Irish Journal of Psychological Medicine (2025), **42**, 170–171
doi:10.1017/ipm.2024.62

CAMBRIDGE UNIVERSITY PRESS

Letter to the Editor

Psychiatric boarding: what is it, how do we recognise it, and what are the implications?

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Dear Editor,

We are writing to address an issue in psychiatry that has significant implications for patient care, resource management, and patient well-being: the lack of understanding, definition, and circumstances of psychiatric boarding.

Patients being held in the emergency department or other inappropriate settings while awaiting a bed in a psychiatric facility is an issue that is poorly defined. The absence of a distinct, universally accepted definition of psychiatric boarding leads to great variation in the results of papers examining these topics, leaving them open to misinterpretation. As a result, clinician-to-clinician communication, research, and hospital policymaking are greatly hampered, ultimately leading to compromised and ineffective care provided to the patient.

This letter aims to highlight the importance of this poorly defined concept to clinicians and managers. Additionally, we propose a standardised definition of psychiatric boarding to facilitate clarity and standardisation in both clinical practice and academic discussion with specific emphasis on an Irish context.

Psychiatric boarding: the present challenge

Psychiatric boarding refers to the practice of holding patients who present with emergent mental health or psychiatric difficulties in emergency departments or other non-psychiatric units where an in-patient psychiatric setting would be more appropriate. The practice of boarding is a recognised phenomenon used to deal with the issue of the lack of immediate hospital beds for a patient deemed in need of admission.

Presently, no one clear definition is being used, and authors and organisations operationally define psychiatric boarding based on their own parameters and standards, with the time after which a patient can be considered 'boarding' varying between authors from 4 hours (The Joint Commission, 2012) to 12 hours (Wharff *et al.*, 2011). The US Joint Commission suggests a definition of 'boarding' as the practice of holding a patient in the emergency department or any other temporary location while they are awaiting placement in a unit for which a bed is not available (The Joint Commission, 2012). It is stated that boarding should not exceed 4 hours (The Joint Commission, 2012). It should be noted that this definition is not specifically for psychiatric patients only but for any patient awaiting placement in a specialist unit. Other authors, such as Misek *et al.* (2015), provide a similar definition but specifically for psychiatric patients. They define boarding as a psychiatric patient remaining in the emergency department for more than 4 hours post-medical clearance. Nolan *et al.* (2015) provide a very similar definition however state that patients must wait for 6 hours before being classed as boarders. Wharff *et al.* (2011) state that patients presenting with a psychiatric complaint must remain in the emergency department for 12 hours or more before being classed as boarders. Claudius *et al.* (2014) differ from the other authors mentioned and define psychiatric boarding based on patient characteristics, that is, as caring for a patient who cannot be safely discharged from the emergency department or is admitted to a medical ward. It is worth noting here that Claudius and colleagues do not discuss a minimum time frame for which patients must remain in the emergency department or non-psychiatric unit before they are defined as boarders.

These varying and often conflicting definitions currently present in the literature paint an unclear picture of the scope of the problem. It is difficult to establish the true rates of psychiatric boarding without a formally proposed definition of the concept. There appears to be some geographic variation in how the practice is referred to. In countries such as the USA and Canada, psychiatric boarding is the term used, whereas other countries such as England refer to the practice as inappropriate admission to paediatric wards (Worrall *et al.*, 2004; Hudson *et al.*, 2024). Therefore, it is important that researchers, both in Ireland and internationally, use a unifying term based on a formally proposed definition for the sake of replication and future research.

Hence, we propose the following definition of psychiatric boarding:

Psychiatric boarding occurs when a patient presenting with a primary psychiatric condition is held in, or admitted to, a non-psychiatric setting, such as the emergency department or medical wards, for a minimum of 18 hours while awaiting psychiatric care or admission to a psychiatric ward.

The proposed definition encompasses several key elements:

1. Primary psychiatric condition: some previous definitions, such as the one provided by The Joint Commission (2012), define boarding for patients of any condition and are not exclusive to psychiatric concerns. Rates of psychiatric and medical boarding may vary; hence in order to study these occurrences properly, there is a need for separate definitions.

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Cite this article: Jones É, O'Gorman C, McNicholas F, and Barrett E. (2025) Psychiatric boarding: what is it, how do we recognise it, and what are the implications?. *Irish Journal of Psychological Medicine* **42**: 170–171, https://doi.org/10.1017/ipm.2024.62

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https://doi.org/10.1017/ipm.2024.62 Published online by Cambridge University Press

2. The patient is held in a non-psychiatric setting: this is a key component of psychiatric boarding, emphasising that the patient is held in a setting that may be clinically inappropriate relative to their psychiatric needs.
3. More than 18 hours: while this time frame is significantly greater than others proposed, it is worth noting that wait times in Irish emergency departments currently average over 11 hours (Health Service Executive 2024) for both psychiatric and non-psychiatric concerns. We suggest a period of 18 hours to allow for the average wait time of 11–12 hours for care in the emergency department, plus an additional period to allow the transition from waiting to boarding. This longer period also acknowledges the significantly longer emergency department wait times than non-psychiatric patients (Ivbijaro *et al.*, 2014). Additionally, we recognise that many services, such as Child and Adolescent Mental Health Services (CAMHS), do not have an out-of-hours or weekend service, increasing the wait time for specialist psychiatric care.

Scope of the issue

More recently, psychiatric boarding has been used to describe young people presenting to the emergency department with psychiatry needs, with one survey outlining that 84% of emergency physicians report boarding such patients (Tavernero 2018). Presently, no research has examined the issue of psychiatric boarding in the Irish healthcare system. This is of significant concern due to the potential negative effects on the patient's health, well-being, safety, and outcomes. Multiple negative effects have been identified in the literature as a result of psychiatric boarding in non-medical wards, including undue stress and anxiety for the patient, inappropriate use of restraints (Tavernero 2018), receiving inappropriate psychopharmacological therapies, and little if any behavioural or psychotherapeutic interventions (Claudius *et al.*, 2014). In addition to these effects, patients boarded in the emergency department prevent over two bed turnovers and cost the department significantly more than non-psychiatric patients (Nicks and Manthey 2012). Non-psychiatric settings often lack the appropriate resources and staff who are trained to manage psychiatric patients (Oketah *et al.*, 2021), which can exacerbate the patient's already stressful experience of in-patient treatment with possible legal ramifications and risks to staff safety.

Further research must be done to establish the prevalence and effects of psychiatric patients being boarded in Irish hospitals and to inform best practices and future policy changes.

Financial support. This research received no specific grant from any funding agency, commercial, or not-for-profit sectors.

Competing interests. None.

Ethical standards. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

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https://doi.org/10.1017/ipm.2024.62 Published online by Cambridge University Press