ATHLETIC TRAINING EDUCATION JOURNAL

www.natajournals.org
ISSN: 1947-380X
DOI: 10.4085/1947-380X-21-093

ORIGINAL RESEARCH

Perspectives of a Mental Health Emergency Standardized Patient Encounter: A Follow-Up Interview of Athletic Trainers

Zachary K. Winkelmann, PhD, SCAT, ATC*; Elizabeth R. Neil, PhD, LAT, ATC†; Kelcey C. Granger, MS, LAT, ATC†; Lindsey E. Eberman, PhD, LAT, ATC‡
*Department of Exercise Science, University of South Carolina, Columbia; †Department of Health and Rehabilitation Sciences, Temple University, Philadelphia, PA; ‡Department of Applied Medicine and Rehabilitation, Indiana State University, Terre Haute

Context: Athletic trainers should be able to recognize, refer, and provide support to patients with mental health challenges such as anxiety, depression, and suicidal ideation. However, clinicians may not have the opportunity to identify the signs and symptoms in an authentic scenario until a patient presents in their facility. Therefore, supplemental clinical education via standardized patient (SP) encounters may allow for an opportunity to practice mental health care in a safe manner. However, data to support if a SP encounter has a lasting effect on one's clinical practice are lacking.

Objective: To reflect on a SP encounter focused on a mental health emergency (suicidal ideation) and the influence, if any, the encounter had on one's clinical practice 1.5 to 3 years following the encounter.

Design: Consensual qualitative research tradition.

Setting: One-on-one interview.

Patients or Other Participants: Twelve graduates from the same postprofessional athletic training program (men = 6, women = 6) participated in this study.

Main Outcome Measure(s): Participants completed a one-on-one interview guided by a 7-question, semistructured interview protocol. A 3-person coding team identified domains and categories.

Results: Two domains emerged from the study: (1) learning experience and (2) patient approach. The learning environment created an emotionally realistic space with reassurance and collaborative learning. Specifically, the participants were able to transform their practice from errors made during the SP encounter. The SP encounter had positive, long-term effects on their clinical care including improvements in empathy, active listening, and emergency planning.

Conclusions: Like other research about the longitudinal effects of SP encounters, participants applied the learning outcomes from the encounter in their clinical practice 1.5 to 3 years later. We suggest mental health SP encounters be used to prepare athletic trainers, regardless of experience, for emergency mental health crises.

Key Words: Simulation, suicide, professional development

Dr Winkelmann is currently Clinical Assistant Professor in the Department of Exercise Science at the University of South Carolina. Please address correspondence to Zachary Winkelmann, PhD, SCAT, ATC, Department of Exercise Science, University of South Carolina, 1300 Wheat Street, Columbia, SC 29208. winkelz@mailbox.sc.edu.

Full Citation:
Winkelmann ZK, Neil ER, Granger KC, Eberman LE. Perspectives of a mental health emergency standardized patient encounter: a follow-up interview of athletic trainers. *Athl Train Educ J.* 2022;17(3):210–220.

Perspectives of a Mental Health Emergency Standardized Patient Encounter: A Follow-Up Interview of Athletic Trainers

Zachary K. Winkelmann, PhD, SCAT, ATC; Elizabeth R. Neil, PhD, LAT, ATC; Kelcey C. Granger, MS, LAT, ATC; Lindsey E. Eberman, PhD, LAT, ATC

KEY POINTS

- Standardized patient encounters focused on mental health, specifically suicidal ideation, provide a safe and realistic way for athletic trainers to practice identifying, referring, and providing support to a patient in crisis.
- A mental health emergency standardized patient encounter has positive, long-term effects on empathy, communication, and immediate care planning.
- Creating a standardized patient encounter for mental health must be realistic and include debrief and other forms of feedback for learners to be reassured in their decision making.

INTRODUCTION

Between 2013 and 2020, the National Collegiate Athletic Association (NCAA) Sport Science Institute convened a task force and created the Mental Health Best Practices for supporting student-athlete wellness. The interassociation consensus document identified 4 key areas including (1) clinical licensure of practitioners providing mental health care, (2) procedures for identification and referral of student-athletes to qualified practitioners, (3) preparticipation mental health screening, and (4) health-promoting environments that support mental wellbeing and resilience.[1] Upon closer examination, the athletic trainer (AT) was identified as the coordinator and first point of contact in managing mental health concerns, the facilitator for referrals, the gatekeeper for stakeholder communication, and the decision maker for screening protocols.[1,2]

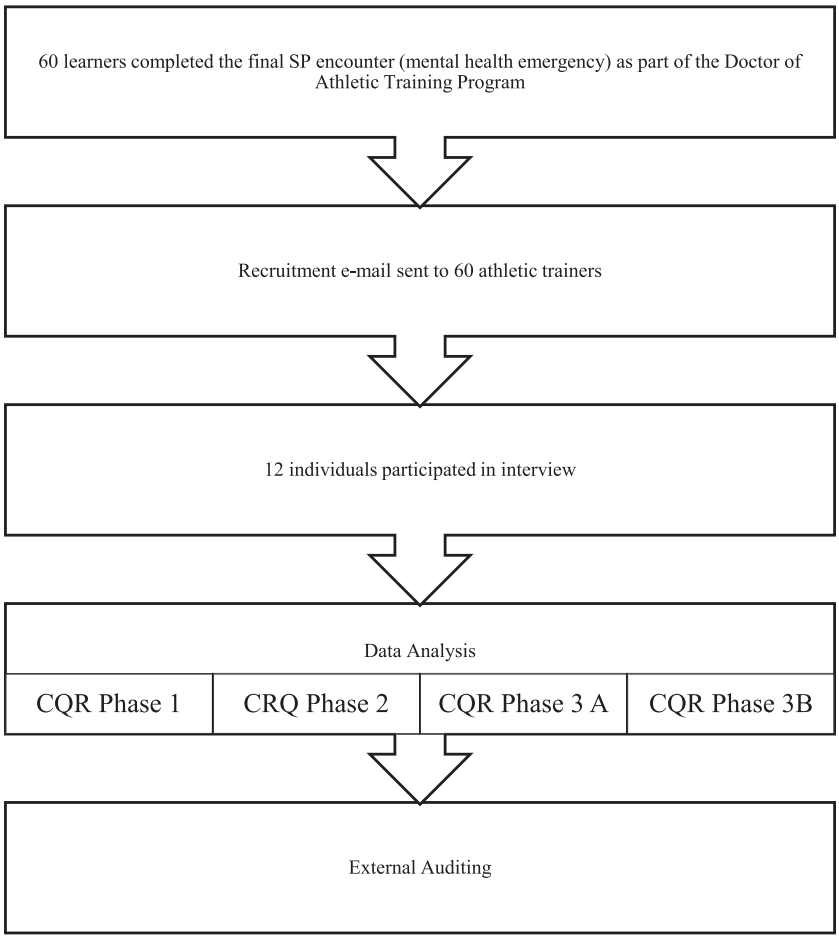
Previous researchers have indicated ATs performed well in recognizing symptoms and referral decision making for behavioral health conditions.[3] However, other researchers, in 2009 and 2012, have described mental health and psychosocial referral as a continued area of professional deficiency for ATs.[4,5] While content on psychosocial intervention and referral has been identified in the curriculum for some athletic training programs[4] before the Commission on Accreditation of Athletic Training Education 2020 Professional Standards requirement (Standard 77),[6] the instructional strategy to deliver the content was typically lectures, discussions, or both and assessed using a traditional exam.[7] Unfortunately, ATs still struggle with selecting psychosocial strategies and the intended course of action, but providers with coursework in sport psychology (or a similar mental health course) were more accurate in their clinical practice, suggesting that educational exposure to mental health improves future integration of these skills into practice.[3] Specifically, a suicide prevention training unit in an athletic training program has been shown to improve clinical readiness and collaboration between behavioral health and athletic training professionals.[8]

The issue though is the translation of the skills and behaviors into clinical practice.[9] Historically, in professional educational environments, if a specific patient encounter was not achieved through traditional clinical experience, athletic training students missed that opportunity, or more often, preceptors have limited the student's exposure as a decision maker in the presenting patient scenario if they feel it is too difficult, intense, or sensitive information.[10] In postprofessional athletic training education, supervisors for certified ATs have noted deficiencies in psychosocial intervention.[11] Due to the practice gap of psychosocial interventions in clinical education, athletic training students and ATs alike must be provided experiences to promote implementation and future integration for patient care.[9] The use of hands-on instruction and assessment, such as role playing and practical exams, has been supported to increase the confidence in a student's psychosocial intervention abilities.[7]

Role playing can be made more authentic through simulation-based learning like standardized patient (SP) encounters. Previous researchers have supported the use of SP encounters to facilitate continual improvement in areas of weakness such as communication, psychosocial interventions, and role execution.[11,12] Professional programs in athletic training have assessed the long-term effect of several entry-level SP encounters.[13] Standardized patients have been found to improve confidence in professional athletic training students.[13–15] In addition, small group SP encounters have developed a learner's ability to provide psychosocial intervention and referral.[16] In postprofessional athletic training programs, researchers have identified that learners were able to improve the organization of their clinical exam, were vulnerable in describing their weaknesses in clinical practice, and improved their patient-centered care.[17] Upon further reflection and within 6 weeks of completing a SP encounter, postprofessional athletic training learners described the importance of how SP encounters transformed their clinical practice and the process of practice reflection as a result of the debriefing process.[18]

Overall, learners who are provided training or course material on mental health improve their ability to recognize and refer for psychosocial interventions.[3,4,7,8,16] In addition, learners who practice these skills in SP encounters improve their skills and abilities in this domain of practice.[16] However, we do not know if there is a translation of these skills and abilities for credentialed ATs after completing their advanced degree and continuing their clinical practice. Therefore, the purpose of our study was to describe how one's clinical practice was influenced by a SP encounter for a mental health emergency 1.5 to 3 years after his or her enrollment in a postprofessional athletic training program.

Figure 1. Flow diagram. Abbreviations: CQR, consensual qualitative research; SP, standardized patient.



METHODS

Design

This qualitative study explored the lived experiences and clinical practices after a mental health emergency SP encounter. Before any data collection, approval was granted from the Indiana State University Institutional Review Board. The quality assessment guidelines for qualitative research established by the Standards for Reporting Qualitative Research[19] were followed.

Educational Experiences

As part of a course in the curriculum, all learners completed a SP encounter at the end of the final semester in the program. The purpose of the encounter was to facilitate an immediate recognition and referral in a SP encounter centered around a mental health emergency specific to suicidal ideation with elements of acute depression, anxiety, and discrimination. The learners were expected to demonstrate patient-centered care, interprofessional and collaborative practice, evidence-based medicine, and health information technology throughout the encounter. The learner needed to act on the mental health emergency to prevent suicide through immediate referral. All participants in the study completed a suicidal ideation SP encounter; however, 4 cases were developed over the course of the program. All 4 SP cases were focused on the same content area of mental health, and each case included elements of suicidal ideation, acute depression, anxiety, and racial discrimination. For the scenarios, clinical specialists in behavioral health and educational specialists in SP case development were consulted to curate the patient cases. To improve the psychological fidelity of the cases, details were gathered from real, documented patient cases. For the encounter, the learners were provided up to 30 minutes to complete their encounter. The encounter was followed by a group debrief with the SP actors within hours of the encounter.

Participants

Participants for this study were recent graduates (at least 1 year) of a postprofessional Doctor of Athletic Training program. These participants had previously completed several SP encounters and simulation-based learning experiences throughout the 2-year program before the final SP encounter described in this study, which was performed during the last week of the final semester in the program. Figure 1 provides a flow diagram of the recruitment and enrollment of the 12 individuals (men = 6, women = 6) that volunteered to participate in the study. Data saturation was achieved when similar responses were being received repeatedly from the participants and no new opinions were being shared. Full demographic information for the participants is provided in Table 1.

Table 1. Participant Demographics

Name	Gender Identity	Age	Certified Experience as AT	Years Since SP Encounter	Current Job Setting as AT
1. Abby	Woman	25	4	1.5	Public service
2. Anthony	Man	27	5	2.5	College or university
3. Caitlyn	Woman	28	6	3	College or university
4. Donald	Man	29	6	1.5	Industrial and academia
5. Jacqueline	Woman	28	7	3	Physician practice
6. Jimmy	Man	49	23	2.5	College or university
7. Leon	Man	34	10	3	Secondary school
8. Leroy	Man	41	16	1.5	College or university and academia
9. Maria	Woman	29	5	1.5	College or university
10. Sasha	Woman	27	4	2.5	Secondary school and community college
11. Timothy	Man	36	7	2.5	Military
12. Ziva	Woman	27	6	1.5	Academia

Abbreviations: AT, athletic trainer; SP, standardized patient.

Instrumentation

Members of the research team created a semistructured interview protocol. The protocol was then sent out to 2 content experts in both simulations and behavioral health content, and minor editorial and sequencing adjustments were made. The final instrument consisted of 5 demographics questions asking about gender identity, age, years of experience as a certified AT, current job setting, and the time since graduation. A total of 7 structured questions, with several structured and semistructured follow-up questions, were asked regarding the mental health SP encounter that the participants completed. Table 2 provides the questions included in the interview protocol.

Data Collection Procedures

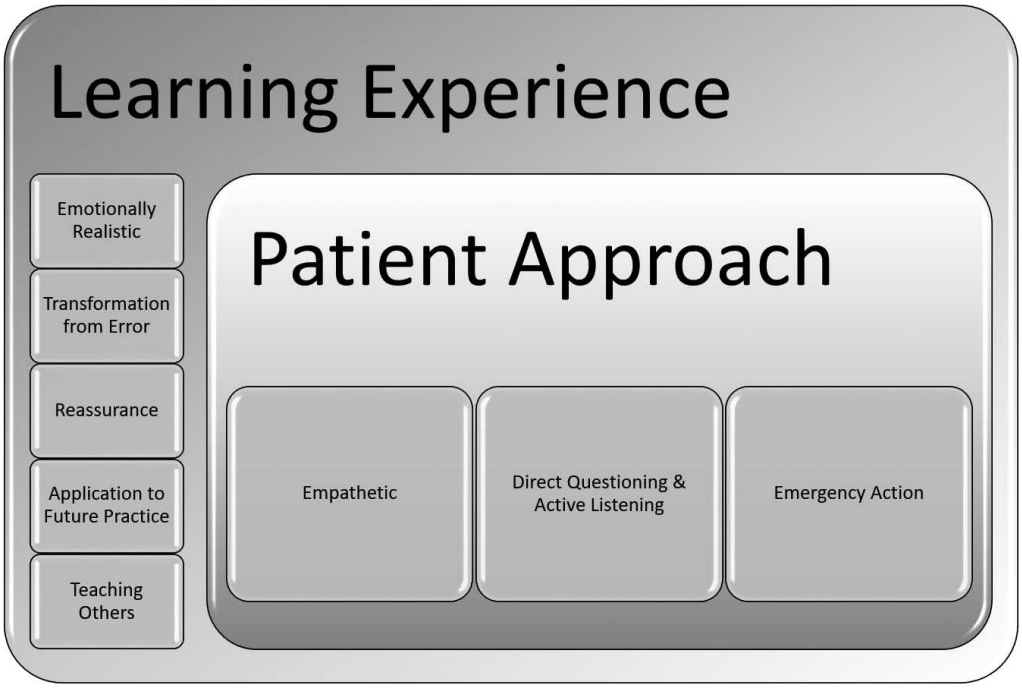
Participants in the study were recruited via e-mail by a member of the research team in the fall 2019. A follow-up e-mail was sent out after the initial recruitment to allow for potential participants to have an additional opportunity to be a part of the study. We continued recruitment into spring 2020 to gather any other participants who wanted to be part of the study. Upon agreeing to take part in the study, participants set a time for an interview with a member of the research team. One member of the research team (K.C.G.) completed the audio interviews. After the interview, the materials (audio file and de-identified transcript) were stored on a secured Cloud drive available only to the interviewer. Member checking was then completed by the research team sending

Table 2. Interview Protocol

Question
(1) To begin the interview, I would like for you to reflect on the last SP encounter from the DAT. Do you remember which encounter this was?
(a) If yes:
(i) Can you please describe the SP encounter?
(ii) What was the most impactful part of the SP encounter?
(iii) Did you feel the SP encounter was a realistic?
(1) If yes, why?
(2) If no, why not?
(b) If no:
(i) The encounter was focused on suicidal ideation prevention within the prevention course. Does this help you reflect on the experience?
(1) If yes, go back to if yes questions.
(2) If no, end the interview.
(2) If at all, how did you use the feedback from the suicidal ideation prevention SP encounter in your professional career?
(3) What have you found to be the overall benefits, if any, to your clinical practice for you from the suicidal ideation prevention SP in your clinical practice?
(4) Specifically, can you describe any patient care management skills, if any, that the suicidal ideation prevention SP encounter helped you to develop in your clinical practice?
(5) Have you had any instances in your clinical practice following the DAT program where you reflected on the suicidal ideation prevention SP encounter during patient care?
(6) Do you feel the suicidal ideation prevention SP encounter had any negative effects on your clinical practice? How so?
(7) Do you have any additional comments or experiences you would like to share or elaborate on at this time?

Abbreviations: DAT, Doctor of Athletic Training; SP, standardized patient.

Figure 2. Domains and categories representing the clinician experiences after an emergency mental health standardized patient encounter.



the participants their interview transcript via e-mail. Each participant was provided 15 days to verify the accuracy of the transcript.

Data Analysis and Trustworthiness

Multiple measures were taken to ensure trustworthiness of the data including member checking, multiple analysts, and an auditor. Once all the interviews were completed, 3 members of the research team (E.R.N., K.C.G., L.E.E.) began coding the transcripts using the consensual qualitative research tradition.[20] This method was chosen for its rigorous process to ensure credibility of the analysis.[21]

For the first phase of the review, each member of the coding team reviewed 4 transcripts to identify core ideas. The group met after the individual review, and the preliminary codebook was created. Next, the team took 2 of the transcripts used in the first phase of review and 2 new transcripts to verify if the preliminary codebook was representative of the data. Once again, the group met to finalize the consensus codebook. The consensus codebook was then used in phase 3 of the coding process. To start the third phase, each member of the coding team used the consensus codebook to independently code 4 of the transcripts each. In the next part of the third phase, the analysts exchanged transcripts, and each member verified the coding in 4 other transcripts. A final meeting occurred where the coding team ensured that each code was confirmed by two-thirds of the review team. After the review, we audited the analysis by sharing the consensus codebook and 4 transcripts with an auditor (Z.K.W.).[21] No changes were made because of auditing. Quotes from the interviews have been selected to substantiate the analytic findings. In addition, frequency counts were produced, and categorical labels were assigned based off how often the participants, as a group, spoke about the category.[21] Categories were assigned as *general* if identified in 12 cases, *typical* if identified in 7 to 11 cases, *variant* if identified in 3 to 6 of the cases, and *rare* if only identified in 2 or fewer cases.

RESULTS

Two emergent domains characterized the data: *learning experiences* and *patient approach* (Figure 2). Frequency counting of the domains and categories are represented in Table 3.

Learning Experience

Within the learning experience domain, participants described their feelings about the encounter as emotionally realistic. The debriefing experience allowed them to consider how they might transform their practice from errors they made or by feeling reassured by decisions they made during the encounter. Many participants were able to apply the experience to future clinical practice, while a handful of participants were able to translate the learning experience into something they could use to teach others.

All the participants in this study stated the SP encounter created a learning environment that was emotionally realistic. The live patient actor, the details of the case, and the realistic setting all helped them suspend reality to complete the encounter. Leroy gave credit to the patient actor, stating, "[The] scenario feels real, and the actress I had was awesome. I was caught off guard completely." Caitlyn echoed these sentiments and shared:

> *I tried to take it as seriously as possible, putting myself in that situation, as if it was a real-world encounter, and just thinking about how much power my words can have over the individual, and feeling the weight of that made me very conscious of what was coming out of my mouth.*

Table 3. Category Frequency Counts

Domain and Category	Counts	Consensual Qualitative Research Assigned Label
Learning experience		
Emotionally realistic	12/12	General
Transformation from error	7/12	Typical
Reassurance	8/12	Typical
Application to future practice	11/12	Typical
Teaching others	5/12	Variant
Patient approach		
Empathetic	10/12	Typical
Direct questioning and active listening	12/12	General
Emergency action	8/12	Typical

Jimmy described the psychological and environmental fidelity that put him in an ideal state to engage with the experience:

> *I think it was the [sic] just the quality of the patient [actor]. The person that was doing this had portrayed [suicidal ideation] very well. There was a real sense that this had happened to this person and that they were deeply affected by the events and what was going on in their lives. That was the most impactful part. This was a very real situation that I felt like I was having to interact and try to intervene in this or figure out the right way to intervene.*

Participants noted their transformation from error by reflecting on specific skills they wished they performed during the encounter or recognized needed to change for future encounters. Donald stated:

> *I knew that I was not perfect, and I am a perfectionist. I did not want to stumble around with it quite like how I felt like I did, at least in certain portions. I would not say it was a bad experience, but I remember it took me a week or so to stop replaying that over and over again in my head.*

Several participants noted that they were not prepared for the encounter, which may have led to their more intense reflection and errors. Leroy shared:

> *I can clearly look back, and I made some screw-ups right away. I did not take away the avenue for her to walk away from me. I did not remove potential distractions that were coming in, potentially, to the doorway. I was not open and receptive to her commentary.*

Ziva summarized her transformation from error when she said: "I think I handled it fine, but I definitely saw places where I could get much better at it." While some students felt they were not prepared for a mental health emergency encounter like this, the reassurance category outlined those learners felt the experience helped build confidence in their current patient care skills. Jacqueline explained:

> *The most impactful part for me was the feedback that I got from the actor, and luckily, I feel like I did a good job. I just came up with my strategy on a whim, and so I feel like there was some reassurance that I would be able to handle this moving forward, but I think that was because of the feedback I got from the person playing that part. That was positive.*

Maria shared a similar sense of reassurance from the encounter by stating:

> *It was really calming to know I could do this for [a patient]. I could give them that sense of peace and make them feel like they were not alone because we already have a plan. We were going to get this done, and it was going to be okay.*

Participants discussed how they have applied the SP encounter to their clinical practice, including patient care and policy development elements. Abby described how she changed the way she uses space in her athletic training facility:

> *I used my office more appropriately. I tried during treatment hours, even if I said I am going to my office to get something, I stayed in there for a couple of minutes. I mean, literally 2 to 3 minutes so that if a patient needed to approach me privately, they could because, otherwise, they did not have a lot of time to do that. That gave people enough of a sense of privacy that they would approach me when needed, or at least I was approached a couple of times. I was also checking in with people more deliberately, asking how they were coping with things, and not waiting for it to get to the point where someone needed to necessarily come up to me and it be a frantic situation, but instead coming to them first, to try to implement prevention strategies.*

Sasha described the importance of planning ahead:

> *It is more than likely that, at some point, I am going to have a patient in some sort of mental health crisis, so coming up with an emergency action plan for that was my big takeaway from that debrief.*

Despite not having a patient with suicidal ideation since the SP encounter, Jimmy was able to reflect on the application the takeaways from the experience by sharing:

> *It has forced a conversation for our own clinical site towards mental health and screening of mental health issues. Mental health is now a part of our annual screening process, going from nothing to something. You are trying to figure out how much can we provide, how much do we work with our university support services, and where is that a good mix? I do not know we have found that yet, but we are at least trying stuff.*

Finally, participants outlined how they have used the knowledge from the simulation to help educate others. Participants described reviewing policy and procedures with coworkers and creating high- and low-fidelity simulations for

students or coworkers to help be prepared for future behavioral health encounters. Donald explained:

> *I had counseling services come in, and they spoke with my clinical class. We talked about how to actually engage in the conversation. That is something I was trying to get them to be more comfortable with, even asking the questions like, do you have a plan?*

Another participant, Anthony, shared:

> *... making sure to take a moment, at least once a year minimum, to have some sort of training or have some sort of conversation. It does not even have to be formal. I can just sit down and say, "Okay, what do you do? What would you do if this happened? Are you going to be ready?"*

Patient Approach

The domain patient approach is represented by participants explaining their approach to patient care, including being empathetic, engaging in direct questioning and active listening, and ensuring effective emergency action planning. Most of the participants described their approach to empathetic care. Jacqueline reflected on the empathetic whole-person health care by stating, "I was talking to the patient about her family and friends." Maria stated feeling caring by "being really sympathetic and empathetic to the [patient's] situation and making them feel like they were in a very nonjudgmental place as they went through this experience."

One participant, Abby, remarked on how to express empathy by creating a conversation. She shared, "I do not just need a yes/no, black-and-white answer so we can whisk her off to counseling. I need her to feel like she can talk to me as well." Caitlyn, however, expressed her empathy from a sense of fear. She said, "I hesitated to ask about a [suicide] plan because I was afraid that was going to make her the [sic] retreat and be less willing to be vulnerable."

All the participants described the use of direct questioning and active listening toward the patient in the SP encounter. The participants expressed that active listening was a useful skill when asking direct questions. Ziva added:

> *I took the action to actually ask them if they wanted to kill themselves. I think, as clinicians, we very often are afraid to ask that hard question or ask someone if they have had ideations, and sometimes, it is getting me over that hump of actually asking it and receiving the answer, and for this patient it was "yes," they had, and they had thought about killing themselves, and they wanted to.*

Timothy shared similar thoughts on direct questioning, "[It] was sort of a common conversation to have... if you are feeling down, depressed, or hopeless, are you having thoughts of harming yourself?" when asking about suicidal feelings. Sasha explained her approach to active listening as:

> *... for me to try and say that "I understand" when I maybe have not had that experience, I feel undermines that person's feelings. The approach to that was very different. I felt like I just needed to be more of a silent listener and then come up with a plan after she had expressed everything that she had felt like expressing.*

Leon continued the active listening by discussing all forms of communication. He shared, "[The experience] is to really work on to reading nonverbal and to really listen to what the person is and is not telling you."

Lastly, participants described emergency action steps they took to help manage the patient or what they concluded upon reflection. Timothy reflected on his emergency care options that he provided to the patient by stating, "[We] got 2 options... either call an ambulance to get you where you need to be, or we can walk to student health services." Leon described how he started making plans with the patient to help manage stress:

> *Let's think of all the problems that you have that you need to solve right now. We went down the list one by one, and I made her verbalize everything that she had to take care of, and then one [task] was talk to her parents because her parents were really mad at her, and I was like, "Okay, well, have you talked to them yet?" "No." I think that is the first place to start.*

Anthony described how he tried to provide resources for the patient, but as they continued talking, he felt another member of the health care team could be of assistance to this patient:

> *I tried to give them resources that would be available on campus, how I can help them, and then I said, "You know what? I am definitely not qualified to be a therapy person for you. I need to find someone who can do better than this."*

Finally, Maria discussed the importance of knowing the policy and procedures when she said, "[It is important] to be able to come up with a plan relatively quickly because of policies and procedures and being able to apply it quickly." Overall, the participants had differing takeaways from the SP encounter that allowed them to reflect on their empathy, communication, and emergency care skills relative to behavioral health.

DISCUSSION

In our study, we tasked participants to reflect on a mental health emergency SP encounter after completing their postprofessional program. The outcomes of this study suggest that a SP encounter focused on mental health, much like previous research in nursing,[22] had a positive immediate and long-term effect on ATs. With the clear intention of the Commission on Accreditation of Athletic Training Education (CAATE) 2020 Standards, professional athletic training students will be required to identify, refer, and give support for patients with behavioral health conditions in didactic and clinical learning experiences.[6] The conditions that athletic training students should be exposed to include depression, anxiety, psychosis, mania, attention deficit disorders, eating disorders, and suicidal ideation.[10] As we continue to elevate our professional education, postprofessional and continuing education must objectively prepare ATs in the content areas that may not have been included when they were in school.

Learning Experiences

The integration of simulation-based learning has been documented in professional athletic training education,[13,15,16]

postprofessional athletic training education,[18,23] and continuing professional development.[24] Similar findings have been identified with nursing students, specifically improvement in confidence after a mental health SP encounter.[25] Most recently, SP encounters have been described as mechanisms for active learning in professional athletic training programs wanting to develop critical thinking and confidence responding to a patient with a mental health challenge.[26]

The participants in our study noted that the learning experience was helpful due to the realistic nature of the patient. The environment must be realistic for the learners to appreciate the scenario and feel immersed or suspend reality in the activity.[27] Realism and fidelity are critical components of SP encounter design which can come in many forms such as physical, psychological, and emotional fidelity[28] through participating in a room that feels like an athletic training facility, creating a stressful experience like that of actual patient care, and the portrayal of accurate symptoms by the live actor. The SP encounters that were included as part of the study required case development and meaningful training of the actors to maximize the fidelity of the experience. Instructors and stakeholders wishing to implement similar techniques into their program as a class activity or workplace as continuing professional development must place high importance on good training to ensure the actors know what to do, how to respond, and when to display certain signs and symptoms.[29]

The participants in this study also shared that they were able to transform through error and progress themselves through reassurance. We believe this finding is supported through the safe environment of learning and providing immediate, direct feedback. The SP encounter was a purposeful time that allowed ATs to practice their mental health recognition and referral skills in a safe environment. Safety is used here to describe that the individual was not suicidal outside of his or her training, meaning if poor word choices, lack of recognition of symptoms, hinderance to referral options, or all the above occurred, the patient actor was not in immediate crisis, and it could be used as a teachable moment. A safe environment is 1 of the 5 domains of best practice set out from the Association of Standardized Patient Educators.[30] Many participants in this study noted that they have learned how to properly treat a patient in a mental health crisis but have never provided care for a patient in real life. A similar sentiment revolving around the safe environment for learning has been noted in previous research specific to athletic training.[23] Additionally, in a study focused on the evaluation of a mental health simulation, nursing students noted the same advantage of getting the time to care for a patient in a scenario that felt real but did not have any negative results if their care was not sufficient.[31] The integration of a SP encounter may be a positive method for learners to practice their skills, especially when providing care during a high stress and emergency scenario like a mental health crisis.

In addition to the safe environment, learners in our study noted the importance of the reassurance of their skills through both the feedback and the structured debriefing process. This concept of reassurance of skills has been noted in undergraduate nursing students.[32] More specifically, in an interprofessional learning opportunity with graduate health professional students in nursing, pharmacy, clinical psychology, and social work, SP encounters focused on mental health care allowed the learners the ability to practice their skills and have reassurance that they could perform these same skills if faced in their clinical practice.[33] We suggest that ATs taking trainings, coursework, or practicing their mental health skills be directly or indirectly observed to allow for self-reflection, direct feedback, and debriefing that promote clinical advancement. The debriefing process is a critical component of a SP encounter. In fact, a SP encounter should never be completed without an opportunity to debrief about the actions, emotions, and translation of their experience to future practice. The process typically allows for reflective practice that increases one's self-confidence after the SP encounter.[34]

Finally, the learning experience allowed for the participants to tangibly have an experience that they could bring back to their current jobs. As postprofessional students, all learners were concurrently working as ATs. The participants shared that they were able to reflect on their practice and bring back their experience to students, coworkers, and subordinates to help them prepare for patients with mental health challenges. The described experience is like the train-the-trainer model for teaching.[35] The train-the-trainer process relies on the resources of the organizing experts—in this case, the postprofessional program—to expose, train, and discuss the information before future dissemination to others in the community. The learners absorbed the materials and became the trainers for mental health best practices when returning to their place of employment. We suggest that similar mechanisms of profession-wide dissemination of best practices continue to occur throughout facets of care.

In addition to the formal procedures of teaching others via classroom instruction, this category also highlights the role of teaching others through patient education. Some participants in the study remarked about changing their practices, speaking with stakeholders, and teaching others about the things they had learned as part of the mental health SP encounter. Our finding aligns with recently published data from the National College Health Assessment which identified that athletes reported receiving more information than nonathletes on mental health information for anxiety, helping others in distress, and suicide prevention.[36] While these data are not directly connected to postprofessional training on mental health, the authors suggest that the increases in receiving information and care-seeking behaviors could be attributed to the ATs and our unique role; however, they also noted increased knowledge recognizing symptoms and referral is necessary to ensure the continuity of the positive findings.[36]

Patient Approach

Findings from the study support the development of empathy as a long-term effect of the mental health SP encounter. Researchers identified that NCAA Division 1 athletes viewed their ATs as patient-centered providers in the realm of individualized, empathetic care.[37] Athletes have defined empathy through actions of their ATs including patient advocacy, reflective listening, and creating personal connection.[38] The participants in our study felt similarly as in previous research where they were able to develop an empathetic approach to the patient encounter. It is vital to note that the description of empathy by the participants in their patient approach may have been better characterized as

Table 4. Starting the Dialogue on Suicide Risk Assessment

Begin by asking direct questions to assess the risk:
(1) Are you having thoughts about harming yourself?
(2) Are you considering suicide?
If yes to question 1 or 2, continue asking about the suicide plan:
(3) Have you thought about how you would kill yourself?
(4) Do you know when you would do it?
(5) Do you have the means necessary to carry out your plan to kill yourself?

sympathy and compassion. These terms are often used interchangeably despite having minute yet distinct differences.[39] Many of the participants described aspects of empathy, such as connection and self-other differentiation, but provided statements that support the multidimensional structure of empathy were lacking.[39] The mental health SP encounter is a viable mechanism for learning that allows for providers to practice their clinician-patient relationship through cognitive, affective, and behavioral aspects.[39]

The participants in this study reflected that direct questioning and active listening were self-identified improvements to practice after the encounter. Direct questioning with patients experiencing suicidal ideation has often been misunderstood in the public. Previous researchers in psychiatric nursing identified that high-fidelity simulation assists students in developing communication strategies when working with patients experiencing mental health challenges.[40] Athletic trainers have reported feeling both responsible and comfortable with discussing mental health concerns with athletes.[41] Despite the comfort, many individual have not had the direct experience to do so during training, meaning hesitancy may exist in asking certain questions depending on the situation. Previous researchers support that asking an at-risk patient about their intentions of killing themselves does not increase the likelihood for attempt or increased ideation.[42] Table 4 provides a framework for direct questioning when assessing suicidal ideation, which can be used to determine the referral and emergency planning process for an AT. Literature in other peer professions, specifically emergency departments, identified that the most essential and efficient method for evaluating suicidality was through a direct, verbal conversation.[43]

Finally, the participants in the study considered mental health in the same realm as other immediate and emergency conditions in terms of their reflection on future planning. The NCAA and the National Athletic Trainers' Association both state that sports medicine teams should develop and implement protocols for the management of emergency mental health situations.[1,44] The reflection on emergency planning by the participants demonstrated a level of personal and professional development. However, it is important to note that, despite the recommendations from member organizations being available, the participants were not actively engaging in professional development around mental health. The reflections shared in the interviews, while not generalizable to all credentialed ATs, emphasize the role of active learning for future professional development. The learners were able to go through an intense, realistic patient encounter requiring immediate referral. The lack of a clear plan or procedure left some participants wanting to do more in their practice after the completion of the postprofessional program. We suggest that ATs engage in similar active continuing professional development to drive meaningful change relative to policy creation and patient care.[45]

Limitations and Future Research

Our study has limitations of generalizability throughout educational pathways. The participants in this study shared about their lived experiences while members of the same postprofessional Doctor of Athletic Training program. The findings, while promising, may not occur for learners throughout other postprofessional programs such as residency and fellowships. While the interview protocol also asked for the participant to reflect upon the SP encounter itself, there is no way to eliminate other professional development and circumstances that may have influenced the outcomes. We suggest that future researchers consider asking about other professional development efforts that the individual may have taken part in during the study timeline to triangulate the findings.

Future researchers should continue to explore the outcomes after the SP encounters. While the educational outcomes of simulation-based learning are promising, continued focus on the patient experience and outcomes of those who underwent training is needed. In addition, the expansion of residency programs within athletic training allows for the development of clinical specialists in behavioral health. The use of mental health SP encounters across the educational pathways including CAATE-accredited professional and residency programs and certificate and advanced practice leadership programs, and continuing professional development programming may provide opportunities to improve comfort and competence for the clinician.

CONCLUSIONS

Like other research about the longitudinal effects of SP encounters, participants applied the learning outcomes from the SP encounter in their clinical practice 1.5 to 3 years later. Specifically, they were able to transform their practice from the errors they made during the SP encounter. The learning environment created an emotionally realistic space with reassurance and collaborative learning, which resulted in personal and professional development. As such, a mental health SP encounter had positive long-term effects on ATs' clinical care including improvements in empathy and emergency planning. We suggest mental health SP encounters be used to prepare ATs, regardless of academic level and years of credentialed experience, and especially when there are substantial consequences to the health and wellbeing of the patients, like in the case of an emergency mental health crisis.

REFERENCES

1. Interassociation consensus document: mental health best practices. NCAA Sport Science Institute. Published 2020. Accessed June 25, 2022. https://ncaaorg.s3.amazonaws.com/ssi/mental/SSI_MentalHealthBestPractices.pdf
2. Lund HG, Reider BD, Whiting AB, Prichard JR. Sleep patterns and predictors of disturbed sleep in a large population of college

students. *J Adolesc Health* 2010;46(2):124–132. doi:10.1016/j.jadohealth.2009.06.016

3. Cormier ML, Zizzi SJ. Athletic trainers' skills in identifying and managing athletes experiencing psychological distress. *J Athl Train*. 2015;50(12):1267–1276. doi:10.4085/1062-6050-50.12.02
4. Stiller-Ostrowski JL, Ostrowski JA. Recently certified athletic trainers' undergraduate educational preparation in psychosocial intervention and referral. *J Athl Train*. 2009;44(1):67–75. doi:10.4085/1062-6050-44.1.67
5. Carr WD, Volberding J. Employer and employee opinions of thematic deficiencies in new athletic training graduates. *Athl Train Educ J*. 2012;7(2):53–59. doi:10.4085/070253
6. Pursuing and maintaining accreditation of professional programs in athletic trainings: Implementation and guide to the CAATE 2020 Professional Standards. Commission on Accreditation of Athletic Training Education. Published 2021. Accessed June 25, 2022. https://caate.net/Portals/0/Documents/Standards%20and%20Procedures%20for%20Accreditation%20of%20Professional%20Programs.pdf
7. Hamson-Utley JJ, Stiller-Ostrowski JL. Athletic training educators' instructional methods and confidence in graduating students' abilities regarding psychosocial intervention and referral. *Athl Train Educ J*. 2011;6(3):154–162. doi:10.4085/1947-380X-6.3.154
8. Plos JM, Crowley K, Polubinsky RL, Cerullo C. Implementing suicide prevention training into an athletic training curriculum: an introductory model. *Athl Train Educ J*. 2021;16(2):87–100. doi:10.4085/1947-380X-19-077
9. Stiller-Ostrowski JL, Hamson-Utley JJ. Athletic trainers' educational satisfaction and technique use within the psychosocial intervention and referral content area. *Athl Train Educ J*. 2010;5(1):4–11. doi:10.4085/1947-380X-5.1.4
10. Thrasher AB, Walker SE, Hankemeier DA. Newly credentialed athletic trainers' perceptions of professional preparation for their role as collegiate graduate assistants. *Athl Train Educ J*. 2018;13(3):227–238. doi:10.4085/1303227
11. Thrasher AB, Walker SE, Hankemeier DA, Pitney WA. Supervising athletic trainers' perceptions of graduate assistant athletic trainers' professional preparation. *Athl Train Educ J*. 2015;10(4):275–286. doi:10.4085/1004275
12. Walker S, Weidner T, Armstrong KJ. Standardized patient encounters and individual case-based simulations improve students' confidence and promote reflection: a preliminary study. *Athl Train Educ J*. 2015;10(2):130–137. doi:10.4085/1002130
13. Armstrong KJ, Jarriel AJ, Hardin BM. The longitudinal impact of standardized patient encounters during professional education on athletic training professional practice. *Athl Train Educ J*. 2021;16(3):169–177. doi:10.4085/1947-380X-20-001
14. Winkelmann Z, Eberman LE. The confidence and abilities to assess a simulated patient using telemedicine. *Athl Train Educ J*. 2020;15(2):132–147. doi:10.4085/1947-380X-62-19
15. Armstrong KJ, Jarriel AJ. Standardized patient encounters improved athletic training students' confidence in clinical evaluations. *Athl Train Educ J*. 2015;10(2):113–121. doi:10.4085/1002113
16. Walker SE, Weidner TG, Thrasher AB. Small-group standardized patient encounter improves athletic training students' psychosocial intervention and referral skills. *Athl Train Educ J*. 2016;11(1):38–44. doi:10.4085/110138
17. Bush JM, Walker SE, Sims-Koenig KN, Winkelmann ZK, Eberman LE. Postprofessional learners' reflections after a standardized patient encounter and debriefing session. *Athl Train Educ J*. 2019;14(1):55–63. doi:10.4085/140155
18. Sims-Koenig KN, Walker SE, Winkelmann ZK, Bush JM, Eberman LE. Translation of standardized patient encounter performance and reflection to clinical practice. *Athl Train Educ J*. 2019;14(2):117–127. doi:10.4085/1402117
19. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. *Acad Med*. 2014;89(9):1245–1251. doi:10.1097/ACM.0000000000000388
20. Hill CE, Thompson BJ, Williams EN. A guide to conducting consensual qualitative research. *Couns Psychol*. 1997;25(4):517–572.
21. Hill CE. Consensual qualitative research (CQR): methods for conducting psychotherapy research. In: Gelo O, Pritz A, Rieken B, eds. *Psychotherapy Research*. Springer; 2015:485–499. doi:10.1007/978-3-7091-1382-0_23
22. Doolen J, Giddings M, Johnson M, de Nathan GG, Badia LO. An evaluation of mental health simulation with standardized patients. *Int J Nurs Educ Scholarsh*. 2014;11(1):55–62. doi:10.1515/ijnes-2013-0075
23. Boddicker B, Winkelmann ZK, Neil ER, Walker SE, Eberman LE. Athletic trainers' perceptions of anxiety before, during, and after a standardized patient encounter. *Athl Train Educ J*. 2020;15(2):156–167. doi:10.4085/1947-380X-63-19
24. Winkelmann ZK, Neil ER, Games KE, Walker SE, Eberman LE, Practice. Simulation-based learning to improve athletic trainers' knowledge of exertional sudden death conditions: a pilot study. *Internet J Allied Health Sci Pract*. 2020;18(3):15. doi:10.46743/1540-580X/2020.1946
25. Alexander L, Dearsley A. Using standardized patients in an undergraduate mental health simulation: a pilot study. *Int J Ment Health*. 2013;42(2–3):149–164. doi:10.2753/IMH0020-7411420209
26. Ostrowski JL, Gray A, Payne EK, Wilkenfeld D, Scifers JR. Interactive activities to aid in a comprehensive understanding of mental health within the professional athletic training curriculum. *Athl Train Educ J*. 2021;16(4):262–269. doi:10.4085/1947-380X-20-73
27. Kaneko RMU, Lopes MHBdM. Realistic health care simulation scenario: what is relevant for its design? *Rev esc enferm USP*. 2019;53. doi:10.1590/S1980-220X2018015703453
28. Sanko JS, Shekhter I, Kyle RR Jr, Di Benedetto S, Birnbach DJ. Establishing a convention for acting in healthcare simulation: merging art and science. *Simul Healthc*. 2013;8(4):215–220. doi:10.1097/SIH.0b013e318293b814
29. Boggs JG, Mickel AE, Holtom BC. Experiential learning through interactive drama: An alternative to student role plays. *J Manag Educ*. 2007;31(6):832–858. doi:10.1177/1052562906294952
30. Lewis KL, Bohnert CA, Gammon WL, et al. The association of standardized patient educators (ASPE) standards of best practice (SOBP). *Adv Simul*. 2017;2:10. doi:10.1186/s41077-017-0043-4
31. Donovan LM, Mullen LK. Expanding nursing simulation programs with a standardized patient protocol on therapeutic communication. *Nurse Educ Pract*. 2019;38:126–131. doi:10.1016/j.nepr.2019.05.015
32. Andrea J, Kotowski P. Using standardized patients in an undergraduate nursing health assessment class. *Clin Simul Nurs*. 2017;13(7):309–313. doi:10.1016/j.ecns.2017.05.003

33. Peterson JA, Brommelsiek M, Graybill T. Standardized patient scenarios: Preparing interprofessional teams for working with veterans. *J Interprof Educ Pract*. 2018;13:12–14. doi:10.1016/j.xjep.2018.08.001
34. Robinson-Smith G, Bradley PK, Meakim C. Evaluating the use of standardized patients in undergraduate psychiatric nursing experiences. *Clin Simul Nurs*. 2009;5(6):e203–e211. doi:10.1016/j.ecns.2009.07.001
35. Orfaly RA, Frances JC, Campbell P, Whittemore B, Joly B, Koh H. Train-the-trainer as an educational model in public health preparedness. 2005;11(6):S123–S127.
36. Edwards B, Froehle AW, Fagan SE. Trends in college student-athlete mental health in the National College Health Assessment (NCHA), 2011–2019. *J Athl Train*. 2021. doi:10.4085/1062-6050-586-21
37. Redinger AS, Winkelmann ZK, Eberman LE. Collegiate student-athletes' perceptions of patient-centered care delivered by athletic trainers. *J Athl Train*. 2021;56(5):499–507. doi:10.4085/130-20
38. David S, Larson M. Athletes' perception of athletic trainer empathy: how important is it? *J Sport Rehabil*. 2018;27(1):8–15. doi:10.1123/jsr.2016-0085
39. Jeffrey D. Empathy, sympathy and compassion in healthcare: is there a problem? Is there a difference? Does it matter? *J R Soc Med*. 2016;109(12):446–452. doi:10.1177/0141076816680120
40. Kameg K, Howard VM, Clochesy J, Mitchell AM, Suresky JM. The impact of high fidelity human simulation on self-efficacy of communication skills. *Issues Ment Health Nurs*. 2010;31(5):315–323. doi:10.3109/01612840903420331
41. Clement D, Arvinen-Barrow M. Athletic trainers' views and experiences of discussing psychosocial and mental health issues with athletes: an exploratory study. *Athl Train Sports Health Care*. 2019;11(5):213–223. doi:10.3928/19425864-20181002-01
42. Mathias CW, Furr RM, Sheftall AH, Hill-Kapturczak N, Crum P, Dougherty DM. What's the harm in asking about suicidal ideation? *Suicide Life Threat Behav*. 2012;42(3):341–351. doi:10.1111/j.1943-278X.2012.0095.x
43. Petrik ML, Gutierrez PM, Berlin JS, Saunders SM. Barriers and facilitators of suicide risk assessment in emergency departments: a qualitative study of provider perspectives. *Gen Hosp Psychiatry*. 2015;37(6):581–586. doi:10.1016/j.genhosppsych.2015.06.018
44. Neal TL, Diamond AB, Goldman S, et al. Inter-association recommendations for developing a plan to recognize and refer student-athletes with psychological concerns at the collegiate level: an executive summary of a consensus statement. *J Athl Train*. 2013;48(5):716–720. doi:10.4085/1062-6050-48.4.13
45. Young J, Neil ER, Granger K, Walker SE, Chadburn JL, Eberman LE. Preparedness, confidence, and best practices in preventing, recognizing, managing mental health cases in NCAA institutions. *J Athl Train*. 2020. doi:10.4085/129-20