Untintended Impact of Psychiatric Safe Rooms in Emergency Departments: The Experiences of Suicidal Males With Substance Use Disorders

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In general hospital emergency departments (EDs), management of psychiatric crises is challenging. We analyzed issues related to use of psychiatric assessment rooms using semi-structured interviews with adult, male, suicidal ED patients, and ED staff (physicians, nurses, and others). An iterative, thematic analytic process was employed. Although ED psychiatric assessment rooms were designed to provide a safe and therapeutic environment, participants held negative attitudes about the physical attributes and the emotional responses to these rooms. Many patients presented at the ED because they were alone, scared, and lacking social supports, but felt punished when assigned to a psychiatric room. Physical separation and observation were said to escalate symptoms leading participants to question the therapeutic value of the rooms. Although believed to be in the best interest of patients and staff, these rooms may have an unintended negative impact. [Brief Treatment and Crisis Intervention 8:264–273 (2008)]

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development of psychiatric assessment rooms arose in response to the increasing role EDs play in the care of these individuals (Allen, Carpenter, Sheets, Miccio, & Ross, 2003; Zun & Downey, 2005). The goal of these rooms is to provide a quiet and secure space for violent patients as well as to reduce safety concerns for medical staff. However, in a survey of general EDs \((n = 443)\) in the United States (Zun & Downey), only 25.6\% reported using seclusion in their ED. As well, studies show that ED-based psychiatric assessment rooms are sometimes located outside of the ED and hospitals usually have only one seclusion room (Allen & Currier, 2004; Zun & Downey).

The experiences of patients assigned to psychiatric assessment rooms and the medical staff who provide care in these ED rooms has received little attention in the literature. As such, we used an exploratory qualitative design to explore the impact of, and attitudes toward, the ED psychiatric assessment rooms from the perspectives of patients and medical staff.

Methods

Using a grounded theory approach (Strauss & Corbin, 1998), ED patients and staff members were interviewed using a semi-structured guide. Interviews focused on issues related to receiving or delivering health care. ED patient participants also completed a diagnostic interview. The study was conducted between January 2004 and October 2004 in the ED at a large urban general hospital in Canada.

A purposeful maximum variation sampling strategy (Patton, 1990) was used to recruit participants. Males (age 18–45), who presented in the ED as suicidal (i.e., both acute and chronic), had a history of suicidality and a current substance use disorder were eligible to participate. The coordinator regularly visited the ED to determine if any eligible patients had been admitted. If an eligible patient was present, the coordinator asked the attending clinician if the patient was medically stable, competent to give informed consent, and willing to be approached for the study. Males who posed an ongoing physical threat to the interviewer as assessed by the attending physician were excluded \((n = 2)\). Patients were approached consecutively and those who agreed to participate in the study were screened for alcohol and substance use problems using CAGE-AID (Brown 1992). Men who screened positive for substance use disorders were then invited to continue in the study that included both qualitative semi-structured and diagnostic interviews. All interviews were conducted after patients were discharged from the ED \((n = 18)\) or after admission to the psychiatric ward \((n = 7)\). Permission to conduct the interviews with patients during their inpatient stay was given by the attending psychiatrist. To recruit ED staff for interviews, a flyer was posted in high traffic staff locations inviting staff to contact the study coordinator about participation in the study. As well, ED personnel were recruited by referral and word of mouth. We recruited nurses (RNs), physicians (MDs), and other multidisciplinary team members including crisis workers, security staff, and social workers.

All participants provided written informed consent and received $25 (Canadian) for their participation. Research Ethics Board approval was obtained from St. Michael’s Hospital and the Centre for Addiction and Mental Health, Toronto, Canada.

The semi-structured patient interview included questions about mental and physical health issues, suicidality, drug and alcohol use, and usage of and attitudes regarding health-care services and lasted 45 min to 2 hr. The ED personnel interviews consisted of questions about the frequency, experience, and attitudes toward providing care to men aged 18–45 years with mental health, suicide, and/or substance use problems, and interviews lasted
30–90 min. The diagnostic interview was conducted by a trained psychometrist and included the structured clinical interview for DSM-IV (SCID I and II) (Spitzer, Williams, Gibbon, & Williams, 1995), Life History of Aggression, Clinical Version (Coccaro, Kavoussi, Sheline, Lish, & Csernansky, 1996), Lifetime Parasuicide Count (Comtois & Linehan, 1999), Toronto Alexithymia Scale (Taylor, Bagby, Ryan, & Parker, 1990), and the Childhood Trauma Questionnaire (Bernstein & Fink, 1998).

Interviews were tape-recorded, transcribed verbatim, and the transcripts verified for accuracy and then entered into N6 software package (QSR N6. QSR International. 2002). Data from the diagnostic interviews were managed using SPSS. An iterative coding process was used wherein several team members coded, re-read, and re-coded transcripts as necessary (Lofland & Lofland 1995; Strauss & Corbin, 1998).

To ensure the trustworthiness of the analysis, each transcript was coded by a team member and the coding was reviewed, revised, and finalized by another team member. The study team discussed the content of the transcripts and emerging themes as a group. Use of maximum variation sampling ensured that multiple perspectives of the phenomenon in question were included in the final interpretation of results (Patton, 1990). Quotes from interviews are presented below to substantiate our findings and narrative (Rubin & Rubin, 1995).

| TABLE 1. Sociodemographic and Diagnostic Data About Patient Participants |
|-----------------|-----------------|
| **Age (years)** | **Number and Percentage** |
| 20–29 | 8/25 = 32% |
| 30–39 | 11/25 = 44% |
| 40+ | 6/25 = 24% |
| **Place of birth** | **Number and Percentage** |
| Canada | 17/25 = 68% |
| **Marital status** | **Number and Percentage** |
| Never married | 16/25 = 64% |
| Divorced or separated | 8/25 = 32% |
| **Parental status** | **Number and Percentage** |
| One or more children | 7/25 = 28% |
| Lived with children | 0 |
| **Main activity** | **Number and Percentage** |
| Working | 6/25 = 25% |
| **Income** | **Number and Percentage** |
| Less than $19,999/year | 17/25 = 68% |
| **Education** | **Number and Percentage** |
| Completed high school or more | 17/25 = 68% |
| **Axis 1 disorders** | **Number and Percentage** |
| Mood | 23/24 = 96% |
| Anxiety | 19/24 = 79% |
| **Axis 2 disorders (personality disorders)** | **Number and Percentage** |
| Avoidant | 7/23 = 30% |
| Obsessive-compulsive | 4/23 = 17% |
| Passive-aggressive | 6/23 = 26% |
| Depressive | 11/23 = 48% |
| Paranoid | 9/23 = 39% |
| Schizoid | 3/23 = 13% |
| Narcissistic | 4/23 = 17% |
| Borderline | 18/24 = 75% |
| Antisocial | 17/24 = 71% |
| Alcohol use disorder | 22/24 = 92% |
| Abuse and dependent | 16/24 = 67% |

**Results**

Twenty-five patients were recruited over a 10-month period. Please see Table 1 for demographic and diagnostic information about the patients. The ED staff members interviewed included six RNs, five MDs, and six other non-medical ED staff members (i.e., crisis team workers and security officers).

**Reasons for Attending the ED**

The purpose of the study was to understand the role EDs play in the pathways to care for suicidal and substance abusing men. This population of men attended the ED for various reasons. For some men, the visit occurred during a period of intense suicidal ideation or following a suicide attempt.
I sat for about a week with a knife to my chest before I went down [to the ED] (Patient #17).

I took 300 Tylenol with codeine. I thought that would be enough to kill a person . . . I figured I might just as well go to the emergency where they can take the pain away and I’d be gone in a day . . . (Patient #5).

Other men who were assessed during triage to be suicidal said that they went to the ED for support because they were feeling hopeless, anxious, or scared.

I felt lost and . . . hopeless . . . I went to the hospital uh to see someone from crisis team, and just talk (Patient #18).

Uh just some support . . . usually when I come here it’s out of fear . . . I’m scared, that’s the only reason I come here . . . I don’t know it’s like I’m desperate, I don’t want to die . . . (Patient #24).

The ED staff members echoed the men’s need for social support.

They come in, they kibitz with some people on the waiting room, kibitz with the triage nurse, and leave, so I guess that’s a social support in a way (ED Other staff #10).

As well, men said that they went to the ED as a way to see a psychiatrist:

I got myself involved with a psychiatrist the only way I knew how, which was to go into the emergency room and tell them I was thinking about killing myself (Patient #8).

All men in the study reported prior ED admissions related to suicidal ideation or attempts; most reported numerous prior admissions. Despite repeated visits, the ED was frequently viewed as a last resort for care:

If I say, ‘I’m here because I’m suicidal’ they, you know, It’s my last resort. I just hate the feeling (Patient #17).

Um, the hospital is always my last resort, because usually when I come into the hospital I end up feeling worse because of the whole procedure and process, and the waiting and, um, it’s more nerve-wracking for me. So I try to avoid that, but if I feel I need to, if I’m really thinking that I’m going to do something . . . (Patient #19).

Although men presented for a variety of reasons, many patients talked about being assigned to ‘The Room,’’ a psychiatric assessment room regardless of whether a certificate of involuntarily admission under the Mental Health Act for the Province of Ontario had been completed. In general, comments about ‘The Room’ were negative and focused on both the physical attributes and location and the emotional responses it provoked.

‘‘The Room’’—Physical Attributes and Location

Although participants spoke about ‘‘The Room’’ in the singular, there are three psychiatric assessment rooms with similar characteristics located within the main body of the ED. These rooms were designed to address the safety concerns of staff members and to provide a quieter environment for psychiatric assessments. Because of the difficulty of determining at the time of ED triage, the potential for violent behavior, most patients presenting with mental health problems are assigned to one of the psychiatric assessment rooms. The rooms are located in a treatment area comprising a central nursing station surrounded by 10 general treatment beds. The rooms have closed circuit monitoring, and security staff is assigned to the area to ensure patient and staff safety and that patients who are being held involuntarily do not leave the ED prior to discharge.
The psychiatric assessment rooms were designed for patients requiring a quiet environment with close supervision.

Those rooms are also for really violent people who come in, and you can’t really have them just next to somebody who’s really sick with a curtain between them … (ED RN staff #5).

Unfortunately, it’s fairly frequent that we have to put people in restraints … for our safety, but the patients’ beds, the way the emerg is set up, are pretty close and you can run ten feet and you’re at the next patient, so you worry about the other patients too (ED MD staff #7).

However, staff members commented that the ED setting was not appropriate for patients in need of a calm environment:

I don’t think emerg is a good place for … a stabilized individual … you look around, it’s death and dying … so someone who’s stable doesn’t need to see it. Someone who’s not stable certainly doesn’t need to see it (ED RN staff #13).

It’s really hard for someone who’s psychotic and hearing voices to go into an area where they may see people who are physically ill … and sometimes psych just doesn’t get the focus, and for suicidality, I find that it’s a really bad area (ED RN staff #14).

Staff members also noted that the rooms were intentionally stark and lacking in furnishings, decoration, or freestanding equipment in order not to impede the work of the staff and to reduce the injury to self, staff, or other patients:

It’s [the psychiatric room] pretty crude, it’s pretty pared down, and it’s meant simply for observation, and the less you have to observe in the environment and you can focus on the client, the better (ED RN staff #3).

Although staff members indicated that the rooms were intentionally bare, they also spoke negatively about this environment:

Looks like a rubber room (ED RN staff #3)

Fishbowl of a room (ED RN staff #13)

Claustrophobic (ED Other staff #16)

I think [the rooms are] kind of isolated and none of them have windows. I wouldn’t want to be sitting there and being all messed up and depressed for however many hours (ED RN staff #5).

Patients also commented negatively on the physical aspects of the room:

Lovely little room that’s not even decorated (Patient #21).

Once again, what is it with always sending depressed people into gross, disgusting, smelly environments? … I don’t get it. It’s like ‘Hey there, feeling depressed? This room really stinks, and it’s really gross and you look at the metal shutters over the windows and there’s dirt marks on the wall; it couldn’t possibly be more uninviting.’ It’s like right. I don’t get that. Like, is it a rule that it’s some sort of therapy that depressed people should be shoved into stinky, smelly rooms? I don’t know. Maybe such is life, but if anyone’s ever wondering, personally I don’t think it’s the best thing (Patient #15).

**Emotional Responses to the Psychiatric Assessment Rooms**

Many patients presented at the ED because they were alone, scared, and had few other social
supports; being assigned to a psychiatric assessment room felt like a punishment. One patient stated “It was very jail-like and reminded me of prison” (Patient 11). Analyses suggested that these rooms might not have made the patient’s feel safe at all. Instead of calming the patients, being both separated from other patients and observed was believed to escalate some symptoms, especially for patients with paranoia or depression.

They’re all facing ... doctors ... and they’re looking out and they’re like ‘are they talking about me?’ and then when the nurses come in to give a report and then turn around kind of eye-balling the room, well now they know ‘they’re talking about me, what are they talking about?’ ... he’s escalating because he’s in that room—there’s no question about it (ED RN staff #13).

I spoke with uh one of the workers there, staff, and I explain. I, I, I believe I told him ‘you know what, I just cannot stay in this room by myself here.’ I feel like claustrophobic, scared, empty, nothing. (Patient #18).

The length of time spent alone was also noted to contribute to negative experiences. Patient participants stated that they were frequently left alone for long time periods:

I felt they felt that they could just push me back and push me back and push me back, that it didn’t really matter because I was on a Form 1 (i.e. certified) and I had to be there ... I believe it’s an excessive amount of time to keep someone waiting, especially in an emergency situation (Patient #7).

I had to sit around and wait, and wait and wait and wait. If I have any disgruntlement about uh the emergency services it’s waiting, but unfortunately that’s the way it is (Patient #17).

Unhelpful Seclusion

During the interviews, participants questioned whether or not the psychiatric assessment rooms were used as intended. Often patients and staff members spoke about the rooms as analogous to seclusion rooms used in the psychiatric in-patient setting particularly for violent patients.

I’m sure it feels insulting to some clients who are actually voluntarily there, who are in distress, and wanting very much to stay safe and be helped, and they perceive we’re treating them like they have absolutely no control (ED RN staff #3).

Furthermore, patients questioned the use of the rooms for nonviolent patients by stating:

It was a pain in the ass for the one room, the psych room. They like to have this one room that they put everyone in, like psychotic patients and depressed patients, and you can see the dents on the wall, the scratches on the wall, and there was a time between when the nurses interviewed me and the doctor came back, and it was an hour and I didn’t know where anyone was, so I thought that was weird. I mean, it’s not helpful for someone’s mental health to be in that room (Patient #2).

... I was put into a room with a bed with walls. It was pretty plain and I think they use it to lock up irate mental patients that they receive ...” (Patient #1).

The “Squeaky Wheel”

Several staff participants questioned the therapeutic value of the rooms on other grounds. Many believed that some patients deliberately misbehaved to ensure they would be restrained
and assigned to “The Room” believing that they enjoyed the attention they received:

He ends up in restraints every time he’s here but he likes that; he likes the attention (ED RN staff #1).

This belief was not without foundation as some patients admitted to using disruptive behavior (e.g., yelling; threatening) to avoid an overly long waiting time and ensure that a physician would see them more quickly:

So then I look at the person in the cell next to me, like the lady. Well, she freaks out ... The prize for freaking out is she gets Form 1’d, so basically I’ve got to go in there and freak out, but I’m not violent, I’m not an outgoing person, I’m rather an introvert, so it’s not in my nature ... (Patient #1).

She [the crisis nurse] came from the Crisis Centre Unit, so she was coming in every little while, and she would say ‘you have to wait, you have to wait; that’s all there is to it’ and she was very good to me. However, I don’t think she did enough to speed up the process and it wasn’t until I went into a temper tantrum that the process was speeded up like that (snaps; Patient #7).

As some staff participants acknowledged, disruptive patients were likely to be seen sooner than calmer patients:

He’s cooperative, he’s laying there, he’s not fighting them, he’s not escalating, so that’s the type of patient that gets missed because if he’s not making a scene then, you know, the squeaky wheel gets the oil type of thing (ED RN staff #12).

That tends to be a squeakier wheel ... I think they just get the attention quicker because if the police and/or EMS bring somebody in, they get to the front of the line ... versus if they walk in the door and sit in a chair, they may actually feel like crap, but if they’re sitting there calmly waiting their turn ... (ED RN staff #3).

Discussion

EDs are faced with a difficult challenge to provide a therapeutic space for psychiatric patients within the confines of a busy, medical department. Our data suggest the need to further examine the potentially negative impact of the psychiatric assessment rooms in the ED. While health-care providers may believe that placement in these rooms is in the best interest of the patients and the medical staff, this experience may have a detrimental impact on their relationships and interactions. In an earlier study, we noted that negative experiences in a health-care setting often resulted in patients avoiding or delaying visits to health-care providers until a crisis ensued (Strike, Rhodes, Bergmans, & Links, 2006). Avoidance and/or delay of help because of a prior bad experience can have negative and potentially fatal consequences for this group of patients. Although prolonged wait times may color the impression some patients have of the psychiatric assessment rooms, many participants distinguished the frustration they felt as a result of waiting from the experience of being isolated in a room characterized as smelly and jail like.

Our thematic analyses suggest that this population of suicidal men with substance use problems attribute to the psychiatric assessment rooms many of the same qualities often attributed to seclusion rooms that are used in psychiatric inpatient settings. In contrast to our ED setting, only a minority of patients presenting at psychiatric inpatient units are placed in seclusion (Busch & Shore, 2000). Previous research
demonstrates that seclusion can be a negative and anxiety-provoking experience for patients in inpatient settings (Binder & McCoy, 1983; Martinez, Grimm, & Adamson, 1999; Sheridan, Henrion, Robinson, & Baxter, 1990) and that seclusion is considered to be a last resort rather than a first-choice, therapeutic modality (Fisher, 1994). Furthermore, in a recent literature review, Busch & Shore (2000) state that there is no data to confirm or refute the therapeutic justification for separating or restraining patients.

Federal regulations in the United States (2003) state that patients have the right to be free from seclusion except to ensure the patient’s physical safety in emergency situations. However, regulations for the use of seclusion in EDs have yet to be established. Staff and patient participants in our study provided several recommendations for the optimal design and positioning of psychiatric assessment rooms within the larger medical ED. These recommendations may serve to reduce the potential negative impact of such rooms in ED settings. Four of these recommendations were of particular importance. First, psychiatric patients may benefit if the psychiatric emergency area is separated from the main ED. In a separate area, a staged assessment by trained staff to assess the propensity for violence would allow patients to move into a more comfortable and less isolating space, if available. A separate department for psychiatric patients would be beneficial for another reason; staff and patient participants noted that exposure to serious medical problems in a noisy and crowded ED often exacerbates the mental health condition of psychiatric patients. Designing the space in EDs to alleviate some of the negative impacts on psychiatric patients is merited but is a challenge given space and funding constraints. Second, our data point to the need to improve the aesthetics of the psychiatric assessment rooms as well as the need for thorough cleaning between patients. Similar recommendations have been made for seclusion rooms in inpatient settings (Martinez et al. 1999; Blank, Keyes, Maynard, Provost, & Santoro, 2004). Third, our data and the results of a recent study (Blank et al.) highlight the need to design ED settings in a way that discourages nonclinical interactions near the seclusion rooms. This issue has general relevance to EDs that provide mental health care because discussions or socializing by staff members around seclusion rooms may lead patients to perceive that conversation and laughter is directed at them. Fourth, prolonged wait times, often experienced in the ED, may lead to increased patient frustration and volatile outbursts, aimed at expediting care and gaining attention. However, reducing wait times for psychiatric and other patient populations is a difficult challenge to overcome.

Although our study design is suitable for qualitative enquiry where the goal is to derive a conceptual understanding, data were derived from convenience samples thus limiting the representativeness of the data. However, a focused recruitment technique was adopted to ensure that a wide variation in opinion was reflected in the data. Our data and analyses are not generalizable to all EDs, all medical staff of EDs or all suicidal men ages 18–45 with substance use problems. Nevertheless, as shown above, the themes raised during the interviews reflect issues raised by others in the literature.

Psychiatric assessment rooms may be designed with the intention of providing a safe, quiet and nonstimulating environment for patients seeking mental health care in the ED. For patients who are not violent, this level of seclusion may be perceived as punishment and add to their sense of isolation.

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References


