ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCES
SCHOOL OF MEDICINE
DEPARTMENT OF PSYCHIATRY

# EXPERIENCES OF PATIENTS ATTENDING THE PSYCHIATRY EMERGENCY OUTPATIENT DEPARTMENT OF AMANUEL MENTAL SPECIALIZED HOSPITAL: QUALITATIVE STUDY

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MARCH, 2024 G.C

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A RESEARCH THESIS TO BE SUBMITTED TO ADDIS ABABA UNIVERSITY SCHOOL OF MEDICINE IN PARTIAL FULFILLMENT FOR THE REQUIRENMENT OF SPECIALITY CERTIFICATE OF PSYCHIATRY

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Experiences of Patients Attending the Psychiatry Emergency Outpatient Department of Amanuel Mental Specialized Hospital; Qualitative study

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## List of Acronyms

| | |
|---|---|
| AMSH | St Amanuel mental specialized hospital |
| CSQ-8 | Client Satisfaction Questionnaire |
| ED | Emergency department |
| ER | Emergency |
| HIC | High income countries |
| ICD-10 | International Classification of Diseases and Related Disorders |
| LMIC | Low- and middle-income countries |
| PED | Psychiatry emergency department |
| PI | Principal Investigator |
| OPD | Outpatient department |
| WHO | World Health Organization |

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## Abstract

**Background**

Psychiatry emergency departments often serve patients who have complex and severe mental health conditions which are meant to relieve the emergent mental health crisis. However, the experiences of the service users at the place of the psychiatry emergency were poorly explored especially from a setting of low-income country. Understanding their experience would help in identifying areas for improvement in the provision of care.

**Objective-**

To explore the experience of patients who had treatment at the psychiatry emergency department of Amanuel Mental Specialized Hospital.

**Methods-**

Qualitative research with phenomenological approach and in-depth interview was employed. The source population included those who had visited the emergency OPD psychiatric unit Participants were recruited using purposive sampling technique. Sampling continued until theoretical saturation was achieved and twelve in depth interviews were done. The interviews were audio recorded, transcribed in Amharic and translated into English. The data were coded using Open code software 4.03. Thematic analysis was used to identify key themes.

**Result-**

A total of four themes emerged from the data. These were participants journey to the ER, positive experiences, negative experiences and future desires and suggestions. Key elements for participants regarding their experience were relief from illness, information and explanation about clinical decisions. Participants also stressed on the importance of participation in their own care, being heard, and making changes in handling the emergency client.

**Conclusion-**

The study examines psychiatry emergency treatment experiences, revealing both positive and negative experiences during psychiatric emergency care, with favorable experiences being connected with good communication with professionals and collaborative treatment. Negative experiences included disregard for emotions, stigma, and a loss of self-governance. Therefore, it is highly recommended to have person centered care for people coming to emergency psychiatry

Key words:Psychiatry emergency,Experience,Patients, Qualitative study

# 1 Introduction

## 1.1 Background

According to the American Psychiatric Association's Task Force psychiatric emergency is defined as:

An acute disturbance of thought, mood, behavior, or relationships that requires an immediate intervention as defined by the patient, family, or the community(1). In addition to this definition, it is also stated that it is a behavior or condition of a person that is often identified by someone else as having the potential to rapidly result in devastating outcome where resources to deal with the situation are not available at the time(1).

Psychiatric patients regularly visit the emergency department (ED) for care during a crisis.

Recent studies show that about 10% of patients in the emergency department have a mental illness(1).Of these, psychomotor agitation/ excitement and self-destructive behaviors or suicidal acts are among the main psychiatric emergencies with the later one accounting for up to 15% of psychiatric emergencies(2).

Psychiatric emergencies may include suicidal ideation, extreme panic, overwhelming life circumstances and mental illnesses that can lead to agitation/violence such as psychosis or mania and medical conditions as well(3),(4).

The initial psychiatric evaluation should focus on symptoms, medical history, psychiatric illness, drug use, allergies, drug side effects, substance use patterns, family history of psychiatric illness, and psychosocial history. It should look for ongoing medical conditions, drug use disorders, withdrawal symptoms, suicidal thoughts, and other psychiatric symptomatology. The major purpose of treating such states of excitation and agitation is to keep the patient from causing harm to oneself and others. This is mostly done using pharmacologic agents and verbal de-escalation strategies that are used to calm the patient and maintain conversational contact(5),(6).

According to the WHO report on mental health and development, people with mental illnesses

who require immediate care are a vulnerable group of people(7).

Although the aim is to manage acute presentations, Some ED encounters in this group of people in psychiatric emergencies maybe ineffective and contribute to recidivism, leading to additional strain on the system for people with mental illness and negative experiences for both patients and professionals(3).

Psychiatry emergency service can be provided as inpatient care and in an outpatient setting. While inpatient care can also be associated with negative experiences like loss of autonomy, limited access to community support systems, social isolation, and cost of the service, it provides a structured treatment environment and greater access to mental health professionals with improved staff patient interaction that can lead to more effective treatment and improved patient outcome (8),(9).

Previous researches from US, UK and Australia have shown that patients in psychiatry emergency departments often experience long waiting times, inadequate communication with healthcare providers, and a lack of access to appropriate treatment options. These challenges can have a significant impact on patient outcomes, including increased risk of hospitalization and decreased quality of life. In addition to this it may have significant impact on their perception of treatment in the future resulting in patients being less likely to seek treatment(10).

Most of the few studies done in Ethiopia regarding patient's experience focuses on the inpatient services and follow up clinics, thus it will be crucial to explore their experience at the psychiatry emergency setting that can help identify areas for improvement in the provision of care for patients experiencing mental health crises.

## 1.2 Statement of the problem

There is limited data on the experiences of patients and their families in psychiatric emergency settings, despite the rising need for psychiatric emergency treatment. There has been no research carried out on emergency psychiatric care practice in Ethiopia and the perspective of the service users that could possibly create a gap in the identification of

problem in the area. By looking into the experiences of those who have sought emergency psychiatric care, this study aims at suggesting potential areas for service delivery improvement.

### 1.3 Rationale

Individuals seeking mental health care in emergency settings face unique challenges, including long waiting times, lack of privacy, and stigma associated with it(11).These challenges can exacerbate the distress of individuals in crisis, leading to negative experiences and reduced engagement in follow-up care. Thus, by exploring the lived individuals' experiences at the emergency department, it would be possible to identify the strength and limitation of the actual service being provided. Later the findings from this study will also help mental health care providers to create more patient-centered and efficient approaches to emergency psychiatric care. It is hoped that this research will be of great importance in recognizing the personal experiences of patients in emergency mental health care and the unmet needs that need to be addressed in the service. It may also benefit emergency mental health care where service-seeking patients receive adequate support and improve the quality of service.

# 2. Literature Review

## 2.1 Theoretical Framework

The theoretical explanation for the appreciation of a situation with a specific mental state of individual relevance can be understood through the Cognitive Appraisal Theory(12),(13),(14). It is a psychological framework which proposes that the way an individual interprets an event or situation determines their emotional response and how individuals make sense of their experiences and how that in turn can have the impact on their mental processes(12),(13).

In the context of a phenomenological study regarding patient experience at psychiatry E0PD, this theory could be relevant in exploring how patients appraise their experiences in the psychiatric setting, especially considering that patients may be subjected to different coercive measures against their will. By understanding how patients perceive the situation of the ED and their emotional experiences at the time, healthcare providers may be able to identify areas for improvement and provide a care in a way that clients' needs are respected. Although the above theory may be useful in understanding the patients' experiences and emotional reactions during a psychiatric emergency visit, this study goes beyond simply exploring their mental state and emotional experience and focuses on grasping their overall perception of their stay at the emergency psychiatry OPD.

## 2.2 Common causes of visit to psychiatry emergency

A nationwide analysis was done on Emergency department use among patients with Psychiatric disorders in the United States in 2018. The results showed that of the total causes of visits to ED, mental disorders, trauma and poisoning were the commonest causes of visit and 16 % of the visits had the psychiatric disorder itself as the main cause for emergency department utilization. Mood disorders (mainly Major depressive disorder) and anxiety disorders were the most common reason for psychiatric ED visits followed by substance use disorders, particularly alcohol intoxication(16).

Another facility-based study was done where a total sample size of 60 was used in one of the referral hospitals in India in 2016/2017.

Most frequent cause of psychiatric referral was the existence of concurrent mental and Somatic symptoms and presenting with overlapping complaints. The study finding indicated that schizophrenia was the commonest diagnosis which is around 30 percent followed by alcohol use accounting for around 25 percent. Mood disorder and anxiety disorders accounted for around 26 percent and 8 percent respectively. The study also showed that among all the patients who visited the emergency 8 percent of them presented to the unit following attempted (17).

A paper that reviewed a six-month chart review of 195 psychiatric emergencies in one of University Hospital in Beirut showed that depression was the most prevalent diagnosis ( 75 individuals), followed by anxiety ( 61 cases). Of the total cases seen 107 patients (54.8%) required admission for adequate treatment.
Being a female, having a family history of psychiatric illness, and having suicidal thoughts were all linked to an increased risk of hospital admission(18).

A study on the presentation patterns of adult psychiatric emergency cases in Nigeria has been conducted. The diagnoses were made using the 10th edition of the International Classification of Diseases and Related Disorders. Patients who were treated in the adult emergency room in one of the hospitals were included, resulting in a total of 180 cases of psychiatric emergencies observed.The study's findings revealed that schizophrenia (24.4%) was the most common diagnosis among the study subjects followed by bipolar affective disorder (17%) and the use of Psychoactive substances (9.4%). Of these, about 90% of the patients were subsequently hospitalized for further management, while 6.1% received outpatient care(19).

Another cross-sectional facility-based research was done in Nigeria on the Urgent and non urgent Presentations to a Psychiatric Emergency Service that was published in 2014. A total of 700 clients who presented to the hospital's emergency room with a major diagnosis of a psychiatric disease in accordance with (ICD10) criteria were recruited. The results of the study showed the percentage of emergency cases among all participants to have been 10.9%. Of the patients with urgent problems, 12.9% were transported by police or ambulance, while 3.8% had been mechanically restrained at home by family members prior to presentation.
Patients who struggled with substance abuse, had a history of suicide thoughts or attempts, and

were defaulters from regular outpatient clinics were found in emergency situations more(20). The study findings differed from the earlier study in terms of the common visits' causes.

According to a study conducted in one of the mental specialized hospitals in Ethiopia on the satisfaction and associated factors among the service users, schizophrenia accounted for the majority of the diagnosis which is around 26.4%, followed by bipolar disorders accounting for around 21%, the rest accounted for depression, anxiety and epilepsy(21).The above study was conducted both in outpatient and inpatient units and there was no study available to see the common causes of visit specifically at the emergency department.

### 2.3 Experiences of patients at psychiatric emergency

A review of qualitative researches on the subjective experience of psychiatric crisis management in the emergency department included39 articles published between January 1, 2000 and April 1, 2020. Twenty-three articles were conducted in the US, 6 in Australia, 5 in Canada, 4 in the UK and 1 in Belgium were reviewed. Although there were some reports of positive treatment experiences, most emergency department participants described the service they received being inadequate and that their needs were not met(10). The study also showed that the participants had invasive investigations and intrusive questioning. The study participants described their experience with restraints at the emergency setting as something that deprived of their dignity and it being degrading and members specifying encounters of physical, verbal, and sexual mishandle during the procedure. The participants also compared their treatment at the emergency to being in jail. The study result also showed that their experience at psychiatric emergency, particularly the use of restraints, to have had a long-term psychological impact on them(10).

Patients with severe agitation and acute episodes with behavioral disorder who have not responded to verbal or non-sedating pharmaceutical therapies may be restrained or sedated. The techniques mentioned above might often be used in an emergency when a patient presents with an acute behavioral disturbance to the emergency department(22). A systematic review that reviewed 26 studies was conducted in 2017 in attempt to study clients' perceptions of scenarios associated with restrictive strategies. The study result showed that communication

and empathic interaction during the time of coercive measure showed association with the participant's experience as being positive or negative(23).

A review and meta-aggregation of qualitative studies published in 2023 found that patients' hospitalization experience and involuntary treatment are linked to decision-making, staff relationships, and perception of effective and safe treatment; and the study suggested encouraging patients' voice and collaboration in decision-making, as well as strengthening patients' viewed closeness, respect, and fairness(24).

The hospitalization experience and patients' perception of the compulsory treatment are found to be influenced by involvement in decision-making, staff relationships, and to meet patient demands, professionals should be more sensitive to their perspective and develop communication skills(23),(25).

A qualitative study was done on the experiences of people who were physically restrained in the emergency department. 25 adults who received a physical restraint order linked with an ED visit in United States between March 2016 and February 2018 participated in semi structured in-depth interviews. The participants insisted that they were forced to be treated against their interest, being degraded, felt their independence being taken away, and reported to have experienced mistreatment with both verbal and physical abuse from ED staff. According to the study, a patient's relationship with the healthcare system may suffer long-term effects because of their emotional reactions to being restrained, which included perplexity, irritation, worry, and a sense of being alone. The clients expressed a need for therapeutic connection and compassion(22).

A research done in 2003 on patient's satisfaction with psychiatric services provided by the emergency department of one of the hospitals' in Australia, demonstrates greater satisfaction, especially with the accessibility of professionals with psychiatric treatment capabilities. The major ranges of disappointment recognized by patients included: long holding up times, need of security within the triage zone and negative demeanors of common staff(11).In another study done in Australia, employees from the emergency department and mental health services identified areas for improvement, including space upgrades, mental health education, referral

services, and hiring more personnel(26).

To address some of the issues pertaining to the patients' perspectives on emergency care, another qualitative type of study was conducted in Canada and published in 2007.The study finding revealed that participants reported feeling abandoned in the waiting rooms, long waiting times, and the respondents in the study also described ED setting to be arousing and terrifying, and it frequently aggravated agitation(27). Professionals who triage patients with mental illnesses are also impacted by the practice environment of the emergency department pointing out the necessity of having a safe, discrete location that is visible to the staff to provide the care(28).

Another study on the satisfaction of patients with emergency department psychiatric treatments in Ireland was published in 2008. In the study, CSQ 8 was used to assess service satisfaction and both qualitative and quantitative means of data collection were applied. The findings indicates that, 14 participants took part, and it was discovered that 35% of respondents scored a low level of satisfaction, 29% a medium level, and 36% high level satisfaction. The study showed that major reasons for their unpleasant experiences at the emergency setting being lack of bed availability and the lack of information that was provided to them by the care providers, long waiting hours till their evaluation time and staff communication(29).

Another qualitative study was conducted in Sweden in 2021 to investigate the significance of collaboration with the prehospital emergency psychiatric unit as well as the experiences of patients, psychiatric and mental health nurses, and significant others. The results from the paper showed that the participants had a positive experience with their encounter with the staffs and that they felt respected and supported. They also reported that the mental health care providers seemed to be experienced, knew how to handle patients and understood them. That, in turn, left them with an experience that created stability and a sense of self-worth(30).

Patients visiting an emergency setting felt they were labeled and stigmatized as psychiatric patient regardless of their presenting complaint and that their concerns were disregarded according to a study done in Canada(27).

Stigma associated with mental illness, particularly stigma within the healthcare system and among healthcare practitioners, has been highlighted as a key barrier to treatment and rehabilitation, resulting in lower care quality for mentally ill persons(31),(32),(33).

According to studies done in developing countries, the stigma of mental illness can arise from a lack of understanding or information, as well as the meaning of the illness itself, such as agitation with the threat of violence and exposing clients to forceful therapeutic procedures(34),(35). According to a study done in Zambia regarding stigma and mental illness, stigma in mental emergencies can stem from a lack of understanding about the condition and its meaning, leading to fear of potential violence(36).To reduce stigma, educational strategies and training for healthcare professionals on how to handle psychiatric emergencies can be implemented to enrich knowledge about the condition(37).

Another study was conducted in South Africa and published in 2023 regarding patients' experience subjected to coercive measures. A cross-sectional study design was used, and the results showed that such measures were associated with negative emotions, such as anger and sadness. Patients reported feeling as though they had lost all autonomy and had no say in their treatment. It further highlights that efforts should be made to ensure that patients take part in making decisions as much as possible and explore alternative strategies to coercive measures whenever possible(38).

A study published in 2022 on the experiences and views of coercive strategies among patients in Nigeria, qualitative study was performed. Participants found the usage of chains to be both dehumanizing and agonizingly unpleasant(39).

As far as the search for this literature review, there is no published data regarding the experiences of individuals who had psychiatry emergency service in Ethiopia. But there was a study done on physical restraint of people with Schizophrenia in community settings in Ethiopia. The primary reasons for restriction were to protect the individual or the community, and to ease transfer to health care institutions.

The reasons given were backed up by a significant caregiver burden, a sense of powerlessness, and widespread stigma against people with schizophrenia. The study emphasizes the violation of rights in community settings in rural Ethiopia, as well as the need for accessible and inexpensive mental health(40).

# 3. Research Question

What are the experiences of patients who had treatment at the psychiatry emergency OPD of Amanuel Mental Specialized Hospital?

# 4. Objective of the Study

## 4.1. General Objective

- To explore the experience of patients who had treatment at the psychiatry emergency OPD of AMSH

## 4.2. Specific Objectives

For patients attending emergency psychiatry OPD of AMSH

- To explore the reasons for seeking psychiatric emergency services
- To explore the circumstance of the presentation of the participants
- To explore on the experiences of people during their psychiatric emergency department visit
- To explore the participant's need regarding the EOPD service
- To explore on the challenges and gaps in care

# 5. Method

## 5.1 Study design

A qualitative study with phenomenological approach/ design was used to examine the experience of patients undergoing psychiatry emergency care at Amanuel mental specialized Hospital.

## 5.2 Study setting

The study was conducted at Amanuel mental Specialized Hospital in Addis Ababa. AMSH is one of the public hospitals and the only mental specialized hospital in Ethiopia. The hospital has 300 beds and 17 OPDs.The monthly average numbers of visits in the outpatient psychiatry emergency department being 461 people.

## 5.3 Study period

The study period was from July 25 to October 10, 2023 G.C.

## 5.4 Study population

The source population included patients who had visited the emergency OPD psychiatric unit at AMSH. The participants were recruited from patients who are on follow up at the hospital OPD and those admitted to wards after visiting the emergency OPD. The source population consists of patients with history of visit to AMSH psychiatry emergency in the last 3-6 months of data collection to minimize a potential recall bias from respondents.

## 5.5. Inclusion and exclusion criteria

**Inclusion criteria**

- Patients who visited AMSH emergency OPD
- Patients aged 18 and above
- Patients who are not acutely ill and having capacity to consent to be involved in the

study based on the treating physician and primary investigators assessment.

- Patients who can speak Amharic

**Exclusion criteria**

- Patients who are acutely ill.
- Patients who are not willing to be involved in the study

### 5.6 Sampling

Purposive sampling was used based on their age, sex, educational status and residency to have rigorous data. The participants were selected based on the eligibility criteria above. They were informed through their treating physicians and healthcare providers about the ongoing study. Once they are informed about the details and the procedure of the study and after informed consent is taken, the interview was conducted through the principal investigator. Sampling continued until theoretical saturation was reached, and twelve participants were interviewed.

### 5.7 Data collection

Data was collected by the principal investigator using semi-structured in-depth individual interviews. Confidentiality and privacy of the information was insured by conducting the interview in private AAU office at AMSH. The in-depth interview guide created for this study was translated to Amharic language and used by the PI for conducting in-person interviews. The interview guide included the experiences of patients at the psychiatry emergency setting. All participants were given information sheet and for those who were able to read and was read and explained for those who did not. Written consent was taken after making sure they understood the purpose of the study and agreed to participate. Data was recorded using an audio recorder, and two participants opted out of the audio record and were not included in the study. There was no participant that faced distress or requested to discontinue after the initiation of the interview. The interview guide included questions

on demographic characteristics and followed by semi-structured in-depth interview. In order to minimize potential bias, leading questions were avoided. The interviews lasted from 30 to 50 minute. Some adjustments were made to the interview guide after discussing with thesis supervisor to gather data with more depth.

### 5.8 Data management and analysis

All the recorded interviews were transcribed into Amharic and translated in to English. All English translations were checked for accuracy through listening to recordings. Then coding was started using Open code software 4.03. Total of 12 participants were included in the result. Then patterns were looked for and codes were sorted into potential themes. Important themes were generated by inductive thematic analysis. Four major themes emerged with thirteen sub-themes. The emerged themes were checked with the original data to minimize bias that may have occurred during translation

### 5.9 Result Dissemination Plan

The study result will be submitted and presented to Addis Ababa University, School of Medicine, and Department of Psychiatry. The findings of the study will also be disseminated to AMSH in hard and soft copies to help fill the gap identified and improve the service provided

## 6 Ethical considerations

Ethical clearance was obtained from the Department of Psychiatry, College of Health Sciences, Addis Ababa University IRB, and Amanuel Mental Specialized Hospital ethical review board. Research participants were given information sheet which contains information on the purposes, procedures and the right not to participate or withdraw from the interview if they felt distressed. Interview was carried out after informed consent was obtained using informed consent sheet. Every caution was taken to ensure that all participants understood their right to withdraw from the study if they felt the need to without any negative impact on their treatment. Confidentiality was insured by omitting personal identifications and not sharing their information to anyone other than the research team and by giving code for a participant.

# 7. Result

## 7.1 Characteristics of the participants

In this study, 12 participants' who have attended the psychiatry service of AMSH EOPD were interviewed. The age range is from 27-43 years and their educational level ranges from 8th grade to masters' degree, apart from one participant who has not attended formal education. Four of them are females and the rest are males.

All participants are included in the analysis. Eight were orthodox Christians, two protestant Christians, one a follower of Jehovah witness and one a follower of Muslim religion. Among the participants seven were single; three were married and have children, and two were divorced. Eight of the patients were from Addis Ababa and four were from the regions (Oromia & Amhara).

The minimum duration of illness among the patients as inferred from the history is 2 years, and the maximum is 15 years. The conditions leading to their treatment at AMSH EOPD include Schizophrenia, Bipolar Disorder, Major Depressive Disorder with psychotic features, Obsessive Compulsive Disorder with depression, and Catatonia

Except for four participants who were visiting the psychiatry emergency department for the first time, all others had multiple visits. Four of the participants were recruited from the outpatient clinics while the rest were recruited from the wards.

| Coded ID | Age | Sex | Religion | Address | Marital status | Educational status | Employment | Diagnosis | Duration of illness |
|---|---|---|---|---|---|---|---|---|---|
| P001 | 43 | F | Orthodox Christian | A.A | Divorced | BSc degree in Applied chemistry | Employed | Bipolar disorder | 13 years |
| P00 2 | 38 | M | Protestant Christian | Oromia Region | Single | BSc degree in theology | Employed | Bipolar disorder | 4 years |
| P003 | 27 | M | Orthodox Christian | A.A | Single | BSc degree in accounting | Employed | Bipolar disorder | 13 years |
| P004 | 30 | M | Jehovah witness | A.A | Single | BSc degree in engineering | Employed | Schizophr enia | 6 years |
| P005 | 29 | F | Orthodox Christian | Amhara region | single | Diploma | unemployed | OCD with MDD | 6 years |
| P006 | 35 | M | Protestant Christian | A.A | Single | College dropout | Employed | Substance induced psychosis | 10 years |
| P007 | 32 | M | Orthodox Christian | Oromia Region | Married | College dropout | Unemployed | Schizophr enia | 11 years |
| P008 | 34 | M | Orthodox Christian | Oromia region | single | MSc degree in teaching | Employed | Catatonia due to schizophre nia | 15 years |
| P009 | 27 | F | Muslim | A.A | Divorced | 8$^{th}$ grade | unemployed | Bipolar disorder | 3 years |
| P010 | 39 | M | Orthodox Christian | AA | Single | 8$^{th}$ grade | Unemployed | Schizophr enia | 2 years |
| P011 | 39 | M | Orthodox Christian | A.A | Married | 9$^{th}$ grade | Employed | Schizophr enia | 12 years |
| P012 | 38 | F | Orthodox Christian | A.A | Married | No formal education | Unemployed | Catatonia due to MDD | 4 years |

*Table 1-Summary of socio demographic and associated data*

## 7.2. Themes identified

In this study experience of clients who have attended the psychiatric EOPD of AMSH was done by using phenomenological method. After analysis was done four major themes and total of thirteen subthemes emerged from the data.

**Theme 1**

- ❖ Journey to ER

**Subthemes**

- Willingness to come to the ER
- Emergent distresses and ailment

**Theme 2**

- ❖ Positive experiences

**Subthemes**

- Prompt and effective treatment
- Good Communication with health care workers
- Future outlook on the ER treatment
- Collaboration in treatment

**Theme 3**

- ❖ Negative experiences

**Subthemes**

- Stigma
- Loss of self-governance
- Challenges and disparities
- Disregard to emotions

**Theme 4**

- ❖ Future desires and suggestions

**Subthemes**

- Emotional validation
- Mutual or joint treatment decisions
- Handling the emergent client

### 7.2.1 Journey to the ER

The participants in the study described a variety of circumstances that led to their presentation to the emergency psychiatry. The study explored the participants' willingness to come to the emergency and the emergent distresses that were present during their presentation to the emergency. The participants described their circumstance of presentation in the following ways.

#### 7.2.1.1. Willingness to come to the ER

Most participants, with a few exceptions, reported that they did not willingly seek emergency psychiatric care and were forced to go by their family members. Some of the participants also mentioned that they did not know where they were being taken at the time. Their forceful presentation produced negative feelings such as frustration, anger, being frightened and sadness.

> *"….I was very exhausted… I was thinking if I was going to die and if the end was near because I was very sick at the time and I was scared and frightened…" P003*

The majority of those who were brought involuntarily linked their reluctance to visit to their state of illness at that time and acknowledged being brought to the emergency during the interview.

> *"……I was resistant to come, so my neighbor was biting me with a belt and also tied me and brought me here. After I have gotten better, I understood all my family did was for my own good …."*

Another male participant reported concerns about being seen by others in a bound state while being brought to the emergency physically restrained and described that he was not aware of the place his families were taking him to.

> *"…They didn't tell me where I was going. I realized that I was coming to Amanuel when I was around Merkato. I know people around there and I was thinking what they would think of me if they saw me like that as I was passing by…" P010*

In addition to this, frustration, arising from the perceived violation upon their autonomy, was a common emotional reaction among those compelled to seek care against their will at the time.

One of the male participants described the strong negative emotions he felt while being brought forcefully to the emergency treatment.

*"…I was brought here by my brother and other relatives restrained. …. I was angry and heartbroken that I had to come forcefully…" P007*

Although majority of them described being brought to the psychiatry emergency unit against their will, there was one participant, who reported to have taken the initiative to come to the emergency considering the distressing illness she had at the time.

*"…The thoughts I had started getting very distressing and out of control … it was a voluntary visit , I asked them to bring me here(referring to her family)…" P005*

#### 7.2.1.2. Emergent distresses and ailment

When participants were asked the reason for their emergency visit, most stated that it was for a mental illness or because of some form of abnormal behavior including aggression or violence towards others, paranoid thoughts and hearing of voices, substance use, and acute exacerbation of an existing mental health conditions. The participants acknowledged the need for the visit at the time reflecting on it retrospectively.

*"…. The reason I came was, I was so irritable and bad tempered, I started breaking things like glasses and spilling things and I was wandering around during night times also …" P009*

*"… A month prior to my current I was sick and visited the ER.I was then admitted and discharged, but that my symptoms relapsed shortly. I had loss of interest, preferred not to talk to anyone, I was bored and later I started sitting at a place for long and stopped communication and eating …" P012*

### 7.2.2. Positive experiences

One of the major themes that was reported by participants was the positive experiences they had from their emergency visit. There were various reasons that contributed to it. Among these, the most common ones were the effective treatment and relief they had from their distressing illness, good communication and collaboration with health care providers

regarding their treatment and how that has positively affected their future outlook on the treatment.

#### 7.2.2.1. Prompt and effective treatment

Participants described the emergency treatment they received as a form of alleviation from their illness. In addition, they often highlighted on the necessity of the emergency treatment which was experienced as a means of immediate relief from their distressing symptoms.

> *"…. I was arguing with everyone and I was telling them that they were going to kill me, then I received injectable medication and slept afterwards. When I woke up, I realized the injections were treatment because it calmed me very much. I understand the injections are like putting a water on a burning fire…" P009*

> *"…The injection I got had a very calming effect. Although it is not the complete treatment, you go back to your old self at least temporarily for that moment..." P003*

One female participant revealed how she was able to sleep after her emergency visit. *"My over all experience at the emergency was good and I was also able to sleep after getting treated". P012*

Although most participants highlighted on the necessity of the emergency treatment and reported it as part of journey towards recovery, in addition to symptom relief, there were few who didn't understand the need for their visit and described it as unnecessary. One of the participants described feeling not trusted at the time because of the forceful treatment he received while believing he was fine.

> *"…I was not disturbing or aggressive the last time I was at the emergency, if I was calm why the need for injection? But they gave me anyways. They asked me some symptoms and told them what was there. It feels as if they don't trust me or trust what I say..."P007*

#### 7.2.2.2. Good Communication with health care workers

The participants mentioned their interactions with staff members, including information

sharing regarding the illness and being given the opportunity to be heard during interviews as a beneficial experience. For most of the participants, such kind of communication with healthcare providers was important and helpful in assisting patients understand their illness and brought pleasant emotions.

> *".... One of the physicians that I encountered took his time and told me in-depth about my illness and gave me some counselling. He was also the one that got me admitted here. That conversation I had with him gave me some relief and helped me in understanding my illness ..." P005*

One of the participants also reported how he felt pleasant emotions as the healthcare professionals he encountered gave their time and opportunity to involve both him and the family member that brought him to the facility noting the importance of having an honest conversation with them during treatment.

> *".... The professionals initially interviewed my sister and then they talked to me, at last they called us both and discussed things with both of us…They allowed me and my sister to have a conversation with each other in the room without getting emotional or her giving me false promises…" P006*

One of the female participants, who was unable to communicate and converse with health care personnel at the time due to her illness, stated how it made her feel good when the professional tried to talk to her despite her condition, and how that instilled hope for the possibility of recovery at the time.

> *".... I was not communicating and replying to them much due to my illness, but they tried to talk to me while giving me the treatment. I felt good at the time and was thinking I was going to feel better…." P012*

There were also participants who reported disappointment regarding the lack of communication they had with the treating staff putting an emphasis on the need to be properly communicated.

#### 7.2.2.3. Collaboration in treatment planning

In this subtheme participants discussed their overview on how the joint effort of health professionals with the patients and at times with families in creating a treatment plan created a positive feeling. Most participants often expressed satisfaction with the process itself, recognizing that their opinion was valued when involved in the decision-making process of their treatment.

> *"…When I returned the next day with my appointment, the physician that treated me at the emergency told me what he was thinking and how he was planning to treat me, we discussed and he convinced me about the admission too. So, it made me feel good, as if I was treated well…" P001*

Another participant who was brought involuntarily and had multiple visits to the emergency, commented about how much better his involvement in the care was than on his prior visits. He added that it made the recent encounter he had more pleasant due to it.

> *"… I would say in my recent visit I was actively involved. In my previous visits I would say maybe 25 percent of the decision was given to me, this time maybe 50 percent or even more….It feels good that I have a say in the treatment I get…." P006*

#### 7.2.2.4. Future treatment outlook in the emergency

Another prevalent theme that arose among the participants was related to the positive influence that their emergency experience had on their future treatment outlook, which was attributed mostly to the relief they had from their illness. It was also perceived by participants as part and means of enrolment in the mental healthcare.

> *"…. The emergency department is the main area where I learned I should get treatment and it is where I was calmed and it is the place where your presenting complaint disappears. And I recommend emergency treatment for anyone who faced similar problems, I think you need to come to the emergency first and then get enrolled in other cares…" P009*

Participants described the emergency experience as an important one not only from the perspectives of their own but from what they observed from other patients experience as well. In addition, they advised and suggested it to others who could be experiencing similar issues.

*"…. I would encourage others or be willing to visit the ER myself if faced with similar problems. I also saw some patients there who had worse presentation and met them at the wards showing great improvement …" P003*

### 7.2.3. Negative experiences

The unpleasant experiences of patients during emergency visits can be categorized under four subthemes. The first subtheme pertains to the stigma that some patients felt from healthcare professionals, the second subtheme relates to the loss of self-governance that some patients experienced during emergency visits leaving them to feel helpless and powerless. The third subtheme is disregard for emotional needs, which refers to the lack of emotional support that some patients received during their emergency visit. Finally, the fourth subtheme pertains the challenges and disparities.

#### 7.2.3.1. Stigma

Among the negative experiences mentioned by participants was feeling stigmatized due to their illness. The use of labels, particularly being identified as "psychiatric patients" in the emergency room was repeatedly reported by the participants. Majority of the participants mentioned how such labeling can contribute to a range of negative consequences, including the imposition of compulsory treatment.

*"…I was the patient but they rather chose to discuss and decide on my admission with my family without telling me. This wouldn't have happened if I was not someone with a mental illness. The thing is everyone assumes you are crazy, so they don't think you would understand…." P010*

In addition to this, one of the participants highlighted on stereotyping associated with being labeled as a psychiatric patient and on how it influenced the attitudes and behaviors of healthcare professionals in the emergency room that subjected her to physical mishandle. The labeling was believed to have resulted in dismissive behavior and a lack of emotional consideration from health care professionals.

*"…No body is concerned about your feelings or emotions; they forcefully hold your*

*hands, pull you over and give you injection once labeled crazy… I felt lots of unpleasant emotions, as if I lost my respect … The thing is even if you are sick, you don't always go completely insane, part of you still feels and knows. It's different between different types of illnesses…" P001*

The issue of mental illness and stigma was also believed to arise from the lack of knowledge and lack of awareness the society has on the matter. This was also believed to be reflected on the hospital staff and particularly guards, which resulted in being devalued according to one participant, expressing disappointment in his experience.

*"…. Most people's understanding about mental illness is very much limited. This is seen especially with the guards here. They treat you with less respect just because you are a psychiatric patient. I am really disappointed in them honestly……" P003*

**7.2.3.2. Loss of self-governance**

The other recurrent theme that emerged was the loss of autonomy felt by the participants who visited the emergency. Participants reported feeling excluded from making decisions in the process of their treatment, feeling powerless and loss of control. These major decisions that they felt being left out from included their treatment initiation, choice of treatment and admission plans.

*"…. What choice did I have besides getting the injection? It makes me feel nauseous and gives me chill. If I resist, they would just give me the injection forcefully. That is what happened previously, I argued and resisted before but it didn't matter. Now I just stopped …" P007*

Participants who had repeated visits to emergency also described how the feeling of being excluded from the decision of their treatment resulted in them giving up on the idea of it due to the repeated similar experience they encountered previously.

*"….They were supposed to talk to the patient, not my father… Back in 2012, when I noticed that they didn't interview me and finished after talking to my father I tried to confront them and asked them why they didn't talk to me, but now I stopped…" P002*

Some participants described on how they are not given the opportunity to be engaged in their care and that anyone could use their diagnosis of mental illness to get them hospitalized despite the state they are in. One of the participants mentioned the experience he had regarding his treatment at the emergency as going to prison where he felt like he was being accused of something.

> *"…when they were talking about my admission and management, they only talked to my wife and her sisters who were with me. I was sitting outside and they were standing and talking with them, it looked like I was being taken to prison and my families were there to give testimony …" P011*

Some participants attributed their lack of involvement in their treatment for their illness. *"…I would have liked it if I were actively involved and done the process myself but the illness has prohibited it…" P008*

#### 7.2.3.3. Disregard to emotions

In this subtheme participants mentioned feelings of their emotional needs being disregarded. They reported feeling ignored or dismissed to express concerns and emotions, leaving them frustrated.

> *"…I always get angry thinking about this, the emergency treatment is about preparing a syringe and giving medications. Nobody cares about your emotions or try to hear you out. Psychiatric illness is about emotions…" P001*

One of the participants noted the impact the lack of emotional consideration may have on ones feeling based on his experience and described on how it resulted in additional distress to the pain he was feeling at the time.

> *"…I think they needed to hear my emotions and understand what I was going through. I'm already in pain and that just adds another suffering…" P002*

#### 7.2.3.4. Challenges and disparities

The fourth subtheme pertains challenges that were faced by the participants. Most of the participants reported feeling uncomfortable and stressed due to these environmental factors, negatively impacting their overall experience.

> *"…There were people, and it was not pleasant, and it was like a chaotic town then, it made me feel stressed and made me anxious added on top of my restlessness…" P009*

Other challenges described by another participant were the issue of the lack of privacy during evaluations in the ER room which was perceived to be crowded. In addition to this, the high physician turnover during ER appointments making clients to disclose information on their illness repeatedly was experienced as challenging and exhausting.

> *"… when I got evaluated, the ER room was so crowded with so many professionals and I think some of them were also trainees and I didn't like that...On top of that there is high physician turnover here, the physician that saw you today won't be there when you return for evaluation the next day. They don't know your case and it's like starting all over again..." P001*

One participant reported the long waiting time he had while receiving treatment as a challenge. *"...I stayed for around 3 hours… I started asking why it was taking long, I was a bit worried about things. I arrived at the emergency around lunch time and by the time we were done with everything it was after 11…" P011*

Another challenge described by one participant who received treatment at emergency, was on the triage system. He described how being evaluated in the same emergency with other patients with severe mental illness was distressing, although his presentation was relatively a milder one at the time.

> "…*It was distressing being around patients who were severely ill while I was somehow better. The initial emergency evaluation would be better if done at separate place..."P006*

On the contrary, there were few participants that described the emergency to be calming and peaceful. One participant who visited the emergency for the first time describing the fear he

felt because of the public’s perception of the hospital’s rough treatment and how his experience changed the perception he held prior to his visit to the emergency.

> *“…Everyone talks how brutally patients are treated at Amanuel…honestly it was a different story, they treated me and accepted me like a mother would accept her child…Also, the thought of the church being next door helped me somehow…”P010*

## 7.2.4. Future desires and suggestions

The preferences expressed by participants highlight the need for emotional validation, patient involvement in treatment decisions, and a change in the pattern of restraint use in psychiatric emergencies.

### 7.2.4.1. Emotional validation

Majority of the participants described the importance of healthcare professionals acknowledging and validating patients' emotions, feelings, and experiences and respecting their perspectives.

> *“…I feel like it would be better if they interview patients, especially those who would be able to give information or talk and also to provide emotional support and care for patients not just medications…” P002*

> *‘…. Mental illness is about your emotions too. Professionals need to talk to you and be concerned for your emotions. They need to give you their time and hear your concern…’’ P001*

### 7.2.4.2. Mutual or joint treatment decisions

The participants also described the desire on the importance of patients taking an active role in their healthcare decisions and treatment, expressing concerns, and participating in shared decision-making with healthcare professionals.

> *“…I would like to see professionals involving us and letting us know about the treatment plans and not just families and see the rights of patients being respected; for*

*the treatment to be more transparent …” P004*

Almost all described the need to be communicated during admission plans with one participant making an emphasis on the weight and impact of the admission decision. He mentioned how admission could have an impact on one's sense of self-worth and described the need to raise opinions during such treatment decisions.

*"…I understand it may be necessary and admission to wards maybe a relief too, but you would still lose a lot of things when you become a patient at psychiatric wards. Being a patient by itself, you feel like you are beneath everyone. There is a big difference between sleeping at home and sleeping at a hospital. It's a big deal and it would have been nice to be asked about our opinions or feelings on it and not just the families when they decided to admit us to the ward…"* P011

#### 7.2.4.3. Handling the emergent client

The necessity for altering the prevalent practice of administering injectable medication and reducing its use in psychiatric emergency situations has been highlighted by most participants. Furthermore, the participants described the need to tailor the administration of such medication to individual patients' requirements.

*"…. If someone is disturbing, I understand about the use of the injection. If not, I don't think they should give it to us. The emergency is all about administering injections, that needs to change…" P007*

The participants also mentioned the significance of treating clients with respect and also commented on minimizing the use of physical restraints that was perceived as inappropriate. In addition to this, majority of the participants stated for the treatment not to always start with injectable medication and suggestions like other means of administering medications were made.

*"…I don't think the treatment should always start with injection. I think there could be a time where po medication would be enough to calm you down or just talking to us*

*may be enough, ... pushing and twisting arms to just administer medication needs to change…" P001*

*"…I would say that I would appreciate it if the guards and nurses treated everyone with respect. It would be good if they realize that someone can someday be at a better place ..." P003*

Although majority of the participants in this study provided suggestions for potential improvement in the service being delivered at the emergency, few of them described the treatment as being really satisfactory. One female participant reported to continue the treatment the way it's being currently given.

*"…I have received an utmost help and I am satisfied with the emergency service, for me I would not change anything about it…" P009*

# 8. Discussion

In this qualitative study, we have explored experiences of twelve participants who visited the Amanuel psychiatric emergency outpatient department by using phenomenological method. Four themes emerged from the data. The themes were journey to the emergency, positive experiences of their emergency visit, negative experiences and future desires and suggestions of participants. This study has also tried to figure out how the positive experiences were attained and factors that contributed for the negative experiences as well as suggestions mentioned by participants regarding the service they received.

This study tried to explore the circumstances of the participants' presentation to the emergency. The majority of participants reported to have experienced unpleasant emotions since they were coerced by family members into an emergency visit that they didn't want at first. The respondents acknowledged the need for the visit at the time reflecting on it retrospectively attributing their lack of desire for the visit to their illness at the time. This experience elicited negative emotions and was associated with a diminished sense of agency over their illness and mentioned it could have been managed through less coercive interventions. A review and meta-aggregation of qualitative studies done provided a thorough understanding of patients' experience of involuntary admissions(24). The review revealed patients' experiences of coercion in acute care setting, influenced by their involvement in decision-making, staff connections, and satisfaction with care. Patients report negative effects and demanded less forceful and more efficient ways, highlighting the need for better care (24). Another qualitative study done in England showed patients often felt mentally unwell before admission and out of control during treatment. The study explores patients' varying views on involuntary visits, with some believing it to be necessary for treatment and recovery, while others wished for less coercive interventions(25). The findings in the above studies were consistent with our study as well with the experience of negative emotions to be associated with involuntary treatments. Most of the participants in our study also revealed and acknowledged the ER visits, wishing the procedure to be less coercive.

According to our study some positive experiences mentioned by participants were experiencing relief from their illness. Furthermore, good communication between patients and healthcare providers was crucial for understanding their illness and reducing negative emotions. The joint effort of health professionals and patients, as well as families, in creating a treatment plan was associated with positive emotions in emergency treatment.
Consistent with previous findings was the idea that pleasant experiences and emotions, such as a sense of self-worth, are linked to effective relationships and communication with staff as well as patient collaboration in the treatment(23),(30). This also aligns with the cognitive appraisal theory, which suggests that individuals' emotional responses are influenced by their perceptions and interpretations of events(12),(14). In the context of effective relationships, communication and collaboration in treatment, positive emotions may stem from favorable appraisal of such experiences, emphasizing the importance of cognitive processes in shaping emotional outcomes.

Among the unpleasant experiences that the participants mentioned in our study was the difficulty of feeling stigmatized by staffs because of their illness and that, due to their condition, participants reported to have experienced devaluation, which left them feeling disrespected and frustrated. According to a study done in Zambia on stigma surrounding mental illness, it is found to be prevalent, impacting the general public, family members, healthcare providers, and government officials due to misconceptions about its cause, fears of infection, and perceived danger(32). A study conducted on psychiatric outpatient and inpatient settings has revealed that stigma is a common experience that negatively impacts the care received by patients. Similar experiences are reported in Low and middle income countries(LMIC) and in high-income countries (HICs) consistent with our study findings showing the consequence of stigma in individuals with mental illness having a negative impact on their self-esteem(27),(37),(35),(33).

A review of 23 qualitative studies from 2000-2020 found (10) that most emergency department participants reported inadequate service, degrading their dignity, and encountering physical, verbal, and sexual mishandling. They compared their stay to jail and experienced long-term psychological impact from restraints in psychiatric emergencies. These findings are also consistent with a study done in US and Nigeria regarding the coercive measures in the

emergency, where patients claimed to have no control over their care and to feel completely abandoned. There were also negative feelings present, such as sadness and the coercive measure was experienced as dehumanizing(22),(39). The respondents in our study also reported to have experienced a loss of self-governance, feeling excluded from decision-making processes and powerless. They also felt their emotional needs were ignored, leading to frustration and a disregard for their concerns and emotions.

The study also explored the challenges the participants faced in the psychiatric emergency department environment which was reported by most respondents as overcrowded, not comforting and chaotic that resulted in aggravating the agitation they were experiencing. The physical environment of ED was found to be a limiting factor for clients' receiving treatment and these environments were considered to be over stimulating and lacking privacy in other studies as well (10),(28),(27),(41).
Another repeated theme that arose from the studies regarding the difficulties with the ED environment was long waiting times, which was only reported by one participant in our study.

This study looked into the participants' needs and suggestions on the emergency care they received. The majority of participants emphasized the significance of healthcare personnel acknowledging and validating patients' emotions, feelings, and experiences, as well as respecting their points of view. Participants also expressed a desire for patients to have an active role in their healthcare decisions and treatment plans, to raise concerns, and to participate in shared decision-making with healthcare providers. They also suggested a need for change in injectable medicine delivery practices, minimizing its use in psychiatric emergency situations, and personalizing medication delivery to specific patient needs. In a study done regarding consumers need in psychiatry emergency (1),(42)it similarly emphasized the necessity of treating patients with respect and including them in treatment decisions which was consistent with our study's findings. They also noted the importance of verbal treatments and collaborative techniques, and oral medications in emergency psychiatry, which also aligns with the recommendation of the Expert consensus guideline on the treatment of behavioral interventions(43), stating the treatment to be guided by individual client's need. Employees from the emergency department and mental health services also summed up the main areas for improvement as the need for , upgrades to the space in the emergency environment, mental

health education, establishing a referral service, and hiring more personnel(26).
Based on the above studies additional suggestion pointed that was different from our study included, establishing pleasant ED environment, utilizing peer support services, enhancing staff training, promoting teamwork, and improving discharge planning and follow-up.

## 9. Strengths and limitations

The major strength of this study is that it has tried to explore the experiences of patients inthe psychiatric emergency which has not been done in past studies in this country.
It has also tried to explore the participants' challenges and their preferences regarding the emergency service provided. To increase the credibility of the data adequate amount of time was given for the participants to express their ideas and participants with varied socio-demographics were interviewed. The process of data collection and analysis was described in detail to optimize dependability.

One of the limitations of this study is the possibility of bias stemming from interviewees' knowledge of the interviewer's psychiatric background, which might limit their desire to disclose difficulties associated with provided services. Additionally, subjective interpretation of data may introduce potential bias by the PI.

## 10. Conclusion

Exploring the experience of participants in psychiatry EOPD might help in identifying what challenges clients face and what contributes to those experiences. This may in turn promote enhancement of the therapeutic relationship and empathetic understanding of patients, possibly improving the service care provided.

In this study, participants reported to have had positive and negative experiences during their psychiatry emergency treatment. Effective communication with staff, collaborative treatment and positive outlook on future treatment were reported by the respondents. Among the negative experiences the participants' described, disregard of emotions, stigma, uncomfortable emergency department environment and loss of self-governance were the prominently mentioned ones. In addition to this the participants emphasized to be involved in their own treatment, to be heard and change in rampant use of injectable medications.

## 11. Recommendations

Based on the findings of this research, we recommend psychiatric emergency departments

- To have effective communication and collaboration between healthcare providers and patients,
- To take measure in balancing the use of both physical and chemical restraints based on client's presentation.
- For other studies to be done on the area including the experience of mental health professionals at the emergency OPD and
- To provide appropriate training to healthcare providers on how to manage patients in a psychiatric emergency department setting.

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# Appendix

## 1.English information sheet and consent form

**Title of the study**

Experiences of Patients attending the emergency outpatient department of Amanuel Mental Specialized Hospital, Qualitative study

**Primary researcher -**Dr Hawi Wondimu, Final year psychiatry resident

Primary advisor**-** Dr Ruth Tsigebrhan

Department -Psychiatry

Address-Addis Ababa

phone number -0913912469

Email-hawiterefe3@gmail.com

**Participant information sheet.**

Hello, my name is Hawi Wondimu. I am a final year psychiatry resident at Addis Ababa university, as part of my training, I am conducting research on the Experiences of Patients attending the emergency outpatient department of Amanuel Mental Specialized Hospital.

**Purpose**

To explore the experience of patients who visited the psychiatry emergency at AMSH.

**procedures**

Patients who had visited the emergency OPD psychiatric unit at AMSH will be included in the study. The interview will take about 60 minutes, in a private office. Notes will be taken in addition to audio recording during the interview. You will be asked about your understanding of the study and once that is checked you will be asked to sign a consent form

**Risks**

There is no anticipated risk in participating in the study. At times people might find some of the questions distressing or time consuming, in which case you are not obligated to answer.

**Benefits**

You will not benefit from this study. But that you will be contributing to the development of a better service at psychiatry emergency and allow other researchers to give attention to the matter.

**Confidentiality**

You will not write any identifying information and audio recording will not be including your identifying information as well. Once the data is analyzed all the recorded data will be cleared. Every effort will be made to keep the confidentiality by the research team.

**Contact information**

If you have questions or complaints about this study, you can contact the researcher and department of psychiatry at AAU through the contact information provided.

Address of AAU- Phone-(+251)118962052

**Voluntary participation**

Your participation in this study is voluntary. If you decide to take part in this study, you will be asked to sign a consent form. Any time during the interview if you decide to no longer participate in the study, you are free to withdraw anytime and will not affect your treatment at AMSH.

**Consent form**

I have understood and accepted the information provided about the research, procedure, risks, and benefits, as well as my participation in the research. I have been notified about the voice recording and that the researchers will make an effort to keep the information I provide private. I have also read and understood that my participation in the study is entirely voluntary and that I may withdraw at any moment. I consent to take part in the research study of experiences of patients attending the psychiatry emergency outpatient department of Amanuel Mental Specialized Hospital.

Participant’s signature-------------------

Date----------------------------------------

Researcher’s signature--------------------

Date-----------------------------------------

**2.Sociodemographic characteristics of the participant's**

Age

Sex

Religion

Marital status

Educational status

Occupation

Living situation

Address

Duration of illness

Working diagnosis

**3. Topic guide**

Thank you for agreeing to participate in this study. I will now be asking you regarding your experience at the psychiatry emergency OPD.

- What was the reason for seeking psychiatric emergency services?
- o What were the symptoms present at the time of visit?
- o What brought the need for psychiatry emergency evaluation?
- o Previous treatment history?
- o Any previous visit to psychiatry emergency/What was the reason for the visit?

- Can you tell me how you arrived at the emergency opd?
- o Who brought you?
- o The circumstance of the arrival at emergency (walking, accompanied, alone, chained, uncommunicative)?
- o Was it voluntary or forced by other people?

- What did you feel when you arrived at the emergency department? Why did you feel that way?
    - o Feelings of safety

- Emotional reactions
- Was there anything that provoked that feeling?

- How long did you wait till you receive treatment?

- Would you tell me more about the services that you received at the psychiatry emergency?
- Were you interviewed?
- How was the hospital staff action towards you? What did you feel and think about that?
- Any use of pharmacologic agents/restraints
- Engagement in the decision making

- What did you feel towards your encounters with your treating physicians at the emergency OPD?

- What are the aspects of your experience at the psychiatry emergency department you saw as a positive experience and what could have been improved up on?

- Would you recommend seeking psychiatry emergency service for someone in need?

## 1.የጥናቱ ተሳታፊዎች መረጃ ቅጽ

ሰላም ስሜ ሀዊ ወንድሙ ይባላል፡፡በአዲስ አበባ ዩንቨርስቲ የአዕምሮ የህክምና ክፍል የመጨረሻ ዓመት ሰልጣኝ ሀኪም ነኝ፡፡ ከስልጠናዬ ጋር በተያያዘ በአማኑኤል የአዕምሮ ስፔሻላይዝድ ሆስፒታል እንክብካቤ በሚደረግላቸዉ ታካሚዎች በድንገተኛ ታካሚ ክፍል የነበራቸዉን ተሞክሮ እያጠናዉ ነዉ፡፡

የጥናቱ አላማ፡- ጥናቱ ታካሚዎች በድንገተኛ የአማኑኤል የአዕምሮ ህክምና ክፍል የነበራቸዉን ተሞክሮ የሚዳስስ ነዉ፡፡

ጥቅሞቹ፡- በዚህ ጥናት ላይ በቀጥታ በመሳተፎ የሚያገኙት ጥቅም ባይኖርም ከዚህ ጥናት የሚገኘው መረጃ ወደፊት የሚሰጠዉን አገልግሎት ለማሻሻል ያግዛል ተብሎ ይታሠባል፡፡የእናንተ መሳተፍ ምርምሩ ያመጣል ተብሎ የሚታሰበዉን አስተዋፅኦ ለማሳካት ይረዳል፡፡

አደጋ ፡-በጥናቱ ላይ የእርሶ ተሳትፎ በፍቃደኝነት ላይ የተመሰረተ ሲሆን በመሳተፎም የሚመጣ ጉዳት አይኖርም፡፡ምናልባት በቃለመጠይቁ ጊዜ የመጨነቅ ስሜት ከተሰማዎት ያለመቀጠል ሙብት ይኖሮታል፡፡ከተሳትፎዎት በማንኛዉም ጊዜ አቋርጠዉ መዉጣት ይችላሉ፡፡ ፡፡ይህ ቃለመጠይቅ በድምፅ ይቀዳል እንዲሁም ወደ ፅሁፍ ተቀይሮ በእንግሊዝኛ ይተረጎማል ቃለ መጠይቁ እስከ 1 ሰዓት ሊፈጅ ይችላል ። ቃለ መጠይቁ የምናደርገው ደህንነቱ በተጠበቀ የግል ቢሮ ውስጥ ነው።በቃለ መጠይቁ ወቅት ምንም መረጃ እንዳያመልጠኝ ከማስታወሻ በተጨማሪ ድምጽ እቀርፃለሁ። የድምጽ መዝገቦቹ ለዚህ ጥናት ብቻ ጥቅም ላይ ይውላሉ። በሁሉም የጥናት ማስታወሻዎች እና ሰነዶች ላይ የኮድ ስሞችን ወይም ቁጥሮችን በመመደብ ምስጢራዊነትዎን እጥብቃለሁ። የእርስዎን ስም ወይም ሌላ መለያ መረጃ አልጠቀምም። ከመቅረፀ-ድምጹ የተገኘው መረጃ በጽሁፍ ከሰፈረ እና መረጃው ከተተነተነ በኋላ የድምጽ መረጃው የሚደመሰስ ይሆናል፡፡ይህ ጥናት ከተጠናቀቀ በኋላ የሰጡን መረጃ ሌሎች ተመራማሪዎች ሊጠቀሙበት ይችላሉ፡፡ነገር ግን በምንም መንገድ የእርስዎን ማንነት ሊያውቁ የሚችሉበት ሁኔታ አይኖርም፡፡ከጥናቱ ጋር በተያያዘ ለሚኖሮዎት ጥያቄ /ቅሬታ ከታች በተገለፀዉ አድራሻ ማናገር ይቻላል።

ስም - ዶ/ር ሀዊ ወንድሙ (የአዕምሮ ህክምና ስፔሻላይዜሽን ሬዚደንት)

ዋና አማካሪ - ዶ/ር ሩት ፅጌብርሀን

የትምህርት ክፍል -የአእምሮ ህክምና ትምህርት ክፍል፣ አዲስ አበባ ዩኒቨርሲቲ

አድራሻ - አዲስ አበባ

ስልክ -0913912469

ኢሜል – hawiterefe3@gmail.com

የአዲስ አበባ ዩኒቨርሲቲ የአእምሮ ህክምና ትምህርት ክፍል አድራሻ፡-

ስልክ- (+251)118962052

**<u>የተሳታፉዎች ፍቃድ መጠየቂያ ፎርም</u>**

**የዚህ የመረጃ ቅጽ አንድ ኮፒ ይሰጥዎታል፡፡**

በዚህ ጥናት ላይ እንዲሳተፉ ተጋብዘዋል፡፡ በጥናቱ ለመሳተፍ መወሰን ያለቦት ለመሳተፍ ከፈለጉ ብቻ ነው፡፡በጥናቱ ለመሳተፍ ፍቃደኛ ሳይሆኑ ቢቀሩ የሚከሰትብዎት ጉዳት ወይም የሚያጡት ጥቅም አይኖርም፡፡በዚህ ጥናት ላይ ለመሳተፍ ከመወሰኖ በፊት ጥናቱ ለምን እንደሚካሄድና ከተደረገልዎት ገለጻ የመነጨ ጥያቄ ካለዎት በፊት መጠይቁን የሚያካሂደውን ግለሰብ ይጠይቁ፡፡

- በማንኛውም ጊዜ በምርምሩ ላለመሳተፍ ከወሰንኩኝ፤ ከምርምሩ እራሴን ላገል እንደምችል ተረድቻለሁ፡፡☐
- በዚህ ጥናት ላይ ለመሳተፍ ከወሰንኩ፤የፈቃደኝነት መጠየቂያ ቅጹን እንድንፈርም እጠየቃለሁ☐
- የሚሰጡን መረጃ ሚስጥራዊነት እንደሚጠበቅና ከሚወጡትም ሪፖርቶች ማንነቶን ለማወቅ እንደማይቻል ተረድቻለሁ፡፡ ☐
- ቃለ መጠይቁ በድምፅ መቅረጫ እንዲቀረፅ ተስማምቻለሁ፡፡ ☐
- የሰጠሁት የግል መረጃ ለተገለፀልኝ አላማ ጥቅም ላይ ይውል ዘንድ ተስማምቻለሁ፡፡ ☐

እኔ ማንነቴ በኮድ የተገለፀዉ ግለሰብ ስለጥናቱ ምንነትና የተሳትፎዬን ሁኔታ በቃልና በጽሁፍ ገለፃ መረዳቴን ገልጻለሁ፡፡

የተሳታፊ ፊርማ ---------------

ቀን—------------------------

የቃለ መጠይቅ አድራጊ ፊርማ **----------------**

ቀን—----------------------------

**2.የተሳታፊ ማንነት**

ስም፡-

ዕድሜ፡

ፆታ፡-

ሀይማኖት፡-

የትዳር ሁኔታ፡-

የትምህርት ደረጃ፡-

የስራ ሁኔታ፡-

አድራሻ፡-

የህመሙ አይነት፡-

የህመም ጊዜ፡-

**3. የርዕስ መምሪያ**

በድጋሚ ፈቃደኛ ሆነዉ ስለመጡ እናመሰግናለን

- ወደ ድንገተኛ የአዕምሮ ህክምና ክፍል የመጡበትን ምክንያት አስረዱኝ፡፡
  - በጊዜዉ የነበሩትን የህመም ምልክቶች ካስታወሱ እባኮዎትን ይንገሩኝ?
  - ከዚህ በፊት መተዉ ታክመዉ ያዉቃሉ?
  - ከአሁን በፊት ወደ ድንገተኛ የአእምሮ ህክምና ክፍል የመጡበት አጋጣሚ ተፈጥሮ ያዉቃል ምንድነበር ምክንያቱ?
- እንዴት ወደ ድንገተኛ ክፍል እንደመጡ ያስታዉሱኛል
  - ከማንጋር ነበር የመጡት?
  - እንዴት ነበር የደረሱት?
  - በፍቃደኝነት ነበር ወይስ በሰዉ ግፊት ነበር የመጡት?
- ምንድነበር የተሰማዎት ድንገተኛ ክፍል ሲደርሱ?ለምን ነበር የተሰማዎት?
  - ይህንን ስሜት የፈጠረዉ ነገር ነበር? እስቲ ስለሱ ይንገሩኝ?
  - ህክምና እስኪያገኙ ምን ያህል ጊዜ ቆዩ?
  - እባኮዎ ያገኙትን ህክምናዎች ምን አንደነበሩ ይንገሩኝ?
  - ከህክምና ባለሙያ ጋር ተገናኝተዉ ነበር?
  - የህክምና ባለሙያዎች ለእርሶ እንዴት ነበሩ?ምን ነበር እያሰቡ እና እየተሰማዎት የነበረዉ?

- ህክምናዎት ላይ እርሶም ተሳትፎ ነበርዎት?

- ህክምና ስለሰጦዎት የህክምና ባለሙያዎች ምንድነበር የተሰማዎት?
- በድንገተኛ ክፍል በነበሮዎት ቆይታ ጥሩ የሚሉት ነገር ነበር? አስቲ ካለ ስለእሱ ይንገሩኝ? ቢሻሻል ቢቀየር የሚሉትስ ነገር አለ?
- ሌላ ሰዉ ተመሳሳይ የሆነ ችግር ቢገጥመዉ ወደ እዚህ የድንገተኛ  የህክምና ክፍል መቶ እንዲታከም ይመክራሉ?

## Declaration of original work

I, the undersigned, declare that this thesis report is my original work, where my work is indebted to the work of others, it has not been accepted or presented for a degree in this or any other university and that all sources of materials used for the thesis have been fully acknowledged.

Name of Investigator: __________________________

Signature: ____________________________

Date of submission: _________

This thesis has been submitted for examination with my approval as University Supervisor

Name and Signature of the first Supervisor _____________________________

Name and Signature of the second supervisor ___________________________