen for risk factors of agitation, 65.3% reported no clinical guidelines for agitation, and 57.1% indicated no physician training in pediatric agitation. A multidisciplinary clinical pathway for agitation in pediatric patients will be outlined. Evidence for the following medication classes will be described: antihistamines, benzodiazepines, typical antipsychotics, atypical antipsychotics, mood stabilizers, anti-depressants, and stimulants. The Consensus Guidelines outline standardized recommendations for medications.

Conclusion: Agitation in pediatric patients is a concern continent-wide, but there is little training or standardization of care. Clinical pathways exist and can ensure identification and early management. Data about psychopharmacological management of agitation exists and updated Consensus Guidelines provide standardized guidelines for the management of agitation.

2 Evidence-based Care for Suspected Pediatric Somatic Symptom and Related Disorders in Emergent Settings

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Introduction: Somatic symptom and related disorders (SSRDs) are a group of diagnoses characterized by the presentation of one or more physical symptoms that are either inconsistent with physical disease based on a thorough medical evaluation or vastly disproportionate to findings on a thorough medical evaluation, and result in significant impairment. These symptoms are often significantly influenced by psychological factors including acute or chronic distress, as well as visceral hypersensitivity and habituation of maladaptive responses to somatic sensations. These conditions are common in pediatric medicine, accounting for up to 50% of primary care visits for abdominal pain, headache, and fatigue. There is a lack of a coordinated approach to SSRD care, often resulting in excessive and unnecessary healthcare utilization, miscommunications, missed opportunities to intervene, and considerable frustration from patients, families and providers.

Methods: There is limited information in the literature for how to provide SSRD care in practice and no current consensus guidelines for SSRD care in youth. At our institution, we convened a multidisciplinary group of providers, used LEAN methodology to assess problematic areas, including areas of inefficiency or disruption in work flow, gathered data from primary care providers statewide to inform understanding, and developed an evidence-based, institutional clinical practice guideline for management of SSRD care within the emergency department (ED) and inpatient setting. In addition, we have integrated education on SSRDs into our pediatric and psychiatric trainee curriculum.

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Results: We will present the consensus-building process and multidisciplinary group formation used at our institution to develop standardized tools, resources, a clinical protocol and a clinical practice guideline. This includes a review of our value stream map as part of incorporating LEAN methodology in our process. We will review current evidence in SSRD practice, including data gathered from a statewide survey on practice. We will share our clinical protocol that outlines a detailed approach to suspect and confirm diagnoses of SSRD starting in the ED setting, as well as principles and contents from an interdisciplinary, hospital-wide clinical practice guideline with several associated clinical resources for practical application of the practice guideline and protocol.

Conclusion: Our institutional and statewide data align closely with existing evidence that indicates SSRDs are common, that providers, both medical and psychiatric, have little training or education on these conditions, that these conditions often present in emergent settings, and that patients and families often seek an overly physical conceptualization to their symptoms that is devoid of mental health involvement, which often leads to unnecessary and significant healthcare utilization. Initial results from our institutional approach, resulting in consensus-based practice guidelines, protocol and resources, suggest a model that can be used in ED and inpatient settings to address the needs of this pediatric population.

3 Pediatric Patients with Behavioral Emergencies: Who's Coming in and What Happens While They're Here?

AR Sanchez, J Sterris, EZ Shoemaker/ Keck School of Medicine of the University of Southern California, Los Angeles, California

Introduction: Children and adolescents evaluated in the emergency department (ED) represent a vulnerable population, especially when presenting for psychiatric symptoms. For these patients the ED environment may be stressful and lacking in needed resources. Data describing children seen within the ED are currently limited; this study aims to describe the pediatric patient population treated for mental health concerns within one ED, which may promote better-tailored treatment and support resources in the future.

Methods: The study describes 339 visits generated over two months in 2017 at LAC+USC Medical Center. We reviewed charts to determine each child's stated age and gender, as well as whether the patient belonged to one or more vulnerable subpopulations. The factors of interest included involvement with the social services and legal systems, history of psychological trauma, diagnoses of post-traumatic stress disorder (PTSD) or autism spectrum disorder (ASD), and whether the patient required a "behavioral code" during his or her visit.

Results: The study determined that 76.1% of the charts included at least one risk factor assessed during our review. Males were more likely than females to present by the age of 11, while the opposite was true for patients age 12-17. We also determined that 38% of patients had been involved with child protective services, or a regional center (system for individuals with developmental disabilities), or the juvenile justice system, and that 5.6% were involved with multiple systems. Two hundred twenty-five patients had experienced psychological trauma, with 30 patients carrying an official diagnosis of PTSD. Of behavior codes called, 23% were for ASD patients, with these patients being far more likely to display dangerous behaviors in the ED compared with neurotypical children.

Conclusion: This study demonstrates that a majority of children evaluated in our ED for psychiatric concerns also belonged to at least one vulnerable subpopulation. Especially striking was that behavioral codes were far more likely to be called for ASD patients than neurotypical patients, implying that EDs that work with this population may benefit from extra training in preventing and managing agitated behavior in children with ASD.

4 Creating Elasticity and Improving Handoffs Increases Throughput on an Emergency Psychiatry Service

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Introduction: As the population of New Orleans continues to increase, psychiatric services at its main safety-net hospital, the relatively new University Medical Center New Orleans (UMCNO), have had to increase with it. At UMCNO, psychiatric patients in the emergency department (ED) are ideally managed in the behavioral health emergency room (BHER) until either admission, transfer, or discharge. The BHER holds 26 beds, but staffing limitations prevent all 26 from being open continuously. Historically, there are fewer discharges from inpatient psychiatric units citywide on weekends, which then causes overflow of the BHER into the main ED and slows throughput throughout the hospital. Because of this, elasticity in the system and effective reassessments by the emergency psychiatry consult service are key to minimizing lengths of stay and saturation events.

Methods: In April 2018, efforts were undertaken to create more elasticity in the BHER as well as more effective handoffs to easily identify what is needed for each patient to ensure a safe discharge. Changes included the following: actively anticipating the need to expand to 26 beds starting Sunday evening; creating a mindset of "continuously seeking an inpatient bed" during peak times; and using the electronic health record (EHR) for handoffs between providers. Lengths of stay (LOS) for patients in the BHER as well as hours on psychiatric saturation were tracked monthly before and after the changes were made, as were the