ORIGINAL RESEARCH

Early identification of mental health disorders: Using the mental health inventory-5 (MHI-5) in a free-standing emergency room

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ABSTRACT

Emotional distress in high-acuity emergency care settings is frequently underrecognized, resulting in missed opportunities for early behavioral health intervention. At a free-standing Emergency Room (ER) in a small, semi-urban city in a largely rural region of Texas, internal audits revealed a 100% miss rate for identifying adult patients with symptoms of depression or anxiety during triage. Professional guidelines, including recommendations from the American Association for Emergency Psychiatry and the U.S. Preventive Services Task Force, emphasize routine mental health screening in emergency departments to improve patient safety and outcomes. National data indicate increasing psychiatric-related visits, particularly among youth, many of whom remain undiagnosed. Undiagnosed emotional distress also places additional burdens on emergency care providers managing complex physical presentations without awareness of underlying psychological factors. This highlights the critical need for structured mental health screening protocols in emergency settings to enhance early detection and support comprehensive patient care. This quality improvement project explored how embedding the Mental Health Inventory-5 (MHI-5) screening tool into the intake process at a freestanding emergency department affected early detection of psychological distress in adults aged 18 and older. Over a nine-week implementation period, 710 of 2,583 eligible patients (27.5%) completed the screening. A total of 147 patients screened positive for psychological distress (20.7%); however, only 38 (25.9%) were documented in the electronic health record, reflecting a significant gap in follow-through. Staff noted increased awareness and confidence in addressing mental health concerns. The MHI-5 screening tool identified emotional needs not captured during routine triage. Recommendations include improving documentation workflows, adding EHR prompts, and continuing staff training to support consistent use.

Key Words: Behavioral health, Documentation, Emergency department, Mental health screening, MHI-5, Quality improvement, Workflow integration

1. INTRODUCTION

1.1 Project description

In high-acuity environments where attention is directed toward physical symptoms, emotional distress is often not documented, resulting in a missed opportunity to improve patient outcomes. At a free-standing Emergency Center in a small, semi-urban city in a largely rural region of Texas, internal audits showed a 100% miss rate for identifying adult patients with symptoms of depression or anxiety during triage before this intervention, indicating a gap in clinical practice and a missed opportunity for early behavioral health engagement. Adult patients presenting with symptoms related to depression or anxiety were not being recognized during the

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patient triage intake. This quality improvement (QI) project implemented screening for depression and anxiety during the patient triage intake, aiming to highlight the need for incorporation into standard practice in this setting. Results were reviewed for statistical significance and application to practice.

1.2 Available knowledge

Professional organizations have acknowledged that gaps exist in emergency care surrounding mental health screening. The American Association for Emergency Psychiatry recommends routine mental health assessments in emergency departments to support early detection and improve patient safety, especially where mental health resources are limited.[1] By May 2025, mental health concerns were recorded in 5,054 per 100,000 emergency department visits in the United States.[2] From 2011 to 2020, psychiatric-related visits among youth increased, with 40.4% of those that completed suicide were not diagnosed with a mental health disorder.[3]

Undiagnosed emotional distress also burdens emergency care providers and support staff, who must manage these complex physical symptoms without insight into the underlying psychological context. Recognizing this challenge, the U.S. Preventive Services Task Force recommends that routine screening for depression and anxiety in adults under 65 is performed.[4,5]

1.3 Project and rationale

This QI project aimed to implement the Mental Health Inventory-5 (MHI-5) into the standard intake process. This five-question tool is brief and reliable, making it a good fit for the fast pace of emergency care. Previous studies have demonstrated that the MHI-5 can identify underlying distress even when patients present with physical symptoms.[6,7] Integration of the MHI-5 required collaboration between registration and clinical staff, which was supported by laminated guides, simple scripting, and education around documentation. The aim was to create a consistent, easy-to-follow process for identifying emotional distress in adult patients ages 18 to 64 that presented to a free-standing Emergency Center. Nurses were provided with a printed resource guide packet that included contact information to help support patients. This effort supported equal access to care and encouraged staff to pay closer attention to mental health concerns. The overarching goal was to make mental health screening a routine part of emergency care rather than an occasional practice.

The team used the Plan-Do-Study-Act (PDSA) model to guide implementation due to the flexible structure and support for stepwise learning. This approach allowed staff to test changes quickly, monitor outcomes, and adjust workflows based on direct feedback throughout the project. Staff engagement was central to each phase, ensuring that screening was conducted consistently, understood, and valued by both nurses and registration personnel. Because the PDSA model was easy to work with, staff could revisit training as needed and adjust support depending on who worked each shift. That flexibility made it possible to keep things practical and fit the project into daily workflow without causing significant disruptions.

To keep the work focused, the team used the PICOT format to shape a clinical question around how screening could improve early identification and intervention: Specifically, in adult patients aged 18 and older presenting to a free-standing emergency department (P), how does the implementation of the MHI-5 screening tool (I), compared to the project's screening protocol (C), affect the identification and documentation of mental health conditions (O), over a nine-week implementation period (T)?

The question was designed to guide efforts that strengthen detection, improve documentation, and ensure timely behavioral health support. It also demonstrated the unique position of emergency care staff to identify and respond to mental health needs that might otherwise go unnoticed.

2. METHODS

2.1 Context

The Institute for Healthcare Improvement's (IHI) Model for Improvement provided the guiding conceptual framework, offering a structured yet flexible approach to testing the MHI-5 screening tool in a high-acuity emergency setting. Its use of iterative PDSA cycles ensured that staff could rapidly adapt workflows, address barriers, and embed mental health screening into routine practice without disrupting patient care.[8] PDSA cycles were used to guide implementation of mental health screening at the clinical site. The model was chosen for its flexibility, rapid-cycle testing, and support for adaptive learning. In December 2024, a pre-implementation audit of 50 charts confirmed that no existing protocol for mental health screening was in place, with a screening compliance rate of 0%. The intervention began January 1, 2025, and concluded February 26, 2025.

The MHI-5 screening tool was introduced in paper format and integrated into the registration process. Triage nurses scored and documented results in the electronic health record (EHR). Scores equal to 60 or lower triggered further evaluation using the PHQ-2 and guided next steps per facility's policy. A multidisciplinary team supported implementation.

The student DNP project lead spearheaded workflow development and data auditing. Clinical oversight was provided by the Medical Director and the Facility Director, an MD and an FNP. Registration also had a team lead who supported intake distribution and frontline coordination. The team collaborated to develop staff materials, identify workflow gaps, and monitor fidelity throughout the project.

PDSA modifications were applied weekly based on observed trends and staff feedback. In week 2, laminated scoring guides were added near charting stations. During week 3, form placement confusion was addressed during shift huddles. In week 6, a new kiosk check-in process affected compliance, prompting additional staff reminders. Real-time audit data guided adjustments and debriefs, which allowed the project to remain responsive while minimizing workflow disruption.

2.2 Setting and population

The setting was a free-standing emergency center located in a small city near mostly rural regions in Texas. This facility sees approximately 80 to 100 adult patients daily and operates without inpatient admission services. Staff includes Emergency Room physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Emergency Technicians, and registration personnel. The majority of the patients are covered by private insurance or pay out-of-pocket, as Medicare and Medicaid are not accepted. All adult patients that were over 18 years-old but below 64 years of age and presented for care between January 1 and February 26, 2025, were eligible for the project. The age range reflects United States Preventive Services Task Force (USPSTF) recommendations for mental health screening in adults under 65 when appropriate follow-up is available.[4]

Patients were excluded if they were critically ill, or unable to complete the form due to cognitive impairment, or if they declined participation. The screening forms were offered in English or Spanish to accommodate patient language preferences (see Appendix A). Bilingual staff were available to help anyone who needed assistance. The free-standing Emergency Center's paper-based intake process made monitoring how and when screenings were completed easy, allowing for real-time observation and on-the-spot coaching. Consistent staffing throughout the project also helped ensure the screening process was applied reliably across different shifts.

2.3 Interventions

Throughout the nine-week rollout, staff received regular reminders during huddles and were supported through brief coaching. During the first few weeks, at times staff would misplace forms or make scoring errors. These problems were addressed by reviewing the protocol with staff and offering regular feedback based on weekly audits. Training focused on applying the tool practically during real patient encounters rather than just understanding it conceptually. Staff was also guided on where the screening fit within their existing duties, so it did not feel like an extra step. The screening process soon become a routine part of patient triage intake. As a result, the process soon became more consistent without slowing down patient care.

Staff received one-on-one training between December 15 and 31, 2024. Each session lasted about 5 to 10 minutes and focused on screening purpose and how to administer, score, and document results correctly. Training materials included visual workflows and quick-reference scoring guides (see Appendix B). Approximately 50 team members completed the training.

The MHI-5 was introduced as a brief, evidence-based tool suitable for acute care. Paper forms were distributed during intake, and triage nurses scored completed responses. Scores above 60 were entered as "not applicable" in the EHR mental health section. Scores of 60 or below initiated PHQ-2 evaluation and follow-up actions.

2.4 Resources

A major benefit from this project implementation was the low resource requirement. The project lead was provided with two hours each week to help staff and keep up with data. Completed screening forms were locked away in a secure Health Insurance and Portability Accountability Act (HIPAA) compliant location to protect patient information. Digital records were stored with password protection, and only project personnel had access. These safeguards helped the team handle information responsibly and safely. The setup worked within the clinic's every day (24-hour) routine, which made it easier to implement changes without slowing down workflow.

2.5 Measures: Outcome, process, and balancing

Over the nine-week implementation period from January 1 to February 26, 2025, outcomes, processes and balancing measures were tracked to effectively evaluate the project's impact and guide measurable improvements.

Compliance looked at how many eligible patients between the ages of 18 and 64 completed the MHI-5 screening. Of the 2,583 eligible patients, 710 completed the form, bringing the compliance rate to 27.5%. While this did not meet the goal of 80%, it was a notable improvement from the starting point, where no screenings were happening. Among those presented with the tool, 554 accepted and completed it (78.0%), while 156 declined (22.0%). These data suggest

high acceptance among those approached. The tool was offered during all intake shifts, and forms were available in English and Spanish. Staff feedback confirmed that the tool was well-received and straightforward to administer.

Patients with MHI-5 scores of 60 or below were considered to have screened positive for potential psychological distress. Of the 710 completed forms, 147 patients (20.7%) fell into this category, making up 5.7% of the eligible group. This rate is consistent with national patterns seen in emergency departments for mental health-related concerns. However, only 38 of those 147 positive results (25.9%) were documented correctly in the electronic health record. The remaining 74.1% represented missed opportunities. Audit remarks identified common issues such as missing scores, misfiled forms, or use of incorrect documentation fields.

Accuracy was measured through weekly random audits of approximately 10% of completed MHI-5 forms. The audit check list checked for correct: log number, date, refusal, language and follow-up actions. While documentation improved over time, errors were marked early in implementation. Reinforcement strategies, including scoring cheat sheets and reminders during huddles, were introduced to improve consistency.

Staff were asked to provide informal input regarding perceived workflow burden. At the beginning there was some pushback from 80% of staff. Most concerns stemmed from the idea that screening for mental health would increase patients requiring "suicide precautions". Around week 4 staff started to see that their interactions with patients were different and were making a difference. Towards the end of week 4 most (80%) of staff reported that the tool was easy to integrate, though occasional feedback noted confusion when multiple intake processes were introduced simultaneously with the kiosk system.

2.6 Analysis

Screening data was de-identified and entered into Microsoft Excel for initial organization. Code variables were then imported into the Statistical Package for Social Sciences (SPSS) Version 28 (IBM Corp.) for statistical analysis. Descriptive statistics summarized demographic characteristics, MHI-5 total scores, and item-level responses. Raw MHI-5 scores (range: 0–20) were converted to a standardized 0–100 scale by dividing the sum of items by 20 and multiplying by 100, as outlined in the scoring protocol. Blank responses were excluded from total score calculations; zeros indicated the absence of symptoms and did not indicate missing data.

Normality was evaluated using the Kolmogorov–Smirnov and Shapiro–Wilk tests. Results for both tests indicated significant deviation from normal distribution ($p < .001$), supporting non-parametric analyses for inferential testing. A Kruskal–Wallis test was used to assess weekly score differences (see Appendix C). Results showed a statistically significant variance in MHI-5 scores across the nine weeks ($p = .019$), suggesting fluctuations in emotional well-being. However, uneven group sizes and operational changes such as introducing kiosk registration may have influenced the result. A Spearman rank-order correlation was run between screening week and MHI-5 total score to assess potential time-related trends (see Appendix C). The correlation was non-significant ($\rho = 0.049$, $p = .246$), suggesting no consistent rise or fall in emotional distress over time.

A control chart examined whether weekly scores stayed within expected limits (see Appendix C). All data points remained within control boundaries, indicating stable process performance without signs of special cause variation. To identify predictors of emotional distress, a multivariate regression analysis examined predictors of distress using total MHI-5 score as the dependent variable (see Appendix C). The model included age, sex, language, documentation accuracy, medication and medical history, and classification of screening result. It explained 70.6% of the variance in MHI-5 scores ($R^2 = 0.706$, $p < .001$). Significant predictors included older age, female sex, Spanish language preference, and classification as a positive screen. English speakers, younger patients, and those who screened positive were more likely to report emotional distress. These findings support the MHI-5's sensitivity across demographic subgroups and emphasize the importance of culturally responsive screening in high-acuity settings. Documentation accuracy and completeness of medication history were not statistically significant in predicting score outcomes.

Finally, a cross-tabulation explored the relationship between chief complaint and likelihood of a positive MHI-5 screen (see Appendix C). Among the 552 patients included in the analysis, the highest rates of psychological distress were associated with presenting complaints such as headache (66.7%), cough (38.5%), and abdominal pain (30.0%). Physical complaints such as rash or injury were less frequently linked to positive screens. These findings align with known patterns of somatic masking in emergency settings, underscoring the importance of routine screening even when patients do not explicitly report psychological symptoms. For example, Downey and Zun (2018) found that many patients presented to the ED with physical complaints while underlying psychiatric illnesses went undiagnosed, and Rumpf et al. (2001) showed that the MHI-5 can uncover such hidden mood and anxiety disorders through screening.[9,10]

2.7 Ethical considerations

The University's Quality Improvement Review Board (QIRB) reviewed and approved this QI project on November 25, 2024. The intervention was designated as a non-research activity to improve internal clinical processes without introducing experimental treatments or generating generalizable knowledge. As such, the project did not require informed consent, randomization, or institutional review board oversight under research protocols. All procedures, including data collection, patient interaction, and workflow modifications, were implemented within standard clinical operations and aligned with the original QIRB-approved scope. QIRB was notified when the project transitioned from a two-site to a single-site implementation to ensure continued compliance with ethical oversight. Participation in the MHI-5 screening was voluntary, and refusal did not affect access to care.

Staff explained the purpose of the MHI-5 tool and informed patients that responses would be kept confidential. Those who declined were noted in audit logs to track how often the screening was offered and were not included in scoring or analysis. Forms were labeled with a log number that would reset every 24 hours and did not contain identifying information. At the end of each shift, completed forms were stored in a locked office. Electronic data were saved on password-protected drives managed by the Emergency Center's information technology (IT) department, with access restricted to the project lead and designated personnel.

The project-maintained compliance with HIPAA regulations and institutional data protection standards throughout. All data used in reporting and dissemination were de-identified, and no patient identifiers appeared in audit summaries, analysis reports, or staff feedback logs. Documentation accuracy was monitored to protect against unintended disclosures of sensitive mental health information, and staff were instructed not to record MHI-5 responses verbatim and any open clinical documentation fields. The screening tool was validated as low risk, and all demographic groups were offered screening. These steps followed ethical guidelines: autonomy, beneficence, non-maleficence, and justice. Culturally sensitive practices such as offering bilingual forms and interpreter support were implemented to support equity. Staff engagement was driven by education, coaching, and collaborative feedback, not performance evaluation or punitive oversight. This balance supported ethical integrity while cultivating a respectful and learning centered improvement culture, consistent with national nursing standards and the American Nurses Association Code of Ethics.[11]

When mental health concerns were identified through the MHI-5, follow-up actions varied according to the severity of the findings. In many cases, providing emotional support, active listening, and brief education from nursing staff was adequate to address immediate patient needs, especially when distress was situational and non-urgent. However, for patients screening positive on the MHI-5 and PHQ-2, were suggestive of immediate psychiatric or behavioral health services were indicated. Although the emergency center does not currently have embedded psychiatric services, staff were encouraged to provide patients with community resources, crisis hotline information, and information of local mental health providers. These steps were important to integrate follow-up protocols into emergency care workflows and ensure that positive screens lead to appropriate interventions rather than missed opportunities for care.

3. Results

3.1 Intervention/evaluation

A total of 2,583 eligible adult patients aged 18 to 64 were screened for mental health using the MHI-5. A total of 710 patients completed the screening, yielding a compliance rate of 27.5%. Of those, 147 individuals (20.7%) scored less than 60, indicating a positive screen for potential psychological distress. Among patients screened positive, only 38 (25.9%) were accurately documented in the EHR. The remaining 109 cases (74.1%) were misclassified or omitted entirely.

Chart audits identified that the most frequent errors were incorrect placement of forms, incomplete scoring, and inconsistent use of the mental health documentation field within the EHR. Descriptive statistics showed that the MHI-5 scores ranged from 20 to 100, with a mean of 76.7 (SD = 17.35). An item-level analysis revealed that the lowest mean score was for "felt calm and peaceful" (M = 2.75). In contrast, "felt happy" had the highest (M = 3.40), consistent with findings in high-acuity environments.

Normality testing using the Kolmogorov–Smirnov and Shapiro–Wilk tests indicated no normal distribution ($p < .001$). This result supported the decision to use non-parametric statistical methods for subsequent analysis. A Kruskal–Wallis test demonstrated a statistically significant difference in MHI-5 scores across the nine weeks ($p = .019$), though week-to-week fluctuations were modest. Post hoc examination suggested that the variance was likely due to the influence of small sample sizes and implementation changes rather than underlying trends in emotional distress.

Spearman's rank-order correlation between week of implementation and total MHI-5 score was not statistically significant ($\rho = 0.049$, $p = .246$), indicating that emotional distress levels did not follow a linear trend over time. Control chart analysis supported mean scores that remained within

expected control limits throughout the project, suggesting stable process performance.

Multivariate linear regression explored factors associated with total MHI-5 scores. The final model included age, sex, language preference, documentation accuracy, completeness of medication history, and classification as a positive or negative screen. The model accounted for 70.6% of variance in total scores ($R^2 = 0.706$, $p < .001$). English speakers, younger patients, and those who screened positive were more likely to report emotional distress (all $p < .05$). Documentation accuracy and medication history were not significant predictors.

A cross-tabulation analysis explored associations between presenting complaint and likelihood of positive screening. Among patients who screened positive, the most frequent complaints were upper respiratory symptoms (n = 43), abdominal pain (n = 9), headache (n = 8), and cough (n = 5). Headache had the highest proportion of positive screens within its group (66.7%), followed by cough (38.5%), back/flank pain (30.8%), and abdominal pain (30.0%). Complaints such as rash or injury were less frequently associated with positive screens. These patterns reinforce prior research indicating that somatic symptoms in emergency care may mask emotional distress.

4. Discussion

This quality improvement initiative showed that integrating the MHI-5 screening tool into an emergency department intake process is practical and beneficial. Within a high-acuity, paper-based environment, the project demonstrated that mental health needs often exist beneath the surface of physical complaints, and that a structured screening process can help uncover them. Despite challenges with documentation and compliance, the project highlighted several valuable takeaways. Final screening compliance reached 27.5%, a vast improvement from the pre-implementation baseline of 0%. While not meeting the initial 80% goal, the rise in screening uptake reflected a cultural shift. Staff began to see mental health screening as part of their standard role, not an add-on.

Positive screenings were identified in 5.7% of all eligible patients, consistent with national and state-level data indicating high rates of anxiety and depression symptoms in adults.[10] These numbers confirmed that a brief tool like the MHI-5 could help identify patients with emotional distress who may not openly discuss it. Documentation accuracy emerged as a key limitation. Only 25.9% of patients screened positive had their results documented correctly in the EHR. The reasons were practical: some staff were unfamiliar with where to chart the result, others forgot during busy shifts, and some forms were misplaced. These errors are not unique to this setting and mirror what has been seen in similar quality improvement projects. Practical tools still need systems that support their proper use.

The team introduced quick fixes like visual scoring guides and a designated drop box for completed forms to address this issue. These small interventions helped, but more sustainable solutions, such as EHR prompts or automated score-flags, are needed to ensure accuracy over time. Most importantly, the project uncovered those who presented with physical symptoms such as headache, cough, or abdominal pain yet screened positive for psychological distress. This is the overlooked truth: in emergency care, emotional struggles often show up as physical complaints. Without a screening tool, these underlying concerns go unnoticed. For medical providers, this reinforces looking beyond the chief complaint and considering the patient's emotional well-being.

Multilinear regression findings showed that younger patients, females, preferred Spanish, or screened positive were likelier to report lower MHI-5 scores. These patterns reflect how emotional distress may show up differently across groups. These findings echo broader disparities in behavioral health and call attention to the need for culturally and linguistically responsive approaches. Staff training should focus on tool administration and how distress may appear differently across patient groups.

While screening remained part of the routine, weekly compliance and documentation rates shifted, especially after a new kiosk check-in system was added without staff preparation. This change disrupted how often forms were handed out and returned. It is a clear example of how new processes, when rolled out without input from frontline staff, can unintentionally interfere with even well-planned improvement work. Still, the overall trajectory was positive.

Staff engagement increased over time, with more frequent requests for resource materials and more interest in behavioral health topics. The MHI-5 gave staff a new way to connect with patients and opened the door to conversations that might not have happened otherwise. While the project was limited to a single site and did not follow patients long-term, it provided a strong foundation for broader implementation. To keep this work moving forward, the following steps should focus on adding the tool to the electronic charting system, ensuring staff stay up to date with training, and having a transparent process when someone screens positive. These efforts would make screening a regular part of care in the emergency setting.

This project aligned with the IHI Triple Aim Framework, which emphasizes improving the patient experience, enhanc-

ing population health, and reducing costs. Embedding this framework offered a practical lens for interpreting the findings, helping to ensure that the proposed interventions address the clinical needs identified in the study while also promoting system-level impact and long-term sustainability.[8]

5. CONCLUSION

This quality improvement initiative demonstrated that implementing the MHI-5 mental health screening tool in a fast-paced, paper-based ER is achievable and meaningful. Even in the absence of digital automation, the screening process successfully identified psychological distress that often goes undocumented in acute care settings. Over nine weeks, the tool helped shift mental health from an overlooked concern to a more visible and regularly addressed triage component. Though screening compliance did not reach the initial 80% target, the 27.5% completion rate signaled a critical first step in normalizing behavioral health assessment. The gap in documentation pointed to deeper issues in the system that need attention if screening will lead to genuine follow-up care. The low rate of entries meeting compliance (due to skipped or undocumented screenings) shows the importance of continued staff training, better-aligned workflows, and clear guidelines to record and act on screening results.

Several patients who screened positive came in with physical complaints like breathing issues or pain, but their MHI-5 scores pointed to emotional distress. This demonstrates that comorbid emotional distress concerns can be hidden behind medical symptoms, underscoring the usefulness of routine behavioral screening in the emergency room. This project laid the groundwork for lasting improvements in identifying and managing mental health concerns during emergency department visits. Staff involvement, changes based on PDSA cycles, and investment from leadership helped raise awareness of emotional concerns in patient care. Moving forward, integrating mental health screening into the electronic health record (EHR), implementing consistent follow-up procedures, and maintaining regular audit-feedback cycles will be essential for improving reliability and closing documentation gaps. Incorporating validated tools, such as the MHI-5, into standard practice can enhance the quality of emergency care, creating a more holistic, responsive, and equitable approach for patients with psychological needs.

Implications for practice

The findings from this quality improvement project support the inclusion of routine mental health screening into emergency care workflows. The MHI-5 was a sensible tool for identifying emotional distress in patients who might have otherwise been treated solely for physical complaints. Utilizing the MHI-5 in the intake routine, the project helped position mental health as a standard part of triage, not just something addressed when time allows, or symptoms are apparent. The low documentation accuracy despite successful screening uptake demonstrated the need for improving EHR integration and staff training focused on mental health charting. As emergency departments serve as critical entry points for behavioral health care equipping staff with simple, validated tools and clear protocols becomes essential to improving early identification and response.[12]

Regression analysis showed that younger patients, English speakers, and those classified as positive screens were more likely to have their distress identified. These findings build cultural awareness and help staff recognize emotional distress across diverse patient populations. Without this, screening efforts may miss key subgroups or unintentionally reinforce disparities.

This project also showed that brief mental health screeners can be a starting point for deeper behavioral health integration. When embedded into intake workflows with staff support and clear documentation pathways, tools like the MHI-5 can help emergency departments respond more fully to patients' emotional needs without disrupting the pace of care. With the proper supports, including visual aids, audit-feedback cycles, and EHR enhancements, mental health screening can become a sustainable part of emergency care, closing long-standing gaps in psychological assessment.

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AUTHORS CONTRIBUTIONS

Dr. Garcia completed this quality improvement project under the guidance of Dr. Glikas. The final manuscript was edited by Dr. Glikas. All authors read and approved the final manuscript.

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The authors declare that there is no conflict of interest.

INFORMED CONSENT

Obtained.

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DATA SHARING STATEMENT

No additional data are available.

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