The Impact of Boarding Psychiatric Patients on the Emergency Department: Scope, Impact and Proposed Solutions
An Information Paper

The boarding of patients with psychiatric and behavioral health complaints in the emergency department (ED) is a tremendous problem with many serious ramifications. This article delineates the scope of the problem; its impact on patients, emergency physicians and emergency department staff; strategies for mitigation; and proposed solutions.

It is traditional to begin articles like this one with a case vignette. We will not do that here. Case vignettes are helpful in providing clinical details that provide a framework for the subsequent discussion. No vignette, however, can adequately convey the factors that matter for our discussion here. Rather, we ask you to recall and empathize with the last patient with psychiatric or behavioral health complaints that you saw boarding in the ED. Imagine being depressed and suicidal and asked to lie in a stretcher in the middle of a busy ED, perhaps surrounded by drunk and psychotic patients who also need to be under clinical and security observation. Imagine being in this situation for days, with no sunlight, no exercise, no good sleep, no hot food and no one to begin to help pull you out of the deep despair that brought you to the hospital. Or, imagine being psychotic, already destabilized and disorganized in your relationship to the world, and made to stay in the further destabilizing, chaotic environment of the ED, again, with no sleep or sunlight, and receiving only medication that is primarily intended to keep you from acting out rather than being tailored to help control your symptoms.

Objective Measures

The scope of the problem

A meaningful understanding of the problem of boarders with psychiatric complaints must start with an appreciation of its scope. Clearly delineating this is somewhat complicated because there is no established definition of a patient who is boarding in the ED.[1,2] As a general statement, we can say a patient is boarding if that patient's ED evaluation is complete and the decision has been made to either hospitalize or transfer the patient, yet the patient remains in the ED, whether because of staffing issues, bed availability, specialized needs of the patient, or other factors.[1]

Impressionistically, emergency physicians well appreciate the problem and its worsening nature. A 2016 ACEP survey of ED physicians showed that more than half of physicians felt that the mental health system in their respective communities worsened over the last year. Nearly half reported that patients with psychiatric and behavioral health complaints boarded in their ED on a daily basis more often than previously.[3] Additionally, in the Department of Health and Human Services survey of hospitals in 2008, the majority indicated that the boarding of psychiatric patients is a problem in their hospital.[4]

We can, however, be more precise. Patients presenting to the ED with psychiatric complaints are more than twice as likely to be admitted than those with medical conditions.[5] Furthermore, data from 2008 (the most recent available) shows that the overall rate of boarding of patients in US EDs was 11 percent, while for patients with psychiatric complaints this rate was almost double, 21.5 percent.[2] Not only do patients requiring psychiatric admission board in the ED more frequently, they remain in the ED for

longer periods of time. One study, for example, showed that the average boarding time for admitted patients was three times higher for patients awaiting a psychiatric bed than for other patients.[6]

Many trends in ED usage and mental health resource availability have contributed to this problem. From 2006 to 2014, overall utilization of the ED increased 14.8 percent. Over this same time frame, ED encounters related to mental health or substance abuse increased by 44.1 percent, with the rate of admission for these patients increasing by 31.8 percent.[7] ED visits for suicidal ideation and intentional self-inflicted injury increased by 414.6 percent.[7] In the face of this rapid growth, in many areas, there has been a contraction of resources available to care for patients with psychiatric and behavioral health complaints who present to the ED. From 1970 to 2014, the total number of inpatient psychiatric beds in the US decreased by 63.9 percent,[8] 35 percent between 1998 and 2013,[9] and 13 percent between 2010 and 2016.[10] Furthermore, 23 percent of ED directors note that they have no community psychiatric resources available and less than a third reported pediatric psychiatric service availability.[11]

Patient Characteristics

While the above data describe the problem in general, there is also much information about which patients with psychiatric and behavioral health complaints are at particular risk for boarding in the ED. Both age greater than 45[12] and being a pediatric patient with a decompensated psychiatric problem have been shown to be risk factors for prolonged ED length of stay.[3, 12,13] Within the pediatric population independent risk factors include suicidal ideation, a diagnosis of autism, developmental delay, medical illness requiring close monitoring, and presenting on nights, weekends, or during months without school vacations.[14] Further characteristics that have been shown to predispose a patient to a prolonged ED length of stay include elevated blood alcohol[13,15,16] or positive urine drug screen;[16] a history of drug or alcohol abuse;[12,15] the use of restraints[13,17,18] or direct observation in the ED;[17,18] administration of haloperidol or lorazepam in the ED;[13] a diagnosis of cognitive disorder or dementia;[17] a diagnosis of personality disorder,[17] schizophrenia or other psychotic disorder;[12,13] male gender;[13] homelessness;[4,17,18] and insurance status.[4,12,15,17-19] (Some studies have found race to be a factor,[12,13] but others have found no correlation.[15,17]) Patients with government insurance are at increased risk. Patients with Medicaid (along with those who were uninsured) are twice as likely to remain in the ED for longer than 24 hours.[19] Patients with government-sponsored insurance are more than twice as likely than patients with private or self-pay insurance status to return to the ED for psychiatric emergencies.[18]

Several systems-related factors also increase the risk that a patient with psychiatric or behavioral health needs will remain in the ED for a prolonged time. These include ED overcapacity at any time in the day of presentation,[13] at least three other patients with psychiatric and behavioral health complaints present at the time of patient arrival,[13] patient arrival in the evening or overnight[4,13] or at any time on the weekend,[4,13,19] and requiring transfer to another facility[4,13,17,19] or admission as an inpatient.[17,19]

Practical Ramifications

ED boarding of patients with psychiatric complaints can have a marked negative impact on patients, on providers, and on the broader hospital and healthcare system. These practical and ethical problems occur in both concrete and less tangible ways. We will first discuss the practical impacts and then consider the ethical dimension.

Impact on patients

Patients who are awaiting inpatient psychiatric care are unlikely to be receiving optimal treatment for their mental health conditions while in the ED.[20] An Emergency Nurses Association report noted that ED caregivers often do not feel comfortable caring for patients with psychiatric illnesses; they often feel

that they are not equipped to care for these patients due to societal, institutional, and educational issues.[21] 62 percent of ED directors indicate that there are no psychiatric services for boarded ED patients with psychiatric disease,[11] which surely amounts to suboptimal care. Patients themselves are aware of this lack of resources and provider comfort. Patients report that they often felt as if they weren't taken seriously and that their treatment in the ED was not a priority.[21] These findings may be related to ED volume, ED staffing, ED acuity, physical resources, or availability of consultants. In general, EDs do not have the physical and staffing resources and specialty expertise to provide definitive psychiatric care.

Even if they receive some psychiatric care, patients with psychiatric and behavioral health complaints who require boarding in the ED frequently decompensate as the often loud and hectic environment of the ED worsens their underlying disease process.[1] Patients with psychiatric and behavioral health complaints who spend prolonged time in the ED are at greater risk for requiring chemical and physical restraints, with the risk increasing proportional to the length of stay in the ED.[22]

These problems lead to measurable negative outcomes for psychiatric patients. One study showed that 65 percent of patients with psychiatric and behavioral health complaints boarded in the ED had a medication error requiring an intervention on their chart. 89 percent of these errors were errors of omission when home medications were not restarted during the time spent boarding in the ED.[23]

Impact on providers

Physicians and other ED staff can face multiple challenges when caring for patients with psychiatric complaints boarded in the ED. This is particularly relevant within the context of increasing violence against emergency department staff. Overall, healthcare providers are at a higher risk for workplace violence—including both physical and verbal attacks—than in private industry.[24] 80 percent of these attacks come from patients.[25] Though no specific diagnosis can accurately predict future violent behavior, some of the highest risk environments for workplace violence are inpatient and acute psychiatric facilities and EDs.[26] Long wait times and crowding have been identified as risk factors predisposing to workplace violence in the ED.[24,26,27] In an ACEP poll, 47 percent of EPs report being assaulted, 71 percent report witnessing an assault, 27 percent report being injured as a result of the assault, and 77 percent report that ED violence has harmed patient care.[28] Violent behavior among patients being evaluated during an involuntary hold for psychiatric reasons is common.[29,30] As ED visits for mental health continue to increase, the risk of violence is also likely to grow.[28]

The stresses created by psychiatric patient boarding can lead to longer-term problems for physicians, including increasing levels of frustration and burnout. Physician burnout is a growing concern, even being referred to as a public health crisis.[31] Patients who must stay in the ED for boarding increase the stress levels of physicians,[32] and, as described above, provide a less safe environment for physicians to work in. These things in concert only serve to worsen the problem of burnout. Mental health workers in general have been shown to have increased levels of compassion fatigue and burnout.[33,34] The boarding of patients with psychiatric and behavioral health complaints in the ED, for all of the reasons previously elucidated, add stress to the already stressful job of caring for these patients. Physicians and other staff are aware of the needs of these patients, but unable to adequately provide for those needs with available resources. This moral distress can lead to a multitude of adverse outcomes for physicians and staff, including burnout.[35]

Impact on systems of care

The considerable burden of boarding of patients with psychiatric complaints in the ED can also adversely impact ED functioning, both on the level of the individual patient and the overall department level. Agitated patients with psychiatric and behavioral health complaints boarded near other ED patients can

cause concern among other patients and their family members, making everyone in the ED uncomfortable.[4]

At the department-wide level, a study at a tertiary referral center in 2007 found that patients with psychiatric and behavioral health complaints awaiting inpatient placement remained in the ED 3.2 times longer than non-psychiatric patients, preventing 2.2 bed turnovers for an estimated cost of approximately $2,250 per patient bed.[6] Given the rates of psychiatric boarding reported in national surveys, the financial impact of this problem is massive with individual hospital systems and government payers bearing the brunt of the financial burden.[4]

Increased boarding of all patients also contributes to patients leaving the ED without treatment or against medical advice.[1] Boarding of patients in the ED uses a considerable amount of ED space and staff time and resources.[4] 85 percent of ED directors believe that if better inpatient psychiatric services were available, ED wait times would be lower.[11] Increased boarding of patients with psychiatric complaints has also been linked to increased staff turnover.[4]

Boarded patients with psychiatric and behavioral health complaints not only receive suboptimal care themselves, but also prevent other patients, both those already under care and not those yet being treated, from accessing the limited resources of the ED.

Ethical Considerations

The situation described above is profoundly ethically troubling. Perhaps the most basic obligation this situation interferes with is that of providing appropriate care to our patients. The first principle in the AMA Principles of Medical Ethics begins: "A physician shall be dedicated to providing competent medical care."[36] We have pointed out many ways in which patients with psychiatric complaints received substandard care, perhaps most particularly by not receiving the specialty care they need, and instead being treated by providers who are uncomfortable taking care of them.

A related matter is the rate of medication errors. This would certainly qualify as suboptimal care, and even more directly, it violates the principle of non-maleficence. Non-maleficence requires that we not harm our patients, and medication errors have the potential to greatly harm our patients. Unlike the harm of being cared for by uncomfortable providers or in a problematic environment, where the harm is often a matter of omission, medication errors involve providers engaging in direct, active harm to patients.

Boarding of psychiatric patients also compromises respect for patient autonomy. As noted above, there is increased use of chemical and physical restraints with prolonged boarding. Any treatment delivered involuntarily to patients is a prima facie violation of their autonomy. Of course, the restraint may have been necessary, precisely because the patient does not have the capacity to control their behavior and participate in medical decision-making, and thus is not itself a violation of their autonomy, since they have already lost it. However, when we ourselves are in part responsible for the patient's arriving at a state that requires such involuntary treatment, by exposing them to prolonged boarding, we are also in part responsible for the patient's loss of autonomy. Taking away a patient's autonomy is as bad as violating it. We are furthermore responsible for their ongoing loss of autonomy, since sedated patients cannot participate in any decisions about their care, even those they would have had the capacity to make, were they not sedated.

There are also ethical harms at a more systemic level, removed from the direct actions of the treating providers. First, the ED resources being absorbed by the boarding patients are unavailable to other ED patients who have need for them. Devoting excess resources to one group of patients over another, equally deserving group violates the principle of justice. Finally, it is unethical to place anyone in

unnecessary physical danger, and, as noted above, increased boarding of patients is associated with increased risk of ED violence. Even simply having an environment that excessively predisposes providers to burnout may be considered a breach of a hospital's moral duty to its employees. (We must, of course, acknowledge here that many of these problems are beyond an individual hospital's control, but this does not mitigate their responsibility to do all they can to reduce the problems.)

Although we have here been describing the boarding crisis as ethically problematic, this is not quite accurate. Situations, that is, facts, cannot be ethical or unethical. Only human choices and actions can be. What we are really saying is that the human decisions that led to this point, and the decisions that led to perpetuating and worsening the situation, are ethically problematic, at least potentially. Potentially, because the true ethics of the situation depend on the details. When someone discriminates against a patient simply because he or she is suffering from a psychiatric ailment, that is unethical. But when the administrators and politicians who are responsible for the systems issues that are at the bottom of this crisis make a decision to direct resources not to fixing this problem but to some other priority, that decision may very well be ethical. It depends on their motivations and calculations. Thus, it is difficult to identify unethical actions here without knowing the available resources and alternatives, as well as the motivations of the decision makers. But we can certainly identify the deleterious ethical consequences of the decisions they make, which they are responsible for weighing in their deliberations.

This distinction between facts and decisions also means that it is not ethically problematic to treat patients within this troubling situation. At a given moment, a provider can only be judged on the decisions made under the prevailing circumstances. Providing the best care possible to our patients in whatever circumstances we find ourselves is not only not morally problematic, it is our moral duty, as is advocating and working for improvement whenever possible.

Solutions

There have been several proposed solutions to this mental health crisis that address all of the issues that the boarding or care of this patient population in the ED raises.[37] Steps should be taken at every level to move toward a resolution of the problem. Individual EPs and EDs should be focused on improving treatment of patients in this situation, hospitals should focus on increasing the response to admission needs as well as devoting resources to the ED to care for these patients, and healthcare systems along with government should work to improve both ambulatory and inpatient options to care for this under-resourced population.[38]

Individual

On the individual physician level, attention to more than the emergent medical and mental health stabilization can mitigate many of the stressors on patients being held in the ED. For example, providing nicotine supplementation, maintenance medications and regular meals would foster a more supportive patient experience. Providers should endeavor to treat these patients with the same respect they afford all other people with whom they interact. Physical restraints, when used, should be discontinued as rapidly as possible.[1]

Department

Management of the ED struggling with mental health boarding should include facilitating the resources necessary to achieve ethical care to patients being held. This may include additional nursing or ancillary staff to enable mental health patients to enjoy some simple activities of daily living (e.g. bathing, walking outside the room). Additionally, ED leaders should advocate for appropriate care for these patients which could include a push for dedicated space with an appropriate environment for cohorting these patients.[37]

Hospital

At the hospital level, resources should be allocated to enable the ED to offer more meaningful care to boarding patients. This should include additional ED staff as well as psychiatric consultants, counselors, therapists, and social workers.[1] Telepsychiatry is another way to provide psychiatric care which can reduce the time patients spend awaiting evaluation and treatment.[37]

Having these resources available can allow for treatment of patients in the ED and possibly prevent admission altogether or at least decrease the duration of inpatient care needed which would open up the scarce resource of inpatient psychiatric beds. Further, these types of resources could increase the opportunity to convert inpatient psychiatric or substance use disorder admissions to outpatient care. For example, social workers in the ED can create outpatient linkage to care for patients who otherwise would need inpatient care. They can also help those who need medication assisted therapy for opioid use disorder, thus mitigating return visits for intoxication or overdose.

Health Care Systems/Government

Increasing community mental health services, especially urgent care/walk-in services could avert the need for admission in patients with severe mental health concerns. Additionally, developing crisis response, stabilization, and observation services for patients with severe mental health complaints could be a satisfactory alternative to inpatient hospitalization and prolonged ED boarding. Including training and resources for adjunct professionals who encounter mental health complaints regularly such as law enforcement, school workers, and group home staff could also mitigate escalation of mental health problems.[1,37] Another recommendation to help drive bed availability for these patients is to increase payment for admitted behavioral health patients and even to create higher acuity inpatient psychiatric reimbursement codes for patients with worse problems, similar to medical ICU codes. Some states are considering creating an online psychiatric inpatient bed registry to make bed availability more transparent.[39]

Washington State

Before leaving this section, we should briefly discuss one state's apparent solution to the problem of psychiatric boarding. In 2014, the Washington State Supreme Court ruled that the boarding of psychiatric patients was illegal.[40] This decision was widely hailed as a strong rebuke of the practice of psychiatric boarding, as well as an end to the practice in Washington.[41]

While this court decision was certainly significant and did result in an immediate change in the psychiatric boarding situation in Washington State, there are several reasons to be cautious about drawing substantial lessons from this case for other states. First, the court did not rule that boarding as such was illegal. Rather, they ruled on the particular way hospitals in Washington administered their boarding. In particular, to comply with the state's civil commitment statutes, hospitals had to have the nonpsychiatric beds their boarding patients were occupying temporarily certified as mental health beds. It was this temporary certification that the court ruled was illegal.[41] This circumstance is not widely applicable. Second, even in Washington, the above circumstances only applied to involuntary patients. The situation for voluntary, but still ill, patients was unchanged.[41]

Third, although the Washington State legislature indeed responded to the court decision by creating more mental health beds, it is not entirely clear where the resources came from. That is, it is not clear what other priorities were downgraded to provide these funds and beds. While a state can certainly be ordered to carry out a certain policy, the value of this path requires assessing not just the benefits, but also the cost. In this regard, a political solution, such as occurred in New Hampshire, where the legislature

autonomously decided to designate funds to alleviate the ED psychiatry boarding crisis,[42] is preferable. This allows the allocation to balance against other competing priorities, rather than being forced by a body (the court) that is considering the problem in isolation.

Finally, while the increased number of beds resolved the impasse at the time, the number of beds is not infinitely expandable. There could, and may well, come a time when the number of patients needing beds again outstrips the number of beds available. At that point, no court ruling will create beds immediately, and providers will be caught between their legal and ethical obligation to care for these patients and the court decision that their only means for doing so is illegal. This bind does nothing for the patients while increasing the legal and emotional burdens on providers. There does not seem to be any data or reports of the long-term impact of the court's decision.

Conclusion

The frequent ED boarding of patients with psychiatric and behavioral health complaints is troubling. Without concerted effort, these patients are likely to have prolonged stays that are inefficient at best and harmful at worst. Yet, there are ways we can work to alleviate these problems, both as individual practitioners and as members of organizations and institutions. With concerted effort, we can help these patients, and all of our patients, have better ED experiences and overall outcomes.

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References

1. Bender D, Pande N, Ludwig M. *A literature review: psychiatric boarding*. Washington, DC: United States Department of Health and Human Services; 2008. Available at: https://aspe.hhs.gov/system/files/pdf/75751/PsyBdLR.pdf (Accessed September 9, 2019)
2. Nolan JM, Fee C, Cooper BA, et al. Psychiatric boarding incidence, duration, and associated factors in united states emergency departments. *J Emerg Nurs*. 2015;41:57-64.
3. ACEP. American College of Emergency Physicians Physician Poll on Psychiatric Emergencies October, 2016. 2016. Available at: http://newsroom.acep.org/download/psychemergencypolloct2016.pdf (Accessed September 9, 2019)
4. Bender D, Pande N, Ludwig M. *Pyschiatric Boarding Interview Summary*. Washington, DC: United States Department of Health and Human Services; 2009. Available at:https://aspe.hhs.gov/system/files/pdf/75756/PsyBdInt.pdf (Accessed September 11, 2019)
5. Owens PL, Mutter R, Stocks C. *Mental health and substance abuse-related emergency department visits among adults, 2007: statistical brief #92*. Rockville, MD: Agency for Healthcare Research and Quality; 2010. Available at: https://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf (Accessed September 9, 2019)
6. Nicks BA, Manthey DM. The impact of psychiatric patient boarding in emergency departments. *Emerg Med Int*. 2012; 2012: Article ID 360308, 5 pages.
7. Moore BJ, Stocks C, Owens PL. *Trends in emergency department visits, 2006-2014: statistical brief #227*. Rockville, MD: Agency for Healthcare Research and Quality; 2017. Available at: https://www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf. (Accessed September 9, 2019)

8. Lutterman T, Shaw R, Fisher W, Mandersheid R. *Trend in psychiatric inpatient capacity, United States and Each State, 1970 to 2014*. Alexandria, VA: Association of State Mental Health Program Directors; 2017. Available at: https://www.nasmhpd.org/sites/default/files/TACPaper.2.Psychiatric-Inpatient-Capacity_508C.pdf (Accessed September 9, 2019)

9. Bastiampillai T, Sharfstein SS, Allison S. Increase in US suicide rates and the critical decline in psychiatric beds. JAMA. 2016;316:2591–2592.

10. Fuller DA, Sinclair E, Geller J, et al. *Going, going, gone: trends and consequences of eliminating state psychiatric beds, 2016*. Arlington, VA: Treatment Advocacy Center, 2016.

11. American College of Emergency Physicians. Psychiatric and Substance Abuse Survey, 2008. Available at: http://www.acep.org/uploadedFiles/ACEP/Advocacy/federal_issues/PsychiatricBoardingSummary.pdf. (Accessed September 9, 2019)

12. Smith JL, DeNadai AS, Storch EA, et al. Correlates of length of stay and boarding in florida emergency departments for patients with psychiatric diagnoses. *Psychiatr Serv*. 2016;67:1169-1174.

13. Warren MB, Campbell RL, Nestler DM, et al. Prolonged length of stay in ED psychiatric patients: a multivariable predictive model. *Am J Emerg Med*. 2016;34:133-139.

14. Wharff EA, Ginnis KB, Ross AM, Blood EA. Predictors of psychiatric boarding in the pediatric emergency department. *Pediatr Emerg Care*. 2011;27:483-489.

15. Pearlmutter MD, Dwyer KH, Burke LG, et al. Analysis of emergency department length of stay for mental health patients at ten Massachusetts emergency departments. *Ann Emerg Med*. 2017;70:193-202.e16.

16. Maniaci MJ, Lachner C, Vadeboncoeur TF, et al. Involuntary patient length-of-stay at a suburban emergency department. *Am J Emerg Med*. 2019 May 24 (epub ahead of print)

17. Chang G, Orav EJ, Smallwood JA, et al. Characteristics of adult psychiatric patients with stays of 24 hours or more in the emergency department. *Psychiatr Serv*. 2012;63:283-286.

18. Misek RK, DeBarba AE, Brill A. Predictors of psychiatric boarding in the emergency department. *West J Emerg Med*. 2015;16:71-75.

19. Stephens RJ, White SE, Cudnik M, Patterson ES. Factors associated with longer length of stay for mental health emergency department patients. *J Emerg Med*. 2014;47:412-419.

20. Alakeson V, Pande N, Ludwig M. A plan to reduce emergency room 'boarding' of psychiatric patients. Health Aff (Millwood). 2010;29:1637-42.

21. Manton A. *Care of the psychiatric patient in the emergency department*. Des Plains, IL; Emergency Nurses' Association; 2013. Available at: https://www.ena.org/docs/default-source/resource-library/practice-resources/white-papers/care-of-psychiatric-patient-in-the-ed.pdf?sfvrsn=3fc76cda_4 (Accessed September 9, 2019)

22. Hsu CC, Chan HY. Factors associated with prolonged length of stay in the psychiatric emergency service. *PLOS ONE*. 2018;13:e0202569.

23. Bakhsh HT, Perona SJ, Shields WA, et al. Medication errors in psychiatric patients boarded in the emergency department. *Int J Risk Saf Med*. 2014;26:191-198.

24. Phillips JP. Workplace violence against health care workers in the United States. *N Engl J Med*. 2016;374:1661-1669.

25. Occupational Safety and Health Administration. Workplace Violence in Healthcare: Understanding the Challenge. 2015. Available at: https://www.osha.gov/Publications/OSHA3826.pdf. (Last accessed September 9, 2019).

26. Occupational Safety and Health Administration. Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. https://www.osha.gov/Publications/osha3148.pdf (Accessed September 9, 2019).

27. Gacki-Smith J. Violence against nurses working in US emergency departments. *J Nurs Adm*. 2009;39:340-349.

28. American College of Emergency Physicians. Violence in emergency departments is increasing, harming patients, new research finds. Available at: http://newsroom.acep.org/2018-10-02-Violence-

in-Emergency-Departments-Is-Increasing-Harming-Patients-New-Research-Finds (Accessed September 9, 2019).

29. Dawson NL, Lachner C, Vadeboncoeur TF, et al. Violent behavior by emergency department patients with an involuntary hold status. *Am J Emerg Med*. 2018;36:392-95.

30. Roy A, Lachner C, Dumitrascu A, et al. Patients on involuntary hold status in the emergency department. *South Med J*. 2019;112:265-70.

31. Jha A, Illif A, Chaoui A, et al. *A crisis in health care: a call to action on physician burnout*. Waltham, MA: Massachusetts Medical Society. No date. Available at: https://cdn1.sph.harvard.edu/wp-content/uploads/sites/21/2019/01/PhysicianBurnoutReport2018FINAL.pdf (Accessed Sept. 9, 2019).

32. Morley C, Unwin M, Peterson GM, et al. Emergency department crowding: A systematic review of causes, consequences and solutions. *PLOS ONE* 13: e0203316.

33. Franza F, Del Buono G, Pellegrino F. Psychiatric caregiver stress: clinical implications of compassion fatigue. *Psychiatr Danub*. 2015;27:S321-S327.

34. Mangoulia P, Koukia E, Alevizopoulos G, et al. Prevalence of secondary traumatic stress among psychiatric nurses in Greece. *Arch Psychiatr Nurs*. 2015;29(5):333-338.

35. Fernandez-Parsons R, Rodriguez L, Goyal D. Moral distress in emergency nurses. *J Emerg Nurs*. 2013;29:547-52.

36. AMA principles of medical ethics. Available at: https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics (Accessed 09/11/2019).

37. ACEP Emergency Medicine Practice Committee. Care of the psychiatric patient in the emergency department—a review of the literature. (2014). Available at:https://www.acep.org/globalassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/mental-health-and-substance-abuse/psychiatric-patient-care-in-the-ed-2014.pdf (Accessed September 23, 2019).

38. Abid Z, Meltzer AC, Lazar D, Pines JM. Psychiatric boarding in U.S. EDs: a multifactorial problem that requires multidisciplinary solutions. (2014*). Center for Health Care Quality*. Paper 1. https://hsrc.himmelfarb.gwu.edu/sphhs_policy_chcq/1 (Accessed September 9, 2019).

39. Green J. Emergency rooms fill up with psych patients - and then they wait. *Crain's Detroit Business*. Jan 28, 2019. p. 11.

40. Detention of D.W. v. Department of Social and Health Services, 332 P.3d 423 (Wash. 2014).

41. Bloom JD. Psychiatric boarding in Washington State and the inadequacy of mental health resources. *J Am Acad Psychiatry Law*. 2015;43:218-222.

42. DeWitt, E. Sununu signs ER boarding crisis bill. *Concord Monitor*. May 22, 2019, p. A1.