Increasing numbers of people in the United States seek mental health care in emergency departments (EDs). From 2009 to 2015, mental health ED visits increased for pediatric and adult patients by 56.5% and 40.8%, respectively, and the ED length of stay among persons awaiting psychiatric hospitalization increased by 31.7%.1

More visits and longer waits result in persons with mental health crises crowding facilities better suited to treating vehicular than psychological trauma. Most ED staff training for the care of patients with mental illness focuses on emergent treatment, and few EDs are designed as therapeutic environments for people with mental illness. Emergency departments are often the opposite of calming; they are fast-paced, high-acuity clinical settings where staff must exert rapid control in chaotic circumstances to save lives.

In contrast, mental health facilities are typically purpose-built as therapeutic environments for individuals experiencing mental health crises. At their best, these facilities are home-like settings designed to promote recovery by providing private spaces and access to natural light and outdoor settings and encouraging engagement with family and staff while eliminating the possibility of harm to self or others. The staff of these facilities are trained and experienced in person-centered, evidence-based care, including how to respond therapeutically to a patient in crisis and how to understand the experiences of persons with mental illness.

When a person experiencing a mental health crisis seeks care in a setting not designed for mental health, the ensuing encounters can be stressful and even traumatizing. In the study by Wong et al,2 the authors described the experiences of 25 patients who experienced agitation, almost all because of mental health crises, and were subsequently restrained in urban EDs. The authors concluded that these patients desired a therapeutic encounter but instead experienced “coercion and physical restraint during their visits that created lasting negative consequences.”2 Patients often reported feeling assaulted or ignored by staff. One patient said, “The experience in the emergency room, it’s traumatic as hell,” and another said, “[W]hen they restrain you they ignore you.”2

For the present study, Wong et al2 carried out qualitative interviews and surveys with a group of patients who had been recently restrained in the ED and were selected to match the demographic characteristics of restrained patients in an earlier prospective observational study of agitated patients in the ED at an urban tertiary referral center.3 Although nearly 60% of the patients they contacted did not or would not participate in the present study, there is little reason to believe nonparticipants had more salutary experiences of being restrained.

Remarkably, more than half of these patients reported mixed or even positive feelings about the use of restraints when needed to prevent harm, which is striking, given that most reported that being restrained was harmful to them in the moment and had lasting deleterious effects on their well-being.2 When participants offered analogies to the ED experiences in which they were restrained, they compared them to incarceration or childhood abuse, not a therapeutic encounter; many described lingering problems with hypervigilance and flashbacks,2 symptoms of incipient posttraumatic stress disorder that can be induced by physical restraints.4

Some patients said they had learned that being restrained is an inevitable outcome of receiving treatment in the ED. The study did not report how many participants had been restrained previously, but the perception that a negative outcome is inevitable is reminiscent of the learned helplessness.
model of depression in which past experiences condition people to expect (and eventually accept) an
erosion of agency, which, if uninterrupted, leads to a self-reinforcing series of failures of personal
efficacy. For persons who accept restraint as inevitable, being restrained in the ED perpetuates a
vicious cycle, making future episodes of loss of self-control and being restrained more likely.

As physicians who encounter agitated patients, we are moved by these patients’ descriptions of
how dehumanizing it is to be restrained, but their words also forced us to consider how
dehumanizing it can be to put another human being in restraints. No ethical ED clinician can feel good
about a patient describing their ED experience like this: “The people that take care of you on the
other floors are considerate and care and talk to you, but the people in the ED ignore you. They don’t
care about you.”2 What toll must it take on clinicians to walk past a person in pain, tied down, crying
out for help—and pretend not to care? What happens to people who feel they must become inured to
such human suffering to perform their jobs? Especially for people whose early life goals and training
were presumably all about alleviating human suffering, we wonder if restraint experiences contribute
to ED clinicians reporting some of the highest rates of burnout among clinical specialties.5

These patients’ voices remind us that we can learn a great deal about clinical care and about
ourselves by listening to the people we meet as patients. Future studies should also seek out family
and staff perspectives. Family members, often the primary caregivers for persons with mental illness,
surely have rich perspectives on the experiences of those with mental illness in EDs. Emergency
department staff members should be asked about their experiences of placing their patients in
restraints, their understanding of less coercive treatment options, and how restraining patients
affects them.

Such conversations might lead to restorative justice approaches, during which patients and staff
could come together after an event in a therapeutic encounter that would acknowledge the potential
necessity of coercive acts within medicine while working together to avoid future negative
outcomes. Such an approach would benefit from having a community advisory panel and adapting
some of the tools and techniques often used to learn from medical errors, which are already being
deployed to improve the use of restraints in psychiatric settings.6

In the meantime, all of us can listen to persons with mental illness. They are among our families,
friends, and peers, and we should ask them about their experiences receiving emergent care.
Whether or not they have ever been restrained, their experiences can be informative for clinicians
seeking to improve.

Another powerful way to listen and learn is to read patient narratives about receiving
involuntary treatment. In her recent best-selling essay collection, the poet Esmé Weijun Wang wrote
about her experience, saying, “for those of us living with severe mental illness, the world is full of
cages where we can be locked in.”7

The ED should not be another cage. Caring and committed people staff our EDs, and when a
person with a mental illness presents there—especially when they present involuntarily, like 68% of
the participants in the study by Wong et al7—the ED and its staff should be prepared for the
possibility of agitation, including with appropriate physical space and trained personnel. Thus
prepared, an ED should be able to care for most agitated patients without restraining them and never
ignoring them. If we listen to the voices of patients and those who love and care for them, we can
advocate for providing care for persons with mental illness in appropriate settings that minimize
coercive practices like restraints.

ARTICLE INFORMATION
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