



# Best Practices in Emergency Mental Health Care

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# LEARNING OBJECTIVES

## **Best Practices in Emergency Mental Health Assessment**

- Approaches to rapid and thorough behavioral health evaluation in the ED
- Risk assessment for suicide, violence, and patient safety
- Trauma-informed and patient-centered communication strategies
- Collaboration with psychiatry, social work, and crisis teams

## **Managing Acute Behavioral Health Emergencies**

- De-escalation techniques and maintaining a safe care environment
- Appropriate use of medications and restraint alternatives
- Addressing substance use and co-occurring psychiatric conditions

## **Prolonged ED Stays and Psychiatric Boarding**

- Operational challenges associated with extended ED stays
- Strategies to support patient dignity, safety, and therapeutic engagement during boarding
- Workflow approaches that reduce strain on ED staff and resources

## **System-Level Solutions and Innovations**

- Partnerships with community mental health resources and crisis services
- Telepsychiatry and alternative care pathways
- Advocacy opportunities to address psychiatric capacity and access issues

# LEARNING OBJECTIVE S

- List reasons for boarding of psychiatric patients in the ED
- Identify ways to enhance behavioral health care for patients during boarding
- Provide perspectives on development of new models of collaborative behavioral health care in emergency departments

# Mayo Clinic ED in Rochester, MN South Pod



# South Pod patient rooms (4)



# Mayo Clinic ED in Rochester, MN North Pod



# North Pod patient rooms (9)



Figure 6. Conceptual model of ED boarding of patients with psychiatric diagnoses (EDBPPD)

### Inflow Factors

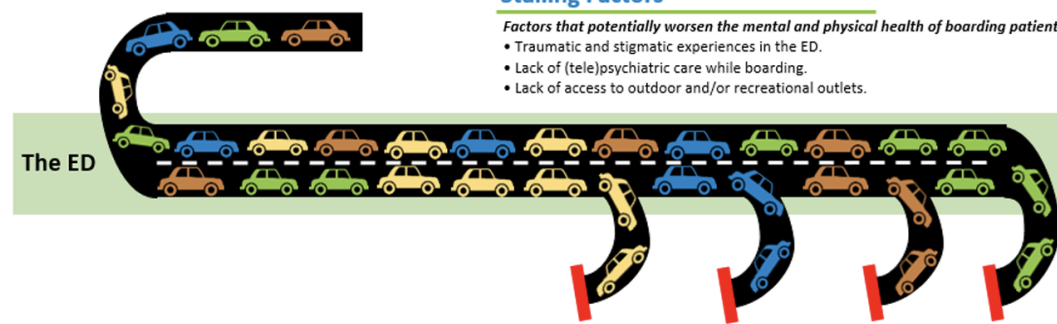
*Factors that lead to high ED utilization by patients in mental health crises.*

- Underlying prevalence of mental illness.
- Lack of patient access to preventative, outpatient mental health services.
- Protocol of conventional dispatch and emergency services during mental health crises.
- Lack of lay familiarity with mental health crisis resources.

### Stalling Factors

*Factors that potentially worsen the mental and physical health of boarding patients.*

- Traumatic and stigmatic experiences in the ED.
- Lack of (tele)psychiatric care while boarding.
- Lack of access to outdoor and/or recreational outlets.



### Outflow Factors

*Reasons why mental health patients get stuck boarding in EDs.*

- Shortages of psychiatric hospital beds for adults, children.
- Shortages of chemical dependency beds for adults, children.
- Shortages of residential (treatment) beds for adults, children.
- Distance of available beds from home, family, and community.
- Residential treatment admission criteria that preclude admission of people with a history of violence or violent criminal convictions.
- Inability of corporate foster care to welcome patients back.

Reasons for  
Psychiatric  
Boarding –  
The Jammed  
Freeway

# Reasons for Psychiatric Boarding

- Limited inpatient beds
- Infection control issues
- Legal issues
  - Commitments
  - Guardianships
  - In custody
- Workforce shortages
- Medical clearance
- Discharge barriers
  - Social issues
  - Patient complexity (intellectual disability, violence/aggression, criminal histories)
- Lack of alternative treatments
  - Intensive outpatient
  - CD Treatment
  - Crisis stabilization

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# Clinical Policy: Critical Issues in the Evaluation and Management of Adult Out-of-Hospital or Emergency Department Patients Presenting With Severe Agitation

*Approved by the ACEP Board of Directors, October 6, 2023*



## Summary

For patients with acute agitation in the ED, a combination of droperidol and midazolam is preferred given the improved time to sedation and side effect profile. If a single agent must be given, droperidol is preferred. If droperidol is not available, use an atypical antipsychotic. In cases where safety calls for the use of ketamine, it must be done in a setting where staff can institute immediate hemodynamic monitoring and advanced airway management when needed.

With respect to special populations, we were unable to make specific recommendations for sedating agents in older patients (more than the age of 65 years) because there was a lack of studies that looked specifically at this patient population. Out-of-hospital studies were included in our literature search; however, none of these studies were determined to be methodologically adequate to inform a specific recommendation, regardless of the agent(s) studied.

From the American College of Emergency Physicians Clinical Policies Subcommittee (Writing Committee) on Agitation:

Molly E. W. Thiessen, MD (Subcommittee Chair)

Steven A. Godwin, MD

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DECEMBER 1, 2023 - 15 MIN

**ACEP Clinical Policy: Sedation of the Agitated Patient**

FOAMcast - An Emergency Medicine Podcast

▶ Play



This episode reviews the new [clinical policy](#) from the American College of Emergency Physicians (ACEP) on medication for acutely agitated patients needing parenteral sedation.

Show notes / references: [FOAMcast.org](https://foamcast.org)

Thanks for listening! Lauren Westafer

# Safer Spaces Drill

- Two “in situ” drills with multidisciplinary staff



## Dignified Gowning for Safety

SaferSpaces In-Situ ED Drill Sheet | Drill Steward Use Only

Developed by Patient & Visitor Conduct in partnership with ED Staff in Rochester

### SCENARIO OVERVIEW

Alex (32) arrives to the ED for mental health evaluation. Alert but distressed, Alex paces, scans the room, grips sweatshirt cuffs, and startles when staff approach. The nurse calmly explains that changing into facility safety scrubs/sweats reduces risk, supports safe care, and is required.

### OBJECTIVE

- Approach with empathy, sensitivity, and privacy.
- Explain purpose, process, and role.
- Offer choices to preserve patient control and dignity.
- Allow appropriate time for the patient to process and recognize when alternatives are necessary.
- Set respectful boundaries and maintain safety.

### INSTRUCTIONS/START

Practice begins with Alex expressing concerns, refusing to change:

- “No. I don’t want to put that on. Why do I have to? None of those other people out there are changing.”

### Engage Empathy:

Promote privacy and acknowledge discomfort—empathy and respect.

- “Alex, I hear you. It makes sense you’d want to stay in your own clothes—they feel familiar. This may feel unfair, and changing can be really uncomfortable or bring up past experiences. A lot has happened, and now strangers are asking you to change.”

### Clarify Role and Limits:

Set expectations, don’t debate fairness.

- “Different patients may have different safety plans. What I can do is explain your plan and help you through it as respectfully as possible.”
- “First we’ll get you seen by the medical team. Your safety is our priority—part of that is changing into safety clothing to help keep you and others safe while we care for you. We’re in this together, and I’ll help you through it.”

### Offer Rationale and Narrate Cares:

- “Changing helps us keep you safe. I’ll remain nearby for safety and support, and to check for any injuries—while respecting your privacy.”
- “I do need to maintain line of sight, but I can limit the number of people, turn away, and use a blanket as a privacy shield. Once you’re changed, we can provide more privacy.”
- Use patient-facing materials and expectations if helpful.

### Honor Choice Where Able:

- “I need to stay close enough to visually check your skin for safety reasons. To help with comfort, you’re welcome to change one piece of clothing at a time. Let me know what feels most comfortable for you.”
- Accommodate patient requests for specific staff attributes (e.g., gender) when clinically appropriate, trauma-informed, and policy-aligned.
- Staff and leadership assess safety and benefit and decline requests that are sexualized, coercive, or unsafe.

### Set Boundaries:

When trust is low, validate, state your intent, and name the safety requirement.

- “It makes sense that you feel unsure. My role here is your safety and dignity.”
- “Changing into safety attire is required for this level of monitoring, and I’ll help you through it respectfully.”

### Offer Options and Next Steps:

- “I want to work with you in a way that is comfortable for you. You can choose how we do this, even though it’s required.”
- “We can take a pause, change here with privacy, invite another staff member, or talk through what would help. What feels best?”

### Also Consider:

- Affirm patient participation and thank them for cooperating with safety gowning to reinforce dignity.
- Safety protocols remain the expectation; however, some patients may refuse for an extended period.
- If a patient refuses gowning or exhibits disruptive behavior, staff should consider engaging the BERT team for support (Rochester; limited availability at other sites)
- Call Security immediately for any threats, attempts to harm self/others, or physically aggressive escalation.

### END / DEBRIEF

1. What if the patient refuses to change due to past trauma or PTSD?
2. How does physician support help promote gowning for safety?

# Emergency Psychiatry Assessment, Treatment, and Healing (EmPATH) Model

- Therapeutic ED treatment environment
- Trained personnel able to rapidly evaluate patients
- Treatment started immediately
  - Medications
  - Psychotherapy
- Adequate time to address crisis (up to 23 hours)





# Space-Invariant Elements of EmPATH

- Collaborative approach to evaluation and treatment with nursing, social work, and prescribers
- Adequate staff training to detect and manage behavioral escalations
- Rapid initiation of treatment for underlying conditions

# Fairview Mental Health and Addiction Services

## Fairview EmPATH

In 2021, M Health Fairview pioneered a new model of emergency mental health care in Minnesota called Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH).

Unlike traditional emergency mental health care, EmPATH creates a calming, choice-based environment where healing can begin the moment someone arrives. The unit is intentionally designed to feel less like a hospital and more like a restorative community space. Recliners, games, soothing music, sensory rooms, weighted blankets, and freedom to move make it a place where people can choose how they want to engage.

No phones or guests are allowed—an intentional decision to create a distraction-free space focused solely on well-being. The average stay is 26 to 33 hours, which gives people time to feel calmer and make a plan for continued care.

## RESULTS!

- Hospitalizations reduced from 30-40% to 6%, as care teams stabilize patients and help avoid unnecessary inpatient stays.
- Repeat emergency visits for mental health crises after leaving EmPATH fell to 17% in 2025.

# Fairview Mental Health and Addiction Services, cont.

## Reducing barrier post discharge

This model reflects our broader commitment to expanding access to whole-person, compassionate care. As the largest provider of mental health care in the Upper Midwest, M Health Fairview continues to advance solutions, including same-day access to behavioral health services, to better meet the needs of our communities.

That commitment is taking shape across our system. Over the past 18 months, we've expanded access by opening new mental health programs for adolescents and adults in six locations, with two additional in Edina, this growth has strengthened a comprehensive hub for mental health services. Two new adult programs opened in 2024, adding to the already robust set of treatment options. After receiving care at EmPATH, patients can be admitted directly to the Partial Hospitalization Program or Intensive Outpatient Program, or substance use treatment, reducing gaps in care between emergency and follow-up care.

# Fairview Mental Health and Addiction Services, cont.



How a mental health unit at Edina hospital has helped thousands of people



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410K subscribers



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