Practical Solutions to Boarding of Psychiatric Patients in the Emergency Department

Does Your Emergency Department Have a Psychiatric Boarding Problem?

Created by members of the ACEP Emergency Medicine Practice Committee

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An Information Paper

Of the estimated 136 million emergency visits yearly, 5%, or nearly 7 million Americans, present to our emergency centers with a primary psychiatric emergency. Limited funding, limited resources, and patient placement difficulties have cumulated to the current crisis of mental health patients boarding in the emergency department (ED).

Hospital crowding and the boarding of medical patients in the ED continues to occur despite overwhelming literature that associates this practice with serious patient safety issues and higher mortality rates. The issues around mental health patient boarding differ in many ways from those of medical patient boarding. The underlying issue is still the inability of admitted patients to go to an inpatient bed. However, many mental health facilities do not operate under EMTALA rules and may "cherry-pick" the patients they receive. Hospitals may refuse to accept a patient because of comorbidities or means of payment. Most importantly, patients with mental health issues often fail to receive a detailed evaluation, any re-evaluation, and any mental health-related care while they are waiting.

According to a 2015 Emergency Medicine Practice Research Network (EMPRN) poll 70% of the emergency physicians surveyed reported psychiatry patients being boarded on their last shift! Over half reported average boarding times of up to two days and up to five patients at a time. The backup and boarding EDs of psychiatric patients waiting for an evaluation or inpatient bed is a troubling phenomenon on a national scale for EDs and mental health consumers alike. The crisis condition of the ED provides a clear picture of a mental health care system in complete dysfunction.

Clinical experience has shown that a call primarily for the creation of more inpatient beds is, at best, a one-dimensional solution to a complex problem. It may also be regressive. The emergency department is a "room with a view."[9] Individuals who are being boarded, if examined in their particularity, prove to be reflections and indicators of the many different aspects of the local mental health system that require improvement. Insufficient inpatient beds may or may not be one of them.

The plight and sheer numbers of these patients can become a powerful motivator for bringing together a broad-based action group of stakeholders in the community besides EDs: the private, public, and academic sectors of mental health care; law enforcement; court system; patient advocates; peer specialists; relevant social agencies; and politicians and policy-makers. Ultimately simple boarding statistics can serve as an elegant metric of the success or failure of the various, concerted efforts that a reform-minded community might undertake.

In this document, we have input from various leaders in emergency medicine and take a peek into how individuals tried to solve this problem at the local, regional, and state level. Although no one mechanism is likely to fix the national problem, one or a combination of these methods may help your individual practice and ultimately provide better care to the population. The most common solutions are listed below, with a brief description, followed by links and additional resources. These solutions are to serve as a guide that you may then combine and morph into a solution that works best in your state, community, and ED.

- **Telepsychiatry Services** – This solution is important in increasing access to a psychiatrist in a more timely fashion. There are various private companies offering this service across the country.
- **Psychiatric Observation Units and Treatment Protocols** – Specific psychiatric emergency department and/or observation units are utilized to pull psychiatric patients out of the general ED once they are stabilized

or medically cleared. Protocols to care for the patient during their lengthened observation stays are often helpful.

- **Patient Navigation/EMS Involvement** – This can be approached from several aspects. One increasingly common approach is "Community Paramedicine Programs" in which paramedics help patients navigate the often cumbersome health care environment. Additionally, some EMS agencies are clearing patients medically in the field and transporting them directly to psychiatric hospitals. Lastly, social workers and case managers can serve as important navigators for patients.
- **Mobile Crisis Units** – These are usually teams of multidisciplinary mental health professionals that respond to individuals in the community requiring assistance with a psychiatric crisis. The team may include social workers, nurses, psychiatrists, psychologists, addiction specialists, mental health technicians, and peer counselors. The mobile crisis team can provide a range of services that can include assessment, crisis intervention, information, referrals, and supportive counseling.
- **Regional/State Health Registries** – A streamlined state or regional dashboard showing bed availability coupled with available transfer mechanisms are helpful in reducing the time and effort it takes to get patients to definitive care.
- **Emergency Department Evaluation, Treatment, Re-evaluation**
- **Protocols for Safe Discharge** – Evidence-based decision tools can be helpful in allowing an emergency physician to safely discharge a patient with a mental health disorder.
- **Lessons Learned Case Studies**

As demonstrated, there is not one fix for this looming issue. It takes community, regional, state, and national stakeholders to tailor and implement methods that work best to serve the patients in your community.

Telepsychiatry Services

Telemedicine has been used in medicine for several years (eg, teleradiology, transmission of ECGs). Telemedicine is used to connect physicians with incarcerated patients, those in nursing homes, and those who want after-hours consultations on the web. Telepsychiatry has been a service offered by many private companies as well as developed within health care systems. Given the shortage of psychiatrists in our country, this delivery method of definitive psychiatric care has been shown to be very helpful. Some states such as Georgia have embraced this technology and several vendors within the state provide services to urban and rural hospitals.[1]

Telepsychiatry is generally provided via video conferencing. In the past, this required elaborate communication monitors for both the physician and the ED. Video conferencing through the web is simple and portable but must be compliant with Health Insurance Portability and Accountability Act (HIPAA) regulations.

Patients with mental health issues often wait for care. At triage, they may be perceived as not having severe illness and wait for an initial assessment. However, that wait is often dwarfed by the wait to see a mental health expert. In a recent National Alliance on Mental Illness survey, 70% of patients reported waiting 10 hours or more to see a mental health expert in the ED. Telemedicine offers the ability not only to decrease that wait, but to connect the patient to a higher level of provider. In a recent survey of 1,333 emergency physicians, only 7% stated that their patients are seen by a psychiatrist in the ED. Another 5% were using telepsychiatry.[2] Telepsychiatry is one answer to the shortage of psychiatrists, especially those with expertise in child and adolescent psychiatry. In rural areas, access to psychiatrists is very limited, with many counties throughout the country having no psychiatrists at all. Waits for evaluation may exceed six months. Insurance coverage varies. While the Center for Medicaid and Medicare Services covers some services, state policies on telemedicine vary. The state of Texas recently voted to not allow telemedicine.

Emergency Psychiatry Services

- Three Basic Models of Emergency Psychiatry Delivery
  Zeller S. Treatment of Psychiatric Patients in Emergency Settings. *Prim Psychiatry*. 2010;17(6):35-41.

- Psychiatric consultant evaluating patients in medical ED. This is the most common model. However most EDs do not have access to a psychiatrist and rely on psychiatric social workers/nurses and psychologists to do the evaluation. This evaluation and decision to admit are often made days before the patient is transferred to a bed. During that time the severity of illness often changes.
  - Advantages:
    - Lowest cost
    - Easiest to implement
    - Less stigma when mixed with all patients
  - Disadvantages:
    - Delay in arrival of psychiatric consultant
    - Limited treatment options: typically admit versus discharge
    - Not conducive setting to extended psychiatric treatments/observation
    - Physical setting (noise, patient volume) not optimal for psychiatric healing
    - Possibly unsafe environment for suicidal patients (instruments, etc)
    - Staff may be less comfortable with psychiatric patients
- Separate section of medical ED dedicated to mental health patients. While this model provides some safety advantages, the model still relies on an evaluation by a mental health provider and has the same issues outlined in the model above.
  - Advantages:
    - More nurturing, conducive environment to psychiatric care
    - Still within medical ED, allowing for full medical assessment and treatment
    - Often allows for more time to arrange an appropriate disposition
  - Disadvantages:
    - Segregation of patients may create stigma regarding treatment in separate wing
    - Area may become overflow area for nonpsychiatric patients
    - May end up with minimal treatment occurring during wait in this area for placement
- Stand-alone Psychiatric Emergency Services (PES)
  - Advantages:
    - Staffed around the clock with psychiatric nurses and other mental health professionals
    - More prompt diagnosis, treatment
    - Typically have extended observation capability
    - Can significantly reduce admission rate
    - Allows for quick decompression of EDs
  - Disadvantages
    - Lacks immediate proximity to emergency medical services
    - More expensive than other models
    - Requires 24/7 staffing and physical location
- Psychiatric Emergencies – Goals of Care
  - Treatment goals:
  - Rule out medical etiologies of symptoms
    - see "Medical Clearance of Psychiatric Patients in the ED"[3]
  - Stabilization of acute crises by means of engaging the patient, treating from the start, and focusing care on the primary goal of safe disposition including discharge for outpatient care when appropriate.
  - Disposition and aftercare plan

- Principles of Practice and Care
  Emergency Care Psychiatric Clinical Framework. Consensus Statement by AAEM, ANA, APNA, ENA, ISPMHN. March 2010.

- Protocols must implement evidence-based clinical guidelines for treatment of patients with mental illness and substance abuse disorders
  - Focused medical assessment
  - Emergency psychiatric evaluation

Psychiatric Evaluation and Stabilization Units

Inpatient mental health beds have decreased over the past several decades, and limited reimbursement particularly for Medicaid recipients provides incentives to delay transfer of these patients. Once it has been determined that a patient needs inpatient treatment, another waiting period sometimes begins.

As EDs and health facilities across the country see the volume of psychiatric emergencies rise, many health care systems are establishing new ways to effectively and efficiently deliver care to a significant segment of this patient population. This has commonly resulted in the development of psychiatric observation units and psychiatric-specific EDs. These units do not replace the need for inpatient beds for new-onset mental illness or the most severely ill psychiatric patients, but can be a useful approach for many acute patients. As with any new delivery model, however, procedures and protocols can be challenging to establish. As such, the information below is intended to be a general resource for this task. It is largely based on a recommendation paper from the APA Task Force on Psychiatric Emergency Services.

Evaluation and Stabilization Units Standards

Report and Recommendations Regarding Psychiatric Emergency and Crisis Services. APA Task Force on Psychiatric Emergency Services. 2002.

This report provides an overview on the provision of services for patients requiring emergency psychiatric services. Hospital-based services, including psychiatric consultation with an emergency physician, specialized psychiatric ED, extended observation or crisis hospitalization, and a variety of community services are presented with a focus on crisis care for individuals with mental health emergencies.

Patient Navigation

Some patients presenting to the ED with behavioral health crises may not require emergent inpatient treatment, but they may not be safe for unsupervised discharge. Patient navigation helps these patients connect with community resources to prevent the need for inpatient beds and ED recidivism. A social worker or case manager can be a strong navigator. Community health workers or other staff can also be trained to fill this role.

Navigators can communicate in real time with a patient's family or social support network and outpatient health providers to plan a safe discharge. Navigators should be familiar with all available mental health and substance abuse resources in the community. Navigators can then provide referrals to or schedule patients for prompt outpatient mental health appointments, community support groups, or other existing community resources prior to discharge from the ED. They can help patients connect with other social services such as housing that also help stabilize their mental health crisis. Navigators may contact the patient after discharge to ensure that patients remain safe and are successfully following their discharge plans.

Community resources that a navigator may use for a patient's discharge plan include:[4]

- Early intervention programs
- Mobile crisis units
- Crisis hotlines
- Crisis stabilization centers

- Peer support services
- Home mental health care
- Telepsychiatry
- Case management
- Outpatient care
- Adult day care
- Partial hospitalization
- Residential treatment programs

The American Hospital Association (AHA) encourages hospitals to take a proactive approach to behavioral health prevention. The AHA emphasizes that investment in community resources or even expansion of a hospital's own behavioral health services can be financially feasible by offsetting emergency care including patient sitters and decreased ED throughput.

Behavioral Health Task Force Report. American Hospital Association. Recommendations for community assessment and implementation of case management principles for mental health. 2007.

Best Practice Examples (from the AHA report):

- Northeast Hospital Corporation, Beverly, MA: Created a dashboard of behavioral health performance indicators to track community resources
- Central Peninsula Hospital, Soldotna, AK: Developed a coalition to provide early intervention services to the community
- Massachusetts General Hospital, Boston, MA: Developed a coalition of community partners to reduce substance abuse in the community
- University of New Mexico, Albuquerque, NM: Opened a psychiatric ED to respond to psychiatric crises

EMS Involvement

The largest contribution that EMS organizations have made to improvements in ED psychiatric boarding within the last decade is the development of community-based paramedicine (CBPM) programs. CBPM programs are intended to support and integrate into existing health care system infrastructures. CBPM programs exist throughout the country, and their roles and responsibilities vary depending on particular community needs; rural programs tend to serve roles in home and non-emergent care delivery, while urban programs tend to focus more on improved integration with existing programs. Thus, there is no "one size fits all" approach, but as regards to improving outcomes around psychiatric boarding in EDs and hospitals, most efforts have been focused around:

- Helping patients navigate through their local health care system more effectively
- Working with local health care resources to seek more effective care delivery models
- Provision of community education, and in particular proper disease management and prevention for this cohort
- Working with regional health care facilities to improve ED and hospital admission usage
- Targeted EMS provider education and training (particularly around the issues of psychosocial patient assessments, home living assessments, medication reconciliation, and chronic disease management)

While this is not the venue for an in-depth discussion on CBPM development, a national framework education program does not exist for CBPMs.

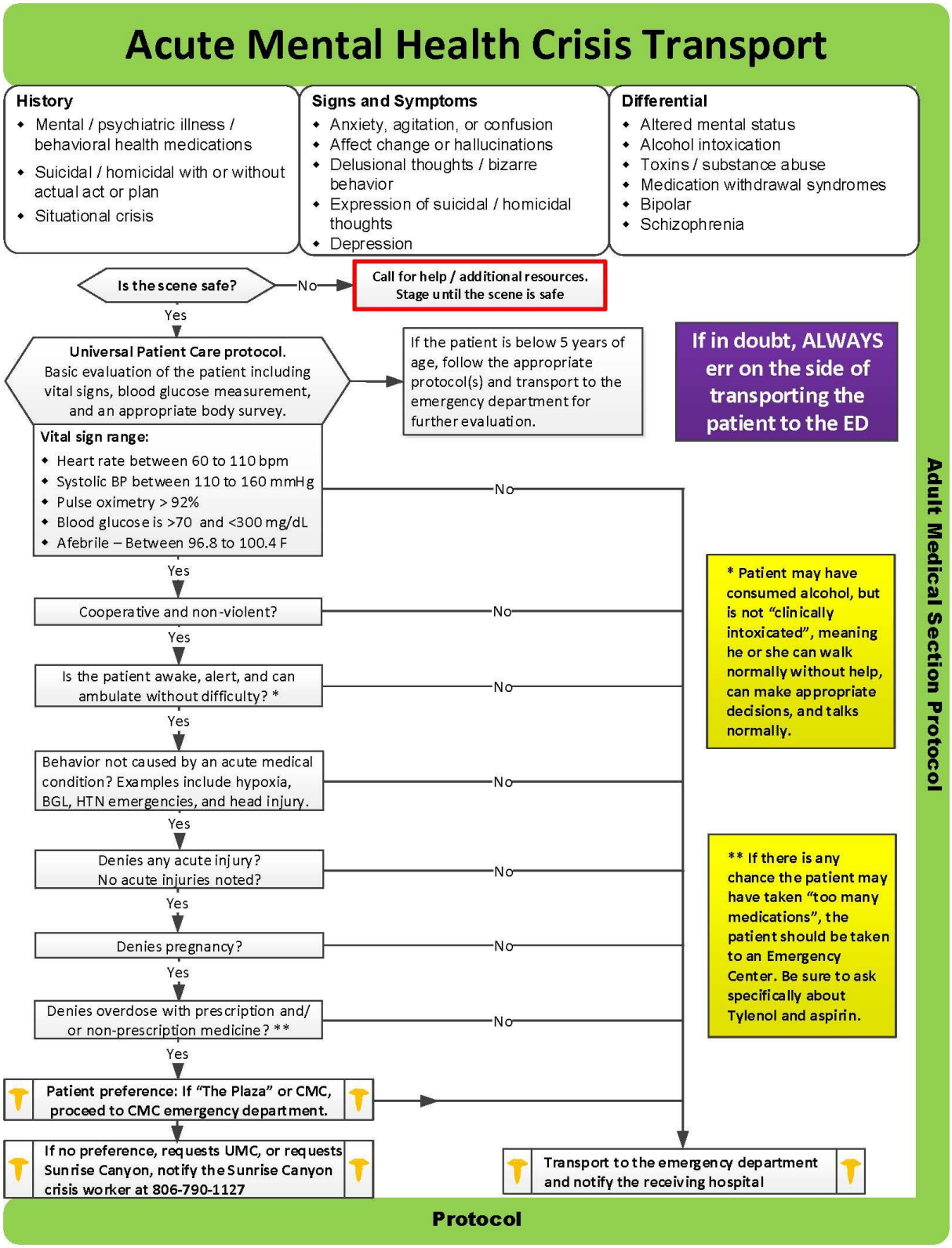
Other efforts being conducted with EMS around psychiatric boarding include:

- Use of regional real-time ED patient volume data to divert EMS units
- Implementation of regional disaster preparedness plans if/when boarding (including psychiatric boarding) reaches certain trigger levels in specified communities
- Some states (North Carolina) have worked with their medical and hospital associations to create systems capable to identifying facilities in their state with capacity to handle psychiatric patients, thus assisting EMS with appropriate transport options, with theoretically less subsequent boarding.
- States such as Texas with true delegated practice from the EMS medical director have incorporated field medical clearance with direct transport to a psychiatry facility. A sample protocol in use is included below.
- More recently, while not targeted specifically to EMS, the "Alameda Model" of emergency psychiatric assessment and treatment does include significant EMS involvement; field screening performed by EMS crews determine if a psychiatric patient is medically stable, and if so, county protocols allow for direct transport to the regional PES stand-alone EDs specific to psychiatric patients.

While several states have passed or promoted legislation around ED and hospital boarding issues, some have specifically targeted EMS usage around this issue:

- Arizona has legislation in place that allows EMS to transport to alternate facilities other than an ED (including psychiatric centers for patients with a primary mental health complaint).
- Nevada passed legislation in 2005 requiring hospitals to have patients placed in beds within 30 minutes of their arrival to an ED or facility, thus avoiding prolonged EMS personnel waits after transporting patients to a hospital facility.

Table. Sample EMS Protocol
Used with permission from UMC EMS, Dr. Gerad Troutman



Mobile Crisis Units

Most mental health emergencies occur outside the hospital and are often the result of interaction between underlying mental illness and an acute event. When feasible, it may be less disruptive and more expeditious to deal with a crisis in the home environment before it escalates further. In addition, delays in care after transport may accelerate the illness. Many communities are investing in mobile crisis units that respond to the crisis outside the hospital, in essence, bringing care to the patient rather than the patient to the care. In addition to acute response, mobile crisis units can ensure that patients discharged from the ED are linked to community services and receive follow-up care.

Mobile crisis units have proved effective. In several studies, the mobile crisis services reduced the need for psychiatric hospitalization by linking patients to outpatient services. In a 2000 study, the average cost was determined to be about $1,500 per case. For police intervention, the cost per case was over $1,900.[5]

Regional/State Health Registries

When patients present to the ED and are in need of psychiatric hospitalization, ED staff are often required to make multiple calls to regional facilities to find available beds and pursue precertification. Once an available bed is found, transportation by ambulance is then arranged. This process typically takes several hours, which can extend into days if no available inpatient space is secured. Patients in need of ongoing psychiatric care are boarded in EDs in the interim, receiving no specific treatment for their behavioral health disorder, which can worsen during this boarding period.

In an effort to reduce boarding times for psychiatric patients in the ED, a handful of states have established electronic behavioral health bed registries. This will allow ED staff to quickly locate where available behavioral health beds are located regionally, and in turn facilitate transfer to an appropriate facility. This database could also be leveraged to help psychiatric facilities "pull" patients from regional EDs into their facilities.

In order to be effective, an electronic behavioral health bed registry must fulfill the following requirements:

1. Reporting of available beds must be mandatory and not voluntary.
2. Availability in both public and private institutions must be included.
3. The database must report available beds in a "real-time" format.
4. The database must list the type of bed and patient acceptable for transfer (eg, pediatric, geriatric, detoxification) as well as treatment services available.
5. All personnel working within a health care facility that provides emergency stabilization and treatment must be able to access the database.

Emergency Department Evaluation, Treatment and Reevaluation[6]

Many psychiatric facilities are uncomfortable caring for patients with medical comorbidities. Some of the hardest patients to place in a mental health facility are those with additional medical diseases. However EDs and their providers are often equally uncomfortable caring for patients with mental health issues. In order for quality care to be provided, both groups will need education. A new coalition sponsored in part by ACEP, the Coalition on Psychiatric Emergencies (COPE), is creating educational programs for psychiatrists to include common medical issues, and for emergency physicians to include common mental health treatment. At a minimum, emergency physicians need to be able to identify the most common mental health disorders such as psychosis, depression, etc. In addition they must be very well versed in the initial treatment of agitation, which includes not only chemical sedation but the use of de-escalation techniques. (See "Behavioral Emergencies: Best Practices in Evaluation and Treatment of Agitation". *Western Journal of Emergency Medicine.* Vol XIII, No. 1, Feb 2012.

Treatment of the underlying symptoms can occur in the ED. Just as emergency diuretics or bronchodilators would not be withheld until the patient is in an inpatient bed, antipsychotics and ~~lithium~~ mood-stabilizers as appropriate can and should be initiated in the ED.

Patients should be re-evaluated prior to final disposition. With proper treatment, many patients will improve enough to be discharged.

Caring for Patients with Suicide Risk: A Consensus-based Guide for Emergency Departments was created by a consensus of providers and patients and has not been tested in a practice situation. It is not endorsed by ACEP. This guide assists ED providers with decisions about the care and discharge of patients with suicide risk with a focus on improving patient outcomes after discharge. It includes brief suicide prevention intervention, screening and decision support tools, and protocols for discharge. A "Quick Guide for Clinicians" is also provided. It is a companion resource to the full guide.

Lessons from the Alameda Model[7]

This model is based on the premise that care of mental health patients should have the same urgency and importance as medical emergencies. The acute psychiatric crisis can actually resolve over hours, rather than days. Early aggressive treatment may reduce short-term and long-term symptoms and may allow the patient to be discharged sooner.

The Alameda model uses dedicated psychiatric EDs, open 24/7, which can screen and treat all patients with acute psychiatric crises in one site. These facilities can accept ambulance and police transported patients directly, as well as transfers from regional medical EDs. Patients are assessed by the psychiatric team for their acute crisis, much like medical departments assess for the presenting complaint. Treatment is initiated early. Patients can stay onsite for up to 24 hours. Less than 30% are admitted to inpatient beds.

Alameda serves as the psychiatric emergency service for over 1.5 million people and accepts patients from 11 adult medical EDs as soon as they are medically stable. They currently see 1,500-1,800 patients per month with about 85% on involuntary detention. Despite the acuity of illness, only 0.1% of patients are placed in restraints.

The Alameda model has reduced boarding times in area EDs by 80%. Because more than 75% of patients were able to be discharged from the psychiatric ED, inpatients beds are saved and this improves access to care for others. More than 60% of patients are brought directly to the center, avoiding the medical ED. Despite the cost of running a separate 24/7 facility, the cost is still less than the cost to board a patient waiting for a bed.

Lessons from Banner Psychiatric Center Model[8]

Steps used to develop a new centralized care model to reduce boarding of mental health patients in the ED included: planning the integration of behavioral health services, improving patient flow processes and educating ED staff, standardized processes related to behavioral health care, and implementation of telepsychiatry services. A unit based on a medical model of a psychiatric emergency room:

- Behavioral health services for a period less than 24 hours
- Separate entrance, lobby with waiting room and interview rooms
- 23-hour observation area with recliners, seclusion, and restraint rooms
- Designed for staff observation of patients
- Staffed 24/7 with psychiatrists, psychiatric NPs, registered nurses, behavioral health technicians, and crisis interventionists

Program goals include: Reduce resource consumption and staffing in the acute care EDs, provide a safe secure environment, refer 70% of behavioral health inpatient admissions to outpatient treatment settings, and reduce the hold times and related expenses for behavioral health patients.

Lessons from Milwaukee Boarding Project[17]

Milwaukee developed a significant problem of boarding and police diversion despite the existence of a robust, well functioning psychiatric emergency service (PES). The PES was positioned to systematically track, analyze, and shepherd every single boarding case to a satisfactory outcome. As a result, the PES was able to identify the gaps in the Milwaukee mental health system and to galvanize the establishment of a task force of community partners in emergency medicine and mental health. This task force then worked to close identified gaps, and circulate and monitor a single line graph of boarding statistics that served as a metric of the task force's success or failure. Ultimately, the boarding and diversion crisis was resolved.

In an excellent review, Alakeson et al[10] identify factors that lead to boarding. The identified factors all pertain to one of three phases of ED care: referral, internal operation, and disposition:

- Unavailability of dual diagnosis medical-psychiatric beds
- Underinsurance
- Underutilization of private psychiatric beds for voluntary and *selected* involuntary patients
- Lack of community-based crisis beds
- Inadequate housing
- Inadequate intermediate-care and outpatient resources
- Inadequate or absent continuity throughout the various levels of care
- Missed opportunities for ED-based treatment and release
- Lack of training in clinical risk assessment and management and overly conservative risk intolerance
- Slowness in adopting best practices in the management of agitation, along with ED-based iatrogenic escalation.[11] Both make transfers appear less appealing to potential receiving facilities.
- Failure to realize that for psychiatric patients, the way they are treated, from the moment they arrive in the ED, is the beginning of treatment. Concomitantly, there is a failure to start the best possible approximation of inpatient treatment the moment a patient enters a boarding scenario.
- Deployment of inexperienced and insufficiently trained mental health staff, eg, bachelor's degreed staff.
- Lack of involvement of emergency-trained psychiatrists and psychologists in all aspects of crisis work, including mobile teams
- Inadequate emergency psychiatry philosophy (eg, one not focused on the goal of "turning an acute patient into an outpatient")[12]
- Insufficient police training in mental health
- Crudely written and/or interpreted mental health law, influenced more by rhetoric and politics than science, permitting both over-commitment of minor cases and under-commitment of the most serious cases
- Lack of cooperation between the private, public, academic, and veteran's affairs mental health sectors
- Under-recognition of treatment-resistant, medication-resistant, severe mental illness[13]
- Un-marshaled political and community will

The experience of emergency psychiatry consultants indicates that the relative proportion of each of these factors is community-specific. One must resist the temptation of simplistic answers and study the characteristics of one's own population.

Poorly managed mental illness, especially on a massive scale, tends to make everyone who is exposed to it more emotional and less rational. Onlookers are inclined to engage in scapegoating, in which various groups and

institutions are targeted: EDs, psychiatrists, police, private hospitals, public health policy makers. In fact, there is more than enough responsibility to go around, and there is room for improvement with each of the causative factors of boarding identified above. The human tendency is to grasp at simplistic solutions and revert to rhetoric and politics in the face of complicated clinical reality. With this in mind, one part of the solution to boarding in every city should be the creation of a problem case study group, to develop comprehensive individualized care plans for the highest ED utilizers and solutions to community-wide healthcare caps.

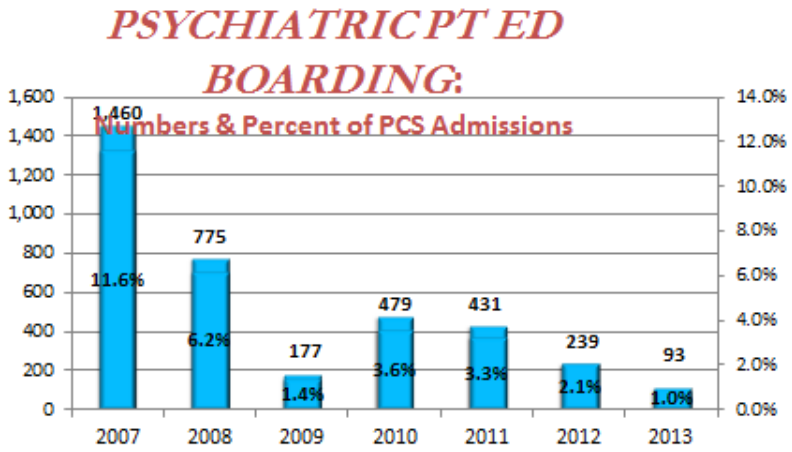
In cities large enough to support it, the creation of a PES with a very intensive brief treatment capacity (24-72 hours), (also encompassed in New York's Comprehensive Psychiatric Emergency Program model), is often the best first step.[8,14,15] However, when the greater mental health system's problems are pervasive enough, even a PES can become overrun, as Milwaukee's was in 2007,[16] forcing it to go on police diversion 21 times, though this is what finally triggered the formation of a serious anti-boarding action plan.

The greatest need is for leadership. Emergency practitioners and psychiatrists, who are a combination of caregiver, scientist, researcher, educator and administrator, are in one of the best positions, by virtue of influence and credibility, to take a constructive role in addressing boarding of psychiatric patients in the ED. Medical directors, managers and administrators will want to work both internally and externally, first looking at ways to improve their own department's care and throughput, then at ways to foster collaboration and creative problem-solving among the various stakeholders and partners.

The boarding crisis is one of those things that can galvanize health care reform. Recent experience suggests it is best approached in a way that is systematic and case-based. Note the experiments in Milwaukee[17] and San Antonio.[18]

There is also a need for the renewal of leadership. As the Milwaukee graph illustrates, the crisis of boarding can be solved but can also recur as old causative factors grow back or new ones appear. During the years of shrinking boarding numbers, the number of county inpatient beds actually declined. However, the recurrence of boarding in 2010-11 reflects how ED boarding is a problem that must be solved and re-solved.

Table 2. Milwaukee project[17]



Enloe, California, (ref: 19)

Hospital administration at Enloe Medical Center in California worked with leadership in the ED there and determined that the backup of mental health patients was impacting other patients in the ED. The medical center does not have a locked inpatient mental health unit, and thus some patients had to be transferred to a separate facility. Patients were seen and evaluated by the psychiatric staff at Enloe and then a bed requested at a separate facility. Since beds are often scarce, patients waited for several days for transfer.

They were able to reduce boarding through several initiatives. First was direct communication between the psychiatrist and the emergency physician. Though the issue and solution were driven by concerns for quality care, an analysis showed a significant financial loss from admitted patients occupying examination rooms. The administration chose to devote an unoccupied inpatient unit space as a holding area for mental health boarding patients. Nursing care is provided by trained psychiatric nurses. The result is better care for patients of all types, as well as increased revenue, which more than offsets the cost.

State-specific Standards - A number of states provide standards on emergency mental health services.

Maine
Adult Mental Health System Standards The State standards for crisis services are provided including crisis assessments, crisis stabilization units, and psychiatric consultation.

Mississippi
Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Services Providers.
This document provides an overview of the Mississippi state emergency/crisis response services, intensive crisis intervention for children and youth, crisis stabilizations services and units, and environment and safety for crisis stabilization units.

New York
The New York State Office of Mental Health provides Patient Safety Standards, Materials and Systems Guidelines for the selection of materials, fixtures and hardware for inpatient psychiatric units with the goal of reducing risk of harm to individuals. This resource could be used to evaluate physical plant risk assessment.

Comprehensive Psychiatric Emergency Programs. 2012 report. Provides information on the use of extended observation beds, hospital-based crisis intervention services and crisis outreach services in the State of New York.

Texas
Extended Observation Unit Standards. Texas Department of State Health
This document addresses the standards for extended psychiatric observation units in the state of Texas including: the availability of services (24/7), the physical plant requirements, staffing including physicians, screening, physical and psychiatric assessment, treatment, and continuation of care.

Tennessee
Crisis services: effectiveness, cost-effectiveness, and funding strategies. SAMHSA 2014. Provides a recent review of mental health services and funding by state.
Example of Tennessee's Case Management System for mental health.

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Additional Resources

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