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Don't Label Me: A Qualitative Study of Patients' Perceptions and Experiences of Sedation During Behavioral Emergencies in the Emergency Department

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Don't Label Me: A Qualitative Study of Patients' Perceptions and Experiences of Sedation during Behavioral Emergency in the Emergency Department

Abstract

Objectives

Behavioral emergencies are commonly seen in emergency departments. Acutely agitated patients can be difficult to manage and sedation may be required to decrease dangerous behavior and to ensure the safety of both the patient and staff. While the experience of staff caring for this population has been reported, patients' experiences with their overall management remains unknown. We aimed to describe the perceptions and experiences of patients regarding the use of sedation during acute behavioral emergencies.

Methods

Face-to-face semi-structured interviews were conducted with adults aged 18 years or older, who had received parenteral sedative medication for the management of a behavioral emergency and were deemed capable to participate. The participants were asked about their experiences of receiving care in the emergency department during the episode and their perceptions of sedation. All interviews were transcribed verbatim and analyzed thematically.

Results

Data saturation was reached after 13 interviews. Two broad themes emerged: trusting relationships; and needs or wants following sedation. A trusting relationship is built through (i) confidence in care; (ii) sedation as an appropriate treatment; (iii) insight into own

behavior; and (iv) humane treatment. Four subthemes of needs or wants were identified: (i) empathy; (ii) debrief; (iii) addressing concerns; and (iv) follow up.

Conclusions

A trusting relationship was identified as crucial to minimize the negative impact of coercive measures used to manage behavioral emergencies. Participants expressed similar needs to patients presenting with medical problems. This study illustrates their needs for compassionate communication, adequate information about the treatment provided, and follow-up care.

Introduction

Acutely agitated patients are commonly seen in emergency departments (ED). As these patients may cause harm to themselves or others, acute agitation is also known as behavioral emergency (BE). A proportion of acutely agitated patients will need to be managed with coercive measures such as restraint and sedation[1,2]. In many cases, the patients do not have the capacity during these emergencies to participate in the therapeutic decision to sedate them.

Several studies have explored patients' experiences of involuntary medication administration during psychiatric emergencies in the inpatient setting.[3-11] In studies which examined patients' emotions after being involuntarily medicated,[5,7-9] the majority of patients expressed being fearful, angry, helpless, and powerless; only a very small proportion expressed relief and gratitude.[5] However, it is not known how these emotions influence the patient-staff relationship, trust and future health seeking behavior.

Current literature addressing patients' perspectives and experiences on BE care, particularly in the ED, is scarce. Allen et al.[12] reported that most respondents did not feel that the staff had adequately addressed their problems or concerns about the treatment during their stay in the ED. More than one half reported that the experience had made them unwilling to seek out psychiatric care again. That U.S based study suggests that the impact of a negative experience could be minimized by identifying and addressing patients' needs during a BE.

Recent studies have reported healthcare providers' experiences in caring for agitated patients in the ED,[13,14] but have not explored patients' accounts of their experiences. Our study aimed to provide a voice for patients who received care during their BEs in a single ED. The objectives were to explore the impact of this experience on the patient-staff relationship and to understand the needs of patients following sedation. Understanding the patient experience could enhance communication between clinicians and patients, inform training, and ultimately optimize patient care in situations where sedation cannot be avoided.

Methods

Study Design

This phenomenological qualitative study was designed to explore patients' experiences within a short one-to-one semi-structured interview (i.e. 30 minutes or less), taking into consideration participants' mental state after recovery from sedation. This study was approved by the Human Research Ethics Committees of Melbourne Health and Monash University.

The research team comprised a diverse, multidisciplinary team with complementary areas of expertise. JK, DT, and MG each have more than two decades of experience in emergency care and extensive research experience in the management of clinical aggression; providing an insider's perspective on this research topic. DK is a pharmacy practice academic with experience in qualitative studies; providing an outsider's perspective to the study design. The interviewer, CY, is a PhD candidate with clinical experience in providing care to patients with mental illness and is trained in qualitative data collection.

Study Setting and Population

This study was conducted in the ED of an Australian metropolitan, tertiary referral, public hospital with an annual census of 70,000 adult presentations. All individuals presenting with a BE are first brought to an emergency behavioural assessment room. The internal security call designated as Code Grey is triggered. Code Grey is a structured team approach that all ED staff and security personnel are trained to implement[2,15,16]. If a show of force and verbal de-escalation fails, the individual will then be restrained and sedated. After initial assessment,

mentally stable patients will be transferred to the behavioral assessment unit (BAU), a discrete area within the ED Observation Unit, specifically designed to create a safe and therapeutic environment for these patients.

All patients aged 18 years or more presenting with BE in the ED, who required parenteral sedative medication, and who were psychologically stable and capable of providing informed consent, were eligible to participate in this study. Potential participants' ability to participate was assessed by the ED doctors, nurses or the emergency mental health clinicians responsible for monitoring the patients, and was based on the Acute Arousal Scale (AAS)[17]. Potential participants were approached only if they had an AAS score of 2 (mildly aroused, pacing, still willing to talk reasonably) or 1 (settled, minimal agitation). Individuals were excluded if they were physically or psychologically unstable or unable to demonstrate capacity to provide informed consent. Participants were enrolled daily from 7 a.m. to 9 p.m. between May and September 2016. Individuals who were treated and discharged overnight were excluded.

Study Protocol

All interviews were conducted in a private cubicle within the BAU while patients waited to be discharged. During the interview, the door was closed and no other people/patients could overhear the conversation. Potential participants were identified by ED staff. To minimize missed cases, BAU staff received daily telephone reminders.

All potential participants were given a plain language statement about their rights and the study objectives. As no reimbursements were offered to participants, there was minimal risk of social desirability bias where participants may have felt more compelled to tell interviewers 'what they wanted to hear'.

To ensure participants were mentally fit to comprehend the plain language statement, informed consent was carried out in two stages (Fig.1). Verbal informed consent was sought from each participant, including permission to audio-record the interview and to access the medical record. After recording verbal consent, the interviewer asked three true/false questions designed to test understanding of the information (e.g. their rights as participants)

given in the Participant Information Form (PIF). Participants were permitted to refer to the PIF when their capacity was being assessed. Participants were deemed to have an adequate understanding to provide informed consent if they received the full score of 3.

If the participant preferred the interview not to be audio-recorded, the interviewer took notes consisting primarily of key phrases, and lists of major points made by the participant. To minimize the risk of introducing professional and personal biases, participants' medical records were only reviewed by the interviewer after each interview.

Data Collection

The interview guide (Data Supplement S1) and study protocol were reviewed by an applied ethicist to assure all appropriate measures were in place to safeguard participant's rights. CY conducted all interviews to avoid interviewer bias. To diffuse any perceived coercion, CY was not involved in the clinical care of participants. Participants were asked to describe their experiences of care in the ED, and to comment specifically on perceptions of sedation, suggestions for improvement, and any other issues. Interviews were audio-recorded, if permitted by the participant and transcribed verbatim. Interviews were conducted until data saturation was reached.

Demographic data, presenting complaints, final diagnosis, sedative medications prescribed, and medical history (e.g. previous experience of similar presentation) were collected to facilitate a deeper understanding of the findings.

Data Analysis

All interview transcripts and field notes were entered into NVivo 11 (QSR International, Victoria, Australia) qualitative data management and analysis software. Data from interviews, field notes, and medical records were triangulated to help corroborate the findings.

Thematic analysis of the interview transcripts followed Braun and Clarke's[18] approach. CY reviewed all transcripts and field notes during the data collection period and, in consultation with JK and MG, created a tentative thematic framework in accordance to the research questions and responses during the process of open coding. These broad themes were then coded line by line. All transcripts were iteratively reviewed and the thematic framework was refined. A third-party member with an experience in qualitative research (KS) independently reviewed the entire data set to ensure consistency in application of codes and to confirm the credibility of the major themes.

Results

Fifteen patients were approached during the study period; two females declined because of ongoing psychosocial crises. Data saturation was achieved from 13 participants, comprising eight males and five females. Participant characteristics are listed in Table 1. Seven participants had presented multiple times to different EDs (range: 2-40) and six participants had presented with a BE for the first time. The interviews lasted between 5 and 35 minutes.

Two main themes were identified: (1) trusting relationships; (2) needs or wants following sedation. Each of these themes comprised four subthemes. Key quotes for the main themes and possible mechanisms to improve care for these patients are summarized in Table 2.

(1) Trusting relationships

Most participants expressed a certain level of trust toward staff, regardless of the measures used to help them calm down. Trust was expressed as staff demonstrating respect for the person.

> *"I was spoken to with respect, I was given choices and they were genuine you know..." (P8)*

> *"I actually have the most respect for the hospital staff. I think they're absolutely fantastic including the guards that restrain me and I know that they are here to help me so I actually have so much respect for the hospital staff." (P11)*

One participant, however, was uncooperative with the staff and expressed serious doubt about getting the needed treatment in the ED:

"Would they give me help? I doubt very much." (P3)

A trusting relationship is built through multiple factors and the following four subthemes were identified: (i) confidence in care; (ii) sedation as an appropriate treatment; (iii) insight into own behavior; and (iv) humane treatment.

Confidence in care: "They know what to do"

Participants with multiple presentations expressed confidence in care from knowing the ED staff have the experience to handle their BE professionally. Despite being restrained or sedated, they believed that these measures were for the benefit of both staff and themselves.

"You know what? I don't mind, because I know they do it properly, they are doing it for their own benefit, for my benefit, they are doing it properly." (P10)

Commonly participants had no recollection of being sedated or restrained; however, on waking to find themselves being cared for in the ED, they believed that what had been done to help them was appropriate.

"…they bring me here, they saved my life. As you said, I can't remember what happened last night. They still bring me here and looked after me…they know what they do and you should just trust them. That's part of their job, they know what to do…" (P5)

Sedation as an appropriate treatment: "It calmed me down"

Although all participants received involuntary sedation, retrospectively they agreed that the sedation was appropriate and necessary. They believed sedation was helpful to calm them down and to regain self-control regardless of the cause of their agitation. One of the participants had no recollection of her sedation event, but she witnessed another episode when she was in the ED.

"I saw a young man this morning, four security guards had to try and get him back to the room… I heard the nurse, she did the right thing, she rang down for them [the security guards] to hurry up and come up with a syringe to knock him out, because he's going to kick and scream and he will probably hurt somebody…I thought it was a good thing give him a needle quickly because if you restrain him he's going to go

crazy. He's going to make a lot of noise – because I do it – so give him a needle. Let them sleep. Then they wake up (and) feel better…" (P10)

One participant expressed her frustration at having many ED staff around her during the BE. Despite the frustration, when asked about what she thinks about sedation, she agreed that the sedation was helpful to calm her down.

"It (the medication) calmed me down…I just don't like the whole process…When they surround me with 12 people, it is embarrassing..." (P3)

Methamphetamine-affected patients tended to fight the sedation process during the BE due to paranoia-inducing effect of methamphetamine; however, they acknowledged that a period of sedation is much needed to relieve the withdrawal effects.

"I didn't want to do it but then… I accept. Like I just, I needed it. I knew I needed it…cause I wanted the relief, just because the ice was just too much…" (P7)

Insight into own behavior: "I can't physically control myself to slow it down again"

Although all participants retrospectively felt ashamed and embarrassed, their perceptions of their management were influenced by their insights into their behavior and their experiences with health professionals and services. One participant recounted the process leading to sedation and emphasized the significance of giving agitated patients sufficient time to comprehend their own crises. A large proportion of patients in acute social crises found it hard to trust others due to their past history of trauma. Therefore, participants appreciated the efforts of the ED staff to encourage patient participation during the BE and allow them time to realize they could trust the staff and allow treatment to be provided. Trust developed through respect and time.

"Yeah, that it just wasn't in out. It was 'Okay this is what's going on'. But it was also okay I got the feedback they were saying to me, you know 'You're getting over the top' and all this sort, and it had to sink into my brain… I realize how distressed I was when I came in, but I've still got the knowledge about myself… At one point I was just going 'I'm going crazy', but alright, let them take over because I'm just, I can't control what's happened to me and it's just a reaction that I can't slow it down and

stop it quick enough I can't (do it) myself. I couldn't get in control of it. I can't physically control myself to slow it down again…. " (P12)

Participants with multiple presentations for BE generally had good insight into their disruptive behaviors due to alcohol or methamphetamine intoxication. When asked what alternatives could be offered to help them, they generally agreed that restraint and sedation are the only options.

"The way they dealt with it was pretty good. Yeah, I couldn't really fault them, the way they dealt with it." (P7)

Humane treatment: "Being treated like a human being"

Participants were asked what is important to them while receiving care in the ED during their BEs. They found it comforting to be treated with respect, autonomy and non-judgmental communication.

"Being treated like a human being, because I've got addiction and psychiatric issues. A lot of people change their point of view, especially when they find out you're using methamphetamine. There's like what I call an ice block that comes in between, it's like a big block that comes in as soon as that word 'methamphetamine' is mentioned, society treats you different. But last night nurses were very professional about it, they've treated me well and I'm feeling a lot more relaxed and calmer today …" (P8)

Similarly, participants appreciated the ability of the ED staff to normalize their psychosocial crisis.

"I think they have a really, really rough job; but every time I've asked for something they're straight on to it helping me out. Yeah, they even have a bit of humor to some of the things that happen …" (P11)

Attentive and coordinated care created feelings of relief and security. Most participants expressed their gratefulness to the staff who had helped them to feel at ease in the ED, despite the ongoing crisis in their lives.

"I've been very lucky. It's been coordinated. If I've asked for something, it's kind of been immediate responses all the time– so I mean it's not like I felt ignored or anything– I find it very attentive…" (P12)

(2) Needs or wants following sedation

Most participants felt shameful about their disruptive behavior when they were mentally unstable. However, they voiced their desires for healthcare providers to look beyond their presenting behavior and focus on the individual's humanity.

> *"See people with addiction problems as the same as yourself. It's just that it can make that person act and be different at times…, it's out of your hands sometimes, how you behave yourself, and if they can see past that…It doesn't mean it's acceptable behavior but it doesn't also mean that you should treat them as beneath you… Talk to them as you'd talk to your best friend or your mother or your father or anybody in the community. But also if that person's obnoxious or is going to be rude or whatever, it doesn't mean that you have to accept that and take it. But then I think you take it from there, and maybe not treat that person as warmly, but also give them what they need…" (P8)*

Participants discussed areas of care that be improved through the following: (i) empathy; (ii) debrief; (iii) addressing concerns; and (iv) follow up.

(i) Empathy: "Agitated, actually, in waiting"

Participants with no recollection of the BE expressed feelings of abandonment after they woke from sedation. The period of waiting generated feelings of unimportance and anxiety. These negative feelings were more prominent among participants who had no previous presentation of BE and no memories of the events surrounding the sedation process.

> *"Yes, I am just freaking out a bit. I know that people are busy but we're talking about a day that I don't remember…I don't feel well…" (P9)*

Making contact with friends and relatives was considered a way of soothing, and alleviating fears of disorientation. Participants stated their need to know that the ED staff have contacted their friends or relatives and that they will be arriving soon.

> *"I still think they're great, I just think they need to provide more closure, especially if someone's here by themselves. I'm just here feeling absolutely like lost, and like really upset as well…I didn't want to be alone, I didn't know what was going on, and*

I still don't. I really just want to see my sister at the minute, because I have no idea why I'm in here…" (P13)

Long waiting times were cited as one of the reasons some participants refused referral services.

"Agitated, actually, in waiting. They could probably do something… you get anxious and they take so long to come around and see you and then they take so long to get organized and then you know and you are not normal, you are anxious…" (P10)

(ii) Debrief: "I haven't been given any closure"

Participants with no previous experience of BE expressed concerns regarding the cause and consequences of their disruptive behaviors. The need for debrief was repetitively brought up by participants with no recollection of the BE. Participants felt that they had not been adequately re-orientated to reality after a period of sedation. This was stressful as they felt that they had lost a sense of time and place.

"This is my body, why are they making me go to sleep without my consent? Well if they told me now, if they came and explained that's why we did it last night, then that'd make me feel better. But I haven't been given any closure about the stuff they've put in my body or why I'm still here…no one's come in and explained to me what has happened, and why I needed to be picked up in an ambulance? What time did I get taken in the ambulance? Who came in the ambulance with me? What was I given in the ambulance? What happened when we got here, like did I walk, did I run, like I don't know anything. How come I don't know what's happened to me? I want those questions answered and I want that closure." (P13)

Participants with no recollection of the events found the designated quiet and private cubicle distressing when they were left alone waiting for the unknown treatment plan, emphasizing the importance of reorientation as soon as they wake from sedation.

"Why am I under surveillance? It's weird. It's a different set up now in the rooms. Obviously does that mean like, that door, does that lock? I can be locked in here. Do I have to be rational or am I going to hurt people…" (P9)

(iii) Addressing concerns: "What was looked at on my body?"

Participants described some of the concerns they faced after woke from the sedation. They wanted to know the cause of their symptoms or to be reassured that nothing was serious. This information was regarded as important to alleviate the anxiety.

> *"My arm, I don't feel my arm…I don't know how did they do this? It is not normal. Is a lump, is not like another arm and I can't feel it. I feel it but not like this one (other arm)… (It would be) helpful if someone come to explain. Since I wake up, maybe already 1 hour, I still feel numb." (P5)*

In parallel with fear related to uncertainty about the severity of the symptoms, participants expressed frustration when no information on the physical and psychological consequences of the current ED presentation was provided.

> *"…whatever I was drugged with, so I don't know anything about that drug. I don't know what the hell they've given me…What was given to me? And what was looked at on my body? And was my heart rate low, was I dehydrated? And then my hands like I've got cuts on my hands. What I have been doing? Look at my face, it was all weird when I was looking in the mirror. I was like 'Whoa'. Like I look horrible, what's going on? These hands feel like they keep floating up. That is really weird. I've got glass in my foot here. It's terrible. I really don't know… Was there a rape test done?" (P9)*

(iv) Follow-up: "That's literally the gap in the system"

Participants with drug and alcohol issues also discussed the limited access to follow-up care after discharge. Enduring long waiting times between ED discharge and the next available appointment for follow-up care in the community setting, both in regard to appointments with their general practitioner (GP) and accessing rehabilitation services, highlighting current gaps in the healthcare system. Withdrawal effects often triggered a relapse or representation to the ED.

> *"Yeah that's like literally the gap in the system. Like trying to get to a GP but feeling absolutely lost…And to be totally honest I think that's when people relapse is because it's so simple if you have a drink again you are fixed again. Like it's as simple as*

that… so it's kind of a bit of a willpower thing for you to be able to (wait until an appointment is available)… So I think that would be probably the main thing that I would recommend– is after-care of some description…" (P11)

Discussion

To our knowledge, this is the first study to explore the experience and perceptions of sedation during a BE from the perspective of patients. Our findings have highlighted opportunities to improve the management of BE. This is particularly important, given that the initial experience in the ED may influence long-term treatment outcomes of this patient group[12].

Individuals presenting with a BE often have highly complex health and psychosocial problems[13,14,19]. Frequent similar re-presentation to the ED often leads healthcare providers to stereotype these patients as manipulative and less important[19]. Healthcare providers repeatedly express their frustration around 'revolving door presentation' [13,14,19]. Despite the challenge of maintaining objectivity and empathy, it is crucial for healthcare providers to recognize that individuals presenting to the ED with a BE are a diverse group, and they need to be treated according to the cause of their presentations.

This study suggests that a trusting patient-staff relationship is key to reducing the negative impacts of the coercive measures used during the BE. Participants expressed their appreciation for compassionate communication, coordinated care and their de-escalation. These findings are consistent with reports from studies of healthcare workers into the need for empathy and compassion when caring for these complex patients [13,14,19]. Participants with previous experience, or having recollection of their BE management, expressed confidence in care, because ED staff were able to provide a rapid response with a structured team approach. They found the de-escalation effort comforting as it was perceived as an attempt by staff to treat them as fellow human beings. The principles of appropriate training, including team structures and verbal de-escalation are well documented[20,21] and should be adopted by EDs as part of annual staff training.

Several qualitative studies have explored the perceptions and experience of healthcare providers in caring for patients presenting with BEs to EDs[14,19]. Giving opportunities to these marginalized patients to share their experiences, allows others to understand that an agitated patient has similar needs and wants to other medical emergency patients. Like other ED patients [22], our participants were anxious about their conditions and having to endure long waiting times.

Our findings suggest that implementing a standardized protocol to address patients' concerns would ensure they understand the rationale for the necessary coercive measures and allow patient participation in subsequent decision making. Consistent with previous research, participants who had no recollection of the event felt that not being adequately debriefed or re-orientated to reality after a period of sedation incurred negative emotions such as anxiety and dissatisfaction [8,9].Frequently asked questions included insight into the cause of the BE, reasons for and duration of sedation, assessment outcome, current care plan (e.g. waiting for psychology or medical assessment) and discharge plan. As stated by experts in BE, the ultimate goal of BE management is the return of autonomy, formation of an alliance and development of a mutually agreeable plan of care [23,24]. These goals can only be achieved when adequate information is provided to empower patients to make informed decisions and allow them to take responsibility for their own health.

Responses from participants with substance addiction resonated with other research, which reported the challenges in receiving support for detoxification and treatment facilities[13,19,25]. It has been well documented that the success of treatment for addiction is highly correlated with internal motivation and perceived ability to recover[26,27]. Before an individual falls into the cycle of continued drug/alcohol use, early intervention should be in place to increase the likelihood of a successful rehabilitation. Therefore, other than implementing a screening program in the ED to identify patients at the early stage of substance addiction, a collaborative care model is required to continuously engage these individuals in a supportive care system. We hypothesize that the development and evaluation of multidisciplinary, trans-institutional interventions can be a useful measure to break the cycle of 'revolving door presentation'. As accessibility to rehabilitation services was mentioned as the main barrier to a successful detoxification, partnering with rehabilitation facilities in the community should be explored to provide expedited care to patients discharged from EDs. Further research into

the barriers provide expedited follow-up after ED care (i.e. rehabilitation or mental health services) should be given greater attention.

Limitations

Qualitative studies do not aim to make generalized hypothesis statement, therefore, sample sizes for these studies are generally much smaller than those used in quantitative studies. A bootstrap analysis of sample sizes and thematic saturation suggested that a median number of 16 (range 11-26) in-depth interviews was required to reach the 90% saturation level[28]. The present sample of 13 participants is within the reported range and appears adequate to address our research questions. Some participants found the encounter to be non-significant and had few comments, hence their short interviews. However, the majority were pleased to have the opportunity to share their views. Interviewing individuals during a period of post-crisis is challenging and the risks and benefits of the research were considered. Although it would have been ideal to have longer interviews for some participants, safeguarding participants' vulnerability was the priority. Despite the small sample and short interviews, this study (i) supports the feasibility of including this group of challenging patients in future research, and (ii) provides important insights into a topic that has, to date, been explored primarily from healthcare providers' perspectives.

As this study was conducted in a single ED, it may have limited external validity, especially in settings where a structured team approach is not implemented. Future research encompassing patients from different types of EDs could have identified additional themes. Our findings provided the basis for future investigations and are not necessarily generalizable.

Our convenience sampling may have introduced selection bias. We did not interview patients who were treated and discharged overnight or those with severe acute psychosis. Despite this limitation, we were able to gain broad and novel insight into the experience of BE from a diverse range of subjects representing typical and atypical cases, including subjects with and without psychiatric comorbidities, and/or substance intoxication.

454

455 **Conclusions**

456 A trusting relationship was identified as crucial to minimize the negative impact of coercive
457 measures used to manage behavioral emergencies. Participants expressed similar needs to
458 patients presenting with medical problems. This study illustrates their needs for
459 compassionate communication, adequate information about the treatment provided, and
460 follow-up care.

461 **Table 1.** Characteristics of Participants

	Participants (n=13)
Age, years, mean (range)	38 (20-72)
Male, n (%)	8 (61.5)
Marital status, n (%)	
Married	3 (23)
Divorced/separated	4 (30.8)
Single	6 (46.2)
Employment, n (%)	
Employed, full/part-time	4 (30.8)
Unemployed/Receive unemployment benefits	6 (46.2)
Retired	1 (7.7)
Student	2 (15.4)
Mode of arrival, n (%)	
Ambulance	5 (38.5)
Police	7 (53.8)
Self-present	1 (7.7)
Type of parenteral sedative medications used, n (%)	
midazolam alone	5 (38.5)
midazolam-droperidol combination	5 (38.5)
midazolam-olanzapine combination	2 (15.4)
diazepam-droperidol combination	1 (7.7)

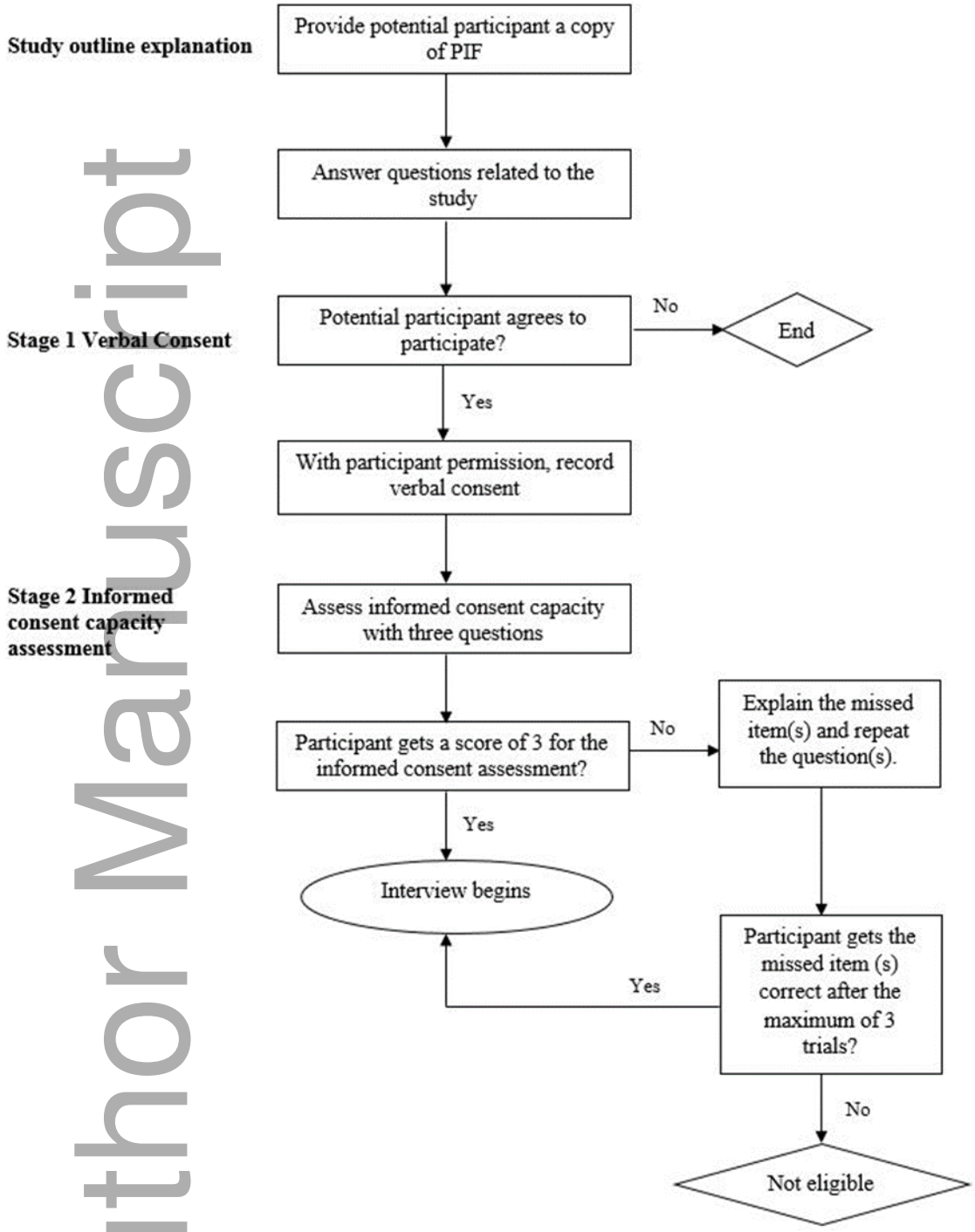
Alcohol intoxicated	6 (46.2)
Illicit drug intoxicated	7 (53.8)
Underlying mental health problems	5 (38.5)

Table 2. Main themes and possible mechanisms to improve care for behavioral emergency patients

Themes	Key Quote(s)	Suggestions from our findings	Possible mechanisms
Trusting relationships	"It's nice to know that they're still caring about you, So you know you kind of realize that there's still always that background (support), you know someone is still doing something to try and get the best out of the situation that I've ended up in…" (P12)	1. Compassion and understanding communication 2. Collaborative model to create coordinated care 3. Verbal de-escalation skills	Staff education
Needs or wants following sedation	"It's just, I don't know, it's just not a very nice room, it's just sad, makes me feel even worse because it feels like there's really something wrong with me because you've got to be placed in a white room… you feel very enclosed, and it makes you feel way sicker than what you are…I didn't want to be alone, (the nursing staff should) let people stay, because this feeling that I'm feeling right now just makes me want to cry because I'm here by myself and I don't know why…Even if the nurses said no(they should leave , so that I can sleep), (they can tell me) my sister would come back and check on me at this time in the morning…" (P13) "But I feel scared 'cause I don't know why I had to be put to sleep. How did I end up here? Someone just said I was	1. Re-orientation to time and place 2. Offer contact to their family or friends at earliest 3. Discuss the cause and consequence of the current emergency department presentation 4. Discuss the rationale for the management and address relevant concerns of patients	Standard protocol to provide post-sedation debrief

wandering around the city with no clothes on. And that doesn't make sense. And then they left…Like has something really bad happened, is all I keep thinking in my head. So why would they put me to sleep? I must have gone like psycho, like crazy, must have been out of this world for them to do that… All I do require is the information, this is doing my head in and I don't think I belong in a psychiatric ward. I just want to know what the hell is going on." (P9)		
"… sometimes they kind of just send me on my way and often you kind of have to fend for yourself, you know, for getting yourself sober again. So I think that would be probably the main thing that I would recommend- is after-care of some description… Probably like even a phone call just to see I am sober, like 'Are you feeling ok?' "(P11) "There is nothing really, unless you had a detox like … hospital. Next door there's a detox so you are very quick if you go there…" (P10)	1. A follow up telephone call 2. Innovative coordinated care models to improve rehabilitation service accessibility	Follow-up

Fig 1. Participant explanation and informed consent process flowchart



*PIF, Patient Information Form

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