

12-2016

The Lived Experiences of Emergency Department Personnel in Working with Individuals with Mental Health Needs

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The Lived Experiences of Emergency Department Personnel in Working with Individuals with
Mental Health Needs

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy in Counselor Education

by

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Abstract

Individuals who work in emergency departments and emergency services in the United States have daunting, overwhelming, and difficult tasks to perform. In addition to medical emergencies that include physical trauma and illnesses, emergency personnel treat individuals with psychiatric emergencies. This qualitative research study explored the lived experiences of ten emergency department personnel that had experienced working with individuals with mental health needs. The ultimate purpose of the study was to break down individuals' experiences into a shared description of a universal phenomenon. The study utilized a phenomenological, qualitative research design to capture the essence of this phenomenon. Participants' responses to semi-structured, open-ended interview questions generated the study's results. The utilization of phenomenological questions in this study may afford insights into the roles of emergency department and their treatment of individuals with mental health issues.

Keywords: emergency department personnel, emergency service workers, mental health issues, mental health treatment, phenomenology, qualitative research

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Acknowledgments

The opportunities that I have had at the University of Arkansas have gone beyond my expectations. A significant part of the learning has been in conjunction with Dr. Roy Farley, Dr. Kristin Higgins, Dr. Stephanie Lusk, and Dr. Mary Ramey. During these past three years, they have taught me to become a better researcher, evaluator, writer, and practitioner. I will always be grateful for their support and wisdom that they have imparted upon me during my studies.

Dedication

This dissertation is dedicated to my family:

To my father, Charles Wohlford, who taught me to never give up.

To my mother, Kim Wohlford, who taught me how to be confident and believe in myself.

To my grandmother, Bobbie Wohlford who taught me what it means to be brave.

To my grandmother, Linda Wells, who provided me with encouragement to go above and beyond.

To my grandfather, John Wells who encouraged me to pursue higher education.

To my brother, John Wohlford, who taught me humility and how to laugh in tough times.

To my sister, Rachel Wohlford, who showed me compassion when I needed it the most.

To my husband, Joseph Neubauer, who encouraged me to be persistent and resilient.

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CHAPTER ONE: INTRODUCTION AND OVERVIEW

Organization of the Chapter

The purpose of this chapter is to provide an overview of the current study of the experiences of emergency personnel in treating individuals with mental illnesses and their perspectives of mental health emergencies. This chapter is organized in the following manner: the significance of the study is presented along with the study's research questions and sub-questions. The study's conceptual framework and the researcher's theoretical sensitivity will be addressed along with the parameters of the study.

Background

Individuals who work in emergency services and departments are faced with acute situations and overwhelming patient loads. In addition to intervening in physical health emergencies, emergency personnel treat and stabilize individuals with psychiatric emergencies and symptoms. Researchers estimate that out of the 95 million visits to emergency departments approximately 12 million instances were related to mental health and/or substance use issues (Minassian, Vike, & Wilson, 2013; Owens et al., 2010). These emergencies include suicidal ideations, suicide attempts, acute exacerbation of a psychotic episode, and experiences of trauma (Bullard, Unger, Spence, & Grafstein, 2008).

At times psychiatric illnesses and their subsequent symptoms can be life threatening and necessitate immediate attention and stabilization. Stabilization includes assessment, immediate management, referrals to inpatient psychiatric treatment centers, and crisis intervention (Hillard, 1994). The experiences of emergency department workers have not been thoroughly captured by

research endeavors (Potter, 2006; Wilstrand, Lindgren, Gilje, & Olofsson, 2007). Emergency department personnel may have had some training in treating individuals with mental health issues, but research indicates that many medical practitioners do not believe that they are adequately trained (Jelinek, Weiland, Mackinaly, Gerdtz, & Hill, 2013; Kerrison & Chapman, 2007; McDonough et al., 2003). The combination of the obligations and roles of emergency department personnel, lack of adequate training and education, and high volumes of clients may contribute to ineffective treatments of individuals with psychiatric conditions (Brunero, Jeon, & Foster, 2012).

In addition to emergency department workers, emergency medical services (EMS) personnel encounter individuals in psychiatric crises frequently. In the United States, EMS workers treat approximately 22 million patients per year (Maguire & Walz, 2004). EMS crews usually include firefighters, paramedics, police officers, and emergency medical technicians (EMTs) (National Highway Traffic Safety Administration, 2008). In response to the increase of mental health related calls, EMS teams developed crisis intervention teams (CIT). CIT establish intelligent and safe approaches to situations that involve individuals with mental health conditions (Dupont & Cochran, 2000; Steadman, Dean, Borum, & Morrissey, 2000; Watson & Fulambarker, 2012). Researchers suggest that CIT implementation may result in increases in treatment referrals (Teller, Munetz, Gil, & Ritter, 2006) and reduction in stereotyping and stigmatization of individuals with mental health conditions (Hanafi, Bahora, Demir, & Compton, 2008).

Purpose of the Study

This phenomenological, qualitative study explored the experiences and training backgrounds of emergency personnel who work with individuals with mental health conditions. The primary purpose of the inquiry was to capture the essence of the experiences of emergency department and service workers in the treatment and stabilization of various psychiatric conditions. The study also addressed two secondary goals that included: to discover and understand how emergency personnel provide treatment for individuals with mental illnesses and to explore their training experiences specifically for working with individuals with mental illnesses.

The study's population of interest was professionals who work in emergency departments or services and encounter individuals with mental health needs. The method and design were appropriate because emergency personnel who had fulfilled the inclusion criteria provided insight into the essence of the phenomenon. The phenomenological approach supplied the researcher with understanding about the impact and understanding of the underlying structure of the phenomenon (Merriam, 2009).

Research Question

How do emergency personnel who have worked with individuals with mental illness describe their lived experiences?

Research Sub-questions

1. How do emergency department professionals provide treatment for individuals with mental illnesses if the primary complaint was specifically related to their psychiatric condition?
2. How do emergency department professionals describe their training for working with individuals with mental health needs?

Significance of the Study

Healthcare organizations and policies attempt to meet the desires and needs of their consumers. The researcher's aim was to examine how emergency personnel addresses mental health needs in the emergency department and potential service gaps in emergency department treatment. Despite the abundance of literature that has investigated emergency departments' services, operations, and structures; limited research has been conducted on emergency personnel's experiences in working with individuals with mental illness. Literature inquiries in various databases including EBSCOhost, Ovid, Google Scholar, and ProQuest databases did not identify any prior research studies that utilized a phenomenological approach to understanding the experiences of emergency personnel in treating individuals with mental health issues. Data gathered from the study may steer administrators to implement protocols and hire additional mental health professionals in emergency departments in effort to better serve individuals with mental health needs.

Conceptual Design

The conceptual diagram provided in Figure 1.1 provides the reader with an understanding of the various factors that were integrated in order to investigate the phenomenon. Four elements of the research design contributed to answering the research question and sub-questions. These included data collection and research methodology, theoretical framework and sensitivity, review of the literature, and trustworthiness. Data collection included interviews, observations, and document collection, which will be discussed in subsequent sections. Research methodology included approaches to data analysis and researcher's role management. The theoretical framework comprised of a phenomenological in nature which answered the research question. Additionally, theoretical sensitivity consisted of personal experience, professional experience, knowledge of the literature, and analytic rigor. Finally, the literature review, as discussed in the previous chapter, contributed to the understanding of the phenomenon by providing existing studies' findings and descriptions of roles of emergency personnel.

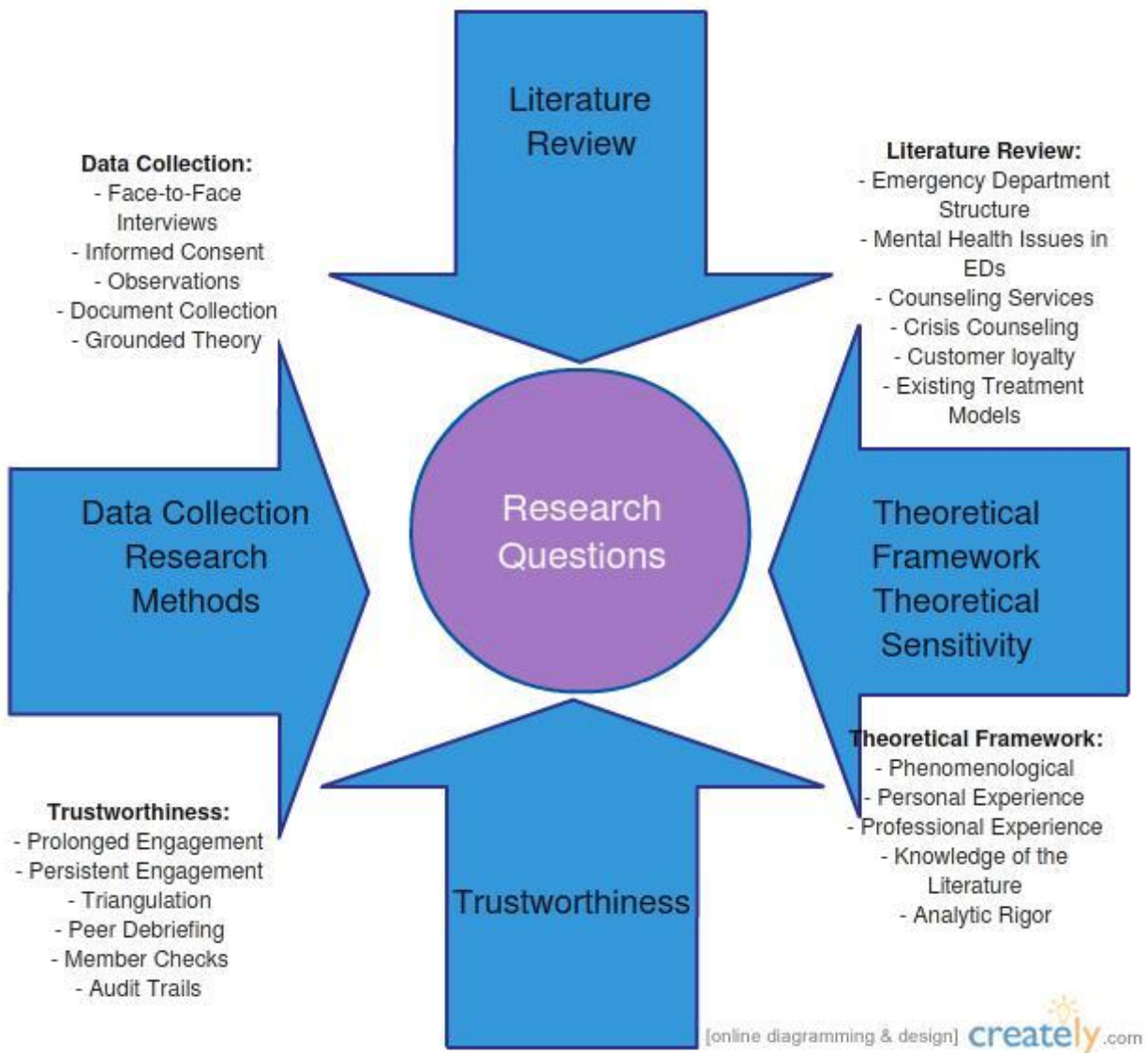


Figure 1.1. Conceptual design for the study.

I experienced interacting with emergency department personnel when working as a mobile crisis assessor. I observed the flows of various emergency, police, emergency medical services (EMS), and fire departments and observed various conversations between staff and

individuals with mental health needs. Additionally, I observed psychiatric emergencies that were occurring in the emergency department.

The first stage of the study was observation of emergency departments and personnel. My observations focused on the individuals directly involved in the treatment of clients who were experiencing psychiatric difficulties. Due to the nature of the services, many of the individuals presenting at the emergency departments were not experiencing mental health issues, rather they were suffering from physical ailments. Observations were recorded and documented in the researcher's journal.

The second stage of the study consisted of conducting purposeful sampling procedures. The purposeful sampling strategy was chosen so that appropriate participants were included in the sample that could describe their experiences within the central phenomenon (Gall, Gall, & Borg, 2007). Participants were recruited from emergency, police, fire, and EMS departments and provided with information about the study. If individuals decided to enroll in the study, they were given the informed consent paperwork and provided with an explanation of the study. I answered questions participants had about the different aspects of the consent papers or about the study protocol.

After the participants provided explicit consent to enroll in the study, I arranged a meeting time and private, secure location for the first interview. The first interview was a semi-structured open-ended interview that lasted approximately twenty to forty minutes. The participant answered a variety of pre-determined questions that explored his/her lived experience of working in the emergency department or services as well as his/her experience in treating

individuals with mental health needs. Following the completion of the initial interview, the participant was provided with his/her incentive and agreed upon a time and location for the second interview.

In between the conclusion of the first interview and commencement of the second interview, the participant was provided with a printed transcript of the first interview. He/she was instructed to note any discrepancies on the transcript and provide clarification of vague comments. The second interview was a semi-structured open-ended interview that focused on clarifying areas that were vague or not addressed in the first interview. The participant was provided with an opportunity to share additional information that he/she believed was relevant to the study's purpose. The second interview concluded with the participant receiving his/her second incentive. I repeated the efforts to maintain confidentiality throughout the study and after the study had concluded.

Theoretical Sensitivity

Theoretical sensitivity refers to the idea of the researcher as an instrument. According to Corbin and Strauss (2014), theoretical sensitivity is comprised of the researcher's characteristics to maintain objectivity and sensitivity to the research endeavor and subsequent data interpretation. Theoretical sensitivity consists of personal experiences of the researcher, professional experience, personal knowledge of the literature, and analytic rigor (Corbin & Strauss, 2014).

Personal experience. My personal experiences with the phenomenon included witnessing mental health crises in emergency rooms both as a family member of an individual

suffering from a psychiatric crisis as well as receiving consultation from ED professionals regarding deaths in the family. I spent a significant amount of time talking to personnel about the need for licensed counselors in emergency rooms in informal conversations prior to commencing the study. Based on my conversations and personal experience, I was compelled to focus my research efforts on the investigation of this phenomenon.

Professional experience. I am a licensed counselor and worked as a mobile assessor for a crisis team. Most of my profession has consisted of working with individuals who are in acute crises and require inpatient psychiatric treatment. The majority of these clients originate from emergency departments across the state. I have worked in conjunction with medical professionals in multiple emergency rooms and have gleaned vital information about the lack of training for mental health issues. Additionally, I have talked with clients' family members who reiterated the need for counseling services in emergency rooms. My professional experiences also involved supervising graduate students in their pursuits of becoming licensed counselors. Many of them have expressed desires to work in emergency settings and have requested resources on crisis counseling methods. This contributed to my awareness of potential resources for emergency departments, as many of the graduate students may be willing to provide services in this setting.

Knowledge of literature. I conducted a thorough investigation of the existing literature concerning emergency department personnel and their experiences with individuals with mental health issues. Researchers have investigated the prevalence of psychiatric-related emergency department visits and emergency department's treatment protocols for psychiatric conditions.

Emergency departments have witnessed increases in visits that are mental health related (Larkin, Claassen, Emond, Pelletier, & Camargo, 2005; Minassian, Vike, & Wilson, 2013; Owens et al., 2010). Despite the extensive training of medical health professionals, limited time is spent learning about effective treatment protocols for individuals experiencing mental health complications.

Analytic Rigor. Analytic rigor refers to the thoroughness with which data were collected and the extent to which the researcher's engagement with data yielded coherent and significant analysis at the end. Padgett (1998) suggests that the researcher should establish a set of strategies in effort to manage reactivity and bias. I conducted a literature review and used the following criteria to establish quality work: relevance to the study, scholarly reviewed, empirical in nature, and quality. When evaluating relevance, I inspected the literature and studies and determined if they were applicable to the study's research questions and context of the study. After establishing relevance for each piece of literature, I checked to see if the material was peer-reviewed, scholarly, and deemed to be high quality. I looked for articles, studies, literature reviews, and books that were written in funnel patterns; that is based on a specific population or phenomenon for the study; supported by statistical analysis; provided foundational structure for the study and conclusions; utilized appropriate scientific terminology; and demonstrated rigor (Heppner & Heppner, 2004).

Parameters of the Study

For methodological parameters of the study, participants were recruited from Arkansas emergency departments and services. The researcher excluded sites that did not have an

emergency department on site as well as clinics that offered emergency services. Participants for the study were identified as medical personnel that worked in the emergency departments. They included registered nurses, firefighters, paramedics, police officers, and other EMS workers. Individuals who did not hold a current license were excluded from the study.

The study focused on the lived experiences of emergency personnel over the age of 18 who were licensed professionals working in emergency departments or employed as a firefighter, police officer, paramedic, or emergency medical technician (EMT). The intent of the study was to interview ten participants that are currently working in emergency departments or emergency services and encounter individuals with mental health needs. The research question and sub-questions sought to enhance an understanding of how medical professionals working in emergency services perceived the need for expanding training on mental health conditions as well as their experiences of working with clients with psychological needs.

Assumptions

For the purposes of this phenomenological study, a few assumptions were identified prior to conducting the study. These assumptions included:

1. The locations of the personnel were not a factor that influenced the results.
2. The gender of the participants was not a factor.
3. The ethnicities of the participants were not an influential factor.
4. The participants responded openly and honestly to the study's questions
5. The age of the participants did not influence their answers to questions.
6. The emergency department personnel were competent in their jobs.

Limitations

Study limitations are areas of potential weaknesses. According to DePoy and Gitlin (2015), limitations usually include small sample sizes, lack of participants, unanswered questions, and issues surrounding data analysis. For this study the participants were individuals who worked in emergency services and departments in a centralized region. Since they came from a particular geographical area and identified with specific professional disciplines, the generalization and transferability of the study's findings are limited. Another limitation is the small number of participants ($n=10$). The study consisted of ten participants who worked in a Southern region of the United States. Due to the small number of participants, the study had limited amount of experiences reported.

Definition of Terms

Definitions and phrases that are well known in the mental healthcare system and medical system require elaboration to ensure a collaborative understanding in the study. Elucidating operational definitions for clarification is of utmost importance in research (Nelson, 2015).

When a researcher presents terminology, he/she is avoiding misinterpretations of data and facts.

The following terms were the consistently used definitions in the study:

Bereavement refers to the emotional and physical response to the loss of another (Watts, 2010).

A *client* is someone who is seeking medical or psychiatric services.

The term *crisis* refers to a state of strong emotion and/or distress.

Crisis intervention is a form of brief therapy that a clinician provides in a highly stressful situation. This type of intervention is aimed at returning an individual to his or her baseline prior to the crisis (Callahan, 1998; Kanel, 2014).

Emergency departments are specific settings based in hospitals that “care(s) for patients that require sudden and immediate action” (Chabner, 2013, p. 168).

Emergency department personnel are individuals who provide medical services to clients presenting at emergency departments.

Emergency medical services (EMS) is a network of services aimed at assisting individuals with prehospital medical care and interventions.

Emergency services personnel are individuals who respond to emergency calls and provide services at the scenes of crises.

Family Based Crisis Intervention (FBCI) is composed of a single-session emergency department intervention that aims to stabilize a client who is in crisis (Wharff, Ginnis, & Ross, 2012).

Lived Experience is a term that phenomenological studies use to describe the significance of an individual’s experiences as conscious beings (Esquibel, 2009). An individual’s lived experience has an emphasis on the past, as phenomenology is not the study of the present or future (van Manen, 1990).

A *psychiatric emergency* is a situation in which an individual is at risk to his or herself or others and/or requires immediate mental health treatment to prevent further decompensation.

Psychiatric Emergency Services (PES) are services that provide psychological interventions or treatments that are aimed at reducing individuals’ distress.

Psychosis is a term that describes an individual's mental state when "he or she is out of touch with reality" (Compton & Broussard, 2009).

A *psychotic episode* is a discrete period of time in which an individual is actively experiencing psychosis.

An individual who is experiencing *suicidal ideation* is an individual who is seriously considering taking his or her own life (Beck, Brown & Steer, 1989).

Trauma is currently defined as a devastating situation (or series of events) in which an individual has been exposed to instances in which he or she was threatened, witnessed a disturbing event, harmed, or sexually violated (Ritchie, Watson, & Friedman, 2015).

The term *triage* refers to the process of decision making by a healthcare provider in prioritizing the treatment of patients according to their acuity (Gerdtz & Bucknall, 2001).

Summary

Emergency department workers and emergency service personnel provide a variety of medical services to individuals presenting with various medical and psychiatric conditions. Their experiences in working with these clients are unique and differ from many other medical disciplines. In addition to providing treatments for medical conditions, emergency department professionals also address and stabilize individuals with mental health needs. Understanding the providers' perspectives and experiences of treating individuals with mental health needs could assist health-care leaders in honing in on specific protocols to ensure that clients are receiving appropriate care. Additionally, the study aimed to identify emergency department personnel's

training in mental health treatment. This aspect may contribute to the development of more in-depth curriculums aimed at alleviating psychiatric symptoms in emergency departments.

Organization of the Dissertation

This chapter presented an overview of the study. The chapter began with a background of the study and the aims of the study. Next the chapter introduced the primary research question and the two sub-questions that were addressed in the study. This was followed by a brief description of the study's conceptual design, theoretical sensitivity, and parameters of the study. Finally, consideration of study limitations was addressed. Key terms and their definitions were included in this chapter.

Chapter Two begins with a presentation of the search strategy utilized by the researcher in effort to understand previous studies' findings. Next an overview of emergency department structures and services are discussed. Following these topics are presentations of psychiatric emergencies and treatment protocols used in emergency departments. The remainder of the chapter provides a literature review across a variety of topics that include: comorbidity of mental health and medical issues, emergency department utilization by individuals with psychiatric needs, counseling services, and gaps in mental health services in emergency departments.

Chapter Three includes the statement of the problem, the research design and timeline, and research ethics. The participant selection process, theoretical framework, data collection protocols, and efforts to enhance trustworthiness are also presented.

Following Chapter Three, Chapter Four presents an introduction to the study's results, transcribed interviews, and participant demographic information. Next is a detailed description

of the data analysis process. Then a discussion of the axial codes occurs followed by a summary of the chapter.

Chapter Five concludes the dissertation with discussion of three theories that answer the main research question. The chapter includes implications for the counseling field, recommendations for future research endeavors, and researcher's recommendations.

CHAPTER TWO: LITERATURE REVIEW

Organization of the Chapter

In an effort to provide context for the dissertation, a review of the literature was conducted to establish a foundation and framework for the study. The chapter begins with an overview of emergency department structure and offered services. These areas are followed by presentations of mental health emergencies in emergency settings, the co-morbidity of mental health and medical issues, and utilization of emergency services by individuals with mental health needs. The chapter concludes with a discussion of counseling services, including crisis counseling, and gaps in mental health services in emergency departments.

Introduction

The purpose of this literature review to establish a foundation for the treatment of individuals with mental health issues in emergency departments. As previously stated, emergency departments are frontlines for treating wide varieties of ailments 24 hours a day, seven days a week (Garrettson, Weiss, McDonald, & Degutis, 2008). Despite the increasing amounts of visits (Tang, Stein, Hsia, Maselli, & Gonzales, 2010), the number of emergency departments dropped from 4,900 to 4,600 between 1996 and 2006 (Cheung et al., 2010). As a result, many emergency departments are overcrowded (Jensen & Crane, 2008) and continually faced with challenges in delivering safe, timely, and professional client-centered care (Rodi, Grau, & Orsini, 2006). Among individuals who seek medical assistance are clients presenting with mental health needs. Researchers estimate that 10 to 15% of all visits are psychiatric in nature (Clarke, Dusome, & Hughes, 2007; Owens et al., 2010). These psychiatric emergencies

include suicidal thoughts and/or attempts, experiences of acute psychosis, and crisis related issues. Studies found that emergency department personnel lack training in treating many mental health conditions and have negative attitudes toward individuals presenting with psychiatric issues (Clarke, Usick, Sanderson, Giles-Smith, & Baker, 2014; Croskerry, Wears, & Binder, 2000; Ross & Goldner, 2009). Despite various endeavors that have attempted to provide education to emergency department staff members (Appleby et al., 2000; Commons-Treloar & Lewis, 2008; McAllister, Moyle, Billett, & Zimmer-Gembeck, 2009), service gaps in mental health treatment are still occurring in emergency departments (Cossette, Frasure-Smith, Vadeboncoeur, McCusker, & Guertin, 2015).

The study aimed at elucidating the lived experiences of emergency department workers when working with individuals with psychiatric needs. The results may assist administrators and educators in preparing service workers with education and training for mental health treatment. The basis of the study stemmed from an extensive literature review that examined previous studies that focused on psychiatric emergencies, protocols for treating psychiatric conditions, and other relevant areas. The following section details the process of the literature review.

Search Strategy

In effort to attain published studies and relevant sources, a variety of techniques were employed. Initially online searches were conducted using various electronic databases including: Google Scholar, PsycINFO, Education Resources Information Center (ERIC), Academic Search Elite, ProQuest, Web of Science, and Digital Dissertations. The primary keywords that were used for the search were emergency department structure, emergency department personnel,

psychiatric emergencies, crisis, individuals with suicidal thoughts, acute psychosis, mental health training, and counselors in emergency departments. To ensure that resources were not overlooked, I searched through databases that yielded the most relevant information two to three times over the course of seven months. No limitations were made up front; however, articles that were not translated in the English language were later removed. The reference lists for each of the articles were searched for additional potential sources that could be added to the literature collection. Though documents published within the past five years of the study were more relevant, many articles prior to 2011 were crucial in demonstrating the significance of the problem and the continuation of unmet needs in emergency department settings.

Emergency Departments

Historically, the need for a specialty that focused on the acutely ill and wounded has been indicated repeatedly. The first documented experience in which emergency medicine was utilized was more than two thousand years ago when a Good Samaritan assisted an injured traveler (Bledsoe, Porter, & Cherry, 2006). Around the same time King Hammurabi developed the “Code of Hammurabi,” a document that addressed fees for medical services (Bledsoe, Porter, & Cherry, 2006). Despite these early findings that pointed to the need for organized emergency medicine care, practitioners and policy-makers did not develop systematic healthcare services until after the Revolutionary War in the United States (Jelenko, Matthews, & Matthews, 1982). The lack of organization, limited transportation, and absence of specialized equipment resulted in high morbidity and mortality rates (Jenlenko Matthews, & Matthews, 1982). The first hospitals in the United States were developed in 1751 in Philadelphia (Jelenko, Matthews, & Matthews,

1982). These hospitals had very few physicians and did not have articulated emergency medicine standards or protocols (Jelenko, Matthews, & Matthews, 1982).

In Europe the need for emergency medicine protocols and organization was also desperately needed. Jean Larrey, one of Napoleon's surgeons, implemented the first triage and mobilization system (Bledsoe, Porter, & Cherry, 2006). This system was expanded by Major Letterman who was serving in the United States Civil War. He trained individuals who did not have prior medical experience to treat minor wounds and injuries (Givens, 2009). Additionally, he assigned laypeople to carry stretchers with wounded soldiers to field stations (Givens, 2009). Following this development, the first hospital-based emergency service began in New York City in 1869 (National Highway Traffic Safety Administration [NHTSA], 1996).

After the Civil War, emergency medicine did not significantly evolve until World War II. During the war, physicians honed patient evaluations into crystallized processes that would eventually be known as triages (Pell 2006). Practitioners prioritized the severity of patients' ailments and categorized the types of wounds or injuries the patients' were experiencing (Pell 2006). During this time more advanced medical equipment and supplies became available to civilians and professionals (Jelenko, Matthews, & Matthews, 1982).

Following World War II practitioners made many advancements in the types of medical equipment and pharmacological technology. The establishments of emergency departments in the 1950's coincided with these developments (Pell, 2006). Despite efforts to treat the acutely injured and ill, a specialized approach had not been developed. The doctors and nurses staffing these departments were not explicitly trained in emergency medicine (Holstege & Powers, 2006).

Additionally, Emergency Medical Technicians (EMTs) and paramedic training programs had not been implemented.

Advancements began to take place in the late 1960s (Alexander, 2000) when the first U.S. meeting of physicians working in emergency departments occurred in 1968 (Leidelmeyer, 1997). In particular, physicians determined cardiopulmonary resuscitation (CPR) to be efficacious (Tanenbaum, 1993). Along with these developments, EMT certification for ambulance drivers assisted in reducing wait times for first aid assistance and expedited the transport of acute and injured individuals (Munger, 2000). Advancements in the understanding of specific illnesses and treatment protocols evolved emergency medicine into a more organized system.

Specializations and training programs for physicians began in the early 1970s. The first specialty training program in emergency medicine was offered to medical school residents (Macy, 1995) and the American Board of Medical Specialties acknowledged emergency medicine as a specialty (Warner, 2005). By the 1980's emergency medical training services offered curricula in basic, advanced, and pediatric life support to physicians, nurses, and paramedics (Pell, 2006). In the early 2000's emergency medicine consisted of 25 separate membership divisions within the American College of Emergency Physicians in which physicians may apply (Pell, 2006). With these developments, the field of emergency medicine blossomed into a highly organized practice that spread across the nation.

Emergency departments provide frontline services for patients in healthcare organizations. Emergency department workers address acute and trauma needs, provide

afterhours and urgent care for many types of presenting problems, and serve uninsured and homeless individuals regardless of payer sources (Haley, 2006; Newton, Keirns, Cunningham, Hayward, & Stanley, 2008). Due to the convenience of twenty-four-hour accessibility, emergency departments have become *one-stop shopping* health centers (Haley, 2006). Patients can receive multiple services including routine screenings to complex diagnostic work in one appointment (McCarthy et al., 2008; Scheck, 2006b).

In a study conducted by Eisenberg and his colleagues (2005), they identified a series of events patients encounter in a typical emergency department visit. The first interaction occurs in the triage area (Jensen & Crane, 2008) where the patients' acuity is assessed and prioritized. Personal data including name, date of birth, and insurance information are gathered and entered into the system. For the majority of cases, nurses do not have access to the patient's medical history or psychiatric record to make an accurate assessment (Eisenberg et al., 2005). Despite this gap, the triage nurse determines the acuity level according to the patient's presenting problem and physiological parameters (Ekwall, Gerdtz, & Manias, 2008). Following this step, the patient is transferred to the treatment area where a physical evaluation is conducted usually by a physician, a physician's assistant, or a nurse practitioner (Eisenberg et al., 2005). If the patient's situation necessitates labs or imaging, the physician orders them. After the test results are received, the physician consults with the patient, provides a diagnosis, and offers a treatment plan. If the patient is deemed medically clear after these steps, he/she is discharged from the emergency department.

Various protocols are often implemented to assist in the assessment of patients including Point-of-Care (POC) testing. For example, patients with vague chest pain are usually assessed with POC testing (Vlahaki, Fiaani, & Ken Milne, 2008). With the utilization of evidenced based assessments, individuals with chief complaints of heart conditions are deemed urgent and usually do not experience waiting time in emergency department lobbies (Jibrin et al., 2008). Emergency department personnel prioritize these patients so that they can prevent heart attacks and strokes by delivering time-sensitive assessments (Kimball, 2008).

Emergency departments provide treatments for medical and psychiatric conditions 24 hours/ 7 days per week. Practitioners provide health-care services to all clients regardless of their abilities to pay (Hoot & Aronksy, 2008; Kuntze, 2008; Mulcahy et al., 2013). Different emergency departments have unique protocols to provide and allocate services for a variety of conditions. Emergency departments are continually faced with increasingly difficult challenges in regards to delivering safe and efficient treatments on daily basis. The following section will examine the current emergency department protocols that most modern sites have in place.

Current Emergency Department Protocols

Despite the fact that the number of visits to emergency departments have risen since 2006, the actual number of emergency departments has decreased from 4,900 to 4,600 from 1996 to 2006 (Kimball, 2008). This decrease created additional issues for emergency departments, especially in regards to overcrowding. Other factors contribute to this issue including the passing of federal regulations such as the Emergency Medical Treatment and Active Labor Act (EMTALA) (Haley, 2006). Currently emergency departments are required to adhere to standards

by the Consolidated Omnibus Budget Reconciliation Act (COBRA) and the Emergency Medical Treatment and Active Labor Act (EMTALA). These acts require that emergency departments have licensed personnel that medically screen all individuals presenting for treatment, regardless of their abilities to pay (Irvin, Fox, & Pothoven, 2003). The medical screening must consist of a qualified medical professional (QMP) assessing an individual and determining whether or not an emergency medical condition is present. If the QMP determines that an emergency condition is present then the facility is required, under EMTALA, to provide treatment if it has the capacity to do so. If the department does not have the capabilities to treat a specific condition, then the staff members must attempt to stabilize the individual to the best of their abilities and transfer him/her to an appropriate facility that can provide care (Strickler, 2006). When a QMP is stabilizing an individual, he or she is providing care to ensure that the condition does not deteriorate prior to transferring the client to an appropriate facility.

Emergency Department Personnel

Among health care providers, professionals who work in emergency departments experience significantly higher levels of occupational stress (McPherson, Hale, Richardson, & Obholzer, 2003). In the United States, approximately 800,000 emergency department workers respond to nearly 16.6 million emergency situation per year (Kellerman, 2006; McCaig & Nawar, 2006). Individuals working in emergency departments are faced with unpredictable workloads, critical patients, and long hours (Rehmani & Norain, 2007). Laposa, Alden, and Fullerton (2003) investigated instances that emergency department personnel identified as stressful. These included: (a) providing care for a dying or critically ill patient who was also a

relative or close friend, (b) being faced with a threat of physical violence that lead to assault, (c) treating massive blood loss or dismemberment, (d) witnessing the death of a child, (e) providing care for an individual who reminded the provider of a loved one, and (f) treating an individual for severe burns (Laposa, Alden, & Fullerton, 2003).

Different types of professionals serve in emergency departments including physicians, nurses, physician assistants, emergency medical technicians (EMTs), social workers, pharmacists, counselors, and technicians (Institute of Medicine Committee on the Future of Emergency Care in the United States Health System, 2006). To best serve their clients, most emergency departments require a charge nurse, triage nurse, floor nurse and ancillary personnel (McBrien, 2009). Each of the professions serves a specific role in the care of individuals seeking medical and mental health care. Emergency physicians conduct evaluations of clients, determine diagnoses, and initiate treatment. In 2009 United States emergency departments employed approximately 39,000 emergency department physicians (Gindi, Cohen, & Kirzinger, 2012).

In addition to emergency department physicians, nurses are also integral contributions to patient care. In 2011 the American Nurses Association (ANA) recognized emergency nursing as a specialty and defined emergency nursing as “the care of individuals across the lifespan with perceived or actual physical or emotional alterations of health that are undiagnosed or require further interventions (ANA, 2011). One of the primary roles of emergency department nurses is to perform triages on all patients who present to the ED (Emergency Nurses Association, 2015). As mentioned previously, a triage is one of the first points of contact between emergency professionals and individuals presenting in emergency departments. The aim of the triage is to

assess and prioritize patients in the order of urgency based on necessity (Brabrand et al., 2010; Huryk, 2006). Various researchers indicated that both nursing strategies and decision-making in triages are complex and guided from professional foundations and experiences (Edwards & Sines, 2008; Wolf, 2010a, b).

Emergency department nurses' experiences are different in nature compared to other nursing settings. They treat a diverse range of individuals with varying presenting complaints that include mental health conditions. The numbers of individuals who present to emergency departments with psychiatric complaints increased over the past twenty years (Minassian, Vilke, & Wilson, 2013). In response to these trends, emergency department nurses are conducting more psychiatric and risk assessments (Plant & White, 2013).

Emergency Services Personnel

In addition to emergency department personnel, emergency workers are on the frontlines of stabilization for individuals with acute mental health needs. First responders arrive to scenes that involve emotional crises, behavioral emergencies, and postmortem situations. Additionally, police officers, firefighters, and EMS workers respond to situations that include the exacerbations of psychiatric symptoms, domestic violence situations, and traumatic instances. According to the Centers for Disease Control (CDC), in 2006 the United States had approximately 800,000 firefighters and around 700,000 licensed emergency services personnel.

Police officers. Across the United States police officers interact with individuals with mental health issues. Researchers estimate between 7 and 31% of emergency calls involve with people with psychiatric conditions (Abbott, 2011; Baess, 2005; Wilson-Bates, 2008). Various

reports attribute the following factors to the increase in police involvement: (a) deinstitutionalization, (b) limited numbers of psychiatric beds, and (c) changes in mental health laws (Cotton & Coleman, 2006; Fisher, Silver, & Wolff, 2006; Lamb, Weinberger, & DeCuir, 2002). The direct results of these factors are police officers serving as the first line of defense to those who are experiencing mental health crises (Patch & Arrigo, 1999).

In response to the increase of interactions between police officers and individuals with mental health issues, police forces created crisis intervention team (CIT) model. CIT approaches are police-based interventions that afford police officers with skills and knowledge concerning responses to people experiencing psychiatric conditions. The Memphis Police Department developed the original model in 1988 alongside the Memphis chapter of the National Alliance for the Mentally Ill (Compton, Esterberg, McGee, Kotwicki, & Oliva, 2006). Within this model, police officers received approximately 40 hours of psychoeducation, de-escalation techniques, and diversion of individuals with mental health conditions to psychiatric facilities as opposed to jails (Morrissey, Fagan, & Coccozza, 2009). Since 1988 more than 500 police forces enacted CIT (Steadman, Deane, Borum, & Morrissey, 2000). Aside from implementing CIT modalities, various police departments developed additional units that specialize in working with mental health crises. In a study conducted by Rosenbaum (2010), a police department and a psychiatrist collaborated on a CIT approach. This intervention was unique as it incorporated a mental health specialist with the trained police force. The study detailed the conceptual reasoning behind the development of the team, but did examine the effectiveness of the CIT enhancement.

EMS Personnel. In the United States five different levels of EMS personnel that include First Responder, EMT-Basic, EMT-Intermediate/85, EMT-Intermediate/99 and Paramedic (National Highway Traffic Safety Administration, 2008). First responders are usually employed by ambulance services and provide basic medical treatment at emergency scenes. They are usually not able to transport individuals to hospitals, but can serve as an attendant on emergency vehicles. EMT-Basics are practitioners who can provide basic emergency care to individuals and have the ability to transport patients to hospitals (Patterson, Probst, Leith, Corwin, & Powell, 2005). Individuals who have EMT-Intermediate/85 and EMT-Intermediate/99 statuses are able to perform more advanced procedures at emergency sites, which varies state to state. In order to obtain these levels, individuals must successfully pass certification classes and tests to practice. Finally, EMT-Paramedics are able to provide the highest level of care, dispense controlled substances, and administer Basic Life Support and Advanced Life Support techniques (Phelps, 2015).

In 1973 the Emergency Medical Services Systems Act was the first official supporting document that endorsed EMS in the United States (Emergency Medical Services Systems Act of 1973, 1973). This Act presented educational criteria to which emergency training services must adhere in regards to the first responder, the emergency medical technician-ambulance (EMT-A), the EMT-Intermediate, and the paramedic. The regulations that were outlined in the Act of 1975 were not enforced until 1996, when the publication of *Emergency Medical Services Agenda for the Future* occurred (United States Department of Transportation et al., 1999). The Educational Agenda propositioned an EMS systematic education plan that consisted of five components

including: (a) national EMS core content, (b) National EMS Scope of Practice Model, (c) national EMS education standards, (d) national EMS certification, and (e) national EMS education program accreditation (Brice et al., 2014).

Mental Health Issues in Emergency Settings

Emergency psychiatric services have become a necessity due to the frequency of individuals presenting to emergency departments with chief complaints of mental health issues. Following the de-institutionalization movement in the early 1950's and 1960's many people who were receiving care in state facilities were left without aftercare plans and access to psychiatric assistance (Huffine & Craig, 1974). Community-based institutions were overwhelmed and insufficient to meet the needs of these individuals who required higher levels of care. As a direct result, people with significant psychiatric conditions were at higher risks to experience exacerbations of their conditions. When their conditions escalated to crises, they would present to emergency departments.

As mentioned in previous sections, emergency departments have become the “catch-all” areas for treating varieties of ailments. In particular individuals who present with mental illness complaints is on the rise internationally. Emergency departments vary in the protocols they use to manage psychiatric symptoms. In a study conducted by Larkin et al. (2005) the results confirmed that mental-health visits to the emergency department have risen from 4.9% to 6.3% from 1992 to 2004. Other researchers have found that out of the 95 million ED visits by adults in the United States, 12 million were related to mental health and/or substance abuse (Owens et al., 2010). The most common mental health and/or substance use related ED visits are for mood

disorders (42.7%), anxiety disorders (26.1%), alcohol use disorders (22.9%), drug use disorders (17.6%), psychotic disorders (9.9%), and self-injurious behaviors (6.6%) (Owens et al. 2010).

When addressing psychiatric emergencies, emergency department personnel may choose to utilize various interventions that have been proven to be clinically effective. Emergency department interventions for substance use issues and other psychiatric conditions have been identified; however, the implementations of protocols vary from hospital to hospital. In emergency departments that do not have psychiatric consultation services, emergency room physicians assume the role of assessing and addressing psychiatric needs. Departments that have access to a psychiatric consultant would dispatch him/her to evaluate the patient. This individual may be a member of another organization or an employee of the hospital. The hospitals that do have access to a psychiatric consultant may choose to keep an individual on-site or on-call (Brown & Schubert, 2010).

Other efforts to address psychiatric complaints in emergency departments have included incorporating other disciplines into treatment teams. Various hospitals have implemented psychiatric emergency nurses (PENs) in emergency departments (Clarke, Dusome, & Hughes, 2007; Clarke & Hughes, 2002; Wand, D'Abrew, Acret, & White, 2016). In these situations, the nurses had separate functions from other nurses in the emergency department. Their roles consisted of communicating with patients and their family members, enacting crisis interventions, assessing symptoms, and assisting with transfers or admissions to psychiatric facilities (Clarke, Dusome, & Hughes, 2007; Clarke & Hughes, 2002; Nelson, Clarke, Febbraro, & Hatzipantelis, 2005; Wand et al., 2016).

A number of emergency departments have implemented processes that include screening, providing brief interventions, and referring patients to treatment, referred to as Screening Brief Intervention and Referral to Treatment (SBIRT) (Babor et al., 2007). Researchers have found that the use of SBIRT is effective in reducing alcohol consumption, smoking, marijuana use, and engaging in risky behaviors (Berstein et al., 2007; Bernstein & D’Onofrio, 2013; Vaca, Winn, Anderson, Kim, & Arcila, 2011).

In response to the increasing number of visits for psychiatric conditions, crisis intervention programs emerged across the county. These programs seem to not have an impact as evidenced by an increase from 4.9% to 6.3% of instances of emergency department visits that consisted of mental health complaints (Larkin, Claassen, Emond, Pelletier, & Camargo, 2005). Emergency department practitioners began to realize that a subspecialty of Emergency Psychiatry needed to be cultivated (Wellin, Slesinger, & Hollister, 1987). Psychiatric emergency medicine focuses on: excluding medical etiologies for symptoms, stabilizing individuals in crisis, avoiding coercion, treating individuals in the least restrictive setting, attaining a therapeutic alliance, and developing an aftercare plan (Zeller, 2010).

In addition to implementing a psychiatrist in the emergency room, other models exist that expand on the emergency department structure or designate a separate area specifically for the treatment of individuals with mental health needs. These include dedicating a mental health wing within an emergency department, setting up a psychiatric emergency service, and implementation of an alternative crisis treatment modality (Zeller & Rieger, 2015). In the case of the dedicated mental health wing, a separate space of the emergency department is allocated for

individuals that require acute psychiatric care (Oliver, 2015). Ideally the space is away from the potential chaotic environment of the emergency department and is staffed with nurses who specialize in treating individuals with mental health needs. The presence of skilled staff members increases the likelihood of developing a therapeutic alliance. Potential drawbacks to this model include the potential for these designated areas to become boarding areas for clients who are waiting for inpatient treatment beds and limited space in the emergency departments.

The second model is the psychiatric emergency services (PES) modality. This module consists of a stand-alone area dedicated to the treatment of individuals in psychiatric crises (Chaput & Lebel, 2007). The unit is separate from the emergency department and other areas of the hospital, but they may be situated close in proximity to the emergency department. PES programs vary in sizes and names (Wellin, Slesinger, & Hollister, 1987). Sometimes they are known as Comprehensive Psychiatric Emergency Programs (CPEP), Emergency Treatment Services (ETS), and Crisis Stabilization Units (CSU) (Zun, Chepenik, Mallory, 2013).

The psychiatric emergency services are the direct result of de-institutionalization of psychiatric clients, the development of community mental health care systems, and the expansion of emergency medicine systems (Hillard, 1994). PES initially evolved along three distinct developmental lines: the makeshift psychiatric emergency care located in the emergency room in a general hospital, an ad hoc after care service in the psychiatric hospital, and the community mental health movement (Wellin, Slesinger, & Hollister, 1987). The emergency department was the first place where PES began to develop. Psychiatric residents on call had duties to address clients brought into the emergency departments with chief complaints of psychiatric issues.

These integrations of a psychiatric professional developed outside of psychiatric wards and were needed adjustments to the demands of mental health necessities.

The second development of the PES occurred in the 1930s in several psychiatric hospitals as a form of discharge services. Clients and their families were given the choice of contacting the psychiatric hospital if clients were experiencing distress. The services were aimed at providing avenues for caring for former clients that were not at acute levels that would require hospitalization.

The third development of PES centered on the community health movement and the de-institutionalization of psychiatric clients. During the 1950's, a variety of community mental health endeavors expanded to emergency mental health services that were located in local settings. In 1958 the president of the American Psychiatric Association (APA) proposed that state hospitals close and their replacements would be community mental health centers. This movement was the result of efforts to reduce the financial burden of states to afford long term inpatient psychiatric treatment in addition to developments in more effective psychotropic medications. The major force for an organized psychiatric emergency service followed the enactment of the Community Mental Health Legislation of 1963 (Hillard, 1994; Wellin, Slesinger, & Hollister, 1987). This piece of legislation recognized five essential components of federally funded community mental health programs that included PES. Community mental health centers, emergency departments, and psychiatric hospitals began to form alliances to provide psychiatric emergency services so that they would be in compliance with the legislation. Usually the PES staff consists of psychiatric nurses, counselors, social workers, and

psychiatrists. Most PES programs adhere to the “Treatment Model” in which an individual is triaged and treated onsite (Redondo & Currier, 2003). Stabilization within a PES involves a focused intervention that addresses the psychiatric complaint and followed by observation by a qualified mental health professional. The two most common treatment modalities in PES facilities are the primary therapist model and the medical model. With the primary therapist model an individual who recently arrived to the facility is assigned to a therapist who is charged with the responsibility of interviewing the individual and gathering information about previous care. This model utilizes several clinicians that work as a team that allows provision of care for multiple clients. The other type of treatment modality is the medical model. The medical model is similar to the medical emergency department, with a physician embodying the team leader position for each individual client (Deacon, 2013). This style of treatment is more cost-efficient and only requires one psychiatrist to delegate treatment.

The final type of emergency department service modality is the alternative crisis treatment modules. These consist of voluntary crisis programs, mobile crisis teams, and acute diversion units. Voluntary crisis programs are open-door settings that provide urgent care for individuals in psychiatric crises. This model offers counseling and medication refills in lieu of the individual seeking out services at an emergency department. The downside to the voluntary crisis program module is that communities do not usually have funds that they could allocate to the service. The mobile crisis team concept has a wide range of definitions and obligations, depending on the location across the United States. Some organizations utilize mobile crisis teams as mental health evaluators in emergency departments to determine if an individual meets

criterion for an inpatient hospitalization. Other teams work with police departments to assist in de-escalation strategies when working with individuals with psychiatric needs. Overall crisis teams conduct assessments, provide counseling interventions, and make referrals.

Another type of alternative crisis treatment model is the acute diversion units. These areas are more comfortable and less restrictive environments that provide support for individuals on the cusp of a psychiatric emergency. The ideal candidate for this treatment type would be individuals who would benefit from hospitalization but are not displaying dangerous behaviors, confusion, or medical complications that would require medical inpatient services.

Despite these efforts to address mental health issues, the challenges of healthcare service delivery to individuals with psychiatric needs are continually noticed on a national level. Various studies have identified service gaps in outpatient, inpatient, and medical settings that include: (a) lack of psychiatric inpatient beds, (b) shortages of psychiatrists, (c) overcrowding in emergency departments, (d) low Medicaid reimbursement rates for psychiatric treatment, and (e) virtual lack of services in rural areas (Cunningham, McKenzie, & Taylor, 2006; Getrich, Heying, Willging, & Waitzkin, 2007; Perese, 2007). In response to these difficulties, two national reviews by the President's New Freedom Commission on Mental Health (2003) and the Institute of Medicine [IOM] (2006) aimed at identifying system breakdown points and restructuring healthcare of individuals experiencing mental illnesses and subsequent symptoms.

The President's New Freedom Commission was established in 2002 and aimed to systematically study the quality and efficacy of the public and private mental health service delivery systems. Additionally, fifteen committees were developed to investigate a range of

mental health topics including acute care, co-occurring disorders, criminal justice and mental health treatment, and various other topics. Each subcommittee investigated more than 2,000 stakeholders and concluded that the mental health system was “fragmented” and “in disarray” (President’s New Freedom Commission on Mental Health, 2003, p.1). In response to these findings the committee published recommendations and goals to transform and improve child, adolescent, and adult mental health systems (Mills et al., 2006). Each goal encompassed one to five subsequent recommendations that were aimed at transforming the mental health system. The committee specifically addressed the treatment of mental health issues in emergency departments by noting that mental health education and training should be implemented in each hospital (President’s New Freedom Commission on Mental Health, 2003). Although these suggestions were presented in 2003, the implementation of new policies to fulfill the committee’s goals has been slow nationwide.

In 2006 the IOM published *Improving the Quality of Health Care for Mental and Substance Use Conditions*, which outlined a strategy for achieving quality care by focusing on a client-centered approach and recognizing the mind-body connection (IOM, 2006). The IOM presented ten goals for healthcare organizations that treat individuals with mental health issues including: (a) care will be based on continuous healing relationships, (b) care will be customized to the individual’s needs and values, (c) the client is the source of control, (d) providers will share knowledge with clients, (e) the decision making process will be evidence-based, (f) safety will be of utmost importance, (g) transparency will be necessary during treatment, (h) needs will

be anticipated, (i) waste will be decreased, and (j) cooperation among clinicians will be a priority (IOM, 2006).

The integration of mental health treatment considerations into physical health systems has become a priority in recent policy endeavors (IOM, 2006; President's New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Services [HHS], 1999). According to a study conducted by Sipe and her colleagues (2015), mental health benefits legislation has been effective in improving financial allocations for services and increasing appropriate utilization of mental health services. Additionally, several groups have converged in the development of psychiatric emergency care. In Illinois, the Behavioral Health Steering Committee established a Task Force in 2006 to identify and implement best practices associated with the treatment of individuals with psychiatric and substance use issues in emergency departments (IHA, 2007). This included developing a team of psychiatrists, psychiatric nurses, psychologists, social workers, and counselors that generated a defined triage scale and "medical clearance" checklist to be used when working with clients with mental health needs (IHA, 2007).

Psychiatric Emergency Prevalence

A psychiatric emergency is a situation in which an individual poses an imminent risk of harm in four different areas: risk of suicide, risk of harm to others, state of impairment in which an individual is at risk to self, and risk to a defenseless victim. Emergency departments have experienced an increase in the number of psychiatric emergencies (Pitts, Niska, Xu, & Burt, 2006). Pitts and co-researchers estimated that psychiatric-related visits in emergency departments increased by 1% from 2003 to 2006. Despite the rising frequency of psychiatric

presentations in emergency departments, mental health is an area of expertise that very few emergency physicians and nurses are highly trained. Individuals presenting with primary psychiatric complaints often require constant monitoring and long periods of time in emergency departments (Smart, Pollard, & Walpole, 1999). Due to the complexity and ambiguity of mental health complaints, emergency department workers may perceive the treatment of these clients as challenging.

Emergency Department Treatment of Suicidal Ideations and Suicide Attempts

Suicide has become an emerging worldwide public health issue. Sullivan, Annet, Luo, Simon, and Dahlburg (2013) estimated that for every completed suicide there are approximately 100 to 200 attempts. In 2000 nearly one million people completed suicide (World Health Organization, 2010). In the United States over 31,000 Americans die from suicide each year (Centers for Disease Control and Prevention, 2006). More individuals die from suicide than homicide in the United States (National Action Alliance for Suicide Prevention, 2014). Due to the difficulty in navigating the mental health care system, many individuals present to emergency departments for psychiatric treatment and/or placement (American College of Emergency Physicians, 2008; Glick, Berlin, Fishkind, & Zeller, 2008). Various studies have found that 6-12% of individuals receiving emergency services endorse suicidal thoughts (Claassen & Larkin, 2005; Ilgen et al., 2009) As direct results, the number of visits for suicide attempts and ideations have doubled over the past two decades (Doshi, Boudreaux, Wang, Peletier, & Camargo, 2005; Hazlett, McCarthy, Londer, & Onyike, 2004; Larkin, Smith, & Beautrais, 2008). Emergency department personnel are considered early points of contact for individuals experiencing suicidal

thoughts or addressing complications from suicide attempts. The Joint Commission National Patient Safety Goal 15.01.01 (2011), mandates that emergency department providers assess all consumers for suicidal risk factors and address immediate safety concerns. Despite the fact that many emergency departments utilize off-site mental health professionals for psychiatric evaluations, emergency room physicians are often charged with responsibilities of determining if individuals require involuntary commitments for treatment of suicidal thoughts or attempts (Ronquillo, Minassian, Vilke, & Wilson, 2012).

Practitioners who evaluate and treat individuals with suicidal thoughts or attempts usually utilize crisis intervention strategies (Aguilera, 1998; Draper, Murphy, Vega, Covington, & McKeon, 2015; Schwartz & Rogers, 2004). In particular, the goals and specific techniques in working with these symptoms are typically based on models of crisis interventions, such as Roberts's 2002 crisis intervention version (Granello & Granello, 2007). This model presents crisis theory as its theoretical foundation and bases its approach with suicidology research and practice.

Roberts details a seven-step approach that provides a framework for evaluating and treating individuals with suicidal thoughts and attempts. The seven steps are as follows: (1) assess lethality, (2) establish rapport, (3) listen to the story, (4) manage the feelings, (5) explore alternatives, (6) use behavioral strategies, and (7) follow up (Roberts, 2002).

Other approaches to suicide risk assessment include Larkin and colleagues' (2009) emergency department specific guidelines. These guiding principles included the notion that any suicide risk assessment tool utilized by personnel must be "brief, easily understood by patients,

available in multiple languages, readily administered in busy general hospital settings, and be capable of generating rapidly available responses for review by ED staff” (p. 1112). Tools that fall into at least two of these categories include: the Behavioral Health Measure-20 (Kopta & Lowry, 2002), the Columbia-Suicide Severity Rating Scale (Posner et al., 2011), and the Risk of Suicide Questionnaire (Horowitz et al., 2001). The Behavioral Health Measure-20 (BHM-20) (Kopta & Lowry, 2002) consists of 20 items and each question provides a global measure of mental health and measures acuity through Likert scales (Kopta & Lowry, 2002). Practitioners utilize this scale due to the brevity, ease of administration, and clear nature of the questions.

Another suicide risk assessment tool is the Columbia-Suicide Severity Rating Scale (C-SSRS), developed by Posner and his colleagues (2011). This instrument evaluates four domains including: (1) severity of suicidal ideations, (2) intensity of suicidal ideations, (3) behaviors that are the results of suicidal thoughts (i.e. suicide attempts, self-injurious behaviors, etc.), and (4) lethality of an attempt (Posner et al., 2011). The C-SSRS is useful in emergency department settings due to its availability in multiple languages and accuracy of detecting suicidal thoughts. One potential shortcoming of the assessment tool is the lengthy scoring instructions that are not readily available to emergency department providers.

Finally, the Risk of Suicide Questionnaire (RSQ) is another tool that assesses for suicidal thoughts and behaviors (Horowitz et al., 2001). The RSQ investigates an individual’s current suicidal state, previous suicidal thoughts and behaviors, and current stressors (Horowitz et al., 2001). For this tool the developers chose to only include four questions to address each area, thus

the assessment time is very brief and concise. One limitation is that the RSQ is not available in languages aside from English.

A study conducted by Betz and colleagues (2013) investigated the knowledge and attitudes of emergency department providers in regards to treating and screening individuals with suicidal thoughts. They found that the participants reported gaps in skills for assessing and counseling individuals with suicidal thoughts (Betz et al., 2013). Additionally, the providers reported that they were skeptic about their abilities to prevent suicide in patients (Betz et al., 2013). In sum the study highlighted the notion that emergency department providers do not believe they are adequately trained to treat individuals with suicidal thoughts and/or gestures.

Treatment of Individuals Experiencing Acute Psychosis

Another type of psychiatric emergency that practitioners encounter in emergency departments is an acute psychotic episode. Individuals who have diagnoses of schizophrenia, schizoaffective disorder, and bipolar often experience psychosis (Keks & Blashki, 2006). Psychosis is a cognitive state that may include hallucination, paranoia, and delusions, as well as the absence of symptoms (negative symptoms). Clinicians and researchers use the terms “positive” and “negative” to differentiate between symptoms of psychotic disorders. The current psychiatric view of the cause of psychosis consists of genetics, variations in brain structures, neurochemical abnormalities, and complications in the fetal environment (McCarthy-Jones et al., 2013; Brown & Patterson, 2011). A psychotic episode refers to a particular period of time in which a client is experiencing psychosis. This episode might last anywhere from a few weeks to month (Compton & Broussard, 2009). Individuals who are experiencing episodes of a psychotic

disorder are often confused and frightened. The first psychotic episode usually occurs around late teens and early twenties (Kessler et al., 2007). Approximately 3% of the population will experience or have experienced psychosis (Perälä et al., 2007). A psychotic episode may occur when an individual is suffering from a psychotic disorder (schizophrenia or bipolar disorder), using hallucinogenic substances, or experiencing delirium (Corlett, Honey, & Fletcher, 2007; Heelis, Hermine, & Jackson, 2016).

When evaluating individuals with psychosis in emergency department settings, clinicians can assist clients more effectively if they obtain thorough histories of physical and mental illnesses. Often when clients are presenting with agitation, bizarre behaviors, and/or disruptive actions, emergency department workers may expedite transfers to psychiatric facilities rather than rule out medical conditions (Aghababian, 2010). To circumvent this from happening, clinicians are encouraged to conduct comprehensive exams and consult with professionals who are specialize in psychiatric conditions.

As far as evaluation of psychotic symptoms in the emergency department, very few instruments have been indicated for administration in this setting. The majority of the instruments require too much time (Dazzi, Picardi, Orso, & Biondi, 2015). Additionally, many scales that evaluate psychotic symptoms are self-administered, meaning the client would have to read, comprehend, and provide responses to each question (Cremniter, Payan, Meidinger, Batista, & Fermanian, 2001). This proves to be difficult, as most of the individuals seeking emergency services are too distressed and/or anxious to appropriately answer questions or accurately describe their symptoms. Thus, researchers have indicated a few scales that could be

administered in emergency departments including the Brief Psychiatric Rating Scale (BPRS) (Brooker, Ricketts, Bennett, & Lemme, 2007; Drake et al., 2016), and the Health of Nation Outcome Scales (Cremniter, Payan, Eidinger, Batista, & Fermanian, 2001; Dazzi, Picardi, Orso, & Biondi, 2015).

The BPRS is an instrument that was originally designed for clinicians working in inpatient settings (Overall & Gorham, 1962). This assessment tool measures global psychopathology in a semi-structured interview format. The BPRS has been researched and used extensively in American and European psychiatric facilities and has been recognized as a reliable instrument (Ohata et al., 2014).

The Health of Nation Outcome Scales is a 12 item assessment tool that measures behavior, impairment, symptoms, and social functioning in individuals with severe mental health conditions (Wing, Curtis, & Beevor, 1996). This instrument is widely used in the United Kingdom in emergency departments to assess the severity of individuals' conditions. Various researchers have investigated the reliability and validity of the scale (Pirkis et al.) and have found that the instrument had "good validity (Pirkis et al., 2005) and "adequate test-retest reliability (Orrel, Yard, Handysides, & Schapira, 1999).

After evaluation of the client has been completed and the type of psychosis has been identified, the next step is to initiate treatment. In cases in which the psychotic episode is attributed to a medical condition or substance use, the decisive treatment would be to address the underlying cause. This treatment may include medical hospitalization for delirium or monitoring the individual for the ingested substance to pass through his/her system. In cases when psychotic

symptoms are the direct result of a psychiatric condition that does not include a substance use disorder, consultation with a psychiatrist would be most appropriate. Additionally, the emergency department physician could order an antipsychotic medication or sedative to alleviate agitation and/or anxiety symptoms. For the clients who are displaying severe psychotic symptoms and pose as a danger to themselves or others or are gravely disabled as determined by a physician, inpatient hospitalizations would be necessary. An inpatient admission may be voluntary or on an involuntary basis, depending on the client's willingness and abilities to provide consent for treatment. The clients, who are not endorsing or displaying severe psychotic symptoms and do not pose risks to themselves or others, may only require outpatient treatment. In these instances, the emergency department social worker, nurse, physician, or counselor can assist the client in making an appointment at an appropriate clinic.

Psychiatric conditions co-morbid with medical conditions.

Traditionally, the majority of health care has consisted of services provided in a primary care setting by physicians trained in the medical model. Intuitively, the treatment that these practitioners administer consists of medication consultations, procedures, and advice (Sperry, Brill, Howard, & Grissom, 2013). Individuals with mental illnesses experience significantly higher rates of medical co-morbidity when compared to the general population (Harris & Barraclough, 1998; Wahlbeck et al. 2011). Researchers have attributed these elevated rates to poor health care (Disability Rights Commission, 2006) and “diagnostic overshadowing”, or misattribution of physical symptoms to mental illness symptoms (Jones, Howard, & Thornicroft. 2008).

A study conducted by Van Nieuwenhuizen and colleagues (2013) investigated the recognition of diagnostic overshadowing among emergency medical personnel and potential factors that contributed to diagnostic overshadowing. They interviewed 25 emergency department clinicians and qualitatively analyzed their responses. The team found that factors that contributed to diagnostic overshadowing included problems of knowledge about mental illness, clinicians' attitudes towards individuals with mental illnesses, difficulties in working with mental health services, and avoidance of individuals with psychiatric diagnoses (Van Nieuwenhuizen et al. 2013).

Another study conducted by Weber, Cowan, Millikan, and Niebuhr (2015) investigated morbidity and mortality from general medical conditions among individuals with the diagnosis of schizophrenia. The team found that individuals with primary diagnoses of schizophrenia were three times more likely to experience hypothyroidism, metabolic disorders, and chronic obstructive pulmonary disease. These high rates of general medical conditions may be due to engagement in unhealthy behaviors, low socioeconomic status, and side effects of psychotropic medications. The findings from this study may encourage medical personnel to attain knowledge of risks of comorbid psychiatric and general medical conditions (Weber, Cowan, Millikan, & Niebuhr, 2015).

Bereavement.

Emergency department personnel encounter death more frequently than most other departments in hospitals. Deaths that are the results of accidents or other unforeseen circumstances are generally unexpected and can cause prolonged grief and psychological issues

(Raphael, 1977). Despite common perceptions of emergency departments as settings for constant resuscitations and near-death experiences, most of the patients who are admitted from the emergency department and die in the hospital are on existing dying trajectories (Zalenski & Compton, 2004). The emergency department has increasingly become the referral site for individuals at the very end-of-life who are seeking support, advice, and symptom control. In addition to treating sudden, unexpected deaths, emergency department personnel are seeing patients who require medical assistance with pre-existing health conditions from which they will most likely die (Bailey, Murphy, & Porock, 2011). Consequently, emergency department workers often are confronted with the tasks of consulting and at times counseling deceased clients' families and loved ones.

Clients and their families who experience loss in a confusing environment may experience difficulties both mentally and physically (Byrne & Raphael, 1997; Holland, Currier, & Neimeyer, 2006; Parkes & Prigerson, 2013; Prigerson et al., 1997; Walters & Tupin, 1991). Individuals who recently experienced the death of a significant other are more vulnerable to developing depressive symptoms (Heberman, Mash, Fullerton, & Ursano, 2013), separation anxiety (especially in children) (Kaplow, Saunders, Angold, & Costello, 2010), and substance abuse issues (Kaplow, Saunders, Angold, & Costello, 2010). To circumvent these repercussions, various researchers developed suggestions for practitioners who work with families who lost a loved one. Neria and Litz (2004) found that individuals who had received the news about an unexpected death were not able to process the information or generate a meaningful interpretation of the event. Thus, demonstrations of care and concern could be the only

meaningful form of communication in the immediate aftermaths of a loss (Kissane & Bloch, 2002; Penninx, Leveille, Ferrucci, van Eijk, & Guralnik, 1999). Other interventions include programs that offer bereavement care to the families up to 13 months after their loved one had passed away (Simonsen & Cooper, 2015).

Crisis Counseling

In the psychiatric field, the concept of crisis has become an umbrella term for a variety of situations and experiences. In some instances, the term refers to personal catastrophes, developmental changes, behavioral health emergencies, natural disasters, and interpersonal conflicts (Callahan, 2009). Crisis events can include suicidal ideations and attempts, instances of physical violence, acute psychotic episodes, and homicidal thoughts (Echterling, Presbury, & McKee; Roberts, 2005). The pervasiveness of crisis has been examined on a national scale by the National Institute of Mental Health (2011). The report indicated that 48% of adults living in the United States will experience or lived through a traumatic loss, severe depression, anxiety, or another psychiatric emergency (National Institute of Mental Health, 2011).

Individuals who experiences crises may experience secondary symptoms following the trauma. Crises may throw individuals into states of disequilibrium and demonstrate symptoms of depression and anxiety (Callahan, 2009). Additionally, individuals who experienced or gone through crises may exhibit signs of acute stress disorder (ASD), which is characterized by depersonalization, amnesia, and depressive symptoms (Morgan III et al., 2015). ASD can manifest within two days of the experience of a traumatic event or crisis, and may develop into posttraumatic stress disorder (PTSD) (Bryant, Harvey, Guthrie, & Moulds, 2000). The American

Psychiatric Association identifies ASD as a condition preceded by a traumatic event which may include symptoms of negative mood, dissociation, sleep difficulties, distressing memories of the event, or exaggerated startle responses (2013). For the diagnosis of ASD to be made the individual must have experienced the distressing symptoms within one month of exposure to the stressful event (APA, 2013). After an individual has experienced symptoms related to witnessing/enduring a traumatic event for 30 days, then she/he may meet criteria for PTSD. Indicators for PTSD may include nightmares, intrusive thoughts, social isolation, or hyperarousal (APA, 2013). Both of these conditions can lead to significant impairments in individuals' lives and are the direct result of a traumatic event.

Crisis and trauma are two discrete, yet related terms as they often appear together throughout literature. Trauma can be defined as a normative response to extraordinary events (Echterling, Presbury, & McKee, 2005). Trauma is a mindset directly resulting from experiencing abuse, violence, or witnessing a disturbing event, such as a murder (Everstine & Everstine, 2013). Callahan (2009) identified two types of traumatic events: Type I and Type II traumas. Type I trauma is a single event that individuals encounter in one instant, whereas Type II trauma consists of perpetual exposures to abuse or traumatic events (Callahan, 2009).

In contrast, a crisis is not necessarily grounded in trauma. A crisis situation is described as an instance when an individual's thoughts and emotions are destabilized (Echterling, Presbury, & McKee, 2005; Everstine & Everstine, 2006; Roberts, 2005). The majority of counselors will encounter an individual in crisis. Various researchers have concluded that counselors have no difficulty in identifying situations in their careers when encountering clients

in the middle of crises (Corey, Haynes, Moulton, & Muratori, 2014; Dupre, 2011; McAdams & Keener, 2008). Counselors, depending on their practice settings, may routinely face situations that demand immediate responses. These circumstances include individuals who are currently experiencing suicidal thoughts, displaying violence, or being victimized (Kleespies, 2009). Individuals usually seek out counseling when situations in their lives reach critical points.

In response to these crisis situations, clinicians and researchers developed a number of crisis intervention models. The bulk of these are founded on the Caplan's crisis theory that was developed in 1964. Caplan (1964) posited that the two tenants are present in most crisis situations including: (1) crises have discrete beginnings or precipitating events and (2) crises are time-limited phenomena. This theory has provided researchers and practitioners with foundations in which they developed interventions.

The primary crisis intervention models that are utilized by emergency personnel and counselors who encounter crises include Roberts' seven-stage model (2005), Cavaiola and Colford's (2010) short-term encounter method, and Echterling and Stewart's (2008) integrative approach. Roberts (2005) developed a seven step crisis intervention approach that he applied to crises including school violence, stalking, and divorce. Cavaiola and Colford (2010) conceptualized crisis intervention as a short-term encounter aimed at restoring a state of equilibrium with the client who is in crisis. They presented a model that involved listening, assessing, planning, and committing (LAPC) that could be used in situations that involve interpersonal violence, child abuse, individuals experiencing suicidal thoughts, and traumatic losses (Cavaiola & Colford, 2006). Finally, Echterling and Stewart (2008) presented an approach

that integrated attachment theory, family systems theory, and elements of play therapy. All of these theories of crisis intervention provide clinicians with guides for approaching individuals experiencing crises as well as conceptualizations of clients' distress.

Existing Treatment Models Including Counselors

Psychiatric visits to emergency departments are recurring challenges to providers and the individuals receiving services. In the United States, very few emergency services incorporate counselors into the frontlines of treatment. The clinicians who have the opportunity to work in emergency departments treat individuals of all ages who present in different states of distress. Emergency responses to psychiatric crises usually involve the collaboration between counselors, social workers, police officers, family members, and emergency department personnel (Everstine & Everstine, 2006).

Treatment models that include counselors in their protocols include Family-Based Crisis Interventions (FBCI). This intervention was developed by Ginnis, White, Ross, and Wharff in 2015. The team first investigated this approach with a pilot study that focused on adolescents who were experiencing suicidal thoughts in emergency departments. FBCI consists of the following steps: (a) psychiatric evaluation of the client; (b) psychoeducation of the presenting mental health condition; (c) cognitive behavioral therapy (CBT) techniques; (d) safety planning; (e) reassessment of the client; (f) treatment planning; and (g) disposition (Ginnis, White, Ross, & Wharff, 2015). The first step in the FBCI model is a psychiatric assessment conducted by a trained clinician or physician. The evaluation would examine different areas of the client's life including mental health treatment in the past, previous diagnoses, current medications, and

relationship statuses. The next step occurs with the clinician providing psychoeducation about depression and suicidality to the caregivers and the client. At this point the professional would draw from the client's narrative and generate parallels between the client's symptomology and facts about depression (Ginnis, White, Ross, & Wharff, 2015). The third phase of the model consists of employing CBT techniques, which are empirically supported in decreasing depressive symptoms (Klein, Jacobs, & Reinecke, 2007; Spirito, Esposito-Smythers, Wolff, & Uhl, 2011). CBT is a type of theoretical approach that focuses on the links between cognitions, behaviors, and thoughts (Dobson & Dobson, 2009). Many researchers demonstrated the efficacy of CBT in treating major depressive disorder (Dobson & Dobson, 2009), generalized anxiety disorder (Barlow, Rapee, & Brown, 1992), panic disorder (Barlow, Gorman, Shear, & Woods, 2000; Shurick & Gross, 2013) and substance use disorders (Hofmann et al., 2012). FBCI utilizes cognitive restructuring, behavioral activation, and problem-solving skills to positively impact the client's mood (Ginnis, White, Ross, & Wharff, 2015). Cognitive restructuring refers to a clinician assisting a client in identifying negative thoughts, such as "I'm not worthy," and developing positive replacement thoughts (Burns & Maritz, 2015). The concept of behavioral activation consists of a client engaging in activities that are associated with positive feelings (Chang, Kahle, Elizabeth, & Hirsch, 2014). The last CBT technique that FBCI incorporates is problem-solving. Problem solving consists of identifying the problem, creating possible solutions, attempting one of these solutions, and employing other solutions if one does not work (Chen, Jordan, & Thompson, 2006). This is a concrete strategy that families can utilize to alleviate anxieties and provide a framework to refer to in future crises.

The next portion of the model is one of the most important aspects. Safety planning involves developing a detailed strategy to ensure personal safety and teaching the individual's parents or care givers about how to help the individual maintain safety (Ginnis, White, Ross, & Wharff, 2015). During the safety planning phase of the intervention, the clinician will reassess the individual for indicators of suicidal thoughts/plans or intentions to engage in self-injurious behaviors. If the clinician finds that the client is not at risk to herself or others, then the intervention protocol will continue. Following this step is treatment planning in which the clinician, the individual who experienced a mental health emergency, and his/her caregivers decide on a specific plan for future treatment. This can include making an appointment with a psychiatrist and counselor or pursuing a day treatment program. Once the treatment plan is developed and agreed upon by all parties, the clinician will provide emergency contact information including the numbers to crisis lines in the event of another mental health emergency.

Need for Multidisciplinary Approaches in Emergency Rooms

At times emergency department personnel may feel that they are not adequately prepared to work with individuals with significant psychiatric issues. Individuals with mental health issues usually experience difficulties in their physical health and social interactions. These difficulties can be addressed by a wide range of services provided by multidisciplinary teams (MDTs). Members of a multidisciplinary team may include psychologists, counselors, social workers, physical therapists, and occupational therapist in addition to doctors and nurses (Mental Health

Commission, 2005). One of the main advantages of MDTs is that it combines efforts of each discipline culminates to a comprehensive approach to client care.

In a study conducted by Plant and White (2013), a qualitative inquiry aimed to capture the experiences of emergency department nurses working with individuals with psychiatric issues. The team utilized focus groups to explore and generate descriptions of their experiences in caring for clients with mental health needs. The team found that the phenomenon of powerlessness was the overarching theme in the study. The participants reported that they “did not know” how to care for clients with mental health complaints. These findings were similar to other studies’ conclusions that highlighted the lack of nurses’ knowledge about mental health care (Happell et al., 2002; Sharrock & Happell, 2006). Implications from these studies (Happell et al., 2002; Plant & White, 2013; Sharrock & Happell, 2006) include: implementing educational seminars about psychiatric topics, including more training in psychiatric assessments and treatment in nursing schools, and designating separate areas in emergency departments specifically for psychiatric complaints.

Summary

Chapter Two provided an overview of the relevant literature and established a context for the study. The chapter began with background information about emergency departments and their evolution. A presentation of mental health emergencies and treatment protocols were then presented. Additionally, mental health issues in medical settings were discussed as well as counseling services including crisis counseling. The chapter synthesized literature across a number of topics including emergency department protocols, mental health emergencies, crisis

counseling, and barriers to services. The review underscored the gaps in the literature related to emergency personnel's training in working with individuals with mental health crises. The study utilized a basic qualitative design to capture the essence of the experiences of emergency department personnel. Chapter Three includes an introduction to the study, sample collection procedures, data collection, assurance of trustworthiness, data analysis, and efforts to ensure confidentiality.

CHAPTER THREE: RESEARCH DESIGN

Organization of the Chapter

Chapter Three begins with an introduction to the study and a brief review of the literature. Next the purpose of the study, research question, and sub-questions are presented. The study's theoretical sensitivity will be explained along with the research design and timeline, which lays out how the research was conducted. In addition to the overview of the research design, site, sample, and selection of participants will be detailed. Next, research ethics will be reviewed and followed by a discussion about depth versus breadth in qualitative research and the study's theoretical framework.

Data collection methods will be reviewed including an overview of various tools utilized in the study. Following the methods discussion, the researcher's role management is explained as well as the management and recording of data. Next the standards for trustworthiness are explained. Finally, the study's evidentiary inadequacies as well as a summary of the chapter will be presented.

Introduction

For the purposes of capturing the essence of the phenomenon of interest, I chose qualitative methodological approach. Qualitative research provides insights into the perpetually changing characteristics of various populations by seeking answers through the viewpoints of participant experiences. According to Creswell (1998), qualitative research is:

an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting (p. 15).

Qualitative research can be described by its capacity to provide deeper meanings, enrich situational descriptions, and divulge lived experiences (Mack, Woodson, MacQueen, Guest, & Namey, 2005). The study's direction is guided by a central question accompanied by subquestions that are intended to investigate, extend, and address the problem. These questions were designed to address the purpose statement that the researcher sought to answer in her study (Creswell, 2002).

Statement of the problem

Limited studies have examined the experiences of emergency department workers in regard to their treatment and stabilization of individuals with mental health needs. Furthermore, few research endeavors have investigated the treatment protocols and prior training for emergency personnel who work with psychiatric emergencies and mental health issues.

Focus of the Study

A qualitative phenomenological research method was utilized in effort to investigate the phenomena of treating mental health issues in emergency departments. The use of this method afforded the researcher with potential for understanding medical personnel's experiences and perceptions of mental health needs in context of emergency department care. Additionally, the qualitative method provided a rich description of the study's participants' viewpoints and insights. A quantitative methodology was not chosen for this study because this would have limited the potential understanding of these perspectives and missed the participants' experiences (Patton, 1990).

The purpose of the qualitative phenomenological study was to explore the lived experiences of ten emergency department personnel who have worked with clients with mental health needs and their treatment of individuals presenting with complaints associated with psychological emergencies. Investigation of the topic revealed information that could assist emergency personnel in addressing mental health issues, as well as identify potential biases in conceptualization of cases. Furthermore, the study detailed the staffs' training in working with individuals with mental health needs.

Research Question

How do emergency personnel who have worked with individuals with mental illness describe their lived experiences?

Research Sub-questions

1. How do emergency department professionals provide treatment for individuals with mental illnesses if the primary complaint was specifically related to their psychiatric condition?
2. How do emergency department professionals describe their training for working with individuals with mental health needs?

Research Design and Timeline

To ensure that all elements of the phenomenon were captured a variety of strategies were employed. Lincoln and Guba (1985) posited that prolonged and persistent engagement are both necessary elements to assure trustworthiness of the study. Prolonged engagement refers to the researcher remaining in the field for an extended period of time. Persistent engagement

encompasses inspecting elements of the data for inconsistencies. For the purposes of the study, surveying and studying various emergency departments were crucial to ensure trustworthiness of the study. I had witnessed and participated in various psychiatric screenings of individuals in many emergency departments over the past three years. Additionally, I had observed triages and medical procedures at the emergency departments where the participants were employed. Over the past three year I had consistent contact and interactions with the emergency departments.

Approval to conduct the study was obtained from the University of Arkansas Institutional Review Board (IRB, see Appendix B). The application for IRB approval encompassed the following areas: the study's description, data collection procedures, funding requirements, potential risks to participants, and confidentiality agreement. The data collection process began with the initial scheduling of interviews. The participants included ten emergency personnel that had worked in the emergency department and had treated individuals with mental health issues. Permission was attained by the participants signing informed consent forms prior to the interview processes. Each participant was provided with an incentive of fifty dollars. I utilized face-to-face interviews with semi-structured formats in order to collect data.

The study included two rounds of qualitative interviews that last approximately forty-five minutes. The choice to perform two sets of interviews was based on a few considerations. As Leech and Onwuegbuzie (2007) indicated, words that are shared in interviews are merely sample units of data that signify the total number of words from the speaker. In order for the listener to understand the individual's experiences an adequate number of words must be collected. Additionally, the study's area of interest has not been thoroughly examined in a qualitative manner.

I chose to utilize two interviews to ensure that the participant generated enough data to reach saturation.

Site and Sample Selection

The current study participants were emergency department staff members of two hospitals located in a specific area. The interviews were conducted either in person in a private area or over a secure internet interface. The hospital's administration and emergency department leadership members had been presented with an overview of the study and IRB approval from the University of Arkansas. Each hospital provided permission to conduct research and collect data from the emergency department staff (Appendix F).

Participants

Purposeful sampling was utilized in the study that identified participants who could appropriately describe their experiences with the phenomenon (Gall, Gall, & Borg, 2007). A purposive sampling strategy enables the researcher to select the most productive sample needed to answer the research question (Alvesson & Sandberg, 2011). For the purposes of the study the sampling technique was chosen to identify "information rich cases" (Merriam, 2009; Patton, 2002). Specific inclusion criteria were determined to distinguish emergency personnel who were able to contribute to understanding the essence of the phenomenon. I followed the recommendations of LeCompte and Preissle (1993) to generate a list of critical participant attributes that reflected the purpose of the study.

The inclusion criteria were:

1. Employment part-time or full-time in an emergency service department or employment in a position that involves treating clients in an emergency department
2. Spend at least 50% of work hours providing direct services to clients;
3. Expressed desire and ability to participate in two qualitative interviews either in person or over web-based technology.

I selected these criteria for two reasons. First the study's primary purpose is to capture the essence of the emergency department and service personnel's experience. Because emergency departments and services employ a variety of professionals, there was a significant amount of variation in the type of training among each employee.

Research Ethics

When working with studies that utilize human subjects, the National Commission of the Protection of Human Subjects of Biomedical and Behavioral Research (1979) were adhered to. The commission identified three major focus areas were concerned with protecting human subjects including: respect for individuals, beneficence, and justice (U.S. National Commission of the Protection of Human Subjects of Biomedical and Behavioral Research, 1979).

In regards to the issue of respecting the individual, researchers are prompted to provide their participants with information and choices in light of the study. For the current study, I provided all participants with a document of informed consent, that detailed the study's purpose, procedures, confidentiality, and potential risks and benefits of participation. The information in the document was thorough and provided the participant with adequate material for the

participant to make an informed decision about joining the study. Additionally, the informed consent utilized language that was easy for the participant to comprehend.

Another area that the commission identified as of utmost importance is that of beneficence. Beneficence is the responsibility of the researcher to promote the welfare of their participants by both doing good and avoiding harm (Shahian & Normand, 2012). For the study I anticipated minimal risks, which included the possibility of feeling a decrease in competence. Additionally, participants may have had concerns that upper management would have discovered potential lack in competencies when working with individuals with mental health issues. To address these risks, I reiterated that all data was confidential and reviewed the efforts that I took to ensure confidentiality and security. Benefits of the study included an increased awareness of the need for more training when working with individuals with mental health issues. The Institutional Review Board (IRB) for the University of Arkansas approved the submitted study protocol (Appendix B) and as indicated by other research committees at each hospital, necessary IRBs approved the study protocol prior to initiation.

Finally, the area of justice was addressed in the study. Justice in research studies refers to the notion that participants must be treated fairly and the benefits and risks of the studies must be evenly distributed in a fair and just manner (Howell et al., 2014). In the current study, participants were invited to enroll based on purposive sampling. Consequently, not a single group experienced more burdens or benefits when compared to other groups (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979)

Prior to enrolling in the study, each participant was provided with a copy of the informed consent paperwork that included a description of the purpose of the study, an explanation that the participant was a part of a doctoral dissertation study, an overview of how the study findings will be utilized, assurance of confidentiality, and clarification that his/her participation is voluntary. These steps were taken to protect participants from any ethical violations associated with the collection and use of the study data.

Depth vs Breadth

The emphasis in qualitative studies is on depth and detail. This approach provides descriptive, rich data as opposed to a quantitative approach that would focus more on the breadth of data. The researcher chose to conduct a qualitative study in order to provide depth of a few participants' experiences with attention to detail and context in effort to explore the phenomenon.

Data Collection Protocol

I collected study data in several stages to ensure credibility. Two rounds of semi-structured interviews that lasted approximately 45 to 60 minutes in length were conducted. Ten individuals who worked in emergency personnel roles were identified as participants during the selection process. For each stage, I presented how my observations and interview questions helped answer the main research question and sub questions. In some instances, the same interview questions were repeated for clarification of the participants' responses. The time frames for the interviews were: Round 1, May and June 2016 and Round II, May and June 2016.

I provided each participant with an opportunity to meet me in a private location that was convenient and secure.

I used an electronic audio recorder to capture all of the interviews. After each interview, the audio recording was uploaded to my personal computer, that requires two passwords to log in to and is in a secure location. After the transmission was completed, the original audio file on the recorder was deleted. To prevent data loss or corruption, the copy on the computer's hard drive was routinely backed up on a password protected external hard drive,

During each interview, I recorded process notes in my researcher's journal while the participant was speaking. These notes included any additional comments that the participant had that were not related to the interview questions and procedural observations. Additionally, I reviewed the audio clip within twenty-four hours and made additional notes about the content of the interview in my researcher's journal.

The interview was transcribed verbatim and the participant was given a copy of their transcript by hand. They were given the manuscript at least seven days prior to the second round of the semi-structured interview. This step afforded them opportunities to clarify answers, ask additional questions, and amend the document. The second interview was also recorded and uploaded in a similar manner as the first interview. The participants were given a copy of their transcript approximately seven days after the second interview and I asked for them to provide me with any changes or clarifications that needed to be amended.

Interviews

In qualitative research, interviews are not simply used to get answers to questions or confirm hypotheses. Rather they are utilized to gain in-depth understandings of the lived experiences of others. Patton (2002) identified five different types of person to person interviews: informal conversational interviews, guided approach interviews, standardized open-ended interviews, and closed, fixed-response interviews. According to Leedy and Ormrod (2005) the preferential method for collecting data in phenomenological studies is interviewing participants. With this approach the researcher does not ask any specific questions but depends on the participant to guide the interview process (McNamara, 2008). Researchers consider this type of interview to be of benefit because the lack of structure facilitates free flowing conversation (Crewswell, 2002). This informal approach to interviews is helpful when a researcher is in the field and is unaware of what will happen, who will be present, or what direction the questions needs to go. A few problems with this type of interview may occur, including the amount of time required to collect the data, difficulty when analyzing the data, and potential for biases.

The second type of interview that Patton (2002) identified was the general interview guide approach. This style is slightly more structured than the informal approach but in some aspects there is flexibility. The interview guide approach includes identification of topics that are explored during the interview. According to McNamara (2009) one of the strengths of this approach is the researcher's ability "to ensure that the same general areas of information are collected from each interviewee; this provides more focus than the conversational approach, but

still allows a degree of freedom and adaptability in getting information from the interviewee” (Types of Interviews section, paragraph 1). A general interview guide approach is a helpful avenue for the researcher to remain on track during interviews,

The third type of interview that Patton (2002) identified is the standardized open-ended interview. With this approach, the researcher identifies specific questions and decides on the wording prior to interacting with the participant. The participants are always asked the same questions but are able to answer in an open-ended fashion (Gall, Gall, & Borg, 2003). One of the weaknesses with this approach is the difficulty with coding the data (Creswell, 2007). Due to the nature of the open-ended interviews, the participants express their responses in as much detail as possible. Although the data generated by the participants is rich and thick in open-ended interviews, the researcher may find it difficult to sort through the responses in effort to generate an overall perspective of all interview answers during the coding process (Creswell, 2007). Alternatively, Gall, Gall, and Borg (2003) suggested that the varying responses to the open-ended questions reduces researcher biases.

The final type of interview that Patton (2002) described is the closed fixed-response interview. This particular interview collects data from a survey format, usually aimed at gathering demographic data. The main advantage of the closed fixed-response interview is ease of analyzing the data. Contrastingly, the weaknesses of this type of interview include depersonalization of answers, influences of the researcher’s grouping of questions, and distortion of answers due to limited categories.

In addition to the aforementioned interview types identified by Patton (2002), semi-structured interviews are utilized for data collection. These interviews consist of predetermined questions that facilitate the exploration of different key areas and also provides the interviewer opportunities to diverge from the inquiries to clarify a response or pursue an idea (Britten, 2007). The particular interview approach is frequently utilized in healthcare studies due to the allowance for the discovery or elaboration of information provided by participant that may not have been thought relevant by the researcher (Gill, Stewart, Treasure, & Chadwick, 2008).

The current study utilized a semi-structured open-ended interview format for data collection. When examining the phenomenon, I was interested in learning about the experiences, behaviors, thoughts, and feelings of emergency department workers who treated individuals with mental health issues. In order to elicit information from participants, I developed interview guides that consisted of specific questions within an adjustable format.

Round I interview protocol. Prior to beginning the interview process, I provided the participants with a summary of the purpose of the study and informed them that the University of Arkansas Institutional Review Board had provided approval for the study. Next I reviewed the informed consent form that had previously been presented to the participants and signed. Following this review, I began to ask the participant different questions about their demographics (Appendix D). I assigned a number to each participant and recorded this number on every form, transcript, and process note that corresponded. The number was randomly generated and did not reflect any of the participant's identifying characteristics.

Next the first semi-structured interview began. Prior to starting the recruitment process, I developed a structure for Round I and II interviews (Appendix E and F), which was based on the literature review. The first part of the interview consisted of reading the following prompt: I am interested in the process of treating an individual with mental health issues in the context of an emergency setting. I am using the term “mental health issue” to refer to the experience of suicidal thoughts, psychosis, trauma, bereavement, and family crises. I would like for you to remember a time in your career when you were treating or working with a client who was experiencing mental health issues. For the purposes of this interview, please identify a situation that occurred when you were working in the emergency department and that you feel comfortable in sharing with me.

The first interview questions for the study were as follows:

- Describe the situation in as much detail as possible.
- How would you describe the chief complaint of the individual in the situation?
- Describe your reactions to this situation.
- Describe the steps that you took to address the situation.
- What lessons did you learn from this experience?
- Describe the training that you have received specifically for treating mental health issues in an emergency room setting.
 - What elements do you utilize when encountering individuals with mental health issues?

- As you look back now, what may have been missing in your training for treating individuals with mental health issues?
- What suggestions do you have for future emergency workers who may encounter individuals with mental health issues?
- Are there certain mental health services that you think are lacking in the emergency department that you work in?
- Is there anything else that you would like to comment?
- What has it been like to talk about your experience?

I asked the participants to verbally attest that they understood these instructions and were ready to proceed. Next the participant was asked questions that appeared on the interview guide. The precise words and order of the questions changed in accordance with Charmaz's (2006) indications for effective interviewing. Frequently the participant spontaneously provided information about the phenomenon without encouragement. Once all of the questions had been asked, I concluded the interview by asking the participant if he/she would like to add anything that was not covered. Following this inquiry, I concluded the interview by turning off the recorder and thanking the participant for providing information. The second interview was scheduled for the following month.

Round II interview protocol. The second interview centered around clarifying any questions about information the participant shared in the first interview and elaborating on his/her answers. An interview guide was developed for the second interview and questions were presented to the participant in a similar manner as the first interview. The second interview

concluded with a reiteration of the efforts to ensure privacy and confidentiality and compensation for the participant.

The second interview questions include the following:

- As you look back on our first interview, is there anything that stands out in your mind?
- Is there anything that you would like to add to our previous discussion about treating individuals with mental health issues?
- Is there anything that you would like to ask me at this point?
- During our first interview you described your experiences and training in working with clients experiencing mental health issues. Would you mind saying more about:
 - (specific theme identified during data analysis)
 - (specific theme identified during data analysis)
 - (specific theme identified during data analysis)
 - (specific theme identified during data analysis)
 - (specific theme identified during data analysis)
- Additional themes emerged from other interviews conducted during the first round.

Would you mind sharing your thoughts about:

(specific theme identified during data analysis)

- (specific theme identified during data analysis)
- (specific theme identified during data analysis)

- What do you think are the most important elements when treating an individual with a mental health issue in the emergency department?
- Is there anything else that you think would be helpful for me to know to understand the experiences of emergency department personnel who work with individuals with mental health issues?
- Is there anything else that you would like to ask me?

Observations. Observations refer to the examinations of actions and interactions of participants. The purpose of field observations is to note and record environmental elements related to the phenomenon directly and prospectively (Giacomini, Cook, & Evidenced-Based Medicine Working Group, 2000). Observations are differentiated from interviews in that the researcher is witnessing where the phenomenon of interests naturally occurs as opposed to an interview setting and the researcher is experiencing the phenomenon as a firsthand encounter (Merriam & Tisdell, 2015). For the purpose of the study observational data included overt acknowledgements of actions and nonverbal cues being recorded and covert surveillances. Covert surveillances involve recording data in which the participants are not aware of the researcher's presence. Both of these methods simultaneously allowed the researcher to examine surface level actions as well as the ability to look beyond the obvious and see things that may be taken for granted by the participants. According to Merriam and Tisdell (2015), the process of collecting data through observations can be divided into three stages: obtaining entry, data collection, and exiting the field. Gaining entry into a specific research location begins with obtaining permission from the governing body that can approve the activity. This can consist of

contacting the ethics board of a particular site or obtaining permission through the site's manager or supervisor. For the purposes of this study I contacted the sites' regulatory boards to obtain permissions to conduct research and provided them with copies of the IRB approval as well as copies of the informed consent forms. The second stage of observation process is data collection. This can consist of recording or writing down different aspects of the phenomenon or having conversations with individuals in a particular setting. For the purposes of this study, I spent over one hundred hours observing and recording different elements of the emergency departments that will be described in the following paragraph. Additionally, I had casual discussions with various medical personnel about various aspects of the setting. The final stage of the observation process is exiting the setting. Patton (2002, p. 323) recommends that researchers consider "an exit or disengagement strategy." My disengagement strategy included notifying the sites that I was wrapping up the study approximately two weeks prior to termination.

The following areas were the foci of my observations: the physical setting, individuals present, activities in the setting, conversations, nuances, and my own behaviors. Initially for observations, I made detailed notes about the physical environment including how the space was allocated, different medical equipment that was present, the layout of the emergency department, and locations of where emergency department personnel travelled during their shifts. Additionally, I noted who was present at the emergency department in regards to how many people were present, their roles, commonalities between professionals. While observing these aspects, I witnessed their interactions with individuals with a variety of medical ailments and at times psychological conditions. Next I observed conversations among the emergency department staff and their

conversations content. Finally, I noted the subtle factors that were present in the emergency department including informal and unplanned activities, symbolic meanings of words, nonverbal communication, and my own behavior during the observation period.

Document collection. In addition to interviewing and recording observations, various artifacts from the research sites can be helpful to the researcher in terms of comprehending the phenomenon. Documents such as charts, journals, websites, brochures, and other artifacts can provide qualitative data (Hodder 1994). Merriam and Tisdell (2015) identified six different types of documents that qualitative researchers may utilize in studies. These included public records, personal documents, cultural documents, visual documents, physical material objects, and researcher generated materials (Merriam & Tisdell, 2015). Public records include current and past records of a community's activities. Guba and Lincoln (1981) stated "the first and most important injunction to anyone looking for official records is to presume that if an event happened, some record of it exists," (p. 253). Document collection included the gathering of emergency department brochures concerning mental health, information about job descriptions of the participants, and training materials about working with mental health issues. Additionally, any mental health pamphlets that were given out in the emergency department sites were collected and included in the study.

Process notes. Throughout the study I wrote process notes during the interviews and observation periods. Additionally, I recorded notes at three different times post interview (within one hour, and after listening to the audio recordings of each interview). The process note was a form that contained four different headings to prompt my recollection of the area of interest

including: my thoughts, feelings, impressions, and questions that I had. Appendix G displays a sample process note. Additionally, at the bottom of the form, a section was assigned for me to write any potential researcher bias that may have come up during the interview. According to Merriam (2009) when a researcher writes detailed process notes, this encourages the researcher to examine one's biases, ideas, and assumptions. Process notes were kept in a secure location and stored along with other research documents.

Managing and Recording Data

Since qualitative data usually consists of participants' responses to questions, researchers must determine the method that they will utilize to record the information being presented to them. Merriam and Tisdell (2015) identified three basic ways that researchers record data including: tape recording, taking notes during the interview, and making notes of the interview after it has concluded. For the purposes of this study, I utilized a digital recorder to capture the participants' responses and took notes during the interview. All data was collected and stored in a secure, double-locked facility and only the researcher had access to the records. The printed transcripts of each interview were kept in a locked file in the investigator's office. To assist in protecting confidentiality of personal information, the researcher limited the personal identifiers collected and stored in the research record. The audio tapes were de-identified and uploaded onto a protected external hard drive that was locked in a filing cabinet at the researcher's office. All electronic research records were maintained on a secure, stand-alone computer not connected to any networks and accessible only to the researcher. Additionally, the electronic files were encrypted as required

by the University of Arkansas's Office of Research Compliance. All data sets for data analysis were de-identified and accessible only to the researcher.

Researcher's Role Management

In qualitative studies, the researcher is the research instrument through which data is collected (De Vos, 2002). Five different types of research participation are indicated for qualitative research studies. These include complete, active, moderate, passive, and nonparticipation (Spradley, 1980). For the purposes of the study I assumed a passive participant role, which meant that I was at the scene of the action but did not participate or interact with others. As I am not a medical professional and I did not conduct activities for the participants to engage in, I was simply a part of the background. During the interviews, I observed manners in which the participants responded to questions as well as listening their statements.

Theoretical Position

Phenomenology is a qualitative research methodology that aims to understand the meanings of human experiences. Contributions of various philosophers and researchers have contributed to a phenomenological approach in research. Qualitative phenomenological research methods are grounded in the aforementioned principles. The purpose of a phenomenological study is to obtain data that captures the essence of the participants' experiences in an area of interest (Giorgi, 1997). The researcher's goal in a phenomenological study is not to interpret data or develop theories. Rather, the main objective is to unbiasedly describe the essence of the phenomenon (Giorgi 1997).

Phenomenology has three distinct categories: the descriptive phenomenology of Husserl, the hermeneutic phenomenology of Heidegger, and the existentialist phenomenology of Merleau-Ponty (Holloway & Wheeler, 2013). For the purposes of the study, only Husserl's approach to phenomenology will be discussed. Phenomenology began with Husserl, who was one of the main developers of this movement. Husserl's main contributions to the phenomenological field included the concepts of intentionality (Langridge, 2007), essences (McAuley, Duberley, & Cohen, 2000), and phenomenological reduction (Churchill, 2000). In Husserl's view, intentionality is "the essential feature of consciousness" which is channeled toward a particular target. As long as an individual is conscious, he/she is always aware of something. When investigating essences of phenomena, Husserl said that the individual's main objective is to understand the core meanings "mutually understood through a phenomenon commonly experiences" (Patton, 2002 p. 106). The third main contribution that Husserl generated was the notion of phenomenological reduction or bracketing (Churchill, 2000). He suggested that an individual needed to "bracket" out the outer world and biases in efforts to achieve understanding of the essence. In order to achieve this objective viewpoint, one must suspend his/her judgement about a particular phenomenon (Morrow, Castaneda-Sound, & Abrams, 2012).

Wertz (2005) identified four basic principles of phenomenology that included a psychological phenomenological stance, the "intuition of the essence" of the phenomenon, intentionality and intentional analysis, and the "lived world" of the self. The first tenant of the psychological phenomenological stance refers to the researcher setting aside all scientific

knowledge about the phenomenon and engaging in self-reflection to develop an understanding of the world of the participant (Husserl, 1970). The second principle, the “intuition of the essence,” refers to the researcher’s examination of the phenomenon from every aspect (Wertz 2005). This allows the researcher to understand the phenomenon’s underlying essences through “imaginative variation,” (Giorgi 1997) that includes intuition or imagination. The third underlying principle of phenomenology is that of intentionality, which implies that the human consciousness is not distinct from the object of its awareness (Wertz 2005). The final tenant of phenomenology is that of the lived world, which extends the self into the context of the outer world (Wertz 2005; Giorgi, 1997).

The phenomenological approach was appropriate for the research question and sub-questions because it provided a framework for the study involving emergency department personnel who experienced working with individuals with mental health issues. Additionally, based on the primary research question, a qualitative approach was deemed most appropriate. The perspectives shared by personnel and the subsequent themes that emerged during the interviews may provide insight for administrators and educators who have direct relationships with emergency department workers. Implementation of the phenomenological approach allocated opportunities for shared experiences and perceptions that led to an understanding of the essence of the phenomenon. The research design supported the primary research question and sub-questions.

Trustworthiness

Researchers who are conducting qualitative studies must demonstrate that their results are honest, meaningful, empirically supported, and credible (Patton, 2002). Trustworthiness is established when a study's findings closely reflect the meanings as described by the study's participants (Lincoln & Guba, 1985). Lincoln and Guba (1985) presented the concept of trustworthiness and identified four areas that a researcher must address when conducting qualitative research. These areas include credibility, transferability, dependability, and confirmability. The credibility of a study considers whether or not the study's findings represent realistic conceptual interpretations of the original data collected from the participants. In other words, credibility refers to the assurance of the investigation was accurately proficient in identifying and explaining the purpose of the study. The concept of transferability is comprised of the extent to which the research findings are applicable and relevant beyond the limitations of the study. The dependability of a study is an assessment of the quality of the research's data collection, data analysis, and theoretical development, as well as the synthesis of the three areas. Finally, confirmability measures how accurately the findings are supported by the data collected.

Threats to trustworthiness include reactivity, biases, and inattention to important details (Padgett, 1998). In order to address these potential threats, researchers must utilize a variety of strategies in order to accurately describe results in ways that are authentic representations of what the participants are conveying (Creswell, 2002; Lietz, Langer, & Furman, 2013; Lincoln & Guba, 1985). These strategies include prolonged engagement, persistent engagement, triangulation, peer debriefing, member checks, and an audit trail (Creswell, 2002; Johnson &

Waterfield, 2004; Lincoln & Guba, 1985; Padgett, 1998). The following sections will describe each aspect in further detail.

Prolonged engagement. Prolonged engagement refers to the researcher being present in the field for sufficient time to perceive patterns in the data. Lincoln and Guba (1985) indicated that prolonged engagement is integral for assurance that researcher collects adequate amounts and types of data. For the purposes of this study I have visited emergency departments over the past two years and observed mental health needs. I engaged in developing rapport with various medical professionals at the two sites. These actions ensured that adequate amounts of interviews, observations, and field notes were included in the study.

Persistent engagement. In addition to prolonged engagement, persistent engagement is essential when conducting qualitative research. According to Lincoln and Guba (1985), persistent engagement refers to the pursuit of addressing all the data, even if the data collected does not seem to address the research study's purpose. For the purposes of the study I included data that seemed to not fit into study's focus and reported the findings in the results section.

Triangulation. Triangulation of data is an important part of ensuring trustworthiness. Triangulation refers to the use of multiple methods or data sources when understanding phenomena (Patton, 1999). Researchers have identified four types of triangulation that include: (a) method triangulation, (b) investigator triangulation, (c) theory triangulation, and (d) data source triangulation (Denzin, 1978; Lincoln & Guba, 1985; Patton, 1999). The first type of triangulation is method triangulation, which involves multiple modes of data collection when investigating the same phenomenon (Polit & Beck, 2012). This type of triangulation involves

interviews, observations, and field notes in order to add breadth to the phenomenon of interest (Patton, 2002). Investigator triangulation refers to the involvement of two or more researchers within the same study to ensure that multiple observations and conclusions are made (Denzin, 1978). Theory triangulation utilizes different theories for analyzing and interpreting data, thus assisting the researcher in supporting or dispelling findings. Finally, data source triangulation involves collecting data from different types of resources including groups, families, professionals, and communities in effort to gain multiple perspectives. For the purposes of this study, I utilized data triangulation that included observational data, interview data, and supporting documents.

Peer debriefing. Peer debriefing is another component of trustworthiness that is essential in qualitative research. This process involves providing data to the researcher's peers and having them define the data. Lincoln and Guba (1985) indicate that peer debriefing may make the researcher's interpretation of the data more credible if the peers define the data in a similar way. For the study, data reviewed with other graduate school students to ensure that I was grasping the information provided by the participants. This enhanced the credibility of the study's findings.

Member checks. Throughout the collection of data, member checking was an important part of ensuring that data was being accurately recorded. Member checking involves providing the participants with the data, categories, and interpretations of the study and eliciting feedback (Sandelowski, 1993; Stake, 2013). In the study, member checking was conducted following transcriptions so that the participants could view and respond to their own words. Each participant was sent a copy of their transcribed interview and given the option of contacting the researcher if

there were any discrepancies. During the initial interviews, questions that clarified the participants' responses were utilized informally.

Audit trail. Finally, an audit trail accomplished the task of analytic rigor. Analytic rigor is the presentation of the process in which the end-product has been achieved (Rubin & Rubin, 1995). An audit trail is an essential part of establishing rigor in qualitative studies because it describes the research procedures (Johnson & Waterfield, 2004; Padgett, 1998). The audit trail accomplishes this requirement for qualitative studies. For the study the audit trail consisted of the proposal, researcher's journal, transcripts of interviews, documented observations, and the final report. Essential the audit trail provides "tracks" that the researcher has left while pursuing an understanding of a phenomenon.

For the purposes of ensuring trustworthiness, notations were made to allow an auditory to retrace my steps if he or she wants clarification of the data or wishes to answer the question. I used notations in Chapter IV that are referenced in Table 3.1.

Table 3.1
Notations for Audit Trail

Notation	Type	Participant
N1, N6, N10	Initial Interview	Emergency Department Nurse
P2, P5, P7	Initial Interview	Police
F3, F4	Initial Interview	Paramedic/Firefighter
T9	Initial Interview	EMT
A8	Initial Interview	Paramedic
N1b, Nb, Nb	Follow-Up Interview	Emergency Department Nurse
P2, P5, P7	Follow-Up Interview	Police
F3b, F4b	Follow-Up Interview	EMS/Firefighter
T9b	Follow-Up Interview	EMT
A8b	Follow-Up Interview	Paramedic
O1-10	Observation	Interview Observations
E1-5	Observation	Emergency Room Observation

Evidentiary Inadequacies

Throughout the study, the researcher must examine data and analysis strategies for evidentiary inadequacies. Erickson (2012) identified five types of evidentiary inadequacy including: (1) inadequate amount of evidence, (2) inadequate variety in the kinds of evidence, (3) faulty interpretative status of evidence, (4) inadequate disconfirming evidence, and (5) inadequate discrepant case analysis. These areas were addressed with the use of prolonged engagement, persistent engagement, triangulation, peer debriefing, member checks, and audit trails. The first type of evidentiary inadequacy was addressed by three months of intense data collection and three years of less-intensive studies and observations in emergency departments.

A second type of potential evidentiary inadequacy is insufficient types of data. This pitfall was circumvented by conducting observations, interviews, and document collections, so that the researcher could integrate the three types of data points into analysis and the final report. Additionally, peer debriefing was employed to avoid biases in regards to interpretation of data.

The third type of inadequacy was the faulty interpretative status of data. In order to address this limitation, member-checks were conducted at the end of the study as well as throughout the interviews. Additionally, persistent engagement was used to prevent the dismissal of data that may not have seemed to fit the researcher's interpretation.

Another type of inadequacy is inadequate discrepant case analysis (Erickson, 2012). This was addressed by interviewing different participants at different site locations in order to ensure that the study had adequate discrepant case analysis.

In conclusion the issue of inadequate disconfirming evidence refers to disregarding data that might not appear to be relevant to the study. This was addressed by the researcher persistently engaging in the field as well as with the participants.

Summary

The focus of this study was the lived experiences of emergency department personnel who have worked with individuals with mental health needs. The study aimed to provide a phenomenological description of the participants' experiences. Qualitative methods were utilized to answer the main research question and sub questions. The study was conducted in stages and included observations, interviews, and document collections. Methods to ensure trustworthiness were detailed as well as strategies to address Erickson's (2012) evidentiary inadequacies. The chapter concluded with an exploration of the study's data analysis process and an overview of grounded theory.

CHAPTER FOUR: PRESENTATION OF THE DATA

Organization of the Chapter

Chapter Three introduced the qualitative research methodology used in the study as well as detailed descriptions of data collection methods. The primary research question that guided the study was: How do emergency personnel who have worked with individuals with mental illness describe their lived experiences? The primary purpose of this study was to detail the experiences of emergency workers who treat individuals with mental health needs. Two additional inquiries for the study included: (1) How do emergency department professionals provide treatment for individuals with mental illnesses if the primary complaint was specifically related to their psychiatric condition? and (2) How do emergency department professionals describe their training for working with individuals with mental health needs? The structure of this chapter will include: results from the study, a review of the research questions, data collection procedures, data analysis, and presentation of the recurring themes throughout the participants' responses.

Chapter Four includes an introduction to the study's results, information about the transcribed interviews, and descriptions of the participant. Next I presented overviews of interviews and an in-depth discussion of the data analysis procedures. I used the following pseudonyms to represent participant experiences: N1, P2, EF3, EF4, P5, N6, P7, A8, T9, and N10. Explanations of open codes and axial codes follow the presentation of the data analysis process. Chapter Four contains eight sections that detail the axial codes. Finally, a presentation

of the study's codes and axial codes brings the chapter to a close. A summary of the chapter is at the conclusion.

Introduction

The study examined the lived experiences of emergency department and service personnel workers who treated individuals with mental health conditions. The primary focus of this study consisted of understanding and detailing the lived experiences of professionals who assist in stabilization of psychiatric crises and subsequent issues stemming from mental health situations. Semi-structured interviews elicited information from the participants and provided glimpses into their experiences. I selected the participants because they worked as emergency service providers and they had interactions with individuals with psychiatric conditions. The sample consisted of ten individuals from various emergency services who responded to interview questions. I also made observations and collected relevant documents pertaining to mental health services. Individuals who participated in the study provided informed consent. The small sample size was purposeful as Patton (2002) and Creswell (2009) indicated that no concrete rules exist for sample sizes in qualitative studies; rather the goal is to attain full saturation.

I chose purposive sampling to recruit emergency service professionals in a localized area. Two rounds of semi-structured interviews captured the participants' experiences and perceptions of the phenomenon. The reports and interviews obtained from the participants were examined and analyzed in effort to develop themes and categories that are consistent for explaining the lived experience in the context of emergency personnel working with mental health crises. Data

analysis was grounded in theory.

Transcribed Interviews

Each participant completed an interview in a face-to-face predetermined location and time. The locations were private offices or spaces to ensure confidentiality and clarity. Prior to the interview the participant provided consent and received a copy of the study's protocol. Any questions that the participants had were addressed prior to beginning the interview. Throughout the interviews, participants were given the opportunity to ask questions or voice concerns about the study. I recorded each interview with a digital recorder that was password protected to ensure confidentiality of data.

After conducting each interview, I uploaded the audio file onto a password protected, secure computer. Following this step, I played the interview and transcribed word for word both the participant's responses and my questions from the semi-structured interview. Transcription involved manually typing every word into Microsoft Word. As mentioned in previous sections, I assigned each participant with a code name to ensure anonymity and confidentiality. After the initial transcription, I listened to the audio file again while reading over the written transcription in effort to correct any inadvertent errors. The interviews were casual in nature as the participants spoke in informal manners and incomplete sentences at times.

Description of the Sample

The purposive sample of this study consisted of ten emergency personnel workers who worked in a centralized location. Each participant met the study criteria previously stated in Chapter Three. I conducted ten digitally recorded, face-to-face interviews. Each recording lasted

approximately 20 to 30 minutes in duration. I chose pseudonyms to protect their identities and maintain confidentiality. I cited each quote in a style that allowed the reader to easily locate the material in the original transcript. For example, (N1,1) signifies that the first nurse is the speaker and the quote appears in Round I transcript on page 1.

Sample Demographics

Throughout the data collection procedure, I collected personal and professional information with the utilization of demographic questionnaires that each participant completed at the beginning of the interview process. The study included three females and seven males. Nine of the participants were Caucasian and one was Asian. Each of the participants had served individuals with mental health needs in an emergency setting situation. Three of the participants worked as emergency department nurses. Four participants served as EMT or paramedics and were firefighters and three others were police officers. Their years of experience within their particular profession ranged from two years to twenty years. Table 4.1 displays a summary of the study participants' demographic information.

Table 4.1

Participants' Demographic Information

Gender	Ethnicity	Profession	Time in Profession	Experience with Mental Health Conditions
Male	Asian	Emergency Department Nurse	>5 years	>5 years
Male	Caucasian	Police Officer	5 years	5 years
Male	Caucasian	Paramedic/Firefighter	10 years	10 years
Male	Caucasian	Paramedic/Firefighter	8 years	10 years
Male	Caucasian	Police Officer	5 years	10 years
Female	Caucasian	Emergency Department Nurse	>5 years	>5 years
Male	Caucasian	Police Officer	17 years	17 years
Male	Caucasian	Paramedic	10 years	10 years
Male	Caucasian	EMT	>5 years	>5 years
Female	Caucasian	Emergency Department Nurse	5-6 years	5-6 years

I chose a small number of participants based on recommendations from experts in qualitative studies (Glaser & Strauss, 2009; Mason, 2010; Patton, 2005). The criteria for study inclusion were emergency personnel positions; experiences in working with individuals with mental health conditions, and ability to provide informed consent. The following are descriptions of each participant's profile.

1. N1 is an emergency department nurse with less than five years of experience in emergency settings. The participant is a male and identifies as Asian.
2. P2 is a male, police officer who has approximately five years of experience working in emergency settings. He received an undergraduate degree in criminal justice.

3. F3 is a male firefighter and paramedic who also worked as a police officer for five years. He has over ten years of experience in working with individuals with mental health conditions.
4. F4 is a male firefighter and paramedic who has over eight years of experience in emergency settings. He worked as a dispatcher for approximately two years prior to becoming a firefighter.
5. P5 is a male police officer with over five years of experiencing in working in an emergency response capacity. He worked as a mental health paraprofessional prior to becoming a police officer.
6. N6 is a female emergency department nurse with over five years of practice in an emergency setting. She achieved undergraduate education with an emphasis in psychology.
7. P7 is a male police officer who serves as a police chief at a local department. He has extensive knowledge about crisis intervention strategies.
8. A8 is a male paramedic who oversees a local ambulance service. He has over ten years of practice in emergency settings and provides instruction to new EMT's and paramedics.
9. T9 is a male EMT who has over five years of experience with working with individuals in states of crisis.

10. N10 is a female emergency room nurse who has an undergraduate degree in nursing. She has over five years of experience in treating individuals in an acute setting.

Data Analysis

Data collection for the study included interviews with the ten participants as well as 100 hours of observations over a period of two months. The grounded theory approach was used for identifying themes related to the study's research questions. Within grounded theory a constant comparative approach generates explanations of phenomenon (Charmaz; 2006; Glaser & Strauss, 1967). In addition, it "generates successfully more abstract concepts and theories through inductive processes of comparing data with data, data with category, category with category, and category with concept" (Charmaz, 2006, p. 187).

Grounded theory is traditionally associated with sociology (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Essentially grounded theory holds that individuals engage with their environments in reflexive ways that elicit environmental responses. Furthermore, individuals' behaviors are goal directed and evolve from social interactions. The grounded theory approach aims to elicit and analyze qualitative data by identifying important categories and generating ideas and theories that are "grounded" in the data (Glaser & Strauss, 1967). I chose grounded theory because it allows researchers to develop and generate a model based on analyses of data (Creswell, 1998). Additionally, this theory allows the researcher to attain control over the data while maintaining flexibility to adapt to his or her theoretical orientation (Glaser, 1999).

Grounded theory analysis is characterized by the following: (a) initial coding or open coding, (b) focused coding, (c) axial coding, and (d) theoretical coding (Morse et al., 2009). Analysis based on grounded theory begins with a line-by-line coding of qualitative text. Within this process the researcher identifies descriptive categories that are compared for similarities and differences. Codes are usually short and will reflect the words that the participants used. After identifying each category, the researcher clusters or merges them at a more conceptual or interpretative level (Burck, 2005). Grounded theorists refer to this as focused coding. Each category undergoes analysis to further elaborate and clarify concepts. In axial coding (Strauss & Corbin, 1990), properties and dimensions are illuminated for each category. The final phase of grounded theory analysis is theoretical coding, which identifies the relationships between each category and provides a basis for articulating the theory. In sum grounded theory affords frameworks for qualitative researchers to understand human processes that are grounded in the data (Charmaz, 2006)

The current study was an investigation into experiences of emergency department personnel workers that relied on verbatim transcripts of semi-structured interviews. I listened to each interview and reviewed each transcript for every participant. Additionally, the participants proofed and verified their own transcripts during the member-checking process detailed previously.

Throughout the study, each participant provided approximately 30-40 minutes of information about the phenomenon of interest. Each interview generated a wealth of data. Elucidating and making sense of each data point is a difficult task when conducting studies. The

primary goal of qualitative studies is to generate rich, deep descriptions of the phenomenon of interest (Patton, 2002). In effort to reach this objective, I implemented prolonged engagement with the data and examined each data point as it presented itself.

Open Coding

After recording the participants' responses and interactions, the first level of analysis involved open coding of the field observation data. This consisted of sorting the data and labeling data points in order to understand the emerging themes uncovered. Multiple categories were grouped into larger themes for the purposes of data reporting (Corbin & Strauss, 2014). Data analysis was completed by hand. Field notes and interviews were transcribed in the following phase. A thematic analysis, rooted in grounded theory, was utilized for interpreting the transcriptions. The research question and sub-question inquiries guided the analyses and included: RQ1: What are the perceptions of needs for incorporating licensed counselors in emergency settings? RQ2: What are the experiences and perceptions of emergency department professionals with mental health needs in the emergency department? and RQ3: How do emergency department professionals describe their training for working with individuals with mental health needs?

Open coding was performed to "form initial categories" (Creswell, 1998, p. 65) to explore the experiences of emergency department personnel with working with individuals with mental health conditions. I was able to focus on preliminary ideas, theories, and deductions that came from each transcript.

Axial Coding

Following open coding, axial coding commenced. The content of field notes and interview transcripts were categorized and grouped into emerging themes in effort to better understand perceptions of implementing counselors in emergency departments. As data coding continued, axial coding was implemented. This approach can be defined as the process of relating categories into subcategories and the development of relating these subsets to an axis, thus linking the categories at the level of properties and dimensions (Corbin & Strauss, 2014). During axial coding, the researcher is concerned with examining the phenomena's structures and processes (Corbin & Strauss, 2014; Charmaz & Mitchell, 2001). Figure 5.1 displays the various axial codes identified from the open codes.

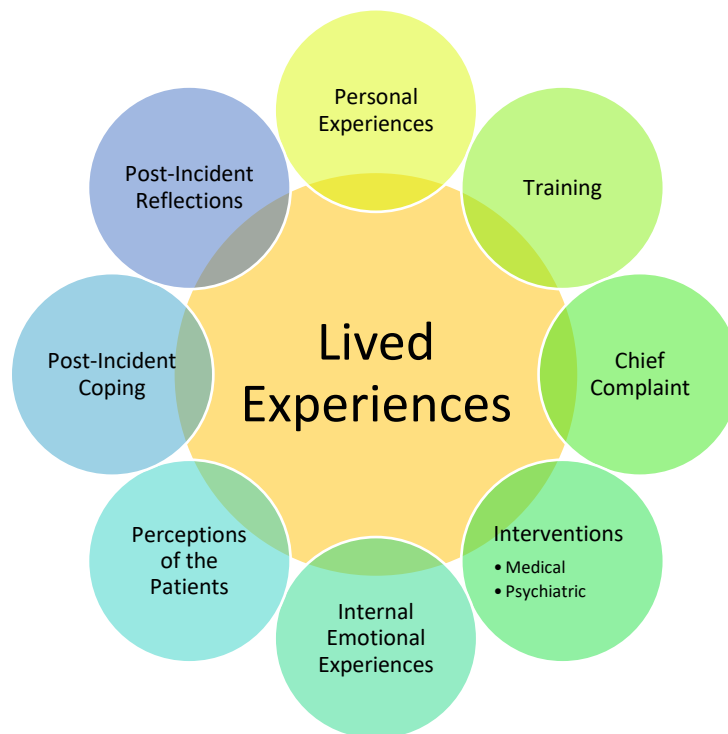


Figure 5.1 Axial codes for the study.

Following axial coding, each axis is grouped together in a structure that enables the researcher to form new explanations about the nature of the phenomena. This is referred to as selective coding, which is the process of incorporating all of the categories' dimensions and relationships to develop a cohesive theory. This step encourages individuals to "obtain data to help explicate categories" (Charmaz, 2006, p. 100). Selective coding will be discussed in Chapter V. I reviewed the literature in effort to understand the study's findings in context.

Presentation of the Axial Codes

The participants' responses to interview questions generated central themes. In addition to their interview answers and comments, their body language and facial expressions provided data for the study. Open codes revealed eight themes or axial codes consisting of: (1) personal history; (2) training; (3) chief complaint; (4) interventions with sub-axes (a) medical and (b) psychiatric; (5) internal emotional experiences; (6) perceptions of the patients; (7) post-incident coping; and (8) post-incident reflections. The following eight sections discuss each axial code in detail and display direct quotes to support the selection of the axial codes. Table 4.2 displays each axial code along with examples of the open codes used by the participants. Each open code was a unique meaning unit that captured the participants' experiences in working with individuals with mental health issues.

Table 4.2

Axial Codes and Samples of Open Codes

Axial Code Name	Sample of Open Codes
Personal History	“best friend committed suicide” “went through this” “reason I became a police officer”
Training	“CEU’s” “on the job” “SAFE program” “criminal justice institute”
Chief Complaint	“suicidal” “psychotic state” “opiates” “killed himself”
Interventions	
Subaxial Code: Medical	“CBC” “urinalysis” “gastric lavage” “EKG” “intubate”
Subaxial Code: Psychiatric	“counseling” “offer guidance” “hooks and barbs” “establish some kind of common ground”
Internal Emotional Experiences	“in shock” “overwhelming” “felt bad for her”
Perceptions of the Patients	“intoxicated” “don’t know how to control their emotions” “they are good people”
Post-Incident Coping	“employee assistance program” “counseling” “talking about this stuff” “put it back in the box”
Post-Incident Reflections	“keep your head on a swivel” “needs to be more facilities” “marked lack of inpatient care facilities”

A Tagcloud is a tool that researchers use to visualize qualitative data. Gill and Griffin (2010) posit that a tag cloud can assist investigators in understanding phenomenon by viewing visual representations of text data, text size, and word count. Generally, websites and various computer software applications generate Tagclouds by mapping aspects of a term in relation to a dimension parameter represented by size (Rivadeneira, Gruen, Muller, & Millen, 2007). For the purposes of this study I utilized Tagcrowd (www.tagcrowd.com) to generate a visual depiction of the participants’ interviews. The website generated 75 words that the participants used most. Common words such as “and,” “the,” “but,” and “um” were eliminated from the tag cloud. I

observed common themes within the participants' word choices and repetition. After initially reviewing the results on the Tagcrowd website, I went back and condensed words that had similar meanings. For example, I consolidated "somebody" and "someone" into "someone."

Figure 5.2 displays the results from Tagcrowd.

The words "medications" and "emergency" stood out upon review and I referred to the interviews for context. Often participants referred to utilizing medications for stabilization of individuals who were experiencing an acute crisis. For example, N6 stated, "Especially if you give them a little cocktail with a sedative medication it will make them sleep. I mean it will make them calm down usually and kind of chill out" (N2/6). Participants also highlighted the effects of nonadherence to medications as the source of crisis. In one case P2 recalled, "The most recent on that I can think of is the lady that quit taking her medication and um, she just felt that everyone was against her and out to get her" (P2/1). Other participants reported similar experiences with encountering individuals who had stopped taking their medications and subsequently experienced crisis.



Figure 5.2 Tag Cloud of Words from Interviews

Personal History

The first axial code was personal history. The qualification of this axial code is that participants commented on themes related to prior experience in working with and going through instances of personal struggles with mental health conditions. One participant reported that his best friend committed suicide as a teenager and he (the participant) found him. He details this experience in the following response:

My actually, my personal experience when I was 18 right before I got into EMS. One of my best friend's committed suicide and my-another friend and I found him... That was a- he called us and told us that he was going to do it. And so we rushed over there and he had of course shot himself. (A8/8)

Another participant, N10, said that based on her personal experience with mental health conditions, she was able to empathize with individuals that she encounters in the emergency department:

I have a history with this because I went through this as a kid, as a teenager. And in those facilities and this is the whole reason why I became a nurse because the way that they treated me-I just-they put you down as some diagnosis and treat you one way instead of individualizing it because people are different... so I think that is why I'm a little more empathetic to these people. Because I've done that I still deal with it. But it makes it easier to help them. Sometimes I can kind of divulge that information and then they're okay. It's not a judgment. So I think that we the ones that deal with this and see this need to be able to have help as well. (N10/12)

Other personal experiences did not necessarily consist of direct encounters with situations resulting from psychiatric illnesses. Rather they reported that prior to entering their field they decided that they would like to help people, in particular individuals who required counseling or other mental health interventions. P5 stated the following:

So, um, you want to as for me the reason why I became a police officer was to help somebody. You know, to help my community. (P5/4)

Another element of the participant's personal history is previous education. One of the emergency department nurses commented that her pursuit of an Associate's Degree in Psychology impacted her interactions with individuals with mental health conditions. She said that she was "able to understand some of it and where people come from and why they might be the way that they are" (N6/7). Thus, choice of educational pursuits prior to entering his or her chosen field influences conversations and treatment of people with psychiatric complaints.

Summary of Personal History

Based on the revelations from the aforementioned participants, one can deduce that prior, personal experiences with mental health conditions or endeavors help those with psychological complaints are important when conceptualizing phenomenon. Additionally, prior educational exposure to psychiatric illnesses also impacts individuals' interactions in emergency situations.

Training

The second axial code was training. Study participants reported that their training ranged from online educational opportunities to on-the-job learning. Participants that received online education reported that this was mandatory in regards to working in emergency services settings. Two police officer, three nurses, and two firefighters/paramedics completed online modules that provided overviews of working with individuals with mental health issues. N1 stated "Yes, we did have training with our CEU's, which are like online training" (N1/2) during his orientation to become an emergency department nurse. A "CEU" refers to a continuing education unit, which can include seminars, educational videos, or articles. Online educational program may offer

CEU's specific for nursing, support professionals, and other caring professions including police officer and paramedics.

Certain hospitals provide their own mental health training, but the participant who received this instruction did feel that this was adequate (N10). She reported that the training mainly focused on de-escalating potentially violent or unsafe situations. The "SAFE" program that she refers to consists of learning de-escalation techniques and physical safety techniques to manage verbal and physical conflicts. She stated the following:

Well they did a hospital wide-it's called the SAFE program that we have to go through and that's just basically to learn how to de-escalate situations and see, you know, be aware of when situations could escalate and try to prevent it. (N10/6)

One of the police officers stated, "So there is a website called Criminal Justice Institute or CJI. Um they put on classes that you can take on your own for free and they-um they cover everything possible so...Like I would definitely every officer to take their classes..." (P5/5). Within that particular model, educators record videos concerning mental health conditions and various approaches that officers can use in working with specific mental health-related situations.

Aside from online training, universities and community colleges offer seminars and classes on working with mental health conditions. One of the police officers reported that online training for working with mental health conditions was offered through a local university. He reported:

The actual the basic police academy it's not as in depth. But they (online program) do offer classes geared specifically toward dealing with the mental health- I think that the CJI it's part of U of A criminal justice institute they've got classes that are geared toward

the mentally ill. I haven't taken it but there are a couple of guys that I have worked with. Its highly recommended. (P2/4)

Police academies also offer classes on working with individuals with mental health conditions. State officials predetermine the requirements for the courses and enforce dissemination of materials with specific task forces. One of the police officers discussed his police academy's course requirements:

State standards um that's the commission for law enforcement standards in training they call it CLEST. That's Commission for Law Enforcement Standards in Training. They establish minimum training standards that all law officers in the state have to have. And um among those they mandate training on response to mentally ill at least every three years... And that training must consist of um learning to recognize people who may be suffering from mental illness based on their behavior. Um, how to approach and talk to someone who appears to be in a mental health crisis and how to access local mental health facilities. So those three things are mandated every three years. (P7/6)

One of the police officers interviewed reported that he received approximately three months of training for working with mental health conditions. He indicated that he would have preferred to receive more training due to the frequency of encountering psychiatric crises. Each of the officers interviewed received training from different police academies, thus each participant's description of training is different. He stated the following:

Um as far as a police officer you know you get thirteen to fourteen weeks of academy training and that's to cover everything as a police officer. I mean so you are not getting any training with mentally ill or you know a suicidal subject or they are all rolled into one. You know... Something like dealing with the mentally ill or something-something to that effect, suicidal subjects. I mean cause 13 to 14 weeks and then that 8 weeks training with another officer is not enough for sure. (P5/5)

When discussing training with participants who were either EMT's or firefighters/paramedics they reported that their training was limited to briefly discussing mental

health conditions or reading a chapter in a textbook about them. For example, one firefighter/paramedic stated the following:

During my EMT class they covered a chapter in the book about it and different ways of dealing with it. Other than that it is mostly on the job. You know. I'm in my ten years I've never heard of a class for dealing with the mentally ill for EMS. Um, I've heard of different classes for the police side of it but I've never heard of it for EMS. (F4/4)

Another participant relayed his experience with training for working as an EMT. He highlighted the lack of exposure to information concerning encounters with individuals with mental health conditions:

I think there probably could have studied more about the different psychiatric issues that you are dealing with and also um, I had no idea the frequency that I would be dealing with them. They don't really train you how to talk to them they just kind of tell you if you can talk to them talk to them. Try to calm them down. (T9/3)

Summary of Training

Most participants who discussed training for treating mental health conditions reported that they did not receive much information or exposure to treatment approaches for addressing mental health conditions. Two participants said that their training experiences were more than adequate. Their situations seemed to be exceptional, as the rest of the participants reported otherwise.

Chief Complaint

The third axial code was the chief complaint. This referred to primary condition or situation that emergency service providers encountered. All of the participants described a situation in which they encountered individuals experiencing psychiatric crises. These instances ranged from working with individuals who were experiencing suicidal thoughts to working with

families who had lost a loved one due to suicide to treating an individual in an acute psychotic episode. Each participant had a particular incident in mind and detailed unique interactions with that specific individual.

One of the most common incidents that participants encountered was addressing individuals with suicidal thoughts or recent suicide attempts. They consisted of suicide attempts, suicide completions, suicidal ideations, homicidal ideations, psychotic states, substance use, and instances of abuse or trauma. Some of the participants classified chief complaints according to the individuals' psychological diagnosis, whereas others categorized incidents with regards to evidence that was at the situation's location. For example, one officer recognized drug paraphernalia at an individual's home and subsequently attributed the individual's erratic behavior to "drugs" (P2/3).

All of the participants identified a situation in which an individual was experiencing suicidal thoughts or had attempted suicide. Each instance varied in severity in regards to lethality and resulting stabilization interventions. One of the most severe cases relayed in the study was that of a police officer who encountered an individual who attempted suicide by hanging himself. The following is his account of the situation:

I was actually at just hired on I was still in training and we got a call to the apartments about a guy hanging in the um, the closet. He tried to hang himself with an electric cord but I was myself and my training officer were the first ones there. We got-we were able to cut the cord down. He just fell down he started breathing immediately so I don't think the drop was too far. So, um, but he-he suffered from drug addiction alcohol. Um, there was obviously something else. He later found out that he was outpatient at one of the local...I don't know exactly. Um, I think he was off his medicine I don't know what he was taking or anything I know that his family said he was off his medication for a few

weeks. So I'm sure that all of that leading up to-just kind of combined at that one night. He was off his meds, doing drugs, and drinking. (P5/3)

The police officer went on to state that the police and ambulance crew attempted to talk with the individual but "he didn't want to talk" (P5/3). The participant said that eventually the individual agreed to transport to a local emergency room where he was medically cleared and placed at a psychiatric facility. A recurring theme throughout the interviews was the notion of "medical clearance" of individuals who presented with psychiatric conditions. Upon observations and casual, unrecorded conversations, I discovered that most of the emergency services' protocols for individuals with suicidal thoughts or attempts involve sending them to emergency departments for medical examination. Medical evaluation consisted of physical examinations, blood analysis, urinalysis, and potentially sutures or stitches (depending on medical necessity). This axial code will be discussed in a subsequent section.

In addition to the three police officers who detailed accounts of individuals with suicidal thoughts, one of the firefighters/paramedics recalled a situation in which someone called 911 and threatened to shoot himself. The firefighter/paramedic said that he could hear the gun's hammer being pulled back as he was on the phone with the individual. He stated the following:

I was on the four to midnight shift I um, answered the 911 call we have had issues with the guy before. We had talked with him a couple of times he told me that he was going to shoot himself. And I didn't really think much into because of the simple fact that we had kind of ran into him before and dealt with him before. And the next thing that I knew I heard the gun, the hammer going back on it. And it took me-EMS- the actual ambulance was probably about ten minutes out from his house and the police were on their way also. It took me a good seven to eight minutes to where he would put the gun down, you know, to where he would step outside away from it. (F4/1)

Another police officer detailed the aftermath of a completed suicide. The emergency dispatcher sent him to a scene in which a teenager used a gun to kill himself. A passerby called in the emergency after she witnessed a young man walking out to his driveway and pulling the trigger. The following captures the officer's experience:

Young man shot himself in the head in the drive way of his grandparents' house. When the call came out I was three blocks away. So I got there very, very quickly and the person who called in was a pizza delivery driver. She just happened to be driving by and saw what happened and she was horribly traumatized. I spent quite a bit of time talking with her just trying to get her to calm down. But the young man's sister was really struggling with trying to cope with the fact that her brother committed suicide there was a witness there is no denying that one. (P7/5)

Even though this particular account of a completed suicide may be difficult to read, the officer's experience highlights the stressful and, at times, traumatic aspects of working with acute situations as an emergency professional.

Another chief complaint was self-injurious behavior. Self-injurious behavior is the deliberate, self-induced destruction of one's body without suicidal intent (Zetterqvist, Lundh, & Svedin, 2012). Determining whether an individual is engaging in self-injurious behaviors or attempting suicide can be difficult for practitioners. Thus, information from family members or close friends can prove to be very helpful in assessment of an individual's behaviors. An EMT described his experience with encountering someone who engaged in these actions:

A memorable one? That was pretty recent. 14 or 15-year-old girl. I guess she had cut herself. And we got there and we found her standing in the middle of her parents' room. She didn't have any bad cuts or anything. 150 different little scratches on her arms, her legs, and her stomach but she didn't have anything (critical cuts). (T9/1)

In addition to distinguishing between self-injurious behaviors and suicide attempts, assessing the validity of an individual's statements about suicidal thoughts can prove to be difficult for emergency personnel. Intoxication can also convolute an individual's thought process. One of the nurses described a situation in which she encountered an individual who stated that he was suicidal while intoxicated and after he became sober, decided that he did not want help. She described the following:

Well we had a gentleman that comes in frequently who has schizophrenia who needs, a bed. Homeless. Lots of drinking and drugs and he comes in and he comes in frequently. We all know him and generally he comes in complaining of being suicidal and homicidal so we end up giving him you know, put him in one the rooms. Try to keep himself safe and try to keep him calm and he usually gets Geodon or Haldol or something to help. And we make sure that he has something to eat and then generally he's okay. But he'll wake up the next day and say, "No, I don't want any help. I don't want any placement." Well what I understand now is that he is actually in jail because we tried to get him connected with the VA and he wouldn't go to the VA. And there was a bunch of things that took place outside of our facilities. (N10/1)

One of the other nurses reported that she had a similar experience with individuals intoxicated with alcohol who arrive to the emergency department and change their minds about placement. She noted that psychological conditions often present alongside substance use issues. She reported:

The most common I would think people coming in intoxicated and saying they are suicidal. Well you know we basically give them fluids and let them sleep it off. Then they wake up and are like, "I'm not suicidal anymore." Because a lot of times there is an underlying psychological issue and they are self-medicating with alcohol and they never get to address. That type thing. But you know when you get upset and you sleep it off you wake up and are like "I kind of feel better now." (N6/2)

Another area that emergency service personnel encounter is substance use issues. Many of the workers reported that opiate misuse, in particular, is a common complaint. One of the emergency department nurses described an ongoing situation with local pain clinics. She reported that many of the local pain management clinics, where individuals can receive opiates or other opiate receptor agonists, are shutting down. Doctor's legal issues and poor management are some of the reasons that these clinics are closing, according to the participant. Furthermore, she said that the emergency department professionals witnessed an increase of pain-related visits that escalated into the individuals being "psychotic" (N10/5). She went on to state:

The pain clinics, the pain management clinics are being shut down because the doctors are going to jail and they, you know we have had a definite influx of pain management requests. That have turned into psychotic-not psychotic episodes but more of like a well sometimes I guess they have panic attacks or they are freaking out because they're withdrawing or whatever so it's causing their psychotic episode. You know. They can make them angry and aggressive or depressed and suicidal. It can all stem from the fact that they were in pain management and don't have a doctor anymore because they got arrested or got their license revoked. There's nothing. So it-it's just a sad situation. (N10/5)

In addition to opiates, alcohol, benzodiazepine, and methamphetamine use were common among individuals presenting to emergency departments. Nurses reported that individuals arrived intoxicated and reported experiencing suicidal or homicidal thoughts. The emergency department staff placed them in psychiatric rooms following triages. These designated areas do not have electrical outlets or any objects that an individual could use to harm his or herself or others. Most emergency rooms that I observed had at least one of these areas. Casual conversations with emergency department workers lead me to understand that these rooms were frequently used by individuals with suicidal or homicidal thoughts.

The following report from a police officer detailed a situation in which an individual was under the influence of methamphetamine and experiencing suicidal thoughts.

So he did not call 911 or anything like that. We kind of dug into it and found out that he was not only using methamphetamine but he was also the reason his sister and brother-in-law were there was because he was suicidal. So they were just trying to check on him and find out what was going on. He was scared they were there because he stole someone else's like some other property and sold it up for drugs so he thought they were there-going to kill him. (P2/1)

Some of the participants described situations in which they encountered individuals experiencing psychotic episodes. For example, one of the firefighters/paramedics described the following situation:

The most recent on that I can think of is the lady that quit taking her medication and um, she just felt that everyone was against her and out to get her. She felt that her body was possessed by Wiccans and her father was trying to get her to go to the hospital and she thinks that if she goes to the hospital you know, that everyone is going to hurt her or harm her. And you know not get her right. You know mainly I think that they feel like they're at their normal state when they are like that instead of when they are regulated and under control. And they feel out of it. I believe that when they are not on their medication or whatever and not like their selves. So that was her main problem that she didn't want them to drug her or get her on her medicine because I guess that she thought she was her normal self. (F3/3)

Non-adherence to medication, use of substances, and exacerbation of symptoms of psychotic disorders were commonly cited reasons for exhibiting indicators of psychosis.

Summary of Chief Complaint

Many situations fell into the category of chief complaint. These included individuals with suicidal and/or homicidal thoughts, psychosis, substance use issues, and suicide completions.

The variety of situations described by the participants underscores the novelty of individual's

presentations and, at times, the difficulty of determining appropriate interventions for each incident.

Interventions

The next axial code consisted of interventions. The data set identified two discrete categories for interventions that included medical and psychiatric. These two categories became sub-axial codes. Both emergency service workers and emergency department personnel described their treatment approaches for working with individuals with mental health conditions.

Medical. The first sub-axial code was medical. When ambulance crews arrived to emergency scenes, they take vital signs of the individual who presented with the emergency. At times the crews encountered situations in which someone had overdosed on substances. Some individuals took large doses of benzodiazepines or opiates. In these cases, they either administered Narcan, an opiate antagonist, or Romazicon, a benzodiazepine antagonist. Another option that EMS workers used was activated charcoal, which caused the individual to immediately vomit. If the crew arrived and the person was not responsive, then they intubated him or her. Intubation involves using a flexible plastic tube into the windpipe in effort to maintain a person's airway (Lossius, Røislien, & Lockey, 2012). This allows EMS workers to facilitate ventilation of the lungs if the individual stopped breathing.

After the emergency service workers stabilized the individual to the best of their abilities, they transported him or her to the emergency department. Once the individual arrived a nurse performed a triage. A triage consists of measuring blood pressure, temperature, heart rate, and performing an electrocardiogram, depending on medical necessity. An electrocardiogram

provides clinicians with information about the speed and amount of electrical activity that travels to the different areas of the heart (American Heart Association, 2007c; Twedell, 2005). Next the nurse collected specimens for various blood tests. One of the nurses reported the following:

We do a UA and a urine drug screen and a CBC, BMP, TSH, and a ETOH. Um, you know see if any alcohol is on board. Um like I said that again-Um that medically clears them and of course all of the facilities will be contacted. They always want to know if their drug screen is positive so that is why we always do their drug screen. (N6/2-3)

Another nurse reported similar protocols for his emergency department:

We run specific tests like chemistry elements to see what their electrolytes are like We run like a urine test usually a drug screen. Even their thyroid levels. Even um a ETOH to see if they are intoxicated. (N1/3)

Individuals who present to emergency departments with dehydration require medical interventions. This usually consists of starting an intravenous therapy (IV) and administering fluid to replenish electrolytes. One of the nurses described a situation in which an individual had reportedly overdosed on a variety of medications and had been out in the heat for at least two days. In her situation the emergency team administered fluids in effort to rehydrate her and stabilize her electrolytes. He described the following:

Um, we gave her fluids to keep her hydrated because we did not know how long she had been outside in the elements. Um. Did blood work, urine, seeing what she was like. (N1/2)

Other medical interventions include administrating medications in situations when individuals display agitated behaviors or experience severe anxiety. According to the participants these medications may include anti-psychotics, benzodiazepines, or antihistamines in effort to

reduce symptoms. One of the nurses reported that medication administration is one of the last interventions that personnel will utilize, “Anything from Ativan to Haldol to Geodon to Benadryl. Um, that’s usually a last resort” (N10/2).

In more acute situations (i.e. significant overdose, unresponsiveness), the emergency crews may perform a gastric lavage. A gastric lavage involves inserting a tube into the stomach and removing small volumes of liquid (Vale & Kulig, 2003). Another option is to administer activated charcoal in cases when an individual has ingested a significant amount of medication or substance. Medical professionals use activated charcoal to address poisonings and overdoses (Chyka, Seger, Krenzelok, & Vale, 2004). One of the nurses provided an overview of encountering individuals who overdosed on medications:

But it happens and if they have like ingested something um like a lot times if it’s been within a certain time frame then we will do a gastric lavage which tries to get everything out. Or give them activated charcoal which tries to bind to it. And if they are not medically stable then they will be admitted to a hospital bed until they are medically stable. (N10/2)

The last piece of medical treatment that emergency department participants discussed was admitting an unstable individual to a medical floor. Often when someone arrives to the emergency department in a critical condition, the emergency workers will attempt to stabilize his/her condition and then send him/her to a medical floor. Professionals who work on the medical floor will monitor and implement life-saving treatments if the individual declines. One of the nurses described the following overview of unstable conditions and admittance to a medical floor:

There are instances when psychiatric patients get admitted to the floor. Usually they are coming in with an overdose. We have to medically stabilize them to make sure that they are safe to go somewhere. Usually if they come in most of the time they go to ICU some of the time they go to the floor. It just depends on the nature of the situation. (N6/4)

One other participant discussed the treatment of intoxicated individuals in a police department setting. He described the various tests that a drug recognition expert could administer in the jail. A drug recognition expert is police officer that completed training under the National Highway Traffic Safety Administration, U.S. Department of Transportation. He or she conducts an investigation as to whether an individual is impaired, if the impairment is drug-related, and which drug category or combination of drugs is causing the impairment (Burns & Adler, 1995).

The following example comes from a participant who was a police officer:

Yes, like for alcohol. Um I'm going to take you down to the jail. I'm going to give you a toxicity meter. You know the breath test. Um. If you blow zeroes and I still feel like you are still intoxicated I'm going to bring you up to the police department and then the drug recognition expert is going to take over at that point. He's going to go through his own field sobriety. He's going to make you do all sorts of different tests. You know he's going to find out if you are on medication if you are prescribed a lot. (P5b/2)

Summary of medical. Participants identified various medical interventions that they use when encountering situations that necessitate assistance. Most individuals who are taken to the emergency department will undergo triages as well as blood tests. If an individual is stable, then he or she is referred to a psychiatric facility when the medical team determines that psychiatric stabilization is necessary. In cases when individuals are not medically stable, the emergency department team will do the best they can to stabilize the individual and then send her/him to a medical floor.

Psychiatric. Another sub-axial code is psychiatric. Emergency service workers often described various psychological approaches in working with individuals with mental health conditions. These ranged from bringing in a spiritual guide, talking with family members, and engaging in active listening skills. Each participant had a specific way that he or she approached individuals in crisis. For example, one of the nurses reported, “all that they want is for someone to listen” (N1/4). One of the participants described a situation in which he established a common ground with an individual in crisis:

Um mainly you try-you try to establish some sort of a common ground you know try to find something that you know-they taught us-you know- in the fire academy and when I was in the police academy that along the lines you have ‘hooks and barbs’. You know a ‘hook’ is something that I say to you that you latch onto and you’re like, ‘Okay I’m going to take that bait.’ A ‘barb’ is something you are automatically like-no I don’t want nothing to do with that. You know it triggers you worse-basically like something that turns it into worse you know ignites the situation, accelerates it past the point of good. You know so we try to talk to them about. (F3/2)

Another participant reported that clarifying safety needs with the participant was helpful in diffusing a situation:

Try to establish something to make them know okay I’m not here to hurt you and I know you are really, really confused and I know that you’re having a lot going on that you don’t know and just try to help them so that they don’t hurt themselves or anybody for that matter. Just try your best. (F3b/2)

At one location staff members had access to a chaplain, who provided spiritual consultation for individuals and families in need. One of the participants described this resource as helpful in regards to obtaining additional information that was relevant to situation:

And um sometimes we'll ask do you want to talk to a chaplain and they will say yes and the chaplain will come down and he will try like you know talk to the patient get the patient to open up so that we can get additional information about what's going on in the patient's life. (N1b/3)

Chaplains were not only used for talking with the individual in crisis, but also for consoling families who had lost a loved one in the emergency department. One of the participants commented that if the emergency department staff suspected an impending death they would call in the chaplain to assist the physician with talking to the family. She described the following:

Most of the time we try to you know any time that there is an impending death we will you know always call the chaplain or you know whatever pastoral service is there. Um, our charge nurse, our doctor, and our house supervisor-we, we page it out. If it's like a trauma or it's you know like a heart attack or stroke or whatever it may be our-it's the chaplain, the um, house supervisor, and security and um...So they are all there and then whenever we have to let them know whether or not-if they're in the family room then the doctor and pastoral care try to go in there at the same time to talk to them. Pastoral care will be the first one to say anything and usually the provider to let them know what happened. Um, however there have been-there's been an incident before where it was a traveling doctor that was just filling in. Um, who was supposed to talk to the family but didn't. The charge nurse wasn't aware that the doctor didn't talk to them and I got left talking to them because I didn't realize that they didn't know. (N10/8-9)

In addition to chaplain support, emergency department staff will call in the nursing supervisor, who is in charge of nursing staff over the entire hospital. This occurs in cases of significant trauma (i.e. car wreck, overdose, consequences of violence), when someone has passed away, or is about to die. One of the nursing participants described the following in which additional support was called in:

Um, that it depends on the situation. Like if they come in and it was a code they came in you know family is already aware of what is going on. You know sometimes they will

take the family in the room if they want to be there I mean at that point. American Heart Association really pushes for that so that they are in there and they can see that you are doing everything that you can to-everything that you possibly can to save their family member or bring them back. Other times you know we take them to the family room and the physician will come and talk to them afterwards. The physicians are usually the one- and the nursing supervisor comes down-but the physicians are the ones that ultimately talk to the family. We'll give them as much time as they need you know in the room-we will have family come in and what have you to say their goodbyes. Whatever they need to do. (N6b/2-3)

In addition to bringing in pastoral support and actively listening, participants cited that being able to talk with families was helpful in obtaining pertinent information. Some of the police officer participants reported that having family members present at scenes could prove to be beneficial both to the individual with mental conditions and the law enforcement officers. For example, one of the officers stated:

Being able to talk to family would be the biggest or if not family someone that lives by them or how they are day to day, see if it was out of the normal was a big benefit. (P2/3)

Another element that participants reported to be important in regards to psychiatric approaches was to maintain everyone's safety. Maintaining safety ensured that no further damage would be done to the individual being treated and those who are administering the treatments. The EMT participant reported the following:

First of all, and they will learn this in school, is to be safe and watch out for themselves first. Um. Even though they might be calm one minute and the next minute might not or they might be upset and angry at you for whatever reason. And the second is that to be empathetic with them and try to understand where they are coming from. (T9/4)

Summary of psychiatric. Participants reported various strategies that they employ when engaging with individuals with mental health conditions. The most commonly cited

approaches were maintaining the individuals' and responders' safety, listening, and requesting additional support from other professions. All of these elements contributed to the treatment of individuals presenting with mental health conditions.

Internal Emotional Experiences

The fifth axial code was internal emotional experiences of the emergency service workers. This axial code refers to the thoughts and feelings of the participants when they encountered emergency situations. They ranged from being shocked to incredulous about the incidents. Each internal emotional experience was unique to the participant. N1 described his internal emotional experience as the following:

In my reaction to the situation was you know like are you serious? Like why would you want to do this to yourself? And it was difficult trying to get medical history and all the meds that she was talking and what is going on with her and in addition to that we also had some pill bottles that was not prescribed to her from someone else and we don't know who's it was or who needed it. (N1/2)

Based on his response, one can detect frustration with the uncertainty of the situation. Additionally, he reported that he did not understand why the particular individual attempted suicide. Another individual reported a similar experience in having difficulties in understanding a situation. He reported:

So it's kind of took some- some thought to try to figure out what was going on I mean like I say it was-he showed all the signs of being on the drug as well as so that was kind of a that's what's going on here. (P2/3)

Other participants described their reactions as being in shock. For example, one participant described a call that he received in which an individual said that he had a gun pointed

at his head. The firefighter/paramedic participant reported that he could hear the gun being caulked. The following is his account of his reaction:

I was just in shock. I was just 17 at the time as a dispatcher, so I was just, in you know shock and awe that what was really going on. Once I heard that gun click back you know. (F4)

Another participant identified his internal experience as shock. He responded to a call concerning a teenage girl who had engaged in self-injurious behaviors. His reaction seemed to be rooted in the novelty of the situation, as he had not treated anyone with extensive cuts that were self-inflicted. He reported:

Um, at first it was kind of like shock just kind of. I mean I had seen people who had cut themselves before but never, you know -marked over- both of her arms and down both of her legs and on her stomach and side. Afterwards it was kind of sadness. I felt bad for her just that she had gone through the things that she did and she felt that she was responsible for it but it was obviously everyone else that was their fault for the things that happened. (T9/2)

In addition to experiencing shock in response to situations, one of the participants reported that he felt “helpless” (P7/2). His experience consisted of encountering an individual with a razorblade who was cutting himself in a public area. At that time, the department did not have access to devices that could render violent individuals immobile. His account follows:

But um you know in a situation like that you just almost feel helpless because you can't get through to them just by talking to them and um you know that state of agitation-I don't know if he was experiencing any auditory or visual hallucinations but it drove him to a point that he was a real danger to himself. And um it was dangerous to us to try to physically overpower him because he had a razorblade in his hands. But that's what we do. We don't have to option to just back off. We have to act. I can't really imagine anyone who does this for a living to choose not to. (P7/2)

Another participant reported experiencing anxiety when encountering individuals with mental health conditions. Specifically, he commented that he felt anxious when he was unsure if someone was carrying a weapon. In that particular situation he responded to a call about an individual who was threatening to jump off of a bridge. He said that the both of the bridge's lanes had traffic and he expressed concern about passengers witnessing the man's suicide attempt. Additionally, he said he was concerned about the individual carrying a weapon, commenting (I think that all of your adrenaline is pumping at once" (P5/4). He stated:

So as far as you know everything like you said, you're worried, you're anxious, you don't know if he has a gun behind his back or tucked into his pants. So uh, and then you have you know the cars driving by on the other side all watching. (P5/4)

Finally, some participants commented on the cumulative effect of working with individuals in crises. One of the participants described repeatedly seeing traumatic situations and erratic behaviors as "horrible" (P7/11). He goes on to state:

We see a lot of horrible, horrible things. And those have an accumulative effect. It-you know that sometimes that person working next to us could use some help too. (P7/11)

Summary of Internal Emotional Experiences

Participants who witnessed and worked with behavioral health crises identified their internal emotional experiences in a variety of ways. They ranged from feeling shocked to anxious to concerned about safety. All of these elements serve to better understand the lived experiences of emergency service workers in working with individuals with mental health conditions.

Perception of Patients

The sixth axial code was perception of patients. The term “patient(s)” is appropriate for the study because it reflects the word choice and interview responses generated by the participants. Every one of the participants used the word patient to describe an individual who was experiencing a psychiatric condition or crisis situation. The participants’ description of the patient reflected his or her preconceived notions and professional experience with working with individuals with mental health conditions.

One of the participants reported that the reason he believed a lot of individuals presented with intoxication was due to difficulties in coping. He reported the following:

We do see quite a bit of those who come in intoxicated because they can’t deal with what’s going on in their lives, um intoxication such as alcohol or opiate whether it’s theirs or someone else’s that they know. (N1b/1)

In addition to having difficulties in coping with emotions, other individuals had trouble in reconciling a loved one’s death. One of the firefighter/paramedics reported an incident in which family members had recently experienced a death. He went on to say that they became violent in response to hearing the news. He stated:

People don’t know how to control their emotions and I guess that they become out of their mind you could call it. I’ve seen family members that just go crazy beating walls beating up other family members um. I was actually told by a crew that ran one here in (local city) that the family threatened to kill them because they didn’t do anything. Which there was nothing that they could have done. (F4/4)

Another perception that participants’ attributed to was that the individual being treated could be anybody. Participants reported that they were aware that mental illness was not

prejudice. People with psychiatric conditions come from a variety of backgrounds. One of the participants reiterated this point by saying:

Just to realize that this is somebody's mom, dad, brother or sister. That they are no different than you or I they just have a different set of problems or you know something that they are dealing with and you need to be respectful the best that they can you know not lose your temper not become impatient and just try the best you can to get them the help they need because all in all they are good people. They just have quit taken medicine or haven't discovered that they've got this problem. (F3/5)

In addition to the firefighter/paramedic's comment, one of the police officers noted that emergency calls may not be about individuals having mental health crises. He stated that "mentally ill people can be victims of crimes" (P7/7), an aspect that is not readily discussed among emergency service workers. The following example addresses his viewpoint:

You know the mentally ill people can be victims of crimes, mentally ill people can be witnesses in crime and you have to—you've got to kind of work with people to get them to accept that. You know it's one of the things that I explain to our new officers. You know people with mental illnesses um they're just like you and I are. If they are getting the treatment that they need, they are getting the medicine that they are supposed to, they can lead normal, productive lives. And yes they can certainly be a witness to a crime. (P7/7)

Some participants speculated about the underlying issues of individuals in crises. He discussed an incident when a man experienced suicidal thoughts and called 911. After talking with the individual the police officer concluded:

So I'm assuming that all the harsh reality was setting in that he was alone. You know for the first time probably for many years. And he was just trying to deal with it any way possible. (P5/3)

The final example of perceptions of patients included frustration. In this case a nurse described her beliefs about placing a patient at a mental health facility. She reported that she

understood the steps that needed to be taken to find placement, which was going to be a lengthy and time-consuming endeavor. She stated:

Well it's frustrating because you know it's going to be a process. It's not like you don't want to help the patient it's just the fact that you know the struggle that comes with that. And you know that they are not probably going to get the actual help that they need. I mean staying at a facility for two or three or four days does not fix that. (N6/4-5)

Summary of Perceptions of Patients

Participants reported their internal understanding and beliefs about patients who were experiencing mental health conditions. They described frustrations and their conceptualization of the patients' condition. Some of the participants conveyed empathy toward the patient, while others detailed exasperation with the process that they knew would occur in regard to placing the patient.

Post-Incident Coping

The seventh axial code was post-incident coping. This axial code consisted of interdepartmental debriefings, comradery, professional services, and relationships between emergency services. Some of the participants reflected on ways that they coped after experiencing distressing incidents related to mental health crises. Many of the participants reported that talking with their co-workers and colleagues was helpful in alleviating stress post-incident.

One of the firefighters/paramedics discussed the importance of relationships within his department. He stated that talking amongst his co-workers was beneficial in normalizing his experiences and diffusing his emotions. He reported the following:

You know it's been-that's how a lot of people you know cope with the things that they've dealt with is that you know you tell stories about it. Or you know stuff like that and you know it's not necessarily- a lot of times you go home and your wife will ask you "How was your day?" And it's like "fine" While at work people know exactly where you are coming from you know- "Well that lady or that guy was really kind of messed up" and they can kind of talk to you and help each other cope. You know it's good to remember not necessarily dwell on it but to get things out that you have inside that you told yourself internally but to actually tell somebody and then give you how they feel and give you- "well man I did this" or you know them telling you the same thing. I think it's helpful in a lot of ways. (F3/5)

Other participants described departmental meetings that followed distressing incidents. Some of the participants reported these to be helpful, while others asserted that they were not adequate in addressing staff members' emotions. For example, one of the nurses detailed the following:

You know sometimes we will have-we will have that- a mass trauma and the next day we will have like a debriefing. I guess it's like a ten-minute debriefing when you talk about it but it does not go away. (N10/12)

Others reported that the meetings were effective in managing remaining feelings. The paramedic reported that his personality may have some influence on his perceptions of the debriefing meetings. He stated:

We really had to have some diffusing and some sit down and everybody talk about what happened. How they feel about it. And you know what do you need as far as time off or do you need time off or do you need to get back-I'm a go do the next one kind of guy and some people want to go home and think about it for a few days or something. (A8/9)

He went on to state that each individual copes with traumatic events in different ways. He commented that he brackets his emotions and thoughts in a way that he can block them out and dismiss them; however, he noted that not everyone has this ability:

So he, um, so you think that talking about this stuff-you think back to all those different things. And I'm honestly talking about different experiences on the ambulance and talking about different things it's...I remember those but I also realize kind of the ability to bring them up talk about them, and see do you have any, how do you feel about that. Are you okay with all of the stuff that's happened? And just put it back in the box. (A8/9)

Some departments had the ability to bring in professional assistance in working with employees following distressing incidents. One of the participant reported that they used an employee assistance program that recruited local counselors to provide services to police department employees. He also commented that following an officer-involved-shooting the department had safeguards in place to ensure mental health wellness for that particular individual. He stated:

Um and you know on things that are particularly traumatic we have an employee assistance program and we will have trained counselors that do debriefings with people. And um one thing in particular that people find traumatic is officer involved shootings. And um when someone is involved in a shooting we put them on paid administrative leave so that not only can they assist where they need to-because there is always an investigation but we also mandate that they go and talk to a counselor or psychologist or psychiatrist. And you know that mental health professional has to say, "Yes they are okay to come back to work." They don't get to come back to work until they go and see somebody and they say that they are okay to come back to work. Um in 2007 we had an officer shot and killed in the line of duty and our counselors were done here that night and you know they were debriefing people left and right. (P7/11)

Finally, participants reported that having a collaborative relationship with other emergency services was helpful in coping with stressful situations. The police officer that discussed the employee assistance program also commented about the "unified front" (P7/3) that police officers, ambulance crews, and firefighters have with one another. He stated the following:

And we have a very close relationship working with EMS. We have um frequent meetings with the directors and we corroborate and put together protocols. We work collectively on those so that we can provide a unified front as to how we are going to handle these situations. (P7/3)

Summary of Post-Incident Coping

The axial code of post-incident coping was appropriate, as many of the participants described strategies that their departments employ to diffuse distressing situations. Additionally, they identified collaborative relationships within and outside of their departments as beneficial in regard to coping.

Post-Incident Reflections

The final axial code was post-incident reflections. This axial code consisted of participants' thoughts on working with individuals with mental health problems, reflections about discussing cases during the interviews, and suggestions for the emergency services field. Their insights prove to be extremely valuable in understanding the phenomenon of their experiences in working with individuals with psychiatric conditions. Suggestions that the participants relayed were more inpatient psychiatric beds, implementation of counselors within emergency departments, and receiving further training in regards to treating mental health conditions.

One of the post-incident reflections that participants commented on was that they had not discussed their experiences prior to the study. For example, when asked about their experience in talking with me one of the participants responded:

It's been um it's been I don't know kind of different, like having to reflect on what really goes on because you know when you are doing all this you don't really think about what

is going on with that patient because you are more worried about presentations such as chest pain or if you need to start IV or administer medications or just take care of them so psychiatric patients you know they are not they are not really on top of our priorities. (N1/5)

One of the police officers reported the following:

Just talking about the experience you know, bringing up the past you know. With that suicidal patient (thinking), “what could I have done differently?” Um I don’t know. Exactly you know how to-theres, theres types of people that you try to talk to and they don’t want to talk and there are the types that want to talk about everything, you know. Um, just you want to make sure that the scene is safe. And looking back (thinking), “was it safe? What could I have done differently to protect my officers? Could I have given them a better update?” You know things like that. (P5b/1)

When asked about different recommendations for future emergency workers, most of the participants had advice regarding approaches and mannerisms that are helpful. Being patient and remaining calm were some of the most common responses to that inquiry. One of the participants reported that being alert was especially important. He indicated:

Always keep you head on swivel you never know what is going to happen with the mentally ill. They you know they always something different every minute. They don’t know what they are doing sometimes; sometimes they do. Just be alert. Be on your toes. Always keep your head on a swivel be ready to move you know. Always maintain your safety first. (F4/4)

Upon reflecting on the frequency of psychiatric crises, some of the emergency service workers commented that more inpatient facilities would be beneficial for both emergency medical services and individuals with mental health needs. For example, one of the firefighters stated the following:

Other than there needs to be more facilities around her. I think it is a strain on the EMS system. Them having to transport them so far. I don’t know if they need to be transported

by EMS honestly. There are some perfectly good buildings around here that if they had the funds would make great facilities for mental health. (F4b/3)

Another participant pointed out the lack of psychiatric beds being a problem statewide.

He seemed to have encountered this issue regularly. He reported:

We are lacking a lot. I think the single biggest problem we have-not just in this area but the entire state is a marked lack of inpatient care facilities. Um you know the state has a hospital in (city) but they've got, what, 160 beds and most of those are occupied by people who are court ordered to the facility. That doesn't leave much room for people that just need help. (P7/9)

Summary of Post-Incident Reflections

The final axial code of post-incident reflections was captured by personal musings, observations, and recommendations for the emergency services field. Many participants had suggestions to how to interact with individuals with mental health conditions, while others had recommendations for mental healthcare structure. All of their responses assisted me in conceptualizing their lived experiences.

Summary

This chapter presented the results of the data analysis process. I collected data over the course of two qualitative interviews with ten emergency service workers. The primary goal of this study was to understand the lived experiences of emergency service workers and their treatment of individuals with mental health conditions. Additionally, the study aimed to explore the training of emergency department workers in regards to mental health treatment and psychological approaches. Each participant identified a situation in which they encountered someone in a mental health crisis and described it in rich detail. Following their descriptions of

the incidents, I asked them a series of open-ended questions about their experiences in working in emergency capacities. Following each interview, I transcribed the participants' answers word for word. Then I used open and axial coding to examine recurring patterns and trends in the data.

Eight major themes emerged in the data. These themes or axial codes represented the participants' experiences in working with mental health conditions, treatment approaches, and internal interpretations of incidents. Each of the participants varied in their experiences in situations that involved individuals with mental health conditions. Additionally, the participants differed in their descriptions of mental health conditions and crises. The amount of training for working with psychological conditions varied widely across each participant.

The chapter presented interview transcripts, sample demographics, and data analysis approaches. Presentation of the axial codes and in-depth descriptions of these codes followed. The chapter concluded with a summary of the collected data. Chapter V presents a review of the open, axial, and selective codes that is followed by a discussion of the three theoretical codes. Next explanations of the data's relationship to the research questions and implications for the field materialize. Finally, I discuss recommendations for the counseling field and future studies. The chapter concludes with an overview of the findings and lessons learned from the study.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

Organization of the Chapter

The purpose of this qualitative, phenomenological study was to capture the lived experiences of emergency department and service personnel who treat individuals with mental health issues. The participants responded to semi-structured interview questions, which served to highlight their experiences and perceptions related to working with clients with psychiatric conditions. The results of the findings provide insight into helpful approaches and potential barriers to treatment in emergency department settings. The study's findings may assist policy makers and clinicians to generate more effective treatment strategies and encourage continuing education opportunities for working with individuals with mental health needs. The themes generated by the data in Chapter Four facilitated understanding of the phenomenon of interest.

The final chapter begins with an introduction to the summary of the results and subsequent recommendations. This is followed by a presentation of open, axial, and selective coding processes. Next, the chapter contains a discussion of the three theories that were conceptualized after data analysis. Answers to the dissertation's research question and sub-question follow the aforementioned section. Finally, interpretation of the data and recommendations in relation to the counseling field and future research endeavors concludes the chapter.

Introduction

The purpose and intent of this phenomenological, qualitative inquiry investigated the lived experiences of emergency service workers with treating individuals with mental health

conditions. By viewing the data through ground theory, I saw patterns in data and acquired a greater understanding of emergency workers' lived experiences, personal meanings, and treatment approaches. I chose a phenomenological approach to understand the essence of the participants' experiences. A purposive sampling approach afforded me with opportunities to investigate multiple professions who work with individuals with mental health conditions. 10 participants, who were working in emergency services settings, completed the study. Each participant had at least one or more years of experience in working with individuals with various mental health conditions. Data collection was accomplished through interviews, observations, and documents collection. I transcribed all interviews word by word and provided participants with copies of their transcripts to ensure credibility. Upon reviewing the transcriptions, I utilized open-coding line by line to identify emerging categories. I used the constant comparison to identify similarities and differences between each data point. After the categories were clustered into themes, theoretical coding occurred to provide context for the study's findings. The following section reviews the open and axial coding process and presents the concept of selective coding.

Codes

Initially I reviewed all the participants' transcripts in order to determine the preliminary coding structures for data organization. Throughout this process I recorded open codes that were units of meaningful data. Next axial coding occurred which consisted of identifying higher level categories that were based on patterns within the open codes. During this process eight axial codes emerged, including: (1) personal history; (2) training; (3) chief complaint; (4)

interventions with sub-axes (a) medical and (b) psychiatric; (5) internal emotional experiences; (6) perceptions of the patients; (7) post-incident coping; and (8) post-incident reflections. The final level of coding focused on distinguishing overarching themes related to pre-incident experiences, in vivo experiences, and post-incident experiences that emerged throughout the study. An overview of selective codes is reviewed in the following section. Table 5.1 displays the relationships between the open, axial, and selective codes.

Table 5.1

Relationships between open, axial, and selective codes

Open Codes	Axial Codes	Selective Codes
“best friend committed suicide”	Personal History	} Pre-Incident Experiences
“CEU’s” “on the job”	Training	
“suicidal” “psychotic”	Chief Complaint	} In Vivo Experiences
“CBC” “gastric lavage”	Interventions (Medical and Psychiatric)	
“counseling” “hooks and barbs” “in shock”		
“overwhelming”	Internal Emotional Experience	} Post Incident Experiences
“intoxicated” “good people”	Perceptions of the Patients	
“counseling” “talking”	Post-Incident Coping	
“need more facilities”	Post-Incident Reflections	

Open Codes

In open coding the researcher relies on the constant comparative method in his/her data analysis (Glaser & Strauss, 1967). Open-coding yields specific units of meanings that accurately describe the experience of the individual. Initial coding remains close to the data and is conducted “word-by-word, line-by-line, meaning unit-by-meaning unit, or incident-to-incident” (Morrow, Castañeda-Sound, & Abrams, 2012, p.101). The researcher identifies codes that are simple, short and as close to the participants’ words as possible. The researcher compares open codes to one another and gradually begins to group them into categories. Open coding affords the research to examine his or her preconceived concepts by comparing them against the data.

Axial Codes

Axial coding consists of the researcher defining the properties of the open codes and formulating the basis for theories about the phenomenon. In this process, the researcher organizes relationships among categories and explicates them. Corbin and Strauss stated “in axial coding categories are related to their subcategories and these relationships tested against data” (Corbin & Strauss, 1990, p.40). Categorizing and assigning properties during axial coding enhances the researcher’s abilities to specify interrelationships among categories and encourages the researcher to develop theories that fit the experiences described by participants (Fassinger, 2005).

Selective Codes

Following axial coding, selective coding occurred. This is the final stage of data analysis in which the creation of theories occurs. The process begins with selective coding during which a

central category is selected that encompasses all other categories into “an exploratory whole” (Strauss & Corbin, 1998, p. 146). The emerging theories answer the researcher’s questions and provide a narrative of important aspects of the data. The emerging theory is constantly compared to the dataset to ensure that it is “grounded in participant’s experiences” (Fassinger, 2005, p.161). Additionally, the researcher compares the theories to the existing literature to enhance understanding. I ensured that data had reached saturation by re-examining the dataset and looking to see if any new themes emerged.

Data analysis revealed eight different axial codes, which were based on open codes supplied by the participants. With the use of grounded theory, the following axial codes developed the theoretical codes: (1) personal history; (2) training; (3) chief complaint; (4) interventions with sub-axes (a) medical and (b) psychiatric; (5) internal emotional experiences; (6) perceptions of the patients; (7) post-incident coping; and (8) post-incident reflections. These axial codes lead to the identification of the following theoretical codes: (a) pre-incident experiences, (b) in-vivo experiences, and (c) post-incident experiences. The results contribute to a framework for working with individuals with mental health conditions and a compelling argument for more training opportunities for learning techniques and strategies for treating psychological conditions.

Discussion of Theory 1: Pre-Incident Experiences

The first selective code to emerge from the data was pre-incident experiences. Two axial codes supported pre-incident experiences and this selective code answered the research question and one sub-question. The axial codes included personal experience and training. The results

suggest that current training endeavors for emergency professionals are limited to a class or online seminar. Multiple participants reported that they believed that the amount of training was not adequate in light of the severity of situations that they frequently encounter.

Three out of the four police officers that were interviewed indicated that they desired additional training for working with individuals with mental health conditions. These results are consistent with the literature in regards to feeling ill-prepared when addressing psychiatric conditions (Bittner, 1967; Reuland, Schwarzfeld, & Draper, 2009). Researchers suggested that officers' misunderstandings of behaviors may enhance these feelings of not being prepared (Morabito et al., 2012). One of the officers had multiple years of experience on the police force and pursued additional training regarding working with mental health conditions, thus he was the exception out of the four participants interviewed.

In regards to the nursing participants, all of them reported that they received a semester of nursing school that focused on mental health conditions. When asked if they believed that additional training would be helpful, every nurse participant responded that they thought this would be beneficial. The firefighter/paramedics also detailed that they received approximately one semester of education about mental health conditions and treatment of various crisis situations. Most of them reported that they did not believe that this was adequate given the frequency of encountering individuals with mental health conditions. These findings are consistent with a study conducted by Alexander and Klein (2001), who reported that 38% of the participants said that better training would have helped them address emergency situations more

successfully. One of the firefighter/paramedics attended a police academy that was unique in regards to preparing emergency service personnel to work in behavioral health crisis conditions.

In addition to training, some of the participants reported that they had personal experiences with psychiatric crises. As mentioned previously, one of the officers described the death of one of his best friends and the impact on his approaches with addressing psychiatric conditions. Another participant, who was an emergency department nurse, mentioned her personal experience with mental health treatment. She said that she felt as if she could relate more with individuals with mental health conditions because she had gone through a similar experience. Both participants' personal experiences and training founded the rationale for choosing pre-incident experiences.

Discussion of Theory 2: In-Vivo Experiences

The second major category of findings reflects the participants' experiences, treatment approaches, and perceptions of situations related to mental health crises or conditions. The selective code that captures these revelations was in-vivo experiences. The participants in this study encountered six different types of psychiatric crises including: (a) suicidal thoughts or attempt, (b) homicidal thoughts or attempt, (c) psychotic episode, (d) substance use, (e) abuse or trauma, and (f) bereavement. In response to these situations each participant described a medical or psychiatric intervention that aimed to decrease distress or eliminate risk factors. Additionally, the participants discussed their internal reactions to the incidents and their perceptions of the patients. All of these factors contributed to the theory of in-vivo experiences.

In general, emergency department workers worldwide report that they are seeing an increase in mental health related visits (Broadbent, Creaton, Moxham, & Dwyer, 2010; Wand & White, 2007; Reed & Fitzgerald, 2005) All of the nurses reported that they conducted a triage process to assess an individual's severity. Researchers cite this intervention frequently when discussing mental health evaluations in emergency department settings (Broadbent, Jarman, & Berk, 2004; Stuhlmiller, Tolchard, Thomas, de Crespigny, & King, 2004). Nurses conducted triages on every situation that they detailed in their responses to interview questions, which is consistent with the literature findings.

Other medical interventions that nurses and paramedics utilized included, “a UA and a urine drug screen and a CBC, BMP, TSH, and a ETOH” (N6/3-4) and administering Narcan or Romazicon in cases of overdoses. Upon comparison with findings from the literature, these interventions are supported by reports from other emergency services personnel (McCaig & Nawar, 2006; Niska, Bhuiya, & Xu, 2010; Sasser et al., 2010). In addition to medical treatment, emergency department and service personnel described psychological interventions used in situations with people with mental health conditions. They included talking with the individual, discussing matters with family members, including spiritual guidance, and verbally de-escalating situations. Throughout the literature, researchers cited psychosocial interventions as effective in reducing relapse rates (Pharoah, Mari, Rathbone, & Wong, 2010), decreasing caregiver burden (Lobban et al., 2013), and improving quality of life (Bernabei et al., 2013). Additionally, researchers discovered that verbal de-escalation is the key when engaging with individuals

experiencing behavioral health crises because this allows them to be active partners in treatment (Richmond et al., 2012).

Cordner (2006) found that police officers often approach situations involving individuals with mental health conditions using the same strategies that they would for any other type of call or encounter. The current study's results supported this finding, as many officers reported that they addressed situations involving people with mental health conditions just as any other call.

Upon further investigation of the literature, the finding that interactions with people with mental illness can be frustrating and unpredictable is common through research findings. In particular, police officers describe interactions with individuals with psychiatric conditions as time-consuming, and a waste of resources (Bittner, 1967; Lurigio & Swartz, 2000; Reuland, Schwarzfeld, & Draper, 2009). When I interviewed the police officer participants, they did not indicate that they experienced frustration nor did they view psychiatric calls as frivolous. In contrast, they expressed empathy toward people who were in psychological crises and viewed them as deserving individuals of support.

In regards to perceptions of the patients, one nurse reported that upon receiving an individual with mental health needs she knew that the process of finding placement would be slow (N6/4). This notion is paralleled by findings of a study conducted by Marynowski-Traczyk and Broadbent in 2011. They examined emergency department nurses who were caring for individuals with mental illness by using semi-structured interviews to capture their lived experiences. They found that nurses perceived individuals with mental health conditions to slow the work pace down and require additional attention. The nurses in the study also reported that

individuals with psychiatric conditions adversely affected their ability to deliver best care (Marynowski-Traczyk & Broadbent, 2011).

Discussion of Theory 3: Post-Incident Experiences

The third and final theory was post-incident experiences. This theory was founded on the axial codes of post-incident coping and post-incident reflections. Emergency service workers often encounter situations that are distressing and at times traumatic. In response to these incidents, personnel cope in different ways. The participants reported talking with co-workers, seeking out counseling, and meeting with other emergency service workers were all helpful ways to deal with difficult emotions and images. A study conducted by Adriaenssens, Gucht, and Mae (2012) found that social support and emotional coping decreased the likelihood of developing PTSD within a sample of emergency department nurses.

Another study explored the effects of coping and social support in regards to psychological distress among police officers (Patterson, 2003). He interviewed 233 officers and assessed their coping mechanisms with a sixty-six item Ways of Coping Questionnaire (WAYS) (Folkman & Lazarus, 1998). The participants indicated that seeking social support and emotion-focused coping provided a buffer between work events and distress (Patterson, 2003). These findings were paralleled with the current study's results.

Finally, the participants' post-incident reflections included reporting the need for more inpatient beds, recommending approaches for future emergency service personnel, and identifying the need for counselors in emergency departments and services. Multiple participants reported the increased need for inpatient beds. This notion is significantly reflected in the

literature (Appelbaum, 2015; Manderscheid, Atay, & Crider, 2015; Zeller, 2010; Zeller, Calma, & Stone, 2014). Additionally, participants described the need for implementing counselors into the emergency workforce. Some states law enforcement agencies integrated mental health professionals into their police forces and witnessed lower arrests rates of individuals with mental illnesses (Steadman, Dean, Borum, & Morrissey, 2000), increased safety and diversion to mental health facilities (Dupont & Cochran, 2000), and reduction of risks to officers and individuals with psychiatric conditions (Hanafi, Bahora, Demir, & Compton, 2008). Recommendations for future emergency service workers included practicing patience and remembering that mental illness does not discriminate.

Answering the Research Question and Sub-questions

The following was the study's main research question:

How do emergency personnel who have worked with individuals with mental illness describe their lived experiences?

To answer this question, I used findings that were gleaned from the data set. As previously mentioned, data analysis included open, axial, and selective coding. Open coding involved the identification of meaning units from the participants' interviews that were clustered into categories. These categories or axial codes were the basis for the selective coding process. I developed three theories based on both the selective codes and findings from the literature. The theories included pre-incident experiences, in-vivo experiences, and post-incident experiences.

The participants' pre-incident experiences referred to their own personal interactions with mental health conditions as well as previous training that they received. Participants described

experiencing the aftermaths of suicides and their own mental health treatment and attributed their approaches to situations as influenced by their situations. For the most part their training did not adequately prepare them for treating individuals with psychiatric conditions. One of the officers said that he received more educational opportunities than most in approaches for crisis situations, but he was an exception. The training afforded participants with a general knowledge about diagnosis and safety protocols in working with mental health conditions.

Another theory was the in-vivo experiences of the participants. Each participant described their lived experiences in encountering individuals with mental health conditions and identified presenting problems that clients had. Their situations ranged from treating individuals with suicidal thoughts to de-escalating violent encounters. In response to these incidents the participants detailed medical and psychiatric treatments that they enacted. Depending on their professional field, they implemented interventions that were conducive to stabilizing the patient. As mentioned in the previous chapter, the term “patient” is appropriate for the purposes of this study as this is the term that the participants used to identify individuals with mental health conditions.

Medical treatment included running blood panels, assessing vital signs, and administering antagonist agents in overdose cases. Psychiatric treatment consisted of using active listening skills and verbally de-escalating patients who were in distress. The participants also described their internal emotional experiences when encountering patients with psychiatric conditions. Most of the participants reported unpleasant emotions such as “shock” and “concerned about

safety.” Their answers were based on their lived experiences in working with individuals in behavioral emergencies and crises.

The final component of the in-vivo experiences was the participants’ perceptions of the patients. In other words, this aspect concerned pre-conceived notions and beliefs about patients’ conditions. Some of the participants described their understanding of chief complaints in relation to the patients’ backgrounds. For example, one of the participants said that a patient was experiencing suicidal thoughts because he was alone. Other participants reported beliefs that placement would be difficult for patients with psychiatric conditions. In sum, the participants described their lived experiences at the time of the situation as identifying a chief complaint, implementing treatment, experiencing emotions in response to the situation, and recognizing pre-conceived notions about patients.

The last theory was post-incident experiences. This theory referred to the participants’ reactions and internalizations to situations in which patients presented with mental health issues. Participants described their recommendations for providing more efficient services for patients with mental health conditions as well as ways that they coped with experiencing crisis situations. Recommendations included more inpatient facilities and implementing counseling services into emergency departments. The suggestion for more inpatient options was common among every participant when asked about advice for treating patients with psychiatric conditions. In regards to coping with situations, some of the participants described talking with co-workers as helpful. Others reported that counseling services were available for emergency service workers following particularly stressful incidents.

In response to the research question, the answer is the lived experiences are captured by pre-incident, in-vivo, and post-incident experiences. All of these theories were derived from the participants' answers to semi-structured interview questions.

In addition to the primary research question, the study's data answered two sub-questions. The two sub-questions were as follows:

1. How do emergency department professionals provide treatment for individuals with mental illnesses if the primary complaint was specifically related to their psychiatric condition?
2. How do emergency department professionals describe their training for working with individuals with mental health needs?

The first research sub-question's answer included in-vivo experiences. As previously stated, each participant reported a situation in which the chief complaint was psychiatric in nature. Their responses included experiences with individuals who reported suicidal thoughts, psychotic symptoms, homicidal thoughts, and experiences of traumatic events. Each situation warranted interventions that included both medical and psychiatric approaches that were discussed in the previous section. As a review, medical interventions included urinalysis, blood analysis, monitoring blood pressure and heart rate, and administering medications if the situation warranted them. Psychiatric approaches included talking with family members, accessing a chaplain for support, and verbally de-escalating crisis situations.

In response to the second sub-question, participants described their training through their pre-incident experiences. The participants came from different professions, thus each discipline

had different training criteria. The emergency department nurses reported that they received training through CEU's and a class they attended in nursing school. Police officer participants reported that they received educational exposure to mental health conditions through online courses taught by the Criminal Justice Institute. Additionally, all of the police officers completed police academy training, which briefly touched on working with individuals with psychiatric conditions. The exception to the collective police officers in the study was one officer who had sought out additional training on a state level. Finally, the firefighter/paramedic and EMT participants reported that they received training through a class during their academic experiences.

Summary of Findings

This qualitative phenomenological study investigated the lived experiences of emergency department and service professionals in regards to working with individuals with mental health conditions. The data answered the researcher's question and sub-questions. This study identified and illuminated various treatment approaches, post-incident coping strategies, and participants' recommendations for the emergency field. Eight axial codes emerged that converged into three theories. Results of the gathered data revealed that participants experienced individuals with mental health conditions in three realms: pre-incident, in-vivo, and post-incident experiences.

Implications of Results to Counseling Field

The phenomenological lived experiences of emergency services professionals gleaned from the study's interviews can facilitate dialogue in the medical field as well as counseling field. Based on the participant's responses to interview questions, one can recognize this

importance of sharing information between both counselors and emergency professionals as to types of treatment options and approaches. The current study investigated the lived experiences of emergency department and services workers who work with individuals with mental health conditions. Eight axial themes emerged from analysis of the data and highlighted similarities and differences within each participant's lived experiences and personal interpretations. These parallels and variations highlight the nature of mental health.

Findings from the study that implicate change in emergency services include: (a) additions of counselors on the front lines of emergency responses, (b) facilitation of meetings regarding service provisions, and (c) expansion of inpatient services within the community. Participants who worked as emergency service personnel responded to crisis calls that often involve individuals with mental health needs. These same participants reported limited training in regards to effective treatment approaches, thus a logical solution to this gap would be to include a counselor alongside emergency service workers. Most counseling programs require students to complete a course in crisis counseling in addition to multiple other counseling courses. Since this is their area of expertise, the inclusion of counselors would be beneficial to the individual in crisis.

Another aspect that administrators and directors could implement is facilitating meetings between various service outlets. These meetings could open a dialogue between professionals about their treatment of individuals with mental health conditions and may lead to problem resolutions. The final area of implication is the expansion of mental health facilities, particularly inpatient facilities. The participants repeatedly underscored the lack of treatment options for

patients with psychiatric conditions. By adding on more beds and expanding facilities' capabilities to treat complex medical issues, overcrowding and wait times in emergency departments most likely would decrease.

Recommendations for the Counseling Field

The findings of the study highlighted the frequency of addressing mental health conditions by providers that are not within mental health settings. All of the participants reported that they encounter individuals with psychiatric conditions on a regular basis. Despite limited initial training in working with mental health conditions, most participants reported that they utilize verbal interventions with individuals. The following are recommendations for the counseling field:

1. Mental health providers working within agency settings should encourage administrators to expand their services to emergency department settings. This endeavor could be collaborative in nature and would serve to smooth out the transitions of clients from emergency department settings to inpatient treatment to outpatient settings.
2. Counselors should pursue additional training concerning treating emergency psychiatric conditions. This could involve going to conferences or participating in seminars.
3. Finally, counselors could facilitate workshops for emergency service and department workers in regards to working with individuals with mental health conditions.

Recommendations for Counselor Educators

The following are recommendations for counselor educators based on the study's findings:

1. The development of treatment protocols specific for working with individuals in emergency settings would be beneficial to both clients and emergency services workers. Very few treatment approaches have been indicated by clinicians and researchers for these specific presenting problems.
2. Extending educational opportunities to emergency service workers would facilitate understanding of mental health conditions and treatment approaches. Additionally, the more events available to other disciplines outside of counseling, more likely helpful conversations will occur concerning better ways to serve clients.
3. Counselor educators could also provide seminars or semester classes to nursing school students to disseminate information about counseling techniques for crisis situations. Additionally, strategies for approaching bereaved individuals in medical settings could be taught by counselor educators to upcoming nurses.
4. Counselor educators could also facilitate discussions with counseling students about implementing appropriate techniques with individuals in emergency situations. Most counseling students learn about crisis counseling within their graduate program, so a logical step would be to present information about real-life situations that would necessitate crisis interventions.

Recommendations for Future Research Endeavors

Recommendations for future research include:

1. Future studies could examine police officer's approaches in working with individuals with mental health conditions on a national level. This could elucidate protocols that are effective for de-escalating situations and ensuring that individuals are linked to mental health services.
2. Additionally, researchers could investigate the experiences of ambulance transport services and their coordination efforts with local hospitals and inpatient psychiatric facilities. Many of the firefighter/paramedic participants reported that transportation of individuals experiencing psychiatric conditions was unnecessary at times.
3. Quantitative approaches could capture the effectiveness of treatment approaches by emergency department nurses in regards to the clients' severity of symptoms. Researchers could administer the Beck Depression Inventory to the participant pre and post talking with emergency department nurses.
4. Additional studies that explore similar phenomena are needed. Upon reviewing the literature concerning this phenomenon, one can clearly identify gaps in understanding experiences of emergency service personnel and treating psychiatric conditions.
5. Finally, emergency service workers' internalization of witnessing repeated trauma could be an area in which researchers could glean information. This could assist

administrators in developing protocols for effectively debriefing service workers after distressing events.

Researcher's Reflections

My personal experience is that I am a licensed counselor and clinical researcher. I encounter individuals in various states of crises on a daily basis. For approximately five years I worked as a mental health professional who assessed individuals in hospitals, jails, police departments, schools, and outpatient clinics for medical necessity of inpatient care. Over the course of my experiences I have concluded that the mental health system has gaps. Gaps refer to the notion that individuals are not receiving adequate mental health treatment due to insurance issues and slow responses to requests for services. My personal and professional interactions with emergency department workers and emergency personnel allowed me to experience the phenomenon.

Upon conducting a literature review, I was struck by the lack of information concerning treatment protocols or approaches with individuals with particular psychiatric conditions. For example, I had difficulty finding evidence-based counseling approaches for working with individuals experiencing suicidal thoughts in a crisis context. Many theories have indications for crisis situations, but limited evidence-based interventions are appropriate for emergency department settings. Another area that intrigued me was the perceived lack of inpatient beds available for patients with psychiatric conditions. I had unrestricted access to knowledge about bed availability at a local inpatient hospital and found that it had multiple beds available during times that emergency department staff were stating otherwise. I am not certain where the

communication breakdown is occurring and whether or not it is purposeful, but it is clear that somewhere along the lines resources are not being properly allocated.

One final area that I found to be important was that almost every participant that I interviewed reported that they had never been asked about their experiences regarding the phenomenon. They were eager to discuss their thoughts and experiences with me, as they had not done so before. I think that tapping into the knowledge base of emergency professionals in regard to providing treatment and streamlining transitions to inpatient care would prove to be valuable for the community.

Conclusion

This chapter brought the investigation of the lived experiences of emergency service workers with individuals presenting with mental health conditions to a close. The chapter began with an overview of the layout, review of data analysis procedures, selective codes, and discussion of theoretical codes. Next I discussed the answers to the research question and sub-questions. Finally, the chapter explored implications for the counseling field, recommendations for counselors and counselor educators, and directions for future research endeavors. The last section of the chapter presented my personal reflections on the phenomenon and my experiences.

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Appendices

Appendix A

Informed Consent Forms

**An Investigation into the Needs for Counselors in Emergency Departments as Perceived by
Emergency Personnel**

Consent to Participate in the Research Study

Principal Researcher: Sarah Neubauer

Faculty Advisor: Dr. Roy Farley

Instructions:

Please read this consent form carefully and take your time about making a decision as to whether to participate. As the researcher discusses this consent form with you, please ask her to explain any words or information that you do not clearly understand. The purpose of the study, risks, inconveniences, discomforts, and any other relevant information about the study are listed below. If you decide to participate you will be given a copy of this form.

Why is this study being done?

This study is being done to investigate the perceptions and experiences of emergency department personnel in regards to mental health issues and the need for licensed counselors. The researcher believes that an understanding of your experiences will help us improve mental health services currently being implemented in emergency rooms.

Why is this considered research?

This is a research study because the researcher is asking you to provide information about your experiences in a real world setting.

Why am I being asked to participate in this study?

You are being asked to take part in this study because you are currently working as a medical professional at an emergency department.

Do I have to participate in this study?

No. You have the right to choose whether or not you want to take part in this study. If you decide to participate and later change your mind, you have the option to stop participation at any time. If you decide to stop participating at any time, all information that you have provided will be destroyed and omitted from the study.

How many people will take part in the study?

Approximately ten individuals will participate in the study.

What is involved in the study?

If you volunteer in the research study, you will be asked to sign this consent form, participate in an interview, and answer any additional follow-up questions the researcher may have.

How long can I expect to be in the study?

IRB #16-04-710
Approved: 05/10/2016
Expires: 05/09/2017

You will be asked to complete the consent form one time prior to engagement in the study. Following completion of the form, you will participate in a 45 to 60 minute interview. Upon completion of the interview, you will be asked by the researcher if she can follow-up with any questions that may arise during the transcription phase of the study's analysis. The follow-up questions would take approximately 10 to 15 minutes to complete.. However, if you decide to discontinue participation at any time you will be immediately released from the study and any information collected will be destroyed.

What are the risks of the study?

Study Procedure

The study does not involved the administration of any medical procedures or test interventions. At this time there are no known physical risks with participation in the research protocol.

Psychological Stress

Some of the questions that the researcher will ask you as a part of the study may make you feel uncomfortable. If any questions cause distress you may discuss its importance with the researcher. After discussing the question, if you still feel uncomfortable you may refuse to answer questions. You may also take a break or stop your participation in this study at any time.

Loss of Confidentiality

Any time information is collected; there is a potential risk for loss of confidentiality. Every effort will be made to keep your information confidential; however, this cannot be guaranteed.

How will risks be minimized or prevented?

The researcher is knowledgeable and experienced in response to emotional and psychological difficulties. During the course of this research study, if you experience any emotional or psychological difficulties you will be referred to appropriate service providers for interventions just as if you were not participating in this study. To help protect the confidentiality of your personal information, the researcher will limit the personal identifiers collected and stored in the research record. Your collected research record will be maintained in a secure, double locked facility, and only the researcher will have access to your research record. When the study is completed and there is no longer a need to use the research, your collected research record will be securely destroyed. All electronic research records will be maintained on a secure, stand-alone computer not connected to any network and accessible only to the researcher. All data sets used for data analysis will be de-identified and accessible only to the researcher.

What are my responsibilities during the study?

Your responsibilities include asking questions about anything that you do not understand, following the researcher's instructions, and reporting to the researcher any discomforts.

If I agree to participate in this study, will I be informed of any new risks that may be found during the course of the study?

IRB #16-04-710
Approved: 05/10/2016
Expires: 05/09/2017

Yes. You will be informed if any new information becomes available during the study that could cause you to change your mind about participating or that is important to your health or safety.

What are the potential benefits of this study?

If you agree to take part in this study, you will receive an incentive of a \$25 gift card after the initial semi-structured interview and additional \$25 gift card after completion of the final interview. The researcher cannot guarantee that you will benefit from participation in the study. Your contributions may help emergency personnel attain better understanding of the potential benefits of implementing counselors into emergency rooms as well as provide insights into mental health issues encountered.

What options are available if I decide not to take part in this research study?

This is not a treatment study. Participation in this study will not impact your medical or psychological care in any way.

If I agree to take part in this research study, can I be removed from the study without my consent?

Yes. The researcher may decide to take you off of this study if the researcher believes that participation is no longer safe for you or if you are unable to follow the researcher's instructions.

Will my information be kept confidential?

Information about you that is collected for this study will remain confidential, unless you give your permission to share it with others or if the researcher is required by law to release it. You should know that certain organizations may look at and copy your medical records for research, quality assurance, and data analysis include:

- Representative of government agencies, like the U.S. Food and Drug Administration, involved in keeping research safe for individuals
- The University of Arkansas Institutional Review Board

Whom do I call if I have questions or problems?

For questions about the study contact Sarah Neubauer at 479-783-3740. For questions about your rights as a research participant, contact the University of Arkansas Institutional Review Board (IRB) Office at 479-575-4572.

IRB #16-04-710
Approved: 05/10/2016
Expires: 05/09/2017

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP.

Your signature below certifies the following:

- You have read (or been read) the information provided above.
- You have received answers to all of your questions and have been told who to call if you have any more questions.
- You have freely decided to participate in this research.
- You understand that you are not giving up any of your legal rights.

Participant's Name (printed)

Participant's Signature

Date

Witness (printed)

Witness (signature)

Date

IRB #16-04-710
Approved: 05/10/2016
Expires: 05/09/2017

Appendix B

IRB Approval



Office of Research Compliance
Institutional Review Board

May 11, 2016

MEMORANDUM

TO: Sarah Wohlford
Roy Farley

FROM: Ro Windwalker
IRB Coordinator

RE: New Protocol Approval

IRB Protocol #: 16-04-710

Protocol Title: *The Lived Experiences of Emergency Department Personnel in Working with Individuals with Mental Health Needs*

Review Type: EXEMPT EXPEDITED FULL IRB

Approved Project Period: Start Date: 05/10/2016 Expiration Date: 05/09/2017

Your protocol has been approved by the IRB. Protocols are approved for a maximum period of one year. If you wish to continue the project past the approved project period (see above), you must submit a request, using the form *Continuing Review for IRB Approved Projects*, prior to the expiration date. This form is available from the IRB Coordinator or on the Research Compliance website (<https://vpred.uark.edu/units/rscp/index.php>). As a courtesy, you will be sent a reminder two months in advance of that date. However, failure to receive a reminder does not negate your obligation to make the request in sufficient time for review and approval. Federal regulations prohibit retroactive approval of continuation. Failure to receive approval to continue the project prior to the expiration date will result in Termination of the protocol approval. The IRB Coordinator can give you guidance on submission times.

This protocol has been approved for 10 participants. If you wish to make any modifications in the approved protocol, including enrolling more than this number, you must seek approval *prior to* implementing those changes. All modifications should be requested in writing (email is acceptable) and must provide sufficient detail to assess the impact of the change.

If you have questions or need any assistance from the IRB, please contact me at 109 MLKG Building, 5-2208, or irb@uark.edu.

Appendix C

Initial and Follow-Up Interview Protocol

Initial Interview:

1. Arrive at the agreed upon interview site. Initiate the verbal exchange with an introduction to the study and ask for the participant's permission to begin digitally recording.
2. Review the inclusion criteria to ensure the participant is eligible for the study.
3. Present the informed consent information and the corresponding form. Allow time for the participant to review the form and verbally summarize the information on the form. Answer any questions or concerns that the participant has about informed consent (Appendix A).
4. After the participant signs the consent form, explain the purpose of the study and assignment of the pseudonym for confidentiality purposes. Summarize the transcription process of the interview and steps to ensure confidentiality. Provide a timeline for the interview.
5. Demographic Questions include:
 - a. Gender: _____Male _____Female
 - b. Age: _____
 - c. Race: _____
 - d. Profession: _____
 - e. Job Title: _____
 - f. Years of Employment in Profession: _____
 - g. Years of Employment in Emergency Department: _____

6. Interview Questions: Prior to asking the interview questions, I began the meeting with a short introduction that included the following:

Introduction: I am interested in the experiences of individuals who work in emergency department settings. In particular I am interested in their experiences of treating or assisting individuals with mental health conditions. In addition, I am interested in the treatment protocols that were administered or enacted when working with these individuals and previous training that the emergency personnel workers had with mental health conditions. For the purposes of this interview, please identify a situation that occurred when working in the emergency department that involved treating an individual with a mental health condition.

Questions:

- Describe the situation in as much detail as possible.
- How would you describe the chief complaint of the individual in the situation?
- Describe your reactions to this situation.
- Describe the steps that you took to address the situation.
- What lessons did you learn from this experience?
- Describe the training that you have received specifically for treating mental health issues in an emergency room setting.
- What approaches do you utilize when encountering individuals with mental health issues?
- As you look back now, what may have been missing in your training for treating

individuals with mental health issues?

- What suggestions do you have for future emergency workers who may encounter individuals with mental health issues?
- Are there certain mental health services that you think are lacking in the emergency department that you work in?
- Is there anything else that you would like to comment?
- What has it been like to talk about your experience?
- Allocate time for the participant to provide feedback, clarification of answers, and reflections about the interview questions.
- Conclude the interview with a reminder about confidentiality and schedule a follow-up interview.

Follow-up Protocol

1. Arrive at the previously agreed on interview site. Ask the participant for permission for digitally recording the interview.
2. Provide the participant with a transcribed interview and prompt the participant to check the transcript for accuracy. If the participant indicates that changes need to be made, the researcher will note these changes in the margins of the transcript.
3. Ask for feedback and reflections if needed.
4. End the follow-up interview with assurance of confidentiality.

Appendix D

Demographic Questionnaire

- What is your gender?
- What is your age?
- What ethnicity do you identify as?
- What is your profession?
- What is your job title?
- How many years have you been employed in your particular profession?
- How many years have you worked in the emergency department?

Appendix E

Semi-structured Interview: Round One

Background Information

Research Topic: Emergency department personnel's experience in working with individuals with mental illnesses.

Research question: How do emergency personnel who have worked with individuals with mental illness describe their lived experiences?

Research sub-questions:

1. How do emergency department professionals provide treatment for individuals with mental illnesses if the primary complaint was specifically related to their psychiatric condition?
2. How do emergency department professionals describe their training for working with individuals with mental health needs?

Introduction: I am interested in the experiences of individuals who work in emergency department settings. In particular I am interested in their experiences of treating or assisting individuals with mental health conditions. In addition, I am interested in the treatment protocols that were administered or enacted when working with these individuals and previous training that the emergency personnel workers had with mental health conditions. For the purposes of this interview, please identify a situation that occurred when working in the emergency department that involved treating an individual with a mental health condition.

Questions:

- Describe the situation in as much detail as possible.
- How would you describe the chief complaint of the individual in the situation?

- Describe your reactions to this situation.
- Describe the steps that you took to address the situation.
- What lessons did you learn from this experience?
- Describe the training that you have received specifically for treating mental health issues in an emergency room setting.
- What approaches do you utilize when encountering individuals with mental health issues?
 - *Optional Prompts:*
 - *What approaches do you use with individuals presenting with suicidal thoughts or attempts?*
 - *What approaches do you use with individuals presenting with psychosis?*
 - *What approaches do you use with individuals presenting with symptoms relating to experiencing traumatic events?*
- As you look back now, what may have been missing in your training for treating individuals with mental health issues?
- What suggestions do you have for future emergency workers who may encounter individuals with mental health issues?
- Are there certain mental health services that you think are lacking in the emergency department that you work in?
- Is there anything else that you would like to comment?
- What has it been like to talk about your experience?

Thank you for your time.

Appendix F

Semi-structure Interview: Round Two

Background Information:

Research Topic: Emergency department personnel's experience in working with individuals with mental illnesses.

Research question: How do emergency personnel who have worked with individuals with mental illness describe their lived experiences?

Research sub-questions:

1. How do emergency department professionals provide treatment for individuals with mental illnesses if the primary complaint was specifically related to their psychiatric condition?
2. How do emergency department professionals describe their training for working with individuals with mental health needs?

Introduction: I am interested in the experiences of individuals who work in emergency department settings. In particular I am interested in their experiences of treating or assisting individuals with mental health conditions. In addition, I am interested in the treatment protocols that were administered or enacted when working with these individuals and previous training that the emergency personnel workers had with mental health conditions. For the purposes of this interview, please identify a situation that occurred when working in the emergency department that involved treating an individual with a mental health condition.

During our last interview, I asked you to recall a situation in the emergency department when you encountered an individual with a mental health condition. I asked you a series of questions about your experiences during that particular instance. In addition to your interview I have

conducted similar interview with other emergency department professionals. Data from the interviews in the first round were analyzed to underscore and interpret each individual's experience and generate themes. During this second interview, I will present these themes to you for further clarification and modification.

Questions:

- As you look back on our first interview, is there anything that stands out in your mind?
- Is there anything that you would like to add to our previous discussion about treating individuals with mental health issues?
- Is there anything that you would like to ask me at this point?
- During our first interview you described your experiences and training in working with clients experiencing mental health issues. Would you mind saying more about:
 - (specific theme identified during data analysis)
 - (specific theme identified during data analysis)
 - (specific theme identified during data analysis)
 - (specific theme identified during data analysis)
 - (specific theme identified during data analysis)
- Additional themes emerged from other interviews conducted during the first round. Would you mind sharing your thoughts about:
(specific theme identified during data analysis)
 - (specific theme identified during data analysis)

- (specific theme identified during data analysis)
- What do you think are the most important elements when treating an individual with a mental health issue in the emergency department?
- Is there anything else that you think would be helpful for me to know to understand the experiences of emergency department personnel who work with individuals with mental health issues?
- Is there anything else that you would like to ask me?

Thank you.

Appendix G

Process Note Example

Thoughts	Feelings	Impressions	Questions
<p>This is rich information coming from a very credible source. I need to follow up and ask him about experience with individuals with substance abuse issues.</p>	<p>I feel anxious talking to this particular participant as he is a high ranking officer. I feel worried that I will not be able to capture all of the details during the interview.</p>	<p>Most of the other police officers do not have access to the type of training that he is describing. If other units could implement this model, maybe local stations would see a reduction in mental health emergencies that escalate.</p>	<p>Is this training offered in other areas? How do an officer's years of experience affect his view of individuals with mental health conditions?</p>