



# DELAYED AND DETERIORATING: Serious Mental Illness and Psychiatric Boarding in Emergency Departments

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## INTRODUCTION

The number and proportion of mental health crisis emergency department visits have been steadily increasing in the United States in recent years. In 2014, there were more than 2.2 million emergency department visits by patients whose primary diagnosis was serious mental illness.<sup>1</sup> And as a result of a multitude of factors and failures in our mental health care system, instead of receiving timely and effective treatment, individuals are boarded in the emergency department, waiting for days or sometimes weeks, with nowhere to go and sometimes no treatment.

Psychiatric boarding occurs when individuals in need of psychiatric treatment present to emergency departments and are forced to wait for extended periods of time until meaningful care is received. The problem is widespread across the United States, with emergency departments commonly referred to as a “safety net”<sup>2</sup> or even a “dumping ground”<sup>3</sup> for people with mental illness seeking care. According to a 2016 survey by the American College of Emergency Physicians, over 90% of emergency physicians say psychiatric patients board in their emergency



departments.<sup>4</sup> And more than 21% of these physicians reported waits of two to five days for an inpatient bed.<sup>5</sup>

Boarding in emergency departments is not unique to individuals with mental illness—anyone can face long wait times that have detrimental effects on the person’s health. However, psychiatric patients are disproportionately affected by boarding.<sup>6</sup> Their waits are also longer, and the effects can be more serious. And for people with the most severe mental illnesses, delays in care simply because treatment is unavailable or inefficient may result in such deterioration in their condition that recovery is less achievable.

## HIGHLIGHTS

- Emergency department visits for people in psychiatric crisis have been steadily increasing in the United States.
- Lack of affordable, comprehensive psychiatric treatment services is largely to blame for psychiatric boarding in emergency departments.
- Individuals with serious mental illness are disproportionately affected by psychiatric boarding.
- Boarding of patients with serious mental illness has significant negative impacts on long-term health outcomes.

## EVIDENCE OF PSYCHIATRIC BOARDING

Although there are a number of external circumstances and patient characteristics that contribute to psychiatric boarding, research suggests that a lack of affordable, comprehensive psychiatric treatment services is largely to blame.<sup>7</sup> An unfulfilled transition from state psychiatric facilities and inpatient beds to community-based treatment beginning in the 1950s, combined with inadequate funding for mental health services generally,<sup>8</sup> has led to an influx of psychiatric patients seeking care in emergency departments.<sup>9</sup> Tellingly, the number of emergency department visits related to mental health or substance use has consistently grown over time, increasing by 41%—from 7.1 million to 10 million—in just six years between 2009 and 2015.<sup>10</sup> And with more and more individuals with mental illness searching for care in places unable to provide it, psychiatric boarding in emergency departments has become commonplace.

There is no agreed-upon definition of how long is “too long” for an emergency department wait or at what point boarding begins.<sup>11</sup> However, a number of studies illustrate the magnitude of the problem by comparing the wait times of psychiatric and nonpsychiatric patients in emergency departments across the country:

- A retrospective analysis of national emergency department data from 2001–2011, using the National Hospital Ambulatory Medical Care Survey (NHAMCS),<sup>12</sup> found that psychiatric patients were more than twice as likely to experience emergency department stays\* longer than six, 12 or 24 hours, compared to patients without primary substance use disorders or mental health concerns.<sup>13</sup>
- Another analysis of NHAMCS data from 2002–2011 also suggests evidence of psychiatric boarding. Psychiatric patients experienced longer lengths of stay\* compared to nonpsychiatric patients, regardless of whether they were admitted for observation, transferred to an inpatient facility or discharged.<sup>14</sup> Psychiatric patients admitted for

observation had a median length of stay of 5.9 hours, while nonpsychiatric patients waited more than an hour less, at 4.7 hours. The difference was starker for patients requiring transfer, with psychiatric patients waiting 5.2 hours after the decision to transfer was made, compared to nonpsychiatric patients, who waited just 3.3 hours. Even when comparing patients who were discharged, people with mental illness faced wait times nearly an hour longer than those of nonpsychiatric patients.

- Earlier research analyzing NHAMCS survey data from 2002–2008<sup>15</sup> and 2001–2006<sup>16</sup> found that mental health–related emergency department visits resulted in an additional 1.20 and 1.25 hours per visit,<sup>†</sup> respectively, compared to non–mental health visits.

### The definition of psychiatric boarding

In the most common definition of the term, psychiatric boarding can be characterized as the period of time a psychiatric patient waits in an emergency department following a disposition decision after evaluation by a clinician (i.e., admission, transfer or discharge). For these patients, clinicians have already determined the next steps in their care, but various barriers—including bed availability, insurance constraints or administrative hurdles—prevent immediate access to treatment or discharge.

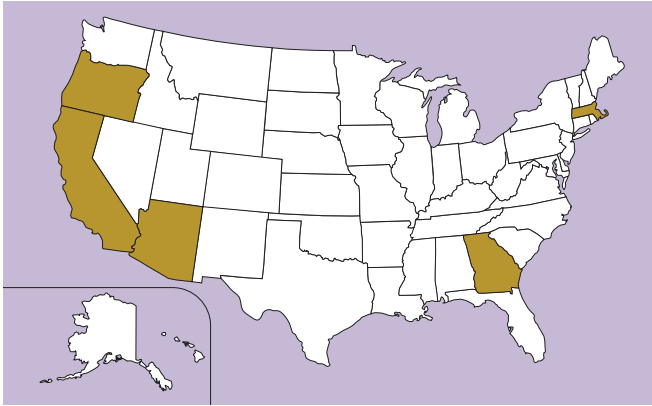
Entire length of stay, which begins as soon as a patient walks through the door of an emergency department and ends when the patient leaves, may be used to measure psychiatric boarding if the time elapsed between a disposition decision and admission, transfer or discharge is not available.

Measurement may also involve selecting a threshold for what constitutes boarding, where portions of or entire lengths of stay are longer than two, four, six, eight, 12 or 24 hours.

\* Where length of stay is defined as the difference in time between triage and departure from the emergency department.

† Where length of stay is defined as the amount of time from emergency department admission to discharge.

### State-specific data also highlight the problem:



- **ARIZONA:** More than 3,000 emergency department patients experienced psychiatric boarding, defined as stays longer than 24 hours following a disposition decision (i.e., admission, transfer or discharge), in 2013.<sup>17</sup>
- **CALIFORNIA:** Between 2007 and 2008, psychiatric patients of a Los Angeles emergency department who required hospitalization waited an average of 18.2 hours for an inpatient bed, compared to just 5.7 hours for nonpsychiatric patients requiring hospitalization.<sup>18</sup> And in a survey of California emergency department directors, respondents reported that in 2010 psychiatric patients waited an average of 10 hours between the decision to admit and placement or transfer to an inpatient bed, while nonpsychiatric patients had an average wait of 7 hours.<sup>19</sup>
- **GEORGIA:** The average emergency department wait for psychiatric patients requiring an inpatient bed exceeded all accepted definitions of boarding, at 34 hours, in 2008.<sup>20</sup>
- **MASSACHUSETTS:** Emergency department psychiatric patients who required admission or transfer saw mean total lengths of stay of 16.5 and 21.5 hours, respectively, compared to just 4.2 and 3.9 hours for medical or surgical patients over a two-week period in 2012.<sup>21</sup> An earlier study of more than 1,000 individuals presenting for emergency psychiatric evaluations at Massachusetts hospitals found that 8% spent more than 24 hours<sup>‡</sup> in the emergency department, with a median stay of 31 hours between 2008 and 2009.<sup>22</sup>

- **OREGON:** More than 2% of all emergency department visits and nearly 15% of those that were psychiatric visits resulted in boarding, defined as stays longer than six hours, between 2014 and 2015. More than 3% of psychiatric visits resulted in stays longer than 24 hours.<sup>23</sup>

## SERIOUS MENTAL ILLNESS IN PSYCHIATRIC BOARDING

Research suggests that the presence of serious mental illness, specifically, may increase the chances that an individual will board in the emergency department:

- Research using national data found that patients with severe psychiatric conditions were more likely to experience long emergency department waits. Patients with bipolar disorder or psychosis faced stays longer than 24 hours more often than patients with other psychiatric diagnoses, such as dual substance use psychiatric disorders or depression.<sup>24</sup> The study authors also note that most patients with a severe mental illness ultimately required admission or transfer to an inpatient facility.<sup>25</sup> The finding aligns with other research suggesting that the risk of psychiatric boarding increases when patients are transferred or admitted.<sup>26</sup> However, even when these patients were discharged, they were still more likely to spend more than 24 hours in the emergency department compared to patients without a severe mental illness.<sup>27</sup>
- According to a study of psychiatric patients in Oregon, which defined boarding as emergency department stays longer than six hours, visits by patients with severe psychiatric conditions were *twice as likely* to result in boarding compared to visits by those with 'non-severe' psychiatric conditions.<sup>28</sup> Nearly one-quarter (24%) of patients with severe psychiatric conditions boarded in the state's emergency departments between October 2014 and September 2015.<sup>29</sup> Of all patients who were boarded, those with severe psychiatric conditions experienced longer stays: 27 hours, compared to 15 hours for patients with

‡ Where length of stay is defined as the interval between presentation to triage and discharge.

'non-severe' psychiatric conditions.<sup>30</sup> Stakeholder interviews with Oregon officials suggested that schizophrenia and bipolar disorder among patients with "severe and persistent mental illness" were the top causes of boarding.<sup>31</sup>

- An analysis of Florida emergency department data from 2010–2013 also noted the role of severe mental illness in psychiatric boarding. Schizophrenia, along with self-harm and suicidality, was associated with longer stays compared to other psychiatric diagnoses.<sup>32</sup>

### Serious Mental Illness and High Utilizers

Individuals with serious mental illness are also overrepresented in the population of patients considered "high utilizers" of health care resources.<sup>33</sup> High utilizers are individuals who use a disproportionate amount of health care services and visit emergency departments more often than the average patient,<sup>34</sup> leaving them with a potentially greater chance of experiencing boarding. In a study of San Diego emergency departments, frequent emergency department users accounted for just 9% of emergency department patients in the region but 37% of total emergency department visits. Of this group, over half (56%) were diagnosed with a psychotic disorder.<sup>35</sup> Among other studies of individuals with serious mental illness and high health care utilization, one group of researchers using predictive modeling techniques found a "consistent increase in the rate of [emergency department] visits as mental illness severity increased from mild to moderate to severe."<sup>36</sup>

### Serious Mental Illness and Insurance

Another factor implicating serious mental illness in psychiatric emergency department boarding is insurance status. A number of studies have shown that psychiatric patients who are uninsured face longer emergency department stays or increased chances of boarding.<sup>37</sup> Conclusions about the effect of public insurance versus private insurance on psychiatric boarding are more mixed, but the data suggest that individuals covered by plans such as Medicare or Medicaid tend to experience longer waits and an increased likelihood of boarding.<sup>38</sup> Data collected by the Substance Abuse and Mental Health

Services Administration suggest that individuals with serious mental illness are more likely to either be uninsured or covered by public insurance compared to the broader population of individuals with any mental illness. In 2018, 13% of individuals with serious mental illness were uninsured and 47% were covered by public insurance programs,<sup>39</sup> while uninsured and public insurance rates for individuals with any mental illness were 11% and 45%, respectively.<sup>40</sup>

## SYSTEMIC FACTORS LEADING TO PSYCHIATRIC BOARDING

The mental health care system is complicated, overburdened and underfunded. Individuals with mental illness face both limited treatment options and structural barriers to receiving appropriate care if or when it is available. The result is a number of systemic factors that lead to psychiatric boarding in emergency departments.

### Gaps and Inefficiencies in the Continuum of Care

The effect of inadequate resources on psychiatric boarding is twofold. By limiting access to vital treatment services, both inpatient and community-based, the health care system prevents individuals with mental illness from addressing and managing their symptoms in a timely manner, before reaching a crisis point. And when dedicated crisis services are also in short supply, individuals in the midst of a psychiatric crisis have nowhere to go but the nearest emergency department<sup>41</sup>

The limited availability of inpatient psychiatric beds also contributes to psychiatric boarding in emergency departments by creating a bottleneck. Patients presenting to the emergency department who require inpatient care may experience extensive waits to be admitted to the hospital or transferred to an appropriate external psychiatric treatment facility, within which there are very few available beds.<sup>42</sup>

The transfer process itself is also problematic, involving "several steps, including medical clearance, psychiatric screening and evaluation, insurance authorization ... and arranging for transportation"<sup>43</sup>—some of which are unique to psychiatric patients.<sup>44</sup> Waits for transfer are worsened by nonstandard admission requirements across inpatient facilities.

Facilities may have entirely different admission requirements based on factors such as preexisting patient conditions, administrative burdens and the results of laboratory testing.<sup>45</sup> One study notes a specific discrepancy between patient transfers to public versus private facilities, with public facilities associated with longer emergency department stays.<sup>46</sup> This results in a phenomenon known as “shotgun referrals,” where an individual is referred by emergency department staff to multiple facilities all at the same time because of the long waits and selective admission practices of hospitals.<sup>47</sup>

In order to access an inpatient psychiatric bed in many parts of the country, an individual must first present to a local emergency department. According to a 2015 survey of state mental health departments, 29 of 46 responding states reported that individuals with mental illness remain in the emergency department while waiting for an appropriate placement.<sup>48</sup>

Given the difficulties associated with bed availability and the transfer processes, a patient’s individual disposition decision can increase the likelihood and length of boarding time as well. Although evidence suggests that psychiatric patients often wait longer in emergency departments than nonpsychiatric patients regardless of disposition,<sup>49</sup> psychiatric patients who are admitted to the hospital for inpatient care or transferred to another inpatient facility are most likely to experience boarding and tend to wait the longest:<sup>50</sup>

- Transferred psychiatric patients boarded<sup>§</sup> for an average of 9.2 hours, compared to six hours for admitted patients and 1.3 hours for discharged patients, in a study of 10 Massachusetts emergency departments in 2012.<sup>51</sup>
- Transferred psychiatric patients had total average lengths of stay<sup>¶</sup> of more than 11.5 hours, compared to discharged patients, who experienced lengths of stay of seven hours, in Florida emergency departments between 2010 and 2013. Over 73% of transferred psychiatric patients were boarded, defined as a length of stay greater than six hours.<sup>52</sup>

- Psychiatric patients transferred to an external location saw an average total length of stay<sup>\*\*</sup> of 15 hours, compared to 8.6 hours for discharged patients, in a study of five Boston-area emergency departments between 2008 and 2009.<sup>53</sup> The authors note that the time spent waiting between a disposition decision and admission or transfer was the primary cause of extended lengths of stay, with admitted and transferred patients waiting an additional 3.3 and 7.4 hours after a decision, respectively.<sup>54</sup>
- Nearly all (94%) psychiatric patients with lengths of stay<sup>††</sup> greater than 24 hours were individuals requiring admission or transfer, in a study of an urban academic emergency department from 2009 to 2010.<sup>55</sup>

### Availability of Treatment Professionals

Complicating matters is the scarcity of psychiatric professionals on-staff in emergency departments. Emergency departments are not designed for care and management of chronic conditions such as mental illness.<sup>56</sup> As a result, many emergency departments do not have dedicated psychiatric services or psychiatrists available at all times,<sup>57</sup> and general emergency department clinicians are not necessarily trained in the provision of appropriate or long-term psychiatric care.<sup>58</sup> Rather, most mental health training for emergency clinicians and nurses focuses on initial diagnosis and emergency interventions such as sedation.<sup>59</sup> As a result, emergency physicians may, for example, “err on the side of caution” in favor of inpatient psychiatric treatment, potentially due to liability concerns if a patient is discharged and then experiences a subsequent crisis.<sup>60</sup> However, this type of decision making can lead to patients waiting hours or days for a psychiatric bed, only to find that inpatient treatment is not appropriate once they are evaluated by a mental health professional.<sup>61</sup>

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§ Where boarding is defined as the time spent waiting between the disposition decision and discharge.

¶ Where length of stay is defined as the time from emergency department arrival to discharge.

\*\* Where total length of stay is defined as the interval between triage time and discharge time.

†† Where length of stay is defined as total length of stay from registration to departure.

## Legal Considerations

The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires stabilization and treatment of all people presenting to an emergency department, regardless of their insurance status or ability to pay. In addition, EMTALA requires transfer to an appropriate facility for stabilization if such services cannot be adequately provided in the current location. The receiving facility has a duty to accept the transferred patient if it has an on-call specialist and capacity to treat the individual.

the care of psychiatric patients in emergency departments may be determined more by complex legal structures than individual patient needs.

When psychiatric patients must be transferred for treatment, inpatient facilities can exacerbate barriers to adequate care. Inpatient psychiatric facilities may have a preference for accepting “lower acuity” patients, or those with less severe and more easily treatable conditions,<sup>66</sup> resulting in a practice known as cherry-picking.<sup>67</sup> The incentive to accept these lower-risk patients leaves emergency departments with

### The Case of Rebecca

Viral video footage from a cold winter night in January 2018 reveals the reality of treatment in emergency departments for people with severe mental illness. The video shows a woman dressed only in a hospital gown despite the freezing temperatures, walking on the street outside University of Maryland Medical Center Midtown in Baltimore. Rebecca was removed by security after resisting discharge from the emergency department, where she had been treated for a head wound after a motorbike accident.

Rebecca suffered from severe mental illness and struggled with adhering to treatment, according to her family. She cycled between various homeless shelters throughout Maryland and had been hospitalized almost 10 times in recent years.

Federal regulators have reportedly charged the hospital with violating patient safety, including violating a patient’s right to receive care in an emergency department in a safe setting. According to Rebecca’s family, she is still being hospitalized due to her mental illness and suffers flashbacks from her experience in Baltimore.

Although the federal government has clarified EMTALA guidelines<sup>††</sup> for psychiatric emergencies, questions remain regarding the minimum clinical standards for stabilization and treatment of psychiatric patients.<sup>63</sup> The process of patient dumping, sometimes referred to as “streeting,” or discharging psychiatric patients who have not yet received appropriate treatment, still occurs as a mechanism to prevent boarding of psychiatric patients who have no appropriate options for timely placement.<sup>64</sup> Conversely, hospitals also report boarding psychiatric patients in emergency departments instead of discharging when appropriate, due to fear of EMTALA violations.<sup>65</sup> In either case,

the remaining high-acuity patients, who, intuitively, are actually the patients most in need of immediate inpatient care. Experts have recommended greater local, state and federal oversight of adherence to EMTALA to prevent such practices.<sup>68</sup>

Between 2002 and 2018, almost 20% of EMTALA violations resulting in civil monetary penalties were due to psychiatric emergencies, with psychiatric emergency violations requiring the largest monetary payouts.<sup>69</sup> More than two-thirds of those cases were due to the hospital failing to provide stabilizing treatment to psychiatric patients in the emergency

<sup>††</sup> According to the Centers for Medicare and Medicaid Services’ interpretive guidelines for EMTALA regulations, “Psychiatric patients are considered stable when they are protected and prevented from injuring or harming him/herself or others.”<sup>62</sup>

department, resulting in situations such as psychiatric boarding or patient dumping. Almost half (44%) of EMTALA violations for psychiatric emergencies cited the hospital for either failing to transfer or failing to accept an appropriate transfer.

### **Financing and Payment**

Insurance structures and reimbursement rates may affect psychiatric boarding as well. Historically, insurance payers have reimbursed physicians for admitted psychiatric patients at low rates,<sup>70</sup> disincentivizing timely treatment for these patients in emergency departments. One study of patients admitted to an academic medical center emergency department found that physician reimbursement rates were 40% lower for psychiatric patients compared to nonpsychiatric patients.<sup>71</sup> A report of the Arizona Hospital and Healthcare Association describes the contractual nature of the relationship between providers and payers, which can lead to some individuals being more readily accepted at inpatient facilities following an emergency department visit, simply because the facility is in their insurance plan's network.<sup>72</sup>

Federal public policy related to mental health care financing and payment also plays a role. For inpatient psychiatric facilities specifically, a federal policy known as the Institutions for Mental Disease (IMD) exclusion categorically prevents Medicaid reimbursement for the care of most individuals with mental illness in facilities with more than 16 total beds.<sup>73</sup> States are currently able to apply for waivers granting them an exception to the policy rule, but the IMD exclusion remains the governing law without proactive efforts on the part of each individual state. Not only does the IMD exclusion serve as an example of the lack of reimbursement parity between mental health and non-mental health services, but it also provides a disincentive for the building and maintenance of large inpatient psychiatric facilities that could provide care to more patients.

## **THE COSTS OF PSYCHIATRIC BOARDING**

Psychiatric boarding has serious consequences for individuals with mental illness, other patients and the health care system overall. Psychiatric patients experience symptom exacerbation and general decompensation, while other patients see their own delays in treatment, physicians feel the stress of crowded conditions, and hospitals face the burdens of increased costs and ambulance diversions.

### **Symptom Exacerbation and Decompensation for Individuals With Mental Illness**

Even when operating efficiently, emergency departments are not designed to provide long-term treatment or management of patients with chronic diseases, particularly mental illness.<sup>74</sup> In addition to lacking sufficient specialized resources, emergency departments are characteristically loud and hectic, creating an environment that is counterproductive for de-escalating psychiatric crises.<sup>75</sup> When psychiatric patients experience boarding, the situation becomes even worse. As they wait for treatment, boarded patients spend extended periods of time in this overstimulating environment, often with infrequent communication from staff and no understanding of the situation.<sup>76</sup> Shuffled wherever they can fit, "they lie on gurneys or sit in chairs ... often filling every available space, including the hallways."<sup>77</sup> Boarded psychiatric patients face constant concerns related to stress, general safety and timeliness of treatment and can see symptoms exacerbated simply due to their stay in the emergency department.<sup>78</sup>

According to a 2008 survey by the American College of Emergency Physicians, a majority (62%) of the nation's emergency department directors reported that "there are no psychiatric services involved with patient care" while boarding,<sup>79</sup> speaking to the potential for significant decompensation over an hours- or dayslong wait. Boarded patients may even require hospitalization purely *as a result of* symptoms that were left untreated or that worsened while boarding.<sup>80</sup> Additional emergency department practices, such as the use of "safe hold" rooms for boarded psychiatric patients, can further traumatize individuals with psychiatric conditions, comparable to the experience of solitary confinement in the criminal justice system.<sup>81</sup>

### **Treatment Delays for Other Patients**

Boarding often leads to emergency department crowding, leaving less space and fewer resources for incoming patients who have their own urgent medical needs. These patients, too, may see delays in treatment<sup>82</sup> and have been shown to report dissatisfaction with their care when boarding is prevalent. Tending to boarded psychiatric patients in common areas such as hallways or waiting rooms also increases the chance that other patients will witness distressing or traumatizing medical events.<sup>83</sup>

### **Increased Stress for Emergency Clinicians**

For emergency clinicians, crowded conditions and patients with untreated mental health needs increase pressure, distractions and stress, making already complex care provision more difficult. Staff may also feel inadequate, as they are unable to effectively treat individuals with serious mental illness due to lack of relevant training.<sup>84</sup> Boarding may also increase the risk to clinicians and staff of physical harm at the hands of aggressive patients whose conditions worsen over the course of extensive stays.<sup>85</sup>

### **Fiscal and Procedural Costs Incurred by the Health Care System**

A psychiatric emergency department visit in which an individual is boarded can cost hundreds of dollars more than a visit that results in timely treatment.<sup>86</sup> Among Oregon emergency department visits covered by Medicaid between October 2014 and September 2015, boarded psychiatric visits cost an average of \$695 per visit, while nonboarded psychiatric visits cost an average of \$418 per visit—a difference of \$277.<sup>87</sup> The unique costs associated with boarding, such as the time a patient spends waiting for transfer, may also not be accounted for in insurance reimbursement rates, leaving facilities operating at a loss when they provide care to boarded patients.<sup>88</sup>

Boarding also prevents emergency departments from admitting, and receiving reimbursement for, additional patients. According to one study of an academic medical center emergency department in Los Angeles, California, the decrease in bed turnover due to the presence of boarded psychiatric patients cost the facility \$2,264 per patient.<sup>89</sup> Relatedly, if

emergency departments have no available space for incoming patients, ambulances transporting these patients must be diverted to alternate hospitals.<sup>90</sup> Ambulance diversion burdens the overall system of emergency care by delaying treatment for patients and consuming greater amounts of paramedics' valuable time.

## **PSYCHIATRIC BOARDING AS A MEASURE OF BED NEED**

While psychiatric boarding presents a number of deeply concerning problems, it may also help answer one of the most salient questions in American mental health care: how many psychiatric beds does a community need?

As localities have wrestled with the closing of psychiatric hospitals, an emphasis on community-based treatment and an overwhelming number of individuals with mental illness in need of care, experts have used a variety of strategies to determine the optimal number of inpatient psychiatric beds.<sup>91</sup> In a novel approach to the problem, psychiatric boarding can serve as a proxy measure to help researchers understand the needed capacity for psychiatric care within a given health care system, and what resources might lessen the burden.

Termed the observed-outcome approach, this new model proposes that levels of access to psychiatric beds can be connected to observable outcomes in systems and populations. By examining the relationship between bed numbers and indicators, researchers can calculate the minimum and optimum bed requirements for a particular area to avoid negative outcomes. Specifically, measures of the extent of psychiatric boarding of patients with severe mental illness in emergency departments can be used as an indicator of adequate inpatient treatment supply.

## CONCLUSION AND RECOMMENDATIONS

A patient in the midst of a heart attack would not be left to languish because treatment is unavailable or inconvenient. The notion that such an individual could be set aside, and his or her condition allowed to deteriorate to the point that recovery is less attainable, would be unthinkable. However, for people with mental illness, society and systems have made the unthinkable a reality.

As a consequence of inadequate preventive treatment options in the community, diminishing supplies of higher levels of care and other factors, individuals in psychiatric crisis present to local emergency departments and wait for treatment. Emergency departments are thus flooded with individuals seeking help for conditions that could be better addressed elsewhere in a functioning system of care. The evidence presented shows that serious mental illness is a significant contributor to emergency department boarding, and any solutions to combat psychiatric boarding must address treatment gaps for individuals suffering from these conditions.

Gaps in treatment options differ from place to place, and all psychiatric beds are not created equal. State statutes, local policies, procedures and financing all dictate who can access what type of bed, when and for how long. Bed types include public psychiatric beds in state hospitals and psychiatric units in general hospitals, as well as acute care, subacute care, crisis and residential beds. Any community could have an adequate supply of one type but a shortage of another, limiting treatment access for people with severe mental illness who will need multiple forms of care at various stages of their illness.

Future work is needed to determine the extent of psychiatric boarding at the state and national level. Such efforts represent a unique opportunity to assist in the development of psychiatric bed targets and help communities better address the critical treatment needs of their populations.

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