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

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Photographs by Brian Ulrich for The New Yorker

When Kim Mitlyng was in college, one of her family members began to experience a mental-health crisis that lasted for years. Whenever Mitlyng's phone rang, she feared that she was about to learn that her loved one had died by suicide. She and her family sought help, but they were overwhelmed by the fragmented and disorganized mental-health-care system. "I felt like we were set up for failure," she told me. "People would just throw a bunch of numbers at us and say, 'Call these and find out what your insurance covers.' " Mitlyng decided to study psychology and, after graduation, trained as a family and marriage counsellor. But she found herself drawn to psychiatric emergencies. "There's something about being with people in the darkest time," Mitlyng said. "Being able to hold that space and give them just a glimmer of hope."

In 2014, Mitlyng took a job as a therapist at an emergency department in the Twin Cities. During Minnesota's icy, gray winters, she would brace herself against the morning cold, hustle through the chaos of the emergency department, and swipe into the "mental-health suite," a locked unit with five spartan rooms, each designed for a single patient. She often found fifteen patients in and around the suite, all of them in urgent need of care. Mitlyng usually had only fifteen minutes with each patient, to conduct a rapid crisis assessment. Then she would decide who could safely leave and who needed to stay. "It was just churning through one patient after another," she said. Some patients ended up boarding in the emergency department for days until a bed opened up at a psychiatric facility. They were generally required to stay inside their rooms, without their belongings and with little to do except stare at a television behind plexiglass. If they had to use the bathroom or wanted food, water, or a pillow, they had to ask a nurse. "They were completely stripped of autonomy," Mitlyng said. "Many patients said it felt like a jail."

One afternoon, Mitlyng was in the mental-health suite when a woman grabbed her by the hair and flung her to the ground. The woman climbed on top of her and struck her before a throng of hospital staff and security guards descended. "I think all of us who worked that job were assaulted or nearly assaulted at some point," Mitlyng told me. It wasn't unusual for a patient's symptoms to escalate during their stay; staff grew accustomed to patients slamming doors, throwing food, and making threats. Mitlyng wondered if she was just shifting unwanted people from place to place. "Everyone was doing the best they could under the circumstances," Mitlyng told me. "I was doing the best I could. But, I thought, It's time to try something new." In the spring of

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2021, she decided to change jobs.

It's hard to imagine a less therapeutic environment for a person in crisis than an emergency department: crowded and windowless rooms; harsh fluorescent lights; the ceaseless ping of alarms; this patient retching, that one screaming. And yet, for every eight patients who present at an emergency department, one is there for a behavioral crisis such as psychosis, suicidality, mania, aggression, or substance use. Often these conditions have a years-long history and can't be treated quickly or straightforwardly, in the way that a broken bone or a knife wound might be. In some cases, showing up at an E.R. can make things worse; patients who pose a danger to themselves or others may be sedated or kept in isolation, even tethered to bedside rails so that they cannot move. When I worked in an emergency department, I often despaired for my own mental health. I would rush from a patient with crushing chest pressure to one with a fractured foot, neglecting those who were in less visible kinds of pain. After my shift, the memory of patients I had never got to—people who had asked for a sandwich or a blanket or a conversation—would gnaw at me. I wanted to give them more time, to show them more empathy, but the circumstances seemed to make it impossible.

Kim Mitlyng, a clinical supervisor at an EmPATH unit in Minnesota.

A sensory room.

In May, I travelled to a suburb of Minneapolis in search of a different approach to mental-health crises. Around 8 A.M., Mitlyng, who has shoulder-length brown hair and a warm smile, met me in the lobby of her new workplace, M Health Fairview Southdale Hospital, which is a ten-minute

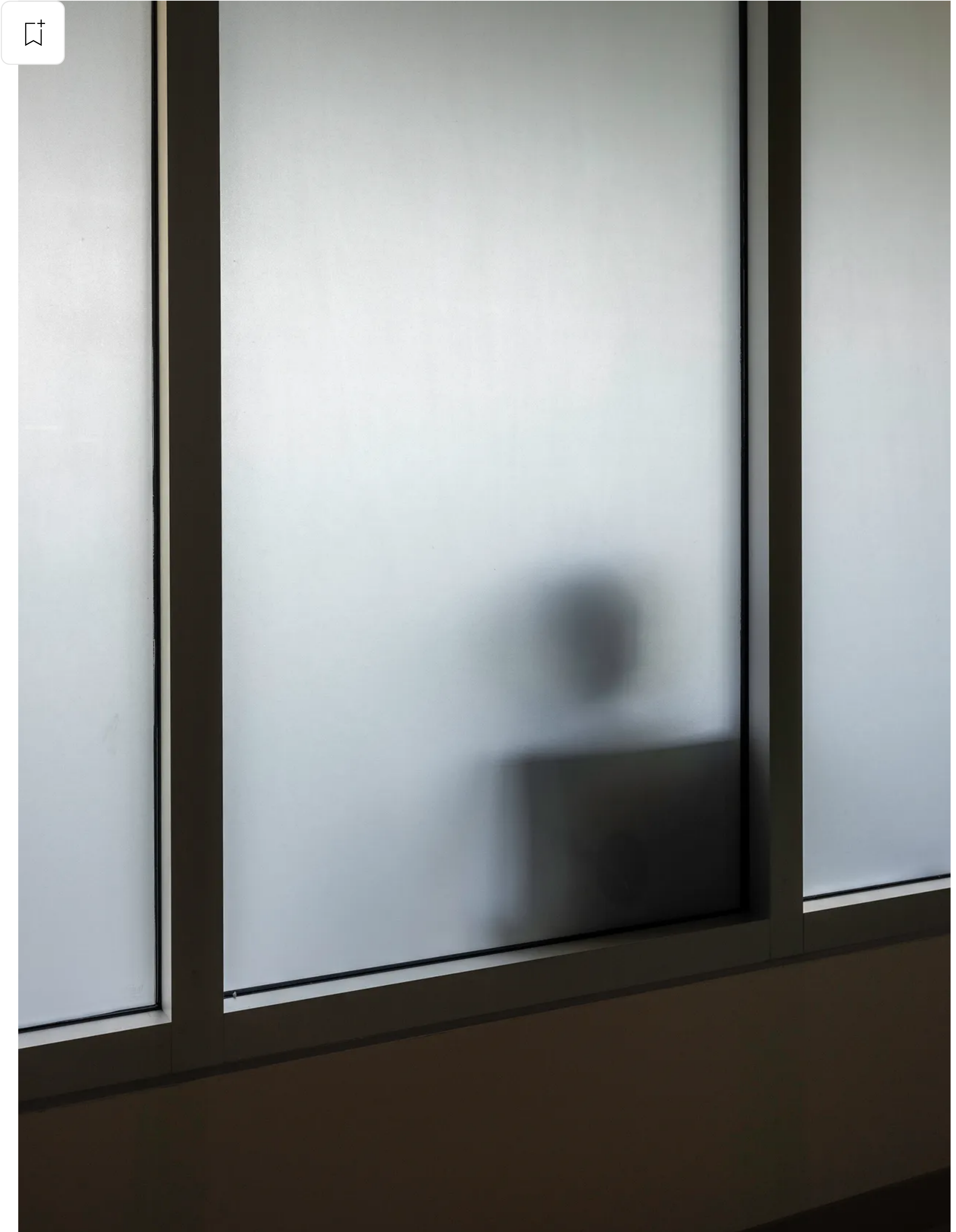
drive from the Mall of America and houses three hundred and ninety beds in a cream-colored complex. Mitlyng led me through the emergency department, which, even at that hour, had a frenzied energy. A stretcher rolled past; monitors flashed vital signs and heart rhythms. A patient moaned, and a nurse called for help. Then we walked down a long hallway to the area where Mitlyng now treats psychiatric emergencies, as a clinical supervisor.

On the other side of a door was a spacious, mellow room that reminded me of an airport's business-class lounge. Floor-to-ceiling windows, which were partially frosted to protect patient privacy, let in the morning sun; an arc of blue light lit up the ceiling. Murals of tree branches, green leaves, and blue skies decorated the walls. A dozen or so patients rested on flatbed recliners. The unit's nurses sat behind a curved wooden desk.

A middle-aged woman in a red T-shirt walked up. "I wanted to tell you about something," she said to one of the nurses. "Of course," the nurse replied. "I'll be over in a minute." The woman shuffled away, pausing at another patient's recliner before plopping into her own. Their exchange was the kind of ordinary human interaction that would seem unusual only in a hospital, where patients often have to fight for attention.

Mitlyng led me to one of the unit's four "sensory rooms." A rocking chair stood next to a beanbag and a yoga mat. "Patients can go in there and listen to music, and change the color and intensity of the lighting," Mitlyng told me. "Just kind of chill out, you know?" Outside, a man helped himself to tea, pudding, and a hard-boiled egg from a snack bar. A warming cabinet offered fresh blankets, and around the corner stood an exercise bike. "When someone's really manic, it helps to externalize that nervous energy," a nurse explained. "We have a shower, too." On a nearby bookshelf, titles on yoga, wellness, and philosophy sat next to Scrabble, Uno, and a "Star Wars" jigsaw puzzle.

The mental-health unit where Mitlyng works is one of only a few dozen EmPATH units, short for Emergency Psychiatry Assessment, Treatment, and Healing. Such units, which were invented about a decade ago, vary in size, staffing, and design, but the core concept is that, instead of leaving patients to languish in an emergency room, caregivers offer them a calm communal environment where they can receive a comprehensive evaluation, start therapy, and, if needed, receive medication. Most patients stay for a day or two; the vast majority are discharged back home, instead of going on to a psychiatric facility. In its two years of existence, M Health Fairview's EmPATH unit has cared for five thousand people. I turned to survey the room: patients sat placidly near one another, blankets pulled to their chins, munching on chips and watching TV. I thought back to my own experiences in the chaos of emergency departments. Was this what an E.R. for mental illness should look like?



Frosted privacy glass surrounds the mental-health unit.

Until the nineteen-sixties, American hospitals did not have emergency departments as we think of them today. Physicians made house calls to provide urgent care, and, in hospitals, nurses and medical trainees staffed "accident rooms" where they treated physical traumas that resulted from falls, fights, car crashes, and other mishaps. If a senior doctor was required, one had to be summoned from elsewhere. Meanwhile, most ambulance services were operated by morticians, because hearses were roomy enough for people to lie flat. In 1961, however, James Mills, a general practitioner in Virginia, persuaded three fellow-physicians to join him in running a twenty-four-hour emergency room at Alexandria Hospital, where he'd recently been elected medical-staff president; when things got really busy, military doctors from a local Army base would help out. The new model insured that acutely ill patients could receive timely care from experienced practitioners. Soon, hospitals in other states were piloting their own versions of what came to be known as the Alexandria Plan. But public demand for emergency services of all kinds continued to swell. A few years later, a National Academy of Sciences report called the U.S. "insensitive to the magnitude of the problem of accidental death and injury," noting that accidents had become the country's fourth leading cause of mortality. In the early seventies, Congress passed legislation to develop regional ambulance systems, and the American Medical Association recognized emergency medicine as a specialty of its own. It is now the fifth largest, based on the number of trainees who choose it.

Over the years, small emergency rooms have grown into comprehensive departments capable of treating a wide range of conditions and saving countless lives. Since the nineties, mortality in emergency departments has fallen by half. Their focus on things like accidents, infections, and heart problems, however, remains ill-suited for psychiatric crises. For more than a decade, mental-health and substance-use emergencies have been surging, especially among young people. Between 2007 and 2020, the share of emergency-department visits for mental-health reasons in the U.S. nearly doubled, and the pandemic has only worsened this trend.

Few emergency physicians are trained to provide mental-health treatment, and their workplaces are not physically designed for it. In a typical E.R., a person experiencing hallucinations, aggression, or psychosis might be evaluated by clinicians looking for a medical cause for his symptoms. Maybe he has an infection, an overactive thyroid, or a medication with psychoactive side effects. Only once these potential causes have been ruled out might the patient see a mental-health practitioner, if one is available. He might then be deemed safe for discharge—or, if doctors think he presents an immediate danger to himself or others, he might be forced to stay. Sometimes, he might wait for days, even weeks, until a bed opens up in a nearby psychiatric facility.

In 2012, Scott Zeller, who was then the head of psychiatric emergency services at the Alameda Health System, in Oakland, California, was growing frustrated with the status quo. Many observers blamed long wait times for psychiatric patients on a sharp decline in the number of psychiatric beds in public hospitals. Zeller thought they were missing a more fundamental point. "Why is mental illness the only emergency where the treatment plan is, Let's find them a bed somewhere?" Zeller asked. "If someone comes in with an asthma attack, we don't say, 'We've got a gurney here in the back for you. We're going to try to find you an asthma hospital in a day or two, so sit tight.' " For psychiatric patients, this transitional time was therapeutic dead space—a missed opportunity. Could it be transformed into a period of healing?

Zeller converted an unused hospital lobby into a large waiting room. He supplied the space with snacks and recliners and organized group activities. A nurse or therapist provided counselling, and a psychiatrist tried to see patients and prescribe medications within an hour. "People said, 'These patients will never be able to be in the same room together—they'll just rile each other up!' " Zeller told me. "Actually, no—not if you create an environment that's less like prison and more like a place of healing."

This approach came to be known as the Alameda Model. After it was implemented, the number of psychiatric patients who stayed overnight in the area's emergency departments fell almost to zero. In a traditional emergency department, as many as twenty per cent of patients experiencing a mental-health crisis might end up being restrained in some way; in Zeller's unit, the number was 0.1 per cent, a difference that he attributes to the calmer environment and specialized staff. The average wait time in the emergency department for people with acute mental-health conditions dropped from more than ten hours to less than two, and, because patients received immediate attention once they got to Zeller's unit, three-quarters were able to go home, where they tend to have better long-term outcomes, instead of being hospitalized. In 2016, Zeller renamed the model "EmPATH." He was advised to copyright the term, but decided not to, so other providers could more easily adopt it.

Soon, Zeller was fielding calls from hospitals around the country interested in creating their own EmPATH units. There are now dozens of them planned or in operation—in Pittsburgh and Sacramento, Lynchburg and Lexington, Billings and Bemidji. Each day, around the country, hundreds of patients in crisis are now quickly evaluated by emergency-department staff, then directed to one of these units for specialized psychiatric care.

Most patients stay for a day or two; the vast majority are discharged back home, instead of going on to a psychiatric facility.

The EMPATH unit at Fairview Southdale Hospital, where I met Mitlyng, is modest in size, with fifteen recliners, but it is still one of the largest in the country. It is led by Lewis Zeidner, a clinical psychologist who's worked in emergency psychiatry for more than four decades. A soft-spoken man with silver hair, a neat mustache, and clear-frame glasses, Zeidner told me that, before

the unit opened, nearly half of psychiatric patients at Fairview Southdale were hospitalized; now, only around one-tenth are. Most people are discharged home with a care plan and follow-up. "Psychiatric hospitalization carries its own kind of trauma, even when it's voluntary," he told me. "We try to avoid it whenever possible." He had told me that I could observe the unit if I agreed not to talk to patients, and if I promised to omit identifying details, to protect their privacy.

Around 9 A.M., the unit's staff gathered in a private workroom to discuss how each patient was doing. On one wall, "emergency ligature cut-down shears" dangled next to a red button, which would summon help if a patient tried to harm himself; another wall was covered with letters from former patients. "Looking forward to brighter days in recovery and you are part of it," one read. Kevan Andish, a serene psychiatrist whose waft of dark hair was graying at the temples, listened as a therapist told him about a patient who had stopped taking her mood-stabilizing drugs, convinced that they were abortion pills; her child's school had reported her erratic behavior. The team decided to keep her overnight for monitoring and treatment.

Another patient, a young man with depression, had been brought in by friends who were alarmed when he'd started talking about suicide. Ordinarily, school provided him with a sense of structure and community; it was now on break. During the course of a couple of days, the team had adjusted his medications and he'd improved. Today was his birthday, and he was asking the staff to let him go to a soccer game with his family.

Next, the therapist told Andish about a woman who was manic, and might benefit from another day of observation, but was determined to leave. I tried to imagine the frustrations of a patient who wasn't here by choice; for her, the relative comfort of the unit might not make much difference. "She told me that there are people like her walking around out there all day, every day," the therapist said. A gentle laughter filled the room.

"She's not wrong," someone said.

"Shows good insight," Mitlyng chimed in. After reviewing her chart, they decided that the woman was safe to discharge.

After the huddle, I wandered back into the unit. A young woman with ginger hair, looking despondent in burnt-orange scrubs provided by the hospital, slowly approached the nursing station and asked for a mask. A nurse smiled and handed her one. The woman, whom I'll call Emma, shuffled back to her recliner. (The EMPATH unit sometimes allows patients to wear their own clothes, but only after a search for potential dangers to themselves or others, like weapons, drugs,

belts, and shoelaces. Patients must give up their cell phones.)

Emma had come in two days before with spiralling anxiety, depression, and paranoia. She'd been eating less than usual, sleeping little, and hearing voices. Her partner had grown concerned and urged her to get help. She'd hardly spoken to anyone at the unit.

Mitlyng walked Emma to a private consultation room with soft lighting. Emma climbed onto a chair, pulled her knees to her chest, and stared at the floor.

"Sounds like yesterday was tough," Mitlyng said.

Emma wrung her hands. Finally, she said, "Yesterday was hard. I kept hearing names, voices."

"What were the voices telling you?" Mitlyng asked. "Did you recognize them?"

"They sounded like people I know," she said, barely audible. "But I couldn't tell who they were."

"Are you hearing something right now that maybe I wouldn't hear?" Mitlyng asked.

Emma fidgeted. For a long while, she didn't respond. Mitlyng put down her yellow notepad and placed a hand under her chin.

"I can't think right now," Emma said. "I'm scared."

"Have you been scared like this before?" Mitlyng asked. She paused and leaned in. "Have you had any thoughts of suicide?"

"I've thought about hanging myself or walking into traffic," Emma said, tears in her eyes. "But I'm scared about how it would feel."

"It's hard to talk about, isn't it?" Mitlyng said. "You're safe here. I promise." Emma removed her yellow mask and took a sip of water.

"Do you need a break?" Mitlyng asked. Emma nodded.

"What can we do for you today to make you more comfortable?" Mitlyng said.

For the first time, Emma looked up. Her partner had dropped off a letter for her and some clothes, she said. "Let's see if we can get them to you," Mitlyng said, standing up. "If you want to talk to me, just let your nurse know. I'm here to talk anytime."

Recently, I spoke with a woman named Allison, whose husband spent time in the Empath unit where Mitlyng works. Allison first heard of the unit because she works as a nurse at an affiliated hospital. Still, when her husband's depression suddenly worsened, a few months ago, "I had no idea how to get him help," she told me. She secured an appointment with a therapist, but it was five weeks away. "I knew we couldn't wait that long," she said. Eventually, she took him to the emergency department at Fairview Southdale Hospital; half an hour later, he was in the Empath unit. "I felt so sad leaving him," Allison told me. "The emergency room can be so traumatic, in and of itself, and now he's going to this psychiatric unit?" Within a few hours, though, a therapist called her to say that Empath staff had helped her husband to schedule two appointments for that same week: one with a therapist, and another with a nurse practitioner, who'd be able to prescribe him medication. He was starting to feel better; if they both felt ready, he could come home. "More than anything, it gave me confidence that we could handle this," she told me.

For patients who are not immediately discharged, the unit offers forms of therapy that I've never encountered in an emergency department. Patients can discuss their goals in the morning, create art in the afternoons, and learn to meditate in the evenings. Sam Atkins, a clinical coördinator who often leads the art groups, told me that, in one exercise, each patient decorates the exterior of a mask with glitter, representing the face they present to the world, and, on the interior, writes about how they really feel. On the day that I visited, they would paint what Atkins called worry stones.

As a clinical manager walked through the unit, asking patients if they'd like to join, I wondered how people in crisis would respond to something so earnest. Some ignored the invitation, but two men and two women—including Emma, now in a hoodie—gathered around a table that was covered with markers, crayons, paintbrushes, and flat gray stones. "Has anyone made worry stones before?" Atkins asked the group. "They're fun to decorate and nice to rub if you're feeling anxious."

A tall, bearded man sat down, squirted some black paint onto a stone, and then stood and walked away. Atkins stuck with it: "Does anyone like making art in their spare time?"

After a long silence, Emma nodded. "Pottery," she said. She looked around tentatively, then asked, "What about you guys?"

One of the others, a dark-haired man, looked up. "Sometimes I like painting," he said. He carefully painted a bird with green feathers, a white breast, and an orange beak onto his stone. "My bird died," he explained. Across the table, a woman sat with her forehead in her left hand. She half-heartedly dotted a stone with purple paint.

After half an hour, I helped Atkins put away the art supplies. When I looked back, Emma remained at the table alone. Sunlight poured in through a window, casting her shadow on the mural behind her. She picked up her stone, which she had painted with pink and blue circles, and smiled. Then she got up and walked back to her recliner.

A service dog.

A craft area with a chalkboard wall.

For the foreseeable future, M Health Fairview's EmPATH unit is likely to lose money. Zeidner wouldn't tell me exactly how much, but the amount is in the hundreds of thousands each year; he said in an e-mail that the hospital administration "tolerates some of our losses because they appreciate the clinical and human value that EmPATH creates," and because the unit reduces the need for psychiatric beds, clearing space for a surgical ward. His unit depends in part on donations; elsewhere, EmPATH units have relied on grants from local governments. One unit I contacted had shut down, owing to a shortage of staff.

Even as the model gains momentum, there is reason to worry that a profit-based medical system can

sustain only so much experimentation. For hospitals, an averted admission often means lost revenue; although insurance companies theoretically stand to gain from lower expenditures, they tend to reimburse for discrete one-time assessments, not the kind of holistic care that EmPATH units offer. "Insurers still don't really understand what this is," Zeller told me. "They say, 'O.K., we'll give you a few hundred dollars to see this patient.' I'm, like, 'That doesn't even cover the security guard.' " Each year, in the United States alone, there are an estimated three-quarters of a million emergency-department visits for mental-health crises; to address the need, hundreds of EmPATH units, each one treating thousands of patients per year, would be required. Zeller is convinced that this can happen. "Every few weeks, I hear from someone wanting to start an EmPATH unit," he said. "People see that the need is just enormous and the way we do things right now is completely broken."

A few weeks after my visit, I reconnected with Mitlyng. I was happy to learn that Emma had improved enough to be discharged shortly after I left, but I was also reminded that, even in the best of circumstances, mental illness can seem intractable. Normally, warmer weather brings an easing of psychiatric emergencies, but for some reason this year the unit was "bursting at the seams," she told me. "The need feels endless." In one case, a patient became agitated in the unit and had to be transferred back to the emergency room. In another, a patient with serious substance-use problems refused treatment after his initial symptoms had subsided. "Their families are so desperate to help them," Mitlyng told me. "We have to say, 'I'm sorry, there's nothing we can do until they're ready.' " But, she went on, "then you'll get one really great experience . . . and it just fills your cup for months."

EMPATH units aim to move patients out of chaotic emergency rooms and into calm communal environments.

Mitlyng told me about a young woman who'd come to the unit with intensifying alcohol use and thoughts of suicide. She'd often considered rehab, but needed a special evaluation before insurance would pay for it, and didn't know how to get one on her own. When she finally came to EMPATH, she told Mitlyng, "If I don't get this under control, I know I'm going to die." Mitlyng helped her get the evaluation, but the woman started having second thoughts: she felt better and was anxious about what rehab would be like. Hoping to persuade her, Mitlyng called several facilities to make sure that they had a spot open. Then she brought over a laptop, and, together, she and the patient looked at photos of the centers. If she wanted, Mitlyng told her, she could go straight from the EMPATH unit to whichever facility she preferred. She called the woman's father and asked him to bring a suitcase with some clothing. Eventually, the woman decided to do it. In moments like those, Mitlyng told me, "I'm caring for people the way I always wanted to."

When I first heard about Empath units, I assumed that their main contribution to mental-health care was empathy. This isn't wrong, but it is incomplete. In my experience, nearly every caregiver aims to show empathy; the question is whether, in an emergency, we have the space and time to do so. In Minnesota, I started to think that the Empath unit's real innovation is a structural shift in how we think about space and time. We usually consider drugs, devices, and procedures the kinds of medical care that make a difference, but physical spaces can be therapeutic, too. It's also easy to forget that, in a crisis, every minute matters. Once a patient reaches an Empath unit, there are no waiting rooms: even if a patient is in line for a transfer to a longer-term facility, she is receiving care while she waits. "You have to capitalize on the moments when someone is motivated to change," Mitlyng said. "You never know if you'll get another chance." What had appeared unusual about M Health Fairview's Empath unit started to seem intuitive, even obvious: beautify bare walls, maximize natural light, strike a balance between privacy and company. A patient with choices—even small ones, like which snack to take from a snack bar—may wind up feeling a little better.

The hospital where I work doesn't have an Empath unit. Even so, many of the model's underlying principles seem within reach, if only health systems broaden their definition of care. Not long ago, I treated a man who needed urgent mental-health care. He spent several moody, agitated days in a windowless room in the emergency department. He slept in the afternoons and tried to roam the halls at night; on my morning rounds, I would orient him to the date and time as he worked on breakfast, much of it landing on his hospital gown. But, a few days into his stay, a bed opened up in a sunlit room with a large window, a view of the East River, and a friendly roommate. On opposite sides of a blue curtain, the two patients synched their televisions, and, when I entered the room after that, I often found myself interrupting lively conversations. He improved quickly. On the morning that I told him I thought he was ready to leave the hospital, he seemed excited but apprehensive. As I left the room, I heard his roommate say, "You got this—I'll be rooting for you." ♦

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