

Rural EmPATH Unit Decreases Subjective Distress Levels in Patients with Psychiatric Complaints Presenting to the Geisinger Medical Center Emergency Department in Danville, Pa.

Kamil Falkowski^{1†}, Tanner Thompson^{1†}, Hunter Yarnell², Mia Gianello^{1†}, and Jennifer Margaret Yarnell³

¹Geisinger College of Health Sciences, Scranton, PA 18509

²Misericordia University, Dallas, PA 18612

³Geisinger Behavioral Health, Danville, PA 17822

[†]Doctor of Medicine Program

Correspondence: kfalkowski@som.geisinger.edu

Abstract

Background: Mental health issues, including substance abuse, are among the leading causes of emergency department (ED) visits and account for an increasing share of overall presentations. Limited psychiatric bed availability contributes to high reliance on ED boarding, resulting in extended wait times, decreased efficiency, and worsening distress. This overcrowding strains ED resources, leading to lower-quality care and increased mortality, especially in rural areas where access to acute mental health care is limited. The Emergency Psychiatry Assessment, Treatment, and Healing (EmPATH) model addresses this gap through creating a hospital-based crisis stabilization unit separate from the general ED, available to all medically cleared patients except those with violent behavior or medical instability. Staffed by psychiatrists, nurses, social workers, and psychologists, EmPATH units provide rapid evaluation, observation, and treatment. Geisinger Medical Center (GMC) ED, like many nationwide, experiences high psychiatric boarding times. In response, a GMC EmPATH unit was established to relieve ED pressure, emphasizing patient safety, emotional regulation, and social engagement. However, data on patient experiences in rural EmPATH units remains limited.

Objective: The study aims to assess changes in patient-reported distress levels from admission to discharge in the EmPATH unit and compare perceived safety and calmness to experiences in the general ED/hospital, along with analyzing qualitative feedback from free-text responses.

Methods: This mixed-methods study integrates quantitative data (survey scores and ratings) and qualitative data (subjective experiences), collected before patient discharge by EmPATH staff. Participation was voluntary with no exclusion criteria. Descriptive and inferential statistics were used for quantitative analysis, and thematic analysis was applied to qualitative responses.

Results: Patients reported a decrease in subjective distress scores: *p-value* 1.78E-14, 95% C.I. (-4.58, -3.25). They also rated the EmPATH unit as providing greater safety: 9.18, and calmness: 8.60, compared to the ED/hospital (using a 1–10 scale with 1 indicating less safe/calm and 10 indicating more safe/calm). Thematic analysis of open-ended responses highlighted themes such as a therapeutic environment, feeling heard and cared for, and identifying the unit as a space for reflection.

Conclusion: Our findings suggest that the EmPATH unit offers a more therapeutic and less traumatizing alternative for patients presenting with psychiatric emergencies. Patients reported significant reductions in distress and greater perceived safety and calmness. Additionally, qualitative findings revealed key themes supporting positive patients' experiences at the EmPATH unit. However, limitations of the study include data collection at a singular point in time, voluntary participation, and limited participant diversity. Future studies should involve larger, more diverse samples and use standardized assessment tools such as the Columbia Suicide Severity Rating Scale to provide more objective measures of patient experiences at the EmPATH unit.

Introduction

In 2014, mental health issues, including substance abuse, were the most common reasons for ED visits nationwide (1). Between 2006 and 2011, ED visits by patients with mental health disorders and comorbidities increased by 20.5% and 53.5%, respectively (2). Mental health-related ED visits now account for approximately 12–15% of all emergency visits (3).

This trend is particularly pronounced in rural areas, where patients face significant challenges accessing timely acute mental health care (4). A literature review highlights the urgent need to address these challenges. Mental health and associated disorders are the fourth most frequently identified rural health priority. Rural areas are disproportionately affected by male suicides, yet nearly 75% of rural counties lack a single psychiatrist, and nearly 95% lack a child psychiatrist (5). Additionally, rural youths present to the ED for self-harm at higher rates than their urban counterparts (6). It is evident that emergency psychiatric care in rural areas is severely lacking, necessitating innovative solutions to improve access.

The surge in mental health ED visits presents significant operational and financial challenges for emergency departments. Limited inpatient psychiatric beds often result in “boarding,” where patients are held in the ED for days without treatment or a hospital room, frequently in hallways or corridors (7, 8). Psychiatric patients awaiting inpatient placement remain in the ED 3.2 times longer than non-psychiatric patients, preventing 2.2 bed turnovers per psychiatric patient (9).

This overcrowding places an immense pressure on EDs, leading to decreased treatment quality and increased mortality (10). Additionally, the noisy, overstimulating ED environment exacerbates self-reported distress levels (11). Financially, prolonged psychiatric patient boarding and reduced turnover result in a loss of \$2,264 per patient (9). Of note, increased boarding times in the ED results in a higher likelihood of symptom escalation leading to greater demands on nursing staff (1:1s) and security needs.

Various programs, such as short-stay mental health crisis units and community crisis centers, aim to reduce ED use by psychiatric patients (12). However, many of these programs exclude more acute patients, ultimately directing them to EDs.

To address this gap, the Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH) model was developed as a hospital-based crisis stabilization unit. Unlike other programs, EmPATH units are designed as destinations for all medically clear patients in crisis, with few exclusion criteria such as violent behavior and medical instability. They feature multidisciplinary staff, including psychiatrists, RNs, social workers, and psychologists, who provide rapid evaluation, observation, and treatment. Notably, restraint use in EmPATH units is typically under 1%. Additionally, these units are distinct from medical EDs, offering open, calming, and comfortable spaces that promote healing.

A review of various EmPATH units demonstrated substantial operational and financial benefits for healthcare systems and emergency departments. These units effectively reduced ED recidivism rates, psychiatric inpatient admissions, restraint use, and boarding times, thereby limiting ED overcrowding. Additionally, they were shown to increase outpatient follow-up care established at discharge. Reports also indicated increased cost savings and ED revenue (13, 14, 15, 16). However, research on patient experiences with the EmPATH model remains limited. One example from an EmPATH unit at the Mercy San Juan Medical Center reported patient satisfaction score of 85% (17).

Overview of Geisinger Medical Center EmPATH Unit

Geisinger Medical Center, located in Danville, Pennsylvania, is part of the Geisinger health system and serves as a Level I Trauma Center for the central PA community, which consists largely of a rural population. As a result, the hospital faces challenges similar to those of other rural healthcare providers in addressing acute psychiatric care.

In January 2021 alone, approximately 100 psychiatric patients at Geisinger Medical Center experienced boarding times exceeding 4 hours. To improve acute psychiatric care and access, an adult EmPATH unit was established in late 2024, featuring a flexible clinical model that emphasizes safety, emotional regulation, and social engagement.

The Geisinger Medical Center EmPATH unit is designed to stabilize psychiatric emergencies and serves as a designated destination for medically cleared patients in crisis before determining the need for inpatient admission. Upon arrival, patients are quickly evaluated by the psychiatry consult

service, and treatment is initiated if they have been determined to be appropriate for the unit. Patients are then closely monitored by medicine and psychiatry with dispositional reassessment every 24 hours. The unit itself is physically separate from the general Emergency Department. It is designed to foster a relaxing and calming environment. It includes an open milieu with murals of nature from the community. There is a quiet room for privacy as well as multiple materials, therapeutic aids for distraction. The unit follows a multidisciplinary staffing model, including a psychiatrist/psychologist, RNs (including one psych RN), a licensed social worker, a peer support specialist, and other assistants/techs.

The Geisinger EmPATH unit also employs a unique nonlinear clinical model to accommodate complex needs, crisis situations, and symptom presentations. This model consists of 3 main principles:

Safety

- Identify target symptoms and triggers
- Conduct risk assessments
- Establish physical and psychological safety in the EmPATH unit

Emotional Regulation

- Implement interventions to modulate affect
- Use cognitive behavioral strategies focused on relaxation and problem-solving

Social Engagement Module

- Identify social supports (e.g., home, work, school)
- Facilitate communication with support systems
- Assist in transitioning to home or a higher level of care
- Social enrichment and other supplemental activities

Overall, the Geisinger Medical Center EmPATH unit aims to provide timely acute psychiatric care while alleviating pressure on the Emergency Department.

Objective

Research on subjective patient experiences in EmPATH units, particularly in rural settings, remains limited. This study aims to assess changes in distress levels in patients with psychiatric complaints from admission to discharge at the Geisinger Medical Center EmPATH unit using statistical analysis.

Additionally, it will evaluate patient comparisons of care at the EmPATH unit versus the Emergency Department/general hospital in 2 key domains: perceived safety and calmness, measured on a 1–10 rating scale, along with qualitative patient experiences gathered through freehand text responses.

Methods

Design

This study employs a mixed-methods approach, integrating quantitative (survey scores and ratings) and qualitative (subjective experiences) data obtained before patient disposition. It is a survey-based observational study conducted at the Geisinger Medical Center EmPATH unit over a 4-month period. In total, 41 surveys were conducted.

Participants

All patients arriving at the EmPATH unit for acute psychiatric care from the Emergency Department are included. Of note, participation in the study survey is voluntary. While there are no study-specific exclusion criteria, admission to the EmPATH unit is restricted to adult patients and does not accept patients with severe medical instability or violent behavior. Recruitment follows consecutive sampling, with EmPATH staff enrolling and obtaining consent from patients.

Ethical Considerations

Nursing staff secured consent before administering anonymous deidentified surveys. Given the vulnerability of the population, participation was voluntary, and patients could decline at any time. IRB exemption was obtained.

Data Collection Procedure

Survey data was collected on a physical copy using a standardized questionnaire upon the patient leaving the EmPATH unit, including:

- Retrospective reported distress score at arrival
- Reported distress score at disposition
- Perceived safety compared to the Emergency Department/hospital
- Perceived calmness compared to the Emergency Department/hospital
- Open-ended response to the following question: “How would you describe the environment and care provided in the EmPATH area of the ED?”

After the surveys were complete, the responses were recorded electronically, and the physical copies were disposed.

Variables and Outcomes

Our study’s variables include perceived distress (at admission and disposition), perceived safety, perceived calmness, and subjective experience. Distress scores refer to patient’s self-reported feeling of distress in the EmPATH unit measured on a 1–10 scale, with 1 indicating less distress, and 10 indicating more distress. Perceived safety refers to patients' self-reported sense of safety in the EmPATH unit compared to the Emergency Department or hospital, measured on a 1–10 scale, with 1 indicating less safe and 10 indicating more safe. Perceived calmness is the patients’ self-reported level of calmness in the EmPATH unit compared to the Emergency Department or hospital, also measured on a 1–10 scale, with 1 indicating less calm and 10 indicating more calm. Subjective experience consists of open-ended responses analyzed using qualitative thematic analysis. Meanwhile, the outcome measured by this study includes the change in reported patient distress from admission to disposition from the EmPATH unit.

Statistical Analysis

Descriptive statistics were used to analyze perceived safety and calmness by identifying average scores across all participants over the study duration. Inferential statistics, specifically a two-tailed paired t-test, was used to assess the change in reported patient distress, determining whether there was a statistically significant change in distress at the EmPATH unit.

Thematic Analysis

Open-ended responses to the survey question “How would you describe the environment and care provided in the EmPATH area of the ED?” were analyzed using thematic analysis to identify recurring themes and patterns in participant responses.

Results

A total of 41 participants provided paired responses for distress scores (Table 1). The retrospective reported distress score at arrival had a mean of 7.55 with a standard deviation of 2.26. The reported distress score at disposition had a mean of 3.63 with a standard deviation of 2.35. The mean change in

reported distress score was –3.91 with a standard deviation of 2.12. The 95% confidence interval for the mean change was –4.58 to –3.25. A two-tailed paired t-test yielded a p-value of 1.78×10^{-14} .

A total of 37 participants provided responses for reported perceived safety, and 36 participants provided responses for reported perceived calmness (Table 2). The reported safety score had a mean of 9.18 with a standard deviation of 1.26. The reported calmness score had a mean of 8.60 with a standard deviation of 2.02.

Thematic analysis was conducted on 35 free-text responses (Table 3). Four major themes were identified: therapeutic environment, feeling heard and cared for, space for reflection, and constructive feedback. Thematic analysis identified 4 major themes of the patient experience at the EmPATH unit (Figure 1). A total of 15 responses referenced the therapeutic environment, followed by 14 responses indicating feeling heard and cared for. Space for reflection was mentioned in 6 responses, and constructive feedback was noted in 4 responses.

	Average	Standard deviation	Number of responses
Retrospective Reported Distress Score at Arrival	7.55	2.26	41
Reported Distress Score at Disposition	3.63	2.35	41
Change in Reported Distress Score	-3.91	2.12	41
P-value (alpha = 0.05)	1.78E-14		
95% Confidence Interval	(-4.58, -3.25)		

Table 1. Reported Distress Scores and Two-Tailed Paired T-Test Results

	Average	Standard deviation	Number of responses
Reported Safety	9.18	1.26	37
Reported Calmness	8.60	2.02	36

Table 2. Reported Perceived Safety and Calmness

Discussion

Our results indicate a statistically significant decrease in subjective patient distress scores. Furthermore, participants in the EmPATH unit reported subjective feelings of increased safety and calmness compared to their experience in the Emergency Department or general hospital setting. Thematic analysis of free-text responses revealed additional insights, with participants noting a therapeutic environment, feeling heard and cared for, and identifying the unit as a space for reflection. The analysis also uncovered constructive feedback that could be used to improve the EmPATH unit.

While our survey results show a highly statistically significant decrease in stress levels, it is important to recognize that statistical significance does not always imply clinical significance. Many outcomes may be statistically significant yet lack clinical relevance from a practical standpoint (18). From a clinical perspective, the average reported distress score at admission was 7.55, and at discharge, it was 3.63, on a scale from 1 (least distress) to 10 (most distress). These values reflect a meaningful shift: participants initially reported distress in the upper range of the scale, which dropped to the lower range by discharge. This notable change supports the argument that the statistically significant drop is also clinically significant.

Additionally, participants' reported increases in perceived safety and calmness compared to the ED/hospital further support clinical relevance, particularly when considered alongside the themes of therapeutic environment and feeling heard and cared for. This aligns with previous studies demonstrating that calming environments can reduce restraint use in other EmPATH units (19, 20). It is not surprising that the peaceful and therapeutic setting of the EmPATH unit resulted in positive subjective experiences.

Literature has shown that environmental noise can elevate cortisol levels, disrupt sleep, increase the need for analgesia and sedation, and alter circadian rhythms (21). In our study, participants reported feeling calmer, sleeping better, and experiencing "space for reflection." One participant noted that the unit offered reassurance and time to reflect without the fear of immediate psychiatric admission. This is important, as prior research suggests that inpatient psychiatric hospitalization can sometimes induce fear or be perceived as traumatic (22). Our findings suggest that the EmPATH unit may function as a safe

<p>Therapeutic Environment Key Words: Calm, Quiet, Peaceful, Heavenly, Safety, Comfort, Soothing, Relaxing Survey responses consistently described a therapeutic environment that provided physical and emotional safety and comfort. This space helped promote relaxation and rest.</p>	<p>"Very calming, quiet, laid back." "Peaceful, soothing, calming." "It is quiet and calm, nice." "Made me feel safe and comforted." "I like the quiet so I could be in my own thoughts, good ones and bad ones." "Calm, more welcoming than traditional ED."</p>
<p>Feeling Heard and Cared for Key words: Caring, Helpful, Kind, Professional, Respectful, Understanding Survey responses highlighted the EmPATH unit staff and their professionalism and empathy. Feeling heard and cared for contributed to participant's wellbeing.</p>	<p>"The caretakers were understanding, kind." "Therapists, nurses, aides, and doctors are all professional and caring towards my anxieties and other problems." "I feel like the staff was very caring and listened to my needs." "Very kind and compassionate. I was treated with dignity."</p>
<p>Space for Reflection Key Words: Time to Reflect, Time to Think, Time to Unravel Some survey responses noted the importance of having dedicated and ample amount of time to reflect, suggesting that the EmPATH unit supported self-awareness, growth, and contemplation.</p>	<p>"I felt I could unravel here and sleep better." "Gave me time to think and I know I have to make changes." "Quiet and a lot of time to think and reflect on life." "Gave me time to wind down and think without the fear of being admitted right away."</p>
<p>Constructive Feedback Some survey responses provided thoughtful feedback on areas that the EmPATH unit could be improved.</p>	<p>"Great idea! Needs kinks worked out – more organized plan." "Some people were more helpful and talkative than others but were nice." "The chair are not comfortable to sleep on though." "The nurse and staff was nice. I felt trapped inside but that's normal."</p>

Table 3. Thematic Analysis: Conducted on 35 free-text responses.

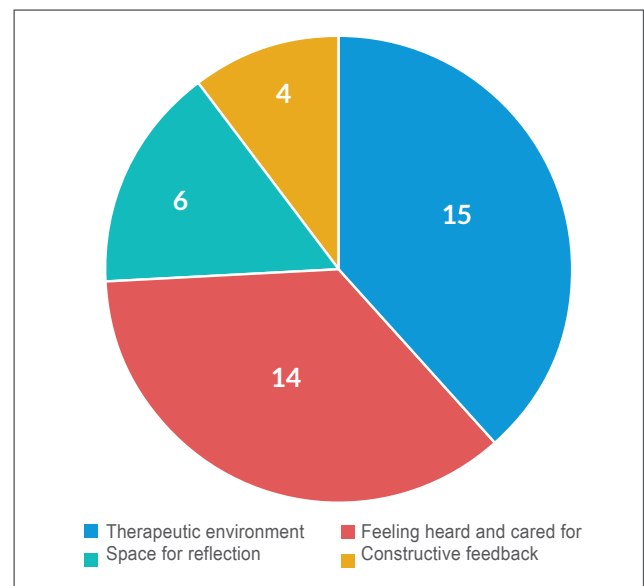


Figure 1. Distribution of Themes

and supportive alternative to inpatient hospitalization, providing patients with a temporary refuge to regroup and reflect.

The Geisinger EmPATH model focuses on 3 domains: safety, emotional regulation, and social engagement. Our results indicate that the unit is effective in promoting safety (both physical and psychological) and emotional regulation, as demonstrated by participant reports of having time to reflect, think, and consider changes. However, our study did not produce adequate data to evaluate the social engagement component of the EmPATH model.

Participants also offered constructive feedback. While the EmPATH unit follows a structured clinical model, its flexibility allows for varied applications depending on the patient and provider. As a result, some participants felt the structure was insufficient for their needs. Another commonly reported challenge was difficulty sleeping in the unit. EmPATH units do not include beds, only chairs that can be converted into a flat position. This limitation, due to space constraints, is not easily remedied. Some patients even returned to the ED to sleep in a bed before rejoining the EmPATH unit the next day. While this workaround is not ideal, it reflects the current physical limitations of the unit. Nevertheless, constructive feedback remains critical in guiding future improvements and enhancing the unit's overall effectiveness.

In our surveys, the term “distress” was intentionally chosen for its ability to broadly capture the emotional and psychological states of patients presenting with a wide range of psychiatric symptoms. Unlike narrower terms like anxiety or depression, “distress” encompasses diverse experiences and symptom clusters. Similarly, “safety” and “calmness” were selected for their inclusive, accessible nature. These familiar terms also helped keep the survey brief and easy to complete, minimizing burden on patients and staff and allowing smoother integration into the discharge process.

However, this choice presents a limitation. Patients may interpret terms like “distress,” “safety,” or “calmness” differently depending on their psychiatric presentation, for instance, a suicidal patient versus one experiencing mania. As such, the study reflects broad, subjective experiences rather than condition-specific insights. Additionally, the anonymous nature of the survey and lack of identifiers like MRNs or

diagnoses prevent linking results to specific psychiatric emergencies.

Survey data were collected at a single point, during patient disposition, to preserve anonymity. Collecting data at both arrival and discharge would have required identifiers on the physical surveys, compromising anonymity. This presents a limitation, as the initial distress score was reported retrospectively rather than at the actual time of admission. Additionally, the study did not account for length of stay, though most patients remained in the EmPATH unit for under 24 hours.

The survey was completed on a voluntary basis, which introduces the possibility of voluntary response bias. Patients who had more positive experiences may have been more likely to complete the survey, potentially leading to skewed results and an underrepresentation of neutral or moderate experiences.

Finally, it is important to acknowledge the limitations related to sample size. The Geisinger Medical Center (GMC) EmPATH unit is relatively new, and the GMC ED serves a predominantly rural population. As such, during the 4-month study period, the number of participants was limited. Consequently, the results are less generalizable to broader populations and may be more reflective of the local rural community in and around Danville, Pennsylvania.

Future studies should aim to include a larger and more diverse sample size to improve generalizability. They should also consider categorizing patients' subjective experiences by specific psychiatric conditions and exploring the use of more precise terminology in survey design. Additionally, incorporating standardized assessment tools, such as the Columbia Suicide Severity Rating Scale, could provide more objective measures of patient responses and enhance the rigor of evaluating the EmPATH unit model. Furthermore, as social engagement is a core domain of the EmPATH model, future research should also examine how structured social engagement impacts patient outcomes and experience, potentially through dedicated survey questions or structured observational measures.

Conclusion

In conclusion, we found that the GMC EmPATH unit significantly reduced patient-reported distress scores over the course of their stay at the unit. Patients

also reported a greater perceived sense of safety and calmness in the EmPATH unit compared to the traditional Emergency Department or general hospital setting. Additionally, thematic analysis of open-ended text responses revealed positive key themes reflecting patients' experiences at the GMC EmPATH unit.

These findings have important clinical relevance. Clinicians strive to minimize harm, yet treating psychiatric emergencies can be particularly challenging in this regard. Involuntary commitment or traditional ED environments can be distressing or even traumatic for patients in crisis. Our findings suggest that EmPATH units may offer a more therapeutic, non-traumatizing alternative for patients presenting to the ED with psychiatric emergencies. By prioritizing safety, calmness, and emotional well-being, the EmPATH model may represent a more patient-centered approach to crisis care.

Disclosures

The authors have no conflicts of interest to declare.

Acknowledgments

We would like to acknowledge the assistance from the GMC Behavioral Health Team

References

1. Weiss AJ, Wier LM, Stocks C, Blanchard J. Characteristics and trends of emergency department visits in the United States (2010–2014). Healthcare Cost and Utilization Project (HCUP) Statistical Briefs. Available from: <https://www.sciencedirect.com>
2. Larkin GL, Claassen CA, Emond JA, Pelletier AJ, Camargo CA Jr. National trends in emergency department visits by adults with mental health disorders. *Psychiatric Services*. 2005;56(6):671–677.
3. Nordstrom K, Berlin JS, Nash SS, Shah SB, Schmelzer NA, Worley LL. Patient perspectives of emergency mental health care in a rural state. *Western Journal of Emergency Medicine*. 2019;20(5):690–695.
4. Nicks BA, Manthey DM. Increasing emergency department visits for mental health conditions in the United States. *Emergency Medicine International*. 2012;2012: Article ID 360308.
5. Gamm LD, Stone S, Pittman S. Mental health and mental disorders—a rural challenge: A literature review. *Journal of Rural Health*. 2010;26(2):115–124.
6. Hoffmann JA, Hall M, Lorenz D, Berry JG. Emergency department visits for suicidal ideation and self-harm in rural and urban youths. *The Journal of Pediatrics*. 2021; 238:282–289.e1.
7. Zeller SL, Calma NM, Stone A. Boarding of mentally ill patients in emergency departments: American Psychiatric Association resource document. *Western Journal of Emergency Medicine*. 2014;15(1):1–6.
8. Zeller SL. "Boarding" psychiatric patients in emergency rooms: One court says "no more." *Primary Psychiatry*. 2013;15(8):60–64.
9. Nicks BA, Manthey DM. The impact of psychiatric patient boarding in emergency departments. *Emergency Medicine International*. 2012;2012: Article ID 360308.
10. Moskop JC, Sklar DP, Geiderman JM, Schears RM, Bookman KJ. Overcrowding in the emergency department: Causes, consequences, and solutions—a narrative review. *Journal of Emergency Medicine*. 2009;42(1):124–132.
11. Basner M, Babisch W, Davis A, Brink M, Clark C, Janssen S, Stansfeld S. Emergency department noise: Mental activation or mental stress? *Emergency Medicine Journal*. 2014;31(6):435–440.
12. Woods HC, Skoog V, Salo M. Short-stay crisis units for mental health patients on crisis care pathways: Systematic review and meta-analysis. *Journal of Psychiatric Research*. 2016; 81:1–9.
13. MacKenzie A, Bilbrey C, Mullennix S. Comparison of emergency department 14-day recidivism rates in emergency behavioral health patients: EmPath versus standard ED care. *Western Journal of Emergency Medicine: Integrating Emergency Care with Population Health*. 2023;24(2.1). Available from: <https://escholarship.org/content/qt6zs8z6fz/qt6zs8z6fz.pdf>
14. Zeller SL, Calma NM, Stone A. Emergency psychiatric assessment, treatment, and healing (EmPATH) unit: A novel model of emergency psychiatric care. *Academic Emergency Medicine*. 2018;25(4):399–406.

15. Zeller SL, Orrock T. Update on EmPATH: Expanding an effective ED boarding solution. *Military Medicine*. 2022.
16. Jeunesse DG, McElroy ML, Salmond LL, Taylor DA. Review of EmPATH units for behavioral health casualties in prolonged field care environments. *Military Medicine*. 2025;190(3-4):e510–e514.
17. Thomas S. My why and the EmPATH model [PowerPoint presentation]. Vituity Emergency Medicine, Mercy San Juan Medical Center.
18. Sharma H. Statistical significance or clinical significance? A researcher's dilemma for appropriate interpretation of research results. *Saudi Journal of Anaesthesia*. 2021;15(4):431–434.
19. Helmsley Charitable Trust. Helmsley Charitable Trust awards \$784,000 to Billings Clinic psychiatric stabilization unit. 2020. Available from: <https://helmsleytrust.org>
20. Zeller S, Orrock T. Update on EmPATH: Expanding an effective ED boarding solution [PowerPoint presentation]. Behavioral Health Care Symposium Riverside, California Hospital Association.
21. Pal J, Taywade M, Pal R, Sethi D. Noise pollution in intensive care unit: A hidden enemy affecting the physical and mental health of patients and caregivers. *Noise and Health*. 2022;24(114):130–136.
22. Jina-Pettersen N. Fear, neglect, coercion, and dehumanization: Is inpatient psychiatric trauma contributing to a public health crisis? *Journal of Patient Experience*. 2022; 9:23743735221079138.