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It's been hard to miss hearing of the nationwide scourge of psychiatric patients languishing for long hours in medical emergency departments (EDs). Known as “boarding,” it is an unfortunate situation that reportedly arises over 90% of EDs on a regular basis.[1]

Individuals suffering a psychiatric emergency or “crisis” — whether calling 911 or seeking help on one's own — frequently find the only possible destination to be their local hospital's ED. These EDs often are ill-equipped and lack proper staff training to intervene effectively with mental health patients.

Far too often, the default care plan is to isolate these patients (often either with a sitter or in restraints) and “board” them, while a staff member begins dialing the phone in a typically lengthy and frustrating search for an elusive psychiatric hospital bed.

Unfortunately, the duration of boarding is almost always long. Recent studies have documented that the average boarding time for a psychiatric patient — defined as from the time they are

considered medically clear for transfer to the moment they finally depart the ED — can run between seven and 34 hours across the country.[2,3]

Boarding Can Lead to Worsening of Psychiatric Symptoms

The status quo benefits no one. Psychiatric symptoms of these patients can often escalate during boarding in the ED, resulting in poorer outcomes. Overcrowded ED facilities and those with "boarders" correlate directly with increases in walkouts, medical errors, and negligence claims. Boarding is also very expensive. One study estimated the average cost to an ED to board a psychiatric patient to be $2,264.[4]

Many suggest the culprit for this situation is a dwindling number of psychiatric inpatient beds in the face of a growing incidence of mental illness, and so call for opening more psychiatric hospitals to solve the boarding dilemma. And indeed, more beds would help — but as a sole solution, it would only perpetuate the unusual circumstance of psychiatric crises being the lone medical emergency in which inpatient hospitalization is the default approach to care.

If we treated another urgent medical condition — for example an asthma attack — like we do psychiatric emergencies, here's how we'd provide care: A patient would come to the ED complaining of an acute asthma attack. The triage nurse would notify security, who would surround the patient and put him into a restraint bed, leaving a nurse's aide to sit with the patient, but not provide any actual care. Another nurse would begin dialing every hospital in a hundred mile radius, talking to several staff members at each program, and then faxing several sets of paperwork, only to be told time and again the patient couldn't be accepted.

At long last, three shifts later on the next day, an inpatient bed is located and an ambulance is summoned to transfer the patient to a hospital two counties away. Four hours afterwards, a low-priority transport ambulance has an opening and picks up the patient for the lengthy drive to the other hospital. The patient eventually arrives at the receiving hospital late in the evening, goes through multiple rounds of intake questions with various staff, and is checked into a room for the night. Around lunchtime the next day, a rounding physician finally comes to evaluate the patient, and writes a medication order. At that point, the nurse hands the patient a puffer.

The absurdity of this analogy makes this approach in psychiatric emergencies also seem out of sorts — and it should. Defaulting to admission no doubt results in far too many patients going hours without treatment, and being unnecessarily hospitalized at a very restrictive and expensive level of care — while the resulting high demand for a limited bed supply logically leads to delays and backups.

We have already confronted scarce medical/surgical beds in general hospitals by expanding outpatient and ambulatory services. Similarly, to reduce psychiatric patient boarding in the ED, rather than just looking at more inpatient space, shouldn't we also be considering psychiatric alternatives at the front end, such as emergency and outpatient levels of care?

Indeed, studies have found that with prompt intervention, the majority of psychiatric emergencies can be resolved in less than 24 hours, with no need for inpatient admission.[5] The

stumbling block in the past has been the lack of swift access to onsite psychiatric consultation in most EDs, leading to the reliance on admissions as a disposition.

But with the widespread search for solutions to the boarding problem, multiple innovative avenues of care are now emerging, both within EDs and at external, outpatient programs. These offer new options to resolve acute psychiatric crises, while reducing ED overcrowding and avoiding unnecessary hospitalizations.

Solutions Within the ED

Commencement of Care Algorithms: Even in situations where a psychiatric evaluation may not be possible for several hours, it does not mean that patients must wait in distress. Many straightforward treatments can start with ED physicians using standard protocols created in concert with their psychiatric consultant.

For example, simple flow charts leading the ED attending to prescribe prompt, standard medications may help alleviate symptoms of psychosis, paranoia, agitation, aggression or anxiety. Suicidality associated with intoxication can resolve over time if a patient is monitored to sobriety and treated for withdrawal symptoms. Often, patients can improve so significantly that by time the consultant does arrive, there is a much better chance for a diversion from hospitalization, compared to the previous method of deferring all care and "let's wait for psych."

On-Demand Emergency Telepsychiatry: In EDs across the country, where physicians are already familiar with telemedicine for radiology and other specialties, there is now a burgeoning presence of on-demand telepsychiatry, with psychiatrists able to evaluate and make recommendations for patients from remote sites.

In South Carolina, a state program provides psychiatric consults to EDs via telemedicine 16 hours a day, seven days a week. The program is reportedly saving over $1400 per patient and has saved over $28 million for the state to date.[6] A number of public and private organizations are now providing emergency telepsychiatry in other regions, which has been associated with improved patient outcomes and rapid stabilization of psychiatric crises, while facilitating patient throughput and avoiding boarding in the ED.[7]

Outpatient Programs External to the ED

Psychiatric Emergency Departments: There now exists over a hundred dedicated emergency rooms in the U.S. just for psychiatric crises, which are known by a number of different acronyms (PES for "Psychiatric Emergency Service," or CPEP for "Comprehensive Psychiatric Emergency Program," to give two examples). These programs serve to evaluate and care for all the acute mental health crises for a given region, accepting patients via ambulance or police delivery, transfer from medical hospitals or self-presentations.

Typically such programs have the ability to treat and observe patients for up to 24 hours, which can give them sufficient time to resolve symptoms and avoid hospitalizations. A study of one such program in California showed it reduced area ED boarding by over 80% compared to state averages, while being able to avoid inpatient admission in over 75% of patients on involuntary psychiatric holds.[8]

Crisis Stabilization Units (CSUs): These programs can serve as designated outpatient alternatives to psychiatric hospitalizations, and are much like Psychiatric Emergency Departments, except that patients are screened and accepted from outside facilities rather than directly presenting. CSUs are often affiliated with a particular medical ED, from which they can accept medically stable patients and, like the psychiatric emergency rooms, will attempt to resolve psychiatric crises in less than 24 hours.

Crisis Residential/Acute Diversion Units are longer-term programs (typically between three and 14 days), often set up in former private homes, which permit subacute mental health patients in need of a period of stabilization to do so in a comfortable community setting. This is much less restrictive and more cost-effective than a hospital bed.

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