



Brigham and Women's Hospital
Founding Member, Mass General Brigham

Acute Psychiatric Management and ED Boarding

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With respect to the following presentation, there has been no relevant (direct or indirect) financial relationship with any for-profit company which could be considered a conflict of interest.

Outline

- Emergency Psychiatric Care
- Emergency Department (ED) Boarding Crisis
- Treatment in the ED Setting
- Models of Emergency Psychiatric Care
- Therapeutic Discharge
- Mental Health Advocacy

Emergency Psychiatric Care

- Problem Scope and Etiology
- Prevalence
- Ongoing Stigma and Separation of Care

Common Psychiatric Emergencies

- Psychiatric Safety Risk Assessment
- Undifferentiated Agitation
- Substance Intoxication/Withdrawal
- Medication Adverse/Side Effects
- Capacity Assessments
- Psychosis
- Mood Symptoms (Depression/Mania)
- Delirium



U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy



A LITERATURE REVIEW:

PSYCHIATRIC BOARDING

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Boarding of Mentally Ill Patients in Emergency Departments: American Psychiatric Association Resource Document

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Emergency Psychiatry: Updates, Future Directions, and Core Concepts

Guest Editor: Tony Thrasher, D.O., M.B.A.

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INFLUENTIAL PUBLICATION

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Emergency Department “Boarding”

- Variable Definitions
- Patient Characteristics
- Monetary Cost
- Non-Monetary Cost

Sources of ED Boarding

- Shortage of Inpatient Psychiatric Beds
- Insufficient Funding for Lower Levels of Care
- Un/Under-Insured
- Managed Care Hurdles
- Severe Psychiatric Illness Burden
- Bed Reduction of State-Funded Psychiatric Beds

ED Boarding: Potential Solutions

- Rapid Treatment of Agitation
- Minimization of Restraint and Seclusion Use
- Evaluation of Medical Comorbidities
- Active Treatment of Psychiatric Illness
- Implementation of Observation Units
- Active Treatment of Substance Intoxication or Withdrawal
- Improved Coordination and Communication Around Disposition
- Other Hospital-Centered Approaches
- Partner with Local Entities
- Focus on Diversion and Coordination

Psychiatric care in the emergency department: Converting boarding time to treatment time

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Case Example

30 year old man with a h/o schizoaffective disorder presents to the ED for intrusive command auditory hallucinations to jump in front of a bus after a few months of stopping his medications. The patient is placed on an involuntary hold and the process of inpatient psychiatric placement is initiated. He is initiated on oral lorazepam as needed for agitation. He begs for a solution to his low mood and intrusive hallucinations and is offered lorazepam as ordered. He becomes agitated as he feels ignored when repeatedly asking when he will be transferred during his 6 days of boarding. He yells at the staff, security is called to the bedside escalating his agitation which leads to physical restraint. Due to this episode of restraint, his inpatient placement is further delayed.

Converting Boarding Time into Treatment Time

- Multimodal Treatment
- Rapid Reinitiation of Home Medications
- Monitoring of Side Effects, Up-Titration of Medication
- Reassessment of Symptoms
- Social Work Assessment
- Family Involvement
- Referral to Outpatient Care

Models of Emergency Psychiatric Care

- Designated Psychiatric Emergency Department
- Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH) Units
- Mental Health Consultation Model
- Behavioral Health Wing of Medical Emergency Department
- Telepsychiatry

Behavioral Health Observation Unit



LIAISON EFFORT:
PSYCHIATRY AND
EMERGENCY MEDICINE



8-BED POD



"COMFORT MENU"



DAILY
INTERDISCIPLINARY
ROUNDS



CARE WITH DIGNITY

Building a 'More Humane' ED

 Brigham and Women's Hospital
Founding Member, Mass General Brigham

Expanding the Brigham's Emergency Department will provide safer and more private care for patients in crisis.



Behavioral Health Rounds

- Daily, Mid-Morning
- Participants
 - EM Team
 - Psychiatry
 - Nursing
 - SW
 - Psychiatric OT
 - Security
 - ED Flow Manager
 - PCAs/ESAs
- Focus on Safe Clinical Care/Barriers to Care Progression
- Team Building/Morale Boosting

Behavioral Health Pamphlet



Behavioral Health Care in the Emergency Department

Our Emergency Department (ED) team works with experts from Psychiatry and Social Work to treat you. Our goal is to keep you safe and address your concerns while we determine what level of care is best for your needs.

Waiting in the Emergency Department

We understand that waiting in the ED can be frustrating. If you need a hospital stay (inpatient treatment), that process often takes some time as well. Please be assured that your care team will meet with you daily to review your treatment plan and provide updates.



Safety

Cell phone guidelines

This is a healing environment, and we need to protect everyone's privacy. Use of cell phone will be at the discretion of the staff. If you would like to use your cell phone, please follow these rules:

- Cameras, video and/or recording (including FaceTime) are not allowed due to state and federal law.
- Use your phone at a low volume and speak softly, especially after 9 p.m. so others may rest and sleep.
- Staff will charge your phone in a secured area. We recommend having your phone charged overnight (9 p.m. - 7 a.m.) so that you get solid rest time.

Access to Belongings

We will secure your personal belongings. You may be allowed access to items that your care team

Self-care, coping and recovery in the Emergency Department

Your safety comes first. Please note these comfort items may not be offered to all patients if safety is a concern.

Feeling anxious?

It is common to experience anxiety while waiting in the ED.

- **Medication:** Please let us know if you would like medication to improve your comfort.
- **Sensory Processing Aids:** Please ask your care team if you would like earplugs, stress balls, or similar items.
- **Nicotine Replacement Therapy:** Smoking is not allowed in the ED. Patients cannot leave the ED to smoke. Smoking is not permitted anywhere on hospital grounds. Please let us know if you would like nicotine patches/

Try these relaxation exercises!

4-7-8 Breathing Exercise

1. Find a comfortable sitting position.
2. Place the tip of your tongue behind your top front teeth.
3. Empty your lungs of air.
4. Breathe in quietly through your nose for 4 seconds.
5. Hold your breath for 7 seconds.
6. Purse your lips and breathe out through your mouth, making a whoosh sound, for 8 seconds.
7. Repeat up to 4 times.

Psychiatric Occupational Therapy

Novel
Intervention

Focus: Symptom
Management,
Coping Skills

Patient
Empowerment

Patient
Advocacy

Data Gathering

Emergency
Psychiatric
Assessment,
Treatment, and
Healing
(EmPATH) Unit

- Goal: Reduce Time in Traditional ED
- Open Unit Concept
- Evaluation: Nursing, Social Work, Psychiatry
- Treatment Modalities
 - Individual and Family Therapy
 - Medication Management
 - Substance Use Treatment Referrals
 - Financial and Housing Assistance

EmPATH Unit: Outcomes

- Primary Outcome—Proportion of Hospital Admissions: ↓
- Return to the ED within 30 Days: ↓
- Mental Health Follow Up Appointments: ↑
- Overall ED Boarding Time: ↓

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NEW YORKER

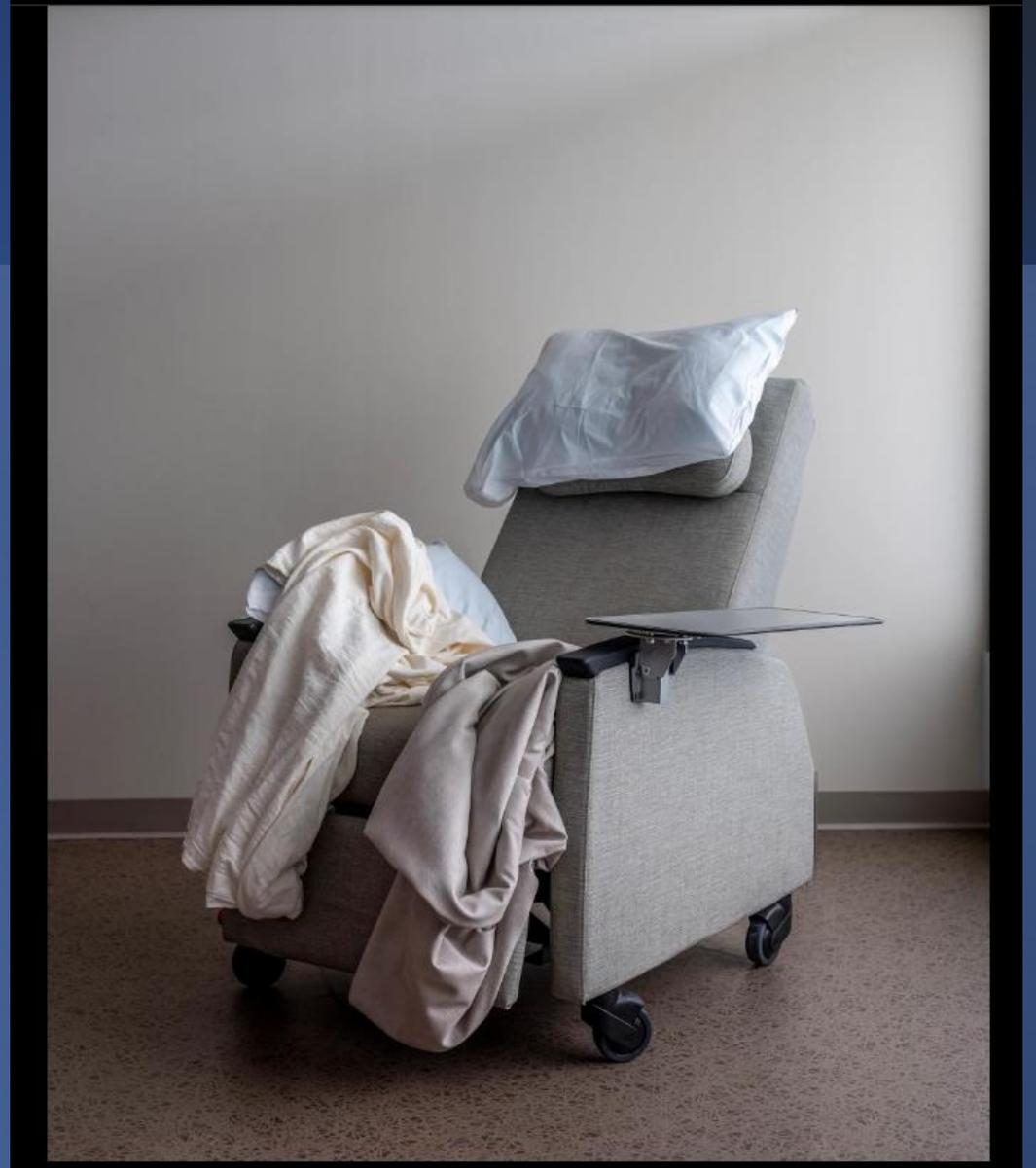
ANNALS OF MEDICINE

REINVENTING THE E.R. FOR AMERICA'S MENTAL-HEALTH CRISIS

*Empath units are advancing a radically new approach to
psychiatric emergencies. It seems to be working.*

By Dhruv Khullar

July 12, 2023



Therapeutic Discharge

- Deceptive Behaviors
- Ethics of Hospitalization
- Data Gathering
- Safety Risk Assessment
- Preparation for Discharge
- Informing the Patient
- Debrief with Staff
- Countertransference Awareness

Patient Formulation

- “Notably, the patient’s reported symptoms of low mood, hopelessness and suicidality are incongruent with objective findings on mental status examination including smiling affect, joking demeanor with nursing staff, and demanding behaviors surrounding specific foods.”
- “The patient’s report of the death of his mother 2 weeks ago is inconsistent with available assessment 10 days ago at an outside emergency department where he did not report this information and a visit 3 years ago where he reported her recent death.”
- “When discussing the plan for potential discharge, the patient’s reported suicidality worsened with low-risk/high-rescue threats to self-harm in the ED.”
- “The patient declined to discuss all offers of other modalities of psychiatric treatment, including same-day referral to an outpatient clinic with provision of transportation.”

Patient Risk Assessment

- “The patient’s chronic psychiatric safety risk remains elevated above the general population due to ongoing substance use and its associated risk for impulsive behaviors, previous (albeit remote) self-harm, and unstable housing situation. These risk factors have been chronic and therefore his imminent risk appears to be low.”
- “Acute psychiatric hospitalization, as evidenced by dozens of admissions in the past, has not been shown to alter the course of the patient’s reported symptoms or course of his illness.”
- “The current presentation appears to be consistent with previous ED visits during which there has been significant concern that the patient’s reported suicidality has been a means to gain other needs met, namely housing, rather than a decompensation of an underlying psychiatric illness and/or a true desire to die.”
- “Future ED visits may allow for ongoing encouragement for longitudinal outpatient care where the patient may focus on development of productive coping strategies in the face of chronic psychosocial distress.”

Therapeutic Discharge Debrief

- Essential!
- 5-10 Minutes
- Reflections
- Offer Individual Check-Ins

Mental Health Advocacy



State Involvement

Alternatives to ED-Based Care
Telepsychiatry Funding
Mental Health Parity



National Efforts

Professional Organizations
Federal Government



Training

Crisis Intervention Training
Expansion of Provider Training

Washington State: Legal Routes

LAW & PSYCHIATRY

“Boarding” Psychiatric Patients in Emergency Rooms: One Court Says “No More”

Paul S. Appelbaum, M.D.

California: Regional Psychiatric Emergency Service

Effects of a Dedicated Regional Psychiatric Emergency Service on Boarding of Psychiatric Patients in Area Emergency Departments

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Roadmap for Behavioral Health Reform

Helping residents access mental health and substance use treatment

Summary

- The Emergency Department as Default for Crisis Care
- Longstanding Crisis of ED Boarding
- Boarding Time = Treatment Time
- Many Models of Emergency Psychiatric Care
- Mental Health Advocacy is Possible at All Levels