E5
Between the Lines with FGI:
Behavioral Health Crisis Units: Scott Zeller
—Transcript—

Content advisory

Bridget McDougall
This episode discusses care environments for those experiencing a mental health-related crisis. Please look after yourself; the topics discussed may be sensitive to some. If you or someone you know is struggling with thoughts of suicide or experiencing a mental health or substance use crisis, please call or text 988 to reach the national Suicide and Crisis Lifeline.

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[Intro music: "Skip to My Lou" by Neal Caine Trio]

Bridget McDougall
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[Music fades out.]

Opening

Dr. Scott Zeller
They would do a feature on, look at the poor ER, it's inundated with psych patients. Here they are all stuck for days waiting for an inpatient bed. And they would always end that story saying,

“Well, clearly, they’re waiting for an inpatient bed, so we need to build more inpatient hospitals. Back to you, Jim!” You know? And having been an emergency psychiatrist my whole career, it’s like, well, that doesn’t make any sense. That’s like if you come into a hospital, and you’re very short of breath, and you’ve got an asthma attack. If we treated you like we treat the psychiatric emergency patients, we’d say, “Oh, come along in sir, we’ve got a place for you in the back hallway. We’re going to strap you down, and we’re going to find you an asthma hospital in the next day or two. Keep breathing. We’re going to take care of you.” That sounds ridiculous, right? But that’s exactly what we do with psych patients.

Intro

[Intro music: “Skip to My Lou” by Neal Caine Trio]

Bridget
Welcome to Between the Lines with FGI, a podcast brought to you by the Facility Guidelines Institute. In this podcast series, we invite you to listen in on casual conversations related to health and residential care design and construction. Coming to you from Washington State, home to the fictional cast of the Twilight book and film series is neither a vampire nor a werewolf, but FGI's very own John Williams, vice president of content and outreach and chair of the 2026 Health Guidelines Revision Committee.

John Williams
And coming to you live and in person from St. Louis, home to a farmers’ market that's older than the actual Bill of Rights, is Bridget McDougall, associate editor with FGI. And we're here because you have a lot of questions around the built environment and healthcare facilities. And while we don't have any answers, we know a few folks that do.

Bridget
The *Guidelines* provide minimum requirements from a built environment standpoint, but there's more there, between the lines, so to speak. And that's what we explore here on this podcast, with the help of some amazing invited guests, and of course, you along for the ride.

John
So, thanks for finding us or coming back to us again and let's get ready to read between the lines with FGI.

[Music fades out.]

Terminology in this episode

John
Hey, Bridget.

Bridget
Hey, John.

John
You know, we love to talk about words and acronyms on this show.

Bridget
That is true, I do love me some work talk.

John
Well, today we've got some new concepts to go over here. During this episode, we're likely gonna bounce back and forth between similar terms or some terms that maybe seem new and some terms that seem outdated. So, I thought it'd be good to go over those and call those out before we begin.

Bridget
I think that's a good idea.

John
All right, so to start off, 50 years ago, we'd be talking about *psychiatric* care a lot. And over the past couple of decades, we've transitioned that term *psychiatric* into mental health care and more recently *behavioral health* care.

Bridget
Yeah, that's right. In fact, in the 2022 edition of the *Guidelines*, the word "psychiatric" was replaced with "behavioral and mental health" in almost all places after the revision committee sought input from the field about which term they preferred. But you're going to hear us and our guest kind of go back and forth and use both terms.

John
And to be clear, there's still some discussion out there in the field, is behavioral health the right term? So, another notable term or term swap is *behavioral health crisis unit* and the concept of EmPATH unit. EmPATH is an acronym for emergency psychiatric assessment, treatment, and healing. And this model, the EmPATH model, was pioneered by our guest as an innovative delivery model to address psychiatric emergencies.

Bridget
That model is what led to the inclusion of the behavioral health crisis units in the 2022 edition of the hospital and outpatient *Guidelines*. During this episode, you'll hear us and our guest interchangeably mentioning both EmPATH and behavioral health crisis units. You can think of it like Kleenex and tissues as far as branding and names go.

John
Right.

Introducing our guest: Who is Dr. Scott Zeller?

John
So, our guest today, Dr. Scott Zeller, was one of the pioneers of the EmPATH unit. And in 2020, he was recognized as one of the top 10 health care design leaders by Healthcare Design Magazine. Also, previously the National Council on Behavioral Health named Dr. Zeller "USA Doctor of the Year." How cool is that?

Bridget
Dr. Zeller has served as chief of psychiatric emergency services at the Alameda Health System in Oakland, California, and is past president of the American Association for Emergency Psychiatry. Dr. Zeller is known across the nation and around the world as a leading expert in psychiatric emergencies. He lectures internationally as a keynote speaker, and he's authored multiple textbooks and numerous peer-reviewed articles.

John
Dr. Zeller is currently an assistant clinical professor at the University of California, Riverside and is vice president for acute psychiatry at Vituity.

[Music fades in: "Skip to My Lou" by Neal Caine Trio]

John [continues]
He's an incredible patient advocate, a pioneer, an innovator, researcher, and really just an all-around great guy. We are so happy to have him on the show today.

[Music plays then fades out.]

Welcome, Scott Zeller

Bridget
Welcome, Scott Zeller!

Scott
Hi, it's, wonderful to be here. Thank you for having me.

Bridget
So, Scott, behavioral health crisis units showed up as its own section in the *Guidelines* in the, really the last edition, the 2022, right? Tell us a little bit more about what these units are.

What are behavioral health crisis units?

Scott
Correct. The 2022 *Guidelines* really were focused on, um, something that was really an emerging concept within the hospital health care facility designs, which is let's have a separate, program, separate location for the behavioral emergency patients who are coming in emergency departments. We knew we had this situation that was all across the United States, in fact, all across the world, something called boarding of psychiatric patients.

Bridget
And what is that?

Scott
What happens is you have a lot of psych patients who come into ERs and then they get stuck there waiting for that elusive inpatient bed to open up. And when that happens, they can wait for hours, sometimes days, some outlier cases, even weeks, waiting for that inpatient bed to open up. And there's usually no trained mental health professionals working with them. There's usually little to no treatment. The only thing that might happen for them, they might get put in, a. . . strapped to a gurney and placed in a hallway and told to wait there for until a bed comes open. So, they might get meals. But they aren't getting any intervention treatment or working with any professionals. The only thing that might happen is they might get a shot of sedation if they start getting unruly or noisy.

John
That's especially tragic, because to a point you've made before, these are patients who are experiencing a true emergency and needing treatment right away.

Bridget
Right.

Scott
Federal law says psychiatric emergencies are medical emergencies, just like heart attacks or car accidents or what have you. So, we should be treating them that way. The vast majority of asthma emergencies who come to the ER get better and go home in a matter of hours. You know, we can treat that asthma patient immediately with a nebulizer, with some oxygen. We can get them breathing again Well, guess what? It turns out that if you use emergency psychiatric techniques, the same thing's true for psychiatric emergencies. You intervene promptly. You get people in the right environment. You help them with the things that they need and rather than just putting them in this waiting area you're actually initiating treatment. The great majority of them get better and can go home in less than 24 hours. So that's the approach when you're seeing this nationwide problem of why are all these people backing up in the ER waiting for inpatient beds. [The solution is not to] build more inpatient beds, which is

only kicking the can down the road. It's like, let's actually start treatment at the front end like we do with every other emergency condition.

What do statistics say about the number of people seeking treatment?

Bridget
What kind of numbers are you seeing in regards to how many folks seek treatment in an ER for mental health emergencies?

Scott
Twenty years ago, one in every 25 patients in an ER was there for a psychiatric emergency—considered suicidal, acutely dangerous to others, very incapacitated, can't take care of themselves safely, all those due to a psychiatric condition. That's what we would call a psychiatric emergency. In the years since then, the growth in the number of those patients coming in has just been astronomical. Just between 2006 and 2016, the number of people coming to hospital ERs in the United States for reasons around suicide went up over 400 percent.

John
Wow.

Scott
And that was only exacerbated by the pandemic. So that now, one out of every seven patients in an ER is there for a behavioral emergency. And, so, the protocol from 25 years ago was the ERs were not set up to help psychiatric emergencies, but there were only one in every 25 patients. So, they had a plan: we're gonna see them, we're gonna make sure they're otherwise medically OK, and then we are going to send them to a psychiatric hospital as their next step. And that's where everything will happen. So, maybe that worked when it was one out of 25 patients and there was actually more psych beds than there are today in existence. Fast forward to now the, um, one in every seven patients and there's actually fewer inpatient psych beds today than there were 25 years ago. So, the math is not going to work.

John
Right, the thinking behind the behavioral health crisis units then is that we can move these folks promptly out of the ER and get them to the appropriate care with the right personnel at the right time.

Scott
The most common version of that is the EmPATH unit. EmPATH is Emergency Psychiatric Assessment, Treatment and Healing unit. And what we've seen with those units, they're created to be an extension of the emergency department specifically to work with these high-acuity patients that otherwise would be stuck waiting for an inpatient bed. You get people into EmPATH, those same patients who would have been waiting for a day or two [a] bed, actually

you initiate treatment with the right staff, comfortable therapeutic environment, 75-80 percent of them get better and are able to go home in less than 24 hours. And that's a game changer for all the math of moving people from one place to another, the whole kind of ethics of how you're going to help people, the humanity of how you're going to help people.

How did BHCUs emerge in the *Guidelines*?

Bridget
You were part of the revision cycle that saw behavioral health crisis units appear in the *Guidelines*. How did that come about?

Scott
As these units have become more widespread around the country, uh, people at the FGI started saying "We're building hospitals and they want to have EmPATH units, they want to have behavioral health crisis units, we'd better start having some guidelines." So, I think that's what led to it, and some of the most amazing people that I've ever met who were all very passionate about emergency psychiatric health care design and health care treatment got together and that's how we ended up with the section in the 2022 *Guidelines*.

Bridget
And to clarify, when you're speaking of EmPATH units, and the *Guidelines* is talking about behavioral health crisis units, functionally, we're talking about the same thing, is that right?

Scott
Most of the time, yeah. In the, in the, uh, the behavioral health crisis unit section, there's a couple of other sections which can allow for a slightly different design than what we would call EmPATH, so [we] wanted to make sure everybody was covered in there. But I think there was an overwhelming, uh, feeling among the committee that this is probably the best way for you to go, but if you absolutely decide you're going in this way, here's guidelines for that direction.

John
So, we've talked about, um, how this podcast is really about the *Guidelines* and the *Guidelines* are about the built environment. Can you talk us through some of those physical environment aspects for this particular unit, uh, and how it might look different than another location that people are more familiar with?

How are these units different from the typical ER?

Scott
Yeah, absolutely. And it's one of the neat things about EmPATH in general and just BHCUs from what we've seen. Everything is kind of situated around a central open environment which is called the *milieu*, and it's a place where people are free to walk about. Every patient can choose their own recliner, which they can sit up in and engage in activities, one-to-one therapy, group

therapy, or they can fold it flat, and they can take a nap. Nobody is restricted to that space. They can move all around. Some of our patients in, in serious mental illness do better by pacing. That helps them to relax. That's, that's OK, an EmPATH unit. There's space dedicated so that people can move around and there's never going to be a staff member yelling at them saying, "Hey, get back in your room! I'm calling security!" Which is a problem if you have that same patient in the emergency department which you can't have them walking around and walking into the trauma surgery room or something like that. You know, it's just not set up for that.

Bridget
In what way?

Scott
The typical ER is more set up for people being in individual, maybe curtained-off area or different rooms, and because of the, uh, the surveying agency's guidelines and the, the suicide precautions, usually if you're there for a behavioral health emergency you're going to have a, um, sitter or a security guard with you at arm's length for the entire time you're visiting the ER. And you can imagine that can be a little distressing, as well. Certainly, you don't feel like you can do anything. You can't talk about anything you feel is too personal because there's this person listening. They're there to prevent you from doing anything. Nothing against the folks who are being the sitters or the security guard. They're doing what they have to do. But if you're a patient, that's got to feel oppressive. It's got to feel like you're imprisoned, that you've done something wrong, and that's why you're there.

John
Right.

The "big open room" concept

Scott
You change that to the EmPATH unit which is this big open room, which is homelike, which is comfortable, you're free to move about. You've got staff that are intermingled. They're not there to be your security guards or your, or your, prison guards. They're there to just be able to help you intervene whenever is necessary and are not going to try to tell you can't do this or can't do that. It's more about making you feel comfortable, relax, and get you treatment initiated as quickly as possible—within minutes—after arrival. So that combination of getting that prompt evaluation, initiation of treatment, being in this comfortable therapeutic space tends to reduce all of the things that patients might do in an individual room, which is have paranoia or claustrophobia or. . . think that everybody is against them and, and wants to fight against the treatment, fight against the meds, cheek the medications, not try to engage with the staff. And all those kind of things are going to lead to, uh, less likelihood of improvement.

Bridget

I've heard you speak to studies that show, you know, the percentage of people that are able to go home [after being treated in] these types of units, compared to hospitals, to EDs.

Scott
Yeah, so it's amazing how consistent the numbers tend to be. It's usually somewhere between 70 percent and 80 percent of the folks who traditionally would have been held for an inpatient bed. If you get them into a BHCU, into an EmPATH, they're able to get better and go home in less than 24 hours.

John
Wow, and that's impressive.

Scott
Yeah, and that, what also that does when we're talking about those other people who are waiting for that inpatient bed, suddenly there's that many beds open for them because you're not just a conduit moving people down, you know, to the next level, you're actually only moving the people there that truly have no alternative. And that's better for, it's better even for the inpatient hospital because they're not getting just a bunch of people and they have to pick and sort who really needs to be there after they're there. So even if you're anybody in that community and you cut yourself on your home bandsaw and you go in there, you're gonna get seen a lot more promptly because we're doing a better job getting better care for the psych patients, and that's opening up beds. So, it really helps everybody in the system, not just the psych patients. That's why we often say it's a win-win-win-win-win-win.

Wouldn't an open room cause *more* patient agitation, not less?

John
Yeah, 360-degree benefit there. You mentioned the big room, the big open room. And I think one of my initial reactions to the model when I first saw it many years ago was, what if something goes wrong with an individual, and will that individual disturb others in that care?

Scott
So that's such a great question and thank you for asking it. And, you know, calming and de-escalation techniques for agitated aggressive individuals has been like the number one thing of my research for the majority of my career. And if you ever want to see on YouTube on how to do verbal de-escalation, there's a video of me doing it that is at 500,000 views now, which I think is close to "Gangnam Style" in terms of popularity.

John
[Laughs]

Bridget
[Laughs]

Scott
A lot of the EmPATH unit idea was designed around how can we minimize the chances for agitation and aggression and if it does start to happen, how can we mitigate it so that it does not become something worse? And like you were saying when you first read about it, why isn't that place just a melee of fistfights and screaming and, you know, you open the door and it's almost like an old movie pie fights going on, you know . . . right? But everybody that's ever worked in an EmPATH unit goes, "Oh my gosh, this place is magic. It's quiet in here. It's like a library. It's like a church. How is it so mellow? How is it so quiet in here?" The design is such that staff are intermingled and the room is open without any kind of blind areas. And so that means that every one of our patients is fully 100 percent seen at all times by our staff members. And that's really important because when we go back to the same folks being in the ER, the Joint Commission CMS Surveyors want them, if they're considered to be at risk for suicide, for example, they need to be within an arm's length of a sitter or security guard. Why? Because they're in a room that's out of sight from the rest of the staff. And that individual placement in rooms is the reason that you have all these added security risks. And when somebody's in one of those rooms by themselves, whatever else is going on outside there, they're not able to see what's going on, they can't get anybody's attention, they hear somebody laughing or doing something like that they think they might be talking about themselves. Other symptoms get worse. Um, none of their needs get met. They can go for hours before getting somebody's attention just because they want a glass of water.

Bridget
That's a dynamic that, as you point out, is a direct result of the physical environment.

Scott
You change that dynamic by putting people in the big open room. You have a station where they can serve themselves beverages, snacks, linens. Suddenly they don't have to beg a staff member to get them a blanket because they're cold or a cup of water because they're thirsty. They can do it themselves. We also know that doing things yourself is a way to mitigate agitation and aggression just as well. It helps you to regain control because you're making your own decisions and you're taking care of yourself. All those things help to reduce your feelings of anxiety, aggression, anger. The other benefit of that open room is that staff can immediately notice if somebody is having that tougher time.

Rooms for calming and de-escalation

John
We have other rooms associated with that big room, like, um, a quiet room, so if someone's having a crisis, we can move them in there. Um, what, what's your experience with, with things, things like that? Do, do those quiet rooms and seclusion rooms get used much?

Scott

We want all the staff working in EmPATH units to be well trained in de-escalation and kind of noticing those warning signs. And then when they do that, one of the staff can immediately go and go right up to patient X and say, “Hey, patient X, you’re uh, it looks like maybe you want to come over here. We could talk about something going on. Looks like something might be on your mind.” And if it’s, uh, a little something more, it’s like, hey, we’ve got a couple of these, what you were calling quiet rooms. I think we’re now more calling calming rooms where they’re unlocked. This is not a punishment. It’s not a cell that you’re put in like the more traditional secure holding rooms were. This is a room that you’re going in there voluntarily and maybe it’s even got some cool things in there. Like instead of a traditional chair, maybe there’s a bean bag chair that you kind of like crash into. Some of them have, um, cool, um, lighting and sound things that you can control yourself, or even videos that are there and kind of chill out for a bit. It’s a place to be in temporarily to kind of get you through that little rise of agitation, anxiety, anger that you might have had. And then you know the staff member can go in there with you and help you with the de-escalation, or they can just say, “Do you want to just hang out here for a bit?” Again, it’s only a temporary room; you don’t get to stay there forever, but it’s supposed to be a place that you can go and decompress.

How does patient restraint factor into these spaces?

Bridget
Does patient restraint ever enter the picture here? That’s different than a quiet room, or calming room, whichever you may call it. Right?

Scott
Technically in most of the BHC user EmPATH units, we would still have the capability to convert into that secure holding room or what you’d call restraint or seclusion room, um, but because you have this alternative, these unlocked rooms; it turns out that the vast majority of them do better in that. You don’t need to lock them in. You don’t need to tie them down. The same population that in a typical emergency department, involuntary psych patients, 20 percent of them would end up into physical restraints in, into the ER, the exact same population, you move them to an EmPATH unit, you’re talking one or two out of every 1,000 patients goes into restraints.

John
Wow.

Scott
It’s a difference between 200 out of every 1,000 to one or two out of every 1,000. It’s all about that different environment, recognition, intervention, and having a place to go that’s not coercive. And all those things together end up with these great, great outcomes.

Bridget

It really speaks to how important this physical space is and these particular rooms. You know, if I were agitated and there's one room there called a "quiet room" and I walk into it, and in it is a bed—I don't care how comfy it looks—and I see straps, you know, and I'm told that this is the place where I can just take a minute to, to calm down and chill out. That's not conducive to de-escalation.

John
A little trauma-inducing there, maybe.

Bridget
Yeah.

Scott
That's an excellent point. No, we always have, uh, that say that the restraints need to be kept elsewhere. It only takes a couple minutes to attach them if that's absolutely what you have to do. But you're right. We talk about something in behavioral health care called trauma-informed care all the time, and we talk about it for a long time, but one of the basic tenets of it is that the great majority of people who are undergoing acute mental health care have had traumatic experiences in their lives and let's not try to resurrect those. And what you just described is a perfect example of that. If you've been in restraints before and you go into a room and they say, hey, look at this room, you're going to be able to like chill out and the first thing you see is a bed with restraints hanging down. I mean, I think that would frighten the vast majority of people.

Bridget
You know, we talked last episode and the one before about the functional program and just really understanding the use of the space before you talk about designing it. And I'm looking at the *Guidelines* where we talk about in 2022, it's called the quiet room and you're right that in 2026, it looks like we're in revision right now, but it looks like it's going towards being called a calming/comfort room to capture the industry's terms right now. But, we say in it, you know, it shall be provided for a patient who needs to be alone for a short period but doesn't require a seclusion room or secure holding room. And we say that it should have a minimum clear floor area of 80 feet, and it should be permitted to serve as a consultation room, but nothing more than that. And you know, that's really up for the facility to decide what it looks like. We don't say, don't put a . . . bed in here with straps, you know, and restraints. And we don't say make it as cold and uninviting as possible. And we don't, we don't say that stuff. So, it seems like that's a time—during that functional program—when folks are designing this space to get the input from people like you who can help inform what these spaces should look like for the purpose and the patient clientele, the population, patient population.

Mental health patient care as one of the lowest-funded priorities

Scott

You make such a good point because the environment is, it makes such a difference. And it's just stunning to me how sometimes people haven't gotten that. Um, and when the EmPATH model was first getting around and people were asking about it, looking into it. This was about eight years ago. I remember being invited to some hospitals where they would show me a, uh, kind of a room next to the boiler room in their basement that was about 12 by 12 and dark, and they'd say, "Hey look, maybe we could use this as an EmPATH unit!" You know? And I was like, yeah, I don't know. Probably, you know, their idea was just let's get them somewhere and shove them in there, you know. So, it's probably not a secret to anybody who'd be listening to this that when we're talking about the average hospital, the mental health department is one of their lowest funding priorities. Um, it is what it is. We have been in this profession for getting close to 40 years now, and it's just . . . we understand it. It's not a glamorous area of health care. Um, there's a lot of stigma involved with it. You open up a new psychiatric program, sometimes they don't even want a ribbon kind of ceremony, because, you know, um, we don't want people to know we have that here. They're worried about it.

John
Yeah, unfortunate, but true.

Bridget
Wow.

Scott
Yeah. Um, so, bearing that in mind, a lot of the idea behind BHCU's, EmPATH more specifically, was how can we create a program that's going to include all of what we know of emergency psychiatry and all the benefits of that, but making it something that's scalable, so any size hospital, any size community, any type of hospital, whether it's academic or community-based or remote or rural, I'm sorry, or . . . you know, downtown urban, that, that the basic philosophy would hold true, but you could adapt it to those different sites, just like we do with any other kind of departments of hospitals. We have different kinds of labor and delivery units, for example, that make more sense for whatever community or type of hospital they're in. And how much better is that than a place that's got nothing? So, we start with the idea that most places have nothing. And can we create something that's relatively easy to create, has minimal investment type thing. You don't need a lot of specialized equipment or a $2 billion machine in there. It's just going to be this kind of simple alternative space that you're going to have some real benefit.

How many of these facilities exist today?

John
So, about how many of these facilities do you see across the country at this point?

Scott

So, because some of them don't call themselves EmPATH, although they admit they're the EmPATH model, but they came up with a different name or the state licensing said they had a different name, it's a little hard to count them sometimes, who qualifies based on the definition. What we pretty much can be confident in saying now, there's several dozen that are operating right now. And we know that there's just off the top of my head, I know of another 40 to 50 that are in development that are about to be built. The state of California gave out 11 grants of $3 million each specifically to build EmPATH units. All of those hospitals are working on doing it now. Not to be outdone, the state of South Carolina gave out 13 grants of $3 million each. Those just went out in the last couple weeks. And so there's going to be 13 new EmPATH units there, 11 new grant hospitals in California with EmPATH units. But I know of four other hospitals in California that are building EmPATH units who didn't even get the grant. We just heard that the state of Georgia is making a big impetus. They just came out with a statewide report saying that EmPATH is their number one recommendation for improving mental health care in the state. I think we're going to be seeing I think by the end of two or three years from now we're going to have more than a hundred in the U.S. And then maybe it's like the old commercial with, "and she told two friends and told one and so on and so on."

John
"He told two friends."

Where are BHCU's in relation to other facilities?

Bridget
So, uh, in the hospital document. It's located in Chapter 2.2 specific requirements for general hospitals and in the outpatient document it's located in Chapter 2.8 specific requirements for freestanding emergency care facilities. And in that outpatient document in location, it says that the behavioral health crisis unit shall be permitted to be part of the freestanding emergency care facility or a separate standalone facility. Can you speak to that a little bit about where, where these things are and where they should be?

Scott
Yeah. Um, it's a real mixed bag out there how people are creating crisis facilities, how they're creating psychiatric emergency facilities. Um, I think one thing that's been important that we've been realizing in the last couple of years, and I think there's even a movement towards within the FGI, is kind of differentiating, um, a hospital-based location, which maybe should be called a behavioral emergency unit, because they're treating the same level of emergency for psychiatry that the ER would be treating for shortness of breath or low blood sugar or losing blood or trauma or something like that. And hospitals don't have orthopedic crises, they have orthopedic emergencies. So maybe psychiatric emergencies are the ones that are in the hospital setting. Then you have this whole wonderful world of behavioral health crisis units that are created in freestanding or in community-operated or a county mental health department will operate. And those are fabulous, wonderful programs. And it's all about a spectrum of care. That sometimes, let's say you're a high-functioning, intelligent, employed, housed, got a family,

but you just had a spouse pass away, you just lost your job. Horrible thing happened to a family member. You're at wits' end, you really need to talk to somebody. It's not like you can stop in somewhere and get a counselor or something through your insurance company, but if you have a county or behavioral health crisis center that you can go to, that's the most amazing thing. And what, they have trained professionals there to help you. Now is that the same level as somebody needs to go to the ER? No, and we would rather they go to that community level. And it's the same kind of spectrum. Like we have medical urgent care, like maybe there's that urgent care center that's next to the Walgreens. You don't want to go there if you're in a plane crash, but if you've got the sniffles, maybe that's a good place to go. And then you reserve the ER for the plane crashes and the heart attacks and things like that. It's the same thing with behavioral emergency units, like EmPATH, which is hospital-based. They work in tandem with an ER, they're part of the same campus, they're all integrated, and then a freestanding crisis program, which are wonderful, but really set up more for people who can live in the community, and they don't need to be hospitalized, they don't need to be confined at that point in time. And it's just, again, it's at different levels of acuity. And that's the way you have to think about it.

There's no one-size-fits-all all for anything in health care in general, and also in psychiatry. It's the same thing. So, we want something that's really good for those stand-alone crisis facilities and hooray for them where they've got trained counselors, and if you're at wits' end that's a great place for you to go where the ER might be a pretty bad place for you to go. But if you have just taken a massive overdose to kill yourself, it's a much better thing to go to the ER where they can treat that overdose, and then get you the psych care that you need rather than going for counseling because, uh, you need to get that overdose treated.

Bridget
I know there's a real push for the 2026 document during this revision cycle to clarify and separate out what these facilities are, where they are specifically in the outpatient document to show that there's, you know, the community based as you mentioned, ones attached to a freestanding ED, ones that are that are separated out and pulling that text and clarifying that text into a different chapter, which is Chapter 2.11, which is for facilities for behavioral mental health patients.

The difference between emergencies and urgencies

Scott
Yeah, no, and I think it's a good thing, and I'm really glad that we're doing that. Um, one of the things I find when I'm out there working with communities, working with hospitals, working with government agencies is a general benign ignorance. I don't think there's anything like evil or wrong on these people who don't understand it, but they have a tendency to think a psych is psych is psych. And it's all the same. And it's not. Just like I was saying, the difference between a medical urgent care and a trauma center, there's a big, huge difference there. If you have a lifelong serious debilitating disease like schizophrenia which is a horrible illness you wouldn't

wish on your worst enemy, what happens with people with that, like maybe you're hearing auditory hallucinations to kill family members. And they're not imagining that. They're actually the part of their brain that lights up, that would light up you listening to me right now, is lighting up in their brain telling them to do awful, awful things. And we can help them, we can intervene with them, but that may not be going to a drop-in counselor, because that's a much more acute, serious, and potentially life-threatening condition. So, we wanna have that different level. And then there's people who are having, you know, they're very frustrated with life, or they're having symptoms of dysphoria, or you know they're having personality issues, or maybe they need referral for situations going on with family interactions, or all these different kinds of situations. That's a great level of care, too. Maybe that's a much larger bandwidth of people that are going to be able to help with that, but just like we need like the intensive care unit for people coming in who are having sepsis or having really bad cardiac disease. Um, we need a different level for that really severe psych conditions, and then this other area for these other situations. And explaining that to hospital leadership, government leadership can often be very, very difficult where they say, like, well it just all sounds like the same place to me. It's like, no, hopefully the way I just described it, there is some dramatic differences between different levels of acuity in mental health situations.

John
So, it sounds like there's this parallel track, not only of trying to help people imagine how to build these spaces, but there's a fair bit of public education around what these spaces are, and maybe updating that social contract of everybody knows to go to the emergency room when, when you're having an emergency, but an urgent care when it's not necessarily emergency, but socializing that, that concept of the difference between emergencies and urgencies, I guess, in the behavioral health world.

Scott
Yes, yes, and also helping them to understand that it might cost more to operate an emergency center than it does to do an urgent care center. So, don't think that they should all be reimbursed for the same patient care.

There was a wonderful article that was written last summer in the *New Yorker* magazine about EmPATH units. And, the author of the article was a physician himself and, and clearly really liked what he saw with EmPATH units. He went and visited the wonderful EmPATH unit at the University of Minnesota. Um, but he had a passage in there in his article that I still use, and I actually have printed out, and I put on my wall. Um, and it's exactly about this topic. And I'm paraphrasing him because I can't remember exactly how it went. But . . . what he said was, you know, those of us as health care providers, as physicians, we usually think of treatments being medications, devices, surgeries. But we need to realize that the environment can be a treatment too. And that's the beauty of EmPATH.

John
So powerful.

Scott
Yeah.

Wrap up/Goodbye

Bridget
At the heart of the Hippocratic oath is of course "first, do no harm" and what you're talking about is looking at patients that are really suffering in a way that we can't always see and the idea of putting them in a space that's not the best space for their healing is doing harm and nobody wants that. So, we really appreciate you coming on today to talk to us about the physical environment spaces and how patients, um, presenting in a state of crisis can be helped, not harmed.

Scott
Well, thank you for having me and what great questions and understanding. It's so nice to talk to people who you clearly get it when I'm talking about it. It's not just a blank look on your faces. So, it's been an honor and a pleasure to be able to discuss these with you.

[Music fades in: "Skip to My Lou" by Neal Caine Trio]

Bridget
The lack of a blank look is entirely due to the fact that you make what can be a complex topic so accessible, so we really thank you for that.

John
Thanks again, Dr. Zeller. We'd have you on our show any time.

Outro

Bridget
And thanks for joining us for this episode of Between the Lines with FGI. Do you have an idea for an episode? Get in touch with us by writing to podcast@fgiguidelines.org.

John
Yes, please do. And as always, if you're interested in becoming a sponsor for one of our episodes or a series of episodes, you can also reach out to us at the same email address, podcast@fgiguidelines.org.

Bridget
Thanks to Neal Caine and the Neal Caine Trio for the use of his song, Skip to My Lou, from the album of the same name.

John
Join us next time as we go between the lines with FGI. Bye, Bridget. Bye, everybody.

Bridget
Bye, John. Bye, you all. See you next time.

[Music fades out.]