

‘The Open Door’ and emergency mental health crisis care in Ireland: meeting people where they are

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On December 10th, 2025, at the RCSI, a meeting entitled *The Open Door* convened various clinicians, service leaders, and partners across urgent emergency and mental health care to explore their shared agenda. How can Ireland provide timely, dignified care for people in crisis with mental health problems and difficulties who attend Emergency Departments (EDs), while also building credible care alternatives to ED in the community?

A recent study by the Mental Health Commission (MHC)¹ describes substantial variation in mental healthcare provided across Irish EDs and persistent challenges in out-of-hours provision. It also notes that injury units do not provide emergency mental health services, further concentrating access through EDs.

The Open Door created a safe space where matters were freely discussed. Following brief presentations and break-out discussions, shared areas of concern and potential remedies emerged.

The participants strongly affirmed the principle that mental health crisis care is a core part of emergency care. ED systems already have tools for safety, reliability, and flow management that can be applied to emergency presentations using structured triage, senior decision-making, team huddles, shared situational awareness, and clear escalation pathways.

Mental health assessment in ED was seen as practicable and values driven. Parallel assessment is not a technical preference, when supported with co-located space and shared documentation. It is a safety intervention that maintains dignity, reduces duplication, shortens time to decision, and reduces harms which can occur when services operate sequentially. This best practice is already recognised in national policy and oversight including the Models of Care of the Emergency Medicine Programme (EMP)² and the National Clinical Programme for Self-Harm and Suicide-related Ideation³.

The Open Door participants addressed system design challenges rather than isolated failures. ED and mental health services may become siloed, creating multiple “lane changes” where

clinicians and service users navigate unclear thresholds, inconsistent access routes, and variable specialist availability. For patients, the pathway can feel like a series of handovers, each one a potential dead end.

The meeting recognised the problem of terminology as a source of difficulty. “A mental health crisis” may describe diverse presentations, from acute suicidality to distress shaped by homelessness, addiction, neurodiversity, disability, and social deprivation. When services disagree about whether a person “fits”, the healthcare system defaults to ED because its door is always “open”.

Participants emphasised the need for 24/7 crisis liaison availability, dedicated psychiatry cover, and upskilling of ED teams. The MHC report similarly highlights the importance of mental health liaison nursing in ED and under-resourcing leading to revolving-door attendance and over-reliance on ED for repeat crises. Staffing is not just about numbers. It is about skill-mix, and the capacity to respond consistently across hours and settings. Gaps in Child and Adolescent Mental Health Services (CAMHS), whether admission beds or liaison input, result in delays in ED for young people without age-appropriate spaces or pathways. Those aged from 16 to 18 are particularly vulnerable to falling between services.

Meeting participants identified bed access as a perennial obstacle turning decisions into delays. When admission is required, locating a bed can take hours, consuming senior clinician time within opaque processes. A centralised bed-bureau and an efficient transport response were viewed as potential interventions, shortening time spent in non-therapeutic environments, supporting ED flow, and making capacity opportunities visible.

The phrase “the ED door is always open” surfaced repeatedly. This ethical and legal reality is increasingly a design by default. EDs exist for undifferentiated presentations, including mental illness, but they should not be the only “port in a storm”.

The Open Door looked to “open other doors” without creating new dead ends. A community-based Navigation Hub, operating as a single point of access with 24/7 streaming of multidisciplinary assessment was raised as a credible alternative to ED defaulting. The aim is not to divert people away from care, but to route them to the most appropriate community care first, with ED available when needed.

It is not a question of choosing between “hospital” or “community” but building a coherent crisis pathway across both. A growing ED–mental health alliance could improve patient experience, with safer practices and improved flow. Building trust between acute and community teams could enhance interprofessional working with shared decision-making and reliable pathways.

This aligns with the MHC emphasis that improvements in ED-based care must be matched by investment in alternatives and strengthened community provision.

Finally, *The Open Door* was honest about the social and ethical dimensions of crisis care. Challenges with access for people experiencing homelessness, consent and family involvement for adults, and digital exclusions, were all discussed as reasons why “a pathway on paper” can fail at the bedside. Participants advocated for the empowerment of service users and families through better mental health literacy and clearer information about options, while acknowledging the limits of individual responsibility in the context of under-resourced services and widening deprivation.

The *Open Door* made a call “to standardise the promise while personalising the route”. The promise may be complex, but the response should be consistent including 24/7 access to a skilled response, timely assessment, non-stigmatising, dignified care, clear next steps, and safe, age-appropriate pathways for children and young people.

ED is required for those who need it or choose it. Better community mental health and primary care alternatives are needed for those for whom ED is unnecessary. A seamless movement between services is essential without forcing people to “go backwards to go forwards”. Achieving this will require culture change, but also operational clarity, resourcing, transparency, and governance, precisely the areas highlighted across national oversight and emergency care planning documents.

Declarations of Conflicts of Interest:

None declared.

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