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ORIGINAL ARTICLE

Staff perspectives of emergency department pathways for people attending in suicidal crisis: A qualitative study

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Accessible Summary

What is known on the subject?

- Emergency departments (ED) are key settings to support and manage suicidal crisis; thus, ED staff are often the first point of contact for people in suicidal crisis. Despite this, some ED staff receive little training and/or education on how to best support such patients.

What the paper adds to existing knowledge:

- Previous research focuses on one staffing role (e.g. triage nurses) whereas this paper includes staff working across the ED pathway. Administrative staff have often been excluded from research, despite representing a key part of the clinical pathway and being a person's initial contact with the ED.
- Overall findings demonstrate that staff experience a lack of confidence, training and burnout due to regularly supporting people in suicidal crisis. Staff also perceive there to be a negative ED culture, which often leads to poor attitudes towards suicidal crisis. The main challenges reported are an increase in working pressures, unavailability of resources and staff retention.
- Findings build upon previous research to highlight key challenges different staff face along the clinical pathway and the implications this can have on a patient's journey and follow-up care provided.

What are the implications for practice?

- Findings are of particular importance and relevance to ED managers, and more broadly NHS England. Negative ED culture, poor staff attitudes and confidence can have a detrimental impact on both staff health and wellbeing, as well as a patient's journey throughout the ED, resulting in repeat presentations and absconding as appropriate support is not received.
- Policymakers need to consider staff burnout and lack of resources in mental health care strategies, and training programmes should be developed to improve culture and confidence among ED staff and managers to improve care for people attending EDs in suicidal crisis.

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Abstract

Introduction: Emergency departments (EDs) are often the first point of contact for people in suicidal crisis. Yet, previous work has tended to focus on only one type of staffing role, failing to account for different staff perspectives along the clinical pathway.

Aims: To explore and synthesise the perspectives of ED administrative (i.e. receptionists), medical (triage nurses) and mental health staff (liaison psychiatrists) working with people presenting in suicidal crisis.

Method: Qualitative study guided by thematic analysis of semi-structured interviews with 23 ED staff across six EDs in Cheshire and Merseyside, England.

Results: Findings demonstrate that staff experience a lack of confidence, training and burnout due to regularly supporting people in suicidal crisis. The main challenges reported are an increase in working pressures, unavailability of resources and staff retention.

Discussion: Staff felt unequipped to deal with suicide-related presentations. Organisational support is perceived to be lacking, with increased staffing pressures and poor service availability. This lack of support was linked to job dissatisfaction.

Implications for Practice: Findings are of particular relevance to individual EDs and NHS England. Addressing the challenges staff are reporting can have positive implications for staff wellbeing, as well as a patient's experience and journey throughout the ED.

KEYWORDS
care pathways, emergency department, staff perceptions, suicidal crisis

1 | INTRODUCTION

Emergency departments (EDs) play a critical role in supporting, managing and treating suicidal crisis presentations, and thus represent a key opportunity for suicide prevention and intervention (Stapelberg et al., 2020). Individuals in suicidal crisis experience significant distress, often including thoughts of death, and the more pervasive the suicidal crisis the more likely the individual is to engage in self-harm or attempt suicide (Knorr et al., 2020). It has been estimated that 9% of the world's population will experience suicidal thoughts at some point in their lives, 30% of whom will go on to make a suicide attempt (Al-Azri, 2020).

Little research, however, has focused on people presenting to EDs in suicidal crisis, particularly in the UK (Laxmisan et al., 2007). This is in stark contrast to people presenting following self-harm for whom recommendation for best practice and care are now included in the National Institute for Health and Care Excellence (NICE) clinical guidelines in England (Holmes et al., 2020). In addition to this, Nursing and Midwifery Council (NMC) standards in the UK include suicide intervention education as part of the undergraduate education for all fields of nursing (Nursing & Midwifery Council, 2023). The National Health Service (NHS, 2019) Long Term Plan further highlights areas of action, however, lack specificity related to suicidal crisis. The plan relates to ensuring people experiencing mental health crisis will have 24/7 access to mental health support and clear standards are available for access to urgent and emergency mental health care. There is also a push for alternative forms of provision for those in crisis, such as crisis lines, as an alternative option to EDs for those who are experiencing a crisis, but do not necessarily have medical needs that require ED admission.

Recent research has explored the reasons and factors which influence whether an individual attends the ED in suicidal crisis; however, the majority of studies have been conducted in Australia (e.g. Chamberlain et al., 2012) or America (e.g. Czyz et al., 2013; Downs & Eisenberg, 2012). One UK study examined the predictors of ED attendance for self-harm in deprived communities and reported increased attendances for people aged 18–24 years, with physical and mental health co-morbidity and lower levels of social support (McCarthy, Saini, et al., 2023). Although this research adds to the UK evidence base, the study did not consider the impact of ED staff on attendances. Moreover, suicidal presentations to EDs are underestimated by as much as 60% (Clements et al., 2016), due to inconsistent and inaccurate recording (McCarthy et al., 2021). Improved surveillance and monitoring of suicide is required for effective suicide prevention strategies and more accurate detection and documentation of who is at risk and who are attending EDs in crisis will better

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inform service developments and crisis care policy (World Health Organization, 2021).

From a patient perspective, research has shown that a negative ED experience can result in individuals being less willing to engage with follow-up care post-discharge (Shand et al., 2018) and to return to the ED in a future suicidal crisis (Rosebrock et al., 2021). People presenting to EDs have often noted these negative experiences in the form of invalidating or stigmatising interactions with staff and excessively long waiting times (Meehan et al., 2021; Quinlivan et al., 2021). Further, due to the medical focus of ED treatment, suicidal crisis presentations often prioritise the assessment of physical safety, resulting in staff emphasising a medical approach over psychological care (Australian Institute of Health and Wellbeing, 2021).

From a healthcare perspective, however, staff have often noted not having appropriate time and resources to build rapport with people presenting in suicidal crisis (Petrik et al., 2015). Some research has suggested ED nurses and doctors have negative views towards those presenting in suicidal crisis and that some staff are inadequately trained in mental health, specifically the causes, crisis intervention and appropriate referral options for suicidal crisis attendances (Chapman & Martin, 2014; Rayner et al., 2019). There is an absence of research, however, examining staff perspectives in a UK ED setting.

Systemic issues within health services are also important considerations in the provision of ED care (Rheinberger et al., 2022). ED staff report struggling to provide appropriate care due to not being able to access essential resources, such as mental health inpatient beds (Cullen et al., 2019; McGough et al., 2022) and internal mental health professionals to ensure specialised person-centred care (Cullen et al., 2021; True et al., 2021). The ED environment is also complex and dynamic, requiring staff to make decisions under time pressure with multiple demands from various stakeholders, such as administrators, patients and colleagues (Al-Azri, 2020; Laxmisan et al., 2007). Understanding the common needs of all those who work within EDs is key to maximising the opportunity to reduce suicidal behaviour and can help future health system reforms to promote staff capacity, capability and wellbeing.

In sum, the number of people presenting to EDs in suicidal crisis has significantly increased over the last decade (Stapelberg et al., 2020); thus, ED staff are often the first point of contact for people in suicidal crisis. Despite this, some ED staff receive minimal psychiatric training and few opportunities for further education on the treatment and management of people presenting in suicidal emergencies (Knorr et al., 2020; Zun, 2012). Despite the stressful and demanding nature of the ED for *all* staff, previous research primarily focuses on one staff group (e.g. triage nurses), who represent only a small fraction of the clinical pathway. ED administrative staff have often been excluded from past research, despite being a patient's initial contact with the ED, with this contact being linked to patient satisfaction (Jahangiri et al., 2023). In an attempt to address the limitations of previous work, the current study aimed to explore and synthesise the perspectives of ED administrative, medical and mental health staff working with people presenting in suicidal crisis to gain novel insights into the key challenges ED staff face when providing care in UK ED settings.

2 | METHOD

Qualitative semi-structured interviews were conducted by the primary author with 23 ED staff who were involved with the management, support and treatment of people presenting in suicidal crisis. A range of staff were recruited across all EDs to ensure staff views were captured at different points along the pathway. For example, ED receptionists at first point of contact, medical and ward staff, as well as mental health teams and psychiatry staff. It is important to note that interviews were conducted during ongoing COVID-19 restrictions, and it was essential to recognise the pressures on EDs and ED staff during this time period.

Interviews were conducted with the aid of a topic guide to explore staff roles, views towards patients presenting in suicidal crisis, training and factors influencing decision-making. Table 1 provides example questions. Interviews started with a brief introduction of the study aims, participants rights to withdraw, data protection and

TABLE 1 Example questions from interview guide.

Overall topic	Core question
Job role and experience	Can you tell me about your role in regard to individuals who are attending EDs in suicidal crisis?
Decision-making	Can you tell me about the decisions that you make when managing patients in suicidal crisis? What factors influence your decisions?
Attitudes	Can you tell me your views towards patients who attend EDs in suicidal crisis? Do you think others have the same view?
Training	Can you tell me about whether you think ED staff are adequately prepared to support patients attending in suicidal crisis?
Contextual factors	Can you tell me about how service staff availability has influenced the care of patients attending in suicidal crisis?
Coding	Can you tell me about the current coding practices for suicidal crisis and any problems that you have noticed?
ED environment	From your perspective, are EDs the best place to resolve suicidal crisis?

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storage. Participants were given an opportunity to ask any questions before the interview commenced. Permission to audio-record the interview was obtained. Ethical approval was granted by the NHS Health Research Authority (IRAS ID: 298407).

2.1 | Data collection

EDs in the areas of Cheshire and Merseyside were approached to take part in the study ($n=9$). Data were collected from six ED sites, which covered a range of socio-demographic localities (three EDs were located in urban areas and three in rural areas). Two Mental Health Trusts were covered, which are responsible for providing health and social care services for people with mental health disorders. All mental health staff were part of the ED core staff and were all based within the ED. The EDs were selected to reflect a broad spectrum of working environments and capture the variability of working practices across EDs. Staff were eligible for inclusion if they were currently working in an ED setting in an administrative, medical or mental health role. No restrictions were placed on age, sex or length of time working in an ED setting.

Eight interviews were conducted online via Microsoft Teams, and 15 were conducted in-person onsite. The reason for conducting onsite interviews was due to COVID restrictions in some ED sites, and for some staff, it was preferred due to time and resource limitations within their role. In-person interviews were conducted through opportunistic sampling to ensure a range of staff views could be captured. Onsite interviews also removed the barrier of certain staff groups, for example ED receptionists being under-represented in research. Interviews took place from May 2022 to November 2022 and varied in length (13 min, 53 s to 1 h, 4 min).

2.2 | Data analysis

Thematic analysis was used to explore patterns across the dataset. Analysis followed Braun and Clarke's (2021) steps of familiarisation, generation and definition of codes, theme searching and development. A hybrid approach was utilised, with a deductive approach to form the initial coding framework and inductive methods to capture unanticipated codes. Codes were then grouped into themes, with each theme representing a meaningful pattern in the data. All final themes were agreed by study authors and discussed with the broader steering group of ED staff and public and patient advisors.

3 | RESULTS

A range of ED staff were recruited to take part in the semi-structured interviews (as shown in Table 2). Thirteen participants identified as female and 10 as male.

Thematic analysis resulted in three themes which explore the perspectives of ED staff towards people presenting in suicidal crisis.

TABLE 2 Recruitment breakdown.

Job role	Number of participants
ED receptionist	2
Physician associate	1
Triage nurse	1
Practice development nurse	1
ED doctor	2
Consultant in emergency medicine	4
Mental health nurse	4
Mental health nursing student	2
Liaison psychiatry doctor	1
Consultant liaison psychiatrist	2
Crisis team manager	1
Advanced nurse practitioner	2

Firstly, the factors that influence staff decision-making which relates to a lack of staff confidence, training, being risk averse, unavailability of resources and ED culture. The second theme focuses on the quality of care, namely the fast-paced ED environment, lack of staff autonomy and increased working pressures. The final theme explores staff burnout, mental health and wellbeing, which has been discussed in relation to lone working, team collegiality, staff retention and recruitment.

3.1 | Factors that influence staff decision-making

This theme describes a number of factors highlighted by ED staff to impact on their decision-making for people presenting in suicidal crisis. The category includes three concepts: lack of confidence, training and being risk averse, and unavailability of resources and negative ED culture.

3.1.1 | Lack of confidence, training and being risk averse

Staff described a lack of confidence regarding talking to patients about self-harm and suicidal thoughts: 'Certain staff [ED ward staff] don't want to ask the question in case they get a "yes".' (Mental Health Nurse: 17). This was partly linked to perceived limitations of current mandatory training. Staff discussed a need to implement training for all ED staff on supporting people presenting in suicidal crisis.

> There is an overall lack of confidence within staff for this patient group in particular, which needs to be addressed through training. But it's the value and quality of training which needs to be improved. You know what mandatory training is like, you click through and

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> you do the quiz at the end, that's the whole thing. So, I think there needs to be something around awareness training, developing people's understanding, values and beliefs, but also enhancing their confidence to have conversation.
>
> (Advanced Nurse Practitioner: 05)

Staff described feeling ‘anxious’, ‘weary’ and ‘fearful’ to make decisions regarding care, particularly in relation to discharge due to the potential risk of harm. Staff felt they cannot guarantee the outcome for the patient so have a sense of ‘needing to protect the Trust’ (Consultant Liaison Psychiatrist: 01). This was evident across mental health staff who were employed by a Mental Health Trust separate to the general hospital staff. Across mental health staff, the issue of responsibility was regularly discussed: ‘…why would we discharge somebody with risk, when you've got a mental health team there commissioned to take that risk?’ (Crisis Team Manager: 12). This was linked with a lack of clarity around job roles and expectations of hospital provision, for example, General Hospital staff not taking ownership over mental health presentations:

> There's a fear of taking ownership of mental health, particularly suicide presentations, and a view that if we keep it at arm's length that's going to be better for our Trust…we've got to protect our trust by being a bit wary about getting involved with that. And that comes from both sides, you can speak to General Hospital Trusts and say, *“well, you're a massive provider of mental health services”* and they be like*oh no”*, almost in denial they play a role and just think that it's the Mental Health Trust's issue.
>
> (Consultant Liaison Psychiatrist: 01)

3.1.2 | Unavailability of resources

Lack of beds contributed to poor flow, crowding and difficulties in providing appropriate care in the ED. In particular, mental health staff often discussed feeling conflicted in decision-making, wanting to support the patient in the least restrictive way, while still recognising the pressure on services.

> …you've got this kind of real delicate balance of someone who's now hesitant to accept admission, because of the bed or staff pressures. At some point, you feel as though there are available beds, but there's not a safe level of staffing to make that transfer of care. And then you're thinking, well do I need to now use the Mental Health Act legislation and that's a big kind of step in kind of intervention.
>
> (Liaison Psychiatry Doctor: 04)

Further, all staff often discussed the impact of high workload combined with waiting time targets and staff shortages on their decision-making. Both medical and mental health staff did not feel they had ‘adequate manpower’ to ‘discuss trauma and suicidal behaviours in a psychologically safe way to inform practice’ (Mental Health Nurse: 23). Participants also noted the long-standing nature of these issues: ‘…our ED has always been overworked and understaffed’ (Consultant in Emergency Medicine: 10) and ‘I think COVID gets the blame for a lot, but we've always been short staffed’ (Crisis Team Manager: 12).

3.1.3 | Negative ED culture

Staff often described their own attitudes towards patients attending in suicidal crisis in a positive way, for example ‘empathetic’, ‘compassionate’ and ‘understanding’. However, terms such as ‘attention seeker’ and ‘cry for help’ were also often used, particularly for people who attended having self-harmed. This inherent, perhaps unintentional, use of negative language was evident across all staffing roles. Negative attitudes were perceived to stem from higher, older management structures, with these in turn shaping the views of newer, more junior staff.

> …it's [attitudes] from the top down. So, if you've still got old management style, structures, cultures, behaviours and values that mental health patients have no right coming into A&E and that they shouldn't be here, then A&E staff will continue to have that culture and those responses to that patient group.
>
> (Crisis Team Manager: 12)

The aforementioned issues with training were linked to further problematic attitudes regarding tendencies to blame patients. Staff discussed the need for services and systems as a whole to address confidence, culture and attitudes.

> We don't have adequate training to support or give us the confidence to advocate for this patient group. So, then it becomes a case of ‘it's not my fault’, it becomes a case of defensive practice…What I tend to see is staff members not having adequate evidence and because of that, what do we do? Blame the patient, find the reasons why they shouldn't be here, and then sometimes invalidate their feelings.
>
> (Mental Health Nurse: 23)

ED staff expressed a strong desire to assist people presenting in suicidal crisis, but were conflicted by feelings of futility, which were compounded with the re-presentation of ‘frequent attenders’. For many, this led to frustration, negative attitudes and reduced empathy. Staff regularly discussed desensitisation to the seriousness of suicidal crisis. For example, participant 04 (Liaison

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Psychiatry Doctor) highlighted 'sometimes staff don't even know what the individual presentation is for, but they see '*Oh, it's Mrs Jones again*' and automatically roll their eyes thinking it's deliberate self-harm'.

Across all staffing roles explored, a lack of confidence and uncertainty was discussed in relation to talking to and supporting people attending in suicidal crisis. This led to risk averse practice among medical and mental health staff. The unavailability of resources, for example lack of mental health inpatient beds, overcrowding and long ED waiting times, were also shown to influence staff decision-making as medical and mental health staff often discussed feeling conflicted in decision-making, wanting to support the patient in the least restrictive way, while still recognising the pressure on services. The final sub-theme provides some exploration into the impact of ED culture on all ED staff. Attitudes, both positive and negative, were considered as well as the aforementioned issues with training specifically for suicide-related presentations.

3.2 | Factors influencing quality of care

Theme two discusses the factors influencing the quality of care provided by ED staff. This is related to the ED fast-paced environment which was reported to impact on all staff (administrative, medical and mental health). Staff autonomy and increased working pressures was also noted; this was particularly evident for mental health nursing staff.

3.2.1 | Fast-Paced environment

The ED environment is ever-changing and fast-paced. Staff discussed this in relation to staying up-to-date on referral pathways, available community services and follow-up advice; the COVID-19 pandemic provided an additional challenge to this with the closure of services and introduction of alternatives, for example crisis lines. A positive initiative discussed by mental health staff was the introduction of the 'Side by Side Initiative' in which mental health liaison services work closely with general hospital staff to conduct assessments.

However, the debate as to whether staff believe EDs are the right environment for people in suicidal crisis was often considered. The 'chaotic', 'stressful' and 'noisy' environment was frequently cited by all staff as having a negative impact on someone in suicidal crisis. This was particularly concerning for ED administrative staff who discussed their 'worry' for people leaving the ED without seeing medical or mental health staff: '*We are the first ones they see, and we are telling them to wait in a horrible noisy waiting room…I worry about them leaving and going on to hurt themselves*' (08: ED Receptionist). Furthermore, staff emphasised the need for, but lack of, a calm and safe space dedicated to individuals seeking help for suicidal crisis:

> A&E is the *wrong place* to be the *only place* for crisis. So, we need to make sure that we provide good care, but there also needs to be thoughts about how patients with non-medical aspects can be supported.
>
> (Consultant in Emergency Medicine: 05)

Staff also felt the ED environment did not allow sufficient time to engage with people in suicidal crisis. Almost all medical and mental health staff felt that this lack of time led to less comprehensive assessments, with a fear that this would result in insufficient treatment plans, and potentially future re-presentations. This was further exacerbated by a mandated key performance indicator whereby staff are expected to see and treat a patient within 4h of admission. Staff also worried that spending the necessary time with people presenting in suicidal crisis limited the time they had for other patients, resulting in increased waiting times.

3.2.2 | Lack of staff autonomy and increased working pressures

All ED staff report increasing role overload as a result of staff shortages, funding cuts, and increased patient numbers and acuity. The impact of working environment stressors was sometimes ameliorated by staff autonomy; however, this was inconsistently applied across EDs, particularly for mental health nursing staff.

> We've had some liaison nurses who've came from other sites and nurses aren't allowed to make a decision there. So, they'll do the assessment, make a plan and then it's got to go through the consultant. I'm sure our consultants here wouldn't be very happy if we rang them up every time!
>
> (Mental Health Nurse: 17)

The aforementioned desensitisation to suicidality was also worsened by long shift patterns, leading them to feel 'morally distressed' (Mental Health Nurse: 23). Staff also raised concerns about individuals in suicidal crisis receiving inadequate care due to competing priorities within the ED. Working pressures were noted in relation to training, a lack of time, resources and the need for staff 'on the shop floor' preventing adequate and ongoing suicide prevention training:

> A&E is in crisis at the moment, staffing wise…what do you send someone on a resuscitation course or mental health course?
>
> (Consultant in Emergency Medicine: 02)

The current physical environment of the ED was discussed by all staff as having significant impacts on the quality of care provided to people presenting in suicidal crisis due to the intensity of noise,

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busyness and lack of privacy. This impinges upon medical and mental health staff's ability to provide effective and timely care to people in suicidal crisis. Furthermore, the 'chaotic' and 'stressful' ED waiting room was a particular concern for administrative ED staff. Increased working pressures was noted by all staff in terms of staff shortages, funding cuts, and increased patient numbers and acuity.

3.3 | Staff burnout, mental health and wellbeing

The final theme explores staff burnout, mental health and wellbeing. This theme includes discussion around burnout, lone working and team collegiality, as well as staff retention and recruitment. Burnout was discussed and shown to impact on all of the different staffing roles recruited, which was mainly noted by medical staff (i.e. Consultants in Emergency Medicine) and mental health staff (i.e. Mental Health Nurses).

3.3.1 | Burnout, lone working and team collegiality

ED staff described emotional exhaustion and trauma due to regularly supporting people in suicidal crisis. Most notably, mental health staff reported feeling futile about addressing patient needs, which they felt were rooted in broader social issues outside of their control. The pervasive feelings of futility alongside a strong willingness to help resulted in many ED staff feeling burned out.

Burnout across all staffing groups was also often noted in the context of lone working at night. Despite the higher number of presentations at night, staff were often alone with risks they were not comfortable or confident taking, which had a significant impact on their wellbeing:

> A lot of our shifts are single manned… from five in the evening to eight in the morning… we are still busy, it's very stressful in there and you're the only receptionist and you've got to sort of take everything on board.
>
> (ED Receptionist: 14)

> I've been impacted significantly. That's why I've actually had to come off of nights because I was seeing four or five patients every night, on my own, taking risks that I felt were more than I had capacity to take… forever been told '*it's on your head if I kill myself*', '*are you going to let me go out here and kill myself*' at least 10 times a week.
>
> (Mental Health Nurse: 20)

However, all staff spoke positively regarding team support and collegiality, which boosted morale. This was particularly evident during the COVID-19 pandemic, where staff reported an increase in mental health presentations, as well as longer shifts with reduced staffing.

> I'm sure there's days that most people walk in, and they go '*oh, I don't think I can see another person*', but you do, and we all rally around each other. And the thing is, we've had quite a difficult time with COVID and lots of changes, but this team has weathered really well compared to others. I think it's because we're quite a strong team. But I think X is a really good hospital, they're really supportive, so that had had a knock-on effect.
>
> (Mental Health Nurse: 17)

3.3.2 | Staff retention and recruitment

High workload, staffing pressures, burnout and poor resource availability were linked with job dissatisfaction. Many medical and mental health staff discussed the potential for early retirement or moving into a more academic role as they felt they 'couldn't make any difference, couldn't make any change' in the clinical ED environment (Mental Health Nurse: 23):

> It's become frustrating, it's become harder. It's not great anymore. I wouldn't be surprised if lots of people leave the profession and a lot of people don't join the profession. I certainly will be leaving it early, earlier than I would have otherwise.
>
> (Consultant in Emergency Medicine: 11)

Mental health nurses in particular discussed how the route into the profession often deters people from joining, amplifying the long-standing issues caused by poor staffing levels and limited resources. Students noted the value of longer placements and experience over university lectures, which lack specificity in relation to mental health.

> You do all those general adult nursing skills and mental health is like, '*oh, and they might be depressed*', and that's literally like the one line at the end of every class. It's just not tailored or specific, it's very general.
>
> (MH Nursing Student: 022)

ED staff experienced several mental health impacts from attempting to provide care to people presenting in suicidal crisis while operating within the constraints of the ED system. Most notably, mental health staff reported feeling futile about addressing the needs of those attending in suicidal crisis, alongside a strong willingness to help which often resulted in staff feeling burned out. Feelings of burnout, high working and staffing pressures also resulted in certain staff discussing early retirement or changing career.

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4 | DISCUSSION

4.1 | Summary of findings

The perspectives of all ED staff who manage and support people presenting in suicidal crisis can offer strategies to guide emergency health system reforms, with mutual benefits for staff and patients. This study sought to explore the perspectives and experiences of administrative, medical and mental health staff who come into contact with people presenting in suicidal crisis. Overall findings demonstrate that staff experience a lack of confidence, training and burnout due to regularly supporting people in suicidal crisis. Staff also perceive there to be a negative ED culture, with often leads to poor attitudes towards suicidal crisis. The main challenges reported are an increase in working pressures, unavailability of resources and staff retention.

4.2 | Comparisons with wider literature

Recent literature has shown that EDs are often the first point of contact for people in suicidal crisis, and are a common gateway to primary or community mental health support (Wise-Harris et al., 2017). All ED staff, however, questioned whether the ED setting is the best place for people experiencing suicide-related distress. The ED environment presented a number of challenges for staff in terms of the 'chaotic', 'noisy' and 'busy' nature; this was particularly worrying for ED administrative staff who experienced many people in suicidal crisis leaving before an assessment. The importance of these findings relates to the narrative that EDs may not be the right place for people in suicidal crisis (e.g. Rheinberger et al., 2022). There needs to be a push within the community for alternatives to EDs, as well as increased awareness of what is available and what services may be better suited to support individual needs (Banfield et al., 2022). Healthcare metrics (e.g. the 4-h discharge target) were also perceived to be counterproductive to patient care by medical and mental health staff. The limited control over environmental factors was further exacerbated by staffs' perceived limited confidence in their ability to engage in conversations about suicide and therefore stratify risk. These findings have been mirrored in quantitative research; for example, McAllister et al. (2002) reported that nurses felt helpless dealing with deliberate self-harm in the ED.

Attitudes towards suicidal crisis were commonly discussed by all participants, both positively (empathy, compassion) and negatively (frustration, lack of understanding). Previous research into staff attitudes has also produced conflicting findings (McCarthy, McIntyre, et al., 2023). McCann et al. (2007) found nurses had a sympathetic attitude towards self-harm and did not discriminate in their decision-making, whereas Egan et al. (2012) reported that the majority of ED medical staff had a 'somewhat negative' attitude towards people presenting with self-harm. The current study furthers these findings to report inconsistent attitudes across a range of staffing roles, including administrative and mental health staff. Efforts should, therefore, be made for more collaborative working between all staffing roles to design evidence-based, regular teaching programme, targeting underlying negative attitudes and skill deficits. Linked with staff attitudes was the sometimes unempathetic culture of the ED that was suggested to be perpetuated by older management structures. While ED culture has often been discussed in relation to patient satisfaction, healthcare quality and staff satisfaction (Armstrong et al., 2019), this study furthers understanding of the impact of culture in relation to suicidal crisis presentations by exploring the perceived reasons behind a negative culture (role of management) and how negative culture may be continually reinforced (issues with training). This is of particular importance and relevance to ED managers, and more broadly NHS England, since negative ED culture can have a detrimental impact on a patient's journey throughout the ED, resulting in repeat presentations and absconding as appropriate support is not received (Quinlivan et al., 2021).

The current study highlights the substantial systemic barriers facing ED staff from the present sample in providing quality care. Limited time, resources and space to have private conversations were noted by medical and mental health staff, resulting in poor care for both staff and patients. Similar findings have been reported in relation to the overall lack of inpatient psychiatric beds in general hospitals, particularly during and following the COVID-19 pandemic. A survey carried out by the Royal College of Psychiatrists (2021), 85% of 320 psychiatrists stated there was more pressure on beds compared with previous years. The vast majority (92%) estimated there were less than 5% of beds available in their Trust, compared with the recommended threshold of 15%. The availability of resources was also shown to have a significant impact on decision-making, with a quarter of respondents stating they would delay admission and treat in the community and a third noting they would look for an out-of-area placement (when a person with acute mental health needs who requires inpatient care is admitted to a unit that does not form part of the usual local network of services) (Royal College of Psychiatrists, 2021). It is important to note, however, that all staff in the current study expressed these issues were also present pre-pandemic indicating long-standing systemic barriers to effective treatment. These findings are of relevance to policy makers and have important implications for allocating funding, as more efforts therefore need to be made to ensure appropriate resources are available inside and outside of the ED to reduce the compound pressure placed upon ED services.

Staff burnout appeared to be linked to poor patient outcomes (e.g. repeat presentations), heightened responsibility (e.g. lone working) and career disillusionment. While the high incidence of burnout in ED medical staff is evident in the literature (Dixon et al., 2022; Moukarzel et al., 2019), mechanisms that contribute to staff burnout, such as lone working and risk burden, have not been previously explored, particularly across different staffing groups. The current study also highlighted how burnout had an impact on all staff, their decision-making and risk averse practices. The fear of future adverse outcomes for a patient, staff member and the organisation has been shown to increase risk-aversion, particularly among mental

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health staff (Nathan et al., 2021). This is consistent with previous studies showing that staff suffering from burnout are more likely to be weary in their decision-making (Gabriel & Aguinis, 2022), less likely to provide positive and compassionate care (Rozo et al., 2017; Watson et al., 2019) and are more likely to transfer or resign from positions in the ED (Li et al., 2018; Schneider et al., 2019). This is problematic given that experienced ED staff are most likely to exhibit positive attitudes towards people presenting in suicidal crisis (Ngune et al., 2021; Østervang et al., 2022). Efforts therefore need to be made within individual hospital trusts, NHS England and education reforms to promote the recruitment and retention of ED staff.

4.3 | Strengths and limitations

The current study is the first qualitative exploration to consider a wide range of ED staff views and experiences related to people presenting in suicidal crisis and provides previously undiscovered insights. Staffing groups such as administrative and mental health nurses are often under-represented in research (Bifarin et al., 2022), yet play a vital role in the support of mental health attendances. This study provides an in-depth analysis of their experiences and roles in supporting suicide-related presentations. Despite this, some key limitations should be considered. The proportions of each role included in this study may not be reflective of the ratios found within EDs. Although attempts were made to examine a wide range of job roles across different EDs, certain staff, for example clinical support workers, were unable to be recruited. Some interviews were also conducted in-person in EDs, which provided additional challenges, such as limited time, external distractions and no private space for staff to speak freely. This may have introduced some bias into responses, particularly when discussing sensitive topics such as attitudes and culture.

4.4 | Clinical and research recommendations

Several recommendations for clinical practice arise from the study, which have been summarised in Table S1.

A key finding from the current study is the inherent, perhaps unintentional, use of negative language across all staffing roles. Particularly novel was the fact that this use of language was not necessarily reflective of outwardly negative attitudes to suicidal crisis, nor was it intended to be disparaging. For instance, staff would often discuss their compassion and empathy for people in suicidal crisis, yet use terms such as ‘attention seeker’. This may be due to the top-down culture within the EDs, whereby out-dated terminology may still be used by managers or more experienced staff members and therefore transferred to more junior staff. Thus, existing management style, structures, language and behaviours towards people in need of mental health support need to be improved. This is particularly relevant for medical and mental health staff in which negative language and attitudes towards suicidal presentations have been linked with a patient's reluctance to engage with services (Masuku, 2019).

Furthermore, administrative and medical staff often discussed how they felt ill-equipped to manage and support suicide-related presentations. Staff felt unsure of how to approach conversations about suicide and feared not knowing what to say whether a patient did disclose such thoughts. This was particularly concerning for administrative staff, who were often presented with these difficult situations, but did not have the clinical training or expertise of medical staff. They noted how having a resource to help with what to say in these situations would help. Future research should explore and evaluate possible resources and training to better equip *all* ED professionals to engage with people presenting in suicidal crisis and Trusts may want to consider offering further training to all staff. Additionally, future reform efforts should consider providing training that integrates a compassion-focused approach, including equipping staff with evidence-based explanatory formulations for patients presenting in suicidal crisis, so that they are able to resist the problematic explanations mentioned above (e.g. attention-seeking).

Following the interviews, mental health nursing staff in particular often reflected on the cathartic nature of discussing their experiences of working with people presenting in suicidal crisis. Limited research has been conducted into the potential therapeutic effects of qualitative research (Opsal et al., 2016), particularly in relation to this topic. There is a possible ‘research as intervention’ effect in which staff taking part in qualitative research seem to benefit from the opportunity to reflect on the wide issues that impact on their role. Organisations that are receptive to this type of research may see a positive impact on staff by allowing them to think and talk freely about these issues.

4.5 | Conclusion

This study examines the experiences and perspectives of ED administrative, medical and mental health staff when supporting people attending in suicidal crisis. Although findings suggest ED staff are motivated to provide a high level of care for people in suicidal crisis, the current ED environment, organisational pressures and staff burnout are significantly impacting on this. The concerns raised by ED staff in this study are consistent with those reported by patients themselves, such as difficult physical environments, and poor access to resources and mental health staff (Rheinberger et al., 2021). Policymakers need to consider staff burnout and lack of resources in mental health care strategies, and training programmes should be developed to improve culture and confidence among ED staff and managers to improve care for people attending EDs in suicidal crisis.

5 | RELEVANCE STATEMENT

ED staff are often the first point of contact for people in suicidal crisis. Previous research, however, fails to account for a wide range

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of staff views and experiences. The current study demonstrate that staff experience a lack of confidence, training and burnout due to regularly supporting people in suicidal crisis. Staff also perceive there to be a negative ED culture, with often leads to poor attitudes towards suicidal crisis. The main challenges reported are an increase in working pressures, unavailability of resources and staff retention. Findings are particularly relevant to individual EDs, as well as more broadly NHS England, and can have important implications for both ED staff wellbeing and patient care. Policymakers need to consider staff burnout and lack of resources in mental health care strategies, and training programmes should be developed to improve culture and confidence among ED staff and managers to improve care for people attending EDs in suicidal crisis.

ETHICS STATEMENT

Ethical approval was granted by NHS Health Research Authority, Integrated Research Application System (IRAS ID: 298407). Verbal consent was obtained, witnessed and audio-recorded from all participants. Participants were given an information sheet and consent form prior to the interview and was given time to read and review the documents. All participants were reminded they could take breaks at any time or refuse to answer any questions without reasoning. The right to withdraw (up until the point of data analysis) was also reinstated prior to the interview.

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CONFLICT OF INTEREST STATEMENT

None declared.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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