SUICIDE ASSESSMENT IN EMERGENCY DEPARTMENTS: AN EXAMINATION OF CLINICIAN STRESS, COPING AND PERCEPTIONS OF CONTEXTUAL VARIABLES

By

Rebecca Leah Levy

July 2020

Director of Dissertation: Damon L. Rappleyea, PhD

Department of Human Development and Family Sciences

Underserved populations have the higher risk to die by suicide. When patients are suffering from suicidal ideation, patients are directed to the emergency department. In order to investigate the experiences of emergency department (ED) clinicians when assessing underserved population patients who present to the ED, three research articles were completed: (a) systematic review of literature of this topic; (b) hermeneutical phenomenological study designed to best grasp the lived experience of ED clinicians assessing patients that are part of underserved populations (c) policy brief of recommendations about how to better provide care for patients who present to the ED with suicidal ideation (SI). The systematic review demonstrated the lack of studies about how ED clinicians assess and perceive patients who presented to the ED with SI. The phenomenological study results in four emergent themes of the lived experience of ED clinicians assessing patients with SI: (1) ED clinicians' interest in environment variety; (2) ED clinicians expressed lack of clarity of their ED role with patients presenting with SI; (3) ED clinicians observed disjointed care resulting in inappropriate placement of patients with SI to ED, and (4) ED clinicians experience contextual variables. The policy brief suggested the need for change in the way patients who present with SI and identify in underserved populations are cared for in the ED. Recommendations are made for more psychiatric EDs as well as more education for clinicians.

SUICIDE ASSESSMENT IN EMERGENCY DEPARTMENTS: AN EXAMINATION OF CLINICIAN STRESS, COPING AND PERCEPTIONS OF CONTEXTUAL VARIABLES

A Dissertation
Presented To the Faculty of the Department of Human Development and Family Science
East Carolina University

In Partial Fulfillment of the Requirements for the Degree
Doctorate in Medical Family Therapy

by
Rebecca Leah Levy

July 2020

SUICIDE ASSESSMENT IN EMERGENCY DEPARTMENTS: AN EXAMINATION OF CLINCIAN STRESS, COPING, AND PERCEPTIONS OF CONTEXUAL VARIABLES

by

Rebecca Leah Levy

APPROVED BY:

DIRECTOR OF DISSERTATION:____
Damon L. Rappleyea, PhD LMFT

COMMITTEE MEMBER: ____
Katherine Didericksen, PhD LMFT

COMMITTEE MEMBER: ____
Joanna Adams, MD

COMMITTEE MEMBER: ____
Kim Larson, PhD

CHAIR OF THE DEPARTMENT
OF HUMAN DEVELOPMENT
AND FAMILY SCIENCE: ____
Sharon Ballard, PhD

DEAN OF THE
GRADUATE SCHOOL: ____
Paul J. Gemperline, PhD

ACKOWLEDEMENTS

There are many people who have been a part of assisting me to complete this dissertation. I would like to first thank my dissertation committee chair, Dr. Damon Rappleyea. I have been challenged academically as well as personally through this journey. Damon has worked with me and accepted my thought processes as well as pushing me to grow through this experience. Thank you for allowing my social justice passion to come alive in my research and nurturing my delivery of this research. Damon, we made it. Without your undoubted support and advocacy, I would not be here. Thank you for constant support of me as a person and my dream.

My committee: Dr. Joanna Adams, you were the steering wheel in this process. You gave so much of your time assisting me in recruiting participants and guiding me on what the medical community needs. Dr. Katherine Didericksen, you have been a support since day one of this program and have allowed me to think more broadly about research and MedFT as a field. You have been such an advocate for my growth. Dr. Kim Larson you have shared with me your insights and understanding of qualitative studies that has assisted in the growth of my dissertation. Thank you, committee for all of your support throughout this process.

Dr. Aubry Koehler, as a mentor and friend, I would not be here without you. You have been a part of this journey every step of the way as an editor of my manuscripts, supervisor in internship and mentor in this career. You have given me so much of your time and I appreciate every second. You guide and lead me by example. You have provided me space to advocate where I felt I couldn’t and allowed me to feel valued.

My family may not have had full understanding of what I was doing during this past three years, but they have given nothing but love and support. To my mother who answered all my phone calls with love and care. You have always encouraged me to keep swimming even when the water was very deep. To my father who challenged me to think about the big picture rather than the little details. You sent me an unlimited amount of journal articles that you think I would be interested in and to push me to think more critically. And to my siblings, Rachel you are my biggest fan and hardest critic. I could not be the woman I am today without your honesty. To Jason, thank you for your bluntness and insight during this process and to keep things direct and simple, not complicated. To Ben, thank you for your intrigue and constant conversation around my challenges to help me best understand this complicated medical system. Saul, we may be very different in so many ways, but we are the same in one, we made our own path. Thank you for showing me that it is possible!

Andrew Josephs, you came into my life right before this process. You watched me work long hours and cry many tears. You read over many manuscripts and listened to many practice presentations. You are a rock for me in this process. Thank you for holding my hand through all the good and bad. Thank you for lifting me up when I was down. Thank you for your unconditional support and love these past 3 years.

This dissertation really took a village to make it happen. I appreciate all that were part of this process.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

PREFACE

When I was completing my master's degree at Drexel University in Philadelphia, PA, I had an experience where one of the patients I was working with attempted suicide. She survived her attempt, but the experience made me re-think my entire treatment with her. I thought about what I could've done differently. I had tremendous anxiety moving forward when patients would disclose their suicidality.

Concurrently during this time, I was also learning about my own privilege as a white woman. My master's program had stressed the importance of understanding privilege and oppression of self and how it relates to patients. I was starting to understand I had a different life because of my social location in the world and this can impact my patient care. I was taught it is important to be aware of this difference and honor patient's experiences.

While these learning experiences were happening, I began to discuss my anxieties with a mentor of mine Dr. Quintin Hunt and we began a paper on how therapist's perceptions impact patients presenting with SI. When writing the paper and researching more, I began to realize that there are many systems involved in the assessment and treatment for these patients. One of the systems included was the emergency department (ED). I started to become curious about the process of the ED assessment and what happened to those patients. I was also curious about how underserved populations were being cared for in this setting. Social justice had been a huge part of therapy training as a way to advocate for those who could not advocate for themselves because of the oppression of the healthcare system and other larger systems.

I hope my readers will learn about how suicide is a pervasive issue in the United States and the current systems set up to help those in need are not working. I hope to assist readers in thinking about how we can better educate and advocated for others.

CHAPTER 1: INTRODUCTION

Suicide in Underserved Populations

Suicide is the tenth leading cause of death today in the United States (CDC, 2017). Suicide is even more prevalent when looking at specific age groups in the U.S., specifically ages 10-34 where it is the *second* leading cause of death (National Institute Mental Health, 2016). The people who are most susceptible to suicide are underserved populations (Curtin & Hedgaard, 2019). Underserved populations are defined as populations that are limited due to their location in geographic, demographic and economic positions (Blumenthal, Mort, & Edwards, 1995; Fiscella et al., 2000). These populations could be racial and ethnic minorities, low-income populations as well as people in minority groups such as the LGBQTI+ (Lesbian, Gay, Bisexual, Queer, Transgender, Intersex and more) population (Substance Abuse & Mental Health Services Administration [SAMSHA], 2020). Underserved populations have the most difficulty receiving adequate healthcare (Miranda, McGuire, Williams, & Wang, 2008). Social rejection and discrimination from the general population is also a moderating factor in the proportionally high suicides rates among ethnic minorities (Odafe, Talavera, Cheref, Hong, & Walker, 2016). Further, previous experiences of minority oppression may decrease the likelihood that a racial and ethnic minority will seek help and/or may affect how they approach help (Goldston et al., 2008; Ford, 2008). This is due to bias within the healthcare system, thus exacerbating the need for change in suicide treatment such as more culturally attuned assessment (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Kaslow et al., 2010).

Records of suicidal behavior can be traced as far back as the Ancient Romans (27 BC-AD 395) and Greeks (509-27 BC; Shields, Hunsaker, & Hunsaker, 2005). Historically, suicide was not associated with mental illness (Barraclough, Bunch, Nelson, & Sainsbury, 1974), nor was it conceptualized as part of the medical field because it was not understood as having a physical health component (Barraclough et al., 1974). Instead, suicide was widely considered to be due to a “moral crisis” resulting from an individual’s wrongdoing (Barraclough et al., 1974).

People were not always directed to the ED when experiencing SI. The ED was developed approximately 50 years ago to provide medical treatment for emergency healthcare needs at any time of the day or night (Suter, 2012). Approximately 141.4 million visits are made to the ED each year (CDC, 2017). In 2013, almost 500,000 people present to an ED for self-inflicted injuries, which included suicide attempts (CDC, 2013). Patients also present to the ED for suicidal thoughts with the intent to self-harm (Knesper, 2010). Particularly concerning is the relationship between visits to the ED for SI and subsequent suicide deaths within two months post ED visit (Knesper, 2011). Unfortunately, in another study concerning people who presented to the ED for SI, results suggest that many of the participants did not go to their scheduled follow-up appointment after discharge (Knesper, 2010). Knesper (2010) found this lack of follow-up is due to the failure of adherence to treatment or access to care for the patient. Lack of access to care is more common for people of underserved groups (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). More culturally attuned work, such as incorporating the culture and beliefs of the patient in their care, while the patient is in the ED could greatly assist in making symptoms decrease for these underserved populations (Kaslow et al., 2010). There is an important need for unique and culturally-informed approaches to SI-related follow-up care (Kaslow et al., 2010).

Researchers have identified several barriers to systemic coordination within the ED, as well as coordination between the ED and other clinicians and services (Knesper, 2011). These barriers include the intricacy of healthcare systems and the time and effort needed for the improvement from treatment (Kobayashi et al, 2008). The established culture in the ED is a significant facilitator and barrier in the functioning of health care clinicians (Kobayashi et al, 2008). The culture around ED medical teams' well-being or experience with intense psychological distress and perceptions can influence the way the ED clinician functions (Suokas, Suominen, & Lönnqvist, 2008). For example, clinicians' perceptions or discomfort may interfere with proper assessment, and this can be exacerbated further when the chief complaint is related to mental health rather than physical health concerns (Ronquillo et al., 2012).

Clinician perceptions can also impact patient care in the ED. Due to the high stress climate of the ED and the time and performance pressure that the staff are under, there is a higher bias against those patients presenting with SI due to these patients' resource-heavy needs. Clarke and colleagues (2014) found that ED clinicians often consider presenting problems relating to mental health to be non-urgent. This in turn creates bias against patients' care urgency which can impact clinicians' work ethic for treating patients with mental health issues (Clarke, et al., 2014). Thus, patients presenting with SI are less likely to receive immediate assessment (Suokas, Suominen, & Lönnqvist, 2008). Suicidal ideation was also found to be a presenting problem that most clinicians in the ED reported that they did not feel comfortable addressing (Chesin et al., 2017). Bias related to mental health can be even further impacted by the stereotyping of patients' racial and ethnic minority status (Blackwell, 2011; Millender, 2011; Lee et al., 2017; Waite & Calamardo, 2009).

In the health research field, there is a lack of information related to underserved patients (patients who fall in a socioeconomic, racial and other minority group that is underserved in healthcare) (Aday, 2001). There is a lack of evidence-based treatments or assessments for these underserved populations (Aday, 2001). As reported by the Surgeon General (2001), underserved populations SI treatment needs are not being met within the United States' current healthcare system. Underserved populations are more likely to receive poor quality health care services (Miranda, McGuire, Williams, & Wang, 2008). There is a disproportionately high number of minorities needing mental health treatment (CDC, 2015), yet ironically, individuals from these populations are less likely to receive this treatment. These statistics demonstrate a greater need for mental health reform to address the challenges experienced by the underserved populations in the United States to increase resources among ED clinicians who are often called upon to be the "first responders" to mental health concerns in emergency care settings (Suicide Prevention Resource Center [SPRC], 2016). With the extensive health disparities endured by members of underserved populations, there is a greater need for future research and intervention development regarding treatment of SI for this underserved population.

The assessment of SI of underserved populations within the ED must be investigated as the clinicians' assessment impact how individuals from these populations are provided care for SI. Because the patients who are experiencing SI go to the ED as a resource in the United States, this is the setting in which investigation is most needed. It is likely that patients who present with SI could be more productively assessed within a framework that accounts for the intersection of larger systems and the impact of implicit cultural bias on treatment and outcomes. Current management of patients presenting with SI appears to not be effective for patients but also to not be cost efficient due to the many returning patients after discharge (Knesper, 2010). Return visits with less follow-up care seem to cause longer treatment (more visits) and less follow-up care (Knesper, 2010). Addressing this need would likely lower costs.

Theory: Transactional Model of Stress and Coping

The Transactional Model of Stress and Coping (TMSC) was used to guide the following chapters of this dissertation. The founders of TMSC, Lazarus and Folkman (1987) suggested that cognitive appraisal and coping follow each other as a reaction to stress (Lazarus & Folkman, 1987). Lazarus and Folkman (1987) concluded this process is four steps: primary appraisal, secondary appraisal, coping, and outcomes. Primary appraisal is defined by emotional suffering. Secondary appraisal refers to how the person assesses the situation, and coping refers to how the person handles their reaction. Outcomes are the result of the appraisal/coping event (Lazarus & Folkman, 1987). Salaina (1994) added attentions for the impact of contextual variables on stress.

Application of Theory

This review proposes the following application of TMSC. Clinicians working with patients presenting to the ED with SI often report feeling overwhelmed (primary appraisal). This, in turn, creates assessment barriers due to the of ambiguity of what SI assessment means and what workup is indicated (Schimitzt et al., 2012). Perceptions can be described as both a secondary appraisal — a guard against fear, harm, or challenge (Jerusalem & Scwarzen, 1992) –– as well as a coping reaction, or a strategy to protect oneself (Lazarus, 1995). In this context, perceptions serve as a warning related to the extent of bodily (emotional reaction) danger associated with SI. The outcome from implementation of this theory is that clinicians are not able to assess patients appropriately. This is largely due to clinicians' appraisal or coping-related attempts at self-protection, which can contribute to the minimization of the patients' needs and SI intensity. If patients are a part of an underserved population this could create further barriers to care because clinicians may also hold biases related to race, ethnicity, sexual orientation, etc. (Suicide Prevention Research Center, 2018)

Transactional Model of Stress and Coping was chosen as a framework for structuring the literature search, data collection and analyzation of this dissertation. A common foundational experience shared by clinicians is the discomfort discharging patients with SI from the ED (Chesin et al., 2017). Sociocultural theories, including stress of being a minority experienced by the patient and racial bias imposed by the clinician, can be understood as overlays on the top of clinician perceptions (Meyer, 1995; Mirowsky & Ross, 1989; Pearlin, 1989). Depending on the racial/ethnic congruence or incongruence of the patient and clinician, sociocultural theories may apply. Therefore, TMSC was selected as a foundational framework on which to build a systematic review that would be inclusive of but not limited to sociocultural theories of minority experiences.

Due to this rising concern of underserved populations experience of SI, this researcher intended to explore and understand the experiences of ED clinicians assessing SI. Through the lens of this model, the researcher has searched the literature, formed a methodology, collected and analyzed the data to best understand ED clinicians' experiences.

Summary

Chapter 2

Chapter 2 of this dissertation is a systematic review of the literature that was guided by three objectives: (a)What are clinicians' attitudes and emotional reactions to treating patients with SI in the ED?; (b) What ED systems or practice guidelines are already in place to reduce clinicians' perceptions related to treatment of SI?; and; (c) What barriers are there to treating SI in underserved populations and if so, what barriers do they identify? The inclusion criteria for the systematic review of the literature were studies that were peer-reviewed and published, conducted in the United States, published after 2008, and with a focus on treating patients experiencing SI in ED settings. Exclusion criteria included articles that had no mention of "emergency care" and articles that included children in their study sample. The results yielded a lack of literature around suicide assessment experiences with underserved populations thus pointing to a need for further understanding around ED clinicians' experiences with assessment of SI in these populations.

In Chapter 3 of this dissertation is the methodology of how the researcher will explore the experiences of ED clinicians working with underserved patients presenting with SI.   This study was conducted through a qualitative lens. The researcher utilized hermetical phenomenology to further explore the phenomena that ED clinicians are experiencing. The researcher paid close attention to the bias and role of the researcher self. The researcher recruited 7 ED clinicians to interview and learn more about their experiences assessing SI in the ED.

In chapter 4 of this dissertation are the findings of previously stated methodology of the study. The findings yielded four themes: (1) ED interest in environment variety; (2) ED clinicians expressed lack of clarity of their ED role with patients presenting with SI; (3) ED clinicians observed disjointed care resulting in inappropriate placement of patients with SI to ED, and (4) ED clinicians experience contextual variables. These findings yield a call for better preventative care, better psychiatric supports and increased training for clinicians.

In chapter 5, the summary of the previous chapters are outlined. A policy brief outlines recommendation for changes in the system for better care and assessment of patients who present with SI. These recommendations include universal healthcare and implications for psychiatric EDs and more attention to education of cultural sensitivity.

REFERENCES

Aday, L. (2001). *At risk in America: The health and health care needs of underserved populations in the United States* (2nd ed.). San Francisco, CA: Jossey-Bass.

Betancourt, J., Green, A., Carrillo, J. E., & Ananeh-Firempong O., (2003). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public health reports*. *118,* 293-302. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497553/pdf/12815076.pdf

Blackwell, C. W. (2015). Assessment and treatment of depression in gay and bisexual men in emergency settings. *Advanced Emergency Nursing Journal*, *37*(2), 116-124. doi:10.1097/TME.0000000000000057

Blumenthal, D., Mort, E., & Edwards, J. (1995). The efficacy of primary care for underserved population groups. *Health services research*, *30*, 253-73.

Clarke, D., Usick, R., Sanderson, A., Giles-Smith, L., & Baker, J. (2014). Emergency department staff attitudes towards mental health consumers: A literature review and thematic content analysis. *International Journal of Mental Health Nursing*, *23*, 273-284. doi:10.1111/inm.12040

Chesin, M. S., Stanley, B., Haigh, E. P., Chaudhury, S. R., Pontoski, K., Knox, K. L., & Brown, G. K. (2017). Staff views of an emergency department intervention using safety planning and structured follow-up with suicidal veterans. *Archives of Suicide Research*, *21*, 127-137. doi:10.1080/13811118.2016.1164642

Curtin, S.C., Hedegaard H. (2019) *Suicide rates for females and males by race and ethnicity: United States, 1999 and 2017.* NCHS Health E-Stat. Retrieved from: https://stacks.cdc.gov/view/cdc/79168

Fiscella, K., Franks, P., Gold, M. R., & Clancy, C. M. (2000). Inequality in quality: addressing socioeconomic, racial, and ethnic disparities in health care. *Journal of American Medicine*, *283*, 2579-2584.

Jerusalem, M., & Schwarzer, R. (1992). Self-efficacy as a resource factor in stress appraisal processes. In R. Schwarzer, R. Schwarzer (Eds.), *Self-efficacy: Thought control of action* (pp. 195-213). Washington, DC, US: Hemisphere Publishing Corp.

Kaslow, N. J., Leiner, A. S., Reviere, S., Jackson, E., Bethea, K., Bhaju, J., ... & Thompson, M. P. (2010). Suicidal, abused African American women's response to a culturally informed intervention. *Journal of Consulting and Clinical Psychology*, *78*(4), 449.

Knesper, D. J. (2010). Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit. Newton, MA: Suicide Prevention Resource Center.

Knesper, D. J., American Association of Suicidology, & Suicide Prevention Resource Center. (2011). Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the Emergency Department of Psychiatry Inpatient Unit. Newton, MA: Education Development Center, Inc.

Kobayashi, L., Overly, F. L., Fairbanks, R. J., Patterson, M., Kaji, A. H., Bruno, E. C., ... & Wears, R. L. (2008). Advanced medical simulation applications for emergency medicine microsystems evaluation and training. *Academic emergency medicine*, *15*, 1058-1070. doi:10.1111/j.1553-2712.2008.00247.x

Lazarus, R.S. & Folkman, S. (1987). Transactional theory and research on emotions and coping. *European Journal of Personality, 1,* 141-169. doi: 10.1002/per.2410010304

Lazarus, R. (1995). Psychological Stress in the Workplace. In Crandall, R. & P.L. Perrewe (Eds.), *Occupational Stress: A Handbook*, Taylor & Frances (pp. 3–13). books.google.com/books?hl=en&lr=&id=2RlZFMZMtZoC&oi=fnd&pg=PA3&dq=lazarus 1995 transactional model of stress&ots=1XQak4kEvr&sig=138yP8UPjaVTiczqikgXDqJ4IOE#v=onepage&q&f=false

Lee, C., Oliffe, J. L., Kelly, M. T., & Ferlatte, O. (2017). Depression and suicidality in gay men: Implications for health care clinicians. *American Journal of Men's Health*, *11*(4), 910-919. doi:10.1177/1557988316685492

Meyer, I.H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36,* 38-56.

Millender, E. (2011). Using stories to bridge cultural disparities, one culture at a time. *The Journal of Continuing Education in Nursing*, *42*(1), 37-42. doi:10.3928/00220124-20100901-01

Miranda, J., McGuire, T. G., Williams, D.R. & Wang, P. (2008). Commentary Mental health in the context of health disparities. *American Journal of Psychiatry. 165,* 1102-1108 doi: 10.1176/appi.ajp.2008.08030333

Mirowsky, J., & Ross, C E. (1989). Social causes of psychological distress. Hawthorne, NY: Aldine de Gruyter.

National Institute of Mental Health. (2018). Suicide Prevention. Retrieved from https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml

Odafe, M. O., Talavera, D. C., Cheref, S., Hong, J. H., & Walker, R. L. (2016). Suicide in racial and ethnic minority adults: A review of the last decade. *Current Psychiatry Reviews*, *12*, 181–198. https://doi-org.jproxy.lib.ecu.edu/10.2174/1573400512666160530124538

Pearlin, L.I. (1989). The sociological study of stress. *Journal of Health and Social Behavior, 30*, 241-256.

Ronquillo, L., Minassian, A., Vilke, G. M., & Wilson, M. P. (2012). Literature-based recommendations for suicide assessment in the emergency department: a review. *The Journal of emergency medicine*, *43*, 836-842. doi:10.1016/j.jemermed.2012.08.015

Saldaina, D. H. (1994). Acculturative stress: Minority status and distress. *Hispanic Journal of Behavioral Sciences*, *16*, 116-128.

Schmitz Jr, W. M., Allen, M. H., Feldman, B. N., Gutin, N. J., Jahn, D. R., Kleespies, P. M., ... & Simpson, S. (2012). Preventing suicide through improved training in suicide risk assessment and care: An American Association of Suicidology Task Force report addressing serious gaps in US mental health training. *Suicide and Life-Threatening Behavior*, *42*, 292-304.

Shields L.B.E., Hunsaker D.M., Hunsaker J.C. (2005) Trends of Suicide in the United States During the 20th Century. In: Tsokos M. (Eds.). *Forensic Pathology Reviews. Forensic Pathology Reviews*, *3*. Humana Press: Totowa, NJ

Substance Abuse and Mental Health Services Administration [SPRC]. (2020). Behavioral Health Equity. Retrieved from https://www.samhsa.gov/behavioral-health-equity

Suicide Prevention Resource Center [SPRC]. (2018). Addressing Suicide among Black Americans. Retrieved from: https://www.sprc.org/news/addressing-suicide-among-black-americans

Suicide Prevention Resource Center (2016). Rate of suicide by Race/Ethnicity, United States 2000-2016. Retrieved from: http://www.sprc.org/racial-ethnic-disparities.

Suokas, J., Suominen, K., & Lönnqvist, J. (2008). Psychological distress and attitudes of emergency personnel towards suicide attempters. *Nordic Journal of Psychiatry*, *62*, 144-146. doi:10.1080/08039480801983547

Waite, R., & Calamaro, C. (2009). Culture and depression: A case example of a young African American man. *Perspectives in Psychiatric Care*, *45*(3), 232.

United States Centers for Disease Control and Prevention (CDC) Suicide: Facts at a glance. (2015). Retrieved from http://www.cdc.gov/ViolencePrevention/suicide

United States Centers for Disease Control and Prevention (CDC). Fast facts sheet on suicide. (2017). Retrieved from https://www.cdc.gov/nchs/fastats/emergency-department.htm

CHAPTER 2: LITERATURE REVIEW

Clinician Perceptions of Patients Presenting with Suicidal Ideation in the Emergency Department

Introduction

Members of underserved populations are less likely to receive adequate behavioral health care (Safran et al., 2009) and are at higher risk for death by suicide than the Non-Hispanic White population (CDC, 2015). Currently, most health care clinicians in the United States direct people who are experiencing suicidal ideation (SI) to the emergency department (ED) for care (CDC, 2013). Literature shows that ED clinicians may hold bias against patients who present with SI in the ED, which can result in clinicians assessing SI as non-urgent (Clarke et al. 2014).

Emergency Departments are often not equipped to address the unique needs of underserved populations (Blumenthal, Mort, & Edwards, 1995; Fiscella et al., 2000). Underserved populations are defined as racial and ethnic groups and/or groups that are prevented from or limited in access to care due to demographic, geographic, or economic features such as different cultural understandings and historical perceptions of the medical community (Blumenthal, Mort, & Edwards, 1995; Fiscella et al., 2000). Suicide prevalence for particular underserved populations, such as racial and ethnic minorities, varies annually but is higher on average when compared to the Non-Hispanic White population (Suicide Prevention Research Center, 2018). Other groups that are at higher risk for suicide that are considered underserved populations are the Lesbian, Gay, Bisexual, Queer, Transgender, Intersex, and Asexual (LGBQTIA+) community and military veterans (Substance Abuse & Mental Health Services Administration [SAMHSA], 2019).

The Severe Acute Respiratory Syndrome Coronavirus-2 (COVID-19) pandemic has laid bare and continues to further compound the deeply entrenched health disparities for historically underserved populations living in the United States (Centers for Disease Control & Prevention, 2020). During the Spanish Flu, behavioral health symptoms increased in not only those recovering from the Spanish Flu but also in the general population (Eghigian, 2020). Within the recovering population, researchers have attributed increased behavioral health symptoms to the organic processes connected to the Spanish Flu and, in the general population, to the impact of trauma related to witnessing and experiencing staggering loss of human life (Eghigian, 2020). Today, the Well Being Trust and Robert Graham Center for Policy Studies in Family Medicine and Primary Care (2020) estimates 75,000 "additional deaths of despair" (defined as deaths from "drug or alcohol misuse and suicide") will occur as a result of COVID-19-related economic downturn, unemployment, and social isolation. Experts have called for proactive strategies including increased access to behavioral health treatment and training in resilience enhancement strategies as well as recommendations regarding storage of firearm and ammunition for at-risk individuals (McIntyre & Lee, 2020).

Now, more than ever, we must investigate what we know about the factors that contribute to inequality in health care and health outcomes. There is minimal research on how clinician assessment of SI for underserved populations impacts care and outcomes (Suicide Prevention Research Center, 2018). Members of underserved populations have reported discrimination and bias within the health care system related to access to healthcare and clinicians (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). This systematic review will explore the current literature by attending to the research question: how does clinicians' perceptions in the ED influence SI assessment for underserved populations?

Theory: Transactional Model of Stress and Coping

The Transactional Model of Stress and Coping (TMSC) was used to guide the search term selection for this systematic review**.** The founders of TMSC, Lazarus and Folkman (1987), derived their model from the ideas of cognitive appraisal and coping. The authors suggest that cognitive appraisal and coping follow each other as a reaction to stress (Lazarus & Folkman, 1987). Lazarus and Folkman (1987) divided this process into four steps: primary appraisal, secondary appraisal, coping, and outcomes. Primary appraisal is defined by emotional suffering. Secondary appraisal refers to how the person evaluates the situation, and coping refers to how the person handles their reaction. Outcomes are defined as the result of the appraisal/coping event (Lazarus & Folkman, 1987). Salaina (1994) added considerations for the impact of contextual variables on stress.

Objectives

The aim of this review is to investigate how clinicians' perceptions are impacting their care of patients from underserved populations presenting with SI and what clinicians are doing to manage their perceptions. Additionally, this review investigated if/how these perceptions manifest within the framework of cultural bias. The research questions that guided this review were: (a) What are clinicians' attitudes and emotional reactions toward treating patients with SI in the ED?; (b) What ED systems/practice guidelines are already in place and what can assist in the assessment of clinicians' perceptions related to assessment of SI?; and, (c) Do clinicians experience particular barriers when treating SI in underserved populations and if so, what barriers do they identify?

Methods

For the purpose of this review, Cooper's (2017) seven-step protocol was used to search the literature on clinicians' perceptions when treating underserved populations with SI in the ED. The databases that were utilized were Pubmed, CINAHL, Proquest, and PsychInfo. Included search terms were suicidal ideation, healthcare personnel, and attitudes that were selected with the support of a research librarian (See Table 1). The inclusion criteria were articles that were peer-reviewed and published, conducted in the United States, published after 2008, and with a focus on treating patients experiencing SI and seeking treatment in ED settings. The rationale for choosing only articles on research conducted in the US is that the term "emergency department" holds different definitions in different countries (Al-Shaqusi, 2010). The timeframe was set due to views of behavioral health changing in the last 10 years as a result of growing research (Parcesepe & Cabassa, 2013), and the author's desire to accurately grasp how perceptions has impacted the ED recently. Exclusion criteria included articles that had no mention of "emergency care". Articles that included mobile crisis units, crisis hotlines and psychiatric emergency rooms were not included. Articles that included adolescents or children were not included.

Results

The original search identified 7,237 articles. These articles were imported into Endnote where duplications of articles where 7,130 articles were deleted. The remainder were moved to Raayan. The use of EndNote did not allow for identification of all duplicates; in Raayan, the raters continued to find duplicates of the articles resulting in 4,839 articles. Following Cooper's model (2010), the raters searched the titles and abstracts for exclusion criteria. Ultimately, the raters agreed on 26 articles that met the search criteria. Three raters reviewed the same 10 articles (10 articles of the 26 articles) to determine interrater reliability. From the 26 articles, the raters began to look for common themes through the lens of the TMSC theory (Refer to Table 2).

Article Characteristics

The articles collected had publication dates that ranged from 2009-2017. The articles were classified as qualitative studies (n=5), quantitative studies (n=15), or evaluations of problem or programs (n=6). Within the quantitative studies, there were experimental studies, quasi-experimental studies, and pilot studies. The remaining 7 articles were evaluations of the process of suicide assessment and perceptions in the ED. The articles were divided into themes in relation to Lazarus and Folkman's (1987) TMSC: primary appraisal, secondary appraisal, coping, and outcomes (See Table 3).

Primary Appraisal

Primary appraisal is defined as emotional suffering in the TMSC (Lazarus & Folkman, 1987). In reference to the first part of the three-part research question (part A), we reviewed articles that explored clinicians' reactions to treating patients presenting with SI in the ED. Within the articles, there was a high prevalence of information about the emotional reactions shared or felt by clinicians (or "attitudes") toward patients presenting with SI and suicide assessment. Both qualitative and quantitative surveys were used to measure clinicians' perceptions. The only evidence-based assessments that were found were *Attitudes Toward Suicide Prevention Scale* (Osteen, Frey, Woods, Ko & Shipe, 2017), *Clinical Risk Management Scale (*Osteen, et al., 2017), and *Treatment Toward Suicide Questionnaire* (Osteen et al., 2017;

Neville & Roan, 2013). There were many different terms by which the articles referred to clinicians' attitudes, but all referenced a similar definition as described below.

Definition of emotional reaction/attitudes of clinicians. Primary appraisal is an "evaluation" of the significance of the problem to the individual, wherein the person relies on their "reactions (attitudes)" which reflects their beliefs (Lazarus, 1994). Through the review, we found many different terms used to describe clinician attitudes in the context of SI. There were a few articles that actually referred to the term "attitudes" (Betz et al., 2015; Bolster, Holliday, Oneal, & Shaw, 2015; Neville & Roan, 2013; Price et al., 2013; Zun 2012). Other articles used the following terms: sense of self-efficacy (Osteen, Frey, & Ko, 2014), perceptions (Levandowski, Cass, Miller, Kemp, & Conner 2017; Petrik, Gutierrez, Berlin, & Saunders, 2014; Roy et al., 2017), knowledge (Betz, et al., 2015; Silva, Smith, Dodd, Covington, & Joiner 2016;), beliefs (Betz, Barber, & Miller 2010; Betz et al., 2013; Betz et al., 2015; Bolster, 2015), bias (Betz et al.,, 2015; Brosinski & Riddell, 2016; Waite & Calamaro, 2009), and discomfort/personal judgment (Venkat & Drori, 2014).

Many of the articles did not specifically focus on the "attitudes" as the central topic because they had other foci. Some articles focused more on the clinicians' attitudes towards specific practice guidelines the hospital had in place such as assessment of firearms (Betz et al., 2010), while others focused on the perception of the effectiveness of safety plans in general (Levandowski et al., 2017). Of the articles reviewed, one suggested that clinicians had attitudes that influenced how they felt about care for patients who presented with SI (Petrik, 2014). Brosinski and Riddell (2016) described the bias ED nurses carried when triaging patients with SI and alcohol intoxication. In addition, Abar and colleagues (2018) reported patients felt clinicians had bias against behavioral health and were concerned it impacted their treatment.

Some articles reported on the beliefs surrounding SI that were influenced by larger systemic factors such as knowledge, education level, religious beliefs, and age of clinicians (Bolster et al, 2015; Neville & Roan, 2013). The type of professional background (i.e. behavioral health training as a nurse, PA or physician etc.) also influenced the accuracy or appropriateness of care for the patient (Descher, Russell, Pappas, & Pepper, 2015).

Secondary Appraisal

Secondary appraisal refers to the clinicians' cognitive process experienced during their evaluation of the situation (Lazurus & Folkman, 1987). In this systematic review, this process of secondary appraisal was understood as researchers' and clinicians' assessment of what they needed in order to effectively cope with patients presenting to the ED with SI and, ultimately, accurately assess patients. In reference to the second part of the research question (part B), we reviewed articles that explored the ED systems/practice guidelines already in place and clinicians' perception of whether or not these systems/practice guidelines were sufficient to assist them with effectively treating patients with SI. Many of the articles touched on the process of whether or not and how clinicians utilized the SI assessment protocol. Of the articles reviewed, many stated that further training and protocol would improve assessment effectiveness or positively change clinicians' attitudes towards patients with SI (Osteen, Frey, & Ko, 2014; Marciano et al., 2012; Matthieu et al., 2009; Zun, 2012; Jacobson, Osteen, Jones, & Berman, 2012; Pease et al., 2017; Betz et al., 2013; Shim & Compton, 2010). Reports of clinicians' evaluation of practice guidelines for SI assessment and treatment training as insufficient was prevalent throughout all of the articles but lacked explanation as to why the clinicians felt this way. The beliefs of the clinicians were also influenced by their understanding of SI (Berman, 2018; Descher, Russel, Pappas & Pepper, 2015). Even though, the articles reviewed did not unpack the intricacies of clinicians' feelings and thoughts, we did find articles that detailed how clinicians coped.

Coping

The third component of TMSC is coping (Lazurus & Folkman, 1987). This part of the model refers to how the person copes with the stressful situation. There are two different types of coping that Folkman and Lazarus (1980) identify: emotion-focused coping and problem-focused coping. Emotion-focused coping is the attempt to reduce the emotional perceptions that the situation is causing through techniques such as denial (Carver, Scheier, & Weintraub, 1989). Problem-focused coping aims to alter the stress that often manifests in finding a solution to the current problem (Carver, Scheier, & Weintraub, 1989). Through the review, there were many studies identified that exemplified how the clinicians coped with their attitudes (primary appraisal) towards patients with SI in the ED.

In relation to emotion-focused coping, many clinicians reported in several articles feeling "uncomfortable" or "discomfort" with screening and assessing patients with SI due to lack of knowledge (Betz et al., 2013; Osteen, et al, 2017; Sevila et al., 2016; Roy, 2017; Venkat & Drori, 2014). Their coping was focused on "second-guessing" their clinical judgment regarding patient safety and not engaging in proper care (Roy, 2017). Other clinicians admitted that they were avoidant about addressing SI altogether (Lee, Oliffe, Kelley & Ferlatte, 2017), another form of emotion-focused coping.

Some articles touched on how clinicians engaged in problem-focused coping. Betz and colleagues (2015) discussed the impact of gatekeepers on the treatment of SI in the ED. Isaac and colleagues (2009) described SI prevention training for gatekeepers who are in those healthcare roles that position them to facilitate changes and treatment for SI. Betz and colleagues (2015), found that many clinicians are exploring solutions to streamline SI assessment as they find their process both time consuming and inefficient. This is problem-focused coping because clinicians are looking for ways to engage in solving this issue in minimal time. Similarly, Roy and colleagues (2017) found clinicians felt that SI assessments that were step-oriented (problem-focused) were not helpful and that resources were limited to their own clinical skills and not the resources of a care team. When clinicians engage in assessing what does not work for them they are utilizing problem-focused coping. Each of these articles congruently show how clinicians used some elements of the problem-focused coping to explore improvements to the SI- related system/practice guidelines in the ED.

Outcomes

The last component of TSCM is the outcomes of the coping event (Lazarus & Folkman, 1987). Contextual variables can impact how stress is managed and coped with (Saldaina, 1994). Outcomes applied to this context would be how the clinicians were or were not able to appropriately manage the stressful encounter with the patient regarding their social location. There were a limited number of articles that looked at these outcomes and these are discussed below.

Underserved populations. In the articles reviewed, there was evidence of a huge gap in the studies: the inclusion of clinicians' management of underserved patients. There was a lack of evidence of clinicians helping these populations to create better outcomes such as improvement in outpatient resources follow-up and less ED visits. Of the 26 studies, only 10 mentioned underserved populations within the context of the paper. The minorities that were mentioned in the studies were included were veterans, gay and bisexual men, African Americans, and immigrants. The majority of the studies were focused on veteran population care (Levankowski et al., 2017; Matthieu et al., 2009; Osteen, Frey, & Ko, 2014; Pease et al., 2017). Levandowski and colleagues (2017) were the only authors that specifically focused on how the clinicians in the ED worked with the veteran population. Their study explored clinicians' perceptions of safety plans as appropriate treatment for the veteran population. Two of the articles focused on cultural considerations when treating patients who present with SI, especially the assumptions clinicians might make about patients, such as stereotypes of underserved groups (Blackwell, 2011; Millender, 2011; Lee et al., 2017; Waite & Calamardo, 2009). A focus on underserved populations was found in only two of the studies that mentioned emergency care of the SI patient. Blackwell (2015) specifically assessed practice guidelines for assessment of SI in the ED related to the gay and bisexual male population. Blackwell (2015) explained how an evidence-based approach was needed due to the "unique" needs of this population because the care outcomes were not positive for this population. There were no articles found with ED clinicians' attitudes nor perceptions towards underserved populations assessment of SI.

Discussion: Cultural Trauma Implications

The results of our literature systematic review regarding information related to ED clinicians' attitudes about SI assessment for underserved populations were largely absent (See Table 3). Clinicians' perceptions during SI assessment, as noted in a few of the articles identified in the study (Blackwell, 2015; Johnson, Somnath, Arbelaex, Beach & Cooper, 2004; Millender, 2011, Lee et al., 2011; Waite & Calamardo, 2009), may have a particularly critical impact on the care patients receive in the ED. By extension, racial and ethnic minorities in the United States, may be particularly underserved if, as hypothesized, they do not receive adequate care due to their minority identification (Blackwell, 2011; Johnson, Somnath, Arbelaex, Beach & Cooper, 2004; Millender, 2011, Lee et al., 2011; Waite & Calamardo, 2009). Some researchers suggest that racial and ethnic minorities are more likely than their Non-Hispanic White counterparts to experience social prejudice and systemic bias that can in turn create disparities in the detection, understanding, assessment, and treatment of various health and psychological concerns (Blackwell, 2011; Johnson, Somnath, Arbelaex, Beach & Cooper, 2004; Millender, 2011, Le et al., 201; Waite & Calamardo, 2009). Social rejection and discrimination from the general population has also been found to be a moderating factor in the proportionally high SI rates among racial and ethnic minorities (Odafe, Talavera, Cheref, Hong, & Walker, 2016). Further, previous experiences of minority oppression may decrease the likelihood that a racial and ethnic minority will seek help and/or may affect how they approach help (Goldston et al., 2008; Ford, 2008).

Limitations

Three limitations may have affected the results of this systematic review. Firstly, it is possible that the searches failed to identify all relevant articles. While search terms were selected with the support of a research librarian in an effort to decrease the likelihood of overlooking relevant articles, this limitation remains a possibility. Secondly, searches included only articles in publication in English-language peer-reviewed journals. Relevant articles not yet catalogued in research databases or in non-peer reviewed or non-English language journals would not have been identified. Thirdly, the searches were limited to articles published in the last 10 years, due to the radical shifts in behavioral health views during this timeframe (Parcesepe & Cabassa, 2013), and the authors' desire to accurately grasp how perceptions has impacted the ED recently. However, it is possible that articles written earlier would have shed some light on this topic.

Conclusion

From this review, it appears that more research needs to be completed in order to adequately assess clinicians' perceptions about patients with SI while working with racially and ethnically underserved populations. Further research could assist in finding the best ways to educate clinicians to manage their perceptions related to SI assessment as well as to challenge biases often held against patients presenting with SI. The ED purpose is to assess, provide care, and move patients to the next stage of care (Morganti et al., 2013). The success rate for providing patients with care in the ED is extremely high but is a barrier is the outside system (Morganti et al., 2013).

Schmitz and others (2012) recommend more training be available and accessible for clinicians and staff. Culturally attuned treatments also need to be in place to support clinicians in offering care that is sensitive to historical oppressions and personal experiences that patients may have experienced in healthcare centers. Unfortunately, there is an unreasonably high number of minorities needing behavioral health treatment (CDC, 2015), but tragically, individuals from these populations are less likely to receive this treatment. A change in education of clinicians could possibly provide more insight into culturally-attuned assessment for these patients. Having more behavioral health on staff or utilizing collaborative care could help with this (Alakeson, Pande, & Ludwig, 2010). Other changes might include focusing on resources on staffing psychiatric EDs, which have been successful across the United Stated in providing specialty care such as at John Hopkins University (Niktin, 2018). There are many solutions to this dynamic problem, overall more understanding would provide better treatment of racial and ethnic minorities struggling with SI.

REFERENCES

Abar, B., Greener, E., DeRienzo, V., Botelho, S., Wiegand, T., & Conner, K. (2018). Perceived access to care among adult patients who attempted suicide. *Psychological Services*, *15*(3), 305-308. doi:10.1037/ser0000196

Alakeson, V., Pande, N., & Ludwig, M. (2010). A plan to reduce emergency room 'boarding' of psychiatric patients. *Health Affairs*, 29(9), 1637-1642. doi:10.1377/hlthaff.2009.0336

Al-Shaqsi S. (2010). Models of International Emergency Medical Service (EMS) Systems. *Oman medical journal*, *25*(4), 320–323. doi:10.5001/omj.2010.92

Berman, A. L. (2018). Risk factors proximate to suicide and suicide risk assessment in the context of denied suicide ideation. *Suicide and Life-Threatening Behavior*, *48*(3), 340-352. doi:10.1111/sltb.12351

Betancourt, J., Green, A., Carrillo, J. E., & Ananeh-Firempong O., (2003). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public health reports*. *118,* 293-302. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497553/pdf/12815076.pdf

Betz, M. E., Arias, S. A., Miller, M., Miller, I., Barber, C., Espinola, J. A., . . . Boudreaux, E. D. (2015). Change in emergency department clinicians’ beliefs and practices after use of new protocols for suicidal patients. *Psychiatric Services, 66*(6), 625-631. doi:10.1176/appi.ps.201400244

Betz, M. E., Barber, C. W., & Miller, M. (2010). Firearm restriction as suicide prevention: Variation in belief and practice among clinicians in an urban emergency department. *Injury Prevention: Journal of the International Society for Child and Adolescent Injury Prevention*, *16*(4), 278-281. doi:10.1136/ip.2009.025296

Betz, M. E., Sullivan, A. F., Manton, A. P., Espinola, J. A., Miller, I., Camargo, C. A., . . . ED-SAFE Investigators. (2013). knowledge, attitudes, and practices of emergency department clinicians in the care of suicidal patients. *Depression and Perceptions*, *30*(10), 1005-1012. doi:10.1002/da.22071

Blackwell, C. W. (2015). Assessment and treatment of depression in gay and bisexual men in emergency settings. *Advanced Emergency Nursing Journal*, *37*(2), 116-124. doi:10.1097/TME.0000000000000057

Blumenthal, D., Mort, E., & Edwards, J. (1995). The efficacy of primary care for underserved population groups. *Health services research*, *30*, 253-73.

Bolster, C., Holliday, C., Oneal, G., & Shaw, M. (2015). Suicide assessment and nurses: What does the evidence show? *Online Journal of Issues in Nursing*, *20*(1), 81-87. Retrieved from http://search.proquest.com.jproxy.lib.ecu.edu/docview/1710044095?accountid=10639

Brosinski, C., & Riddell, A. (2015). Mitigating nursing biases in management of intoxicated and suicidal patients. *Journal of Emergency Nursing*, *41*(4), 296-299. doi:10.1016/j.jen.2014.11.002

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: a theoretically based approach. Journal of personality and social psychology, 56(2), 267.

Centers for Disease Control & Prevention. (2020). COVID-19 in racial and ethnic minority groups. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html

Clarke, D., Usick, R., Sanderson, A., Giles-Smith, L., & Baker, J. (2014). Emergency department staff attitudes towards mental health consumers: A literature review and thematic content analysis. *International Journal of Mental Health Nursing*, *23*, 273-284. doi:10.1111/inm.12040

Cooper, H. (2017). *Research synthesis and meta-analysis: A step-by-step approach (5th edition).* Los Angeles: Sage.

Drescher, M. J., Russell, F. M., Pappas, M., & Pepper, D. A. (2015). Can emergency medicine practitioners predict disposition of psychiatric patients based on a brief medical evaluation? *European Journal of Emergency Medicine*, *22*(3), 188-191. doi:10.1097/MEJ.0000000000000131

Eghigian, E. (2020). The Spanish Flu pandemic and mental health: A historical perspective. *Psychiatric Times.* Retrieved from https://www.psychiatrictimes.com/coronavirus/spanish-flu-pandemic-and-mental-health-historical-perspective

Fiscella, K., Franks, P., Gold, M. R., & Clancy, C. M. (2000). Inequality in quality: addressing socioeconomic, racial, and ethnic disparities in health care. *Journal of American Medicine*, *283*, 2579-2584.

Freedenthal, S. (2007). Racial disparities in mental health service use by adolescents who thought about or attempted suicide. *Suicide & Life -Threatening Behavior*, *37*, 22-34. Retrieved from http://search.proquest.com.jproxy.lib.ecu.edu/docview/224890811?accountid=10639

Hodgson, J., Lamson, A., Mendenhall, T., & Crane, D. R. (Eds.). (2014). Medical family therapy: Advanced applications. Springer Science & Business Media.

Isaac, M., Elias, B., Katz, L. Y., Belik, S., Deane, F. P., Enns, M. W., & Sareen, J. (2009). Gatekeeper training as a preventative intervention for suicide: A systematic review. *Canadian Journal of Psychiatry, 54*(4), 260-268. doi:http://dx.doi.org.jproxy.lib.ecu.edu/10.1177/070674370905400407

Johnson, R. L., Saha, S., Arbelaez, J. J., Beach, M. C., & Cooper, L. A. (2004). Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. *Journal of general internal medicine*, *19*(2), 101-110.

Jacobson, J. M., Osteen, P., Jones, A., & Berman, A. (2012). Evaluation of the recognizing and responding to suicide risk training. *Suicide and Life-Threatening Behavior*, *42*(5), 471-485. doi:10.1111/j.1943-278X.2012.00105.x

Lazarus, R. S. (1994). 'Psychological stress in the workplace', In: Crandall, R. and Perrew6, P. L. (Eds), Occupational Stress. A Handbook, Taylor and Francis, New York

Lazarus, R.S. & Folkman, S. (1987). Transactional theory and research on emotions and coping. *European Journal of Personality, 1*, 141-169. doi: 10.1002/per.2410010304

Lazarus, R. (1995). Psychological Stress in the Workplace. In Crandall, R. & P.L. Perrewe (Eds.), *Occupational Stress: A Handbook*, Taylor & Frances (pp. 3–13). books.google.com/books?hl=en&lr=&id=2RlZFMZMtZoC&oi=fnd&pg=PA3&dq=lazarus 1995 transactional model of stress&ots=1XQak4kEvr&sig=138yP8UPjaVTiczqikgXDqJ4IOE#v=onepage&q&f=false

Lee, C., Oliffe, J. L., Kelly, M. T., & Ferlatte, O. (2017). Depression and suicidality in gay men: Implications for health care clinicians. *American Journal of Men's Health*, *11*(4), 910-919. doi:10.1177/1557988316685492

Levandowski, B. A., Cass, C. M., Miller, S. N., Kemp, J. E., & Conner, K. R. (2017). An intervention with meaning. *Crisis, 38*(6), 376.

Marciano, R., Mullis, D. M., Jauch, E. C., Carr, C. M., Raney, L., Martin, R. H., . . . Saef, S. H. (2012). Does targeted education of emergency physicians improve their comfort level in treating psychiatric patients? *The Western Journal of Emergency Medicine*, *13*(6), 453-457. doi:10.5811/westjem.2012.3.6899

Matthieu, M. M., Chen, Y., Schohn, M., Lantinga, L. J., & Knox, K. L. (2009). Educational preferences and outcomes from suicide prevention training in the veterans health administration: One-year follow-up with healthcare employees in upstate New York. *Military Medicine*, *174*(11), 1123-1131. doi:10.7205/MILMED-D-00-1109

McIntyre, R., & Lee, Y. (2020). Preventing suicide in the context of the COVID-19 pandemic. *World Psychiatry, 19*(2), 250-251. doi:10.1002/wps.20767

Millender, E. (2011). Using stories to bridge cultural disparities, one culture at a time. *The Journal of Continuing Education in Nursing, 42*(1), 37-42. doi:10.3928/00220124-20100901-01

Mirowsky, J., & Ross, C E. (1989). Social causes of psychological distress. Hawthorne, NY: Aldine de Gruyter.

Mokkenstorm, J. K., Kerkhof, A. J. F. M., Smit, J. H., & Beekman, A. T. F. (2018). Is it rational to pursue zero suicides among patients in health care? *Suicide and Life-Threatening Behavior, 48*(6), 745-754. doi:10.1111/sltb.12396

Morganti, K. G., Bauhoff, S., Blanchard, J. C., Abir, M., Iyer, N., & Rand Corporation. (2013). The evolving role of emergency departments in the united states. Santa Monica, California: Rand. doi:10.7249/j.ctt3fh1ft

Motto J.A., Bostrom, A.G. (2001) A randomized controlled trial of postcrisis suicide prevention. *Psychiatric Services*. *52*, 828-833.

Nestor, B. A., Cheek, S. M., & Liu, R. T. (2016). Ethnic and racial differences in mental health service utilization for suicidal ideation and behavior in a nationally representative sample of adolescents. *Journal of Affective Disorders, 202,* 197–202. https://doi-org.jproxy.lib.ecu.edu/10.1016/j.jad.2016.05.021

Neville, K., & Roan, N. M. (2013). Suicide in hospitalized medical-surgical patients: Exploring nurses' attitudes. *Journal of Psychosocial Nursing and Mental Health Services*, *51*(1), 35-43. doi:10.3928/02793695-20121204-01

Niktin, K (2018, September/October). The changing dynamics of emergency psychiatric care. DOME. Retrieved from https://www.hopkinsmedicine.org/news/articles/the-changing-dynamics-of-emergency-psychiatric-care

Odafe, M. O., Talavera, D. C., Cheref, S., Hong, J. H., & Walker, R. L. (2016). Suicide in racial and ethnic minority adults: A review of the last decade. *Current Psychiatry Reviews*, *12*, 181–198. https://doi-org.jproxy.lib.ecu.edu/10.2174/1573400512666160530124538

Osteen, P. J., Frey, J. J., & Ko, J. (2014). Advancing training to identify, intervene, and follow up with individuals at risk for suicide through research. *American Journal of Preventive Medicine, 47*(3), S216-S221. doi:10.1016/j.amepre.2014.05.033

Osteen, P., Frey, J. M., Woods, M. N., Ko, J., & Shipe, S. (2017). Modeling the longitudinal direct and indirect effects of attitudes, Self-Efficacy, and behavioral intentions on practice behavior outcomes of suicide intervention training. *Suicide and Life-Threatening Behavior, 47*(4), 410-420. doi:10.1111/sltb.12288

Parcesepe, A. M., & Cabassa, L. J. (2013). Public stigma of mental illness in the United States: a systematic literature review. Administration and policy in mental health, 40(5), 384–399. doi:10.1007/s10488-012-0430-z

Pease, J. L., Forster, J. E., Davidson, C. L., Holliman, B. D., Genco, E., & Brenner, L. A. (2017). How veterans health administration suicide prevention coordinators assess suicide risk: How veterans health administration. *Clinical Psychology & Psychotherapy*, *24*(2), 401-410. doi:10.1002/cpp.2011

Pearlin, L.I. (1989). The sociological study of stress. Journal of Health and Social Behavior, 30, 241-256.

Petrik, M. L., Gutierrez, P. M., Berlin, J. S., & Saunders, S. M., (2015). Barriers and facilitators of suicide risk assessment in emergency departments: A qualitative study of clinician perspectives. *General Hospital Psychiatry*, *37*(6), 581-586. doi:10.1016/j.genhosppsych.2015.06.018

Price, J. H., Thompson, A., Khubchandani, J., Wiblishauser, M., Dowling, J., & Teeple, K., (2013). Perceived roles of emergency department physicians regarding anticipatory guidance on firearm safety. *Journal of Emergency Medicine*, *44*(5), 1007-1016. doi:10.1016/j.jemermed.2012.11.010

Roy, W., Roaten, K., Downs, D., Khan, F., Pollio, D. E., & North, C. S. (2017). Suicide risk assessment and management: Real-world experience and perceptions of emergency medicine physicians. *Archives of Suicide Research, 21*(3), 365-378. doi:10.1080/13811118.2016.1199987

Safran, M. A., Mays, R. A., Huang, L. N., McCuan, R., Pham, P. K., Fisher, S. K., … Trachtenberg, A. (2009). Mental Health Disparities. *American Journal of Public Health*, *99*, 1962–1966. http://doi.org/10.2105/AJPH.2009.167346

Saldaina, D. H. (1994). Acculturative stress: Minority status and distress. *Hispanic Journal of Behavioral Sciences*, *16*, 116-128.

Schmitz Jr, W. M., Allen, M. H., Feldman, B. N., Gutin, N. J., Jahn, D. R., Kleespies, P. M., ... & Simpson, S. (2012). Preventing suicide through improved training in suicide risk assessment and care: An American Association of Suicidology Task Force report addressing serious gaps in US mental health training. *Suicide and Life-Threatening Behavior*, *42*, 292-304.

Shaikh, U., Qamar, I., Jafry, F., Hassan, M., Shagufta, S., Odhejo, Y. I., & Ahmed, S. (2017). Patients with borderline personality disorder in emergency departments. *Frontiers in Psychiatry, 8*, 136. doi:10.3389/fpsyt.2017.00136

Shim, R. S., & Compton, M. T. (2010). Pilot testing and preliminary evaluation of a suicide prevention education program for emergency department personnel. *Community Mental Health Journal, 46*(6), 585-590. doi:10.1007/s10597-009-9241-4

Silva, C., Smith, A. R., Dodd, D. R., Covington, D. W., & Joiner, T. E. (2016). Suicide-related knowledge and confidence among behavioral health care staff in seven states. *Psychiatric Services, 67*(11), 1240-1245. doi:10.1176/appi.ps.201500271

Suicide Prevention Resource Center (2016). Rate of suicide by Race/Ethnicity, United States 2000-2016. Retrieved from: http://www.sprc.org/racial-ethnic-disparities.

Suicide Prevention Resource Center (2018). Addressing Suicide among Black Americans. Retrieved from: https://www.sprc.org/news/addressing-suicide-among-black-americans

U.S. Department of Health and Human Services. (2001). Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

U.S. Department of Health and Human Services, National Institutes of Health. (2001). NIH guidelines on the inclusion of women and minorities as subjects in clinical research – Amended, October, 2001. Retrieved from http://grants.nih.gov/grants/funding/women_min/guidelines_amended_10_2001.htm

United States Centers for Disease Control and Prevention (CDC). Fast facts sheet on suicide. (2017). Retrieved from https://www.cdc.gov/nchs/fastats/emergency-department.htm

United States Centers for Disease Control and Prevention (CDC) Suicide: Facts at a glance. (2015). Retrieved from http://www.cdc.gov/ViolencePrevention/suicide

United States Centers for Disease Control and Prevention (CDC) Understanding suicide: Fact sheet. (2013). Retrieved from https://www.cdc.gov/violenceprevention/pdf/suicide_factsheet-a.pdf

Venkat, A., Drori, J. (2014). When to say when: Responding to a suicide attempt in the acute care setting. Narrative Inquiry in Bioethics, *4*(3), 263-270. doi:10.1353/nib.2014.0075

Washington, H. A. (2006). *Medical apartheid: The dark history of the medical experimentation on Black Americans from colonial times to the present*. Random House Digital, Inc.

Waite, R., & Calamaro, C. (2009). Culture and depression: A case example of a young African American man. *Perspectives in Psychiatric Care, 45*(3), 232.

Well Being Trust and Robert Graham Center for Policy Studies in Family Medicine and Primary Care. (2020). The COVID pandemic could lead to 75,000 additional deaths from alcohol and drug misuse and suicide. Retrieved from https://wellbeingtrust.org/areas-of-focus/policy-and-advocacy/reports/projected-deaths-of-despair-during-covid-19/

Wilson, M. P., Nordstrom, K., & Zeller, S. L. (2013). Practical management of the suicidal patient in the emergency department. *Emergency Medicine Reports, 35.*

Zun, L. S., MD. (2012). Pitfalls in the care of the psychiatric patient in the emergency department. *Journal of Emergency Medicine*, *43*(5), 829-835. doi:10.1016/j.jemermed.2012.01.064

Table 1: ***Search Terms with Databases***

Concept group	Suicidal ideation	Health care personnel	Attitudes
PubMed MeSH	Suicidal ideation	Health personnel Physicians Nurses Nurse practitioners Physician assistants	Attitude of health personnel
PubMed Keywords	Suicide Suicides Suicidal Suicidality Suicidal ideation Suicidal ideations Suicidal behavior Suicidal behaviors Suicidal thoughts Suicidal intent	Clinician Clinicians Doctor Doctors Health care personnel Health care clinician Health care clinicians Health care staff Health care worker Health care workers Health personnel Healthcare staff Healthcare personnel Healthcare clinician Healthcare clinicians Healthcare worker Healthcare workers Medical staff Nurse Nurses Nursing staff Physician Physicians Practitioner	Anxieties Perceptions Attitude Attitudes Belief Beliefs Bias Biased Biases Emotional responses Emotional reactions Opinion Opinions Perception Perceptions Prejudice Prejudices Stigma View Views

		Practitioners Nurse practitioner Nurse practitioners Physician assistant Physician assistants	
CINAHL & PsycINFO subject headings (EBSCO) (all same as PubMed)	Suicidal ideation	Health personnel Physicians Nurses Nurse practitioners Physician assistants	Attitude of health personnel
CINAHL & PsycINFO keywords (all same as PubMed)	Suicide Suicides Suicidal Suicidality	Clinician Clinicians Doctor Doctors Health care personnel Health care clinician Health care clinicians Health care staff Health care worker Health care workers Health personnel Healthcare staff Healthcare personnel Healthcare clinician Healthcare clinicians Healthcare worker Healthcare workers Medical staff Nurse Nurses Nursing staff	Anxieties Perceptions Attitude Attitudes Belief Beliefs Bias Biased Biases Emotional responses Emotional reactions Opinion Opinions Perception Perceptions Prejudice Prejudices Stigma View Views

		Physician Physicians Practitioner Practitioners	
Nursing & Allied Health; Psychology; Sociology (ProQuest) subject headings	Suicides & suicide attempts	Medical personnel	Attitudes
ProQuest keywords	Suicide Suicides Suicidal Suicidality Suicidal ideation		

Figure 1: ***PRISMA***

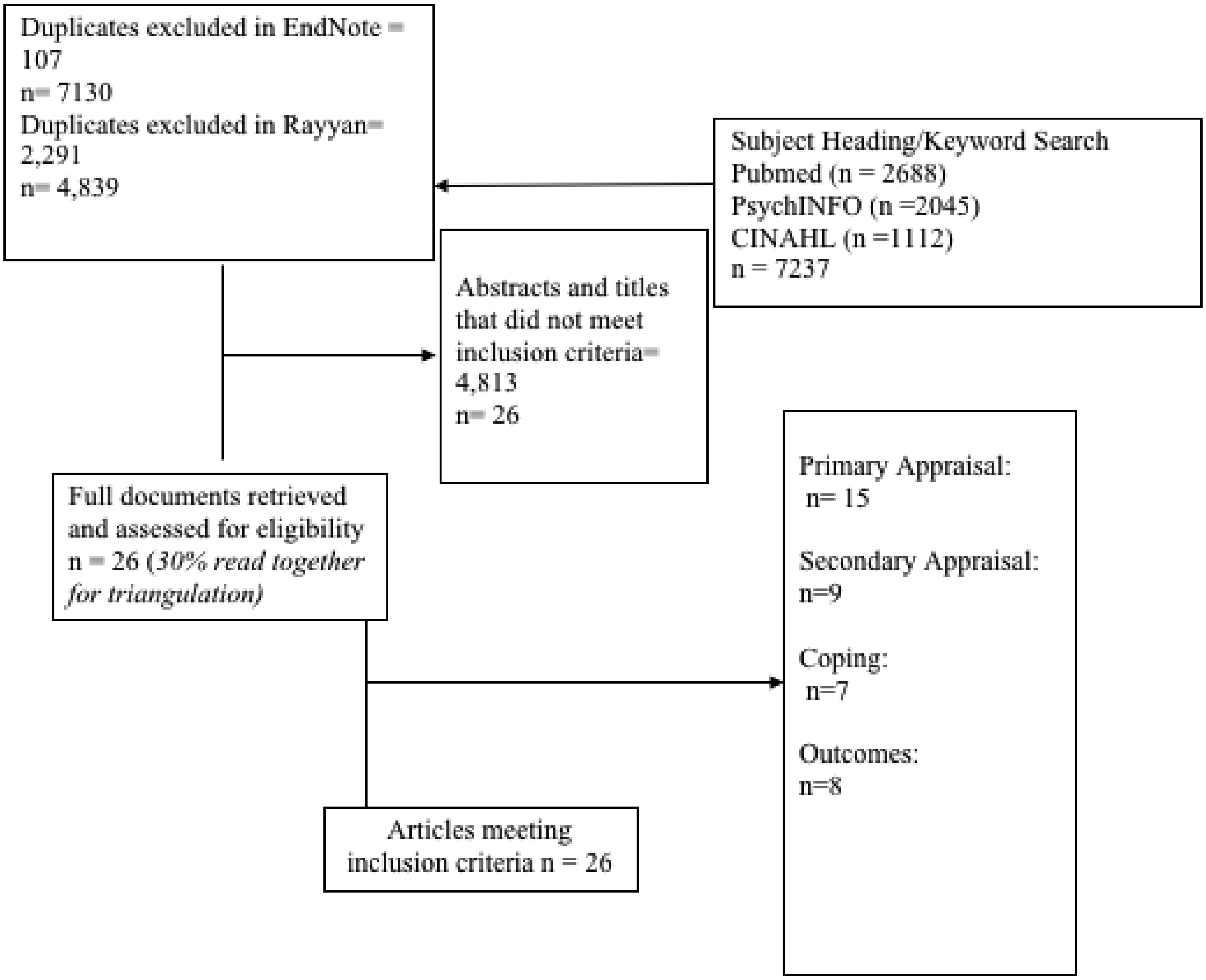


Table 2: ***Transactional Model of Stress & Coping***

Author name	**Participants in Study**	**Primary appraisal**	**Secondary appraisal**	**Coping (emotion vs. problem-focused coping)**	**Outcomes**
Abar et al., 2018	Not specified	Clinicians' bias against mental health and impact of treatment			
Berman, 2018	Clinicians		• Further training and protocol improve attitudes • Influenced clinical judgement		
Betz et al., 2015	Nurses and attending physicians	Attitudes, knowledge, beliefs, bias of clinicians		Find solutions that are not time consuming and inefficient	
Betz et al., 2010	Physicians, nurses and psychiatrists	Beliefs of clinicins, specific beliefs around protocols			
Betz et al., 2013	Nurses, resident physicians, and physicians		Further training and protocol improve attitudes	Discomfort and uncomfortable with	

				screening and assessing	
Blackwell, 2015	Healthcare clinicians				Stereotypes of patients Gay and bisexual males need for unique care
Bronsinski & Riddell, 2016	Nurses	Bias of clinicians, especially with patients with alcohol intoxication			
Descher et al., 2015	Physicians, Nurse practitioners, nurses, Physicians assistants, resident physicians, psychiatrists, phycologists		Beliefs about patient care		
Jacobson, et al, 2010	Healthcare Clinicians		Further training and protocol improve attitudes		
Lee et al., 2017	Healthcare clinicians			Avoidant in addressing suicide	Stereotypes of patients
Levandowski et al., 2017	Clinicians	Perceptions of clinicians (in particular effectiveness of safety plan)			Veteran population care

Marciano et al., 2012	Physicians		Further training and protocol improve attitudes		
Matthieu et al., 2009	Healthcare clinicians, administrative positions		Further training and protocol improve attitudes		Veteran population care
Millender, 2011	Nurses				Stereotypes of patients, Immigrants
Neville & Roan, 2013	Nurses	• Attitudes of clinicians • *Treatment Toward Suicide Questionnaire* • Systemic factors impacting attitudes			
Osteen, Frey & Ko, 2014	Healthcare clinicians	Self-efficacy of clinicians	Further training and protocol improve attitudes		Veteran population care
Osteen et al., 2017	Clinicians	*Attitudes Toward Suicide Prevention Scale, Treatment Toward Suicide Questionnaire*		Discomfort and uncomfortable with screening and assessing	
Pease et al., 2017	Behavioral health clinicians, nurses			Discomfort and uncomfortable with	Veteran population care

				screening and assessing	
Petrik, et al., 2015	Physicians, Physicians assistants, residents, fellows, nurses nurse practitioners and social workers	Perceptions of clinicians, attitudes influenced how they felt about patients			
Price et al., 2013	Physicians	Attitudes of clinicians			
Roy et al., 2017	Physicians and resident physicians	Perceptions and perceptions of clinicians		• Discomfort and second guessing with screening and assessing • Step-oriented not helpful for treatment	
Shim & Compton, 2010	ED "personnel"		Further training and protocol improve attitudes		
Silva et al., 2016	Behavioral health clinicians, phychians, administrators	Knowledge of clinicians			
Venkat & Drori, 2014	Physicians	Discomfort and personal judgement of clinicians		Discomfort and uncomfortable with	

				screening and assessing	
Waite Calamardo, 2009	Not specific	Bias of clinicians			Stereotypes of patients, African Americans
Zun, 2012	Physicians and nurses	Attitudes of clinicians	Further training and protocol improve attitudes		

CHAPTER 3: METHODOLOGY

Suicide in the United States is at the highest rate since World War II (33% increase of deaths), especially for those belonging to underserved populations (Curtin & Hedgaard, 2019). Current medical practice directs patient's at high risk for suicide to the emergency department (ED) for assessment (Suicide Prevention Resource Center [SPRC], 2016). When patients enter the ED, clinicians and staff assess patients' risk level and the treatment referral process begins (Farrohknia et al., 2011). The purpose of an ED is to provide urgent care or immediate medical treatment, which is provided through a linear workflow to move patients into and out of the ED (Mugdh & Pilla, 2011; Kobayashi et al., 2008). Linear care in the ED is a treatment workflow in which one clinician treats the patient and subsequently the next clinician moves into the room (Wang, 2013). When the assessment triage begins, patients who present with suicidal ideation (SI) are put through the linear process (Farrohknia et al., 2011).

Research on experiences of emergency care clinicians assessing for suicide risk is limited, especially studies that seek to understand how and why clinicians react emotionally towards patients presenting with SI. The previous chapter in this dissertation presented the systematic review of the current literature on suicide assessment experiences in the ED and highlighted the biases ED clinicians experience towards such patients. In general, clinicians lack an understanding of the patient's SI experiences (Betz, et al., 2015; Silva, Smith, Dodd, Covington, & Joiner 2016), especially for underserved patient populations (Blackwell, 2011; Millender, 2011; Lee et al., 2017; Waite & Calamardo, 2009). Thus, the purpose of this study is to explore the experiences of clinicians, specifically physicians, in the ED who assess underserved patients presenting with SI.

This chapter includes a review of the phenomenological method selected, sample and setting, study trustworthiness, data collection and data analysis. The study design and protocol setting has been approved by the East Carolina University and Vidant Medical Center Institutional Review Boards.

Study Design

The purpose of this study is to understand the experiences of clinicians in the ED who care for patients with SI. The term "clinicians" refers to medical doctors, physician assistants, and nurse practitioners, who are not behavioral health providers and are primarily managing patients in the Emergency Department who present with SI. This study was guided by the Transactional Model of Stress and Coping (TMSC) framework with the perspective that coping is a reaction to stress. The TMSC guided insight into how ED clinicians cope with their environment (Lazarus & Folkman, 1987). The researcher intended to investigate these experiences using a qualitative hermeneutical phenomenological approach.

Qualitative Research

A qualitative researcher seeks to interpret the data within the research environment while bringing meaning to these interpretations (Denzin & Lincoln, 2011). Qualitative research foregrounds the participant's voice and is indicated when little is known about a particular phenomenon (found in previous chapter). This approach is used when little is known about a topic, such as ED clinicians' experiences assessing SI in underserved populations; the researcher has chosen to utilize this approach. There is strong evidence that ED clinicians have reactions about patients presenting with SI, yet no evidence on why the clinicians experience these reactions.

Phenomenology. Qualitative research takes the form of many approaches. One of these approaches is phenomenological. The goal of a phenomenological approach is to explore a particular occurrence and to understand *how* a participant experienced it (Creswell & Poth, 2018). A core concept of phenomenology is to explore the essence of a natural experience without assumptions about the experience (Creswell and Poth, 2018). The goal is to translate a subjective experience of a participant into an objective experience to which others can relate (Cohen, 2007). There are many types of phenomenology: descriptive phenomenology, interpretive phenomenology, Husserlian phenomenology and hermeneutical phenomenology (among others). For the purpose of this study, the qualitative tradition of hermeneutical phenomenology was used to guide, analyze and interpret participant response.

Hermeneutical phenomenology. The researcher used a hermeneutical phenomenology approach to capture the human experiences of the ED clinician as well as his/her perceptions (van Manen,1990). Van Manen (1990) realizes that the researcher comes into the research with his/her own ideas about the phenomenon and wants that to be challenged through the actual experience being captured. The researcher aims to grasp a holistic understanding of the life experience, where multiple and complex “dimensions” of the experience are captured (Crowther, Ironside, Spense & Smythe, 2017). This type of phenomenology allows questioning of why the phenomenon is occurring (van Manen, 1997).

Hermeneutical phenomenology focuses on the participant’s “narrative” (Crist & Tanner, 2003). This approach aims to capture the account of the participant; a focus on subjective experience (Kafle, 2011). Van Manen (1990) views this process of understanding the narrative of the experience through specific steps. The first being thinking about the concern at hand: the research question. The researcher is then to think about themes related to the experience they are concerned about (van Manen, 1990). In the next step, the researcher further process what the narrative is by using the data collected to further grasp the phenomenon (van Manen, 1990). The purpose is to interpret the narrative of the phenomena (Bernard, Wutich & Ryan, 2017). The researcher is investigating the experience of the ED clinician to further understand their experience when assessing SI in underserved patients in the ED.

Study Design

In order for the current study to meet credibility guidelines, the researcher highlights how she met the criteria for a well-vetted study. Tracy’s (2010) eight standards informed study design: worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethics, and meaningful coherence.

Worthy Topic

First, the researcher’s topic is a worthy topic as there is a lack of information on clinicians’ experiences treating patients with SI in the ED, especially concerning underserved patient populations. The previous chapter of the systematic review of the current literature demonstrates the need for this study.

Rich Rigor

In order to conduct a rigorous study, the researcher kept an audit trail to track decisions made during the research study, including those that ensure study rigor (e.g., IRB submission, participant contacts, dates and times of interview, interview guide development and motivation) (See Appendix A). The researcher also engaged in a pilot interview before starting the official study to test interview questions and best understand how the questions would be understood. The researcher learned how to utilize purposeful questions in order to gather more information about experiences, particularly questions around experiences with underserved populations.

Sincerity

The researcher's bias (sincerity) was be monitored through engagement with her dissertation committee and their feedback throughout the process of conducting the study and analyzing the data. This assisted the researcher in assessing her own biases about SI treatment as well as her family of origin issues with ED clinicians. To assess the researcher's own biases, the researcher engaged in experiential and reflective exercises of her own evolving perspectives of ED clinicians and behavioral health. The researcher engaged in reflexivity regarding her assumptions and biases throughout the process of conducting the study. She engaged in "memoing" (Birks, Chapman, Francis, 2008) and reached out for feedback and consultation from her dissertation committee.

Self-reflexivity. The researcher is part of a medically-oriented family in which she has not felt her behavioral health profession is/was valued. As such, she brings a bias into the study that ED clinicians hold certain perceptions and perceptions around SI. The researcher chose the topic of suicide after studying and exploring her own experiences of treating clients with SI. She experienced one client attempting suicide along with many others presenting with SI. As a consequence of her research into behavioral health providers' experiences with patients who present with SI, she assumed that experiences (or perceptions) are not just isolated to therapists but can affect all health care providers who treat individuals with SI.

Choosing to study suicide was the researcher's form of "rebellion" because, for her, suicide was the ultimate expression of the potential severity of behavioral health issues. The researcher felt if she could prove that these issues were a problem, she could show her family that her profession was worth something. Her motivation has changed into wanting to share the experiences of all clinicians working with patients presenting with SI. She believes there is value in hearing why something is persisting, such as the current lack of treatment of SI and how SI assessment can be better assisted for both clinician and patient. To mitigate and explore her own biases, the researcher engaged in a photo reflexivity project on the journey of her biases through the lens of a hike that she took. Through this project, the researcher explored her biases around ED clinicians as well as her own self-worth in relation to her family of origin. Through the collection and data analysis the researcher was mindful of this bias and accessed triangulation to assist in mitigating bias.

Credibility

The credibility or trustworthiness was maintained through triangulation (Tracey, 2010). This took the form of method, investigator, and data source triangulation (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014). Method triangulation occurred through the use of interview audio tapes, transcripts, and interviewing authors' written reflections. Investigator triangulation will occur through the involvement of two of the authors' involvement in the data analysis. Data source triangulation occurred through the use of in-depth interviews, researcher reflections, and a thorough member-checking process. The inter-rater validation process involved asking probing questions to the participant to confirm the accuracy of the data and match their own perceptions (Bernard, Wutich & Ryan, 2017). Participants also engaged member-checking process which allowed for the participants to validate that the data collected and synthesized is credible (Birt, Scott, Cavers, Campbell, Walter, 2016)

Resonance and Significant Contribution

The researcher used resonance to impact the audience throughout the study. This correlates to the study being a “significant contribution” wherein it can improve the intended profession or practice (Tracey, 2010). The current study’s results aimed to provide insight into understanding how ED clinicians can assess and refer patients presenting with SI for treatment. The intent is that this research will promote future studies to explore how to decrease suicide rates.

Ethics and Meaningful coherence

Study ethics refers to the responsibility of the researcher to ensure consistent procedures are done without harm to the participants and that consequences are accounted for (Tracey, 2010). This is done through procedural ethics such as informed consent (Tracey, 2010), relational ethics which encompasses the respect for the relationship between researchers and participants (Tracey, 2010), and self-reflection to reduce bias. This also entails maintaining appropriate confidentiality throughout the research process. The researcher abided by ethical standards through the creation of an informed consent document and protocol (i.e., discussion of the study with the participant and agreement sought before proceeding with interview).

Meaningful coherence was obtained, as the study engaged in following through with its purpose and was linked with previous theoretical paradigms (Tracey, 2010). In order to engage in meaningful coherence, the researcher guided her work with the theory of Transactional Coping and Stress model and also relied on the previous systematic review to guide understandings of previous literature.

Research Qualifications

The researcher is a doctoral student in the medical family therapy program. She graduated from an accredited Couples' and Family Therapy Masters' Degree program in 2017. She has published a phenomenological study on therapists' perceptions around suicide treatment (Levy, R. L., Koehler, A. N., & Hunt, Q. A. [2019]). She has engaged in and completed a qualitative class in spring 2019 (HLTH 7100). Researcher has also engaged in a qualitative professional development course around data analysis with Dr. Sharon Knight. Researcher has presented on suicide treatment at national conferences such as The American Association of Marriage and Family Therapy as well as the The Collaborate Family Healthcare Association. Researcher has lead undergraduate lectures concerning suicide. The researcher has received guidance from her committee chair and advisor, Dr. Damon Rappleyea, throughout her qualitative study. A qualitative expert in the health field, Dr. Kim Larson, a professor in nursing, assisted with the qualitative methods of this study. Dr. Katharine Didericksen, a human development professor, guided the study methodology ensuring it was grounded in theory related to the discipline of Medical Family Therapy. Dr. Joanna Adams, Emergency Medicine physician, was the expert guiding information related to clinicians and clinical practice.

Procedure

Participants

For this study, the researcher purposively sampled from a participant population of ED clinicians in a rural Southeastern academic medical center. Participants were recruited from the ECU Physician umbrella (in Greenville and Beaufort). Inclusion criteria for participants was that each must: (a) hold the position of a physician, nurse practitioner, or physician assistant in the ED and (b) be employed fulltime with the academic medical center in the ED setting (c) have experience with patients with Behavioral Health issues. Exclusion criterion included those who exclusively hold a behavioral health degree (i.e., social workers, marriage and family therapists), registered nurses, licensed practicing nurses, medical assistants, and psychologists. The purpose of choosing these clinicians is to understand the experience of health care clinicians who have (a) direct contact with patients presenting to the ED with SI, (b) lack a mental health degree, and (c) possess the authority of decision making in providing care.

Recruitment

Consistent with qualitative research approaches (Creswell & Poth, 2018) the researcher employed a convenient sample to identify 5-10 study participants who meet participation criteria for the study. Evaluation of the number of participants was monitored throughout the study to make sure the point of saturation was reached (Malterud, Siersma, Guassora, 2016). Further, an email was sent for recruitment to all ED clinicians (see Appendix C). The study was also advertised in faculty meetings through dissertation committee member Dr. Joanna Adams, MD. This was a convenience sample and the limitations be discussed.

Consent and Data Collection

The researcher conducted the interviews via Webex in the video and audio format. Before starting the interview, the researcher verbally administered informed consent covering the following: privacy, confidentiality, and potential benefits and risk (see Appendix B). She documented the interviews on a tape recorder and copied the information onto a secure digital audio file with a password protected encrypted hard drive. The researcher transcribed data into a word document which included participant number only and no other identifying markers via *rev.com*. The researcher included a demographic questionnaire which contained questions about professional background and gender as part of data collection.

The researcher used an interview guide through the constructs of TCSM to understand the experience of the clinicians (see Appendix D for Interview Guide). The interviews ranged from 45-60 minutes long, both in person or through video conferencing. The guide was set up in parts to best understand the experience: demographics, introduction questions, primary appraisal, secondary appraisal, coping and outcomes questions. The questions were open-ended and non-directional while moving toward the central question (Creswell, 2007). The interview started with a description of what is like to be an ED clinician (effectively a “grand tour”) (Spradley, 1979, 1980). Part of the interview included ‘probing” questions in which researcher aimed to gain trustworthiness in the data by asking the participant for clarifications (Bernard, Wutich & Ryan, 2017). The follow-up questions were grounded around the TCSM to best understand the phenomena of the experiences of ED clinicians.

Data Management

The researcher managed data associated with the study by employing the following strategies. The researcher collected the data first in the form of video and audio recordings. The researcher sent the transcriptions to *rev.com* where the recorded data was transcribed verbatim. The transcription was paid for by the researcher. To achieve full understanding of phenomena, the number of interviews ranged from 5-7 with about 20 double-space typed pages of transcript per interview (Creswell & Poth, 2018). Qualitative researchers strive for “saturation” in order for full understanding and intend on striving for saturation.

A hard-copy of the consent forms, audio recordings, transcripts, analysis memos, list of participants and contact info, interview guide, and codebook was kept in a locked safety box in the researcher’s home. A digital file of the interview transcriptions and audio files is retained on a password protected hard drive. The audio recordings and transcriptions will be destroyed seven years after collection. Participants’ anonymity was protected through use of number system and the list of the coding for these assigned numbers were stored in the password protected hard drive. Demographic data was stored in a separate location from the interview/transcription data. Both had copies and electronic were stored properly.

Qualitative Data Analysis

Using a phenomenological approach, the researcher aims to understand the experiences and perspectives of ED clinicians’ assessment of patients who present with SI. In order to investigate this the researcher engaged in data analysis of the transcripts. Data analysis through the hermeneutical approach is done through the iterative process of reading, transcribing, and coding the data to find themes relevant to the experience being studied (van Manan, 1997).

Reading Transcript

The researcher listened to the entire audio-recorded interview at least once through before reading through the transcription. The researcher was using the “hermeneutical circle” in order to identify and understand the phenomena (Langdridge, 2007). The hermeneutical circle entails recognizing previous assumptions, meaning biases or ideas about research before learning about the topic (Grondin, 2015). The researcher must be aware that reality is reflected by our biases and something cannot exist without the experiences described by the person (Husserl, 29131). The researcher engaged in bracketing in which the researcher puts aside biases (Bernard, Wutich & Ryan, 2017). This was essential in thinking about assumptions when approaching the transcript and beginning to interpret the data.

Transcription and Coding

After receiving a verbatim transcription, the researcher read through the interviews twice before coding. Indications of such things as sighs, crying, laughing etc., were noted in the transcription. Throughout the process of writing and reading about each experience, the researcher began to better understand the entire phenomenon (Sloan & Bowe, 2014)

Coding the Transcript

The codebook was developed through the essentials of van Mann’s (1997) “essentials”: lived space, lived body, lived time, and lived human relation. This constitutes that as a researcher, we are looking for the “meaning” through each of these levels in which humans live (Palesjö, Nordgren & Asp, 2015). (See Appendix E)

Following Van Manen's (1990) guidelines for phenomenological coding transcripts were coded: (1) at the line-by-line level; (2) at each thematic content level; and (3) at a broad whole-experience level. The first step of this was to gather information about the narrative presented in the data (Bernard, Wutich & Ryan, 2017). Bracketing was a part of coding through filtering one's own biases and cultural lens to begin to identify the "essentials" of the phenomenon. (Bernard, Wutich & Ryan, 2017).

Coding began with thorough and numerous reading of each transcript (Bernard, Wutich & Ryan, 2017). In each reading, words or phrases were coded. These themes were pulled from exact words or phrases of the transcripts (Bernard, Wutich & Ryan, 2017). In these initial readings, a list of the common themes called "lean coding" was comprised where the researcher made "about labels" for the themes and continued to edit down (Creswell, 2007). Not all codes were kept due to "winnowing" because not all information is kept in a study; however most codes were kept (Wolcott, 1994b). The researcher developed a code book through these "essentials" to develop the themes. The codebook "in vivo codes" was utilized where the codes came from the exact words of participants (Creswell, 2007).

Summary

Through this methodology, the researcher intended to best understand the experiences of ED clinicians and their experiences of assessing patients in the ED presenting with SI. Qualitative hermetical phenomenology was employed for the purpose of creating understanding around the phenomena occurring for these ED clinicians during the assessment of patients with SI. Careful attention was paid to the role of researcher and the biases she holds. Through data analysis, the researcher attempted to capture the thematic content of this phenomena. The results of this study attempt to aid in the comprehension of how ED clinicians are handling their stress around patients with SI and what can be improved to minimize such stress.

REFERENCES

Bernard, H. R., Wutich, A., & Ryan, G. W. (2017). Introduction to text: qualitative data analysis. *Analyzing Qualitative Data.* Thousand Oaks, CA. Sage.

Birks, M., Chapman, Y., & Francis, K. (2008). Memoing in qualitative research: Probing data and processes. *Journal of research in nursing*, *13*(1), 68-75. Doi: 10.1177/ 1744987107081254

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: a tool to enhance trustworthiness or merely a nod to validation?. *Qualitative health research*, *26*(13), 1802-1811.

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum, 41*(5), 545-547. doi:10.1188/14.ONF.545-547

Cohen, L., Mannion, L., Morrison, K. (2007) *Research methods in education,* 6th ed. London, England: Routledge.

Creswell, J.W. (2007). *Qualitative inquiry and research design: choosing among five approaches*, 2nd ed. Thousand Oaks, CA: Sage Publications Ltd.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Crist, J. D., & Tanner, C. A. (2003). Interpretation/analysis methods in hermeneutic interpretive phenomenology. *Nursing research*, *52*(3), 202-205.

Crowther, S., Ironside, P., Spence, D., & Smythe, L. (2017). Crafting stories in hermeneutic phenomenology research: A methodological device. *Qualitative Health Research, 27*(6), 826-835. doi:10.1177/1049732316656161

Curtin, S.C., Hedegaard H. (2019) *Suicide rates for females and males by race and ethnicity: United States, 1999 and 2017.* NCHS Health E-Stat. Retrieved from: https://stacks.cdc.gov/view/cdc/79168

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2011). *The Sage handbook of qualitative research*. London, UK: Sage Publications.

Farrohknia, N., Castrén, M., Ehrenberg, A., Lind, L., Oredsson, S., Jonsson, H., ... & Göransson, K. E. (2011). Emergency department triage scales and their components: a systematic review of the scientific evidence. Scandinavian journal of trauma, resuscitation and emergency medicine, *19*(1), 42.

Goodman, Leo A. (1961). Snowball Sampling. *Annals of Mathematical Statistics. 32,* 148-170. doi:10.1214/aoms/1177705148. https://projecteuclid.org/euclid.aoms/1177705148

Grondin, J. (2015). The hermeneutical circle. (pp. 299-305). In *A companion to Hermeneutics.* Hoboken, NJ: John Wiley & Sons, Inc. doi:10.1002/9781118529812.ch34

Heidegger, M. (1962). *Being and time.* New York: Harper. (Original work published 1927)

Husserl, E. (1931). *Ideas: General introduction to pure phenomenology.* Evanston, IL: Northwestern University Press.

Kafle, N. P. (2011). Hermeneutic phenomenological research method simplified. *Bodhi: An interdisciplinary journal*, *5*, 181-200.

Kobayashi, L., Overly, F. L., Fairbanks, R. J., Patterson, M., Kaji, A. H., Bruno, E. C., ... & Wears, R. L. (2008). Advanced medical simulation applications for emergency medicine microsystems evaluation and training. *Academic emergency medicine*, *15*, 1058-1070. doi:10.1111/j.1553-2712.2008.00247.x

Langdridge, D. (2007). *Phenomenological psychology: theory, research and method*. Harlow, England, London, New York: Pearson Education Limited.

Lazarus, R.S. & Folkman, S. (1987). Transactional theory and research on emotions and coping. *European Journal of Personality, 1,* 141-169. doi: 10.1002/per.2410010304

Levy, R. L., Koehler, A. N., & Hunt, Q. A. (2019) A Phenomenological Investigation of Therapists' Experiences When Working with Suicide. *Journal of Feminist Family Therapy,* 1-18. doi: https://doi.org/10.1080/08952833.2019.1603922 .

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research, 26*(13), 1753-1760. doi:10.1177/1049732315617444

Mugdh, M., & Pilla, S. (2011). A conceptual framework for achieving balance between innovation and resilience in optimizing emergency department operations. *The Health Care Manager*, *30*, 352-360. doi:10.1097/HCM.0b013e3182351898

Palesjö, C., Nordgren, L., & Asp, M.(2015). Being in a critical illness-recovery process: A phenomenological hermeneutical study. *Journal of Clinical Nursing*, *24*(23-24), 3494-3502. doi:10.1111/jocn.13002

Sloan, A., & Bowe, B. (2014). Phenomenology and hermeneutic phenomenology: The philosophy, the methodologies, and using hermeneutic phenomenology to investigate lecturers' experiences of curriculum design. *Quality & Quantity, 48*(3), 1291-1303.

Spradley, J.P. (1979). *The Ethnographic interview.* New York: Holt, Rinehard & Winston.

Spradley, J.P. (1980). *Participant observation.* New York: Holt, Rinehard & Winston.

Suicide Prevention Resource Center (2016). *Rate of suicide by Race/Ethnicity, United States 2000-2016.* Retrieved from: http://www.sprc.org/racial-ethnic-disparities.

Suter, R. E. (2012). Emergency medicine in the United States: A systemic review. *World Journal of Emergency Medicine, 3*, 5–10. doi:10.58471920-8642.2012.01.001

Tracy, S. J. (2010). Qualitative quality: Eight “big-tent” criteria for excellent qualitative research. *Qualitative inquiry*, *16*(10), 837-851.doi: 10.1177/107800410383121

United States Centers for Disease Control and Prevention (CDC). *Fast facts sheet on suicide.* (2017). Retrieved from https://www.cdc.gov/nchs/fastats/emergency-department.htm

United States Centers for Disease Control and Prevention (CDC) *Suicide: Facts at a glance*. (2015). Retrieved from http://www.cdc.gov/ViolencePrevention/suicide

United States Centers for Disease Control and Prevention (CDC) Understanding suicide: Fact sheet. (2013). Retrieved from https://www.cdc.gov/violenceprevention/pdf/suicide_factsheet-a.pdf

van Manen, M. (1990). *Researching lived experiences: Human science for an action sensitive pedagogy.* Albany, NY: State University of New York Press

van Manen, M. (1997). *Researching lived experience: human science for an action sensitive pedagogy*, 2nd ed., University of Western Ontario, London: The Althouse Press.

Wang, X. (2013). Emergency department staffing: A separated continuous linear programming approach. *Mathematical Problems in Engineering, 2013*. doi:10.1155/2013/680152

Wolcott, H.F. (1994b). *Transforming qualitative data: Description, analysis, and interpretation*. Thousand Oaks, CA: Sage.

CHAPTER 4: FINDINGS

Introduction

Suicide is the second leading cause of death in the United States for people raging from ages 10 to 34 years old (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2020). Members of underserved populations are in particular at more high risk for suicidal ideation (Center for Disease Control and Prevention, 2015). Underserved populations include racial and ethnic minorities, low-income populations, and people in minority groups such as the Lesbian, Gay, Bisexual, Queer, Transgender, Intersex and more (LGBQTI+) population (Substance Abuse & Mental Health Services Administration [SAMSHA], 2020). Members of these underserved groups experience disproportionate resource and access limitations due to their location geographically, demographically and/or economically (Blumenthal, Mort, & Edwards, 1995; Fiscella et al., 2000). Because of these limited resources, underserved populations experience an overall lack of mental health care which leads to SI.

When a person is experiencing suicidal ideation (SI), they are typically directed (by other providers or self) to go to the Emergency Department (ED) (Suicide Prevention Resource Center [SPRC], 2016). When patients enter the ED, clinicians assess their risk and safety levels. Unfortunately, ED clinicians face provider- and larger system-level limitations that compromise their ability to help patients, especially those from underserved populations (Babeva, Hughes and Asarnow, 2016). Some ED clinicians report that they do not have the time or energy required to locate resources for patients experiencing SI when they must manage multiple other patients simultaneously. Or, ED clinicians state that they consider SI "non-urgent" when compared to other problems that present to the ED (Clarke et al., 2014). Even if proper assessment and treatment are delivered within the ED, lack of resources post-discharge and low patient adherence to follow-up jeopardize patients' long-term behavioral health outcomes (Knesper, 2010). For underserved populations, these issues are compounded due to a lack of access to both general (physical) and behavioral health care, as both clinician and systemic biases disproportionately affect minority racial and ethnic groups. (CDC, 2015; Blackwell, 2011; Millender, 2011; Lee et al., 2017; Waite & Calamardo, 2009).

Literature Review

Documentation of suicidal ideation can be traced back to the Ancient Romans (27 BC-AD 395) and Greeks (509-27 BC; Shields, Hunsaker, & Hunsaker, 2005). Historically suicidal ideation was conceptualized as a "moral crisis" over one's wrongdoing (Barraclough et al., 1974). Previously, when people were experiencing suicidal ideation they were not directed to the ED. The concept of an ED for "emergency needs" was only developed 50 years ago (Suter, 2012). In 2017, 141.4 million visits were made to the ED (CDC, 2017). In the past two years, there has been a 25.5% increase in ED visits for people struggling with SI (Zwald, Holland, & Annor, 2010). Patients who present to the ED with suicidal ideation have a higher risk of death 30 days after leaving the ED when compared to other patient presentations (Knesper, 2010). Of patients who were discharged from the ED for suicidal ideation, 70% did not go to scheduled outpatient appointments (Knesper, 2010).

Barriers to systemic coordination in the ED and beyond to outside providers have been identified (Knesper, 2010). Researchers have found that complications of the healthcare systems and the time needed for productive involvement create barriers for patients (Kobayash et al., 2008). The current healthcare environment is stressful and quick-moving, which can influence how the ED clinicians provide care (Suokas, Suominen, & Lönnqvist, 2008). Clinicians have reported that they have felt discomfort with behavioral health issues (Ronquillo et al., 2012).

Clinicians have also reported discomfort with assessing patients who present with SI due to lack of understanding and knowledge of behavioral health (Betz et al., 2013; Osteen, et al, 2017; Sevila et al., 2016; Roy, 2017; Venkat & Drori, 2014).

As mentioned earlier, underserved populations have a higher risk of SI and further are less likely to receive behavioral health care (Miranda, McGuire, Williams, & Wang, 2008; Suicide Prevention Research Center, 2018; SAMASHA, 2019). Emergency departments are not equipped to handle behavioral health in any capacity, but specifically struggle with underserved populations due to the unique needs that they present (Blumenthal, Mort, & Edwards, 1995; Fiscella et al., 2000). Underserved populations have reported discrimination within the health care system concerning access to both healthcare and clinicians (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). There has been a lack of literature to understand ED clinicians' experiences regarding underserved populations presenting with SI. This study will explore this type of experience of these clinicians.

Objectives

In Chapter 2 of this dissertation, we found that there is an absence of literature about ED clinicians' perceptions of treatment for underserved populations experiencing SI. The objective of this study is to explore the experience of ED clinicians who have assessed underserved patients presenting with SI.

Study Design

This study was guided by the Transactional Model of Stress and Coping (TMSC) framework, which rests on a founding assumption that coping is a reaction to stress (Lazarus & Folkman, 1987). The semi-structured interview guide was mirrored after the TMSC framework to best grasp and understand the experiences of the clinicians. In addition to preliminary questions of demographics and introductory information, the TMSC was used to loosely structure the interview guide (See Appendix D). To best understand the experience, the guide is set up into parts: demographics, introduction questions, primary appraisal questions, secondary appraisal questions, coping questions, and outcomes questions. Using the semi-structured interview guide, participants were interviewed via a secure videoconferencing platform or phone for 45-60 minutes.

Procedures

Recruitment and Consent

An ED clinician gatekeeper recruited participants into this study by emailing the Department of Emergency Medicine at a Southeastern Academic Medical Center. Inclusion criteria for participants were: (a) designated as a physician, nurse practitioner, or physician assistant in the ED; (b) be employed fulltime with the academic medical center in the ED setting; and (c) have experience with patients presenting with behavioral health needs. Excluded from participation were (a) those who exclusively held a behavioral health degree (i.e., social workers, marriage and family therapists, psychologists); (b) those employed in the ED but designated as part-time employees; or(c) those working in the ED who are classified as registered nurses, licensed practicing nurses, and medical assistants.

Recruitment of participants occurred by way of email, flyers, and active invitation (if a prospective participant met inclusion criteria guidelines over 5 months via convenient sample. A total of 7 participants responded and were subsequently interviewed for the study. Participants completed and signed an Institutional Review Board (IRB) approved consent form before engaging in the study (see Appendix B) and completed a brief demographic survey that included general social location variables and questions about inclusion/exclusion for study participation.

Participant Demographics

Of the total number of study participants, two were male, and five were female. Six of the participants identified as ED physicians and one who identified as a Physician Assistant (PA). The age range of participants was 33-56 years old. The majority of participants identified as white, two of which identified as another minority population.

Data Analysis

Hermeneutical Phenomenology guided the data analysis of this study. This method was utilized to best explore the essence of a natural experience without assumptions about the experience (Creswell and Poth, 2018). This analysis allows for a focus on the participant's "narrative" (Crist & Tanner 2003). Van Manen (1990) states that the researcher comes into the research with his/her own ideas about the phenomenon. The goal of this analysis is to be challenged through the actual experience being captured. Hermeneutical phenomenology permits the questioning of why the phenomenon is occurring (van Manen, 1997).

In this type of data analysis, the researcher is then to think about themes related to the experience with which they are concerned (van Manen, 1990). In the next step, the researcher used the collected data to write what the narrative encompasses to further grasp the desired phenomenon (van Manen, 1990). By using Van Manen's (1990) guidelines for phenomenological coding transcripts, the researcher began to code at the following levels: (1) at the line-by-line level; (2) at each thematic content level; and (3) at a broad whole-experience level. The researcher also bracketed as part of coding through filtering her own biases and cultural lens to begin to identify the "essentials" of the phenomenon. This task was done by keeping a journal of reflections. (Bernard, Wutich & Ryan, 2017).

Coding through this lens began with thorough and numerous readings of each transcript where the researcher engaged in thorough reading and coding words and phrases. (Bernard, Wutich & Ryan, 2017). Codes were reflected through exact words and phrases of the transcripts. (Bernard, Wutich & Ryan, 2017). In these initial readings, the researcher found common themes through "lean coding," where the researcher made labels for themes and continued to edit them down. (Creswell, 2007). "In vivo codes" were utilized where the codes were created from the exact words of the participants (Creswell, 2007). Codes were excluded through "winnowing" because it is not beneficial to keep all information in a study (Wolcott, 1994b). The researcher developed a codebook through these "essentials" to develop the themes.

The research team coded data through the lens of hermeneutical phenomenology in order to capture the human experience and perceptions of ED clinicians (van Manen, 1990). The researcher transcribed the interviews using *rev.com*. After reading through the transcripts and listening to the audio of recordings of the interviews, the research team began to underline significant statements. The research team then began then to pull together significant statements within the interview questions. After these groups were combined, similar words were grouped together to make one general term through the given theory. These terms were grouped into themes (see Appendix E).

Credibility. The inter-rater validation process involved asking the participants probing questions to confirm that the data gathered accurately matched participants' perceptions (Bernard, Wutich & Ryan, 2017). The research team also kept a reflection journal that was used for documentation after each interview to enhance interviewer awareness about scope and direction of study, personal biases and general impressions of the interview process. Reflective journal impressions were incorporated into routine "debriefing" meetings with research team members throughout the duration of the study. Reflective journal processing and research team debriefings resulted in minor revisions to the interview guide, question sequencing, or general interview improvement. At the conclusion of the coding process, a triangulated reviewer evaluated the transcripts and coded themes to verify that the content of the transcripts matched the established coding mechanisms and that emerging themes were consistent with participant "voices" (Webb, 1966). The triangulated researcher evaluated each emerging theme and deliberated with the primary investigator to reach consensus about the findings (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014; see Appendix F). The researcher also engaged in member-checking by sending a summary of findings to participants for validation (Birt, Scott, Cavers, Campbell, & Walter, 2016).

Findings

Four major themes that emerged from the interviews with ED clinicians regarding their experiences assessing underserved patients SI are as follows: (1) ED interest in environment variety; (2) ED Clinicians Expressed Lack of Role Clarity with Patients Presenting with SI (3) ED Clinicians Observed Failure of the Healthcare System with SI, and (4) ED clinicians experience contextual variables.

Theme 1: ED Clinicians' Interest in Environment Variety

The first theme that emerged from the data pertained to the reason ED clinicians sought careers in Emergency Medicine. When asked why the clinicians chose to work in the ED, all the participants expressed similar sentiments of enjoying the variety of presenting problems.

Further, participants also stated that the ED was a place where patients would be cared for regardless of insurance status, thus resulting in a diverse patient population. They reported that the ED was a place where all people could get access to healthcare. Participant 1 reported that he enjoyed the "caring for patients with all sorts of problems" as "whether it's relatively minor (illnesses) or relatively sick" patients. Participant 4 shared the same sentiment, adding that she enjoyed being the "first line" of care as the opportunity to use her critical thinking skills to solve patient problems.

Participant 7 stated why she was drawn to the ED, by saying she wanted:

> [T]o mainly help people but also because I didn't have a choice whether or not to treat people who are insured or not. I treat everyone. … I didn't want to say 'no' to somebody to provide care… I've seen a lot of poverty and sometimes there is not equitable distribution of resources.

More than 4 participants reported that the ED was a place where all patients could obtain equal access to healthcare, which they determined was not always the case in other healthcare delivery spaces. Ironically, the similarity of clinicians wanting a variety of experiences in the ED was contradicted when the ED clinicians provided assessment to SI patients put in positions that are tough for them, especially when treating patients with SI.

Theme 2: ED Clinicians Expressed Lack of Role Clarity with Patients Presenting with SI

A second theme was the lack of understanding of what the role of the ED clinician was in SI assessment. Participants also expressed a commonality in the way in which they managed to address issues of role confusion; namely, by accessing assistance from other experts (such as psychiatrists) to fill gaps in their knowledge of ED care. The first common experience was confusion on how to respond to patients with SI in the ED. Participant 7 stated:

> I don’t have the time to spend with them that they necessarily need. …My role as an emergency physician with suicidal patients is to make sure they’re physically and medically okay. I am not sure…I am not a psychiatrist.

Participants reported that they struggled in determining how best to serve the patients with SI while simultaneously needing to address other patients’ needs in a timely manner. Participant 5 expressed her frustration in trying to manage her time appropriately for these patients with SI. She stated,

> I don't want to seem inattentive to that. So I actually try to cut it off early saying, you know, I don't want them ... it's sort of a weird kind of dynamic. In one way, I would like for it to develop a little bit of a relationship with them, but in the other way, I can't because I don't want to cut you off in the middle of it because I've got to go do some other stuff. You know?

She continued to talk about how at times she had to “depersonalize,” because it was, “emotionally taxing to get involved like that” with patients’ distress. Participant 2 expanded on this tension that clinicians feel between the desire to build rapport and the importance of keeping up with the ED’s rapid pace:

> I think sometimes I feel sorry for them [patients with SI] because this is a tough place to come in for those complaints because we are so often aren’t doing therapy. You know? If you're short of breath, I'm going to do a breathing treatment. There's not an immediate treatment that I'm going to do in the Emergency Department that's going to begin to alleviate your symptoms or your condition… There is no immediate treatment that I’m going to do in the emergency department that’s going to begin to alleviate your symptoms or your condition.

These participants felt stuck within a complex system with trying to fulfill the role of SI assessor as a clinician. They reported that they knew they had to hold boundaries around their roles given their limited behavioral health training as ED clinicians, but they were confused about how to do this and still ensure adequate assessment and management of patients with SI within the ED setting.

Sub-Theme 1: Relief from confusion. Participants reported that there were resources that relieved some of the pressure clinicians felt to operate roles outside of the bounds of their role and clinical skillset. Most of the participants stated that having a psychiatrist available was very “helpful” in clarifying their role as an ED clinician. Participants shared that not having access to this resource was anxiety-provoking for them. Without the help of psychiatry, participants expressed that they were solely “responsible” for SI assessment –a task for which they believed they lacked adequate training. Participant 6 stated that recently her hospital lost their behavioral health unit and with it, their onsite psychiatrist. According to her, no longer having access to a psychiatrist led to an increase in her stress concerning whether or not she is “appropriately assessing” patients who present with SI for safety (if the patient is safe to not hurt themselves by being released from the ED). The only participant who was a PA, shared that reporting to an upper level also relieved her stress when making a safety call.

Sub-Theme 2: Solidification of roles. Another experience that the participants reported were the times when they did feel impactful to a patient presenting with SI. They stated they felt more impactful because they had time to assess and listen as well as when there were collaborators, such as onsite psychiatrists, there to provide support. Participant 4 explained that when she was able to “talk and reassure” and “create relationship” with patients, she felt more impactful. Participants also discussed how having collaborators made them feel like they were providing better patient care. Participant 3 reported he felt “helpful” to patients when there were accessible resources, (e.g., follow-up care and inpatient hospital bed available) to offer. Participant 1 expanded on this idea, stating that he felt helpful not only when he was able to give patients “resources” but also when there was a lack of other co-morbid issues such as insurance substance use issues. Similarly, Participant 4 said she felt most effective with patients who presented with straightforward presentations of SI:

> The patient who comes in who has legit depression and legit suicidal ideations and has a plan, and you just know that they are sad and depressed, and they need help, and the stats line up and you can get them to an inpatient facility where they need to go and they get the treatment that they need.

Overall, the participants shared that when there were fewer patient-relation and system related complexities (i.e. straightforward patient presentation of SI, access to follow-up care- to the patient), they felt more certain of their “role” and effective as an ED clinician.

Theme 3: ED Clinicians Observed Failure of the Healthcare System with SI

Throughout the interviews, participants reported the greatest struggles they had were with the dysfunction of the larger healthcare system. This challenge, as shared by the participants, was the lack of larger-system functionality. Participants shared they felt forced into a role because of the larger system issues. Participant 3 stated that the healthcare system “fail[s]” patients who present with SI, because they are coming into the ED for care that they are not able to access outside of the ED.” The participants felt that patients end up in the ED because the healthcare system has already failed them. In other words, participants identified that patient presentation to the ED in behavioral health crisis was a symptom of the lack of access to outpatient behavioral health resources. Participant 3 continued to discuss her frustration, by stating, “[when] someone comes in with suicidal thoughts or suicidal ideation, and you just know that they’re stuck. There’s not enough [behavioral health resources] for them.” Participant 7 further shared this opinion by stating, “I feel hopeless when treating them [patients with SI] because I feel like, again it’s this revolving door to the Emergency Department.” She described the “revolving door” as a phenomenon of patients coming in and out of the ED over and over again with no support post-discharge due to lack of behavioral health follow-up and/or lack of resources.

Participants shared their frustration about a lack of behavioral health care for patients, but also the lack of preventative care. Participant 4 said that when patients were in the ED waiting for transport to a psychiatric unit, they would sometimes wait for days or weeks. She stated that patients in this situation are stuck in “ED jail” while only being provided with stabilizing medication. Participant 5 shared that she believed the best care was preventive care by explaining, “The ability to guide the patient to seek the best preventative care, primary care, appropriate follow-up, appropriate counseling, appropriate medical therapy regardless of ability to pay.” Unfortunately, the ED clinicians interviewed felt that this kind of preventative care was largely inaccessible in the United States. Participant 7 expressed that she is, “putting a Band-Aid over this great big wound.” Participant 1 shared that he felt psychiatric care was always being cut from healthcare budgets. He explained:

> I really think the reason for our ability to do that is because if psych patient complains, it’s no big deal. Nobody cares. Nobody listens to them because they’re crazy. If patient with heart disease complains, he is going to make a big stink and write to his congressman and complain about it if he doesn’t get good care and the psychiatric patient

> just gets ignored, unfortunately. That's just the reality of our societies, or at least in the Western world anyways.

According to the participant, the bias against behavioral health within the healthcare system causes more issues for patients struggling with behavioral health and leaves them to turn to the ED for care. The participants also expressed their feelings about marginalized populations and their experiences of working with these patients.

Theme 4: ED Clinicians Experience of Contextual Variables

Participants explained a variety of experiences that they had with patients of underserved populations. Many of their experiences working with these patients concerned patients' socioeconomic struggles. With socioeconomic-related constraints on care (e.g. lack of insurance coverage, access to adequate transportation and/or housing, etc.), ED clinicians shared that they have to be critical thinkers in order to best provide resources for patients who present with SI. Participant 2 shared how patients' socioeconomic status impacts patient care:

> The wealthier you are the more conventional you are in any sense the easier it is for you to find other resources. I mean, wealthy people can find other resources. They come through, but they just simply have better access to resources all around

Participant 2 shared how the larger system dynamics of health care insurance and payor models impact the care of patients with the same presenting issue: SI. All participants discussed how the larger healthcare system impacts how the ED is overloaded with behavioral health cases and it becomes hard to differentiate the "actual" needs of the patient. They defer to trying to figure out if the patient needs behavioral health care, a safe place to sleep, or a place to detox from drugs. Participant 4 reported that she has difficulty when patients present to the ED and have intersecting behavioral health and socioeconomic needs. For example, she stated that some patients who are homeless will share they are suicidal but really are seeking shelter.

Sub-theme 1: Empathy for contextual factor congruence. Participants shared that contextual variables impacted their care of SI when patients with SI presented to the ED. Participants largely discussed these variables in terms of effects of the clinician-patient race and gender congruence (or lack thereof) on care. Participant 7 shared that she more easily relates to patients when they are of the same gender and this, in turn, affects rapport-building. She states:

> I think women open up to me quite a bit more. But I think also, maybe some minorities don’t open up to me as much. Maybe they think that I won’t understand where they’re coming from or I’m not going to empathize. That’s not the case, but that’s just something, maybe they’ve had prior experience in the healthcare system, and they’re thinking I’m going to be the same way, I guess.

Participant 7 highlighted how gender congruence is something that creates more empathy for the patient. Conversely, she also highlighted how gender incongruence or other contextual variables can create less trust in clinicians and their care. Participant 5 also shared that the cognitive/emotional process that happens around gender and race congruence “[is] not intentional, I think it’s just human nature in a way. I mean, I’m open to knowing that that is a possibility…. I’m going to probably be able to develop a rapport maybe with someone more similar to me than someone not similar to me.” Participants acknowledged that clinician-patient gender and race congruence did impact their care and rapport-building with or without intention. Participants also shared about how their assessments are impacted by the ways in which patient’s present themselves. Participant 4 shared that “I think the factors that impact their care is their demeanor towards providers”.

Sub-theme 2: Reflection about biases. Through the interviews, participants explained the different ways that they cope with their reactions to patients from marginalized communities who present with SI. Participant 1 shared that he thinks about all people as "human beings… There's no difference between you, me and the next guy on the street, whether he's a bum or some professor…I might treat you differently, but I'll do so in a respectful way so that I can maximize your medical care." Participant 7 shared that she practices in mindfulness when she is engaged in giving patient care. She explained:

> I try to focus on the individual, and not to, in my mind, especially if I'm taking care of patients, start worrying and thinking about the whole systems' issue. I know a lot of things are out of my hands. I feel like sometimes physicians know what's best for their patients, but then the system fails them. The people who are operating the system don't realize, I think, necessarily what needs to be done for our patients that's going to be ... Do they need a longer-term stay or whatever?

Some participants shared that contextual variables were a way to assess patients' risk factors. Some participants reported they do not recognize their own biases affecting participant care, the bias (5 or the 7 participants), stating they do not believe it is a factor but still reflected that the system as a whole is broken. When the first author read participants a vignette about a Latinx patient who is using an interpreter to share his SI with a clinician, the majority of participants did not mention the potential impact of the clinician's contextual variables on assessment and treatment. Participant 4 explained how these clinician biases towards the patient's contextual variable present, but it is up to the clinician to recognize them. She stated: "I'm sure there are biases that I am not even aware of. I mean I'm a white woman, you know? I have biases." Participant 4 felt this is an individual decision to be aware of these contextual variables.

Exhaustive Description

This qualitative phenomenological study was designed to explore ED clinicians' experience of assessing patients from marginalized populations who present with SI. Major themes that emerged from this study were: (1) ED clinicians' interest in environment variety; (2) ED clinicians expressed lack of clarity of their ED role with patients presenting with SI; (3) ED clinicians observed disjointed care results in inappropriate placement of patients with SI to the ED; and (4) ED clinicians experiences with contextual variables.

The first theme was ED clinicians' interest in the ED environment. Participants shared that they appreciated the availability that the ED provides to all patients, while disregarding the patients' insurance status. Participants also shared they appreciated the variety of patients and presenting problems for which they were able to care for.

The second theme was that ED clinicians expressed a lack of clarity of their ED role with patients presenting with SI. Participants shared that they felt their roles as a clinician was unclear. As a result, ED clinicians had to create boundaries with patients in order to balance the needs of multiple patients simultaneously. Participants did explain that having collaborators available, such as an onsite psychiatrist, was an invaluable resource and assisted in clarifying their role.

The third theme was that ED clinicians observed the disjointed care resulting in the inappropriate placement of patients with SI in the ED. Participants shared that they felt that a broken healthcare system was responsible for a lack of behavioral health preventative, outpatient, and follow-up care. A result of this lack of care, participants stated, was overloaded EDs. They stated they were not able to do enough in the ED to appropriately care for these patients and that, while the ED may have been the patient's only option in crisis, so much could have been done leading up to crisis (in the way of preventative, outpatient, and follow-up care) to help prevent it.

The last theme was that ED clinicians reported varying levels of reflection on patient's contextual variables. Participants also reported that they felt that there were disparities in health care for marginalized populations. They explained that patients were treated differently within the health care system based on their different contextual variables. Finally, participants shared they felt they can empathize best with patients whom they shared gender and racial congruence. Different participants reported different understandings of their biases related to patient-clinician congruence. Among participants, some stated they were self-reflective of their own biases and others shared that they did not feel they had any biases.

Discussion

Transactional Model of Stress and Coping (TMSC)

These findings reflect the process of coping with a difficult situation, in this case, ED clinicians caring for underserved patients presenting with SI. This process can be understood through the Transactional Model of Stress and Coping (TMSC). Lazarus and Folkman (1987) stated that coping with stress is a four-step process: primary appraisal, secondary appraisal, coping, and outcomes. Primary appraisal is defined by emotional reaction/distress. Secondary appraisal refers to how the person evaluates the situation, while coping refers to how the person handles their reaction. Outcomes are defined as the result of the appraisal/coping event (Lazarus & Folkman, 1987). Salaina (1994) added considerations for the impact of contextual variables on stress. She found that stress from being a minority also affects how such individuals cope. (See Table 5)

Primary Appraisal. The primary appraisal process is used to mirror how ED clinicians described their experience. Primary appraisal is reflected in the reasons why the ED clinicians are drawn to the ED. The clinicians that stated that patient access to the ED (regardless of insurance status, for example), as well as variety, drew them to the ED service. This is their primary appraisal (or emotional draw) to their decision to become ED clinicians in the first place, and what inspires them to continue to come back to this work despite the challenges and hardships. This is a particularly interesting finding because what draws clinicians to the environment (the ED's ability to bypass a disjointed healthcare system and address a variety of problems) is the exact reason why a growing number of patients are presenting to the ED with SI. This finding is congruent with previous findings of clinicians' personality traits that seek an environment with accessibility and variety for working in the ED, which is consistent with **Theme 1** (Kennedy et al., 2014).

Secondary Appraisal. Secondary appraisal is reflected when the ED clinicians evaluate the space they are in when underserved patients present with SI to the ED. Participants reported that they need to evaluate how best to provide care for these patients. Ultimately, they do so by defining their role more clearly and/or bringing in collaborators to make that space more effective. Other researchers have also confirmed this finding by stating that the assistance of behavioral health liaisons in the ED is helpful for clinicians to provide care (Wand & Happell, 2001; Wynaden et al., 2003)), which is consistent with **Theme 2**.

Coping. Consistently, ED clinicians must determine how to cope with a disjointed healthcare system that funnels patients with SI often inappropriately into the ED. According to Lazarus and Folkman (1984), there are two types of coping: problem focused coping and emotion focused coping. Problem focused coping is thinking about the problem and looking into other solutions by weighing the pros and cons of those potential solutions (Lazarus & Folkman, 1984). Emotion focused coping is how the person deals with the stress by reappraising, such as distancing from the stressor or isolating themselves.

Clinicians utilize their problem focused coping when they state that they attempt to put a "band-aid" on the problem. They do everything in their power and within the scope of the ED to meets patients' needs, despite a disjointed and broken healthcare system over which they have little to no control. Other researchers have found that the dysfunctional environment of the healthcare system leaves inappropriate coping of inadequacy where clinicians feel they cannot care for patients (Wolf et al., 2015), which is consistent with **Theme 3**.

Clinicians engage in emotion focused coping when they report feelings of helplessness in their position as ED clinicians with regard to having limited access to resources and follow-up options for their patients. Previous literature has also highlighted that a lack of support from larger healthcare systems such as administrative systems contributes to ED clinicians' stress (Laposa, Alden, & Fullerton 2003). Other researchers have identified that workload and disorganization have a profound impact on clinician stress in the ED (Flowerdew et al., 2012). This, again, is compounded by the disjointed healthcare system within which ED clinicians are trying to function.

Outcomes. The outcomes piece of the ED experience for underserved patients presenting with SI was as follows: with limited access to behavioral health resources, training and team members (while also operating under high pressure and time restrictions), ED clinicians were pushed to interpret the impact of the patients' contextual variables of the patients' presentation (such as patient's gender or race). How the ED clinician interpreted contextual variables is varied. Some participants reported that patient-clinician congruence (or lack thereof) in contextual variables (i.e. patient and clinician shared the same or different sex/gender, race/ethnicity, etc.) impacted assessment, while others stated congruence/incongruence did not have an impact. The clinicians that did interpret the larger understanding of the patient reflected on its impact. The clinicians who reported that they did not believe identity played a role in patient's presentation, clinical interactions and care, may be constrained by the fast-paced and intense environment they are functioning within. That is, in a slower-paced less intense environment, these clinicians may have demonstrated more reflection. This was due to the feeling that the clinician was not looking at them with all of their identities. Ashton and colleagues (2003) found that racial-minority patients struggle to trust clinicians and that they look for clinicians to acknowledge patients' identities before extending trust. This is reflective in **Theme 4** of how providers feel that congruence of gender and ethnicity is helpful for rapport.

Implications

Preventative Care and Available Psychiatrist

The larger systems of heath care may need to change if ED clinicians are to change their provision of care on an individual level. Hospital Administrators can fund educational opportunities for ED clinicians, but those same clinicians will still struggle to manage their patients without increasing access to preventative, outpatient, and follow-up patient care. Dixon and Hertelendy (2014) reported that more preventative care would lower total costs as well as the number of sick patients presenting for emergent care. Glauser (2001), who is a medical provider, shares: "Once 'stabilized,' [medically] Americans currently have no guaranteed access to any further care" (p.1104).

Patients need better access to behavioral health care in order for these clinicians to be able to effectively help and guide their patients post-ED or inpatient discharge. More psychiatrists and behavioral health providers need to be available in the ED, as well. These providers have more training and more time to spend with patients to accurately assess behavioral health issues, like SI (Betz & Boudreaux, 2015). Shiraishi and colleagues (2018) found that having psychiatry consults greatly decreased future suicide attempts. Further, there are other options that could assist in providing better patient care such as psychiatric emergency departments.

Other ways that behavioral health clinicians can intervene within the ED without being present. When behavioral health primary care clinicians send patients to the ED, there is opportunity to call the ED and fill in the ED clinicians of the concerns of this patient. Providing collaborative information can relieve stress from (Reddy and Spence, 2008)

Psychiatric Emergency Departments

In order to assist ED clinicians in assessing underserved patients presenting with SI, health care system administrators should consider creating an ED specifically for psychiatric needs. In the article "'Psych ED' relieves main department: The monthly update on emergency department management," Chair of the American College of Emergency Physicians, Dr. Steve Sterner, MD, shared that this type of ED could assist as a more therapeutic place for psychiatric patients to be cared for until they are transferred to inpatient units (Sterner, 2008*)*. In Nashville, Tennessee, patient satisfaction has increased with having a psychiatric ED (Zeller, Calma, & Stone, 2014). Data has shown psychiatric EDs assist in decreasing wait for inpatient stays by 80%, reduce hospitalization costs, and provide more mental stabilization for patients (Zeller, Calma, & Stone, 2014). Developing specialized care units for patients can assist in providing better psychiatric care and also appropriate care for underserved patients as this may be their only access to psychiatric care. For psychiatric EDs, data has shown that having interdisciplinary teams within the department to assist in holistic care. Petrik and colleagues (2015) conclude from their findings that “suicide risk assessment is impacted by environmental and systemic aspects of the ED, such as the duration of an ED visit, patient privacy, the multidisciplinary nature of the care and the standardization of the assessment in the routine care” (p.584). Recommendations for alternative destinations of care is also recommended. Currently there are ambulances that strictly serve behavioral health crisis to meet the individual needs of behavioral health patients. This has been implemented in other countries such as the Sweden.

Accrediting Bodies and Healthcare System Administrators

These findings suggest a need for more clinical training to bolster larger healthcare system change. Participants admitted that they are put in a difficult position while caring for underserved patients presenting with SI without adequate clinical (SI assessment) and cultural humility/structural competency training. To increase the likelihood that clinicians are able to reflect on their role and contextual variables, more education is needed on the impact of contextual variables on care.

For this education to be incorporated into Emergency Medicine residents’ training on a national level, Accreditation Council for Graduate Medical Education (ACGME) should consider revising their minimum requirements for Emergency Medicine Residency Programs. This research demonstrates a need for additional required training in SI assessment and cultural humility/structural competency. Post-residency, healthcare administrators need to protect the time and funding for ED clinicians’ and staff members’ continuing education on the topics of SI assessment and working with underserved populations.

According to the competencies for Emergency Medicine under the Accreditation Council for Graduation Medical Education, ED residents must demonstrate “sensitivity and responsiveness to patients’ culture, age, sex, and disabilities” (Chapman et al., 2004, p. 680). Previous literature has shown that education on suicidality increased ED residents’ ability to deliver appropriate behavioral health patient care with more understanding of behavioral health (Horwtiz et al., 2011). Along the lines of professionalism, the Consensus Group on Education has been encouraging ED clinicians to become more educated on health disparities as a part of their professional development (Hamilton & Marco, 2003). Hawala-Druy and Hill (2012) found that this type of training raises awareness and understanding for health care providers.

Limitations

Amount of Participants Explanation

In this study, there were some limitations. One limitation of this study was the small sample size. The lead researcher was still active in recruitment in March 2020 when COVID-19 pandemic reached the US and transformed the public health and healthcare landscape nationwide. The target sample for this study was the very individuals involved in the front lines of care for patients presenting with COVID-19. Due to these rapidly evolving circumstances, ED clinician availability for interviews was limited. Although this pandemic did impact the number of participants recruited for the study, the research team felt that themes did reach saturation. Due to the purposeful specificity of the topic, anticipated homogeneity of the sample, and inclusion criteria, the researchers planned that saturation would be attained from 8-12 interviews (Mason, 2012).

Another limitation was the heterogeneity of the group of participants. Given the circumstances, only one PA was part of the study. The limitation of heterogeneity was also true for gender, race and ethnicity. In future studies, it would be advisable to interview more PA's and participants of different backgrounds to better understand their unique experience. Because this study was recruited through convenient sample which has limitation of not reaching all of the population.

Conclusion

The findings have shown that (1) ED interest in environment variety; (2) ED Clinicians Expressed Lack of Role Clarity with Patients Presenting with SI (3) ED Clinicians Observed Failure of the Healthcare System with SI, and (4) ED clinicians experience contextual variables All of these findings suggest a change is needed within the larger healthcare system. We cannot blame the ED clinicians when the larger system puts them in a difficult position. A larger system change may be more difficult but will provide better overall care for all patents and further will allow for higher clinician job satisfaction.

REFERENCES

Babeva, K., Hughes, J. L., & Asarnow, J. (2016). Emergency department screening for suicide and mental health risk. *Current Psychiatry Reports*, *18*(11), 1-12. doi:10.1007/s11920-016-0738-6

Betancourt, J., Green, A., Carrillo, J. E., & Ananeh-Firempong O., (2003). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public health reports*. *118,* 293-302. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497553/pdf/12815076.pdf

Betz, M. E., & Boudreaux, E. D. (2016). Managing Suicidal Patients in the Emergency Department. *Annals of emergency medicine*, *67*(2), 276–282. https://doi.org/10.1016/j.annemergmed.2015.09.001

Betz, M. E., Sullivan, A. F., Manton, A. P., Espinola, J. A., Miller, I., Camargo, C. A., . . . ED-SAFE Investigators. (2013). knowledge, attitudes, and practices of emergency department clinicians in the care of suicidal patients. *Depression and Perceptions*, *30*(10), 1005-1012. doi:10.1002/da.22071

Blackwell, C. W. (2015). Assessment and treatment of depression in gay and bisexual men in emergency settings. *Advanced Emergency Nursing Journal*, *37*(2), 116-124. doi:10.1097/TME.0000000000000057

Bernard, H. R., Wutich, A., & Ryan, G. W. (2017). Introduction to text: qualitative data analysis. *Analyzing Qualitative Data.* Thousand Oaks, CA. Sage.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: a tool to enhance trustworthiness or merely a nod to validation?. *Qualitative health research*, *26*(13), 1802-1811.

Blumenthal, D., Mort, E., & Edwards, J. (1995). The efficacy of primary care for underserved population groups. *Health services research*, *30*, 253-73.

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014, September). The use of triangulation in qualitative research. In *Oncology nursing forum* (Vol. 41, No. 5).

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (February 2020). Retrieved from www.cdc.gov/injury/wisqars.

Chapman, D. M., Hayden, S., Sanders, A. B., Binder, L. S., Chinnis, A., Corrigan, K., ... & Sulton, L. (2004). Integrating the Accreditation Council for Graduate Medical Education Core competencies into the model of the clinical practice of emergency medicine. *Annals of emergency medicine*, *43*(6), 756-769.

Clarke, D., Usick, R., Sanderson, A., Giles-Smith, L., & Baker, J. (2014). Emergency department staff attitudes towards mental health consumers: A literature review and thematic content analysis. *International Journal of Mental Health Nursing*, *23*, 273-284. doi:10.1111/inm.12040

Creswell, J.W. (2007). *Qualitative inquiry and research design: choosing among five approaches*, 2nd ed. Thousand Oaks, CA: Sage Publications Ltd.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Crist, J. D., & Tanner, C. A. (2003). Interpretation/analysis methods in hermeneutic interpretive phenomenology. *Nursing research*, *52*(3), 202-205.

Dixon, R. B., & Hertelendy, A. J. (2014). Interrelation of preventive care benefits and shared costs under the Affordable Care Act (ACA). *International journal of health policy and management, 3(*3), 145.

Fiscella, K., Franks, P., Gold, M. R., & Clancy, C. M. (2000). Inequality in quality: addressing socioeconomic, racial, and ethnic disparities in health care. *Journal of American Medicine*, *283*, 2579-2584.

Flowerdew, L., Brown, R., Russ, S., Vincent, C., & Woloshynowych, M. (2012). Teams under pressure in the emergency department: an interview study. *Emerg Med J*, *29*(12), e2-e2.

Glauser, J. (2001). Rationing and the role of the emergency department as society's safety net. *Academic Emergency Medicine*, *8*(11), 1101-1106.

Hamilton, G., & Marco, C. A. (2003). Emergency medicine education and health care disparities. *Academic emergency medicine*, *10*(11), 1189-1192.

Hawala-Druy, S., & Hill, M. H. (2012). Interdisciplinary: Cultural competency and culturally congruent education for millennials in health professions. *Nurse education today*, *32*(7), 772-778.

Horwitz, S. M., Heinberg, L. J., Storfer-Isser, A., Barnes, D. H., Smith, M., Kapur, R., ... & Wilkens, K. (2011). Teaching physicians to assess suicidal youth presenting to the emergency department. *Pediatric emergency care*, *27*(7), 601-605.

Kennedy, B., Curtis, K., & Waters, D. (2014). The personality of emergency nurses: is it unique?. *Australasian Emergency Nursing Journal*, *17*(4), 139-145.

Knesper, D. J. (2010). Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit. Newton, MA: Suicide Prevention Resource Center.

Knesper, D. J., American Association of Suicidology, & Suicide Prevention Resource Center. (2011). Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the Emergency Department of Psychiatry Inpatient Unit. Newton, MA: Education Development Center, Inc.

Kobayashi, L., Overly, F. L., Fairbanks, R. J., Patterson, M., Kaji, A. H., Bruno, E. C., ... & Wears, R. L. (2008). Advanced medical simulation applications for emergency medicine microsystems evaluation and training. *Academic emergency medicine*, *15*, 1058-1070. doi:10.1111/j.1553-2712.2008.00247.x

Laposa, J. M., Alden, L. E., & Fullerton, L. M. (2003). Work stress and posttraumatic stress disorder in ED nurses/personnel (CE). *Journal of emergency nursing*, *29*(1), 23-28.

Lazarus, R. S. (1994). 'Psychological stress in the workplace', In: Crandall, R. and Perrew6, P. L. (Eds), Occupational Stress. A Handbook, Taylor and Francis, New York

Lazarus, R.S. & Folkman, S. (1987). Transactional theory and research on emotions and coping. *European Journal of Personality, 1,* 141-169. doi: 10.1002/per.2410010304

Lazarus, R. (1995). Psychological Stress in the Workplace. In Crandall, R. & P.L. Perrewe (Eds.), *Occupational Stress: A Handbook*, Taylor & Frances (pp. 3–13). books.google.com/books?hl=en&lr=&id=2RlZFMZMtZoC&oi=fnd&pg=PA3&dq=lazarus 1995 transactional model of stress&ots=1XQak4kEvr&sig=138yP8UPjaVTiczqikgXDqJ4IOE#v=onepage&q&f=false

Lee, C., Oliffe, J. L., Kelly, M. T., & Ferlatte, O. (2017). Depression and suicidality in gay men: Implications for health care clinicians. *American Journal of Men's Health, 11*(4), 910-919. doi:10.1177/1557988316685492

Niktin, K (2018, September/October). The changing dynamics of emergency psychiatric care. DOME. Retrieved from https://www.hopkinsmedicine.org/news/articles/the-changing-dynamics-of-emergency-psychiatric-care

Mason, M. (2010). Sample Size and Saturation in PhD Studies Using Qualitative Interviews. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, *11*(3). doi:http://dx.doi.org/10.17169/fqs-11.3.1428

Millender, E. (2011). Using stories to bridge cultural disparities, one culture at a time. *The Journal of Continuing Education in Nursing*, *42*(1), 37-42. doi:10.3928/00220124-20100901-01

Miranda, J., McGuire, T. G., Williams, D.R. & Wang, P. (2008). Commentary Mental health in the context of health disparities. *American Journal of Psychiatry. 165*, 1102-1108 doi: 10.1176/appi.ajp.2008.08030333

Osteen, P., Frey, J. M., Woods, M. N., Ko, J., & Shipe, S. (2017). Modeling the longitudinal direct and indirect effects of attitudes, Self-Efficacy, and behavioral intentions on practice behavior outcomes of suicide intervention training. *Suicide and Life-Threatening Behavior*, *47*(4), 410-420. doi:10.1111/sltb.12288

New psych unit eases patient burden in ED: The monthly update on emergency department management the monthly update on emergency department management. (2008). *ED Management,* , 68-9. Retrieved from https://search.proquest.com/docview/758860457?accountid=10639

Petrik, M. L., Gutierrez, P. M., Berlin, J. S., & Saunders, S. M. (2015). Barriers and facilitators of suicide risk assessment in emergency departments: a qualitative study of provider perspectives. *General hospital psychiatry, 37*(6), 581-586.

'Psych ED' relieves main department: The monthly update on emergency department management the monthly update on emergency department management. (2008). *ED Management,* Retrieved from https://search.proquest.com/docview/758860186?accountid=10639

Reddy, M. C., & Spence, P. R. (2008). Collaborative information seeking: A field study of a multidisciplinary patient care team. *Information processing & management*, *44*(1), 242-255.

Ronquillo, L., Minassian, A., Vilke, G. M., & Wilson, M. P. (2012). Literature-based recommendations for suicide assessment in the emergency department: a review. *The Journal of emergency medicine*, *43*, 836-842. doi:10.1016/j.jemermed.2012.08.015

Roy, W., Roaten, K., Downs, D., Khan, F., Pollio, D. E., & North, C. S. (2017). Suicide risk assessment and management: Real-world experience and perceptions of emergency medicine physicians. *Archives of Suicide Research, 21*(3), 365-378. doi:10.1080/13811118.2016.1199987

Saldaina, D. H. (1994). Acculturative stress: Minority status and distress. *Hispanic Journal of Behavioral Sciences, 16,* 116-128.

Sessanna, L., Finnell, D., & Jezewski, M. A. (2007). Spirituality in nursing and health-related literature: a concept analysis. *Journal of Holistic Nursing*, *25*(4), 252-262. doi: 10.1177/0898010107303890

Shiraishi, M., Ishii, T., Kigawa, Y., Tayama, M., Inoue, K., Narita, K., Tateno, M., & Kawanishi, C. (2018). Psychiatric Consultations at an Emergency Department in a Metropolitan University Hospital in Northern Japan. *Psychiatry investigation*, *15*(7), 739–742. https://doi.org/10.30773/pi.2018.04.04

Shields L.B.E., Hunsaker D.M., Hunsaker J.C. (2005) Trends of Suicide in the United States During the 20th Century. In: Tsokos M. (Eds.). *Forensic Pathology Reviews. Forensic Pathology Reviews, 3*. Humana Press: Totowa, NJ

Silva, C., Smith, A. R., Dodd, D. R., Covington, D. W., & Joiner, T. E. (2016). Suicide-related knowledge and confidence among behavioral health care staff in seven states. *Psychiatric Services, 67*(11), 1240-1245. doi:10.1176/appi.ps.201500271

Substance Abuse and Mental Health Services Administration [SPRC]. (2020). Behavioral Health Equity. Retrieved from https://www.samhsa.gov/behavioral-health-equity

Suicide Prevention Resource Center (2016). Rate of suicide by Race/Ethnicity, United States 2000-2016. Retrieved from: http://www.sprc.org/racial-ethnic-disparities.

Suicide Prevention Resource Center (2018). Addressing Suicide among Black Americans. Retrieved from: https://www.sprc.org/news/addressing-suicide-among-black-americans

Suokas, J., Suominen, K., & Lönnqvist, J. (2008). Psychological distress and attitudes of emergency personnel towards suicide attempters. *Nordic Journal of Psychiatry*, *62*, 144-146. doi:10.1080/08039480801983547

Suter, R. E. (2012). Emergency medicine in the United States: A systemic review. *World Journal of Emergency Medicine*, *3*, 5–10. doi:10.58471920-8642.2012.01.001

United States Centers for Disease Control and Prevention (CDC) Suicide: Facts at a glance. (2015). Retrieved from http://www.cdc.gov/ViolencePrevention/suicide

U.S. Department of Health and Human Services. (2001). Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

United States Centers for Disease Control and Prevention (CDC). *Fast facts sheet on suicide.* (2017). Retrieved from https://www.cdc.gov/nchs/fastats/emergency-department.htm

van Manen, M. (1990). *Researching lived experiences: Human science for an action sensitive pedagogy.* Albany, NY: State University of New York Press

van Manen, M. (1997). *Researching lived experience: human science for an action sensitive pedagogy*, 2nd ed., University of Western Ontario, London: The Althouse Press.

Venkat, A., Drori, J. (2014). When to say when: Responding to a suicide attempt in the acute care setting. *Narrative Inquiry in Bioethics*, *4*(3), 263-270. doi:10.1353/nib.2014.0075

Waite, R., & Calamaro, C. (2009). Culture and depression: A case example of a young African American man. *Perspectives in Psychiatric Care*, *45*(3), 232.

Wand, T., & Happell, B. (2001). The mental health nurse: contributing to improved outcomes for patients in the emergency department. *Accident and Emergency Nursing*, *9*(3), 166-176.

Webb, Eugene J. (1966). "Unconventionality, Triangulation, and Inference." *Proceedings of the Invitational Conference on Testing Problems,* October 29 (pp. 34–43). Reprinted in Norman K. Denzin, ed, *Sociological Methods: A Sourcebook*, 1970 Chicago: Aldine, (pp. 191–210).

Wolcott, H.F. (1994b). *Transforming qualitative data: Description, analysis, and interpretation*. Thousand Oaks, CA: Sage.

Wolf, L. A., Perhats, C., Delao, A. M., Moon, M. D., Clark, P. R., & Zavotsky, K. E. (2016). “It’s a burden you carry”: describing moral distress in emergency nursing. *Journal of emergency nursing*, *42*(1), 37-46.

Wynaden, D., Chapman, R., McGowan, S., McDonough, S., Finn, M., & Hood, S. (2003). Emergency department mental health triage consultancy service: a qualitative evaluation. *Accident and emergency nursing*, *11*(3), 158-165.

Zeller, S., Calma, N., & Stone, A. (2014). Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. *The Western Journal of Emergency medicine*, *15*(1), 1–6. https://doi.org/10.5811/westjem.2013.6.17848

Zwald, M. L., Holland, K. M., Annor, F. B., Kite-Powell, A., Sumner, S. A., Bowen, D. A., ... & Crosby, A. E. (2020). Syndromic surveillance of suicidal ideation and self-directed violence—United States, January 2017–December 2018. *Morbidity and Mortality Weekly Report*, *69*(4), 103.

Table 3: TMSC Findings

Themes	**Theory process step**	**Explanation of process**
ED clinicians’ interest in environment variety	Primary Appraisal- emotional reaction/stress	ED clinician’s *emotional draw* to challenging environment
ED clinicians expressed lack of clarity of their ED role with patients presenting with SI	Secondary Appraisal- evaluates situation	-Evaluate the ED environment with underserved patients -Unclear roles of clinician helped by consults
ED clinicians observed disjointed care results in inappropriate placement of patients with SI to ED	Coping- handles their own reaction	-Disjointed healthcare impacting ED, weights pros and cons of difficult position put in -Clinicians feel helpless
ED clinicians experience of contextual variables	Outcomes- result of previous steps	-Limited resources of patients in underserved populations -Lack of resources lead to lack of productive patient care

CHAPTER 5: DISCUSSION

Policy Brief:

“All For One!”: Improving Suicide Assessment in US Emergency Departments

Suicide rates have continued to rise over the past two decades with an increase of 10.4 to 13.5 per 100,000 people from 2001 to 2016 (Hedegaard et al., 2018). Suicide is the second leading cause of death in the United States for people ranging from ages 10 to 34 years (Hedegaard et al., 2018). People who are members of an underserved population (i.e., populations limited by social factors such as age, race, and/or socioeconomics) are more likely to die by suicide (Center for Disease Control and Prevention, 2015). As reported by the Surgeon General (2001), when it comes to the treatment of suicidal ideation (SI), the needs of underserved populations are not being met within the current healthcare system. Members of underserved populations who seek healthcare services are more likely to receive poor service as compared to other populations (Miranda, McGuire, Williams, & Wang, 2008).

When people are struggling with SI, they are typically routed to the emergency department (ED) for assessment and further care by healthcare providers (Suicide Prevention Resource Center [SPRC], 2016). When assessing patients who are members of underserved populations, ED clinicians face issues within the healthcare system as well as patient-clinician interaction barriers for treatment (Babeva, Hughes and Asarnow, 2016).

Along with the lack of appropriate care services offered to underserved populations, Clarke and colleagues (2014) found that ED clinicians often consider presenting problems relating to behavioral health to be non-urgent. This, in turn, creates a bias against patients’ care urgency which can impact clinicians’ assessment and treatment of patients with behavioral health issues (Clarke, et al., 2014). Clinicians also reported that SI was a presenting problem that they did not feel comfortable addressing (Chesin et al., 2017). Perceptions related to behavioral health can be even further impacted by the stereotyping of patients' racial/ethnic minority status (Blackwell, 2011; Millender, 2011; Lee et al., 2017; Waite & Calamardo, 2009).

Methods

Levy and colleagues (Levy et al., 2020) conducted a systematic review of the literature in order to identify: (a) What are clinicians' attitudes and emotional reactions toward treating patients with SI in the ED?; (b) What ED systems/practice guidelines are already in place and what can assist in the assessment of clinicians' perceptions related to the assessment of SI?; and, (c) Do clinicians experience particular barriers when treating SI in underserved populations and if so, what barriers do they identify? After this review, the authors also conducted a qualitative study that aimed to identify the experiences of ED clinicians in assessing patients who are members of underserved populations presenting to the ED with SI. These studies were conducted through the lens of the Transactional Model of Stress and Coping (TMSC) theory in order to best grasp an understanding of the experience of the ED clinicians.

Systematic Review

The systematic review followed Cooper's (2017) seven-step protocol. The authors utilized Pubmed, CINAHL, Proquest, and PsychInfo for the search. The search identified 7,237 articles. Ultimately, the raters agreed on 26 articles that met the search criteria. Three raters reviewed the same 10 articles (10 articles of the 26 articles) to determine interrater reliability. From the 26 articles, the raters began to look for common themes through the lens of the Transactional Model of Stress and Coping (TMSC) theory.

Qualitative Study

From the qualitative study, the authors interviewed seven ED clinicians in order to better understand the experience of the ED clinicians working with patients who are members of underserved populations presenting to the ED with SI. The inclusion criteria for the study were: (a) designated as a physician, nurse practitioner, or physician assistant in the ED; (b) employed fulltime with the academic medical center in the ED setting; and, (c) experience with patients presenting with behavioral health needs. Excluded from participation were (a) those who exclusively held a behavioral health degree (i.e., social workers, marriage and family therapists, psychologists); (b) those employed in the ED but designated as part-time employees; and/or, (c) those working in ED who were classified as registered nurses, licensed practicing nurses, and medical assistants.

The qualitative portion of this study was designed in alignment with hermeneutical phenomenology to focus on the participants' "narrative" (Crist & Tanner, 2003). Van Manen (1990) views this process as one of understanding the narrative of the experience through a series of steps. The first step is thinking about the concern at hand, the research question. The research team conceptualizes themes related to the experience they are concerned about (van Manen, 1990). The last step is to do data analysis, in which the research team writes what the narrative is through the data collected from participants to further grasp the phenomenon (van Manen, 1990). The purpose of this qualitative study was to interpret the narrative of the phenomenon (Bernard, Wutich & Ryan, 2017).

Results

Systematic Review

The systematic review yielded a lack of literature related to ED clinicians' attitudes about SI assessment for underserved populations. The review did identify articles on perceptions of clinicians of SI assessment for the general population (Blackwell, 2015; Johnson, Somnath, Arbelaex, Beach & Cooper, 2004; Millender, 2011, Lee et al., 2011; Waite & Calamardo, 2009). Of the articles reviewed, many stated that further training and protocol would improve assessment effectiveness and positively change clinicians' attitudes towards patients with SI (Osteen, Frey, & Ko, 2014; Marciano et al., 2012; Matthieu et al., 2009; Zun, 2012; Jacobson, Osteen, Jones, & Berman, 2012; Pease et al., 2017; Betz et al., 2013; Shim & Compton, 2010). The review identified many studies that exemplified how the clinicians coped with their attitudes, but the literature lacked an inclusion of perceptions of ED clinicians for underserved populations presenting with SI (Table 1).

Qualitative Study

Through the qualitative study, four themes emerged: (1) ED interest in environment variety; (2) ED Clinicians Expressed Lack of Role Clarity with Patients Presenting with SI (3) ED Clinicians Observed Failure of the Healthcare System with SI, and (4) ED clinicians experience contextual variables

The first theme was ED clinicians' interest an environmental variety where participants shared that they appreciated ED environment variety and access patients have while disregarding the patients' insurance status. Participants also stated they appreciated the variety of patients and presenting problems for which they were able to provide care.

The second theme was ED clinicians expressed a lack of clarity of their ED role with patients presenting with SI. Participants shared that they felt their role as clinicians was ambiguous. As a result, ED clinicians had to create boundaries around the scope of their patient care in order to balance the needs of multiple patients concurrently. Having teammates available, such as an onsite psychiatrist and/or other behavioral health providers, served as an invaluable resource and assisted ED clinicians in clarifying their role.

The third theme was ED clinicians observed disjointed care resulting in the inappropriate placement of patients with SI in the ED. Participants stated that they felt a lack of behavioral health preventative, outpatient, and follow-up care was due to a broken healthcare system. They stated that the ED may have been patients' only option in crisis but that so much could have been done leading up to the crisis (in the way of preventative, outpatient, and follow-up care) to help prevent it.

The last theme was ED clinicians reported varying levels of thought of patients' contextual variables. Participants also reported that they felt that there were disparities in health care for underserved populations. Participants demonstrated various reactions about patient-clinician congruence (i.e., same or different racial/ethnic status and/or gender between patient and clinician) and their understandings of potential biases related to this. Some stated that they were self-reflective of their own biases, while others shared that they did not feel that they had any biases.

Executive Summary and Recommendations

Recommendations

These findings suggest a critical need for change within the healthcare system to support ED clinicians in properly assessing SI. ED clinicians cannot sustainably change their practice without the larger system of health care changing. From the years of 2006 to 2014, the number of patients being assessed in EDs in the US for suicidality increased by 414% (Moore, Stocks & Owens, 2017). Currently, patients are more likely to be discharged and return to the ED due to psychiatric issues, including SI than physical health issues (Morris et al., 2018). Morris and colleagues (2018) found that this was due to issues with coordinating outpatient as well as community care. The ED management of patients presenting with SI appears to be ineffective for patients and also costly due to so many patients bouncing back after discharge (Knesper, 2010). Return ED visits and/or inpatient admissions with insufficient follow-up care often leads to longer treatment (more ED visits/inpatient visits) and perpetuates the issue of insufficient follow-up care (Knesper, 2010). Addressing this need for follow-up care would likely lower costs by decreasing ED visits and inpatient admissions. The research team recommends policy change to assist where underserved patients go for their psychiatric needs specifically is providing ***universal health care*** and more ***psychiatric EDs***.

Universal Health Care. Currently, the United States does not operate under a universal healthcare system. Data shows that access to behavioral health care is not equitably available to all (Miranda, McGuire, Williams, & Wang, 2008). The World Health Organization defines universal healthcare with three objectives "(a)Equity in access to health services - everyone who needs services should get them, not only those who can pay for them; (b)The quality of health services should be good enough to improve the health of those receiving services; and (c) People should be protected against financial-risk, ensuring that the cost of using services does not put people at risk of financial harm." (WHO, 2019). Studies have shown that universal healthcare leads to better health outcomes with those in lower economic populations benefiting (Moreno-

Serra & Smith, 2012). With this consideration to change how healthcare is provided more attention also needs to be paid to how the system distributes the money to behavioral health.

Telehealth. Along with universal health, telehealth would be able to provide more access to care to all populations especially those who do not have access to healthcare geographically near. Telehealth has been shown to be a significant help in rural communities to provide healthcare (Fordyce, Chen, Doescher, & Hart, 2007; US Department of Health and Human Services, 2012). Telehealth should also be a consideration due to the current pandemic of COVID-19. The CDC recommends that telehealth be utilized for safer healthcare during the pandemic. According to the company that responds to suicide hotline calls, FirstLink, calls to have increased about 300% due to the stress of the pandemic (2020). Given this statistic, the use of telehealth would benefit this struggling country.

Psychiatric ED. Psychiatric EDs have been started in many states and have shown to deliver better patient care through more comprehensive assessment as well as decreased wait time prior to inpatient admission (Zeller, Calma, & Stone, 2014). Psychiatric EDs have also been associated with lower hospitalization costs, because fewer patients are being admitted onto inpatient units due to better ED assessment and care (Zeller, Calma, & Stone, 2014). 138 EDs were surveyed about their own protocols for caring for patients who present with SI, and over 80% said they had no standard of care (Bourdreux et al, 2011). The current wait time for inpatient admission for a patient who is presenting with a psychiatric concern is 3.2 times longer than the wait time for a physical presenting issue (Nicks & Manthew, 2012).

Dr. Zeller has outlined “Six goals of Emergency Psychiatry” for psychiatric EDs to follow: “1) Exclude medical etiologies of symptoms and ensure medical stability; 2) Rapidly stabilize the acute crisis; 3) Avoid coercion; 4) Treat in the least restrictive setting; 5) Form a therapeutic alliance; 6) Formulate an appropriate disposition and aftercare plan" (Zeller, 2019). With the use of these goals, psychiatric EDs have been shown to stabilize over half the patients who present with acute symptoms, negating the need for an inpatient admission (Zeller, 2019). Currently, there is a lengthy wait for patients to get into inpatient behavioral health units (Nicks & Manthey, 2012)

By increasing access to psychiatric EDs, specialized care would be available for patients who are experiencing psychiatric concerns but also members of underserved populations. A psychiatric ED at John Hopkins University has found that a higher volume and greater variety of people [e.g. racial/ethnic, SES) are able to present to the psychiatric ED, compared to standard ED, due to the accessibility and lack of competing presenting issues common ED's take (Nitkin, 2018).

Cultural sensitivity is essential to be able to provide helpful and purposeful care to underserved populations (Aday, 2001). Zeller's (2014) goals three and five for psychiatric EDs (avoid coercion and form a therapeutic alliance, respectively) reflect cultural sensitivity. Additionally, clinicians working in psychiatric EDs will be able to focus primarily on behavioral health concerns, rather than juggling patients with both physical and behavioral health issues, leaving more time for cultural sensitivity. In contrast, ED clinicians in the previous qualitative study reported that they were not able to attend to issues of gender/race congruence or incongruence or other psychosocial issue requiring cultural sensitivity due to the time constraints in a standard ED.

Recommendations of culturally sensitive training set forth by medical education accreditation bodies are needed to improve service delivery for underserved populations. Cultural sensitivity is stressed by the Accreditation Council for Graduate Medical Education (ACGME) is stressed as part of the professionalism of the clinician, unfortunately it has been found that only 50% of programs in the US offer cultural competency training (Brotherthon, Rockey, and Etzel, 2004). More push for cultural sensitivity training needs to be offered to residents to better provide appropriate care.

All these pieces considered; it is important to think about how this will be accomplished. Hospital administrators might consider thining about monetary distribution towards creating a psychiatric ED for better care and longer-term monetary savings. ED clinicians as well as psychiatrists need to advocate for this type of healthcare for better patient care. Medical education accreditation bodies need to be more purposeful about educating medical providers to improve service delivery for underserved populations.

Collaborative care. The findings suggest that having a psychiatrist and other behavioral experts available would assist with ED clinicians stress and assessment. Having a collaborative team in an ED environment has been shown to provide better care for patient. Pitrick et al. (2015) states that collaborative care is "another principal theme was the effective suicide risk assessment requires a collective effort across multiple disciplines and providers" (p.583). The collaborative team needs to consist of the systems that the patient is living in. This includes: the system of the psychiatric emergency room, the family system, and the system of the environment outside the psychiatric emergency room. The role of the medical family therapist is essential within that team in addition to the staff. Medical family therapist provide treatment for the patient and the family who are in charge of their care (McDaniel, Doherty, and Hepworth, 2014). They are systemic in treatment outside of those systems as well to work with the medical team treating the patient (McDaniel, Doherty, and Hepworth, 2014). Medical family therapy's foundation of skill is on the framework of Biopsychosocial model (BPS), which is framed to look at the patient from each aspect, biological, psychological, social, and spiritual (Engel, 1980). The spiritual piece (BPSS) was added to encompass beliefs and values of patients (Sessanna et al., 2007). The specialty of the medical family therapist is not just systemic knowledge of the family system but who that system interacts with the medical field and each of the parts of the BPSS model.

Latimer, Gariepy, and Greenfield (2014) found that a form of collaborative team was more cost effective and treatment effective over regular treatment in the emergency room. The functionality of the system works in a way that benefits each piece. The study involved testing to see if a team for treating suicide ideation of teenagers in the emergency department was more cost effective. When the collaborative team was implemented in the emergency department the costs of for the hospital decreased (Latimer, Gariepy, and Greenfield, 2014). There was about a $2,000 difference in the cost for treating someone who was being treated by the collaborative team (Latimer, Gariepy, and Greenfield 2014). With the collaborative team in place, not only will the patient and the team feel better treated, the cost of treatment will be decreased. The medical family therapist also needs to be part of the team for more cost effectiveness. Hodgson, Lamson, Mendenhall, and Crane (2014) discuss the effectiveness of medical family therapist by sharing that it could provide “medical cost-offsets to healthcare contexts” (p.431). Within this discussion the authors share that the types of services offered by a medical family therapist is systemically more than just one provider (Hodgson et al. 2014).

Conclusion

Suicide rates have continued to rise over the years. The life expectancy rate has decreased due to the death rate associated with suicide and substance abuse issues. A large-scale change is necessary in order to provide the framework and support for smaller scale changes on the ED and at the clinician level. Universal healthcare with telehealth along with psychiatric ED's are a possible solution to this larger scale issue in the healthcare system.

REFERENCES

Aday, L. (2001). *At risk in America: The health and health care needs of underserved populations in the United States* (2nd ed.). San Francisco, CA: Jossey-Bass.

Babeva, K., Hughes, J. L., & Asarnow, J. (2016). Emergency department screening for suicide and mental health risk. *Current Psychiatry Reports, 18*(11), 1-12. doi:10.1007/s11920-016-0738-6

Bernard, H. R., Wutich, A., & Ryan, G. W. (2017). Introduction to text: qualitative data analysis. *Analyzing Qualitative Data.* Thousand Oaks, CA. Sage.

Betz, M. E., Arias, S. A., Miller, M., Miller, I., Barber, C., Espinola, J. A., . . . Boudreaux, E. D. (2015). Change in emergency department clinicians' beliefs and practices after use of new protocols for suicidal patients. *Psychiatric Services, 66*(6), 625-631. doi:10.1176/appi.ps.201400244

Betz, M. E., Barber, C. W., & Miller, M. (2010). Firearm restriction as suicide prevention: Variation in belief and practice among clinicians in an urban emergency department. *Injury Prevention: Journal of the International Society for Child and Adolescent Injury Prevention, 16*(4), 278-281. doi:10.1136/ip.2009.025296

Betz, M. E., Sullivan, A. F., Manton, A. P., Espinola, J. A., Miller, I., Camargo, C. A., . . . ED-SAFE Investigators. (2013). knowledge, attitudes, and practices of emergency department clinicians in the care of suicidal patients. *Depression and Perceptions, 30*(10), 1005-1012. doi:10.1002/da.22071

Blackwell, C. W. (2015). Assessment and treatment of depression in gay and bisexual men in emergency settings. *Advanced Emergency Nursing Journal, 37*(2), 116-124. doi:10.1097/TME.0000000000000057

Boudreaux, E. D., Ph.D, Niro, K., Sullivan, Ashley, M.S., M.P.H, Rosenbaum, C. D., M.D, Allen, M., M.D, & Camargo, Carlos A., M.D., Dr.P.H. (2011). Current practices for mental health follow-up after psychiatric emergency department/psychiatric emergency service visits: A national survey of academic emergency departments. *General Hospital Psychiatry*, 33(6), 631-633. doi:10.1016/j.genhosppsych.2011.05.020

Brotherton SE, Rockey PH, Etzel SI. US graduate medical education, 2003–2004. *Journal of American Medical Association 2004*; *292*(9):1032–7.

Centers for Disease Control & Prevention. (2020). COVID-19 in racial and ethnic minority groups. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html

Chesin, M. S., Stanley, B., Haigh, E. P., Chaudhury, S. R., Pontoski, K., Knox, K. L., & Brown, G. K. (2017). Staff views of an emergency department intervention using safety planning and structured follow-up with suicidal veterans. *Archives of Suicide Research*, *21*, 127-137. doi:10.1080/13811118.2016.1164642

Clarke, D., Usick, R., Sanderson, A., Giles-Smith, L., & Baker, J. (2014). Emergency department staff attitudes towards mental health consumers: A literature review and thematic content analysis. *International Journal of Mental Health Nursing*, *23*, 273-284. doi:10.1111/inm.12040

Crist, J. D., & Tanner, C. A. (2003). Interpretation/analysis methods in hermeneutic interpretive phenomenology. *Nursing research*, *52*(3), 202-205.

Cooper, H. (2017). *Research synthesis and meta-analysis: A step-by-step approach (5th edition).* Los Angeles: Sage.

Engel, G. L. (1980). The clinical application of the biopsychosocial model. Am J Psychiatry, 137(5), 535-544.

Fordyce, M. A., Chen, F. M., Doescher, M. P., & Hart, L. G. (2007). 2005 physician supply and distribution in rural areas of the United States. *Final Report*, *116*.

FirstLink 50 (2020). Retrieved from https://myfirstlink.org/

Hedegaard, H., et al. (2018). Suicide rates in the United States continue to increase. NCHS Data Brief No. 309. National Center for Health Statistics. Available at www.cdc.gov/nchs/products/databriefs/db309.htm.

Hodgson, J., Lamson, A., Mendenhall, T., & Crane, D. R. (Eds.). (2014). Medical family therapy: Advanced applications. Springer Science & Business Media.

Jacobson, J. M., Osteen, P., Jones, A., & Berman, A. (2012). Evaluation of the recognizing and responding to suicide risk training. *Suicide and Life-Threatening Behavior*, *42*(5), 471-485. doi:10.1111/j.1943-278X.2012.00105.x

Johnson, R. L., Saha, S., Arbelaez, J. J., Beach, M. C., & Cooper, L. A. (2004). Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. *Journal of general internal medicine*, *19*(2), 101-110.

Knesper, D. J. (2010). Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit. Newton, MA: Suicide Prevention Resource Center.

Knesper, D. J., American Association of Suicidology, & Suicide Prevention Resource Center. (2011). Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the Emergency Department of Psychiatry Inpatient Unit. Newton, MA: Education Development Center, Inc.

Latimer, E. A., Gariépy, G., & Greenfield, B. (2014). Cost-effectiveness of a rapid response team intervention for suicidal youth presenting at an emergency department. *The Canadian Journal Of Psychiatry / La Revue Canadienne De Psychiatrie*, *59*(6), 310-318.

Lazarus, R. S. (1994). 'Psychological stress in the workplace', In: Crandall, R. and Perrew6, P. L. (Eds), Occupational Stress. A Handbook, Taylor and Francis, New York

Lazarus, R.S. & Folkman, S. (1987). Transactional theory and research on emotions and coping. *European Journal of Personality, 1,* 141-169. doi: 10.1002/per.2410010304

Lazarus, R. (1995). Psychological Stress in the Workplace. In Crandall, R. & P.L. Perrewe (Eds.), *Occupational Stress: A Handbook*, Taylor & Frances (pp. 3–13). books.google.com/books?hl=en&lr=&id=2RlZFMZMtZoC&oi=fnd&pg=PA3&dq=lazarus 1995 transactional model of stress&ots=1XQak4kEvr&sig=138yP8UPjaVTiczqikgXDqJ4IOE#v=onepage&q&f=false

Lee, C., Oliffe, J. L., Kelly, M. T., & Ferlatte, O. (2017). Depression and suicidality in gay men: Implications for health care clinicians. *American Journal of Men's Health*, *11*(4), 910-919. doi:10.1177/1557988316685492

Marciano, R., Mullis, D. M., Jauch, E. C., Carr, C. M., Raney, L., Martin, R. H., . . . Saef, S. H. (2012). Does targeted education of emergency physicians improve their comfort level in treating psychiatric patients? *The Western Journal of Emergency Medicine*, *13*(6), 453-457. doi:10.5811/westjem.2012.3.6899

McDaniel, S. H., Doherty, W. J., & Hepworth, J. (2014). Medical family therapy and integrated care. Washington, D.C.: American Psychological Association.

Moreno-Serra, R., & Smith, P. C. (2012). Does progress towards universal health coverage improve population health?. *The Lancet*, *380*(9845), 917-923.

Matthieu, M. M., Chen, Y., Schohn, M., Lantinga, L. J., & Knox, K. L. (2009). Educational preferences and outcomes from suicide prevention training in the veterans health administration: One-year follow-up with healthcare employees in upstate New York. *Military Medicine*, *174*(11), 1123-1131. doi:10.7205/MILMED-D-00-1109

Millender, E. (2011). Using stories to bridge cultural disparities, one culture at a time. *The Journal of Continuing Education in Nursing*, *42*(1), 37-42. doi:10.3928/00220124-20100901-01

Miranda, J., McGuire, T. G., Williams, D.R. & Wang, P. (2008). Commentary Mental health in the context of health disparities. *American Journal of Psychiatry. 165*, 1102-1108 doi: 10.1176/appi.ajp.2008.08030333

Moore, B. J., Stocks, C., & Owens, P. L. (2017). Trends in emergency department visits, 2006–2014. *Rockville, MD: Agency for Healthcare Research and Quality*.

Morris, D. W., Ghose, S., Williams, E., Brown, K., & Khan, F. (2018). Evaluating psychiatric readmissions in the emergency department of a large public hospital. *Neuropsychiatric disease and treatment*, *14*, 671–679. https://doi.org/10.2147/NDT.S143004

Nicks, B. A., & Manthey, D. M. (2012). The impact of psychiatric patient boarding in emergency departments. *Emergency medicine international*, *2012*.

Niktin, K (2018, September/October). The changing dynamics of emergency psychiatric care. DOME. Retrieved from https://www.hopkinsmedicine.org/news/articles/the-changing-dynamics-of-emergency-psychiatric-care

Osteen, P. J., Frey, J. J., & Ko, J. (2014). Advancing training to identify, intervene, and follow up with individuals at risk for suicide through research. *American Journal of Preventive Medicine*, *47*(3), S216-S221. doi:10.1016/j.amepre.2014.05.033

Osteen, P., Frey, J. M., Woods, M. N., Ko, J., & Shipe, S. (2017). Modeling the longitudinal direct and indirect effects of attitudes, Self-Efficacy, and behavioral intentions on practice behavior outcomes of suicide intervention training. *Suicide and Life-Threatening Behavior*, *47*(4), 410-420. doi:10.1111/sltb.12288

Pease, J. L., Forster, J. E., Davidson, C. L., Holliman, B. D., Genco, E., & Brenner, L. A. (2017). How veterans health administration suicide prevention coordinators assess suicide risk: How veterans health administration. *Clinical Psychology & Psychotherapy*, *24*(2), 401-410. doi:10.1002/cpp.2011

Petrik, M. L., Gutierrez, P. M., Berlin, J. S., & Saunders, S. M. (2015). Barriers and facilitators of suicide risk assessment in emergency departments: a qualitative study of provider perspectives. *General hospital psychiatry, 37*(6), 581-586.

Sessanna, L., Finnell, D., & Jezewski, M. A. (2007). Spirituality in nursing and health-related literature: a concept analysis. *Journal of Holistic Nursing*, *25*(4), 252-262. doi: 10.1177/0898010107303890

Shim, R. S., & Compton, M. T. (2010). Pilot testing and preliminary evaluation of a suicide prevention education program for emergency department personnel. *Community Mental Health Journal, 46*(6), 585-590. doi:10.1007/s10597-009-9241-4

Suicide Prevention Resource Center (2016). Rate of suicide by Race/Ethnicity, United States 2000-2016. Retrieved from: http://www.sprc.org/racial-ethnic-disparities.

Suicide Prevention Resource Center (2018). Addressing Suicide among Black Americans. Retrieved from: https://www.sprc.org/news/addressing-suicide-among-black-americans

US Department of Health and Human Services. (2012). National Advisory Committee on Rural Health and Human Services. *The 2006 Report to the Secretary: Rural Health and Human Service Issues*.

United States Centers for Disease Control and Prevention (CDC) Suicide: Facts at a glance. (2015). Retrieved from http://www.cdc.gov/ViolencePrevention/suicide

U.S. Department of Health and Human Services. (2001). Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

van Manen, M. (1990). *Researching lived experiences: Human science for an action sensitive pedagogy.* Albany, NY: State University of New York Press

van Manen, M. (1997). *Researching lived experience: human science for an action sensitive pedagogy*, 2nd ed., University of Western Ontario, London: The Althouse Press.

Waite, R., & Calamaro, C. (2009). Culture and depression: A case example of a young African American man. *Perspectives in Psychiatric Care*, *45*(3), 232.

World Health Organization (2020) What is health financing for universal coverage. Retrieved from https://www.who.int/health_financing/universal_coverage_definition/en/

Zeller S, Calma N, Stone A. Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. *West J Emerg Med*. 2014;15:1-6.

Zun, L. S., MD. (2012). Pitfalls in the care of the psychiatric patient in the emergency department. *Journal of Emergency Medicine*, *43*(5), 829-835. doi:10.1016/j.jemermed.2012.01.064

Table 2: ***Transactional Model of Stress & Coping***

Author name	**Participants in Study**	**Primary appraisal**	**Secondary appraisal**	**Coping (emotion vs. problem-focused coping)**	**Outcomes**
Abar et al., 2018	Not specified	Clinicians' bias against mental health and impact of treatment			
Berman, 2018	Clinicians		• Further training and protocol improve attitudes • Influenced clinical judgement		
Betz et al., 2015	Nurses and attending physicians	Attitudes, knowledge, beliefs, bias of clinicians		Find solutions that are not time consuming and inefficient	
Betz et al., 2010	Physicians, nurses and psychiatrists	Beliefs of clinicins, specific beliefs around protocols			
Betz et al., 2013	Nurses, resident physicians, and physicians		Further training and protocol improve attitudes	Discomfort and uncomfortable with screening and assessing	

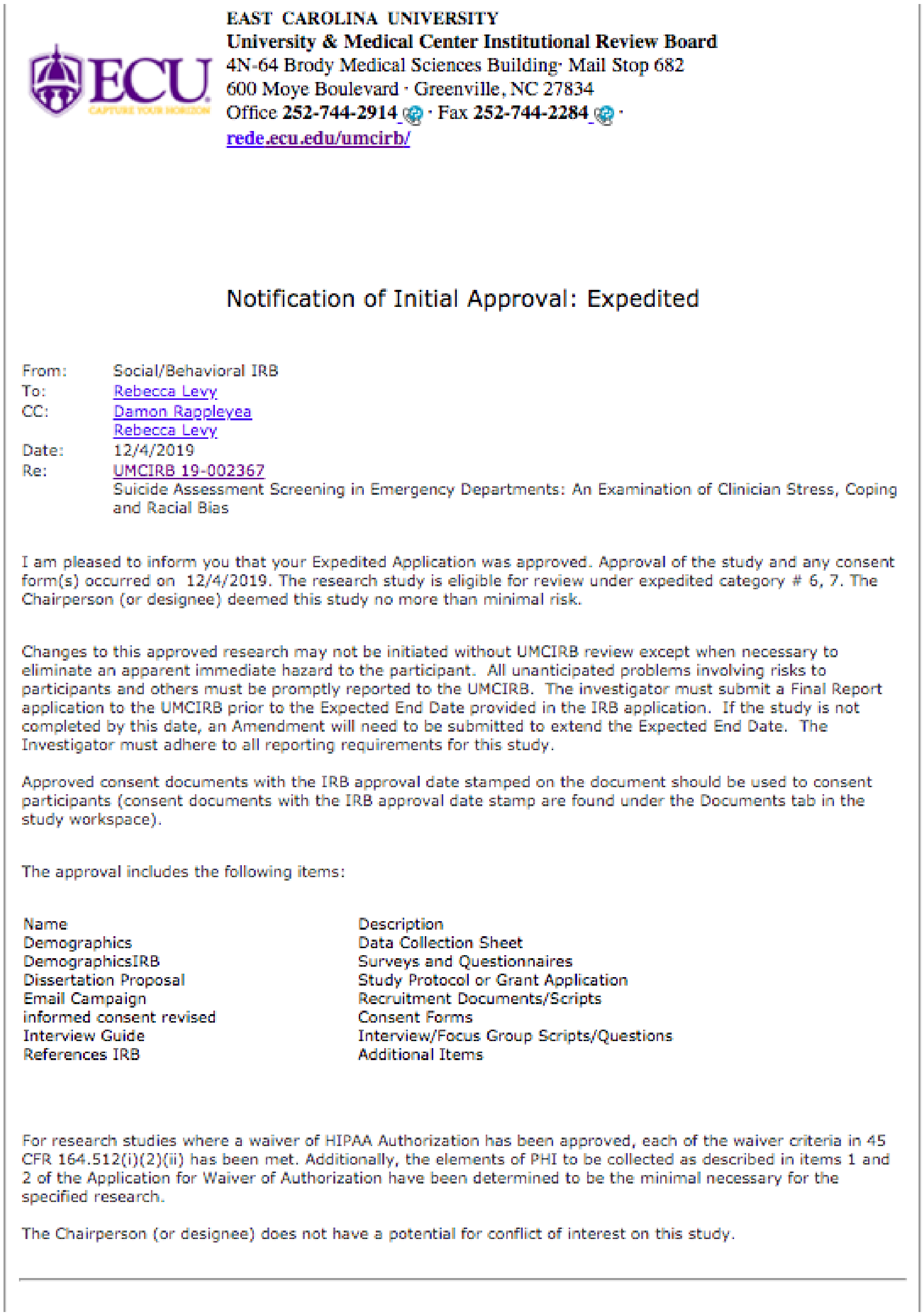
Blackwell, 2015	Healthcare clinicians				Stereotypes of patients Gay and bisexual males need for unique care
Bronsinski & Riddell, 2016	Nurses	Bias of clinicians, especially with patients with alcohol intoxication			
Descher et al., 2015	Physicians, Nurse practitioners, nurses, Physicians assistants, resident physicians, psychiatrists, phycologists		Beliefs about patient care		
Jacobson, et al, 2010	Healthcare Clinicians		Further training and protocol improve attitudes		
Lee et al., 2017	Healthcare clinicians			Avoidant in addressing suicide	Stereotypes of patients
Levandowski et al., 2017	Clinicians	Perceptions of clinicians (in particular effectiveness of safety plan)			Veteran population care
Marciano et al., 2012	Physicians		Further training and protocol improve attitudes		

Matthieu et al., 2009	Healthcare clinicians, administrative positions		Further training and protocol improve attitudes		Veteran population care
Millender, 2011	Nurses				Stereotypes of patients, Immigrants
Neville & Roan, 2013	Nurses	• Attitudes of clinicians • *Treatment Toward Suicide Questionnaire* • Systemic factors impacting attitudes			
Osteen, Frey & Ko, 2014	Healthcare clinicians	Self-efficacy of clinicians	Further training and protocol improve attitudes		Veteran population care
Osteen et al., 2017	Clinicians	*Attitudes Toward Suicide Prevention Scale, Treatment Toward Suicide Questionnaire*		Discomfort and uncomfortable with screening and assessing	
Pease et al., 2017	Behavioral health clinicians, nurses			Discomfort and uncomfortable with screening and assessing	Veteran population care
Petrik, et al., 2015	Physicians, Physicians assistants, residents, fellows,	Perceptions of clinicians, attitudes influenced how			

	nurses nurse practitioners and social workers	they felt about patients			
Price et al., 2013	Physicians	Attitudes of clinicians			
Roy et al., 2017	Physicians and resident physicians	Perceptions and perceptions of clinicians		• Discomfort and second guessing with screening and assessing • Step-oriented not helpful for treatment	
Shim & Compton, 2010	ED “personnel”		Further training and protocol improve attitudes		
Silva et al., 2016	Behavioral health clinicians, phychians, administrators	Knowledge of clinicians			
Venkat & Drori, 2014	Physicians	Discomfort and personal judgement of clinicians		Discomfort and uncomfortable with screening and assessing	
Waite Calamardo, 2009	Not specific	Bias of clinicians			Stereotypes of patients, African Americans
Zun, 2012	Physicians and nurses	Attitudes of clinicians	Further training and		

			protocol improve attitudes		

APPENDIX A: IRB APPROVAL



EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board
4N-64 Brody Medical Sciences Building· Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** ·
rede.ecu.edu/umcirb/

Notification of Initial Approval: Expedited

From: Social/Behavioral IRB
To: Rebecca Levy
CC: Damon Rappleyea
Rebecca Levy
Date: 12/4/2019
Re: UMCIRB 19-002367
Suicide Assessment Screening in Emergency Departments: An Examination of Clinician Stress, Coping and Racial Bias

I am pleased to inform you that your Expedited Application was approved. Approval of the study and any consent form(s) occurred on 12/4/2019. The research study is eligible for review under expedited category # 6, 7. The Chairperson (or designee) deemed this study no more than minimal risk.

Changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a Final Report application to the UMCIRB prior to the Expected End Date provided in the IRB application. If the study is not completed by this date, an Amendment will need to be submitted to extend the Expected End Date. The Investigator must adhere to all reporting requirements for this study.

Approved consent documents with the IRB approval date stamped on the document should be used to consent participants (consent documents with the IRB approval date stamp are found under the Documents tab in the study workspace).

The approval includes the following items:

Name	Description
Demographics	Data Collection Sheet
DemographicsIRB	Surveys and Questionnaires
Dissertation Proposal	Study Protocol or Grant Application
Email Campaign	Recruitment Documents/Scripts
informed consent revised	Consent Forms
Interview Guide	Interview/Focus Group Scripts/Questions
References IRB	Additional Items

For research studies where a waiver of HIPAA Authorization has been approved, each of the waiver criteria in 45 CFR 164.512(i)(2)(ii) has been met. Additionally, the elements of PHI to be collected as described in items 1 and 2 of the Application for Waiver of Authorization have been determined to be the minimal necessary for the specified research.

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

APPENDIX B: CONSENT FORM

Informed Consent to Participate in Research

Information to consider before taking part in research that has no more than minimal risk.

Title of Research Study: Suicide Assessment Screening in Emergency Departments: An Examination of Clinical Stress, Coping and Racial Bias

Principal Investigator: Rebecca Levy
Institution, Department or Division: East Carolina University, College of Health and Human Performance, Human Development and Family Science Department
Address: Rivers RW
Greenville, NC 27858
Telephone #: 706-580-7450

Participant Full Name: ___________________________________Date of Birth: ____________________
Please PRINT clearly

Researchers at East Carolina University (ECU) and Vidant issues related to society, health problems, environmental problems, behavior problems and the human condition. To do this, we need the help of volunteers who are willing to take part in research.

Why am I being invited to take part in this research?

The purpose of this research is to explore the experiences and perspectives of emergency department (ED) providers in treating patients who present to the ED with suicidal ideation (SI). There is interest in learning from you about your experiences with and thoughts about caring for these particular patients. You are being invited to take part in this research because you are a clinician in the ED with at least 2 years experiences and an interaction with a patient presenting with SI in the ED. The decision to take part in this research is yours to make. By doing this research, we hope to learn the experience of the ED clinician to further understand their experience when assessing suicide in underserved patients in the ED.

If you volunteer to take part in this research, you will be one of about 15 people to do so.

Are there reasons I should not take part in this research?

I understand I should not volunteer for this study if I am not an ED clinician who has not practiced in the ED for less than 2 years and has not had any interactions with patient presenting with SI. I should not volunteer if you have a mental health degree.

What other choices do I have if I do not take part in this research?

You can choose not to participate.

Where is the research going to take place and how long will it last?

The research will be conducted on the phone. The total amount of time you will be asked to volunteer for this study is 45-60 minutes for a one-time interview.

What will I be asked to do?

You will be asked to do the following:

- Answer questions regarding your demographics as well as your own experiences as a clinician in the ED
- The interviews will be audio recorded and transcribed anonymously into documents
- A hard-copy of the consent forms, audio recordings, transcripts, analysis memos, list of participants and contact info, interview guide, and codebook will be kept in a locked safety box in the researcher's home. A digital file of the interview transcriptions and audio files will be retained on a password protected hard drive. The audio recordings and transcriptions will be destroyed seven years after collection. Participants' anonymity will be protected through use of number system and the list of the coding for these assigned numbers will be stored in the password protected hard drive (Pirate Drive). Careful collection and storage, the researcher will be prepared to engage in the analysis process.

What might I experience if I take part in the research?

We don't know of any risks (the chance of harm) associated with this research. Any risks that may occur with this research are no more than what you would experience in everyday life. We don't know if you will benefit from taking part in this study. There may not be any personal benefit to you but the information gained by doing this research may help others in the future. SI assessment in ED settings is increasingly common and participation in this research study adds to our body of knowledge about this complex issue

By participating in this research study, you may experience these benefits: It is possible that you may benefit from your participation in this study personally or professionally. Participation in an open-ended interview may provide you with an opportunity for self-reflection regarding working with patients who present to the ED with suicidal ideation.

Will I be paid for taking part in this research?

We will not be able to pay you for the time you volunteer while being in this study.

Will it cost me to take part in this research?

It will not cost you any money to be part of the research.

Who will know that I took part in this research and learn personal information about me?

ECU and the people and organizations listed below may know that you took part in this research and may see information about you that is normally kept private. With your permission, these people may use your private information to do this research:

- Participation in the study will be strictly anonymous and confidential. Location of participants will be generalized (e.g. a southeastern rural health care facility) and names will be deidentified.
- The University & Medical Center Institutional Review Board (UMCIRB) and its staff have responsibility for overseeing your welfare during this research and may need to see research records that identify you. Research is being conducted with Vidant Medical Center

How will you keep the information you collect about me secure? How long will you keep it?

A hard-copy of the consent forms, audio recordings, transcripts, analysis memos, list of participants and contact info, interview guide, and codebook will be kept in a locked safety box in the researcher's home. A digital file of the interview transcriptions and audio files will be retained on a password protected hard drive. The audio recordings and transcriptions will be destroyed seven years after collection. Participants' anonymity will be protected through use of number system and the list of the coding for these assigned numbers will be stored in the password protected hard drive (Pirate Drive). I will keep the digital downloaded version of the recorded interview on a password protected hard drive. I will back-up the recording on a USB (jump) drive and will keep the drive in a locked box that is located at my residence Careful collection and storage, the researcher will be prepared to engage in the analysis process.

What if I decide I don't want to continue in this research?

You can stop at any time after it has already started. There will be no consequences if you stop and you will not be criticized. You will not lose any benefits that you normally receive.

Who should I contact if I have questions?

The people conducting this study will be able to answer any questions concerning this research, now or in the future. You may contact the Principal Investigator at 706-580-7450 M-F between the hours of 8-5PM.

If you have questions about your rights as someone taking part in research, you may call the University & Medical Center Institutional Review Board (UMCIRB) at phone number 252-744-2914 (days, 8:00 am-5:00 pm). If you would like to report a complaint or concern about this research study, you may call the Director for Human Research Protections, at 252-744-2914 and the Vidant Medical Center Risk Management Office at 252-847-4473". When using Vidant medical records, please include the following: You may also contact Vidant Health's Privacy Office at 1-888-777-2617.

Is there anything else I should know?

Most people outside the research team will not see your name on your research record. This includes people who try to get your information using a court order. The summary of results will be shared with you before publication submission when the paper is under review for publication.

I have decided I want to take part in this research. What should I do now?

The person obtaining informed consent will ask you to read the following and if you agree, you should sign this form:

- I have read (or had read to me) all of the above information.
- I have had an opportunity to ask questions about things in this research I did not understand and have received satisfactory answers.
- I know that I can stop taking part in this study at any time.
- By signing this informed consent form, I am not giving up any of my rights.
- I have been given a copy of this consent document, and it is mine to keep.

____

Participant's Name (PRINT)   Signature   Date

Person Obtaining Informed Consent: I have conducted the initial informed consent process. I have orally reviewed the contents of the consent document with the person who has signed above, and answered all of the person's questions about the research.

____

Person Obtaining Consent (PRINT)   Signature   Date

____

Principal Investigator   (PRINT)   Signature   Date
(If other than person obtaining informed consent)

APPENDIX C: RECRUITMENT EMAIL

Dear Participant,

My name is Rebecca Levy, and I am a third-year doctoral student at ECU in the Medical Therapy Program. I just started data collection for my dissertation and am in need of support to obtain qualified participants to complete my study.

I am contacting you because you have a unique understanding of my research topic. I am interested in understanding the experiences of ED clinicians and their work with patients that present with suicidal ideation. I was hoping you might be willing to participate in my study and would be willing to set up an interview time for us to talk via phone about your experiences.

The interview will take no longer than an hour of your time. The interview is anonymous and the information will be de-identified for analysis.

Please contact me via email (levyr17@students.ecu.edu) or phone (706-580-7450). I look forward to hearing from you. Thank you so much for your time!

APPENDIX D: INTERVIEW QUESTIONS

Demographic questions

How old are you?
M/F/Transgender?
What type of clinician, physician, NP, or PA?
How long have you worked as an ED clinician? What training or post training did you have after residency or profession noted?
What training did you have? Have you had exposure to behavioral health training outside of the basic curriculum? If so, what has that been?

Introduction Questions

- What is it like to be a clinician in the ED?
- Why did you become an ED clinician? What is your favorite part?
- What is the most challenging part of your work in the ED?

Primary Appraisal (emotional suffering)

- What has been your experience of working with patients presenting with suicidal ideation in the ED?
- What is first thought when you are told patient with suicidal ideation or go see a patient who is struggling with SI (primary app)
    - (***Secondary)*** what do your feelings about those thoughts around the patient?
- Please compare how you feel when a patient comes in with suicidal ideation versus physical symptoms?
- What is your reaction to finding out you need to see a patient with SI?

Secondary Appraisal (evaluation of situation)

- What have been the challenges for you as a provider in working with this population with patients presenting with suicidal ideation?
    - Probe: can you give me an example of a particularly challenging situation?
- Tell me about a time you felt effective working with patients who present with SI.
- What has been helpful to you in working with patients who present with SI?
    - Probe: Resources for assistance?

Coping

- How do you manage those thoughts and feeling around patients who come in with SI? How do you cope?
- Do you ever feel like the staff uses degrading terms with pts? (coping)
- What training have you had in working with patients who present with suicide?
    - How useful was the training, given your real-life experiences?
    - What additional inclusions would you suggest for such SI assessment training?
    - Are there ones (trainings) you would have liked to have had?

- Is there anything else that you think I should know about working with patients who come to the ED with suicidal ideation?

Outcomes

- Do you think the factors about patient’s identity impact your evaluation of SI?
- How do you think other patient factors such as sexual orientation, gender identity, socioeconomic status?
- Do you think there are other factors that impact your assessment of patients with SI?
- Do you think there are benefits or disadvantages of patients that may look/act the same as you or for patients that appear/act dissimilar to you?

Could you please interpret this vignette:
22 y.o. Hispanic male indicates through an interpreter that he has thoughts of killing himself and has a gun at his home.

APPENDIX E: DATA ANALYSIS

Introduction Questions:

- **What is it like to be a clinician in the ED?**
  - **Variable, sorts of problems, mix**
  - **Shifts, everyday different**
  - **Space everyone can walk through**
  - **Scope of encounters**
  - **Lack of resources (BEUFORT I)**
  - **Comfortable with everything that comes in**
  - **Diverse population encounters**
- **Why did you become an ED clinician? What is your favorite part?**
  - **Variable, make someone better**
  - **Different groups of patients, generalist**
  - **Shift work**
  - **Procedures opportunity, hands on opportunity**
  - **Environment**
  - **Ready for worst case scenario**
  - **No choice to treat who I wanted to**
  - **Safety net of society**
  - **Solution to the problem is resolved**
- **What is the most challenging part of your work in the ED?**
  - **Broken system**
  - **Competing demands, system**
  - **Narcotic crisis**
  - **No idea what is going to happen**
  - **Adapt pretty quick**
  - **Getting other doctors to do jobs (consults)**

Primary Appraisal (emotional suffering)

- **What has been your experience of working with patients presenting with suicidal ideation in the ED?**
  - **Cyclical of what comes in**
  - **Varies on day to day**
  - **Different causes/ reasons for SI**
  - **Not enough treatment available , lack of resources**
  - **Lots of variety of why SI**
  - **Regimented (copes by compartmentalizing these experiences)**
- **What is first thought when you are told patient with suicidal ideation or go see a patient who is struggling with SI (primary app)**
  - **Safety of me and staff,**
  - **unpredictable**
  - **varies: social issues, substance abuse mental health**

- **educated decision**
    - **time consuming**
    - **feel sorry for them**
    - **not immediate care**
    - **medically stable**
    - **complicated case**
    - **people changing story**
    - **children and SI is challenging with parents**
    - **“here’s another one”**
    - **System is failing**
    - **Don’t have time for them**
    - **Not adequate for them here**
    - **(*Secondary)* what do your feelings about those thoughts around the patient?**
- **Please compare how you feel when a patient comes in with suicidal ideation versus physical symptoms?**
    - **Si quicker work-up – 2 stated this**
    - **Physical more straightforward**
    - **Time consuming for SI**
    - **More emotional pieces**
    - **Deal wth intoxication as a factor**
    - **Ask more questions with SI**
    - **Don’t feel like I can fix it**
    - **Feel frustrated**
    - **Resource issue**
    - **“revolving door” for patients**
    - **Resentment to system**
    - **Frustration**
- **What is your reaction to finding out you need to see a patient with SI?**

Secondary Appraisal (evaluation of situation)

- **What have been the challenges for you as a provider in working with this population with patients presenting with suicidal ideation?**
    - **Lack of care available**
    - **System is broken**
    - **“truly sick”**
    - **Stuck in ED forever**
    - **Substance abuse dynamic, no detox on site (BEUFORT) as well as other systems at plan for approval**
    - **Management of syx that’s all**
    - **Categories of patients of type of presenting SI (substance abuse co morbid)**
    - **Probe: can you give me an example of a particularly challenging situation?**
- **Tell me about a time you felt effective working with patients who present with SI.**
    - **Student who doesn’t have co-morbidities**
    - **Has insurance**
    - **I had time to listen**
    - **Passive SI**

        - **Able to keep safe**
- **What has been helpful to you in working with patients who present with SI?**
    - **Working with psychiatrist "light at end of tunnel"**
    - **Learning from psychiatrist if being manipulated**
    - **Social workers**
    - **Psych triage but tele psyh is limited ultimately doc has to make decision**
    - **When I can listen and they thank me**
    - **Probe: Resources for assistance?**

Coping

- **How do you manage those thoughts and feeling around patients who come in with SI?**
    - **Not different for me, make sure they don't die**
    - **Empathy when they have closer to come characteristics (just like motor accident)**
    - **"numb to it"**
    - **Feel like im putting a bandaid over a wound**
    - **Focus on individual and use self-reflection**
    - **compartmentalize**
- **How do you cope?**
    - **I don't cope with them, I don't think it needs management**
    - **PA opportunity to lean on attending**
    - **Second opinion helps**
    - **Self reflect**
    - **Patience**
    - **Compartmentalize/ depersonalization**
- **Do you ever feel like the staff uses degrading terms with pts? (coping)**
    - **Substance abuse**
    - **Getting training on de-stigmatization**
    - **Manipulative but not having to do with suicidal**
    - **Alterative motives**
    - **Larger system issue : mental health difficult to treat --- broken healthcare system**
    - **Acutely psychotic**
- **What training have you had in working with patients who present with suicide?**
    - **Trainings changed in the past 30 years**
    - **Risk stratification**
    - **Provider safety**
    - **doing while learning**
    - **risk factors of pt**
    - **medication assistance**
    - **any kind of training because we clear them for the site**
    - **How useful was the training, given your real-life experiences?**
        - **What overdose medications actually do medically**
        - **Gathering collateral info from family and friends**

    - **What additional inclusions would you suggest for such SI assessment training?**
        - **Lack of research on medications for mental health medications: cardiology example**
        - **Prevention vs back end**
        - **Life style**
    - **Are there ones (trainings) you would have liked to have had?**
    - **Immedicate vs long term suicidal risk**
- **Is there anything else that you think I should know about working with patients who come to the ED with suicidal ideation?**

Steps for coding this data

- Read through interviews twice underlining significant statements (each group of questions is under the theory core concepts: emotional suffering, evaluation of situation, coping, outcomes)
- Pulled together significant statements within the questions (combined if similar under the question group)
- Group similar words together to make one general term through the given theory
- Turn these groups of words into themes

Groups of similar words:

Introduction questions

Reason for wanting to be ED clinician: variety, space for all (providers and patients no mater background)

Challenging part of ED: broken system

Primary appraisal

Experience of working with patients with SI: varies on how patient presents**,** lack of resources for patients in ED

First thoughts of patient presenting with SI: safety for me, complicated, time consuming, failing system, what brought them here SOCIAL ISSUES and SUBSTANCE ABUSE

Thoughts physical vs SI patients: Mixed time constraints (unpredictable), problem that I cant fi here in ED, SYSTEM problem

Secondary Appraisal

Challenging with working with patients with SI: system fail, lack of care that can be provided within ED

Effective when working with SI: time to listen, resources were available

What is helpful for working with patients with SI: having psychiatry and other experts on team

Coping

Manage OWN thoughts around patients with SI: feel more empathy when we are similar, focus on individual
How to you cope as provider: collaboration, ignore cope, self-reflect patience, depersonalization
Degrading terms: manipulative, substance abuse, violence, psychotic, overall mental health stigma
Wanted trainings/helpful trainings: Risk factors, medication/ overdose info, collateral info
**All shared a need for less bandaid care and more prevention for mental health

Outcomes
Factors of identity impact eval: use them to assess access to resource, risk factors, rapport
Other factors: family system, ses,
Advantages and disadvantages of looking alike or different: alike may relate more, dislike may not relate,
A lot of participants did not feel this was relevant--- lack of insight?? Lack of understanding??

Themes that have come out of this data:

1. **Type of person who works in ED**: Clinicians who work in ED appreciate variety and unknown and equality that ED serves all populations
    a. Yet SI is unknown due to systemic lack of resources (substance abuse and mental health treatment beds)
2. **Confusion SI assessment** and what the role of MD is in treatment/assessment
    a. Feel better when: Helpful when team is there, Expert is available, know that they will get f/u, give time to patient
    b. Some define boundaries with patients to protect themselves as providers
3. **Systems impacting small systems**: Outcomes of marginalized patient care is impacted by many factors: awareness of bias of providers vary, but all feel biased system patient care
    a. Larger healthcare system as a "whole" impacts how the ED system functions (primary care, stigma, mental health hospitals)
    b. Congruence of identity helps with empathy of patient
    c. System of training provider has had on self-reflection of coping with SI

APPENDIX F: SECONDARY REVIEW FEEDBACK

* I read each transcript once, then read it alongside the Coded Themes doc to verify content from transcript matching codes
* I felt like 99% of your coded themes captured what I was reading in the scripts, but there were a few areas that I thought the theme/code of what the participant was saying wasn't reflecting in the Coded Themes doc. Here are my notes per transcript:
* Noticed there were no codes under the bullet "What is your reaction to finding out you need to see a patient with SI?"
* 1- All coded themes capture the theme of response for this participant's interview.
* 2- For "What is the most challenging part of your work in the ED?" p2 I see "space" and/or "control" as a coded theme based on this interview.
* 3- For "Do you ever feel like the staff uses degrading terms with pts? (coping)" p7 you have "alterative motives" I think you mean alternative, based on what I am picking up from this interview (patients trying to defer from jail by claiming SI)
* 4- For "Why did you become an ED clinician? What is your favorite part?" maybe add a code about "being the first to assess and treat" or "novelty"
* 5- this transcript was incomplete, only had a few demographic Q&A
* 6- All coded themes capture the theme of response for this participant's interview.
* 7- All coded themes capture the theme of response for this participant's interview.
* Review of groupings- After the above process I reviewed the coded themes doc next to the "steps for coding this data" doc to verify themes
* "Coping- Manage OWN thoughts around patients with SI: feel more empathy when we are similar, focus on individual"
* I did not really pick up on the "feel more empathy when we are similar" from the transcripts, but maybe more empathy when there is more of a focus on mental health factors (sadness and hopelessness) than social factors- like participants were empathetic towards people who had severe depression that led to SI compared to frequent flyers, people trying to avoid the criminal justice system, people who were aggressive in their ED encounter
* Review of main themes:
* This part might be easier to talk through. I think your themes definitely make sense. (For your writing- make sure you have a quote to support each of these). I am sharing just my impressions/thoughts on these below if it is helpful.
* Type of person who works in ED: Clinicians who work in ED appreciate variety and unknown and equality that ED serves all populations; Yet SI is unknown due to systemic lack of resources (substance abuse and mental health treatment beds)
* ED providers want to help all with everything
* Confusion SI assessment and what the role of MD is in treatment/assessment; Feel better when: Helpful when team is there, Expert is available, know that they will get f/u, give time to patient; Some define boundaries with patients to protect themselves as providers
* I think the missing clarity here is what the role of the ED is for treatment assessment. Maybe that is what you meant by MD. The ED seems like a pass through for SI, the providers are extremely skilled in dealing with SI, but they are not equipped.

* Systems impacting small systems Outcomes of marginalized patient care is impacted by many factors: awareness of bias of providers vary, but all feel biased system patient care
* From what I read, it sounded like when people reach the ED, there is already a plethora of issues, and marginalized social identities compounds the frustration of possibly the patient (feeling oppression from institutional oppression) and the provider (the system is already working against the patient, and hurting them, it will be even harder to get them in a good place of recovery)
* One major theme I saw was that the ED providers feel helpless to treat SI unless there is a psych consult or a bed available, and that there are severe limitations in what they can do for SI in the ED- because the mental health resources in the system are so incredibly small compared to medical resources.