ETHNOGRAPHY IN THE PRE-HOSPITAL FIELD: AN EXPLORATION OF THE CULTURE OF HOW PARAMEDICS IDENTIFY, ASSESS AND MANAGE PSYCHIATRIC PRESENTATIONS IN THE COMMUNITY

Louise Roberts
Bachelor of Health Sciences (Paramedic) Hons.
Bachelor of Nursing

School of Nursing & Midwifery
Faculty of Health Sciences
Flinders University
Adelaide, Australia

Submitted for requirements of the award of Doctor of Philosophy
September 2012

Contents

Tables and figures **ix**

Abbreviations and key terms **x**

Summary **xii**

Declaration **xv**

Acknowledgments **xvi**

Chapter 1 Introduction **1**

1.0 Introduction 1
1.1 The research question and objectives 3
1.2 The rationale for the research and its significance 4
1.2.1 Personal significance 5
1.2.2 Literature review 6
1.3 Methodology—the theoretical stance 7
1.4 Research method 8
1.5 The findings 9
1.5.1 Part 1: Dispatch, arrival and the approach 9
1.5.2 Part 2: Assessment, assumptions and influences 10
1.5.3 Part 3: Handover and case cards 11
1.6 Discussion and conclusion 12

Chapter 2 Literature review **14**

2.0 Introduction 14
2.1 Section 1: No health without mental health 17
2.1.1 Prevalence 17
2.1.2 Comorbidity and disability 24
2.1.3 Mortality and suicide 26
2.2 Section 2: Resources for mental health—scarcity, inequity, and inefficiency 27
2.2.1 Community resources 29
2.2.2 Discrimination and stigma 34

2.3 Section 3: The mental health system—where are we now? 37
2.3.1 National policy and reform 37
2.3.2 Australian's *National Mental Health Report* 40
2.4 Section 4: Care of mental disorders: Culture and demand 42
2.4.1 Emergency departments and emergency service demand 42
2.4.2 Emergency services: ambulance / emergency medical services 50
2.5 Conclusion 54

Chapter 3 Methodology 55
3.0 Introduction 55
3.1 Research methodology: Crotty's definitions 56
3.2 Symbolic interactionism 60
3.2.1 The nature of symbolic interactionism 60
3.2.2 Nature of human society or human group life 64
3.2.3 The human being as an acting organism 65
3.2.4 Pragmatism as the intellectual basis for symbolic interactionism 68
3.3 Epistemology—how the world is known in symbolic interactionism 70
3.3.1 Constructionism and constructivism 70
3.3.2 Critical stance towards taken-for-granted-knowledge 72
3.3.3 Historical and cultural specificity 73
3.3.4 Knowledge is sustained by social processes 74
3.3.5 Knowledge and social action go together 75
3.3.6 Anti-essentialism 76
3.3.7 Anti-realism: relativism vs. realism 77
3.4.8 'The publicly available systems of intelligibility': culture and the individual 79
3.4 How theory meets method 81

Chapter 4 Research method part 1: The framework—ethnography and culture 84
4.0 Introduction 84
4.1. Ethnography and culture 85
4.1.1 A brief account: ethnography and relevance to practice 85
4.1.2 Ethnography: the holistic perspective 88
4.1.3 The insider and outsider: the emic and etic perspectives 89
4.1.4 Ethnography as a means to explain work life 90
4.1.5 Culture 91

4.2 The use of focussed ethnography and how the research fits the method 94
4.2.1 Why description is relevant to practice 97
4.3 Conclusion 99

Chapter 5 Research method part 2: The process—access, ethics, observation, interviews and documents 100

5.0 Introduction 100
5.1 The process: The beginning—access, gatekeepers and ethics 100
5.1.1 Access to field sites 100
5.1.2 Hierarchy and gatekeepers 104
5.1.3 Ethics 106
5.1.4 The collaborative, emergent research design and prior informed consent 108
5.2 The challenges encountered 110
5.2.1 Participant consent: the challenge of prior informed consent of paramedics 111
5.2.2 The interview and interview questions 114
5.3 When, where and how of data collection 116
5.4 Profile and recruitment of study participants 118
5.4.1 Profile of study participants 118
5.4.2 Recruitment of participants 119
5.4.3 The potential sample 120
5.4.4 Duration of the study 120
5.5 Principles behind the ethnography techniques 120
5.5.1 Non-participant observation 120
5.5.2 Interviews 124
5.6 Documents in social research 128
5.7 Data analysis: ethnographic analysis 134
5.7.1 Analysis 134
5.7.2 Domain analysis 134
5.7.3 Taxonomic analysis and coding: Interviews and observations 136
5.8 Conclusion 138

Chapter 6 Findings part 1: Dispatch, arrival and the approach **139**

6.0 Introduction 139

6.1 Theme 1: Dispatch, on arrival and first impressions 142

6.1.1 Reason for attendance 143

6.1.2 Certainty vs. uncertainty: what you get told and what you find 148

6.2 Theme 2: The approach 151

6.2.1 Attempt to approach professionally: a challenge and a case-by-case approach 152

6.2.2 Do or do not engage, matter of fact and keep it simple 164

6.2.3 Communication and adaptability: Not what you can learn from a textbook 169

6.3 Theme 3: Compliance and non-compliance: explaining the options 174

6.3.1 Risk to themselves, to others and whether to involve the police 177

6.3.2 The patient's choice and whether they can make decisions about their health 179

6.3.3 Offer to take the patient to hospital on 'medical grounds' 181

6.4 Theme 4: Caution, risk, safety and the ultimate goal 182

6.4.1 Situations we enter and being an unexpected arrival 185

Chapter 7 Findings part 2: Assessment, assumptions and influences **189**

7.0 Introduction 189

7.1 Theme 5: Assessment—what they see, hear and search for 190

7.1.1 What they see and hear 190

7.1.2 The measured observations 201

7.2 The scene 203

7.2.1 The search and filling in the picture 205

7.2.2 History, history from others and social history 209

7.3 Complexity and comorbidity: a process of elimination and can we treat any underlying medical causes of the disturbed behaviour 215

7.3.1 'Body' first 220

7.4 Conclusion 223

Chapter 8 Findings part 2: Assessment, assumptions and influences (Section 2—assumptions and influences) 224

8.0 Introduction 224

8.1 Treatment: strategies, interaction and provision of care (Can we clinically provide care?) 224

8.1.1 The traditional role of emergency care versus changing practice 224

8.2 Managing the consequences of patient actions and alternative strategies 226

8.3 Keeping it calm and using diversion 228

8.4 Focusing on the relevant information 230

8.5 The interactions and actions 232

8.6 The broader social reasons behind the need for care 236

8.7 Theme 6: Is it genuine, assumptions and influences 239

8.7.1 'Is it genuine?' attention seekers, regulars and are we just a taxi service? 240

8.7.2 The patients behaviour and knowing the system 241

8.7.3 Are we the right people to help? 243

8.7.4 How paramedics see their role 244

8.7.5 The reasons for the frustration and disconnection with psychiatric patients 248

8.7.6 Drug and alcohol use, fatigue and shift work 253

8.7.7 The 'regulars' 255

8.8 Assumptions and influences: what you see, general perception, what do others model, life experience and past and present 'on-road' experience 257

8.8.1 The emergency department: not the right place 260

8.8.2 'Life' experience versus 'on-road' experience 261

8.9 Role modelling and the dangers of categorising 267

8.10 Education 270

8.11 Conclusion 272

Chapter 9 Findings part 3: Handover and case cards (Section 1—Handover) 274

9.0 Introduction 274
9.1 Handover: the place, space and information transfer 275
9.1.1 Theme 7: Place and space: the 'ramp' and the 'fishbowl' 275
9.1.2 Ownership of space 277
9.2 Negotiation of space and time: the busy ED 280
9.2.1 Peak times: the eleven and three rush ('you can almost set your clock by it') 282
9.2.2 The paramedics: how they get the process done 284
9.2.3 The communication and negotiation of the handover process 286
9.3 Availability of space and resources 287
9.4 Relationships within the fishbowl 291
9.5 Theme 8: Handover 293
9.5.1 Information received and information given: The process and the social history 294
9.5.2 The limited information from the scene and the acknowledgement from ED staff 302
9.6 The police, 'detained' patients and the handover 305
9.7 The double check by the ED staff 309
9.8 The judgement and the regulars 312
9.9 Conclusion 315

Chapter 10 Findings part 3: Handover and case cards (Section 2—case cards) 317

10.0 Introduction: the case card (the patient report form) 317
10.1 Presenting complaint 318
10.2 Past history and current event/history 321
10.3 On arrival (O/A) and on examination (O/E) 328
10.3.1 On arrival: the scene—the patient 333
10.3.2 On examination: seen, heard and measured 334
10.4 Conclusion 341
10.5 Summary of the major themes 342

Chapter 11 Discussion **348**

11.0 Introduction 348

11.1 Defining role 352

11.2 Defining ‘emergency’ and the context of pre-hospital work 354

11.2.1 Comorbidity: Drug and alcohol use in conjunction with mental illness 356

11.3 Transition work: Caught between episodic and long- term care 358

11.3.1 Traditional versus changing role expectations: tensions and confusion 359

11.4 The scaffolding: industry constraints 364

11.4.1 Organisational structures, procedures and professional boundaries 364

11.4.2 The influence of organisational structure and policy: the gap between national and state direction and ‘on-road’ reality 368

11.4.3 How to define and develop the professional boundaries 370

11.4.4 Education 373

11.5 Thwarted identity: Balancing personal and public expectations and ‘on-road’ reality 376

11.5.1 Psychiatric patients as anti-heroic work 376

11.5.2 Ambulance work as risky and repugnant: safety and caution first 378

11.6 Attributed identity: dangerousness, legitimate vs. illegitimate need for care, assumed liberty in gathering the history, stigma and consequences of action 379

11.6.1 Risk, caution and safety 380

11.6.2 The concept of dangerousness 381

11.6.3 Stigma: mental illness and spoiled identity 384

11.6.4 Rationalised self-interest and trading of patient care and scene safety 388

11.7 Assuming control: taking the offensive position to gain certainty in the uncertain and unpredictable 389

11.7.1 Compliance 390

11.7.2 Gaining control of the physical and social space 395

11.7.3 The activities in the physical and social space: the use of continual monitoring 396

11.7.4 The trading of responsibility 398

11.8 Collateral (continual) monitoring and how it relates to Mead’s symbolic interactionism 399

11.9 Conclusion 401

Chapter 12 Conclusion and Recommendations **403**
12.0 Introduction 403
12.1 Recommendations 405
12.1.1 Collaboration and communication with the mental health sector 405
12.1.2 Organisational structure and protocols: alternative to the patient report card 409
12.1.3 Education 411
12.2 Limitations 414
12.3 Conclusion 415

Appendix A Paramedic Participant Information Sheet **417**

Appendix B Consent to Participation in Research—Paramedic Participants **420**

Appendix C Flinders Medical Centre Emergency Department Staff Participant Information Sheet **421**

Appendix D Consent to Participation in Research—Emergency Department Staff Participants **424**

Appendix E Paramedic and Emergency Department Staff Interview Guides **425**

Appendix F Paramedic Participant Details **428**

Appendix G Duration of Case Interviews **429**

Appendix H Observation Overview **430**

Appendix I Field notes **433**

Appendix J Emergency Department Floor Plan **435**

Appendix K SA Ambulance Patient Report Form (The Case Card) **436**

Tables and figures

Table 2.1	Assumptions and realities of deinstitutionalisation	33
Table 2.2	South Australian inpatient beds and community residential services numbers	42
Table 5.1	Case card and GCS criteria	132
Table 6.1	Overview of dispatch categories and expected response times	144
Table 10.2	Past history and history/current event	323
Table 10.3	Medications	328
Table 10.4	On arrival and on examination	330

Figure 3.1	Blumer's lines of communication and meaning	67
Figure 6.1	Summary of the major themes and subthemes from the findings	141
Figure 10.1	Overview of the findings: The nature of information collection and delivery	347
Figure 11.1	Discussion overview	351
Figure I.1	Field notes sample 1	433
Figure I.2	Field notes sample 2	433
Figure I.3	Field notes: transcribed with reflective notes	434

Abbreviations and key terms

ACIS	Assessment Crisis Intervention Service (Community Mental Health Team)
AIHW	Australian Institute of Health and Welfare
BOiMHC	Better Outcomes in Mental Health Care
Case Card	South Australian Patient Report Form
Code Black	A code used in hospitals to denote an emergency situation where security and other medical assistance is required
DALYs	Disability Adjusted Life Years
DSM–IV–TR	Diagnostic and Statistical Manual of Mental Disorders—IV–text revised
ECP	Extended Care Paramedic
ED	Emergency Department
EMS	Emergency Medical Services
EOC	Emergency Operations Centre
ETOH	Ethanol and OH (oxygen hydroxyl group) suspected alcohol intoxication
GCS	Glasgow Coma Score
ICD-10-AM	International Classification of Disease—10
IRCP	International Roundtable of Community Paramedicine
LOS	Length of stay
MHNIP	Mental Health Nursing Incentive Programme
MOU	Memorandum of Understanding

NAD	Nil abnormalities detected
NMHS	National Mental Health Strategy
O/A	On Arrival
Obs.	Observation and measurement of the patient’s vital signs e.g. pulse rate, blood pressure, respiration rate, oxygen saturation levels within the blood
OD	Overdose
O/E	On Examination
Paramedics Australasia	Formerly: Australian College of Ambulance Professionals (ACAP) is the peak body representing paramedics in Australia and New Zealand
PHx	Past Medical History
Psychiatric presentation	The term used to describe patients that present with altered behaviour and thought process and are believed to be experiencing mental health concerns
SAAS	South Australian Ambulance Service
SAPOL	South Australian Police
WHO	World Health Organization

Summary

Over the last decade there have been marked increases in the utilisation of ambulance services nationally in Australia. These increases have been attributed to factors such as the shift in health care provision from acute settings to the community, pressures on the primary health care sector, an aging population, health workforce shortages and the prevalence of chronic conditions. These social and structural changes present the paramedic workforce with changing demands, expectations in service delivery and greater responsibility for clinical decision making and treatment. Paramedics attend and care for an increasing number of lower acuity presentations and those with complex needs which dictates triage, management and referral decisions. The shift from institutional to community based care in mental health reform has seen increases in emergency attendance to individuals needing mental health care. Patients that present with complex needs require extended scene time and care provision and do not fit the traditional mould of emergency care which is forcing organisational and structural changes. These changes include a move to becoming a profession, university based training, electronic documentation and further training both at graduate and post graduate levels.

This thesis explores the culture of paramedic work when identifying, assessing and managing individuals with changes in behaviour attributed to mental health

concerns (psychiatric presentations) in the community. As the link between pre-hospital and further care, paramedics have a vital role to play, but to date paramedics' 'on-road' experiences and culture when attending psychiatric presentation has not been widely researched.

This ethnographic account of paramedic actions and beliefs, their culture, is based in the theory of symbolic interactionism and social constructivism which asserts that human interaction is central to how individuals construct meaning and knowledge. The data was collected over an eleven month period from 2009–2010 at a tertiary public hospital in South Australia. The ethnographic methods used were observation of the ambulance arrival and emergency department triage areas, interviews with paramedics and emergency department staff, and document analysis. Using thematic analysis based on cultural domains, the findings follow a linear case history, beginning from dispatch and arrival, paramedics' first impressions and their approach, assessment, and finally to handover and reporting.

This demonstrates how paramedics are caught between the provision of traditional acute care and extended scene times and management of complex presentations such as mental illness. It outlines how the changing expectations and demands place paramedics in a conflicting position and challenges the concept of their role and their identity. Key findings include the paramedics' reliance on their first impressions and 'on-road' experience due to the limited information they receive from dispatch when attending psychiatric presentations. Findings explore how

organisational structures such as the communication system (dispatch), documentation, and handover shape their approach and subsequent assessment. This includes the importance of their role as emergency clinicians and the high priority placed on risk, safety, and caution. The heightened perception of risk and the need to control the unpredictable through strategies which assume control tends to promote actions which focus on transport to further care and compliance. The thesis explores the limited care paramedics feel they can provide due to the nature of the environment, their scope of practice, their limited education and professional development in mental health, and associated patient comorbidities. This leaves paramedics dealing with the consequences of the patient's behaviour, such as self-harm while aiming to meet their duty of care by transporting the patient safely to further care, usually the emergency department (ED). These cultural considerations placed an emphasis on the paramedics overriding duty of care, generated feelings of frustration with the patient and the mental health system, and created a situation where paramedics were forced to practice between their traditional role of acute care and managing those needing complex care.

Documenting the nature of paramedic work with patients suffering a mental illness assists with identifying the structural, educational, policy, and resource needs required to make operating in this environment more tenable leading to better patient care and outcomes.

Declaration

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Louise Roberts

Signature: Date: March 2013

Acknowledgments

First and foremost I would like to acknowledge the support, time, and honesty given by the paramedics and the ED staff who participated in this study. Without their willingness to share their stories and beliefs, which gives this thesis its narrative, the research would not have happened. Through the stories I have been privileged to hear the whole process has been both professionally and personally rich and rewarding.

To the senior management of the SA (South Australian) Ambulance Service and the ED thank you for the opportunity, access and support in conducting the research. Again without your crucial contribution the research would not have been possible.

To my three supervisors a heartfelt thank you. To my principal supervisor Professor Eimear Muir-Cochrane for all her patience, feedback, encouragement and willingness to undertake the long PhD process with me. To Dr Julie Henderson for her belief in me, her mentorship, compassion, and friendship which she managed to keep separate (most of the time) from the job of supervisor with a critical eye on my thesis. To Associate Professor Eileen Willis who brought social and theoretical concepts to life for me with creativity and genuine enthusiasm. I am grateful to all three for providing a safe and exciting environment for lively debate and discussion

which has created a love of research and critical thinking and a passion for ideas and the area of mental health.

My love and thanks goes to my amazingly talented and giving parents, Peter and Geraldine Roberts, for their love, patience and thoughtful discussion. To my dad for being the considered, well-read thinker who posed many questions and counter arguments which helped me to clarify and structure my thoughts. You have taken to the assumptions of my philosophical stance with grace, although you come from the ‘dark side’ of quantitative research with its numbers and statistical reasoning. To mum for your passion and wisdom in all things people orientated. Here is to your practical and pragmatic approach to the subject of care and mental health and protective counsel on keeping the balance in my life during the PhD process.

I would finally like to acknowledge my supportive and loving sisters and brothers Karen, Andrew, Rachel, and Matthew for their encouragement and debate.

Chapter 1

Introduction

I went to a young man who was clearly unwell, just his body language was indicating that, he just said he felt nervous to start with and then he stood up and just said 'I'm Jesus' and he was quite clear about that, and I said 'Do you think you're Jesus?' 'Yes I do.' 'Ok.' 'Do you have a mental illness at all?' 'No, no there's nothing wrong with me, I'm just Jesus.' You know and he was young and I don't know whether he had a diagnosis of schizophrenia or whether he'd sought treatment. He was only late teens, early 20s living alone, clearly not managing at home.

(Emma, paramedic, interview 3)[1]

1.0 Introduction

Emma was a paramedic in her early forties with children of her own. She has been in the ambulance service for approximately six years. The quotation above is only part of her story of her interaction with this particular patient experiencing delusions and hallucinations. Emma described feelings of protectiveness, concern and almost wanting 'to place her arms around him'. She found the situation clinically difficult, stressful, and emotional because she wanted to be able to do something constructive for this young man in her care. Emma found herself relating her reactions to this patient to her own mothering instincts to protect and nurture. In reality, all she felt she could do at the time was to provide support so that he remained calm. She had attempted to convince him to come to hospital, but to no

1. All participants' names throughout this thesis are pseudonyms.

avail and in the end the paramedics required police support to safely transport him to further care. Emma's story and her perceptions of the work she performs when caring for those with mental illness is an example of what this research aims to uncover.

Operating in the community as a provider of out-of-hospital emergency medical care, paramedics are confronted by situations which challenge their skills and resources. This ethnography is a narrative of the professional and personal stories of paramedics and their work with people experiencing a mental illness. The thesis documents and explores paramedic actions, culture and their 'on-road' realities. This introductory chapter provides an overview of the research question, the objectives of the study and the rationale for exploring paramedic culture in the context of their work with those they identify as mentally ill ('psychiatric presentations').

Symbolic interactionism and social constructivism, the theoretical stance, informs the research with its emphasis on the centrality of human interaction to understanding how people derive meaning and knowledge. Exploring people's actions provides a window into understanding the meaning they attribute to their world and how their knowledge is used in everyday interactions. Ethnography, the study and exploration of culture, provides the methods and structure for data collection and analysis in this thesis. To conclude, each chapter of this thesis is briefly introduced to give the narrative its direction and structure.

1.1 The research question and objectives

The research question for this thesis is:

> *What is the paramedic culture regarding the identification, assessment, and management of psychiatric presentations in the community?*

The four areas that this research aims to explore are the cultural factors which affect:

- How paramedics identify those they believe are suffering a mental illness or, in their terms, are 'psychiatric presentations'?
- How they assess and make decisions on care for psychiatric presentations and what influences those decisions?
- How paramedics manage and provide care for psychiatric presentations?
- How paramedics handover and document psychiatric presentations?

The objective of this thesis is to provide an exploratory and descriptive account of paramedic culture. It documents paramedics' actions, group and individual beliefs, and the organisational structures which construct paramedic practice. The intent is to provide a snapshot of paramedic working life and the issues they face when attending someone with a mental illness with the aim of informing practice, education, and policy development. To achieve an understanding of paramedic culture, including the facilitators and barriers to care, ethnography provides the means to compose their story. Ethnography, through the use of observation, interviews and document analysis, enables an in-depth exploration of the type of

cases paramedics consider to be related to mental illness and how they approach and assess them. No study of culture can ignore the socially and individually constructed assumptions and organisational influences that underlie personal actions and work practices. These assumptions and organisational boundaries, in the context of this thesis, affect the assessment and care provided by paramedics to those they encounter.

1.2 The rationale for the research and its significance

Paramedics in Australia are undergoing a shift in service provision from a traditional emergency model of care to a more primary care focus as demand and public needs change (The Australian College of Ambulance Professionals 2011; O'Meara et al. 2012). Paramedics Australasia (formerly the Australian College of Ambulance Professionals—ACAP) as the professional body representing paramedics in Australasia advocates for, and is currently facilitating a greater health care role for paramedics. Their aim is to improve patient outcomes and ultimately to provide a more comprehensive out-of-hospital emergency medical service (The Australian College of Ambulance Professionals 2011, p. 9). As part of the changing face of out-of-hospital emergency medical care, there is a need to understand how paramedics treat those with complex needs such as the elderly, those with disabilities, those with persistent and long-term illnesses, and those in need of mental health care.

1.2.1 Personal significance

On a personal level being involved with people with complex needs throughout the majority of my life as a volunteer, carer, and nurse, I cannot discount my own experience as a motivation for conducting this research. As a student paramedic, one case which highlighted for me how vital the initial contact from paramedics can be for those in need of mental health care is the story of a woman in her late thirties that we attended. We attended expecting to treat someone who was an insulin dependent diabetic suffering hypoglycaemia (low blood glucose level), but there was a lot more to the woman's circumstances. We found on arrival that she was very distressed, crying and agitated. The attending paramedic showed great empathy and communication skills as he comforted her while we tested her blood glucose levels and treated her. She appeared to improve and her distress seemed to decrease and she became calm. Her blood glucose levels increased to within normal levels and the paramedics offered to take her back to her residence (she had been out walking and was not far from her own home). As we were taking her home the attending paramedic began to ask more about her life and how often she found herself suffering hypoglycaemic attacks. She answered his questions, but something about her answers and her initial presentation triggered concern and a suspicion that something else was actually happening.

We found out that she lived with her mother and the attending paramedic gently asked if he could talk with her mother before we left and if she would mind sitting in the ambulance for a few minutes. As we sat in the back of the ambulance she

began to relay her story by telling me that she had overdosed on insulin with the intent to kill herself. We found out that this had been her fourth attempt to overdose on insulin within the last five weeks and that she had tried to access treatment but was not able to cope. After spending an hour and a half talking with her and eventually convincing her mother, who was reluctant to let her daughter go to hospital for further support and care, we transported her to the ED and stayed to make sure she was seen by the mental health team. The attending paramedic showed great compassion and awareness towards this patient, and his ability to discern that there was more to the patient's story than first impressions was part of my inspiration to research the area.

1.2.2 Literature review

Internationally, and here in Australia there is limited qualitative research into the culture of paramedics and their interaction with patients with mental illness. The integration of mental health services into the general health system and a greater emphasis on community care has increased the contact between community and emergency service personnel and people who present with mental illness (Shaban 2004; Weiland et al. 2011). This increased contact with those in need of mental health care has changed the characteristics of emergency work and has placed greater responsibility on emergency medical services and their staff to provide appropriate and timely care (Morphet et al. 2012, p. 149). The literature review (Chapter 2) focuses on how the reforms in the mental health system internationally, nationally and at a state level have affected the demand for mental health care

seen in the pre-hospital setting. Presently, ambulance annual reports differ in the detail relating to psychiatric presentations, due to the way the data is collected and reported (SA Ambulance & SA Health 2012; Department of Community Safety 2012; Ambulance Victoria 2012). Therefore, ED data is used as an adjunct to describe the environment faced by paramedics when attending those with a mental illness and why it is a significant part of their practice.

1.3 Methodology—the theoretical stance

The study's theoretical stance (Chapter 3) has a basis in symbolic interactionism and social constructivism, mainly focusing on the work of George Herbert Mead (1863–1931) and Herbert Blumer (1900–1987). Symbolic interactionism assumes meaning and knowledge is generated out of the interactions human beings have with each other and the world within which they exist (Blumer 1969, p. 3). Social constructivism places the individual and their understanding of the world at the centre of the social environment (Crotty 1998, p. 58). Mead proposed that as distinct entities we have the ability to develop what he considered a concept of 'self' and we have the capacity to respond reflexively to ourselves and others. Indeed 'self' can only be defined by reflecting on ourselves as part of an ongoing social interaction with those around us (Stryker 2008, p. 17). Another important aspect to Mead's symbolic interactionism is the ability of human beings to take on a specific identity, a constructed social role, which is only possible if we can conceptualise another's social position and the expectations associated with that given role (Crotty 1998, p. 58). This allows us to anticipate responses to our actions

when we interact with those around us. Paramedics create meaning and their social position from their practice and actions they perform including their interactions with those experiencing a mental illness. Symbolic interactionism and social constructivism provided the conceptual basis to understand how these meanings are generated and integrated into culture.

1.4 Research method

The method used in this thesis is a focussed ethnography which allows a culture, a given set of collective practices, beliefs and values held by a group, to be explored and documented (Hammersley & Atkinson 2007, p. 1). Chapter 4 (Part 1: The framework—ethnography and culture) provides a definition, brief history and explanation of ethnography and why a focussed ethnography is appropriate for this study. This chapter also defines the concept of culture and how using a narrative and descriptive method is applicable to practice. Chapter 5 (Part 2: The process—access, ethics, observation, interviews and documents) outlines the process of conducting this ethnography with a description of the field site, ethics approval, and the gatekeepers.

The ethnographic methods used in this thesis included observation, interviews, and document analysis. The observation occurred over an 11 month period in 2009–2010 within the ED (triage area) and ambulance arrival area of a tertiary hospital in South Australia. The semi-structured interviews involved a short interview followed by a longer second interview with paramedics and brief interviews with ED staff

directly involved with the handover. Twenty shorter interviews, 17 longer interviews with paramedics, and 13 interviews with ED staff were completed.

Chapter 5 concludes by describing the data analysis using open and axial coding based on cultural domains. The document analysis follows the same thematic analysis as the interview and observation data, but was based in the terminology and categories used in the patient report card (the case card).

1.5 The findings

The findings are structured as a linear case history which follows the paramedics' narrative from dispatch, their approach and assessment, through to handover and case card documentation. Part 1 explores the dispatch information, the paramedics' arrival at the scene, first impressions, and their approach to the patient. Part 2 details the assessment process and the assumptions held by paramedics regarding the care they provide to those they deem psychiatric presentations. Part 3 completes the linear case history by documenting the environment at handover, the handover process and the documentation of the case.

1.5.1 Part 1: Dispatch, arrival and the approach

Chapter 6 explores how paramedics described the initial information they received from dispatch and their first impressions of the case. The chapter describes the actions that paramedics took when they first arrived at the scene and how they approached the patient. Included in this chapter is the concept of going to the

scene with limited information and the difference between what paramedics get told beforehand and what they find on arrival. The chapter details how this limited information influenced the approach to the patient, how it focuses interaction on the willingness of the patient to follow direction, and the challenges of engagement and developing a rapport with the patient.

1.5.2 Part 2: Assessment, assumptions and influences

Chapters 7 and 8 continue the ethnographic narrative focussing on the assessment process and the environmental, social and cultural influences which affect it. Chapter 7 (Assessment) outlines the observations and information that paramedics take note of when attending someone suffering a mental illness**.** These observations included what paramedics saw and heard, the patient's outward physical and behavioural characteristics, the measured observations, and any evidence of self-harm or substance use. The history gained from the patient and from others was often limited due to circumstance, which left paramedics searching the scene to complete the picture of what they were attending. The paramedics generally found themselves trying to manage the consequences of the patient's actions rather than viewing themselves as actually treating the patient and their mental illness.

Chapter 8 (Assumptions) explores the circumstances and assumptions which influenced the information that paramedics valued and collected during their assessment. These concepts, such as 'is the patient genuine', the effect of the 'regulars' on the paramedics and the system, how effective and beneficial is their

attendance, and the importance of life and 'on-road' experience to care, have implications for education and safe practice. The chapter goes on to identify the crucial role that supervision and modelling of practice in conjunction with their existing formal education has on paramedic interaction with those with mental illness.

1.5.3 Part 3: Handover and case cards

Chapter 9 (Handover) creates a picture of the environment at handover that paramedics encountered and the type of information prioritised and delivered to the ED staff for cases paramedics deemed psychiatric presentations. Negotiation of space and time within a busy ED, particularly at peak times, had a major influence on the handover process and the mechanisms by which paramedics and ED staff negotiated the process. The time pressures on the handover and the ownership of the space encouraged a standardising and rationalisation of the information that paramedics gained at the scene. This short and concise relaying of patient details supports value being placed by paramedics on information which pertains to the physical, immediate and short history of the patient.

Chapter 10 (Case cards) deals with the documentation of the cases deemed 'psychiatric' as the final component to the story of paramedic attendance, care and transfer. The documentation demonstrates the way the system is designed to focus the process of assessment on the immediacy of care and physical presentation, with little space to expand and document complex presentations.

1.6 Discussion and conclusion

The ‘Discussion’ (Chapter 11) brings together the findings under the themes of *transition work*, *the scaffolding*, *thwarted identity*, *assuming control* and *attributed identity*. These themes are linked to an overarching concept of role, role identity and role expectations. The discussion explores the paramedics’ position between doing acute episodic care and the need to do extended care when dealing with those with chronic illnesses, especially those with mental illness. Organisational policies and operational protocols influence the scope of practice which both constrain and enable paramedic practice in this area of their work. The scaffolding explores how they navigate this gap between expectations and ‘on-road’ reality. Thwarted and attributed identity propose the idea that dealing with psychiatric patients is something that challenges the paramedics traditional clinically hands-on identity and leads to practices that operate within their known and familiar ways of constructing that identity. To manage this in-between world paramedics use strategies that assume control to generate a sense of purpose, to manage the unpredictable, and try to anticipate the worst case scenario to preserve both their own safety and the safety of the patient.

The final chapter, ‘Conclusion and recommendations’ (Chapter 12), summarises the major elements of the thesis, acknowledges the limitations within the study and suggests recommendations to help address some of the issues raised by

paramedics. The recommendations include greater consumer[2] involvement in the development of curriculum, greater networking and collaboration between the ambulance service, paramedics at the ‘coal face’ and the mental health service providers, and the development of specific documentation processes which could enhance the transfer of information.

2. Consumer is the term used in the mental health field to denote an individual who is accessing mental health services. The move from language such as patient which has connotations of a certain role and position to the individual having a role as a ‘consumer’ of a service aims to decrease the stigma and power imbalance between the individual and the health sector. The thesis uses the term consumer when not using the paramedics’ language of patient.

Chapter 2

Literature review

2.0 Introduction

> *For too long, the needs of those with common mental health problems have been marginalised by the society in which we live, the social systems we rely on and our traditional health care systems.* (Hickie & McGorry 2007, p. 100)

In Australia and globally, mental disorders significantly affect the lives of individuals, carers, families, friends, and communities. Higher demand for community and acute mental health services, the associated financial costs, and the current workforce shortages have far reaching consequences for individuals living in the community with mental illness and for society in general (Rosenberg et al. 2009, p. 193). Mental illness for the purposes of this thesis encompasses the cognitive, emotional and behavioural disorders that interfere with a person's social and emotional wellbeing leading to a significant effect on their lives and everyday functioning (Department of Health and Ageing, 2000). Mental illness makes a sizeable contribution to the burden of disease worldwide. Globally, neuropsychiatric conditions, which are conditions with both neurological and psychiatric features, account for up to a quarter of all disability-adjusted life-years and up to a third of those attributed to non-communicable diseases. Major contributors to this burden of disability are unipolar and bipolar affective disorders, substance and alcohol use disorders, schizophrenia and dementia (Prince et al. 2007, p. 859).

Deinstitutionalisation, the movement of people from stand-alone psychiatric institutions to community-based models of care, and the accompanying slow development of community treatment options have seen an increase in attendance by emergency services to people with mental illness (Shafiei et al. 2011, pp. 9-10). Holmes et al. (2006, p. 272) describes a social and health care environment where individuals with mental illness are often characterised by poor compliance, persistent and chronic symptoms, substance use disorders, poor nutrition, and a lack of stable accommodation. Care of those suffering chronic mental illness by the public health system is characterised by a sequence of crisis intervention, brief admissions, and discontinuity of care (Holmes et al. 2006, p. 272). The objective of this literature review is to outline the current state of mental health care globally, nationally and in South Australia which has led to the increased involvement in the provision of care by the ambulance service, and paramedics.

This chapter cover the following concepts:

- **Section 1: No health without mental health**

  The concept that there is no health without mental health explores the relationship between mental disorders and other health conditions (comorbidity). This section establishes the demand for community care, the complex nature of mental illness and the subsequent effect on paramedic attendance. The section will also discuss the difficulties for paramedics in

assessing and providing care for this group in the out-of-hospital and community environment.

- **Section 2: Resources for mental health—scarcity, inequity, and inefficiency**

  This section examines the allocation of resources and the associated scarcity, inequity and inefficiencies that result in the patchy delivery of mental health care. The resources available for the provision of mental health care directly affect the paramedics' ability to access further specialist care and treatment options for their patients. This section examines community resources and the effect stigma and discrimination has on the willingness of people to access services and care.

  Section 3: The mental health system—where are we now?

  This section covers the national reforms which affect service delivery of mental health care. This section overviews the *National mental health report 2010*: *a summary of fifteen years of reform in Australia's mental health services under the National mental health strategy (1993–2008),* which details the Australian perspective on funding, service provision and distribution of services nationally and state by state.

- **Section 4: Treatment of mental disorders**

  The final section deals with the increasing demand on EDs and emergency services in providing acute mental health care and the culture which this occurs within. This section examines issues such as the increase in presentations,

detention, length of stay and resources that need to be addressed to be able to provide a safe and effective level of care to this particular group with complex and high needs. This section concludes by briefly discussing the mental health work conducted by mental health nurses and ED staff which situates paramedic culture and work into the wider provision of mental health care.

2.1 Section 1: No health without mental health

2.1.1 Prevalence

Global perspective

Globally, the prevalence and burden of neuropsychiatric disorders is estimated to be 14 percent. The chronically disabling nature of depression and other common mental illness, alcohol-use, substance-use disorders, and psychosis constitute the majority of this burden (Prince et al. 2007, p. 859). Mental disorders are an important cause of long term disability and dependency. The World Health Organization's *Global Burden of Disease* (2005) examined the effect various diseases and health conditions have on the community and individuals. The measure of disability-adjusted life-years, which is an integrated measure of the sum of years lived with disability and years of life lost, was used as its basis for analysis (World Health Organization 2005). The report attributed 31.7% of all year's lived-with-disability to neuropsychiatric disorders. The five major contributors were unipolar depression (11.8%), alcohol use disorder (3.3%), schizophrenia (2.8%), bipolar depression (2.4%) and dementia (1.6%).

Subsequent regional reports demonstrate the massive toll that mental disorders pose to global health systems in terms of service provision. Irrespective of the evidence provided by these reports, mental health remains a low priority in most low and middle income countries with mental health remaining a peripheral issue in global health. Four decades since the WHO first identified mental health as a priority the vast majority of people with mental disorders still do not receive evidence-based care; this treatment gap approaches 90% in some countries (Prince et al. 2007, p. 860).

Prince et al. (2007, pp. 870–871) outlines the following issues as significant to addressing the burden of mental disorders:

- WHO advocates for mental health as an integral part of public health policy;
- mental health needs to be incorporated into health improvement and poverty reduction strategies;
- integrate mental health into health planning and across multiple areas of care from primary to tertiary care to maximise the small workforce;
- primary health-care workers need to be trained in recognition and evidence-based treatment of mental disorders and given adequate access to support;
- primary and secondary care providers should overcome their reluctance to treat patients with severe mental illness and learn effective ways to interact and communicate with these patients; and

- inequities in access and provision of good-quality physical-health care for people with mental health disorders must be considered and addressed.

As part of the health system, paramedics have a vital role in the early provision of care and as such, need to be included in the call to improve both primary health care providers' knowledge and skills in this area (Paramedics Australasia 2011, p. 4). This is especially significant as national recommendations in Australia for registration and recognition of paramedics as a profession have individual practice, cultural and ambulance provision implications. The Australian government's health reform agenda, which aims to include allied health professionals to a greater extent in community health care, in holistic care and in a multidisciplinary environment, will require paramedics to have greater involvement in community care. This includes mental health care, a greater emphasis on professional development, greater scrutiny and expectations regarding curriculum development, university education and service provision (Joyce et al. 2009; Paramedics Australasia 2011). Population increases and the demand for health care in the community have promoted an organisational and cultural emphasis on 'hospital- avoidance' and the up skilling of those who work in the community including out-of-hospital emergency services (Kendall et al. 2009; Hoyle et al. 2012). In part this recognition of greater involvement and changing needs in the community has been recognised by the advent of Extended Care Paramedics (ECPs) (Hoyle et al. 2012, p. 652). Paramedic practice has evolved from a transport, response based and non-invasive series of activities which tended to end at the hospital door to a complex practice based on

problem solving and clinical judgement which is now finding broader roles in the health system i.e. extended care and primary health care (Sheather 2009, p. 63).

Paramedics have a role to play in mental health policy and practice across disciplines to optimise outcomes and access for individuals. Paramedics are perfectly situated to act as an information resource for professionals in the mental health field and the ED as they work across the boundary from immediate and primary care to tertiary care. Their unique access to the person during a crisis enables them to potentially provide extensive situational information to the ED staff and mental health teams which might not be available from any other source.

National perspective

In Australia, estimates of mental illness prevalence are based on the National Survey of Mental Health and Wellbeing conducted in 2007. The most common illnesses are anxiety, affective (mood) and substance use disorders, with approximately one in five (20%) of the adult Australian population, 16–85 years of age, experiencing one of these mental illnesses within the previous 12 months. This equates to about 3.2 million Australian being affected. One quarter of the adult population affected by mental illness will experience two or more of these conditions within the same 12 month period. Prevalence rates of mental illness are highest in the early adult years with sixteen to twenty year olds being one third higher at 26% than the average for the adult population (Department of Health & Aging 2010, p. 16). Low prevalence disorders such schizophrenia, bipolar disorder,

other psychosis, eating disorders, and severe personality disorder are believed to affect 2– 3% of the adult population. Psychosis[3] involves a much smaller proportion of the adult population approximately 0.4– 0.7%.

Within the child and adolescent population about 14 percent are affected by mental illness within any six month period, approximately 500,000 people. Half of the top ten leading causes of disease burden in young males and three of ten leading causes in young females were mental health disorders (AIHW 2008, p. 49). These statistics support the call from Hickie and McGorry (2007, p. 100) for removal of barriers to care for adolescents and young adults due to 75 percent of mental disorders commencing before the age of 25 years.

South Australian perspective

In South Australia, the South Australian Social Inclusion Board (2007) estimate that between 4900 and 6000 individuals aged 18 to 65 at any one time are receiving clinical support from community mental health services. The data gathered in relation to hospital usage concluded that 4404 individuals were hospitalised during 2004–2005, some of them more than once. As previously stated the nationally estimate of the prevalence of psychotic conditions is between 0.4% and 0.7% of the

3. Psychosis refers to a group of disorders, including schizophrenia, in which there is misinterpretation of the nature of reality. Changes or disturbance in thought perception (hallucinations), disturbances in belief and interpretation of the environment (delusions), and disorganised speech patterns (thought disorder) are characteristic symptoms of psychosis and can be evident for short periods or be longer term. Source Hungerford, C, Clancy, R, Hodgson, D, Jones, T, Harrison, A, Hart, C, 2012 Mental health care: An introduction for health professionals, John Wiley & Sons, Australia, Queensland.

adult population at any one time. In South Australia this equates too approximately between 3900 and 6700 people suffering a psychotic condition (South Australian Social Inclusion Board 2007, p. 12).

The National Mental Health Strategy was designed to place mental health into the national, state and territories' policy framework. *Time for service: solving Australia's mental health crisis* (2006), by the Mental Health Council of Australia (MHCA) (the then peak non-government body) describes the mental health system as still in crisis despite the instigation of a national mental health policy. The priorities the MHCA cite for the future is a system that focuses on recovery. To meet this priority the mental health system needs to provide:

- services designed to prevent mental illness and provide for early intervention. Investment currently is too focused on services for people once they become acutely unwell;
- services designed to assist people to live independently in their homes and adequate support for families and carers as well as consumers;
- services to assist with education, work support and opportunities, and programmes to help the consumer to participate in social and community life; and
- proper funding for community services needed to make deinstitutionalisation really work for people with a mental illness. This includes a wide spectrum of

> health care services, education, accommodation options from short to longer term, and rehabilitation services (MHCA 2006, p. 2).

These issues are relevant to paramedics and the ambulance service because current debate and reform focuses on the governments' traditional response to the mental health crisis which has been further investment in hospital beds. This response is seen as inadequate and is supported by unpublished data that up to 40 percent of patients in acute mental health inpatient facilities could be discharged from these facilities if sufficient and appropriate community services were available (MHCA 2006). Currently the demand is overwhelming the hospital system and it is common for people to be discharged from hospital without receiving adequate clinical care (Hickie & McGorry 2007; MHCA 2010). Individuals then find themselves in the community in need of care with little or no support. As a consequence paramedics, general practitioners, ED staff and police potentially become the primary service providers for these people as they come in contact with them in the community and are the gateway to further care (Lamb et al. 2002; Mclean & Marshall 2010; Shafiei et al. 2011). As frontline care providers paramedics are dealing with individuals in the community that need complex clinical care which includes those with accompanying comorbidity and disability.

2.1.2 Comorbidity and disability

The interaction between mental illness and disability is complex and extensive (Bruce et al. 1994, p. 1796). Comorbidity between mental illness and other health conditions is widely recognised as a major factor in the effectiveness of treatment, assessment, continuity of care and patient outcomes (Mitchell et al. 2009, p. 491). Mental illness is a major risk factor for the development of communicable and non-communicable diseases, and contributes to accidental and non-accidental injuries. Many health conditions also increase the risk of mental illness, or lengthen episodes of mental illness. Comorbidity complicates help-seeking, diagnosis, quality of care provided, treatment, maintenance of treatment, and affects the outcomes of treatment of physical conditions, including disease related mortality (Prince 2007, p. 859). Mitchell et al. (2009, p. 496) in their systematic review of the physical care provided to people with and without comorbid mental illness state that clinician factors such as willingness to investigate, ability and enthusiasm to treat, and willingness to offer follow-up care are important indicators of quality of care.

In a study by van Nieuwenhuizen et al. (2012) exploring the phenomena of 'diagnostic overshadowing' in the ED they argued that one reason for the significant link between physical illness, early morbidity and mortality and mental illness is 'diagnostic overshadowing' as a form of discrimination and stigma. They define 'diagnostic overshadowing 'as the 'misattribution of physical symptoms to pre-existing mental illness' (van Nieuwenhuizen et al. 2012, p. 1). The study examined

the clinician's perspectives on the structural, operational and cultural factors which affect clinical judgement and contribute to physical illness not being recognised or dismissed in those with mental illnesses. The study identified difficulties such as obtaining a history, problems with examination, clinician's lack of knowledge of mental illness, environmental constraints of the ED, lack of privacy, labelling and stigma, fear of violence and avoidance, time pressures, and lack of implementation of parallel working with psychiatry as existing barriers to providing holistic care in the ED for those with mental illness (van Nieuwenhuizen et al. 2012, pp. 4-6).

Paramedics are confronted by similar difficulties when attending someone suspected to be experiencing a mental illness in the community. Working in the community paramedics are caring for their patients in circumstances where the individual may not be able to provide an extensive history or family members and/or bystanders are not present to provide the information. The physical environment and the social circumstances of the patient, such as shared accommodation or family violence, can pose a challenge to privacy and safety. Organisational and personal expectations regarding response times to incidents and scene times add to the pressure to provide timely care and create a similar culture of meeting both the needs of the patient and the structures of emergency service provision.

2.1.3 Mortality and suicide

Every year approximately one million people commit suicide, 86 percent of whom are in low-income and middle-income countries, with half aged between 15 and 44 years (Larkin, Smith & Beautrais 2008, pp. 73–74). The Orygen Youth Health Research Centre (2009) in a submission to the Senate Inquiry into Suicide in Australia cites data from the Australian Bureau of Statistics (ABS) that:

> *Suicide is one of the leading causes of mortality in Australia, accounting for a greater number of deaths per year than road traffic accidents. In 2007 (the year for which the most recent data are available) 1,881 Australians died by suicide. In the case of young people aged 15 to 24, suicide accounted for 245 deaths, which represents around 20% of all deaths in this age group*

The submission acknowledges that mental illness and previous suicidal behaviour are major indicators for an individual's increased risk of suicide. In almost 90% of cases of completed suicide, depression was found to be present when psychological autopsy studies were carried out (Orygen 2009, p. 2). The submission found individuals who commit suicide will have, in fifteen percent of cases, attended EDs for deliberate self-harm during the previous 12 months. Significantly the majority of these individuals did not receive a psychiatric assessment (Orygen 2009, p. 2).

In light of these statistics, prevention, identification, and appropriate management of mental illness are vital elements of suicide prevention. Emergency services, including paramedics, often deal directly with the immediate outcomes of a suicide

or suicide attempt. If appropriate early intervention strategies were supported and instigated, then the flow on cost to emergency services and associated health services could be reduced.

2.2 Section 2: Resources for mental health—scarcity, inequity, and inefficiency

To achieve sufficient access to effective and humane treatment for those who suffer from a mental illness human, social and financial resources are required. The WHO's Atlas project shows widespread, systematic and long term neglect in the provision and distribution of mental health care. To reduce the burden of mental illness, mental health policies and their implementation are necessary to coordinate service delivery for better outcomes (Saxena et al. 2007, p. 878).

Availability of psychiatric beds relative to the mental health budget is one indicator of insufficient resource and service allocation for serious mental illness. If the majority of the service provision is centred on large institutional settings such as standalone psychiatric hospitals custodial care tends to be the norm for treatment of serious mental illness. This leads to a reduction in choice in treatments, services are often distant from the person's home and they are isolated from their family or existing support networks.

Human resources are essential to any mental health system where care relies on professionals. A mental health workforce shortage in conjunction with the lack of

multidisciplinary professional collaboration hampers treatment and care (Saxena et al. 2007, p. 880). Low-income countries have a median of 0.05 psychiatrists and 0.16 psychiatric nurses per 100,000 of the population. In comparison high-income countries have a ratio of psychiatric health workers that is about 200 times higher (Saxena et al. 2007, p. 881). These figures demonstrate the huge inequities in the distribution of skilled human resources for mental health across the world, especially for children and adolescents. This is a significant resource issue when about half of all the long term mental disorders begin before the age of 14 years. Worldwide prevalence rates for child and adolescent mental disorders are around 20 %, and similar types of disorders are reported in different cultures (Saxena et al. 2007, p. 883).

The lack of resources for mental health, inequity in the access to them, the uneven distribution of services, and inefficiencies in their delivery has grave consequences. The most significant consequence of the lack of community and acute resources is that people who need mental health care do not receive it. As an example, one in three individuals with schizophrenia and other non-affective psychoses do not receive any treatment. The treatment gaps for depression and dysthymia, bipolar disorder, panic, generalised anxiety and obsessive compulsive disorders are all above fifty percent (Saxena et al. 2007, p. 886).

Internationally and within Australia there is growing evidence of the importance of understanding the social determinants of health as a means of addressing health

inequities and inequality. The inequities seen between groups and within groups of individuals according to the MHCA (2010, p. 6) are now:

> *overwhelmingly attributed to social, economic and environmental circumstances yet in the context of the NHHN [National Health and Hospital Networks] reform agenda, there is little in the reforms or major funding announcements to the end of 2010 that tackles social determinants of ill health and mental illness.*

The widespread stigma associated with mental illness means access to any care is poor but for those with low incomes or in marginalised populations' access is almost impossible (MHCA 2010, p. 6). The lack of access can lead to complex social problems such as family violence, addictive behaviours (gambling and substance misuse), poorer educational and employment outcomes, and further poverty. These social factors are significant and clearly evident when paramedics attend individuals with a mental illness. As a group of health professionals they are in the unique position of observing and documenting the individual's circumstances which can have a major effect on patient outcomes.

2.2.1 Community resources

Care of people with mental illness frequently relies on limited community resources that include formally structured bodies; international and indigenous non-governmental organisations (NGOs); consumer and family associations; and informal resources of family, friends, and other social networks. These community structures and families often take responsibility for the majority of the burden of

care. NGOs, when adequately funded, support or are at the forefront of innovation by developing new services, or supplement inadequate national or state infrastructure for mental health care. Although a balance of community-based and hospital based services has been shown to be the most effective form of comprehensive mental health care such a balance has only been achieved in a few high-income countries, where financial resources have been matched by the political will to increase community-based care (Desjarlais et al. 1995; Saxena et al. 2007; Thornicroft et al. 2008). In Australia, the progress to community based care specifically the development of specialised mental health residential services has not been consistent across the states and territories with a three-fold difference in the number of available inpatient and 24 hour staffed residential beds across different jurisdictions. All Australian states and territories in recent years have experienced increased demand for mental health care right across the health sector, and in particular, for acute inpatient care (Department of Health & Ageing 2010, p. 7).

The most effective model of care has been shown to be well structured, integrated and multidisciplinary collaborative care instead of what is more often isolated, disorganised and episodic care for people with common anxiety and depressive disorders. Collaborative care is typically described as '… a multifaceted intervention involving combinations of three distinct professionals working collaboratively within the primary care setting. Collaborative care not only improves depression outcomes at six months, but continues to show benefits for up to five years (Hickie & McGorry

2007, p. 100). A major difficulty in the implementation of community-based care is the ‘double funding’ required as the move from hospital-based care to the developing community-based system takes place (Singh & Castle 2007, p. 410). A shortage of appropriately trained staff makes it difficult or impossible to implement many of the evidenced-based interventions and transitions to community care. Even in high income countries there is a shortage in the mental health workforce due to the low recruitment numbers and retention of staff. Another hurdle to community-based care is the differing perspectives of mental health professionals and patients on the one hand and the general public on the other, on the success or otherwise of deinstitutionalisation (Singh & Castle 2007; Department of Health & Ageing 2010).

Practising in a least restrictive manner allows for a more humanitarian approach to the care health professionals provide. Consumers who experienced the institutionalisation era testify to improvement in the quality and enjoyment of life living in the community (Singh & Castle 2007, p. 410). Although improvements have been made many consumers still recount their ongoing frustrations and difficulties with access particularly for acute and ongoing support for families and carers from the mental health system. Some sectors and individuals, in the interest of patient and community safety, are suggesting re-institutionalisation. While strategies aimed at prevention and early intervention for mental illnesses are fully supported, such strategies have not yet brought about a major reduction in the numbers of individuals living with disabling chronic mental illness. Table 2.1 outlines some of

the assumptions and realities proposed by Singh and Castle (2007, pp. 410–411) to explain why Australian community-based mental health services are finding it difficult to provide services.

Deinstitutionalisation according to Singh and Castle (2007, p. 410) was seen as the corner stone of the National Mental Health Strategy despite the fact that the majority of long stay beds had been closed in the 30 years before 1992. Also deinstitutionalisation was also only one of the twelve areas covered in the National Mental Health Strategy. Delivery of mental health services in the community is characterised by one-to-one interactions between professionals which is labour intensive (Hickie & McGorry 2007; Singh & Castle 2007). Effective delivery of improved mental health care depends not only on financial support for individual services, but also on administrative and resource support for the most relevant systems of care. Unless funding is significantly increased, a minimalist system of providing welfare care for most patients, and diverting care and scarce community resources in a targeted manner to those who will benefit most (e.g. 'revolving door' patients) may be the only option left to service providers (Singh & Castle 2007, p. 411). This minimalist system will continue to have flow on effects to the emergency and primary care sectors as they will continue to attend patients that are in high need in the community.

Table 2.1 **Assumptions and realities of deinstitutionalisation**

	Premise	Reality
1	Psychotropic drugs will control most or all of the psychotic symptoms associated with mental illness, allowing the vast majority of affected patients to return to normal life in the community.	In reality, while there have been significant advances in psychopharmacology antipsychotic medication continue to offer only a partial control of the full range of psychotic symptoms and only if they are taken regularly and consistently.
2	As a result of treatment, patients will gain insight in to their illness and adhere to treatment guidelines.	'Insight' is not an all or none phenomenon. While insight into the fact of illness may be better, lack of insight into the need for medication is a particular problem, and non-adherence is a potent cause of relapse, with consequent requirement for acute hospitalisation.
3	Intensive case management will only be required for limited periods and patients will be able to incorporate the gains achieved during these periods to reduce relapse.	For many patients, high-intensity case management needs to be continuing and long-term; the benefits may dissipate when such management is withdrawn.
4	As a result of insights gained about the effect of substance misuse on their symptoms, patients will be able to modulate their intake, even in communities in which availability and acceptability of use of both licit and illicit substances is increasing.	People with illnesses such as schizophrenia are at much higher risk than the general population of ongoing use of substances, particularly illicit substances. This in turn leaves them particularly vulnerable to relapse of illness, and to general psychosocial decline, including itinerancy, homelessness, and of falling out of contact with treatment agencies.
5	Over time, the community will show increasing acceptance and tolerance of the presence of significant numbers of mentally ill people in their midst, accepting that their human rights need to be honoured.	Stigma regarding mental illness remains an omnipresent problem in the general community, with substantial community backlash if a person acts in an abnormal manner or perpetrates a crime.
6	Adequate safe accommodation options will be provided for those no longer living in long stay institutions, but who do not require acute hospitalisations.	There is a chronic shortage of appropriate housing for people with major mental illness, and many languish in sub-optimal conditions or are homeless.
7	Moving the care of the mentally ill from institutions to the community will reduce the stigma they experience within the general health sector, which will acknowledge and meet their needs.	The mentally ill are over-represented in general hospital emergency departments, often because they are forced to seek help 'in crisis' as a result of a lack of early intervention services. Also the severely mentally ill carry a grave burden of physical health problems, including specifically diabetes and cardiovascular problems; these physical health problems are often not adequately managed, and they result in premature mortality and high levels of disability.
8	Effective community services will reduce the need for acute mental health beds, and virtually eliminate the need for long term adult psychiatric beds.	There is ongoing intense pressure on acute beds, continuing need for midterm (step-up or step-down beds), and greater than expected need for some long-term psychiatric beds.
9	Demand for mental health services will remain stable or increase only gradually.	Increased awareness in the general community, as well as greater community expectations of what will be provided, have led to much greater non-specific demand on mental health services.
10	The cost of the community care service model will be constrained by limiting service to the 'severely' mentally ill (essentially those with psychosis and the most severe of the high prevalence disorders , with treatment of most other mental health problems being left to private psychiatrists and general practitioners.	Increasing numbers of those whose illnesses are too severe or complex for private system care, or who cannot access the private system because they have limited or non-existent private health insurance or funds, are being left to fall between the cracks in terms of service provision. This has led to increasing dissatisfaction by patients, their families and their doctors.

Source: Singh B & Castle D 2007, 'Why are community psychiatric services in Australia doing it so hard?' *Medical Journal of Australia*, vol. 187, no. 7, pp. 410–411.

Another continuing major deficit is the lack of provision of supported accommodation for people with mental illness, with adequate staffing and input from both clinical and non-clinical staff that can identify, provide and resource the provision of care that will meet the needs of individual at that particular stage in their recovery (Hickie & McGorry 2007; Singh & Castle 2007; South Australian Social Inclusion Board 2007).

Improvements in the continuity of care and integration of general practitioners, the private sector, non-government psychiatric, disability and rehabilitation services and organisations is urgently needed. Improved integration of services will enable and empower patients and families by providing assistance to navigate the complex mental health system more effectively.

2.2.2 Discrimination and stigma

Discrimination against people with mental disorders continues to be widespread, often formalised, and sometimes codified in law. For example, although most countries have some provision for disability benefits, 41 (22%) of countries worldwide, and 26 (45%) of low-income countries, specifically exclude mentally ill people from such entitlements (Saxena et al. 2007, p. 884). Despite the lack of funding and provision of care and resources, which remains the most important barrier to effective mental health care, even in the highest income countries, most individuals with mental disorders do not receive effective care. For example, in the US, two thirds of people with a mental disorder receive no treatment and half who

did receive treatment did not meet diagnostic criteria for a mental disorder (Kessler et al. 2005, p. 2518). The use of mental health care is therefore influenced or restrained by demand as well as supply.

Stigma and discrimination are significant factors in the reluctance of many people worldwide to seek help, or even accept that their difficulties relate to mental illness. Structural or organisational discrimination, in which people with mental illness are not considered to have the same value as people who do not have a mental illness, is exacerbated by misunderstandings by the public and health professionals of mental illness. Individuals suffering a mental illness often experience outright abuses and loss of human rights, including abuses occurring within institutions and treatment facilities. Ross and Goldner (2009, p. 559) state that one of the main reasons that consumers give for not seeking or continuing with treatment is the stigma experienced at the hands of health professionals. As a significant contributor to stigma and discrimination Ross and Goldner identified three role based themes in relation to how nurses working in a general medical setting, such as the ED, might act as 'stigmatisers', 'the stigmatised', and the role of 'de-stigmatiser'. The theme of 'Nurses as 'the stigmatiser' explores the origin of negative attitudes as beginning early in life from cultural and historical contexts, but they argue that familiarity and working with those with mental illness does not necessarily overcome these early socialisations. The relationship between health professionals understanding and attitudes is much more complex and stigma still remains a significant barrier to empathetic care even when the primary reason for

admission is not mental health related but physical in origin (Ross & Goldner 2009, p. 560).

This discrimination or popular misunderstanding affects the person's ability to seek help and make known their problems. Stigma leads to avoidance and under-use of mental health care, contributes to inequality, since individuals in greatest need of help experience the most stigma, which leads to self-blame and isolation effectively excluding the individual from care (Saxena et al. 2007, p. 885).

The objectives of the United Nations Charter on Human Rights and other relevant international agreements form the fundamental basis for mental health legislation (Gostin & Gable 2004, pp. 21–22). They state the person's rights to privacy, individual autonomy, and freedom from inhuman and degrading treatment. The Charters also support the principal of a least restrictive treatment environment, the consumer's right to information and participation, as well as the concepts of equity and non-discrimination. Weller (2010, p. 66) describes the right to health as being guided by the principals of accessibility and availability. Accessibility includes the physical location, safety, cost, and equitable funding of health goods and services. Availability refers to the quantity, distribution, and functioning of public health and health services. Based on the convention of rights for people with a disability Weller (2010, p. 67) argues that a social model of disability 'draws attention to the relationship between stigma, discrimination, structural inequalities, inadequate service provision and deficits in health'.

2.3 Section 3: The mental health system—where are we now?

2.3.1 National policy and reform

Most low-income and middle-income countries give low priority to mental health policies despite evidence that mental disorders cause high and growing disability burden and long-term effects on quality of life and that treatment for mental disorders are relatively cost effective compared to those of other conditions (Patel et al. 2007; Saxena et al. 2007).

In Australia the development of the National Mental Health Strategy in 1992, provided the policy framework to begin addressing the social and service provision issues that had arisen due to deinstitutionalisation. The National Mental Health Strategy, through its four strategic plans, aimed to facilitate and bring a framework for the movement of service delivery for mental health care from standalone psychiatric hospitals to general hospitals for acute based services and a community-based model of service delivery. The strategy also recognised the need to address issues such as workforce shortages, promotion and prevention and early intervention. Implementing support for primary care services enables the staff working in these areas to identify and treat people with mental disorders. Adequate training, assistance, and supervision by available mental health staff, is seen as one of the most effective ways to extend mental health services to the population (WHO *World health report*, 2001). Until recently paramedics, emergency services

personnel and ED staff have received little training in the area of psychiatric emergency treatment and management (Shaban 2009, p. 119).

Five key areas were identified for the expansion of primary care to achieve improvements in general adult mental health care. These include the development of outpatient or ambulatory care clinics; mobile community mental health teams for outreach services; acute inpatient care; long-term community based residential care; rehabilitation, work, and occupation services (Thornicroft et al. 2003; Wiley-Exly 2007). In Australia, the National Mental Health Report is structured to report on the progress and development nationally and by state and territories of outpatient and ambulatory care services, mental health spending, service mix, the staffing levels of various parts of the mental health care sector, the number in relation to acute in-patient care and long-term community based residential care. Although the most recent report (Department of Health & Ageing 2010) indicates there has been progress towards a community-based service model supported by adequate acute and long-term residential services for mental health care it has been varied and patchy over the various states and territories.

In Australia, the need for coordinated national health and welfare services for people with mental health and substance misuse problems has been recognised on many occasions by government and supported in national policy. Despite this, Hickie and McGorry contend that although a far reaching and internationally recognised national mental health strategy has been established since the early

1990s, insufficient investment, lack of accountability, divided systems of government and changing health care demands resulted in uneven reform. Due to this inconsistent reform and insufficient investment, the barriers to primary and specialist care persist within Australia (Hickie & McGorry 2007, pp. 100–101). They identified there was insufficient development of systems to promote evidence-based psychological therapies, innovative early intervention programs, new electronic media health strategies, supported housing, community-based acute care and post-treatment recovery services in Australia. Since 1996, the provision of services by specialist psychiatrist declined by 6.5 percent, while out of pocket costs to those receiving care increased by 48 percent (Hickie & McGorry 2007, p. 100). As a consequence, much of the work of providing mental health care has remained on the shoulders of general practitioners poorly supported by both public and privately funded systems. In response to the need for greater primary care the *Better Outcomes in Mental Health Care* (BOiMHC) was launched in 2001. This program enabled consumers to claim through the universal health care scheme, Medicare, for psychological services and was later supplemented and broadened in 2006 through the *Better Access* program (Fletcher et al. 2009; Henderson & Fuller 2011). The mental health nurse incentive program (MHNIP) has also been a part of these reforms in the provision of primary mental health care. The MHNIP attempts to engage credentialed mental health nurses in the coordinated clinical care of those with severe mental disorders in primary care setting. However, recently, support for the *Better Access* scheme has been reduced and funding has been redirected to Medicare Locals and non-government organisations which support populations that

are viewed as having less access to existing or other resources (Henderson & Fuller 2011, p. 185). The MHNIP is also finding it difficult to attract credentialed mental health nurses due to its current funding model and the lack of national primary mental health care policy in Australia (Olasoji & Maude 2010, p. 114). This continues to leave general practitioners as the principal primary care providers for people with mental health problems.

One of the outcomes of limited investment and decreased access to specialist services is the increased use of the ambulance service as a means to get care. In South Australia, the ambulance service (SA Ambulance Service or SAAS) experienced a continued increased in their workload in relation to attending cases of disturbed behaviour. The percentage of SA Ambulance workload in 2001–02 was 2.14% which increased to 3.22% in 2003–04. The percentage remained above 3% to mid-2007 and paramedic perception of their workload in this area is between 10 and 20% (Roberts & Henderson 2009). Both nationally and within the state the demand for ambulance service is forecast to grow at approximately 10% over the next 5 years.

2.3.2 Australian's *National Mental Health Report*

Mental health accounted for 7% of total expenditure on health care and 7.5% of government health spending in 2008 in Australia. These proportions have remained relatively stable over the course of the National Mental Health Strategy (Department of Health & Ageing 2010, p. 2). Growth has kept mental health in step with expenditure in the overall health sector, but the implication is that the mental

health sector has only maintained its relative position in the health industry rather than increasing its share of the health dollar. State and territory hospital services make up the largest share of national mental health spending (28%) followed by ambulatory care services (24%). Growth at the national level concealed differences in spending and an increasing gap between the highest and lowest spending states and territories from 1993–2008 (Department of Health & Ageing 2010, p. 3). South Australia according to the *National Mental Health Report* (2010) remains heavily dependent upon its standalone psychiatric hospital. The need for acute care and ongoing care in the community is continuing to grow and South Australia in comparison to other states and territories continues to be the state with the lowest proportion of acute beds located in general hospitals. In the latter part of the *Third National Mental Health Plan* there was substantial growth in the general hospital based mental health services (Department of Health & Ageing 2010, p. 43). Table 2.2 details the number of available inpatient beds, community residential services and ambulatory services in South Australia in 2008. The bed numbers demonstrate the limited availability for medium and long term care compared to demand which directly influences the need for care in the community and the flow on affect to emergency services.

Table 2.2 **South Australian inpatient beds and community residential services numbers**

Number of available non-acute and acute beds in standalone psychiatric hospitals, as of June 2008	375
Number of available non-acute and acute beds in co-located units, as of June 2008	243
Total	**600**
Number of available acute beds in standalone psychiatric hospitals, as of June 2008 (excluding forensic and prison based beds)	107
Number of available acute beds in co-located units, as of June 2008	243
Total	**350**
Number of available beds in 24 hour staffed general adult community residential services as of June 2008	64
Number of supported public housing places available at 30 June 2008	112
Number of full-time equivalent (FTE) direct care staff employed in specialist mental health services per 100,000 population by service setting, 2007–08:	
Inpatient services	68.8
Ambulatory mental health services	51.9
Community residential services	3.0

Department of Health and Ageing 2010, *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the national mental health strategy 1993-2008*, Commonwealth of Australia, Canberra.

2.4 Section 4: Care of mental disorders: Culture and demand

2.4.1 Emergency departments and emergency service demand

> *When was the last time you were comfortable delaying implementation of care to a patient whom you knew was deteriorating while waiting for specialty care? … But that delay is precisely what is tolerated in many EDs across the US when it comes to initiating care for psychiatric patients on the brink of crisis. ... we tolerate the wait for intervention by psychiatric staff, even if this means we wait until a bed is available hours or even days after patient presentation.* (Wolff 2008, p. 458)

This quotation demonstrates the current practice and working policy that both ED and pre-hospital staff are confronted with when dealing with psychiatric presentations. Larkin (2009, pp. 1110–1111) maintains that mental disorders are the fastest growing area in emergency practice. As a result of the increasing need and utilisation of EDs, emergency health professionals are being forced to take on greater responsibility for providing both primary and acute mental health care. The increasing need for mental health care challenges and directly clashes with the traditional cultural and operational context of emergency services.

In Australia, deinstitutionalisation and 'mainstreaming' of psychiatric services has resulted in increasing numbers of mental health presentations to EDs within our public hospitals (Kalucy et al. 2005, p. 75). According to the Australian Institute of Health and Welfare (AIHW) (2011) the number of recorded mental health-related ED occasions of service has increased at an average annual rate of 3.6 percent over the 5 years to 2009–10. Deinstitutionalisation and the mainstreaming of mental health services has not always been accompanied by sufficient funding of community services and the ED has become the entry point for care with community mental health services directing patients to the ED. The majority of mental health-related ED occasions of service in 2009–10 according to the AIHW (2011) were classified as either urgent or semi-urgent (81.8%). The data from state and territory authorities showed that more than 1 in 9 (19,360, 11.2%) were classified as emergency (requiring care within 10 minutes) and less than one in a hundred (1,531, 0.9%) as resuscitation (immediate care). Almost half of mental

health ED presentations (79,961, 46.4%) were triaged as urgent (within 30 minutes) and a third (61,021, 35.4%) were recorded as semi-urgent (within 60 minutes). More than 1 in 16 (10,569, 6.1%) of mental health-related occasions of service in EDs were considered non-urgent (requiring care within 120 minutes). The AIHW (2011) states that in '2009–10, mental health-related occasions of service were more likely than all emergency department occasions of service to be assessed as either urgent or emergency (57.6% and 41.4% respectively)'. The annual report by the South Australian chief psychiatrist 2010-2011 (p. 9) details the volume of emergency service use provided through metropolitan EDs, SAAS, SA Police and the RFDS. Of the total 307,000 events attended by SAAS mental health accounted for 4,605 (1.5%) of that total. Metropolitan EDs cared for 383,992 presentations in total and mental health accounted for 2.92 percent (11,220).

In the US, it is estimated that the number of ED visits related to psychiatric presentations has risen by as much as 14% in recent years. Eppling (2008, p. 211) directly attributes the increased ED utilisation by mentally ill patients to the decrease in funding for mental health services, including limited outpatient and clinical services, as well as a decreasing number of psychiatric beds and the closure of entire psychiatric programmes. Psychiatric patients are using the ED as primary care for their mental illness because of these diminishing services and are presenting at increasing rates (Kalucy et al. 2005; Eppling 2008). These patients may be held in the ED from several hours to several days because of limited resources and a lack of available inpatient beds.

Historically, several studies here in Australia show the increased reliance on and use of EDs by individuals with mental health care needs. In South Australia, Kalucy (2005, p. 76) found that during the 10 years since 1993 the percentage of mental health presentations had risen from 0.3 to 3.5 percent, a tenfold increase, within a southern based public hospital. In New South Wales and Victoria, the 'Working Group for Mental Health Care in Emergency Departments' (1998) and the Victorian Department of Human Services (DHS), Emergency Demand Coordination Group (2002) estimated that between 0.6 and 10 percent of all ED presentations have a chief psychiatric complaint and in Victoria during 2000 to 2002, there had been a 13.2% increase in mental health presentations to Victorian EDs from 26,902 to 30,985 (Knott et al. 2007). The increasing demand on community mental health care and the relatively low provision of inpatient beds increased the pressure at the interface of these services: the ED and arguably, the ambulance service.

The AIHW (2011) statistics on mental health-related principle diagnosis are based on the broad categories within the Mental and behavioural disorders chapter in the ICD-10-AM (International Classification of Disease -10th edition, Chapter 5). The AIHW (2011) found that more than three-quarters (81.8%) of mental health-related emergency department occasions of service were categorised by one of four principal diagnosis codes in 2009–10. These were neurotic, stress-related and somatoform disorders (F40–F48; 28.2%), mental and behavioural disorders due to psychoactive substance use (F10–F19; 24.9%), mood (affective) disorders (F30–F39; 15.9%) and schizophrenia, schizotypal and delusional disorders (F20–F29; 12.8%)..

In South Australia, at a major public tertiary hospital (2002–2003) 22.5% of patients who presented to the ED with psychiatric illness were detained under the Mental Health Act, an increase from 12.3% in 2000 and 2001. In 2003, psychotic patients represented less than 20% of all mental health patients in the ED, but accounted for over 40% of all detentions (Knott et al. 2007, pp. 761–762). One major feature common to ED admissions is that patients with psychosis or mania were much more likely to be admitted. Knott et al. (2007, pp. 761–762) found that if a patient was detained and required physical restraint the median time that physical restraint was required was 180 minutes with a maximum time of 2340 minutes (39 hours). Chemical restraint was required for 394 patients (10.6%), out of the 3702, using one or more drugs. Diazepam (41.9%) and midazolam (36.3) were most commonly used drugs within the ED and overall, 359 patients (9.7%) required one-on-one nursing care.

One of the major difficulties faced by mental health patients in the ED is the amount of time they spend immersed in an environment that is generally not considered optimal for people with serious psychiatric disorders (Kalucy 2005, p. 75). The EDs original purpose and function as a primary critical setting is being redefined and is slowly evolving with changing needs, but remains an often hectic, high stimulus and high pressured environment which is acknowledged by health professional as a barrier for the effective care of those with mental illness (Marynowski-Traczyk & Broadbent 2011; Weiland et al. 2011). According to Marynowski-Traczyk and

Broadbent (2011, pp. 175) time in the ED is a causative force which affects both the patient and the ED staff. ED nurses are trained and focussed on quick assessment and episodic care in an environment which is highly technological, fast moving, and the flow of patients to be assessed and cared for is a priority. These cultural and operational imperatives directly clash with the unique skills needed to care for someone with a mental illness. The short client interaction within the ED and in the pre-hospital setting are not the optimum conditions to care for the emotional needs of the patient and can foster a feeling of frustration and inadequacy for the health professional and the patient. The suboptimal environment increases staff and patient stress and ultimately disrupts effective communication leading to poorer patient outcomes (Marynowski-Traczyk & Broadbent 2011, p. 176). The principles and definition of recovery in terms of mental health care in itself creates difficulty for those working in the provision of emergency care. The expertise developed in ED staff and paramedics to deal with urgent, episodic presentations commonly associated with physical illness based in the traditional medical model of recovery and wellness is challenged when confronted by patients that frequently attend for care of chronic conditions that they cannot 'fix' and require a shift in care provision.

Factors that influence the length of stay (LOS) in the ED are general workload in the ED, delays accessing specialist staff, and problems with the lack of available beds in psychiatric wards for those patients that need to be admitted. Heslop et al. (2000, p. 139) reported LOS for their first six month sample as being between 1 and 30 hours with the average of 7–8 hours. Knott et al. (2007, pp. 761–763) noted that

patients with mental illness were more likely to present after hours, especially between 20:00 hours and 04:00 hours and there were few presentations where immediate assessment (category 1) was required. They found a higher proportion of patients were triaged as category 3 or as category 4 than for the non-mental health ED population. They estimated the median time to be seen by a clinician (usually a doctor) was 26 minutes, 75% of patients were seen in less than 1 hour and less than 1% waited greater than 4 hours to be seen. When they examined the LOS there was a large variation across the five ED sites, with the proportion staying greater than 24 hours in the ED varying from 0% to 11.6%. When the reason for presentation was related to the lack of acute mental health beds available, the median ED length of stay was 17 hours and 39 minutes. Others reasons for the increased LOS within the ED were related to revoked community treatment orders, the individual requires one-to-one nursing care, admission to a psychiatric ward or involuntary admission. Following ED assessment, 90.6% of patients within the Knott (2007) study were referred to a mental health service, either the Assessment Crisis Intervention Service or inpatient unit.

Kalucy et al. (2005, p. 77) found similar findings for South Australia with an average stay of 16.45 hours and 30.86 hours for detained patients within the ED. The increase was again considered to be due to the lack of resources and timely access to community-based care which is not mandated, equipped or required to provide care for patients deemed in need of detention, non-adherence to advice, or other health concerns meant that the ED was deemed by the individual or the mental

health provider as the appropriate place for care. Larkin (2006, p. 86) considers it possible that intervention by emergency services could prevent community management of the mental health issue because a majority of mental health presentations are transported either by ambulance or police straight to the ED.

A difficult situation arises when a patient presents to the ED intoxicated because typically, ED management of mental health patients precludes mental health assessment when the patient is intoxicated. Mental health wards do not readily accept patients while intoxicated and medical wards may not be able to provide a secure environment for mental health patients at risk (Larkin et al. 2006, p. 86). Models of co-operative and multidisciplinary care should be developed to allow co-management of mental health issues and drug and alcohol use (intoxication) in order to improve patient care and timely management of comorbid presentations in the emergency setting. The provision of care in the ED to those with comorbid alcohol/substance use and mental illness is an important resource issue because most are non-secure environments for mental health patients at risk of self-harm, harm to others or absconding. Future ED design may need to accommodate the longer duration of stay for these patients unless alternative strategies can be developed. In the out-of- hospital setting issues such as the need for extra crews, the police, consult to mental health specialist and crisis team support all influence the care, resources required and time that paramedics need when attending mental health patients.

2.4.2 Emergency services: ambulance / emergency medical services

In the current environment of increasing prevalence, demand, state and federal governments attempting to address the historical lack of funding and resources within the mental health care system, the ambulance service are faced with an escalating need for their services. The lack of community and specialist services and overcrowding of EDs has placed serious compensatory strains on existing out-of-hospital resources, resulting in longer transport times, increased number of ambulance diversions, and longer out-of-service times for individual units and crews (Larkin et al. 2006, p. 82). ED studies demonstrate that mentally ill patients often rely on out-of-hospital care, while attending to psychiatric presentations is an increasing burden on emergency services (Larkin et al. 2006, p. 83).

Within Australia, while no large studies have examined the specific predictors of ambulance usage among patients presenting with mental illness to an ED, they are an important and rapidly growing subgroup of the community seeking emergency care. Of 16.2 million ambulance presentations to EDs in the US in 2003, 7.4 million were deemed mental health patients. Estimates suggest that nearly one in three (31%) used an ambulance to access the ED (Larkin et al. 2006, p. 83). In Australia, the *Queensland Ambulance Service audit report* (2007) showed a growth in service demand for attendance to presentations coded psychiatric, abnormal behaviour and suicide attempts. The growth in the second tier dispatch category (2A and 2B) from 2003–04 to 2006–07 was 97.4% (3594 cases in 2003–04 to 7094 cases in 2006–07) in category 2A and a 99.3% growth (857 cases in 2003–04 to 1708 cases in

2006–07) in category 2B. The attendance and prevalence data for EDs and the limited out-of-hospital data contextualises the broader environment of the mental health system which paramedics are working in and demonstrates why paramedics are, by necessity, involved in the initial care of those with mental health problems.

Providing appropriate health care to those suffering mentally ill in a busy ED and in the out-of-hospital setting has been and will continue to be a challenge. The type of mental health work in the ED and pre-hospital setting focusses on de-escalation, maintaining self and patient safety , medically clearing or managing physical injury and illness, reducing the environmental stimulus, promoting a calm environment, and to develop an initial rapport with the person and obtain further psychiatric (specialist) support. The aim of care then moves to gaining a brief targeted mental health assessment and gathering important information regarding the patient's social circumstances and providing concise and detailed documentation (Shaban 2009, pp. 123-124). The difficulty with defining mental health work in an emergency medical setting arises when there is conceptual and attitudinal difference in their understanding of their role leading to fragmentation of patient care and devaluation of mental health work and psychiatry. The conceptual separation of care is clearly defined in the terms used by general medical staff and paramedics to delineate attending to the 'physical' and 'psychiatric' needs of the patient. This is often accompanied by a demonstrated devaluing of the mental health component of emergency medical care as 'not their job' (Ross & Goldner 2009, p. 561). Descriptions and beliefs by nursing and general medical staff, such as

there were better uses for health resources, priority given to those who are 'really sick' and to those that have not brought it on themselves, point towards a disparity between stated professional missions and educational aims within health care and the treatment provided (Ross & Goldner 2009; Hazelton et al. 2011).

Understanding existing prejudice against psychiatric patients is important, as a study by Schmidt et al. (2001, p. 369) suggested that emergency medical services (EMS) workers commonly and systematically under-triage patients with mental health problems. Even among health care professionals, psychiatric care is not always perceived as requiring immediate or close attention. Westwood (2001, p. 205) cites Bailey (1994), Tehan & Murray (1996), and Jones et al. (1984) as describing ED health professional staff as having 'punitive attitudes towards and little sympathy for patients with suicidal behaviours' and that up to 90% of emergency nurses had difficulty interacting with mentally ill patients. Frequently, these types of patients are bypassed because they look healthy, and other patients with medical needs are seen and treated first (Curry 1993; Ross & Goldner 2009). ED staff often believe that psychiatric patients are challenging, and they do not believe they have the necessary skills and experience to care for such patients appropriately (Eppling 2008, p. 214). The observation that mental health visits have higher urgency and admission rates, yet longer waiting times, may reflect a similar bias against such patients. In a study of accounts given by paramedic in Australia it suggests that 'official accounts most frequently identified mentally ill patients as presenting with violent, suicidal, drug induced, overdosed, or overtly psychotic

behaviour' (Shaban 2005). Shaban (2009, pp.120-122) identified the rapidly expanding paramedic role, poor education and training , managing more complex and chronic presentations of mental illness, and the lack of integrated mental health services as significant factors that paramedics believed increased the uncertainty and personal and professional stress when caring for those with mental illness. In the absence of clear physical signs and symptoms Shaban reports that paramedics almost exclusively relied on their experience and intuition to cope and care for their suspected mentally ill patients (Shaban 2009, p. 120). In conjunction with feelings of personal fear and threat to themselves paramedics felt their clinical decision–making was often directed by strict guidelines and protocols relating to transport decisions and that further treatment was the most viable option to meet both clinical and organisational imperatives (Shaban 2009, p. 121).

These accounts seemed to dominate the experiences of paramedics in the out-of-hospital setting. The research in to how paramedics identify, assess and manage psychiatric patients has only recently begun to receive attention. Currently little is known about what culturally what drives paramedic actions in an environment of increasing demand. The current need for mental health care in South Australia and the adoption of a stepped approach as directed by the South Australian Social Inclusion Board (2007) suggests that it is timely to explore the cultural influences which affect the early provision of care by paramedics. Identifying culturally what influences how paramedics structure their care, how they identify and prioritise their actions, their beliefs and values, and the surrounding organisational structures

contributes to and situates their work in the wider context of mental health work and how it is negotiated in the community setting.

2.5 Conclusion

The struggle to provide community mental health care, the move to mainstream mental health care into general hospitals and the ever increasing need and demand has placed EDs and the ambulance service at the forefront of service provision. The difficulty in accessing specialist services creates a situation where people with a mental disorder are accessing out-of-hospital care to gain entry to the mental health system. The level of care needed by the individual once in the ED or in the out-of-hospital setting is significant because they often delay accessing support until crisis point so are admitted or receive prompt care. Therefore paramedics are attending patients that are requiring high levels of understanding, skills and specialist support.

Chapter 3 introduces the theoretical foundations of this study, symbolic interactionist thought and social constructivism, and argues why these philosophical stances are useful in understanding paramedic culture and action. The chapter examines the major assumptions of how interaction generates meaning and knowledge for individuals and how these are demonstrated in the cultures of groups.

Chapter 3

Methodology

3.0 Introduction

This chapter outlines the theoretical framework which this thesis uses to interpret paramedic practice. How paramedics view their management of psychiatric patients is essential to understanding the culture and meaning paramedics attribute to their work in this area. The following description of a 'psych call out' comes from a student who was on clinical placement with the ambulance service.

> Over the radio comes a description of a 38 year old female who has rung triple 000 because her heart has stopped. The paramedics glance at each other with puzzled expressions as the student looks on and they ask over the radio *'The patient's heart has stopped but they have been talking to you for the last 5 minutes or has someone called in regards to a collapse?'*
>
> The call taker relays the small amount of history that they have been able to obtain, regarding self-harm and mental health issues. The paramedics explain to the student *'We know this lady; she is one of our regulars. She has an extensive history of mental illness; we attend when she needs transport to hospital or things are getting too much for her.'*

As they arrive she is waiting for the ambulance crew by the gate with her bags packed. The paramedics and student make her comfortable on the stretcher and perform a preliminary assessment and begin asking her about the current reason she has needed paramedic assistance. She states:

> *'The voices have been really mean and they keep telling me to kill myself. I am a worthless person and they think it would be better for me to kill myself. I feel the need to cut open my arms again to let the bad blood flow out of me.'* The paramedics notice extensive scarring on both arms and torso (personal account, 2006).

The idea that culture exists in action and that meaning is constructed through interaction provides a framework for exploring paramedic practice and cases such as the one above. Symbolic interactionism is distinctive in its approach to the study of human groups and human conduct. One of the major guiding principles of symbolic interactionism is that objects, events and actions have meaning for human beings and are central in their own right. To ignore the meaning that humans attribute to things that they act towards is to falsify the behaviour under study (Blumer 1969, p. 3). Social constructivism, the bodies of knowledge that individuals construct and internalise, and social constructionism, a group's or society's construction of knowledge which occurs through human practice and interaction, form the foundations which underlie symbolic interactionism.

This chapter explores these assumptions and the logic behind symbolic interactionism. Exploring how knowledge is identified and understood in symbolic interactionism and social constructionist thought and how it is applied in this thesis.

3.1 Research methodology: Crotty's definitions

The theoretical perspective provides the philosophical context for the process of thinking, it's logic, and its criteria. The theoretical perspective is the attempt to

state how the assumptions that underlie the methodology are reflected in what we do, and how we do it (Crotty 1998, p. 7). For example, if data is collected through interviews or participant observations, how are the assumptions such as language, issues of intersubjectivity and communication within this process taken into account and justified? Crotty (1998, p. 7) reasons that by stating our theoretical perspective, our view of the human world and the social life within that world, we can reveal the origins of such assumptions and how they function to generate meaning.

> *Symbolic interactionism is a theoretical perspective that grounds these assumptions in the most explicit fashion. It deals directly with issues such as language, communication, interrelationships and community. … symbolic interactionism is all about those basic social interactions whereby we enter into the perceptions, attitudes and values of a community, becoming persons in the process.* (Crotty 1998, p. 8)

Denzin and Lincoln (2008) define perspectives as being less defined and less universal than theoretical paradigms. They suggest that perspectives may share many of the same elements as paradigms, such as a common set of methodological assumptions or a particular epistemology; they define a paradigm as a 'basic set of beliefs that guide action'. They contend that paradigms deal with first principles, ultimates or the foundations of knowledge. As human constructions these beliefs are not able to be established in terms of their ultimate truthfulness, but define the 'worldview' and are used as common understandings and assumptions that underpin social functioning (Denzin & Lincoln 2008, p. 245).

Cuff, Sharrock and Francis (1990, pp. 144–145 & 163) make the point that symbolic interactionism and ethnomethodology can best be understood as perspectives rather than classical theories, since they do not provide an all-encompassing theory of society, instead come under the interpretive approach of which symbolic interactionism and ethnomethodology are probably the best known. Symbolic interactionism grounds this research in the 'worldview' of how human beings interact, the meaning generated through action and the assumptions that underlie this particular way of viewing social functioning.

The theoretical perspective as a way of looking at the world and making sense of it, involves knowledge and a certain understanding of what is entailed in knowing (Crotty 1998, p. 8). Epistemology deals with what constitutes knowledge or 'truth' and how that has been determined (Guba & Lincoln 1994; Crotty 1998; Grbich 2007). Constructivism and social constructionism consider that the individual and the group create knowledge through the process of interaction which forms the basis of symbolic interaction. Symbolic interactionism starts with the assumption that knowledge is understood through interaction, in this case paramedic actions, and then focuses its lens on how that knowledge is created.

The other major concept which informs a theoretical perspective is the concept of ontology. Ontology focuses on the nature of being and reality (Guba & Lincoln 1994; Grbich 2007). Ontology asks what reality is and what makes up that reality. Crotty (1998, p. 10) places the epistemology and ontology side by side, as one asks 'What

is?' (ontology) and the other asks 'What it means to know?' (epistemology), and both inform each other as well as informing a theoretical perspective. Crotty suggests that when you talk of the construction of meaning you are therefore in this case also talking about the construction of meaningful reality. Because these ideas are so closely linked it is often hard to keep the concepts of ontology, the meaningful reality, and the epistemological framework of knowledge through the construction of meaning, separate.

The assumptions and the different ways of viewing the world shape the different ways of researching the world. Denzin and Lincoln (2008) cite Bateson (1972, p. 314) to describe how the researcher is shaped by the assumptions and beliefs that form the lens with which they view the world. Bateson suggests that the researcher is 'bound within a net of epistemological and ontological premises which—regardless of ultimate truth or falsity—become partially self validating'. To minimise the researcher being caught in this trap of self-validating premises the actual process of analysis and methods used in data collection, such as field notes allows the researcher to separate personal understandings and reflect on the data gained.

3.2 Symbolic interactionism

3.2.1 The nature of symbolic interactionism

> *Only in terms of gestures as significant symbols is the existence of mind or intelligence possible; for only in terms of gestures which are significant symbols can thinking – which is simply an internalised or implicit conversation of the individual with himself by means of such gestures – take place.* (Mead 1934, p. 47)

This quotation by Mead explicitly links the concept that we as human beings exist only through our actions and gestures. The mind and therefore thinking only exists in the world of symbolic gestures. Crotty (1998, p. 74) encapsulates this by noting that Mead attributes 'our very personhood to the social forces that shape us and our behaviour'. To understand the implications of these concepts on how social groups and the individuals within them behave and interact, we need to examine the tenets of symbolic interactionism. The tenets of symbolic interactionism situate the practices found in any given culture as central and indeed as the very source of personhood for those encompassed by the group. From the symbolic interactionist perspective, society shapes us to become conscious and self-conscious beings which can only occur through our interactions (Crotty 1998, p. 74).

The three core assumptions of symbolic interactionism

Symbolic interactionism holds at its core three identified assumptions.

Premise 1: Action on the basis of meaning

The first premise is 'that human beings act toward things on the basis of the meanings that these things have for them' (Blumer 1969, p. 2). This premise places the meaning of an act or situation at the centre of the study of human beings. Instead of meaning being taken for granted and placed aside as unimportant or regarded as a neutral link between the factors seen as responsible for human behaviour, meaning becomes the cornerstone that provides the explanation for behaviour (Blumer 1969; Cheek et al. 1996; Crotty 1998). As Blumer (1969, p. 3) describes 'the position of the symbolic interactionist is that the meanings that things have for human beings are central in their own right' and to ignore those significant meanings which guide people's actions is to misrepresent the behaviour under study. By exploring paramedics' actions and their reasoning behind those actions this study places meaning at the centre of understanding how paramedics interact with people presenting with mental illness.

Premise 2: Meaning generated from social interaction

Blumer defines the term 'meaning' as arising in the process of interaction between people, how the individual and others respond and react to a given 'object'. This is the foundation of the second assumption: 'that the meaning of such things is derived from, and arises out of, the social interaction that one has with one's fellows (Blumer 1969, p. 2). Implicit in this definition is that meaning does not emanate from the object' itself or generate from the psychological makeup of the

individual. Meaning is not intrinsic to the object but develops out of the interaction with other humans and the ways in which humans act towards the object.

> *Thus, symbolic interactionism sees meanings as social products, as creations that are formed in and through the defining activities of people as they interact. This point of view gives symbolic interactionism a very distinctive position, with profound implications* … (Blumer 1969, p. 5)

There are three distinct categories of 'objects' which Blumer uses as a foundation to define the things that individuals create meaning around. The first refers to the physical world, such things as trees, cars and other structures within the world. The second refers to social bonds or social objects such as friends, colleagues and parents. The final category relates to abstract objects such as values, morals and ideas. Only those objects that have social meaning for us as individuals exist in our environment (Blumer 1969; Crotty 1998).

Meaning as social constructions created by people as they interact and go about their everyday activities implies that we do things for a purpose and that before we act we formulate what that purpose is. We also enter a world that exists and has social context, so objects will have an existing meaning. Blumer cautions that just because we as actors may exist in a given world we still have to indicate, identify and interpret those 'objects' that have meaning for us. In other words the individual can be shown a specific meaning of an object, but to be incorporated and used by the individual, the individual still has to recognise and accept that the object has meaning for them. The value placed by the paramedics on their interactions with

mentally ill patients is constructed through that interaction and how they see those actions in relation to their social role.

Premise 3: Meaning is interpreted and modified

The third assumption, 'that these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters', is an important key to separating symbolic interactionism from other approaches (Blumer 1969, p. 2). It implies that as 'we interact with others around objects, situations and ideas; we interpret the process in an ongoing act of self-interaction' (Cheek et al. 1996, p. 123). This process is an internal conversation, only possible if the individual can recognise themselves as a distinct 'object' or as having a sense of self, which leads the actor to identify, interpret, reflect and handle meaning. The actor selects, checks, suspends, regroups, or transforms the meaning in relation to the given situation. In these terms interpretation should not be seen as the simple application of given meanings, but a dynamic and formative process where meanings are used and revised as instruments that guide and form action (Blumer 1969, p. 5). Another crucial aspect to this whole process of discovery of how people act towards a given situation is that the individual has to be able to take the role of the other (to use Mead's term). In simpler terms, to be able to engage in action or transmit and receive meaning the individual needs to have a sense of the other person's view or position.

In clinical decision making the person has to adapt and interpret the many sources of information which are available to them and from that information formulate action. By exploring action and the rationale behind that action the observer can begin to establish what has 'meaning' for that individual or group and how that has directed action.

3.2.2 Nature of human society or human group life

The nature of human society or group life, as viewed by symbolic interactionists, consists of individuals engaging in action. Group life involves individuals who are engaged in a multitude of activities as they encounter one another and manage the continuous series of situations they face every day. The individual may act singularly; they may act collectively or as representative of an organisation. Fundamentally human groups exist in action and accordingly must be seen in terms of action (Blumer 1969, p. 6). Even the two dominant conceptions of society, those of culture and social structure, can be seen, according to symbolic interactionists, as the ongoing, complex representation of activity that constitutes group life. Culture whether defined as customs, traditions, norms, values and rules according to Blumer (1996, p. 6) is clearly derived from what people do. In these terms the 'culture' of a group is defined by the actions of the human beings within the group. The social interaction between members' forms the individual's and group's conduct instead of being merely a means for their expression. De Laine (1997, p. 63) proposes that 'group life is not merely release or expression of structure but a

diversified social process in which people engage in forming joint actions to deal with situations confronting them'.

In practice what this means is that individuals, when interacting with one another, take into account each other's activities or what others are about to do; they are forced to direct their own conduct or handle situations in terms of what they observe, interpret and take into account. The activity of others acts as a force, either negative or positive, in the formation of their own conduct. The action of others may force the individuals to abandon an intention, revise it, check or suspend it, support it or replace it which suggests that the individual is an acting and reacting organism.

3.2.3 The human being as an acting organism

Weber (1970) describes the individual and his or her action as the central component of 'interpretive sociology' (Cheek et al. 1996). The individual provides the parameters that define meaningful conduct and concepts such as 'state', 'organisation', 'association' and others identify particular categories of human interaction. The study of the meanings and values associated with action forms the multitude of related links or 'the meaning complex' that surrounds the individual and the group they function within. To unravel the links between individuals and their actions aids in constructing how they affect their culture, societal 'norms', environment, work structures, and religious influences and in turn, how these inform and influence the individual.

Mead refers to two levels of social interaction in society, ‘the conversations of gestures’ and ‘the use of significant symbols’. Blumer terms them respectively ‘non-symbolic interaction’ and ‘symbolic interaction’ (Blumer 1969, p. 10). Non-symbolic interaction occurs when one responds directly to the action of another without interpreting that action; symbolic interaction involves interpretation of that action. Although in their association human beings engage in non-symbolic interaction as they respond immediately and unreflectively to each other’s body movements, expressions, and tones of voice, their characteristic mode of interaction is on the symbolic level, as they seek to understand the meanings of each other’s action. Mead, according to Blumer (1969, p. 7), sees symbolic interaction as a presentation of gestures and a response to those gestures. The initial gesture from person 1 (the initiator) conveys the idea, intention, meaning and plan of action of that individual to person 2 (the receiver). The receiver organises his or her response on the basis of the meaning of the gesture as they see it, and so on. The gesture has meaning for both the person who makes it and for the person at whom it is directed. When the gesture has the same meaning for both parties and the communication and intent are understood, a shared action can result. If there is any disruption, confusion or misunderstanding between any of the lines of meaning then communication is ineffective, interaction is impeded, and the formation of joint action is blocked as illustrated in Figure 3.1.

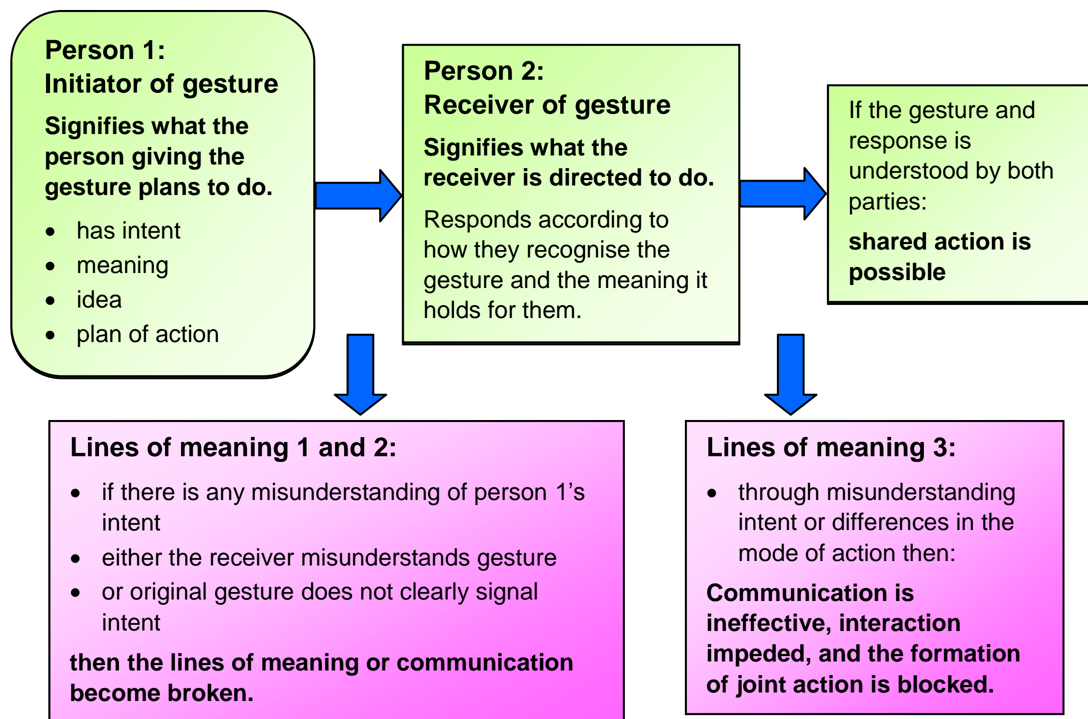


Figure 3.1 **Blumer's lines of communication and meaning**

In any interaction, specifically with persons that may have an altered sense of their own reality, the break in the lines of meanings may require a change of gesture or strategy from the person initiating the interaction. A large number of factors such as language, tone of voice, body language, physical presence, environment and personal experiences and social beliefs, can all affect the lines of meaning between the person initiating the gesture and the person receiving the gesture.

William Thomas (1966) argued two ideas with regards to how a situation is defined and incorporated in symbolic interactionism. The first is that human action is not a stimulus-response activity, but that we engage in a period of reflection before action which varies slightly from Blumer's and Mead's view that there are two types

of interaction. The period of reflection or deliberation he referred to as the 'defining of the situation'. His second concept deals with the results or consequences of defining a situation in a particular way. In this context he suggests that the subjective meaning that people bring to their actions should be fully investigated to develop an understanding of an event. He believed that behaviour could be explained by how people make sense of a given situation (Cheek et al. 1996, p. 114).

3.2.4 Pragmatism as the intellectual basis for symbolic interactionism

Pragmatism, described by Cheek et al. (1996, p. 113) is an essentially American school of philosophy, sees the meaning of an event or object as arising out of its practical application. A pragmatist approach places the usefulness of the outcome or the application of a concept, meaning or belief as essentially the benchmark for the value, 'truth' and rightness of an action or meaning (Crotty 1998, p. 114). The original work by Peirce (1931–58), saw pragmatism as a method of reflection which had the potential to clarify and inform meaning. Crotty (1998, p. 73) contends that more recent views of pragmatism became an uncritical exploration of cultural ideas and values in terms of their practical outcomes.

The intellectual foundations of interactionism arise from what is considered to be the bridging of two contradictory ideas of pragmatism and formalism, both of which had their origins in European thought (Rock 2001, p. 27). Pragmatism, at its core,

suggests three major concepts. First, it suggests the importance of dealing with the concrete and the particular rather than the abstract and universal. The second concept is the idea that the search for 'the truth' is untenable. The objective idea that the 'one truth' is obtainable and is the only valid understanding or meaning is counter to the ideas that the search for multiple interpretations, understandings (truths) and meanings are possible and necessary to understanding the social world. The third idea from pragmatism is that the mind is not a structure but a process in interaction with the world. As a consequence humans play a role in shaping their environment and communication is seen as intrinsically linked to understanding and meaning, making human society possible.

Plummer (1991, p. 41) describes one of the most difficult ironies in interactionist thought as its tendency to embrace, yet deny, a range of philosophical dualisms:

> *it looks at both subject and object, studies voluntarism within determinism, accepts the relativity of truths whilst seeking the underlying forms of social interaction, and manages to be both phenomenalist and essentialist at the same time.*

He contends that interactionism dismisses these wider philosophical dualisms as in practice and everyday life being irrelevant, or in concrete everyday experience they make little real sense. He describes symbolic interactionism as being a fully dialectical theory 'where subject and object, creativity and restraint, pattern and chaos, structure and meaning, knowledge and action are infinitely linked and emerge and grow together' (Plummer 1991, p. 41) . In exploring paramedic culture

what they do has a practical and real element, a pragmatic, outcome focused meaning, based in task orientated practice. The idea of multiple meanings and competing priorities which occurs in the clinical decision making, especially when dealing with complex presentations such as mental illness, fits with a dialectical theory that acknowledges knowledge and action grow together.

3.3 Epistemology—how the world is known in symbolic interactionism

3.3.1 Constructionism and constructivism

The concepts of social constructionism and constructivism focus on the way, in the interpretive world that knowledge is understood and therefore 'reality' is perceived. Crotty (1998, p. 58) reserves the term 'social constructionism' to define meaning and knowledge where the 'social' is central to the event from those where it is not. Social constructionism encompasses the collective generation and transmission of meaning, which underpins interactionist thought. Distinct from this definition, Crotty uses the term constructivism for deliberations dealing exclusively with the meaning making activity of the individual's mind. If the generation of knowledge and meaning and therefore 'reality' is intrinsically linked to the individual then accordingly what we take to be objective knowledge and truth is the result of perspectives (Crotty 1998, p. 43). Crotty's definition of constructivism places meaning primarily as the individual's perspective within the social environment in which they live. The study of meaning and culture using constructivist epistemology allows the unique experience of each of us to be acknowledged and valued. It

suggests that each individual's way of making sense of the world is crucial to understanding how and why they act, and therefore has value. To broaden the context, social constructionism allows the thinking to move from the individual, without excluding them, to social or group considerations. One particular issue of interest is the hold our culture has on us, how it shapes the way in which we see things, and gives us a definite view of the world. The shaping of our minds by culture is what makes us human and gives us the freedom and limitations that we consciously or unconsciously experience every day.

Constructionism as a concept is encapsulated in the following quotation by Crotty:

> *all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context*. (Crotty 1998, p. 42)

Underlying social constructionism is the clear assumption that we as human beings do not create meaning, but construct meaning, which suggests that the essential building blocks are already in place. As Heidegger and Merleau-Ponty (1962) express, the world is 'always already there', it exists and is open to interaction. Objects have potential meaning, but actual meaning emerges only when consciousness engages with them (Crotty 1998, p. 44). As Humphrey describes the world consists of world-stuff, but the properties of this world-stuff had yet to be represented by the mind (Humphrey 1993, p. 17).

The crucial aspect of our role as active participants in the generation of knowledge is that although the world and objects in the world may in themselves yet to have meaning, they are our partners in the generation of meaning and therefore are crucial to the process. Crotty has a distinct view of the way the individual plays their part in the process of construction. He sees them as working with the materials that they are presented with and their skill lies in the ability to reconceptualise existing frameworks and ways of operating to develop a new knowledge or reinforce existing knowledge. The active engagement by people in their world, constructivists contend, develops theory that is consistent with the experienced reality, as opposed to theory that is not.

Constructivist thought is diverse, moving, evolving and changing (Gergen 1985; Bredo 2001; Burr 2003). The social constructivist approach has at its foundation the following key assumptions.

3.3.2 Critical stance towards taken-for-granted-knowledge

The first assumption is a critical stance towards taken-for-granted knowledge and understanding of the world. According to Burr (2003, p. 3) social constructionism requires a critical stance towards the accepted or customary ways of understanding the world, including the individual and their position within the world. Constructionism challenges the idea that the world is there in essence to be discovered and it will reveal its nature to us and we just have to look. It also challenges the view that conventional knowledge is based upon objective, unbiased

observation of the world. Social constructionism encourages us to question our assumptions about how the world appears to be.

If knowledge and reality are social constructs created by the individual or group through interaction and activity, then to understand their knowledge and reality all the underlying possible assumptions and interpretations need to be explored. A constructivist framework enables each possibility to be considered valid and by nature directs the exploration to openly question held perceptions, beliefs, actions and processes, including the viewer's held perceptions. It enables the position of the individual, group and observer to be stated.

3.3.3 Historical and cultural specificity

The second assumption is the historical and cultural specificity of the way we understand the world. Burr (2003, p. 3) outlines that within social constructionism, the ways in which we commonly understand the world, the categories and concepts we use as a basis for understanding action and interaction, are historically and culturally specific. The individual's understanding of a given idea or situation is dependent on experience, the culture the person lives within and where and when in the world they live.

From this assumption all ways of knowing and understanding the world around us are historically and culturally relative. Not only are they specific to particular cultures and periods in history, they are also seen as products of that culture and

history, and are dependent on the particular social and economic arrangements prevailing in that culture at that time. The particular forms of knowledge that abound in any culture are therefore artefacts of it, and we should not assume that one way of understanding is necessarily any better (in terms of being nearer the truth) than other ways.

If knowledge is an artefact of a culture and historical context then constructivism as a framework requires the description and portrayal of that culture and history to enable the understanding of how the knowledge was generated, used, transmitted and understood in context.

3.3.4 Knowledge is sustained by social processes

If our knowledge of the world is not derived from the nature of the world, where does it come from? The social constructionist answer is that people construct it between them. It is through the daily interactions between people in the course of social life that our versions of knowledge become constructed. Therefore social interactions of all kinds are of great interest to social constructionists. The conversations and actions that occur between people in the course of their daily lives are seen as the practices during which our shared versions of knowledge are generated. Therefore what we regard as truth, which varies historically and cross-culturally, may be thought of as our current accepted ways of understanding the world. These are a product not of objective observation of the world, but of the social processes and interactions in which people are constantly engaged. This also

means that the interaction and knowledge generated is equally open to continual questioning and reframing as a part of the ongoing process of understanding the social world.

Kant (1949) believed that the mind plays an important role in defining the categories we as individuals use as a grid to organise our everyday experience. The society, physical and sensory world that we live in provides the concrete features that reinforce and give the cognitive categories their shape.

> *Kant argued that both mental organisation and sensory input are involved in knowing. The mind provides the basic categories or relationships, such as spatial, temporal and causal relations that provide form to experience. Sensory experience, for its part, provides concrete particulars that give specific content to the mind's categories. Therefore even the most basic experiences are constructs since they have been given form by mental categories and relationships. No escape from the influence of our priori assumptions. However, since the implicit categories of thought are universal, we all live in a common (albeit constructed) world.*
> (Bredo 2001, p. 129)

Observation and conversation are two critical ways of discovering how the social process is developed by individuals within a group, sustained by individuals and a group, and how dynamic these processes are within a group or society.

3.3.5 Knowledge and social action go together

These negotiated understandings could take a wide variety of different forms, and we can therefore talk of numerous possible social constructions of the world. But

each different construction also brings with it, or invites and directs, a different kind of action. Descriptions of the world therefore sustain some patterns of social action and exclude others. What is sustained and excluded in our constructions of the world are closely linked to the relationships and power relations between individuals because they have implications for what it is permissible for different people to do, and how they may treat others.

This concept is vital to the way we understand the rationale behind what individuals and groups do in practice. To understand the internal and external factors that determine whether an action is proceeded with, suspended or modified, points to the underlying meaning and construction of the activities performed by individuals and groups.

3.3.6 Anti-essentialism

Anti-essentialism suggests that since the social world, including ourselves as people is the product of social processes, object s and even we as people do not have a determined nature or essence. Social constructionism is not just implying that one's cultural surroundings have a vital influence on action and interaction or even our nature is a product of environmental, including social, rather than biological factors (Phillips 1997; Bredo 2001; Burr 2003), but behaviour, actions, and the world only become essential or acknowledged once the players engage and interact. Therefore the meaning, understanding and knowledge as such, is constructed by the group and individuals within that group or society.

The underlying and possibly the more controversial point that Bredo (2001, p. 131) makes is that if knowledge is constructed, then the relationship between subject and object must be also viewed in a specific way. Constructivists contend that the subject and object, knower and known, mind and reality, are intertwined and co-constructing. It is the traditional assumption of the fixed, separate, and well defined identities of subject and object that is challenged the most by constructivists. As Bredo (2001, p. 131) states, for constructivists 'not only is knowledge made but, more fundamentally, that the objects and properties that we experience and know are themselves in some manner products of human (mental or physical) activity'.

3.3.7 Anti-realism: relativism vs. realism

Crotty (1998, p. 43) proposes that from the constructionist viewpoint, meaning, or what he terms as truth, cannot be simply labelled as 'objective' or 'subjective'. He suggests that when constructionism is portrayed as simply taking meaning as constructed by a group and imposing it on reality it discounts the concept of humans as beings-in-the-world and the phenomenological concept of intentionality. This total subjectivism goes against the idea that human beings have agency and are part of the construction and can be viewed as an acting 'organism' (Mead's term) within their world. Bredo (2001, p. 132) suggests that as soon as you question what is considered real, the enquiry then becomes focussed on the process and activity (fundamental to symbolic interactionism) that one goes through to reach those conclusions rather than taking the conclusion for granted.

Intentionality, in this context, refers to the idea of ‘reaching out for’, ‘moving towards’ or ‘directing oneself to’ (Crotty 1998, p. 44). In other words, all conscious thought is conscious of something and has reference, context, as well as direction. Intentionality suggests a very intimate and very active relationship; not only is consciousness intentional, but human beings in their totality are intentionally related to their world. Experiences do not constitute a sphere of subjective reality separate from, and in contrast to, the objective realm of the external world. In relation to action or clinical practice, there is an active and intimate relationship between the practitioner and the consumer whether for either what is perceived as a positive or negative outcome. Because the individual and the object, event or subjects are so closely linked, the description not only needs to describe both these separate identities but also the explicit links between them, which is where the meaning in the interaction lies. These links open up the opportunity to view or reinterpret a given set of data in new ways as Saukko (2000, p. 300) states, ‘exploring several perspectives in an open fashion may enrich systematic analyses by focusing attention on developments that do not fit the initial framework’.

Social constructionism denies that our knowledge is a direct perception of reality. In fact it might be said that we construct our own versions of reality (as a culture or society) between us (Burr 2003, p. 6). Since constructionists assume that all forms of knowledge are culturally and historically derived and linked, then trying to fit the notion of ‘truth’ into this framework becomes problematic. Berger and Luckmann’s (1966) *The social construction of reality* argues the anti-essentialist account of social

life which encompasses that human beings together create and sustain all social phenomena through social practices. They propose the three processes of externalisation, objectivation, and internalisation are responsible for maintaining social phenomena and the social construction of reality. Externalisation involves the potential for shared ways of thinking about the world to become externalised when they take the form of social practices or artefacts. These then become 'objects' (objectivation) for a social group, and acquire a sense of shared meaning. They then become a part of the thinking of individual members of the social group (internalisation) and new members are introduced to the concepts and practices around them. Meaning in this sense is not constructed in a vacuum, but rather as human beings existing in a world that has established cultures and knowledge. Therefore we enter a world where concepts and ideas are shared, learned and established through interaction. The making of meaning is an ongoing process and accomplishment, with 'the conclusion being that all objects are made not found and that they are made by the interpretive strategies we set in motion' (Fish 1990, p. 191)

3.4.8 'The publicly available systems of intelligibility': culture and the individual

Crotty (1998, p. 53) suggests that the existing frameworks, meanings and culture that we enter into and which 'precede us' are there to be experienced, introduced to and incorporated in to our lives as individuals. Crotty calls it 'a publicly available system of intelligibility', where these existing frameworks function to provide us

with a wider sense of the public and conventional meanings of the world we live in. These institutions are the source of the interpretive strategies which we use to construct meaning. Geertz (1973, p. 42) speaks of ‘a system of significant symbols’ and the meaningful symbols that constitute culture as indispensable guides to human behaviour. As a direct consequence of the way in which we humans have evolved, we depend on culture to direct our behaviour and organise our experience. Culture, according to Geertz (1973, p. 44), has been viewed in the past as ‘complexes of concrete behaviour patterns: customs, traditions, habit clusters’, which, if viewed predominately in this way, is to regard culture as an outcome of human thought and action. Crotty (1998, p. 53) proposes reversing this view of culture and contends that culture is best seen as the source rather than the result of human thought and behaviour. He cites Geertz (1973, p. 44) as describing culture as ‘a set of control mechanisms: plans, receipts, rules, instructions for the governing of behaviour’. Within this view of culture Crotty (1998, p. 53) represents human thought as ‘basically both social and public’. To illustrate this he uses the description from Geertz (1973, p. 49) that thinking occurs not only in the ‘mind’ but is the ‘traffic’ or interplay of ‘significant symbols’. Culture as a system of significant symbols suggests that these symbols for any individual are already functionally established and are current within the community that the individual is born into or operates as a member of (Geertz 1973; Crotty 1998). As this system changes and evolves so do the symbols that constitute what is significant and mutually shared.

This portrayal of social constructionism concludes that all meaningful reality is socially constructed, with no exceptions, including natural or physical realities. The counter understanding of 'social constructionism' is that the meaning refers to only social realities having a social basis and not the natural or physical world. This distinction is described by Crotty as understanding social constructionism as denoting 'the construction of social reality' rather than 'the social construction of reality'. Crotty (1998) contends that social constructionism 'is at once realist and relativist'. He notes that 'to say that meaningful reality is socially constructed is not to say that it is not real'. He argues that those who compare 'constructionism' and 'realism' are mistaken and realism should be set against 'idealism'. Idealism is the philosophical view that what is real consists of what is recognised by the mind and can be seen as 'ideas' in practice. Crotty (1998) suggests that social constructionism does not limit or confine reality in this way (Crotty 1998, pp. 42- 65).

3.4 How theory meets method

Symbolic interactionism, constructivism and social constructionism, with their focus firmly on action and in particular the concept of culture, provides the perfect back drop to understanding paramedic practice and how that practice is constructed when dealing with psychiatric presentations.

Denzin (2001, p. 2) outlines several ways the interpretive approach can be used to understand action and practice within work life and everyday social understandings.

At the applied or practice level, the interpretive approach can contribute to evaluative research in the following ways. First it can help researchers to identify different definitions of a problem and perceptions from the different players through the use of personal stories and rich descriptions. The interpretive approach also allows researchers to locate the assumptions that are held by various interested parties. These assumptions are often taken for granted or in practice without the parties being aware of their influence. The interpretive approach can identify strategic points of intervention into social situations and bring to the fore issues that are relevant to and affect practice, action and service delivery. Lastly, the interpretive approach makes it possible for the researcher to suggest 'alternative moral points of view' from which the problem, policy, or the program can be interpreted and assessed.

One such interpretive approach which captures these objectives is ethnography. Ethnographic tenets guide the study of culture and the generation of meaning by individuals and groups. Ethnography is performed in natural settings—'the field'—uses multiple sources of information, and is relatively unstructured and small-scale to facilitate in-depth exploration. The analysis of data involves interpretations of the meanings, functions, and consequences of human actions and institutional practices, and how these are implicated in local, and perhaps also wider, contexts.

> *Ethnographic enquiry in the spirit of symbolic interactionism seeks to undercover meanings and perceptions of the people participating in the research, viewing these understandings against the backdrop of the people's overall world view or 'culture'. In line with this approach, the*

researcher strives to see things from the perception of the participants
(Crotty 1998, p. 7)

This intention to place yourself as the researcher in the participants' worldview provides the logic behind the use of methods such as participant observation, unstructured or semi-structured interviews, and the use of non-directive forms of questioning within them, and document analysis. The following chapters provide more detail on these specific methods and how they have been employed in this research.

Chapter 4

Research method part 1: The framework—ethnography and culture

4.0 Introduction

> *It is evident that any research grounded in symbolic interactionism will be tentative, empirical and responsive to meaning. The social world is taken to be a place where little can be taken for granted…, a place not of statistics but of process, where acts, objects and people have evolving and intertwined local identities that may not be revealed at the outset or to an outsider.*
> (Rock 2001, p. 29)

Ethnography as a technique for investigating actions and meanings allows us to enter the world of paramedic practice, explore stories of their everyday work with people who are experiencing mental illness, and observe the transition from pre-hospital to hospital care. This chapter outlines the concepts that support ethnography as a method for conducting qualitative research in the pre-hospital field. Part 1 defines ethnography and explores the concept of culture and how it pertains to my research. Part 2 outlines how access was achieved, the negotiations with gatekeepers, and the gaining of ethics approval. The latter sections detail the techniques used during data collection and issues of rigour for ethnographic research.

4.1. Ethnography and culture

4.1.1 A brief account: ethnography and relevance to practice

The questions of what is 'ethnography' and what does the term 'culture' mean are essential to understanding *what* constitutes a 'cultural lens' and *how* that informs data collection and analysis. Ethnography is to:

> *tell a credible, rigorous and authentic story by giving voice to people in their own local context, typically relying on verbatim quotations and a "thick description" of events. The story is told through the eyes of local people as they pursue their daily lives in their own communities.*
> (Fetterman 2009, p. 1)

The intent of ethnography is to observe, document and interpret behaviour and actions with primacy given to individual and group accounts within a cultural context. Ethnography found its origins in nineteenth century Western anthropology as a term that denoted a descriptive account of a community or culture that was usually located outside the known groups and societies of that era. During that time 'ethnography' was viewed as complementary to 'ethnology', the historical and comparative analysis of non-Western societies and cultures. As anthropologists began to do their own field work the term ethnography evolved to mean 'an integration of both first-hand empirical investigation and the theoretical and comparative interpretation of social organisations and culture' (Hammersley & Atkinson 2007, p. 1). Brewer makes the point that ethnography is not only studying people in their natural setting, but attempts not to impose an external meaning on what is seen and heard. He writes that ethnography is:

> *... the study of people in naturally occurring settings or 'fields' by means of methods which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting, if not also the activities, in order to collect data in a systematic manner but without meaning being imposed on them externally.* (Brewer 2000, p. 1)

Fieldwork became central to anthropology as researchers became directly involved in the systematic observation and study of people. Fieldwork required extended and involved periods of time within the group being studied, to achieve the ethnographic goal of documenting and interpreting the distinctive ways of life, the beliefs and values that underpinned a group. This extended presence in the field lent itself to ethnography being considered not only a process but also a product; not only the generation of understanding of human experiences and their meanings, but also the researcher's lived involvement within the field of study (Tedlock 2003, p. 165). These accounts form the basis from which themes, descriptions, interpretations and representations develop to gain insight into the studied group, culture or organisation.

During the twentieth century, alongside this fundamental change within anthropology, the ethnographic model was beginning to be adopted by other disciplines, particularly Western sociology. During this time sociologists working at the University of Chicago, during the 1920s to the 1950s, developed an approach along the lines of anthropological ethnography to study human social life. The Chicago School, as it was known, documented a range of different groups and

subgroups, including those found in the city, and how these were shaped by the urban social forces that were developing at the time (Deegan 2001, pp. 11–12).

The move from traditional anthropological ethnography to the study of subcultures and sections of urban life by other disciplines within the social sciences has seen the creation of micro-ethnographies, also known as rapid, short stay or focused ethnography. These disciplines embrace the major tenets of cultural understanding and interpretation. However, for practice based researchers, traditional ethnography was extremely culture-and-context orientated, broad in its aims and goals, required extensive time in the field and was time consuming for their purposes (Wolcott 1990, p. 50). This shortened form of ethnography, Wolcott (1999, p. 25) suggests, recognised that:

> *in the process of ethnography taking the long, slow, but apparently inevitable process of "coming home", ethnography lost its single most defining feature as the study of others, or at least others who differed dramatically from the ethnographer.*

In the process of ethnography 'coming home' and researchers becoming more engaged with issues that were significant in their own culture, instead of looking to those outside their own back yard, researchers did not require the same length of time to become familiar with the culture and could focus on a defined area of interest.

Continuing into the current day ethnography has been taken on board by many different disciplines and influenced by a variety of theoretical perspectives ranging from: anthropological and sociological functionalism, philosophical pragmatism and symbolic interactionism, Marxism, phenomenology, hermeneutics, structuralism, feminism, constructionism, post-structuralism and post-modernism (Hammersley & Atkinson 2007, p. 2). The choice of symbolic interactionism and constructivism as the theoretical base for this study has been outlined in the previous chapter giving an interpretive framework for the process of data collection and analysis.

4.1.2 Ethnography: the holistic perspective

The fundamental aims of cultural interpretation, namely adopting a holistic perspective, providing context for the studied phenomena, and non-judgemental views of reality, all shape ethnography (Fetterman 2009, pp. 18–22). Adopting a holistic perspective allows exploring beyond the mere observation and interview information, to develop a context for the group being studied and a backdrop for their actions and commentary (Fetterman 2009, p. 18). Wolcott (1999, p. 78) incorporates the idea of wholeness or integration in ethnography. This situates phenomena not just as a single identity but in relation to a wider context, attempts to explore phenomena in its entirety, and interprets how the ideas and actions interrelate, and the complexity of those relationships. To gather a holistic view, fieldwork again takes prominence and the ethnographer becomes the predominant tool, as an integral part of the process of gathering data. The extended time in the

field and the use of multiple data sources enables a complex, detailed and contextualised representation.

4.1.3 The insider and outsider: the emic and etic perspectives

Studying a culture from the 'outsider' (the etic) perspective fosters a broad understanding of actions, behaviour and culture from listening to insider accounts and interpretations. Both the 'insider' and the 'outsider' bring their own understandings and perspectives to the phenomena incorporating their own history and connectedness to what they are experiencing and exploring. To allow the insiders' voice, the participants' world view, to prevail and to create the credible story, multiple data sources are generally used in ethnography. This allows the researcher to cross check concepts and to reaffirm with participants the interpretation and meaning.

Adopting of non-judgemental orientation helps in a number of important areas. A non-judgemental orientation fosters the openness to explore new ideas and directions that were not expected. This openness allows the researcher to follow ideas and concepts, check their truthfulness, and establish an audit trail for these with participants. The non-judgemental orientation also prevents the contamination of the data, and finally and most importantly this fundamental guide prevents ethnographers from 'making inappropriate and unnecessary value judgments about what they observe' (Fetterman 2009, p. 23).

4.1.4 Ethnography as a means to explain work life

Ethnography has been highly effective in uncovering the skills, the rules, and the complexities of work and what influences work lives (Smith 2001, p. 221). The ethnographic account has the ability to explain the conceptual basis of decision making and actions, the strategies workers use to accomplish their work and the control in people's work lives (Smith 2001, p. 221). Observation is viewed as a necessary means to obtain and measure the subtle practices, ideas and behaviours of workers and management which are often hidden behind easily proffered categories and explanations (Smith 2001, p. 222). Ethnography offers a framework to research paramedics' actions (clinical practice), and their decisions, beliefs and understandings when attending psychiatric presentations. The focus on culture and cultural interpretations encompasses operating policies, work related practices, personal understandings and beliefs, organisational structures and how they influence clinical practice. Wolcott (1990, p. 51) proposes that a study of problems defined and dealt with by a society or group within society reflects the goals of ethnography, as well as the wider context that underpin such accounts. Shaban (2009, p. 118) succinctly identifies the problem for mental health and emergency services personnel:

> *The decentralisation of mental health services has resulted in increased attendance of individuals with mental health problems presenting to emergency departments and emergency medical services by patients – something well documented in Australia and around the world.*

In pursuing ethnography to gain insight into paramedic practice with people presenting with a mental illness, the central idea of 'culture' needs to be explored. As Wolcott (1990, p. 69) asserts, in committing oneself to ethnography, whether it is at the macro (anthropological) or micro level, is to engage in the continual debate about what culture is in general, how culture influences societies and groups, and how culture endeavours to depict unique or specific aspects of the practices and views of a particular group.

4.1.5 Culture

Culture, the principal and broadest ethnographic concept, is considered elusive like ethnography itself and yet it is offered as the best single criteria from which to judge ethnographic accounts. There is caution and debate by those, such as cultural anthropologists and sociologists surrounding the term 'culture' and exactly what it refers to (de Laine 1997, p. 103). Taking a stance of a 'model for behaviour' Goodenough defines culture as:

> *standards for deciding what is, standards for deciding what can be, standards for deciding how one feels about it, standards for deciding what to do about it, and standards for deciding how to go about doing it.* (Goodenough 1971, pp. 21–22)

Fetterman (2009, p. 16) suggests that definitions of culture advocate either a materialist or an ideational perspective. The materialist interpretation of culture views culture in terms of the sum of a group's observable patterns of behaviour, customs, and way of life. The focus is specifically on behaviour and the two

components that de Laine sees as the ‘patterns *for* behaviour’ and a ‘pattern *of* behaviour’ that commonly comprise the understanding of culture (de Laine 1997, p. 103). Alternatively the ideational definition of culture examines the cognitive aspects of culture which encompass the ideas, beliefs and knowledge that characterise a particular group of people (Fetterman 2009, p. 16). Although this definition excludes behaviour, when used in conjunction with a materialist definition of culture a structure for examining both cultural behaviour and cultural knowledge emerges.

Broadly, Fetterman (2009, p. 16) outlines three major areas that are essential in understanding culture. These involve the concepts that culture emerges in adaptive interactions between humans and environments; that culture consists of shared elements; and that culture is transmitted across time periods and generations. These characteristic appear to support and fit other recent definitions of culture, for example, that of Fiske:

> *A culture is a socially transmitted or socially constructed constellation consisting of such things as practices, competencies, ideas, schemas, symbols, values, norms, institutions, goals, constitutive rules, artifacts, and modifications of the physical environment.* (Fiske 2002, p. 85)

The task of capturing the ‘culture’ of particular groups, such as paramedics, needs not only the descriptive material to adequately create a picture of the group’s actions, views, beliefs, and everyday routine, but also a way to structure that information in cultural terms. Wolcott suggests three broad concepts: cultural

orientation, cultural know-how and cultural beliefs to assist in achieving the cultural picture (Wolcott 1990, p. 91). Cultural orientation addresses the question of where the people being described are situated, whether it is in terms of their physical environment, their major activities, or their world view. Cultural orientation is one way of defining for the audience the 'outer physical and experiential boundaries' of time, place and circumstance of those within the group being described. Cultural know-how focuses on the daily routine and activities that occur within a group and what tools or strategies they use to achieve their daily work. The last distinction that Wolcott makes is between cultural know-how and cultural beliefs. He acknowledges that both are interrelated, but he describes cultural beliefs as the context and cognitive understandings that surround the activity and actions. The distinction, as he views it, is between 'knowing how' and 'knowing that' (Wolcott 1990, pp. 91–97). These broad concepts form the overlying aim of capturing the physical and situational environment that paramedics work within, what they do and how they do it, and how they think about and view their work in relation to patients with mental illness.

The concepts of culture and ethnography are the broad underlying concepts for this study. The next section outlines in more detail the rationale for using focused ethnography, and how the underlying principles of ethnography and description are relevant to this study.

4.2 The use of focussed ethnography and how the research fits the method

In the tradition of large scale ethnographies it was not unusual to spend over twelve months to several years studying a group or culture to discover how that group actively constructs their world. Focused ethnographies developed as the realisation that most researchers do not have the extended time to spend in the field. The focus of these studies became more specific, usually identifying one aspect to study in-depth and working within their own culture which is familiar. Time constraints became a limiting factor to traditional ethnography particularly in the event where the researcher has been engaged to do commissioned work and faces an expectation to provide quick answers to key social and health related questions (de Laine 1997). Although an ethnographic study will have a particular area of interest, or what Malinowski referred to as a 'foreshadowed problem', the process is an exploratory one (Hammersley & Atkinson 2007, p. 3). The task is:

> *to investigate some aspect of the lives of the people who are being studied, and this includes finding out how these people view the situation they face, how they regard one another, and also how they see themselves.*
> (Hammersley & Atkinson 2007, p. 3)

This study targets paramedics as the specified group of interest; it focuses on a defined area of practice, specifically how paramedics identify, assess and manage psychiatric presentations. It was conducted within a limited time frame (11 months), conducted at a single site, and involved in-depth interviews with a comparatively small group. These features all meet the concepts behind a focused

ethnography. One last important point that completes the rationale for using a focused ethnography is my familiarity with the subject and the area of interest. The idea that a focussed ethnography can be done in a shortened time period is justified by the assumption that there is familiarity and an understanding of the environment being studied, and therefore the research was not started from a position of total ignorance. I bring to the study a background in both nursing and paramedics as a basis to understanding how processes work in each organisation, terminology used, policy, and general operational protocols.

The physical positioning of the research, or the field site, is integral to both small and large scale ethnographies. The two areas that comprised the research field for this ethnography were the ‘on the ramp’ arrival point for paramedics and the triage area of the emergency department. This follows the principle that people’s actions and accounts are studied in everyday contexts, rather than under conditions created by the researcher, such as in experimental setups or in highly structured interview situations. In ethnography, observation becomes a key to understanding the way the participants operate and view the world they live within. The close association between researcher and participants is based on the premise that one of the central aims of the social sciences is to understand people’s actions and their view of the world, and the ways in which their actions are created and driven from these experience and beliefs (Brewer 2000; de Laine 1997). The concept of people as creating and attributing meaning to action is portrayed by Tedlock (2003, p. 165)

in terms of ‘experience as meaningful, and human behaviour is generated from and informed by this meaningfulness’.

Another fundamental feature of ethnographies is its open-ended approach to research design, data collection and analysis. Data collection is ‘unstructured’ in two important ways. First it does not involve following through a fixed and detailed research design specified at the start. Second, the categories that are used for interpreting what people say or do are not built into the data collection process through the use of observation schedules or questionnaires. Instead they are generated out of the data itself during the process of data analysis. The analysis involves the detailed coding of transcripts of interviews, field notes and Case Card documents which all contributed to the development of descriptions and themes regarding paramedic actions and culture. Data analysis involves interpretations of the meanings, functions and consequences of human actions and institutional practices, and of how these are implicated in local, and perhaps also wider, contexts. What are produced, for the most part, are verbal descriptions, explanations, and theories (Hammersley & Atkinson 2007, p. 3).

The development of descriptions from data is one of the key processes in ethnography, but how do those descriptions relate to the development of theories or to practice? The following discusses how Hammersley views what he terms theoretical description, and its relevance to this study.

4.2.1 Why description is relevant to practice

Hammersley (1992, p. 12) tells of the emphasis ethnography places on description, but not only description as a way to outline events or phenomena but as a distinctive kind of description.

> *... all description use concepts that refer to an infinite number of phenomena (past, present, future and possible), and all descriptions are structured by theoretical assumption: what we include in descriptions is determined in part by what we think causes what. In short, descriptions cannot be theories, but all descriptions are theoretical in the sense that they rely on concepts and theories.* (Hammersley 1992, p. 13)

Insightful description, as it suggests, provides the ethnographer with the opportunity to see the actions, motivations, and communication of the individual or the 'society' under study in new and different ways. The insight may provide new ways of connecting old concepts or develop new concepts from data that might not have been captured before. In this case there has been very little research focused on how paramedics operate within their practice regarding patients presenting with mental illness. Insightful description enables their actions and how they view those actions to be captured and placed in the wider context of culture. Another benefit of insightful descriptions is the ability to remove thinking and observation from previous frameworks, which may have been used routinely to construct what is considered 'reality', to open them to different possibilities. The framework that is new to this idea of viewing paramedic practice is the underlying theoretical

concepts of constructivism and symbolic interactionism where meaning for the participants is generated through action and interaction.

One of the major questions surrounding this concept of description as insightful description is the notion that if insights are the end product of ethnography, are participants' insights and commentaries of value in themselves or do they provide the basis for further potential hypotheses that can be developed and verified in other ways? The insights provided by the paramedics clearly place the issues and actions that they consider important, affect their ability to connect to their patients and how they perform their duties into the fore, which both gives the paramedics' insights value in themselves as well as being a basis for further study and hypotheses development. This allows for more work to be considered in the areas of education, and policy development. It also allows a linkage between the 'on-road' experience and personal, social, organisational and environmental influences.

A debate closely linked to the theory base of ethnographic description is the idea of theory as the description of 'social microcosms'. This concept proposes that although the description may focus on particular or unique events or phenomena, they are also examples of broader universal social thought or processes. Through the study of particular events or social settings the general features of human social life can be revealed and discovered (Hammersley 1992, p. 16). The debate surrounding whether universal principles are able to be distinguished from the description of particular phenomena has significance to the value placed on

ethnographic work. The value of ethnographic work is often dependent on demonstrating that the description or particular phenomena support or refute a generally held practice, belief or theory that is significant in the social world (Hammersley 1992, pp. 17–18). As part of the ongoing debate is the question on what basis can ethnographers make the links between data and theory? The process of validation and talking more broadly to paramedics within the second interview about dealing with mentally ill patients aims to place the description as an overall picture of their social and practice world, with links to wider paramedic practice.

4.3 Conclusion

Focussed ethnography, as a method to capture the culture of paramedic practice, provides the foundation for data gathering and interpretation in this thesis. The historical basis of ethnography and the move from traditional to more focused explorations of subgroups within society provides a rationale for the use of ethnographic techniques for this thesis. Insightful description as a means to contextualise work life and culture, a 'social microcosm', creates the setting for the findings and gives credence to the paramedics' voices and their actions.

Chapter 5

Research method part 2: The process—access, ethics, observation, interviews and documents

5.0 Introduction

Gaining access to the field site and ethics approval were the initial challenges to conducting this focused ethnography. Extensive communication and negotiation with the Ambulance Services hierarchy and gatekeepers, the Human Research Ethics Committee, the paramedics and ED staff, was required before the research could commence.

5.1 The process: The beginning—access, gatekeepers and ethics

5.1.1 Access to field sites

Ethnography in the pre-hospital setting presents challenges in terms of both access to the field site and developing the relationships essential for the insightful description characteristic of ethnography. As Long, Hunter and van der Geest (2008, p. 71) emphasise once the sociological interest is created it is necessary to develop a relationship between the ethnographer, the ethnographic method and the chosen area as a field site. For any relationship to develop the interest needs to be shared between the researcher and the researched. The essential starting point for this study was to generate interest between the researcher and the researched.

In the study of health care, major barriers can arise in accessing hospital or clinical spaces due to organisational protocol, the actual logistics of accessing participants, and the traditionally highly structured, protected, exclusive and excluding institutional nature of these settings. Long, Hunter and van der Geest (2008, p. 72) contend that this protective behaviour can make clinical settings initially difficult to access for ethnographic inquiry. They also contend that to gain access the main focus of initial ethnographic studies into health care were on the structural and organisational features as institutional systems, rather than culture and practice which could be open to observation and criticism. Research in the pre-hospital environment has tended not to focus on the culture behind practice. Currently there is very little research into the practices and views of paramedics when attending psychiatric presentations. As Shaban (2009, p. 119) notes:

> *... how paramedics have dealt with such events [mental health reforms and increased presentation of individuals suffering mental health problems] and how they are able to contribute, or otherwise, to the care of the mentally ill in the emergency primary health care context has not been the subject of sustained systematic research or enquiry.*

Hammersley and Atkinson describe access as not only a practical concern, but a discovery and learning process in itself:

> *Not only does its achievement depend upon theoretical understanding, often disguised as 'native wit', but also the discovery of obstacles to access, and perhaps of effective means of overcoming them, itself provides, insights into the social organisation of the setting or the orientations of the people being researched.* (Hammersley & Atkinson 2007, p. 41)

Access cannot be taken for granted and requires extended time working with key people and participants to ensure the establishment and continuation of the relationship.

To generate the necessary relationship, interest and understanding of the ethnographic process, the starting point was to gather key senior people from the ambulance service and ED to discuss the type of research planned and to further define the research question. Initial consultation with the advisory committee dealt with concerns such as access, the most effective way to disseminate information, research aims, and logistics. A major hurdle identified in the initial discussion and later during the ethics process turned out to be the logistics of gaining consent from paramedics who are spread over several sites and rotating shift rosters. Operational protocols such as 'clearing', defined as being on standby to accept the next call once patient transfer and documentation has been completed (usually the crew is returning to their station at this stage), 'crib' (allocated breaks within a single shift) and interruptions due to the need for the paramedics to attend cases were all considered in the development process.

Other considerations involved the attendance at ambulance stations which potentially could impinge on ambulance personnel and required careful negotiation. Ambulance stations are considered the paramedics' domain, their space, their work base and safe haven from the stresses of their job. In terms of access and support for the research the ambulance service provided the

opportunity to negotiate, supported the concept behind the study, assisted in information dissemination and contributed to the design and planning of this study. In some instances such as access to stations, training days and length of the interviews, the ambulance service placed boundaries on access to protect their staff and ensure that operations continued without significant disruption or burden. This protectiveness may have been generated from the open and emergent nature of the ethnographic research, which creates a natural concern with how the organisation and paramedics may be portrayed, a lack of familiarity with the ethnographic method and the current rapidly changing professional environment within the pre-hospital setting.

These issues constitute part of the reason this research was based at the emergency department 'on the ramp', which was perceived as neutral ground. It also provided, logistically, the opportunity to talk to paramedics and emergency department staff and allowed for the negotiation of follow up interviews. The initial recruitment phase with the paramedics was designed to gain access to paramedics on terms that did not impinge on their time at station, met concerns from the ethics committee and enabled opportunities for paramedics to ask questions regarding the research before giving consent. It also gave the opportunity to outline the idea of ethnography, the ethnographic method and the importance of the field of study to paramedics.

5.1.2 Hierarchy and gatekeepers

> *There are also dilemmas involved in access such as the choice of site for ease of access, limitations to access and the continual negotiation with those that grant the access, besides ethics committees, such as approaching chief executives, consultants, directors of nursing services or others in positions of authority and power.* (Mulhall 2003, p. 310)

Access to the field also involves not only the practical issues of physical access but the negotiation and acknowledgement of the organisation's gatekeepers, as without their permission access can be controlled or denied. According to Mulhall (2003, p. 310) 'negotiating access also involves a subtle but rarely acknowledged process of presenting oneself in the 'correct' way'. Access may be denied or blocked if knowingly or unconsciously the researcher does not approach and meet the expectations of those that hold the decisions in providing access. The way one dresses, speaks, or imparts particular knowledge is significant to the process of access and meeting the gatekeeper's expectations. Waddington (1994, pp. 107–122) discusses how gaining access involves a process of managing your identity, projecting an image, and convincing gatekeepers that you are non-threatening.

The initial discussion with the advisory group suggested that logistically attending cases with paramedic crews may be difficult in two respects. First, the crews may not attend a case that they deem psychiatric within the shift therefore the actual ability to capture cases for the study may be an issue. Second, the presence of a third person may create operational difficulties if the police or intensive care paramedics are required to assist in the ambulance. From these discussions the

suggestion arose to situate the study ‘on the ramp’ and within the triage area to capture cases as they arrived. This posed the problem of how initial reactions and strategies used by paramedics were to be captured in the study. An initial interview with paramedics after they had transferred the care of the patient was thought to enable first impressions and thoughts to be explored while the case and the feelings were still immediate and present in the paramedics’ minds. The second interview was negotiated, due to its longer duration, so that it could be conducted at the stations as long as operational requirements took precedence, which meant that the interview may be interrupted and incomplete.

The field site had now been established, but in the busy emergency department the issue remained of how paramedics and emergency department staff could identify me, as the researcher, so they could approach if they had a possible case. It was recommended that during observation and interviews I wear the university paramedic student uniform top and identification to enable easy recognition. Initially I believed this would create difficulties in being able to blend in to the culture and become ‘part of the furniture’, which is essential when conducting ethnography, but in practice it provided an avenue for informal conversations and opportunities to discuss the research with paramedics and emergency department staff.

The gaining of ethics approval, discussed in more detail in the next section as a form of gatekeeping within this research process, posed several challenges to both design

and implementation of the research. After gaining ethics approval, the discussion continued with the Acting Team Leaders, the regional leaders who manage the operational side of everyday station life. This provided a direct link to paramedics for information dissemination. The Acting Team Leaders having agreed to outline the research at team meetings, provided information sheets and envelopes to their paramedics, and supported the access to paramedics on station for the longer second interviews.

The necessity to negotiate with those that hold the key to access may in the process override the wishes of the people you actually wish to engage with, for example if the group's supervisor, manager or director has agreed to a study it is sometimes difficult for staff under their direction to refuse to be involved. It might be argued that this problem is overcome by ensuring that informed consent is obtained from participants, but in practice and in the field this is not that simple. The recruitment phase and my extended time in the field enabled the paramedics to consider their involvement independently of organisation, peers and managers. The time in the field allowed the crucial relationships to develop that lead to the unique connections between researched and researcher within ethnography.

5.1.3 Ethics

The ethical review process, as the role of research ethics committees, has become re-institutionalised particularly in the United States and the United Kingdom as more guiding statements, reformulation of existing ethical policies and governance

has placed social research under further scrutiny. Ethical review boards have gained a powerful role as gatekeeper in the research process.

The structure, regulatory nature and design of ethics review bodies still pose challenges when assessing ethnographic proposals. Although qualitative research methods are increasingly accepted as important in both their focus and contribution, ethics review difficulties occur not because ethnographic work is free from ethical challenges, but such regulatory regimes are based on traditionally quantitative, clinically focused paradigms (Murphy & Dingwall 2007, p. 2224). Langlois argues that although the 2007 *National Statement on Ethical Conduct in Human Research* (2007) went a long way in recognising qualitative and social research the:

> *… underlying architecture of research ethics review remained the same; the fundamental institutional model, based around HRECs, also remained the same; and, as a consequence, the ill fit between the requirements of this model of research ethics review and the nature of humanities and social sciences research.* (Langlois 2011, p. 143)

The research framework of investigators being outside the process, having control over variables and an ability to estimate what the potential risks may be for a given intervention is distinctly different from the ethical concerns when assessing social research. Therefore challenges arise when trying to assess the potential risk to participants, the potential benefit for participants, ensured anticipatory informed consent and ensured confidentiality (Boser 2007, p. 1063). The regulatory

framework also seems to discount the potential for human agency of the participants, the shared nature of the relationship building within participatory research design and process, and the inclusion of the stakeholders and often the participants in each stage of the process.

5.1.4 The collaborative, emergent research design and prior informed consent

The complex and collaborative nature of the relationships within social research means that a full detailed account of the all the possible contingencies for the ethics approval process is often not able to be provided from the beginning and often situations arise that cannot be foreseen. As O'Neill (2002, p. 17) indicates:

> *In ethnography, both the research focus and the research design typically emerge during the course of the research.*

In contrast to the prior 'specification of hypotheses, design, instruments and implementation in protocols that are completed before the study commences' (Murphy & Dingwall 2007, p. 2224), ethnographic research is an open ended design with development of questions and concepts throughout the process. This is in line with the shared capacity and relationship building principles with participants that are central to this form of enquiry.

The flexibility of research design and the ability to respond to emerging insights and developments are one reason that ethnography is well suited to explore cultures,

practices and organisations. Although flexibility and the emergent nature of the research design have distinct benefits it complicates the process of prior informed consent and full disclosure of information to participants from the outset.

> *This requirement that the project be fully known in advance is trouble-some in qualitative research, where the notion of discovery during inquiry is usually considered a strength – not a weakness – of the approach.*
> (O'Neill 2002, p. 18)

In ethnography participant consent may be initially tentative and dictated by the organisation or participants themselves. Over time as the organisation and participants get to know the ethnographer and the relationship builds, the information they provide may become more open and detailed. Murphy and Dingwall (2007) argue that the very nature of ethnography, where the research is often carried out over long periods of time makes the process of consent a negotiated and renegotiated process. They suggest the traditional contractual type of agreement with the participant for a short, defined, episodic intervention characteristic of clinical trials or biomedical experimentation may hinder the shared building of the relationship between parties (Murphy & Dingwall 2007, p. 2225). Katz and Fox (2004, p. 5) suggest that ethnographic consent is a relational and sequential process in response to the ever changing dynamics found in ethnographic (natural setting) research and lasts throughout the research period.

Mulhall raises a further consideration in the consent and observational process in qualitative research, which is the practical and logistical difficulties in informing

participants, gaining consent prior to and during observational fieldwork (Mulhall 2003, p. 309). Informing and continually reiterating the research to potential participant and others is one of the major ethical issues facing observational work. The field setting itself can pose problems with the practicalities of informing and obtaining consent from everyone who might ‘enter’ into the field, particularly if the field is a large and busy social setting such as an ED. These challenges and how they are negotiated are some of the ongoing issue of debate within social research (Mulhall 2003, p. 309).

5.2 The challenges encountered

This study encountered a number of challenges during the ethics approval process. This section outlines those challenges, specifically how the traditional understandings of the relationship between researcher and participant posed difficulties for the approval process and affected the review process and eventual design.

As part of the application process for qualitative research to the joint University and Hospital Human Research Ethics Committee (HREC) examples of previous work from supervisors detailing ethnographic and thematic processes was required (Roberts et al. 2012. p. 8). The research proposal provided detail regarding the proposed target group, the aims and objectives of the research, how many interviews were proposed and how they were to be conducted, the purpose of the observations, the sample size of current operational paramedics within the catchment area of the

research site, and how information would be distributed and how consent would be obtained. As mentioned previously the access and logistics of consent had been discussed with industry through the advisory group prior to the development of the ethics proposal.

The original ethics proposal was rejected on two occasions based on a number of concerns from the committee, which related to the process of consent, particularly for paramedics, the idea of risk and vulnerability of the participants, specific enrolment into the study, and clarification of the interview questions and process.

5.2.1 Participant consent: the challenge of prior informed consent of paramedics

The HREC raised specific concerns regarding the original process of consent for paramedics. The original process, considered an 'opt out' rather than an 'opt in' format, raised concerns that the paramedics would not be able to decline participation, or consent would not be gained prior to the commencement of the study. The letter from the committee stated:

> *The committee suggests that consent takes place via an 'opt in' process rather than an 'opt out' process and preferably prior to the interviews taking place, so that paramedics do not feel obliged to partake in the study.* (Response from Ethics Committee, 8/9/2008)

In the original proposal, paramedics would be provided with information sheets (Appendix A), consent forms, flyers, electronic information and information from

key senior members at least four weeks prior to commencement of the data collection phase with a reminder two weeks prior to data collection. Consent forms were provided in both electronic and hard copy form with reply paid envelopes to provide opportunity for the paramedics to ‘opt in’ to the study (Appendix B). The committee suggested that the paramedics required more opportunity to ask questions and that a direct approach after they had transferred the care of their patient while ‘on the ramp’ may place the paramedics under pressure to agree to the study.

After significant negotiation three possible alternatives were developed to address the concerns of the ethics committee. The first option was to spend time attending stations to talk to paramedics in small groups or on an individual basis, the second to attend training days to inform paramedics in larger groups with consent forms distributed at this time. Due to operational and training concerns the ambulance service was not supportive of these two options, but final agreement was reached on the third option. The third option involved a recruitment period before the commencement of interviews and observations on the ramp. This involved at least a one month initial recruitment period to talk to paramedics while ‘on the ramp’ before any observations or interviews were conducted. The recruitment period lasted for two months in the attempt to inform, prior to the data collection, as many paramedics as possible (covering roster rotations, different crew rotations and paramedics that rotate within the system to provide extra staff when needed).

Emergency department staff (ED) recruitment involved a less challenging process because physical access was not as great an issue. Staff received information sheets (Appendix C), flyers, return paid envelopes, information sessions at staff meetings as well as continual information sharing, checking and discussion while at the ED. At the beginning of each data collection period at the triage area the process involved informing senior staff that I was present in the triage area, confirming with triage staff that they were still willing to be involved, making sure consent forms (Appendix D) and register were available to be signed, although many had signed at staff meetings prior to the commencement of data collection, and answering any questions as needed.

Due to the nature of the study, there was the need to inform both paramedics and ED staff of the aims and methods involved in the research over the 11 month period of data collection. This major challenge to the concept of 'informed prior consent' required ongoing communication and provision of information sheets throughout the data collection phase. The recruitment period involved information being given to those who might not have received the information previously and consent would be organised at the next encounter. Interviews and observation of handover would occur at the next available opportunity, when both parties were in the ED and paramedics were handing over a case they deemed was a psychiatric presentation. Consent was reaffirmed with each participant before interviews or informal conversations were conducted even though earlier consent had been given. This continual verbal confirmation initially slowed the process of becoming an

integrated ‘fixture’ in the participants’ world, particularly due to the continual flow in and out of the field of participants. Despite this slow beginning over the first three to four months in the field I and the nature of my research became well known to the paramedics and the ED staff. Offering to assist with the make-up of the stretcher or help wipe down equipment, when safe and within protocol, maintained and developed the connections which placed myself as a ‘known identity’.

5.2.2 The interview and interview questions

Another issue that arose during the ethics process was the nature of the questions proposed and the negotiation of the interviews with participants. The questions were developed with the broad concepts of assessment, education, strategies within practice, and culture. The questions developed were designed as a guide and not intended to limit the discussion from the paramedics on how they identify, assess and manage psychiatric presentations, but formed the basis for the unstructured interviews (Appendix E).

The HREC needed clarification regarding the number of questions, how they were going to be used and the time frame for the interviews. They note:

> *The committee is still concerned that the first interview, which is proposed to be done within 5–10 minutes, will not be possible as the questions are quite lengthy.* (HREC response, 4/10/2008)

The HREC required assurance that staff time, workload and operational requirements were to take precedence. Agreement was given that interviews would be conducted in negotiation with participants and ceased if required. Additional concerns were raised by HREC about the ability to track refusal or completion rates and what would happen if the interviews were not completed.

In response to these concerns two detailed letters were provided which addressed the purpose of the questions, how they were going to be used, and provided examples regarding ethnographic methods and data analysis. This was in addition to copies of previous ethnographic research conducted in the mental health field already included in the original research proposal. The letters and continuing discussion with the Chair of the HREC outlined that ethnography was not number dependent, and the interview and observation analysis were based on the data obtained not what was missed. The final result was that the interview questions with minor rewording and modifications were accepted. This enabled the interviews and observation process to remain semi-structured in line with ethnographic tenets.

The HREC also strongly recommended the best time to conduct the interviews with ED staff was early in the shift or the next day. In practice this was difficult and almost unworkable due to the changing rosters of the staff, the ability of ED staff to recall the case after many different presentations during a shift, and being able to negotiate a time, which took almost as long as the interview itself. As the research process became understood and the relationship developed with staff within the ED

they would come to me and dictate when the interview would occur. This development and ownership of the process is clearly denoted by the term Murphy and Dingwall (2007, p. 2225) use to describe the participants as 'hosts'. The term emphasises the relationship between the researcher and those participating and the importance of shared power of the relationship. Ethnographers are guests in someone else's environment, which has associated expectations of conduct and how one presents oneself within that role. These expectations are sometimes clear, if not always explicit, but in many cases are developed with careful negotiation and relationship building that takes both time and presence in the field.

The overall process of ethics approval took approximately seven months to finalise. After the negotiation and meetings with industry and the Chair of the HREC the concerns regarding the nature of the research, the consent process, the questions and observations were all addressed to each group's satisfaction.

The next phase after ethics approval was granted was to begin the data collection and analysis. The following details the participants, methods of data collection and how they were implemented within this study.

5.3 When, where and how of data collection

The study was based at the ED of a large public hospital in South Australia. The recruitment, observation and interviews were conducted in the triage area and 'on the ramp', the arrival area of the ED, where paramedics were met as they arrived.

The observations and informal conversations with paramedics and ED staff were recorded using field notes. The semi-structured interviews with paramedics occurred in two stages. The first interview of five to ten minutes in length occurred on the ramp, after the transfer of the patient to ED staff care. The second interview, of longer duration, occurred either at the paramedic's station, on the ramp or, at the paramedic's request, at their home. The ED staff were interviewed within the triage area during a break or when the workload during the shift allowed. The final source of data was the de-identified section of the Patient Report Form, colloquially known as the 'case card'. The interviews were audio taped with consent from participants.

Observation captured the 'on the ramp' and ED environment, the handover, the potential barriers to the transfer of information and the interaction between paramedics, patients and ED staff. The interviews explored the actions and meanings paramedics attribute to their work when attending psychiatric presentations. The study targeted 20 cases as a foundation to explore paramedic care of psychiatric patients. The document analysis aided in the understanding of the processes and priorities in information delivery that paramedics employ. The data was collected at different periods during the day and night, on different days of the week. Time spent in the ED was in blocks of four to six hours. Appendix (H) outlines the dates, times and duration of the observation for this study.

5.4 Profile and recruitment of study participants

5.4.1 Profile of study participants

The study participants were sought from consenting paramedics who were attending patients they had assessed as psychiatric presentations. The ED staff that elected to participate were directly involved in the handover from paramedics and patient care. The participants were current employees of the ambulance service and the ED.

Appendix (F) outlines the gender, age, education and length of service information of the paramedics who participated in the interviews. Appendix (G) details the length of the interviews. The second interviews for cases 5, 13, and 18 could not be obtained due to logistical difficulties in meeting with the paramedics, and their workload. If the second interview could not be obtained by the second negotiated attempt then it was not pursued, to prevent overburdening the paramedics. The interview with the ED staff encountered the same challenges regarding time and workload. Therefore only 13 of the interviews were obtained out of the 20 cases. Another issue was that different paramedic crews would be handing over their patient to the same ED staff member and, again to prevent overburdening staff, I only interviewed the same ED staff for a maximum of two cases. This occurred only once in the data collection (Cases 4 and 5).

5.4.2 Recruitment of participants

Paramedic participants were recruited through the provision of information sheets, consent forms and flyers sent both electronically and by hard copy. The consent form and information sheet were provided to paramedics through the ambulance service's internal e-mail system four weeks prior to the recruitment period. They were also distributed in hard copy by Clinical Support Officers and Acting Team Leaders within the ambulance service's southern metropolitan and regional centres, along with reply paid envelopes. Information sheets were also distributed to metropolitan centres that were within the proposed research catchment area of the hospital. A two month recruitment period from the beginning of March 2009 to the end of April 2009 provided an opportunity for paramedics to ask questions regarding the research and to receive further details if required. During this stage information sheets were provided directly to paramedics by the researcher. At this stage the paramedics were only provided with the information and informed that if they wished to be involved they could fill out the consent form at a future time when next they were at the ED. To cater for changes in roster and shift allocation during the data collection phase information sheets were provided to paramedics and ED staff throughout the study. ED staff participants were recruited by information packs placed within the ED and by attending staff meetings during the same period. Consent was confirmed with the paramedics and ED staff each time a case was identified.

5.4.3 The potential sample

The approximate population size for this catchment area at the time of the study was 479 emergency operational personnel (paramedics). The majority of the participants came from the southern metropolitan area. Within a six month period approximately 200 nurses and 50 to 60 doctors serviced the ED. From this potential sample I intended to interview the ED staff member directly involved in receiving the handover and triaging for each of the 20 targeted psychiatric cases presented by paramedics.

5.4.4 Duration of the study

The interviews and observations were conducted over an 11 month period beginning in March 2009 and finishing at the end of January 2010.

5.5 Principles behind the ethnography techniques

This following section details the principles and processes that constitute each fieldwork technique.

5.5.1 Non-participant observation

In conventional anthropology the term observation refers to ethnographic techniques used to describe 'interactional particulars' (Becher 1989; de Laine 1997). Observation based in the symbolic interactionist tradition, as Silverman suggests:

> *encompasses symbolic interactionism's methodological principles and 'involves taking the viewpoint of those studied, understanding the situated*

character of interaction, viewing social processes over time, and can encourage attempts to develop formal theories grounded in first hand data'. (Silverman 1985, p. 104)

Observations are not only directed at the verbal and concrete physical actions of the individuals or group's movements but also at the non-verbal meanings they attribute to their everyday functioning (de Laine 1997; Mulhall 2003). Unstructured observation, based within the interpretist/constructivist paradigm recognises context and the co-construction of knowledge between researcher and 'researched' as important to understanding cultural behaviour (Mulhall 2003, p. 306). Observation is not considered unstructured in the sense that it is unsystematic or does not involve rigour. However, it does not follow the approach of strictly checking a list of predetermined behaviours. Instead, observers using unstructured methods usually enter 'the field' with no predetermined ideas as to the discrete behaviours that they might observe.

What people perceive that they do and what they actually do are important and valid in their own right and represent different perspectives on the data (Mulhall 2003, p. 308). Although observational data provides freedom and autonomy for the researcher in regard to the focus of the observation, how they filter that information, and how it is analysed are open to misconception and misinterpretation. This places emphasis on the ethnographer to clearly describe and critically appraise the observation and check interpretations with participants.

Observation places the researcher in a position where they can capture the other person's or group's point of view by an interactive process. The process is an ongoing and dynamic activity. Observations provide evidence for the way individuals' structure and carry out their movements and activities, something which is continually evolving. According to Mulhall (2003, p. 308) the influence of the physical environment tends to be lacking in nursing research and arguably also in the pre-hospital setting, where the focus tends to be on the limited space within the ambulance and on scene management. The pre-hospital focus on the physical space is due to the potential hazards to the patient and the paramedics at a scene, or the need to administer treatment within a confined space. Observations are made of people's behaviour, but data about the physical environment seldom accompanies that description. As Silverman (1993, p. 42) notes:

> *Unfortunately, we have all become a little reluctant to use our eyes as well as our ears during observational work. The way people move, dress, interact and use space is very much a part of how particular social settings are constructed. Observation is the key method for collecting data about such matters.*

Informal conversations, recordings of events and impressions, and the recording of handover all contributed to the observational data.

Observations centred on two very distinct areas: the arrival area for the ambulances, known as 'the ramp', and the 'fish bowl', the term given to the triage area within the ED. These areas were distinct in function and in the nature of the

interaction. The ramp is the entry point for paramedics, allowing for connections and informal conversations within a paramedic dominated space, while the 'fish bowl' is the transition point where the triage staff hold the dominant position. Observations were recorded in a small notebook and on a digital voice recorder. The field notes were transcribed to a computer at the end of each observation period within the ED. Small notebooks enabled recording of observations while waiting on the ramp for paramedics, or while standing near the triage desk during handover without being intrusive. A digital recorder allowed impressions and reflections to be recorded at regular intervals when away from staff.

Informal conversations and observations occurred as paramedics were doing their routine jobs 'on the ramp' such as preparing the stretcher for the next job, cleaning the ambulance if needed, replacing equipment or getting more sheets and blankets. I assisted where possible with all these activities in order to become part of the 'on ramp' environment and as a practical way to get to know the paramedics. Finding a position to conduct the observations so that the daily activity was not interrupted initially took time and changed as circumstances necessitated. Towards the back of the 'fish bowl' in front of the cupboard that held the operational protocols turned out to be the position which disrupted those participating in the space the least. This position allowed for observation of the majority of the triage space and direct observation of handover.

The initial observations described the environment, the actions and relationships in an attempt to get an impression of the two spaces. Further into the study the observations became focused on the transition of care for psychiatric presentations and informal conversations regarding paramedics' actions when caring for an individual with mental illness. This deliberate use of unstructured observations of the emergency department and the ramp environment allowed for practices and interactions to be viewed in a broad context. The more focused observations identified how interaction and the environment affected the information transfer, particularly for psychiatric presentations. The interviews and informal conversations with paramedics and emergency department staff throughout this study enabled me to check my interpretations with the participants.

In Appendix I, Figure 1 is an example of field notes based on the environment and process. Figure 2 documents informal conversations specifically about patients with a suspected mental illness. Figure 3 is a sample of the observations and interpretations as documented after the day's events into an electronic format.

5.5.2 Interviews

Kvale and Brinkmann (2009, p. 3) describe the qualitative interview as going beyond the exchange of views in everyday conversations, and evolving into a careful questioning and listening approach with the intended outcome of gaining knowledge and information. The interview is a social construction between two people. During the interview process knowledge is constructed through the

interactions and conversation between the interviewer and the interviewee. Both people act and react to each other during the interview, which can influence the exchange and the willingness to impart information (Kvale & Brinkmann 2009, p. 32). The qualitative interview:

> *… attempts to obtain descriptions that are as inclusive and presuppositionless as possible …* (Kvale & Brinkmann 2009, p. 31)

The qualitative research interview attempts to operate at two levels; the factual level and the meaning level. The qualitative interview aims at nuanced accounts of the topic with the focus on different perspectives and meaning given to that account. The focus on detailed descriptions moves the information gained in the interview away from general opinions allowing for the generation of comprehensive accounts and analysis on a more concrete basis (Kvale & Brinkmann 2009, p. 31). The care taken in the description and rigour in the building of meaning in qualitative interviews, in Kvale and Brinkmann's estimation corresponds to exactness in quantitative measures.

The interview process can be structured to ensure the main features are addressed but can allow for flexibility and broad discussion. A clear direction may loosely organise the interview process, but the use of open questions allows the interviewee to express their own thoughts and opinions, as they contribute to the development of knowledge.

> *The interview is focused on particular themes; it is neither strictly structured with standard questions, nor entirely 'nondirective'. Through open questions the interview focuses on the topic of research. It is then up to the subject to bring forth the dimensions he or she finds important in the theme of inquiry. The interviewer leads the subject towards certain themes, but not to specific opinions about these themes.* (Kvale & Brinkmann 2009, p. 31)

Statements can have several possible meanings and interpretations. The aim of the qualitative interview is not to end up with quantifiable meanings, but to clarify whether the inconsistencies come from communication during the interview or they reflect the inconstancies and contradiction of the world in which the person lives (Kvale & Brinkmann 2009, p. 31). A deliberate openness creates a receptive interview process to the new and unexpected. The level of openness is often dependent on the knowledge of the field under study by the interviewer, from the understandings of a complete novice to the area to the immersed practitioner in the field (Kvale & Brinkmann 2009, p. 31).

Awareness of one's own understandings implies that there is a critical awareness of the interviewer's own world view and not to impose that world view on what is being seen or heard. One method suggested by Kvale and Brinkmann (2009, p. 30) to establish the participants' world view is to formulate what is thought to be said and rephrase it back to the participant providing the opportunity for the subject to confirm, clarify or disconfirm the interpretation. One way this was achieved in the study was by the use of the initial interview as a foundation to restate and explore

comments and practices with paramedics in the second interview. Encouraging the paramedics to describe as fully as possible their experience, how they felt, and how they acted, generated detailed accounts of their actions, the rationale behind those actions and the meaning attributed to them.

The ‘on the ramp’ interview, although brief, provided cases that were placed in context and formed the background of the paramedic’s actions and clinical processes in each particular case. The handover-like nature of the interview captured the initial assessment and feelings for the case. For example, the comment ‘sitter in the back, just a transport’ and ‘the behaviour not quite right, but not threatening’ (Don, initial interview: Case 1) set the tone for how the paramedic viewed the case, their approach, their thoughts and feelings, and clinical strategies. Using an approach reminiscent of case study, during the second interview paramedics were able to illustrate and describe the issues they faced. These issues ranged from the difficulty in assessing someone if they will not let you into their home, someone with associated drug and alcohol use, someone experiencing thought disturbance, to cases that challenged or reinforced their beliefs regarding psychiatric presentations.

During the time between the initial interview and the second interview paramedics had the opportunity to reflect on the case and raise further considerations during the second interview. This allowed diversity in meaning and interpretation to develop and prevented a fixed categorisation of the event or topic. The quieter

environment of the station, and on two occasions the paramedics' homes, created a more relaxed, private environment that allowed for the open discussion of pre-hospital culture and practice. The exploration of these wider issues was often left till the second interview for this reason.

The guide of questions (Appendix E) deliberately remained broad in scope and flexible to capture the emerging themes. The questions were adjusted to follow the paramedics' direction and focus. For example the questions developed regarding the initial interview became almost redundant when the paramedics were asked just to describe the case. Both interviews offered unique opportunities to explore ideas and phenomena in different and varied ways. Both generated a broad range of categories from which to consider the whole process of caring for an individual who presents with a mental illness in the pre-hospital setting. Two examples of this unique exploration were the ideas of legitimacy of their attendance and communication as treatment. These explorations at times challenged or built upon already existing ideas.

5.6 Documents in social research

Ethnography traditionally has emphasised face-to-face interactions, encounters and events to the exclusion of other key features of the social world (Hammersley & Atkinson 2007, p. 121). The social worlds we engage with generate and use specific written documentation. These documents have a particular purposes and context. They are sources which construct 'facts', 'records', 'diagnosis' or in the pre-hospital

field ‘preliminary diagnosis’, ‘decisions’, and ‘rules’ that are crucially involved in social activities (Prior 2003, pp. 3–6). Documents have an important part to play in what are literate and complex societies that rely on documents for communication and are a substantial feature in everyday work life.

According to Hammersley and Atkinson documents can provide information about the setting being studied or about their wider contexts, and particularly about key figures or processes. This information is sometimes unique to the documentation and is not necessarily available from other sources. Documents can be equally useful in providing important corroboration, or may challenge, information from interviews and observation (Hammersley & Atkinson 2007, p. 122).

> *Given the historical and intellectual roots of ethnographic work, one can often detect a romantic legacy that privileges the oral over the literate. It is easy (but wrong) to assume that the spoken account is more ‘authentic’ or more ‘spontaneous’ than the written.*
> (Hammersley & Atkinson 2007, p. 128)

This quotation from Hammersley and Atkinson is particularly relevant when they argue that ‘there is still, apparently, a tacit assumption that ethnographic research can appropriately represent contemporary social worlds as essentially oral cultures’ (2007, p. 129). They argue that ethnographic work around medical settings accounts have tended to be focused exclusively on the spoken interaction between health professionals or health professionals and their patients, with little attention given to the documents written and read throughout their daily routine.

Hammersley and Atkinson (2007, pp. 129–130) cite the work done by Pettinari (1988) to demonstrate the important role of 'writing' in a medical setting. Pettinari provides a detailed account of how surgeons communicate and write their reports regarding the operations they perform. He focuses on how, in particular, junior surgeons acquire the occupational skills and formula to writing a representative and 'competent' report.

Records are produced and used in accordance with organisational routines and depend on shared cultural understandings and assumptions to be intelligible (Hammersley & Atkinson 2007, p. 132). In medical documents, for example, a short hand of medical terminology is used that is assumed will be understood by others in the field. Hammersley and Atkinson (2007, p. 132) describe that records such as these construct what they term a 'documentary reality' or a story of professional action which by this very act grants them a certain standing or credence. Official records, because of the credence afforded to them by members, tend to be treated as objective, factual statements rather than as mere personal belief, opinion, or guesswork.

A comprehensive ethnographic account which includes reference to how organisational documents are read, interpreted and used in practice is particularly significant in the study of the pre-hospital setting. The transfer of information from pre-hospital to hospital staff involves a limited time frame for oral handover and a reliance on the written document. Essential information is carefully prioritised for

handover and often there is little time for expansion of that information and the written account is the only other means by which the patient presentation is communicated.

The paramedic ‘case card’ (Appendix K) is one such organisational document that is integral to their practice. The case card connects the pre-hospital and tertiary health care settings, by being the legal documentation of pre-hospital management of the patient which is often crucial to ongoing medical treatment. As in the case of surgeons, the case card, its production and use is an important piece in the jigsaw of understanding how paramedics approach and treat the patients under their care.

The de-identified section of the case card was obtained with the consent of the organisation and the participating paramedics. The purpose of including the case card in this ethnography was twofold. The case card provides the written evidence of the case, adding to the broad number of sources accessed to create a picture of paramedic practice in this field. It also provides the opportunity to compare how verbal and written accounts work together in the transfer of information from pre-hospital to further care, especially what is included or excluded from the written document.

In the pre-hospital setting, part of the clinical and arguably the social occupational training is around the process of ‘handover’, the transfer of information to other professionals, which includes other paramedics, the police and ED staff. It involves

the development of skills to write the ‘case card’, which provides specific information and is written following given criteria. The criteria cover the broad categories as seen in Table 5.1 below as a guide for paramedics:

Table 5.1 **Case card and GCS criteria**

<table>
<tr><td colspan="3">1) history or current event / complaint</td></tr>
<tr><td colspan="3">2) past history</td></tr>
<tr><td colspan="3">3) primary survey</td></tr>
<tr><td colspan="3">4) secondary survey</td></tr>
<tr><td colspan="3">5) level of consciousness scale (Glasgow Coma Score (GCS))</td></tr>
<tr><td rowspan="4">Eye Opening Response</td><td>Spontaneous--open with blinking at baseline</td><td>4 points</td></tr>
<tr><td>Opens to verbal command, speech, or shout</td><td>3 points</td></tr>
<tr><td>Opens to pain, not applied to face</td><td>2 points</td></tr>
<tr><td>None</td><td>1 point</td></tr>
<tr><td rowspan="5">Verbal Response</td><td>Oriented</td><td>5 points</td></tr>
<tr><td>Confused conversation, but able to answer questions</td><td>4 points</td></tr>
<tr><td>Inappropriate responses, words discernible</td><td>3 points</td></tr>
<tr><td>Incomprehensible speech</td><td>2 points</td></tr>
<tr><td>None</td><td>1 point</td></tr>
<tr><td rowspan="6">Motor Response</td><td>Obeys commands for movement</td><td>6 points</td></tr>
<tr><td>Purposeful movement to painful stimulus</td><td>5 points</td></tr>
<tr><td>Withdraws from pain</td><td>4 points</td></tr>
<tr><td>Abnormal (spastic) flexion, decorticate posture</td><td>3 points</td></tr>
<tr><td>Extensor (rigid) response, decerebrate posture</td><td>2 points</td></tr>
<tr><td>None</td><td>1 point</td></tr>
<tr><td colspan="3">Russ Rowlett and the University of North Carolina at Chapel Hill How Many? A Dictionary of Units of Measurement
http://www.unc.edu/~rowlett/units/scales/glasgow.htm</td></tr>
<tr><td colspan="3">6) medications</td></tr>
<tr><td colspan="3">7) vital signs (blood pressure, pulse, respirations, oxygen saturations)</td></tr>
<tr><td colspan="3">8) treatment provided</td></tr>
</table>

These categories also provide the basis for the document analysis and the reporting of information from the case card.

The role of documents as means of accountability and 'transparency' plays an important part in the way documents are produced, used and viewed. The case card when produced is influenced by the fact that the author, the paramedic, is aware that it can be held up in court as a legal document and the information contained in the document will be used by others. Therefore the way the document is written is again guided by given acceptable criteria, for example the description should be factual, objective, legible, and detailed enough to cover what was observed and measured and what action was taken. In pre-hospital work the writing of 'provisional diagnosis' or 'no official diagnosis' but chief complaint leaves the document as an open case, which requires further investigation and testing to reach a firm diagnosis.

Documents provide a rich and valuable source of information, data and analytic topics for the ethnographer. Documents raise important questions about how organisations are structured and how information is conveyed by asking such questions as (Hammersley & Atkinson 2007, p. 132): How are documents written and by whom? Who reads them and why? What is recorded and how is it structured? What is omitted? What does the writer take for granted? What does the reader need to know to make sense of the document? Where is the document

placed? These questions aid the ethnographer in portraying the systematic examination of each aspect of practice and life in the setting being researched.

5.7 Data analysis: ethnographic analysis

5.7.1 Analysis

Spradley (1980, p. 85) describes analysis in the following way:

> *Analysis of any kind involves a way of thinking. It refers to the systematic examination of something to determine its parts, the relationship among parts, and their relationship to the whole. Analysis is a search for patterns.*

He explains culture as patterns of behaviour, artefacts and knowledge that people have which is distinct from simply identifying and describing social situations. Spradley (1980, p. 86) refers to 'social situations' as the stream of activities and behaviours performed by people (actors) in a particular location and time in contrast to the patterns he defines as culture. Spradley (1980, p. 87) suggests that to move from mere observing and describing a social situation to discovering a 'cultural scene', you 'first have to discover the parts or elements of cultural meaning and then find out how they are organised'. The basic unit in every culture, the cultural domain, is the important starting point for classical ethnographic analysis.

5.7.2 Domain analysis

A cultural domain analysis can be used alongside thematic analysis or separately depending on the data collected. A cultural domain is a category of cultural

meaning that includes other smaller categories (Spradley 1980, p. 88). Grbich raises the notion of domains as structures that symbols, items, entities or ideas belong to. These are defined by the participants as having significance and importance. Within these structures there are meaningful links and relationships (Grbich 2007, p. 41).

The three elements of a domain are what Spradley (1980) describes as the *cover term* (the name of the domain or category), *included terms* (the name for all the subcategories within the domain), and *semantic relationship* (the relationship or linking together of categories). The semantic relationship functions on the general principle of inclusion. It defines the reason for the ideas or artefacts being placed inside that domain. Grbich (2007, p. 43) summarises Spradley's ideas regarding domain analysis the following way:

> *… according to Spradley (1980) the overall process of domain analysis involves initial data collection, the identification of the major domains of data which might include the structure and rituals which serve to support maintain and provide uniqueness to the particular culture under study, further data collection to elicit more details or to clarify the types/parts of these domains.*

The data gained in this research was analysed by identifying common practices, beliefs, rationale and strategies in the form of emerging themes that describe paramedic work. The analysis searched for the general patterns of behaviour, management and features that form the basis of paramedic practice when attending psychiatric presentations. The analysis of the field notes, interview

transcripts, and the 'case card' began with reading the data through twice to gain an impression of the day's activities and interactions, the case description, and key features in the documentation. The data was then coded for common cultural domains. Initially ten key cultural domains were identified that were then refined into nine. The nine cultural domains (major themes) focussed on key interactions and activities such as the dispatch, approach, assessment, assumptions, provision of care (treatment), communication and strategies to transport, and handover of care. Each section of the findings follows the key cultural domains identified in the initial data analysis.

5.7.3 Taxonomic analysis and coding: Interviews and observations

The next step in analysis is developing taxonomies within a cultural domain. The taxonomy (the groupings, subsets and hierarchies) shows the relationships among the ideas, objects and subjects (all *included terms*) within a domain. Taxonomy reveals subsets and the way they relate to the whole (Spradley 1980, p. 113).

Open coding involves sectioning and analysing the data from observation and or interviews word by word or sentence by sentence, by phrase or paragraph. The process of coding makes the data manageable for interpretation. It involves taking the data and placing a code or index which denotes a particular concept, theme or topic against the paragraph, sentence or extract from the transcription. The reading and re-reading of the text allows the analyst to initially identify and code the text into sections, which in the interpretive phase can be rechecked and relationships

can be established between the different sections. Open coding can facilitate the building of categories from data (de Laine 1997, p. 243).

After the cultural domains were initially identified within the field note, interview transcripts, and 'case card' open coding was then used sentence by sentence and subthemes were identified. The subthemes focussed on the relationships and the components which constituted the major themes, such as the legitimacy of the need for ambulance care (assessment and assumptions) and the difference between the information received through dispatch and what was actually attended to at the scene (dispatch). There were seventy codes initially that were then refined into the twenty four subthemes plus those specific for the document analysis described through the following findings chapters. The codes were organised into categories and relationships using spread sheets and Nivo 9 software.

Axial coding provides a systematic means to organise material in new ways, examining how the dimensions and components identified in open coding relate and interact with each other and affect other relations, such as culture, motives, actions, interactions, strategies and outcomes (de Laine 1997, p. 246). Axial coding aids the development of concepts and builds links between these and culture. The data from observation is pulled apart to be reassembled in new ways to make connections between categories (de Laine 1997; Grbich 2007).

From the themes and subthemes using axial coding the field notes, interview transcripts and the 'case cards' were again read to code for the relationship between these to an overarching concept of role and role identity. The overarching theme describes paramedic practice in this specific area and identifies areas for future education and policy development.

Themes were regularly checked with participants during observation and during the second interview with participants. Initial analysis of the observation data and the first two to three short interviews provided the developing broader themes and subthemes which were continually added to and refined as the data was analysed throughout the collection period. These were raised with paramedics 'on the ramp' during informal conversations and then in the second longer interview with paramedics. After the short interview with paramedics the data gain was analysed so that it could be discussed and expanded on during the second interview. The specific details regarding the cases precented and the actions associated were further explored and confirmed by the paramedics during the second interviews

5.8 Conclusion

The use of ethnographic methods unpins the data collection for this study and links the data to the social and cultural actions that paramedics utilise in their everyday work when dealing with people with a mental illness. The use of interviews, observations and documents organises the data into a format that provides an audit trail and structure for the findings and discussion chapters that follow.

Chapter 6

Findings part 1:
Dispatch, arrival and the approach

6.0 Introduction

Guided by symbolic interactionist framework the initial interview with paramedics began with the simple imperative 'tell me about the case' The open nature of the interviews created a narrative for paramedics involved in the study to tell their story regarding the psychiatric case they had attended. The following quotation from Atkinson (1991) succinctly illustrates the social and contextual nature of writing ethnographic findings. The process of ethnographic writing is not done in isolation as a separate endeavour but is instead wholly connected to the environment and the people involved.

> *the anthropological or sociological "findings" are inscribed in the way we write about things; they are not detached from the presentation of observations, reflections, and interpretations.* (Atkinson 1991, p. 164)

The case based, almost handover like manner in which paramedics narrated their actions lent itself to be written like a case history. The case history illustrates their actions, reveals the meanings associated with those actions and places their stories in the context of their everyday work. The case history like narrative provided the framework (the cultural domains) in a linear thematic analysis which follows the paramedics through dispatch, their arrival at the scene, their first impressions, their

approach, their assessment with its many components and influences, and finally to the handover and document analysis.

The ‘case history’ is separated in to three parts. Part 1, chapter 6, covers the dispatch, on arrival and the approach. The dispatch, on arrival and first impressions sets the scene for the paramedic. The process of dispatch establishes the rationale for their attendance and supplies the first details of the case with further information, understandings and impressions of the case ‘on arrival’. The approach explores issues such as maintaining a professional approach to the patient, how they communicate with the patient and the need to be aware of and adaptable to changing patient status and environments.

Part 2, Chapters 7 and 8; explore the strategies, actions, meaning and assessment once the paramedic is at the scene and with the patient. This section deals with what paramedics see and hear, how they obtain information from the scene and the patient, and the personal, professional, social and organisational factors which shape their assessment and practice.

Part 3, Chapters 9 and 10, concludes the ethnographic findings with an account of the handover process from the paramedics to the triage staff and the case card analysis. The handover and case card analysis offer insight into how the transition process and the emergency department environment create barriers in the handover of care. Figure 6.1 summarises the major themes in the findings.

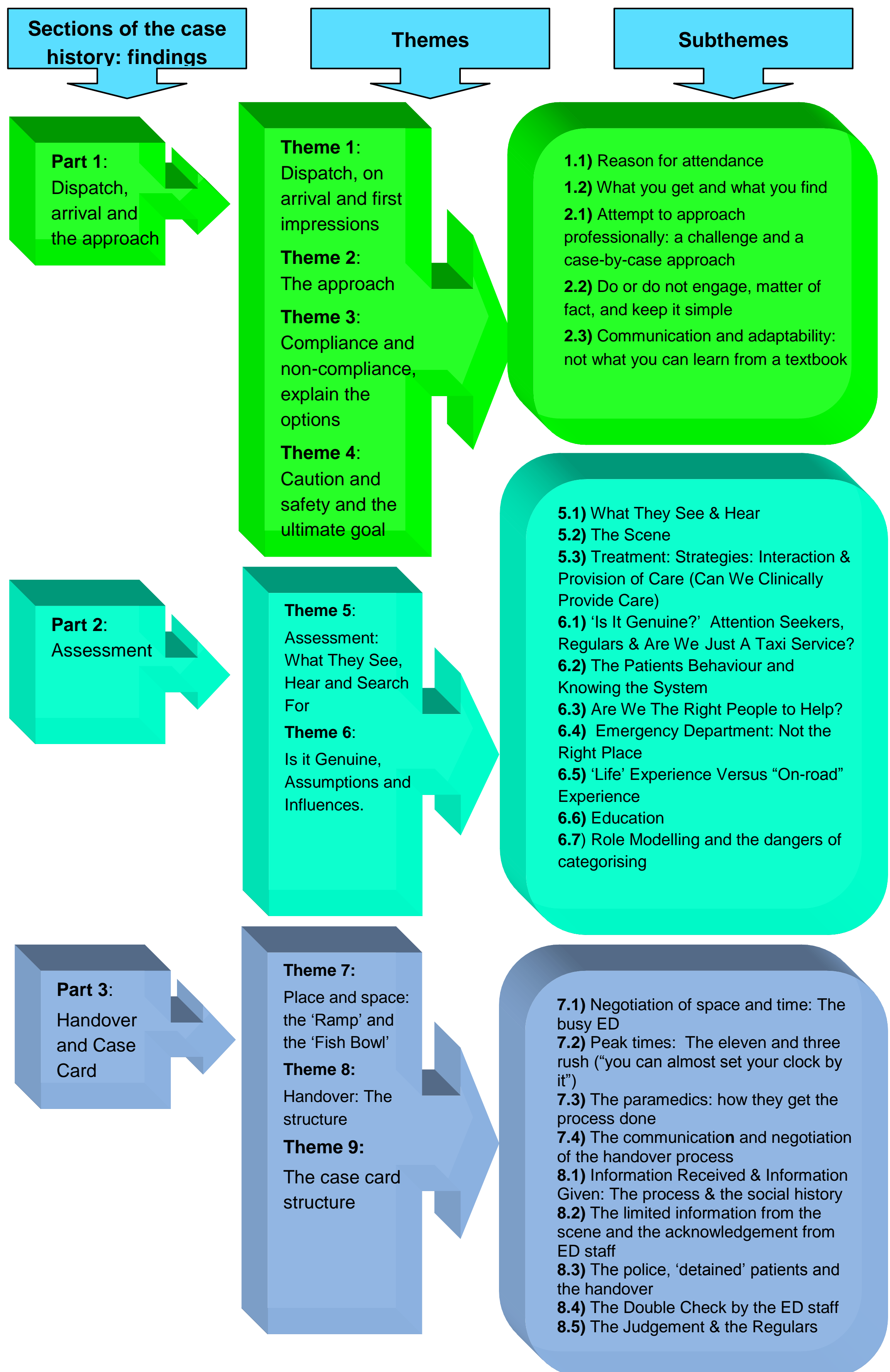


Figure 6.1 Summary of the major themes and subthemes from the findings

6.1 Theme 1: Dispatch, on arrival and first impressions

The case history begins at the point of dispatch which logically develops as the starting point for the thematic analysis of the interviews and observation data. This theme was derived from the paramedics' description of the reason for dispatch, their attendance and their first impressions upon arrival.

The information the paramedics receive from the Emergency Operations Centre (EOC) or colloquially called 'Communications Centre' (COMMs)[4] regarding the urgency of the dispatch and the nature of the presentation sets the scene for the paramedics. This initial information operationally forms the rationale behind ambulance attendance and dictates the urgency of the response and how the paramedics are dispatched. Culturally, the nature of the call system and how priorities are allocated defines the paramedic role as emergency provision of care and how paramedics operate within that role. The information from dispatch gives the paramedics a framework for what they are attending. The dispatch information gives the paramedic a sense of whether it will be a 'run of the mill job', one of their

4. 'SAAS's Emergency Operations Centre (EOC) has a vital role to play in the health system as it is often the first point of contact patients have with not only the ambulance service, but the South Australian health system.
The EOC receives all triple zero (000) calls for emergency ambulance assistance in South Australia. This equates to hundreds of triple zero (000) calls every single day. Highly trained staff in the EOC also handle and organise all transport requests received by SAAS including emergency, urgent and routine journeys (whether received by telephone, fax or electronic means), coordinate the use of ambulance resources across the state and manage rescue operations in collaboration with health and emergency service colleagues.
The EOC also houses SA Health's Assessment and Crisis Intervention Service (ACIS), in which mental health staff provide specialised triage of patients with a mental illness.' (SA Ambulance Service Annual Report 2009–10)

‘regulars’ or one that may require more resources, such as when they are dealing with a patient exhibiting disturbed behaviour or a history of aggressive and violent behaviour. These cases may require the assistance of the police to physical restrain or transport the individual safely to further care.

The other significant aspect of this theme is the discrepancy between what paramedics are told they are dispatched to and what they actually attend. This difference in ‘what you get told and what you find’, although common in emergency settings and in the community health settings in general, fosters a sense of uncertainty and creates a situation where paramedics are continually reviewing information as they receive it, making decisions ‘on the run’, adjusting to the changing nature of the patients they attend, and to the physical environment they work in.

6.1.1 Reason for attendance

The reason for attendance was prefaced with the phrases such as ‘we were dispatched to’, ‘we were called to’ or ‘we attended’ preceded by the age and gender of the patient and then the major reason for attendance. These phrases give shape to the case: they indicate the major features of the presentation, and the priority given to the attendance. Tracy’s account is a typical example of the rationale for attendance including the category of dispatch. In the operational world of paramedics and others in the emergency field this brief information conveys the urgency of the case and portrays an immediate sense of the situation attended.

Tracy
Case 5:
Initial interview

We were called, category B to a 41 year old male with a history of psych who has allegedly overdosed on 48 Panadol and alcohol, called his social worker and she'd called us as a third party.

Each priority category has key performance indicators that are associated with the response times expected within the ambulance service. These are outlined in Table 6.1 and were set in 2008–09 by SAAS and SA Health (the South Australian Health Department). Category A, being the highest level priority allocated within the Medical Priority Dispatch System (MPDS), indicates a 'lights and sirens' response to emergency (life threatening) cases. Category B, the second level, is categorised as a prompt response to potentially life-threatening cases, and Category C is for urgent but non life-threatening cases. These categories can be upgraded or downgraded depending on what is found at the scene and the patient needs.

Table 6.1 **Overview of dispatch categories and expected response times**

Category A	Ambulance intervention to 50 per cent of emergency (life-threatening) cases within 8 minutes (Australian Bureau of Statistics (ABS) urban centres)
Category A	Ambulance transport capability on scene within 18 minutes for 90 per cent of emergency (life-threatening) cases (ABS urban centres)
Category B	Ambulance transport response on scene within 18 minutes for 90 per cent of potentially life-threatening cases (ABS urban centres)
Category C	Ambulance transport capability on scene within 60 minutes for 90 per cent of urgent cases (ABS urban centres)

Source: SA Ambulance Service Annual Report 2008–2009 (Government of South Australia; SA Health and SA Ambulance Service, June 2010) p. 20[5]

5. Australian Bureau of Statistics (ABS) defines urban centres as locations with a population cluster of 1000 or more people. A 'Bounded Locality' is generally defined as a population cluster of between 200 and 999 people. People living in Urban Centres are classified as urban for statistical purposes while those in 'Bounded Localities' are classified as rural (i.e. non-urban).

Len, within a few sentences, paints a comprehensive picture of the scene on arrival and the patient presentation. This brief and to the point overview is indicative of how paramedics and others in the emergency field prioritise and encapsulate information to be relayed to others.

Len
Case 10:
Initial interview

We were given the job as a 32 year old male; collapsed, unresponsive, suspected poly pharmacy overdose query alcohol, arrived at scene was directed by a friend at scene to a patient collapsed in the back yard

Where the case involves more than a straight forward explanation of the reason for attendance the paramedics include a brief background of the patient's history. Robert and Jessica, Case 7 and 8 respectively, demonstrate how paramedics incorporate this brief history and their initial perceptions of the presentation when the reason for attendance did not appear to be the whole story.

Robert
Case 7:
Initial interview

We were called to a 42 year old with acute onset of abdo pain. And on arrival at the address we've got a 42 year old female who was quite distressed and upset, describing lower abdominal pain, and after talking to her for a while and getting a bit of a medical history and her medication, she had bipolar – suffers from bipolar – and was on olanzapine for that. She takes wafers each night. But I sort of picked up that she had quite a lot of anxiety, so, obviously, she had other issues going on. And then, even questioning her about the lower abdo pain, about being pregnant, and she seemed to have fairly low self esteem as well. … So, I knew I sort of had two issues really, she's got her lower abdo pain, and then, I asked her if she'd like a review of her psychiatric condition and she said yes …

Jessica
Case 8:
Initial interview

We were dispatched to a female patient who when we got there said she was worried about becoming suicidal and that her schizoaffective disorder symptoms of anxiety and depression were increasing and she wanted us to take her hospital because of that and on further questioning it's actually the lice infestation she has, that's increasing her anxiety and making her not get enough sleep.

Nathan and Samantha succinctly overview the realities of what paramedics find at the scene. The detail regarding the patient's position, mobility and apparent willingness to be transported is significant in this early stage as indicative of the patient's physical status and their frame of mind. The observation made by Samantha of the patient's conscious decision to access further care gives the impression the case would turn out to be straightforward.

Nathan
Case 13:
Initial interview

We got called by the police for a 45 year old gentleman that had rung his doctor saying that he was and some other friends of his, saying his goodbyes and threatening self-harm. We arrived at his house and the police gained entry and found the gentleman in his bedroom and had taken some benzo tablets as means of self-harm.

Samantha
Case 14:
Initial interview

Attended to a 50 year old female patient, we got the job as an End[6]ep overdose. When we arrived she actually walked out to the ambulance and met us, had her bags packed so she was already organised and thinking and knew that she was going to the hospital.

---

[6] Endep – Amitriptyline (Tricyclic antidepressant-TCAs) inhibits the reuptake of noradrenaline and serotonin in presynaptic terminals. TCAs also block cholinergic, histaminergic, $alpha_1$ – adrenergic and serotonergic receptors increasing the availability of noradrenaline and serotonin. Source Bryant, B, Bryant, BJ, Knights, KM, Salerno, E, & Knights, K 2010, *Pharmacology for health professionals*, Mosby. p. 354-362

The final piece in this brief overview of the case was the mention of other services and the paramedics' impressions of those at the scene. The mention of other services, such as the police and ACIS (Assessment & Crisis Intervention Service—the community mental health teams) by paramedics' in their initial statements indicates the need for resources at the scene and gives a broad impression of who took on which roles at the scene. Troy, in particular gives a clear indication of where the paramedics situated themselves in terms of their role. In this case it was evident that the paramedics felt that their role was purely transportation.

Troy
Case 9:
Initial interview

We've been called to a case where ACIS and SAPOL have gone to the scene, they have detained a patient in her 60s for increased aggression with a history of paranoid schizophrenia and they need her to be transported to [name of hospital] *so they've called us.*

Comments that portray the paramedics' impressions of others hinted at the underlying tensions in meeting the requirements of their job and getting adequate information from others. Adam felt the staff at the community care facility were having ongoing issues with this particular individual and appeared keen to transfer his care to them. Sonya identified the waiting game which accompanies their work when trying to coordinate with other services like ACIS.

Adam
Case 12:
Initial interview

… arm lacerations at [name of place] *supportive care which I believe is a psych place and got there, it's just a bloke who's had a hallucination today, which told him to cut his arms so he's done that with a razor blade and I think there's been some ongoing issues, 'cause the staff were pretty keen to get rid of him ...*

Sonya
Case 16:
Initial interview

Half an hour later when Southern Mental Health turned up we were told it's for a 43 year old lady who is schizophrenic, hadn't been on her meds since September, which was fine, she was coping well but in the last two weeks she'd been back on methamphetamines so she was getting paranoid, delusional, off the rails.

These comments, in addition to the brief overview of the case, provide insight into the condensed story paramedics use to initially capture the information within a case. The brief overview also provides a glimpse into the relationships that paramedics have with others when performing their role. Difficulty in obtaining accurate information from the dispatch and the discrepancy between 'what you get told and what you find' forces paramedics to base their actions on the immediacy of what they find. The limited opportunity to prepare before entering a scene affects how paramedics initially respond to the environment and the patient and promotes a cautious approach.

6.1.2 Certainty vs. uncertainty: what you get told and what you find

'What you get told and what you find', explores the limited information paramedics receive through the dispatch system in comparison to what they find at the scene. Paramedics reason that the call takers within the EOC are not often privy to a complete, coherent or detailed picture of the situation from the caller. The caller can be a third party (e.g. a doctor's surgery, a friend, the public) and not necessarily someone who may know the patient intimately. The programme used by the call takers follows a structured format which assists in the allocation of the priority for dispatch, but potentially limits the information call takers can obtain to relay to the

paramedics. Don and Abigail particularly emphasised the vagueness of the information paramedics receive from dispatch. As a consequence they felt they acknowledged the information but were selective in what they took on board.

Don
Case 1:
2nd interview

Sometimes the information is vague and if the description we get over the radio is lodged at the time is quite limited, information I get over the radio I tend to take on board, but I don't – I try not to take – make any concrete decisions or ideas until I've actually talked to the patient and got an in-depth description of what's happening from the patient. COMMs description is good and it's good to think about it on the way to the job and how you're going to approach however I don't take it as gospel.

Abigail
Case 15:
2nd interview

You get the job and you think most of the time it's not what you're going to be going to anyway because the whole call system doesn't work very well in my opinion, not very accurate, so you sort of take a little bit just so you know what to take in but don't go in there knowing you're sure you've got a chest pain and it might be something else.

The resulting lack of information creates a situation where paramedics' on-road are often attending scenes with no background information. This led to uncertainty in regarding to how sick the patient actually is, how the patient will respond to their presence, whether the patient is currently being treated or knows the paramedics have been contacted, and what they will ultimately find at the scene. These factors influenced the paramedics approach, how they proceeded with identifying the major presenting problem and whether they saw themselves as providing treatment. Joyce suggested that ultimately paramedics reserved judgement until they have seen the patient. More importantly paramedics made the point that

attending a scene with limited information is typical and they have become accustomed to this uncertainty and plan accordingly.

Joyce
Case 2:
2nd interview

[Is it hard to put that aside sometimes, to say I'm just going to assess this person as I see them regardless of what sort of prior information you might have?]

No – we are pretty use[d] to it because a lot of the information we get isn't accurate, so a lot of the time we do go in without, we sort of – …we put that at the back our head walk in and go oh you've got chest pain okay great, alright – so I think we're used to it, …

Even though the dispatch information and the system itself is limited the paramedics suggested there is still an overriding duty of care and they 'go in' even though there may be a caution or previous history relating to aggression or violence.

Joyce
Case 2:
2nd interview

If there is a caution there then we will listen to that, perhaps they have been aggressive or something, but we still – it doesn't stop us from going in.

The support of the police (SAPOL) in these unknown situations, depending on the dispatch information and the circumstances, may be required and can be sent in conjunction with the ambulance service. The prompt dispatch of support was vital to reduce the incidence of paramedics attending alone scenes which could be threatening and dangerous. The police were dispatched if there was a direct threat to the public, intended self-harm or a potential for violence or a history of violence. In circumstances where the police have been the first in attendance they may request the paramedics to assist with the medical care of the individual. SAAS and

SAPOL often provided backup to the mental health teams when transport of an individual under the mental health act is required.

Tracy Case 5: Initial interview	*Well this patient has a history of violence and he's already pre-known to SAAS so SAPOL are already despatched immediately to his address due to his history of violence.*
Sonya Case 16: Initial interview	*We were called, we didn't get a lot of information, we got the job of a forty-three year old lady, we were to meet up with SAPOL and Southern Mental Health for some sort of mental health issue, the patient to be detained by Southern Mental Health.*

The dispatch and the first impressions were the first moments of contact and interaction between the paramedic and the patient and formed the basis for their approach. Theme two explores the components that make up the paramedic approach to a scene and a psychiatric presentation.

6.2 Theme 2: The approach

'The approach', the second theme in the narrative, although technically still a part of the paramedics overall assessment, emerged as a separate themes. This theme explored how paramedics regarded their conduct with the patient and the environment rather than their clinical actions.

Paramedics described their approach to psychiatric cases as a case-by-case evaluation of the situation. They described their attempts to keep the approach professional and consistent. Paramedics acknowledged their attempts to maintain a

professional demeanour could be tested by circumstance and patient behaviour. The successful or otherwise maintenance of professional conduct was dependent on both the manner adopted by the paramedic and the nature of the patient presentation. The paramedics experienced a dilemma between choosing whether to engage with the patient or to keep the interaction as matter of fact and as simple as possible. The 'keeping it simple' approach in essence meant finding the most efficient way of getting the patient to further care, which they considered the ultimate goal. In the process of getting the patient to further care in the most timely and efficient manner possible, the 'load and go' philosophy was viewed as a functional and strategic option to meet the desired outcome.

6.2.1 Attempt to approach professionally: a challenge and a case-by-case approach

Paramedics approach all cases with the Australian Resuscitation Council (2011) guidelines as a foundation. The structured process of checking for danger, the patient's airway, breathing and circulation form the basis of what they consider their primary role in attending life threatening situations[7]. Paramedic education and operational protocols reinforce these guides and are essential for the performance of this vital part of their role. This primary role of managing life threatening medical emergencies is central to what paramedics do, but when dealing with cases such as psychiatric presentations where the patient passes the primary survey these skills

7. The resuscitation guides were developed through the International Liaison Committee on Resuscitation (ILCOR) which is made up of eight worldwide resuscitation committees which bring together and evaluate current emergency care research.

are often secondary to skills that focus on communication, de-escalation techniques and being able to address a patient's emotional and mental needs in the pre-hospital setting.

Conduct the basics first: primary survey and risk assessment

Don and Robert both mentioned the need to conduct a basic risk assessment as essential whenever approaching a situation. Don used a joking, laughing, offhand manner and black humour when he discussed 'the patient wielding a rifle' as an extreme example and commentary on the serious issue of safety of themselves and others in the situations that they attend.

Don
Case 1:
2nd interview

First of all obviously the first thing we do is to check for dangers to ourselves and others, so obviously if I can see a patient wielding a rifle then I can immediately assume that's an immediate risk and that I should get out of the situation.

Robert
Case 7:
Initial interview

As a paramedic in an emergency setting, we're looking at life threatening things first, and then, once you know that there's nothing that's going to sort of endanger your patient, then all the other things are nice to have knowledge, you know, …

There was a distinct separation between what paramedic consider 'need to know' and what was 'nice to know' information to perform their job. The following section, Part 2, explores the subjects of paramedic assessment, treatment, and education and how they fit into the actions of the paramedics.

The automatic nature of the approach

The approach was described as an automatic process that paramedics rarely analyse, but with experience they develop a sense of a situation, a ‘feeling’, and ‘on-road’ knowledge. The development of tacit knowledge coupled with adopting strategies which work for the paramedic and the patient acted as the foundation for their approach to psychiatric presentations.

Len Case 10: 2nd interview	*And you don't really think about it, you don't analyse your approach to the patient it’s just; you change your approach according to what's working and what's not working.*
Andrew Case 11: 2nd interview	*Well you do all that automatically anyway* [check for danger, checking the scene and approach only if safe to do so]. *You sort of do it without realising you’re doing it because sometimes you just go well something’s not right here and we’ve not gone in yet, but yeah if the job has been given a psych patient with knife or something you know I’m not even going to go inside, or if someone else is with the patient yeah you’re going to check if they’ve had sharps removed from them or are they aware we’re coming, you know are they’re happy to see us.*

Andrew offered a glimpse into how paramedics use situational cues when arriving at a scene to evaluate what is occurring in the environment and with the patient. Situational awareness is not exclusive to psychiatric cases, can trigger for the paramedic feelings that something is not quite right, and plays an important role in assessing an unknown situation. Consistently paramedics stated they did not perceive their approach to psychiatric cases as different from other cases. Statements such as ‘you still do all the same things you do at a normal job’ and ‘we

do the usual routine' from Emma and Andrew were typical examples of the routine nature of their approach.

Andrew
Case 11:
2nd interview

Yeah, I mean you still do all the same things you do at a normal job you know but if you get, you know, your sixth sense tells you that something's wrong like you rock up and all the lights are off in the house, at a scene you're supposed to be going to or there's people there that shouldn't, don't need to be there or, do so you do all that stuff.

Emma
Case 3:
Initial interview

We do the usual routine – just say look come into my office and we'll come and sit down and once you've usually got them by themselves which is something I try and do you could've said look what's been happening and what's been going on,…

Although the approach to psychiatric presentations follows the same structure as any other patient, the use of the term 'normal job' suggests psychiatric cases are viewed as 'other' cases, outside the usual and are separate to what is considered the norm[8].

Defining the professional approach and the effect on patient outcome

After portraying how they perform their initial primary survey, paramedics identified what they considered to be a professional approach to their patients. The paramedics interviewed depicted their varied attempts to treat the patient in an

---

8. The *SA Ambulance service annual report 2009–2010* states neurological 8.8 percent, total medical and general 24.5 percent, and overdose 2.6 percent incident types across the state resulting in patients transported (although it is not clear what the percentage of psychiatric presentations is within these), *Queensland ambulance audit report* (2007) states an increase in psychiatric related attendances particularly in category 2 dispatches (refer to page). The annual reports for Victoria and Western Australia (2010–2011) do not specifically detail the ambulance response to psychiatric presentations.

unbiased, non-judgemental, consistent and case-by-case manner which they saw as essential to professional behaviour.

Andrew Case 11: 2nd interview	*Yeah, I mean I can still approach, as I say every job the same, like I think I'm known for not exuding enthusiasm so I just use the same sort of approach to anyone 'G'day mate, what's your name, what's going on?'*
Don Case 1: 2nd interview	*I try – personally try to maintain an unbiased view, a independent view, an impartial view, so that I can look upon a patient without preconceived ideas, judgements, prejudice, all that kind of stuff.*
Abigail Case 15: 2nd interview	*I mean I don't feel like I make my mind up based on what anyone else has said to me before I make my own assessment anyway.*

The perceived need to remain 'unbiased' and maintain a detached manner suggests that there is a consciousness about how paramedics approach psychiatric presentations. This may be due to past personal experience, the awareness of the stigma and discrimination surrounding mental illness or 'on-road' experience which embeds the sense of uniqueness and difference that separates psychiatric presentations.

The paramedics, with wry humour and a sense of frustration, told stories of when they were not successful in maintaining that unbiased and professional demeanour. Don identified the feeling of being threatened as a major reason for changing his approach to maintain personal and patient safety. This awareness of potential threatening behaviour echoed throughout the other interviews with safety seen as a priority when dealing with psychiatric presentations. Don stressed he tries to be

consistent in his approach to all patients including mentally ill patients. He reflected that his approach was based more on constructive, positive actions rather than presentation type. The distinct use of the term 'mental health' by this paramedic instead of 'psych patient' was significant in the way he discussed and talked about patients as people and not just a case.

Don
Case 1:
2nd interview

It can, if I'm feeling threatened it definitely does, but I try and – I try to not change my approach to mental health patients, maybe I do, maybe I don't, but I try and – I try, I guess make the patient feel comfortable, that I'm no threat, that I'm merely trying to offer assistance, there's definitely different ways you can approach the patient.

The paramedics' demeanour, their behaviour and attitude during the interaction with the individual was viewed as significant, playing an important part in the approach to the patient and patient outcomes.

Don
Case 1:
2nd interview

I've seen a lot of different ways that [you can approach a patient] – you definitely want to think about how you're approaching the patient and your behaviour, 'cause I think the outcomes can be very different according to how you approach them.

Joyce
Case 2:
2nd interview

A lot of it probably has to do with the persons that you're with that's attending, because we have some people who just don't like it, some people sometimes treat them badly, you might be really driven with mental health patients, so a lot of things depends on the person.

The paramedic's own view of patients with mental illness, whether they have a basic dislike of these individuals, the paramedic's 'driven' nature, or just wanting to get the job done, as Joyce described could result in 'bad' treatment and poor

outcomes for the patient. These observations reinforce the idea that commonly held beliefs leading to stigma and discrimination of the mentally ill, such as dangerousness, the individual's own willingness to do something about their problems, and that they are not really in a crisis, still exist as part of paramedic culture.

The casual, non-authoritarian, non-threatening approach and when to change

The casual as opposed to an 'authoritarian' style approach was one strategy adopted with generally successful results. Robert believed the use of non-derogatory communication directly related to more positive outcomes for the patient.

Robert Case 7: 2nd interview	*Obviously, you're not, like coming storming into their house and being the big authority or anything, so, I take a pretty casual approach and treat them – don't speak to them in a derogatory manner, just talk to them more as a friend.*

Psychiatric cases, Robert maintained, require an approach that is non-threatening with a gentle tone of voice and open body language. A clear explanation to the patient regarding what is happening and the steps being taken to help them by the paramedic, Robert believed, aids in alleviating distress and calms the individual. An honest, open approach assists the patient to understand their rights and responsibilities, clearly establishes the paramedics' duty of care, and the parameters paramedics operate under. Protecting the person, getting the patient to

further care and upholding their duty of care while not getting involved in what Robert described as ‘the games’ were at the forefront of their actions.

Robert Case 7: 2nd interview	*in a non-threatening manner, quiet voice, don't get caught up in their game, like I don't play their game, I'll keep my tone fairly flat, and don't lie to them – don't try to trick them into anything – tell them exactly what's going on, so they understand what my rights are and what their rights are, especially if it's someone doing self- harm or something. Obviously, we've got to protect them from themselves, or if they're a danger to other people.*

The expression ‘don’t get caught up in their game, like I don’t play their game’ hints at stigmatising the individual with mental illness by creating the impression that they have only called the ambulance service to play games; they are manipulative. In some cases the paramedics felt they were being used as a social service, a way for the individual to get attention. Paramedics considered the response from the patient was often negative and abusive if they suggested that the ED might not be the best place for the person, as this could be understood by the patient as not meeting their needs and leading to feelings in both parties of being manipulated.

Andrew clearly felt that the experience he had gained over time changed the way he modified his approach, especially with individuals viewed as ‘regulars’ or those seeming to present with confrontational behaviour. He felt that with experience he learnt to adjust, managing his own feelings of anger and frustration, and become generic almost in the approach as a means of coping.

Andrew
Case 11:
2nd interview

But yeah, do I approach it differently; no I'd say I guess with a bit of experience initially like perhaps early on in the piece you're more likely to get angry at these people, but you find that these people love that, like that's what they want, they want confrontation. We had one in particular, real super regular like three or four times a day, at [name of place] when I first started, and you just can't, it was that confrontation they want, so yeah, so probably you know a few years later now I'd approach the same job as any other job, 'G'day mate, what's your name?' whatever they're saying, 'What's your name? Okay, what's going on?' 'Okay, do you want to go hospital, yes or no?' and don't engage them, and I guess I've changed a bit that way.

Paramedics own demeanour and the patient response

Len emphasised not only do paramedics need to be aware of their own demeanour but they need to be adaptable in their approach according to the response that they receive from the patient. A more direct and forceful approach by the paramedic may be required to meet the main objective of getting the patient safely to appropriate care. The idea of 'compliance' and the ease to which that objective was obtained became central to this interaction.

Len
Case 10:
2nd interview

Yes, I mean it very much depends on the type of patient, yes. I mean some patients, you get down to their level and empathic and reassure them and that's enough to reassure them and they become compliant and they'll come along to the hospital with you. Others require, you pick up that they might require a more forceful approach 'Well come on, we need to go to hospital, this is what we're going to do'. I'm not forcing them but I'm just being a little more – clear and concise, that this is what needs to happen and this is what we're going to do, yes.

Paramedics acknowledged they have witnessed or taken an approach that has not worked or is more forceful than may have been required. Preconceptions of mental

illness and the individual's behaviour appear to underlie the more forceful approach with the connotations that this person is 'crazy'. This was clearly recognised as an attitude which still exists, but not considered an effective means of helping the person.

Don Case 1: 2nd interview	*I've seen some people go in and with a quite bolshy attitude and demand answers and automatically have preconceived ideas that the patient's crazy and that the paramedic knows best and all this kind of stuff and I don't really think it's probably – I don't think that's the best way to approach these cases, I think it's important to take it easy and approach the patient like you would anyone else.*

Len Case 10: 2nd interview	*I guess you've been on jobs where perhaps it's been a little bit rushed for the person and you could see it was causing them to become a little bit agitated. As you said before, you know you go in 'Come on let's go' type thing which doesn't always work.*

A rationale provided by the paramedics for the more forceful approach was the nature of the self-harm. They took into account the urgency of the overdose or haemorrhage from lacerations, and how time critical it appeared for further care.

Len Case 10: 2nd interview	*I guess it depends on the time critical nature of the case too. You know, sometimes the bull at a gate can be a reflection of, you know the patients taken 100 different medications or have injured themselves in such a way and they're a bit more time critical and you need to get them to hospital and you haven't got time to sit there and put all the icing on the cake.*

Patient awareness of illness and familiarity with the patient

The paramedic's familiarity with the individual and the individual's awareness of their illness, two prominent issues, played a significant role in the paramedic's

approach. How successfully the paramedic could communicate with the patient depended on whether a coherent story could be obtained. This was instrumental to the paramedic's clinical decisions regarding the best way to manage the person. The presence of hallucinations and delusions in the patient in particular, created a situation where the paramedics had few options and the decision for safe transport was generally easily made. Distraction and as Len (Case 10) aptly describes 'getting a feeling of what is going on in their head' were practical steps paramedics took to understand the patient and how to manage their altered behaviour. The paramedics cite numerous examples of altered behaviour and changes in insight that they had witnessed during their dealings with patients. Examples ranged from a woman who had a great understanding of her depression and would seek help to others who did not comprehend what was going on around them and were experiencing significant delusions. One such example which Rose described was an older lady who believed 'The Queen' (referring to the Queen of England) was controlling her life through the television.

Len
Case 10:
2nd interview

I mean it depends how deep they are into their hallucinations and delusions and need to get the feeling for what's going on in their head as to whether you're going to be able to communicate with them and reason with them, what sort of insight they have. And it really depends, if they have some insight and some grasp of reality then I guess I'm just finding out what's been going on. Distraction, I find works really well.

Emma
Case 3:
Initial interview

She's got quite a good awareness of her illness – her depressive illness so when she feels herself losing control she will make attempts to go and see doctors or to do something before she actually gets to that point where she does sort of act out.

Abigail
Case 15:
2nd interview

The other girl we'd explain to her this, this and this and she just wouldn't hear it at all, she wasn't rational, she wasn't understanding at all.

Familiarity with the patient and their environment enabled the paramedics to approach the scene with some prior knowledge. Tracy, for example, spoke about the patient she had just handed over who happened to be well known to her and who she had cared for on a number of occasions. She describes being very familiar with the individual's house, previous presentations and the nature of his two large malamute dogs. In normal circumstances the crew would not have been as confident entering the house, as they would not have had the prior knowledge of the patient and the initial rapport.

Tracy
Case 5:
Initial interview

[Patient known to the paramedic and the paramedic has attended to the individual on several occasions previously]

Patient was barricading himself inside the house with his two dogs.

[So how did they actually get him out eventually?]

Because he trusts us, I asked if I could come back inside the house, got the patient into hallway and shut the dogs in the lounge room, so that SAPOL could enter.

Although the person may be well known to them, Tracy stressed there was still a need to approach each situation as a new event as the patient's presentation and needs may have changed. Others reinforced this sentiment, but there was concern

regarding the risk paramedics take if they do leave a patient at home and there is a resultant adverse outcome. As a result they tend to err on the side of caution.

> *patient is stating the same ideations, and would be safe if left and follow up with appropriate services was arranged, but there is that risk that if something has changed and you have missed something and the resultant bad outcome.* (Field notes, 20 January 2010)

After considering the safety and the professionalism of the approach the major topics of discussion became concepts of engagement with the patient and how communication is an adaptable tool, generally learned through 'on road' experience.

6.2.2 Do or do not engage, matter of fact and keep it simple

This subtheme was characterised by two major ideas the first being the imperative to try and minimise actions that would exacerbate the situation, cause the patient more distress and increase the patient's agitation. The second being the degree to which the paramedic felt they could and should engage the patient.

Actions that do not antagonise and keeping it simple

The nature of the presentation, the small space within the ambulance, and the community space that paramedics occupy all affect how they approach the patient and the scene. The small space afforded in the back of the ambulance and the relative unknowns when attending someone's home reinforced the adoption of an approach which consciously did not make the situation worse. This is particularly

apparent when paramedics approached someone with altered behaviour. The paramedics refrained from creating a situation which would further distress the patient and cause the individual to escalate in their behaviour. Often simple actions like acknowledging the presence of hallucinations, but not actively engaging with the patient in those hallucinations, was a means of keeping the patient calm and feeling acknowledged.

Andrew
Case 11:
2nd interview

Whatever I can do not to exacerbate that situation, I don't you know I don't play games with them or anything like you know if they're saying they can see, some delusion (sic) or something, the same as I teach my students that don't like agree with them, but don't actively disagree, if you know what I mean? So, look I hear what you're saying but I can't see them …

Depending on the circumstances, keeping the interaction and approach simple, and using the strategy of 'load and go', the path of least resistance, was a practical strategy to meet the paramedics' duty of care. A simple approach also achieved the main goal of getting the patient safely to appropriate care. Jessica, for example, recounted a story where she and her partner (the paramedic crew) appeared to reach the end of their patience after trying alternative suggestions and the 'load and go' seemed to be the practical solution. Jessica emphasised the change in the patient's demeanour when they suggested that there may be alternatives to coming to hospital and eventually they resorted to saying to the patient 'just look, just come with us and shut up'. They acknowledged this was not treating the patient with respect or being professional, but in their view achieved the desired outcome of transport.

Jessica
Case 8:
Initial interview

She was initially quiet. Approachable, answered all our questions, but when we started alluding to the fact that perhaps she didn't need to come to hospital she did raise her voice and did get aggressive, that's probably a little bit too far, but she did get a little bit argumentative and did raise her voice and yell. So that's when we said 'just look, just come with us and shut up', to be honest.

The direct approach

Paramedics employed a disengaged approach when dealing with patients that exhibit behaviour they associated with a borderline personality disorder. This encompassed behaviour they viewed as manipulative or 'attention seeking'. In these situations the paramedics would rather not engage the patient and the disengaged approach was considered a strategy which decreased the potential for being in direct conflict with the individual. The potential conflict with the patient was seen as not worth the effort when the patient was intent on going to hospital. This also poses the question in the paramedic's mind as to whether they were being used appropriately as an emergency service or being used as a 'taxi' service.

Andrew
Case 11:
2nd interview

That's what they want. Get a bit of attention, go to hospital, and usually they're walking out of the door before we've even finished our paperwork. … Yeah don't engage, don't give them anything to, don't give them a hook to bite on like and or arc them up in any way, and yeah the regulars 'What's going on today?' 'Yeah, all right' that is not …, that is just not worth arguing 'Jump in, let's go' like, because I would rather my ambulance be available for – an emergency, yeah, that happen occasionally [said as an aside—almost an afterthought].

Len
Case 10:
2nd interview

'I'm going to take your blood pressure, I'm going to get an ECG, right, I'm going to take you along to hospital' and keep it very clinical rather than general conversation and being, I'm not saying being nasty to them, I'm just saying more or a clinical approach.

Andrew revealed the conflict for paramedics in wanting 'to be available for an emergency', their primary role, but in reality on-road 'true emergencies', the ones 'that happen occasionally', are not the bulk of their workload. Andrew mentioned with a sense of irony that what seems to occur in many cases is that the patient walks out the ED door before they have even completed their paperwork. Paramedics were left in a position of feeling that they put in the effort and have met their duty of care successfully only to see their patient walk straight back out of the ED without what appears to be any follow up or adequate further assessment and care. In these circumstances paramedics understandably question how useful their attendance was when they consider that there are others in the public who are in real need of their care. The paramedics understood that the ED staff are facing similar frustrations with the constraints of the ED and the mental health system. They understood it is the patient's right to choose not to accept assessment or treatment and to decide not to remain in the ED, even though they may require the care, but they questioned why they were called in the first place if this is the case.

The level of engagement

Paramedics varied in how engaged they became with psychiatric patients from not engaging with the patient and 'not giving them a hook to bite on', to the middle

ground of maintaining a direct approach, to the other end of the spectrum of being empathic and friendly. The extent of engagement depended on the nature of the presentation and the behaviour exhibited by the patient. The variability in the level of engagement suggests that paramedics did not necessarily perceive that engagement as a valuable tool in communication and treatment. Abigail questioned whether engaging the patient with a personality disorder had the potential to make the situation worse by what could be perceived as reinforcing the individual's behaviour. She posed the question, were they being 'too nice' in some circumstances?

Abigail Case 15: 2nd interview	*Borderline personality disorders, just purely because, I mean, I quite often, you, and I'm no expert in the area but you get the impression that you're, by you being there you're actually fulfilling one of their needs and part of their manipulative personality by attending to them, and they're difficult because it depends on your personality and how you approach patients too, but, sometimes I can see myself, perhaps being a little bit too friendly and empathic towards those patients which I think then just feeds their manipulative behaviour where, you know those sorts of patients probably need a more purely clinical approach.*

Paramedics, in some circumstances, are provided with recommendations from the mental health liaison in the EOC or ED on how to engage with individuals they see regularly with psychiatric issues. Evan suggested that with some patients they were directed to have minimal interaction. He described it as a caring but specific approach which incorporates boundaries for the patient, guides the paramedic, includes alternative care pathways and is more collaborative with other health professionals (Field notes, 21st Oct. 2009). Evan felt the collaborative approach

seems to achive positive outcomes not only for the patient but for the service as well.

Communication, effective engagement, and adaptability are essential tools to meet the objective of keeping the patient calm, creating situational awareness so the paramedic does not exacerbate the patient's anxiety or distress. The following subtheme focuses on communication as a skill that cannot be learnt from a textbook, and develops as the paramedic gains on-road experience.

6.2.3 Communication and adaptability: Not what you can learn from a textbook

The paramedics made a clear distinction between the skills they developed through their own life experience, on the job experience, and the skills and knowledge they received through structured education. All three were seen as having an important role in their approach and interaction with patients, particularly psychiatric presentations. Communication was a skill considered to develop on the job and not something that could be learned from a textbook or the classroom. The paramedic's ability to adapt, modify and adjust their communication and actions according to the situation was considered essential to being able to operate in the field and achieving safe care and transport of the individual. In particular the ability to recognise and manage if the situation was rapidly changing and going 'pear-shaped'.

Emma
Case 3:
2nd interview

That's part of getting a feel for the patient and where they're coming from and what's going to work best for them. And I mean, sometimes you start off on the wrong foot and you take the wrong approach and I guess you need to be able to recognise that and change your approach accordingly.

Len
Case 10:
2nd interview

I think the hardest bit is probably that area of modifying your communication and the way you approach the patient, that's the hardest bit, that's the bit that you can't get from a textbook or something that you need to, with experience you learn different approaches and as I said you don't even think about it, you just modify your approach to suit the situation or the patient's needs.

Communication: not a treatment but a practical, strategic and outcome focused tool

Although communication was not seen as treatment, its importance was couched in terms of honesty, encouragement, providing a clear explanation to the patient, recognition of their duty of care, and adopting a non-aggressive demeanour. The paramedic narrative below talks about communication as a practical, strategic and outcome focused tool.

Emma
Case 3:
2nd interview

And honesty, honesty is really, really important. You can't go in and just say look everything's okay, because it's not and telling them lies, as soon as you tell someone a lie you've lost that communication, you've lost that trust and the situation will go pear shaped, there's no doubt about that.

Len
Case 10:
2nd interview

…again it comes down to communication and then the patient may initially adamantly refuse to go to hospital but I think a good communicator can quite often bring them around and encourage them to see it through your eyes and head along to hospital, but I mean, obviously there will be patients where it doesn't matter what you say it's not going to change it.

The depth of information paramedics gather from the patient and their surrounds has a direct effect on patient care and the priority the patient receives in triage. Abigail highlights the importance of being a good communicator and the real consequences to patient care if they are unable to provide a complete and accurate handover:

Abigail
Case 15:
2nd interview

First of all just explain that we're here to help her, we know that she's taken some [tablets], we need to know, she's not in trouble, we just need to know what she's taken so the hospital can help her, it just depends especially with something like Panadol or other substances the treatment that they might get at the hospital and how quickly they might get it because what we hand over to the hospital might determine how long they wait for treatment.

Developing the rapport and reiterating they are there to help

Emma outlined alternative communication strategies she used to get a better patient outcome, instead of a defensive or aggressive response to the patient. She endeavoured to reinforce that they have a duty of care to the patient, attempts to convey to the patient that they are concerned for their wellbeing, and identifies others that may reiterate that sentiment. She found that conveying the simple fact

to the patient that she was there to help, cares about the person and is happy to sit and talk, reassured the patient and effectively opened the lines of communication.

The idea of time and the use of time by paramedics becomes an important concept when talking about influences on their assessment and what treatment they could provide.

Emma
Case 3:
2nd interview

Being aggressive back is the worst thing you could do in my view. I tend to just talk quietly to them, explain that I believe that they need to go and that I've got a duty of care that I've been called and I'm concerned about their health and say like family members or any other supporting persons that know them are concerned about their care and that I've got plenty of time and that I'm happy to sit here and talk to them for a little while until we can find a solution generally.

A common thread throughout the interviews and observations was the significance of building a rapport with the patient. Finding common ground with the patient was one strategy referred to regularly by paramedics as a means of developing that rapport. They searched for ideas or subjects generated from the patient's surroundings or the patient's comments which would open up communication with the patient and build the rapport. Robert identified some of the strategies he used to build this connection with the patient and to gather information.

Robert
Case 7:
2nd interview

You know, you can be sitting in the room and sometimes there's pictures and models of planes, or something, and hobbies, or just find something that you've both got a little bit of knowledge about and start to just talk and break the ice with that, and then, find out if they want help, and what's been going on, and the medications.

Difficult communication

Another aspect of communication, labelled difficult communication, involves situations where the patient is not willing to communicate with the paramedic or the communication is challenging due to the nature of the presentation. The lack of communication with the patient engendered feelings for Kate of not being able to fulfil her role and 'I'll just sit here and do nothing'. The associated frustration with the lack of communication was pragmatically viewed as 'part of the job', an inevitable outcome of disturbed behaviour. Kate surmised that if the patient 'wants to talk then that's great' and any lack of communication was part of what the individual was dealing with on the day. When the patient did not wish to talk Kate felt it was better not to press the situation and increase the patient's agitation.

Kate
Case 17:
2nd interview

[Just explain some of the feelings and perceptions that you get when you're dealing with someone who you find communicating with quite difficult.]

I guess it can be a little frustrating not being able to talk to the person and assess them, but you get that with all kinds of cases not just psychiatric cases, quite often people don't want to talk to us in general or don't want to answer our questions. Generally that's a little bit frustrating and you kind of feel like 'I'll just sit here and do nothing'. I don't know whether it affects my perception of the person generally because that's part of their overall condition on the day and that's just whatever it is that they're dealing with, so as I was saying in my first interview if they don't want to talk to me then that's fine I'm not going to make them agitated by trying to force them to talk, and if they do want to talk then that's great and we'll talk, but if they don't that's kind of up to them really.

The idea of compliance and non-compliance emerged as a distinct theme in association with the paramedics' approach and communication with the patient. Whether the patient voluntarily agreed to come to hospital or the situation posed considerations for police involvement, caution and risk were high on the paramedics' list of decision-making considerations. 'Non-compliance' meant the paramedic was now involved in a complex situation dealing with a person who is not willing to follow direction or refuses further care.

6.3 Theme 3: Compliance and non-compliance: explaining the options

Themes 3 and 4 capture two important considerations for paramedics in how they proceed with a case, the first being whether the patient is able to follow paramedic direction: are they going to be compliant and cooperative? The next is the sense of caution for their own safety and the ever present awareness of the risks involved at

the scene and during transport. These issues played a key role in the approach and the assessment that followed. In practical terms it gave the paramedic a sense of what logistical problems they faced to get the patient to further care.

Troy
Case 9:
2nd interview

I think every patient, as far as we're concerned, our first assessment is whether they're compliant or not, and what logistical problems we're going to have them to come with us to the hospital.

Len
Case 10:
2nd interview

I guess it really depends on you get a feel for the patient as to one, whether they're going to be cooperative and compliant or whether they're going to be a difficult patient. …

I always ask, yes, particularly if we haven't got SAPOL involved. I ask them 'Are you carrying any weapons?' And I also ask them, now obviously going to take them to hospital in an ambulance 'Are you going to behave yourself and be compliant on the way?' And usually you can pick up from that whether there's going to be any problems or not.

Due to the confined space within the back of the ambulance the potential for injury increases particularly if the patient becomes agitated, aggressive or violent or decides they want to hop out of the moving vehicle. In both circumstances the patient can do serious harm to themselves and to the paramedic. The responsiveness of the patient is one way paramedics identified any foreseeable risks before they entered the ambulance. Robert described the measures he took to reduce the foreseeable risks and patient access to objects which may be used as potential weapons. He conveyed a sense of the proximity to the patient and the balance between personal safety and maintaining the patient's rights.

Robert
Case 7:
2nd interview

I always like to see – keep my psych patient in one spot, and if they start wandering around looking through bags, or telling me they've got to get something out of their car, or – so, you want to keep them in one spot, and I suppose it's the old police saying keep your hands where I can see them, sort of – but you don't want to be too aggressive with that, either. You want them to be able to go and get their mobile phone out of their jacket in their bedroom. They're allowed to, and they're allowed to get their wallet. I always ask them have they got any weapons or anything sharp, or that can hurts us, in their pockets, if we're going to transport them. Because I'm going to be sitting within 30 centimetres of them for a period of time, so, if I've got someone I expect violent, I do all these basic things, like take my pens out of my ... pocket, so, if they needed to grab a weapon or something, I make sure there's no scissors or anything in the car, so they can't do anything immediately. Another technique I use is, once I know they've got nothing in their pockets, whether you need the police to search them is – I like to put a blanket over the top of them with their hands on top of the blanket, so they can't – if they've got anything else anywhere else, and they want to get a weapon, they can't, they've got to go under the blanket, and there's no reason to go under the blanket, and I can see that easy. So, I use a blanket as a bit of a shield, so they can't touch anything on their body.

The unpredictable nature of psychiatric presentations created a heightened awareness of personal safety and the potential for adverse events. This unpredictability was both a perception generated by a misunderstanding of mental illness and the reality of acute presentations which involve altered thought perceptions and patterns. Drug and alcohol use whether separate from the mental illness or in association with the presentation also featured as a prominent factor in the level of cooperation seen.

6.3.1 Risk to themselves, to others and whether to involve the police

The assessment of compliance and risk was based on both subjective and objective information gained from the patient. The patient's reactions to the paramedic informed their clinical decisions regarding whether the patient was a risk to themselves or to others. The extent to which the patient was compliant alongside their need for care dictated whether the police became involved to enforce transport to hospital. Paramedics operated either side of a fine line to either force the issue to get the patient to hospital, get the police involved or to offer alternatives and try and organise follow up care.

Tracy Case 5: Initial interview	*We didn't stay in the house for long because the patient was non-compliant. I stated to the patient that he had admitted to taking an overdose which he agreed to at the time, right from that minute I'm not leaving the patient in the house, he's obviously at risk for self harm, so he needed to go to hospital, patient was refusing, refusing to put the dogs in a safe place for us and SAPOL so we decided to back out of the house and leave him in the house until SAPOL could organise further backup to take the patient safely out of the house.*

Police involvement to get the patient to hospital was considered a last resort to fulfil their duty of care and the ultimate goal of providing access to expert assessment and treatment. Forced transport was seen as an unfortunate necessity if the individual was deemed ill by the paramedic, non-compliant and lacking the ability to make rational decisions regarding their own care. Paramedics described attempting other limited alternatives available to them before they got the police involved, but ended up resorting to this option. Paramedics in a straightforward, upfront manner outlined the two options to the patient. The patient can either

come voluntarily to hospital, viewed as the easiest and least stressful way for everyone, or they could be forced into complying by the police under Section 23 of the Mental Health Act (1993). The direct mention of police involvement often was enough to encourage the patient to go voluntarily.

Jessica
Case 8:
Initial interview

... but if they are wanting to hurt themselves or other people then our duty of care comes in, we have to take them to hospital and I guess the other – the options we can say is to them, maybe to say look we won't detain [sic] you if you come voluntary, if you come involuntary then we have to get the police involved and sometimes just that, the threat of getting the police involved makes them want to, okay, okay, okay, and I guess maybe ringing family members and getting them to convince them that they need help and go to hospital.

Emma
Case 3:
2nd interview

When despite attempts at trying to talk to them calmly and trying to get them to calm down has failed and I've tried to get them to understand duty of care and tried to get them to understand that they need to come and that I'm in a position where I believe that they're unwell enough to enforce my duty of care, I have to take them I will explain to them that that is the case. And it just depends on their cognition too, sometimes they just don't understand and I'll say to them if you come with us quietly we'll just sit in the back and have a chat and I'll just get some details and we'll talk about it and we'll just go up [to the hospital]. I said otherwise the other alternative is I have to call the police and that's what I have to do and I will explain it and they will be understanding but they will also be under my direction and that they'll have to go.

Robert, using similar strategies, attempted to explain the necessity of coming to hospital to the patient and employed all the resources available to him to try and convince the patient to get care. He raised the point that the patient cannot dictate the process for the whole night. He felt that paramedics have a responsibility to others that might need their urgent care. This led to a conflicting situation where

the paramedics found themselves and their resources in demand and trying to balance caring for the patient but not wanting to be overlong in the delivery of that care.

Robert
Case 7:
2nd interview

... after having carers, family – everyone – trying to bring them around to see, look we've got to get in the ambulance, we've got to go to the hospital to get whatever the condition is reviewed – once everyone's had a go – the police have tried, we've tried, family have tried, everyone has tried, and they're still not budging, obviously we can't let them control the rest of the night, and if they're a threat to themselves or others, so normally, people when you tell them that – when they are going to forcibly do something, they come around.

6.3.2 The patient's choice and whether they can make decisions about their health

In Len's experience some individuals appeared to make the choice to be forced into going to hospital even though alternatives were offered. The question for the paramedics in these circumstances is why would the patient want to be forced into transport and care. Is the nature of the patients illness playing a part in the decision process, has the patient been released too early on previous occasions, what has their prior experience of the mental health system been and is this a way to gain further care? Alternatively is the whole process being over simplified in the attempt to get the patient to further care in a timely manner?

Len
Case 10:
2nd interview

I always give my patients the option. I explain to them what, you know, if I deem that the patient needs to go to hospital in my opinion because they're at risk to themselves or risk to others then I would explain that to them and explain the process to them, you know 'You can either come with us non-detained and compliantly or the other option is the police who will detain you and force you to go to hospital' and discuss which option is going to be better for them. Some patients actually go 'Well I want to be detained and I want to go down that route' and others will go 'Well if I'm going to have to go to hospital anyway then I might as well just go'.

In cases like Emma's the patient's ability to understand what was occurring around them and their own knowledge about their mental health had a significant effect on how compliant they were with the paramedics.

Emma
Case 3:
2nd interview

And we got one like that yesterday and when we got there and SAPOL got there a lot before us and the lady was quite compliant and there was no need to enforce Section 23, she just was unwell, she understood she was unwell, she had had a friend over to try and get some support and it was the friend that had found her with the knife and was going to hurt herself and he's the one that called. So when we got there she was very compliant and she understood and we just got the bed out and said would you mind popping on it, do you want a blanket and are you comfortable?

In other circumstances the patient's belief and insistence on going to hospital, became a point of conflict. If the paramedic felt that the person may be better served by not going to the crowded ED, other attempts were made to try and keep the person out of hospital. These decisions were based on considerations of self-harm and harm to others. If the patient was considered not in immediate danger

then accessing local general practitioners and others such as ACIS were considered possible alternatives.

Jessica
Case 8:
2nd interview

If they are hallucinating is it important that that's checked out at hospital sort of thing or checked out by a doctor. I guess some of the other options, if their hallucinations or if they're auditory hallucinations aren't telling them to hurt themselves or anyone else, I get that gives us a bit of extra leeway. You can perhaps convince a family member to take them to the GP right now …, someone that the person knows, might be a little bit easier than off to hospital.

Jessica
Case 8:
Initial interview

… on further questioning it's actually the lice infestation she has, that's increasing her anxiety and making her not get enough sleep but she didn't want to do any more washing to get rid of the lice because she couldn't face the washing machine anymore and we offered to put a load of washing in for her so she wouldn't have to come to hospital, but she was quite determined, was quite insistent on coming to hospital, so we took her.

6.3.3 Offer to take the patient to hospital on 'medical grounds'

In cases of self-harm with associated trauma or overdose, one strategy Troy employed to reduce the focus on purely the psychiatric needs of the patient is to offer to take them to hospital on 'medical grounds'. As an attempt to reduce the stigma experienced by the patient this approach was a positive strategy, but it has failings in two areas. One, it maintains the idea that dealing with mental health and illness is outside or separated from other medical conditions, and also the patient may actually want to be recognised as having a 'legitimate' problem. This approach may unfortunately have the effect of minimising the importance of the self-harm and the wider effect this has on the patient's life. The basic intent may not be to

dismiss or minimise what the patient is experiencing, and there appeared to be a willingness to help the individual get the care they need, and changing the focus from psychiatric to medical could ultimately be the most helpful way to get the patient to care.

Another issue was the assumption that the individual will automatically be assessed for both the physical and mental aspects of their health when they reach hospital. This may not happen in the busy environment of the ED and their mental health may be missed unless the paramedic, the individual or an accompanying person can advocate for the care.

Troy
Case 9:
2nd interview

Obviously getting the patient to come voluntarily is always our first choice of action and so we try and make it as appealing as possible to them. Sometimes, if it's a case that involves self harm then we can take them, offer to take them to hospital on medical grounds because of the harm that they've done, so whether it's trauma to themselves or overdose, then obviously they'll need to go to hospital on medical grounds and not necessarily on psychiatric grounds and they'll obviously be assessed for both when they arrive.

Theme 4 builds on the discussion regarding compliance and examines the concepts surrounding caution, risk and safety which featured as a predominant consideration in all paramedic actions.

6.4 Theme 4: Caution, risk, safety and the ultimate goal

Situational and cultural factors reinforced both the paramedics' awareness of potential risks and the adoption of a cautious approach. The cultural factors

revolved around their understanding of their role and job description. The obligation to provide emergency care, transport to further care when required, working in the community which is an ever changing work environment, and the associated legal responsibilities, created a situation where the paramedics experienced a tension between doing their job and the apprehension of going into unknown situations. This uncertain working environment coupled with education which focuses on safety, guides what paramedics should look for and how to respond.

Paramedics emphasised the ever present awareness of their own safety, safety of others and the patient. The sense of caution and wariness, which surrounded psychiatric cases, was engendered by the potential for violence and aggression and the sense of the unknown; the difficulty in seeing behind the closed wire door.

Joyce
Case 2:
2nd interview

Mental health you always approach it with caution. …Some mental health cases you go to when SAPOL is not called you still approach with caution but the likelihood of aggression is less.

Abigail
Case 15:
2nd interview

The danger thing is always in our mind because you can go into chest pain that is actually a psych patient that's upset or a hypoxic patient that's aggressive, it doesn't matter. Certainly I'm always wary before I actually see the patient, you know when you're standing on the other side of the door and you can't see through, it's just a wire door, I feel nervous yeah.

Although paramedics recognised aggressive or violent behaviour can be related to other causes such as alcohol and drug use, hypoxia or hypoglycaemia it is not until they get face to face with the patient that they can even begin to make that

assessment. Don made the point that in cases of acute illness the aggression or violent behaviour, if directed towards the paramedic, is not essentially the person but the illness which is driving the behaviour.

Don
Case 1:
2nd interview

Also a recommendation from ACIS and SAPOL saying that this patient has a potential to be aggressive, I would take on board, also in acute illness, something like a psychosis for example where the patient just isn't thinking straight, an acute psychosis, you could probably begin to think, if the patient isn't thinking correctly or like a normal person would, then they have the potential to react totally differently to what we perceive as a normal reaction, so if the patient was to want to go punch a paramedic as they arrive on the scene, you can understand that that's actually the psychosis doing that, not actually the patient, so that's another risk I guess.

In contrast, Jessica expressed how her feelings changed when faced with aggression, from an empathetic or even apathetic feeling to 'backing off', an increase in wariness and a decreased level of empathy.

Jessica
Case 8:
2nd interview

If they're violent or aggressive or any behaviour that makes me feel threatened I guess makes me back off quite a bit and I guess decreases the amount of empathy or anything or apathy I might have for them.

Paramedics again stressed their approach had a direct effect on the way the patient reacted to their presence and they reiterated that the ultimate goal was to get this person safely to further care.

Len acknowledged that although they may not complete tasks, such as an entire assessment or complete their full list of observations, such as blood pressure, pulse,

respirations, they needed to keep the main goal, safe transport to hospital, as a focus of their overall management of the patient. The ED remained the definitive point of care for the majority of their patients although it might not necessarily be the most effective.

Len
Case 10:
2nd interview

... risk to us as a crew, risk to the patient, and how am I best going to approach this patient in order to get them to hospital in the safest manner, I mean it's pretty much what it's all about. You know, even if you don't end up doing that full assessment on the patient but you just continually reassure them and chat with them, use distraction to be able to get them on to hospital, they can get assessed properly.

Len
Case 10:
2nd interview

You know, it's a difficult one and I guess you just need to assess it at the time and make a judgement call as to what's going to be, I mean the ultimate thing is what's best for the patient and the ultimate goal is if they need to be at hospital, is to get them to hospital as safely and as quickly as possible.

6.4.1 Situations we enter and being an unexpected arrival

The situations that paramedics attend enforced their own sense of caution. Factors such as the lack of information when dispatched, unknown entity on arrival, and the physical environment, especially entry and exit points, all contributed to a sense of caution. Other factors which had a bearing on the potential risks were the presence of bystanders, attending a patient with a known history of violence and aggression, and the potential for the situation to change quickly.

Tracy
Case 5:
Initial interview

I made sure I had an exit, I'm aware of his house because I've been in there before, the dogs aren't violent towards us at all they're more violent towards males anyway, so once the dogs were locked away I think he saw the inevitable coming and he did resist being detained, but he could have made things a lot worse for himself, but he didn't.

Gerry
Case 19:
Initial interview

[Was there a concern that he would actually hurt you or the police at all since there was that history?]

Yes there is a history of him having to be physically detained, so the police were pretty standoffish as were we and that's why it took an hour to get him to come with us which is a very long time.

The accessibility of the patient at the scene, the entry and exits points, and logistical issues which can place the paramedic and the patient in danger were part of the overall situational assessment of risk. The number of bystanders and how they are connected to the event played an important role in gaining information. Other issues were whether there may be more than one person who might require their care, if they may be threatened or obstructed by bystanders, and how they position the ambulance and their equipment.

Joyce
Case 2:
2nd interview

... but if there's junk everywhere that can also prove a problem for us if we need to get out, so we sort of – we're not always looking at it just for our own safety, but also how to get out of the house, how to get somebody out of the house; where are we going to put the stretcher; if there is lots of broken windows; if there is people milling around you sort of take that into account, you would probably be a bit more cautious – especially if it's not a clear cut chest pain case or something like that. If you can't get the right information you have to wonder why you or the call takers can't get the information.

The unexpected arrival of paramedics significantly changed the dynamics of the situation and could alter the stress involved for both the patient and the paramedic. Often another party has contacted the ambulance service to request help in these circumstances and the person may not have been told creating an uncertain situation for the paramedics. Abigail made the point that it is quite different if the actual patient has rung the service

Abigail Case 15: Initial interview	*We actually had three ambos on so we had another crew which is why we approached the house because we thought with three of us it would be safer so that was obviously a concern, we couldn't see in through the security door so obviously it felt the safest just walking up to the house, we didn't know if she was actually expecting us or not because the surgery called us.* *… It's different when they call us but when someone else has called us then we're a little bit more wary of just walking up. Once I could hear her voice and said 'do you know why we're here?' and she said 'yes', then I realised that we were probably safe and she answered the door, usually by then you know they're probably going to cooperate.*

In this particular case the paramedics believed that there would be safety in numbers and since there were three of them at the scene they approached the house to talk to the patient. The response from the patient was significant to the paramedics in terms of the patient's awareness of who they were and the reason for their presence. Emma discussed the importance, when faced with the situation of being the unexpected arrival, of adequately explaining to the patient why they are attending to reduce or alleviate the possibility of aggression or violence.

Emma
Case 3:
2nd interview

Oh yeah, I've had someone who was a very, very large, a very big man who we'd been called because he was talking to his ex-wife on the phone and he said I've just taken all these tablets and he had a violent history towards woman and when we got there he wasn't aware that we were coming and we knocked on the door and you just act very tentatively, you know do you realise that we're here because we've been called and because we've been called once again if you explain to people that you're not trying to be pushy or you're not there to dominate, you're just there to help and that you've also got a legal obligation now that you're there that's beyond your control and you just need to fulfil that in order to go or for you to stay, normally they're pretty good.

The 'legal obligation', their duty of care, operationally places constraints on the scope of what the paramedics can do in a given situation. Once the patient knows this, from the impression in case three, the majority of patients understand this fact and it leads to a modification in behaviour.

The paramedics' legal obligations, evaluation of risk and patient compliance come together to affect not only the approach but also the way paramedics assess the scene and the patient. Part 2 explores the next step in the *'*case history', the 'Assessment'. The *'*assessment' explores the cultural factors which contribute to how paramedics conduct their assessment, their perception of their role with psychiatric patients, and their perceptions of treatment and care.

Chapter 7

Findings part 2: Assessment, assumptions and influences

7.0 Introduction

The following two chapters explore what paramedics identify and assess when at the scene and with the patient. They deal with the assessment of the psychiatric patient, paramedic actions, and their interpretation and meaning. From the point of dispatch, assessment starts as a general formulation of what paramedics may be attending, but the 'real' or substantive assessment begins as the paramedics arrive at the patient. The subthemes outline what paramedics reported they observe and hear while attending psychiatric cases, what paramedics identify from the scene – 'the search', the information from the patient and others and, importantly, what assumptions and impressions shape the process of assessment. The chapters explore whether the patient's social history is important, what is considered treatment, the effect of comorbidities, and finally judgements such as 'is it genuine'? These assumptions and influences play a part in how paramedics see their role when attending psychiatric presentations.

7.1 Theme 5: Assessment—what they see, hear and search for

7.1.1 What they see and hear

'What they see and hear' captures what paramedics do as their primary means of assessment. The theme combines paramedics' observations of psychiatric presentations and how they use that information as a basis for their assessment. The paramedics' observations naturally grouped themselves into three separate areas. The three areas focus on the outward physical and behavioural aspects of the patient's presentation, the measuring of vital signs—'concrete' observations, and the information gained from the scene.

The physical and behavioural characteristics of the patient presentation included observations such as the patient's movements, their body language, their appearance, general tone of voice, and the content of the patient's conversation. The measured vital signs although not always obtainable or considered the most essential when dealing with psychiatric presentations were a means of determining whether the patient is what paramedics consider medically stable. The information from the scene is often the only way for paramedics to determine and confirm the story surrounding the patient's presentation. The scene and bystanders become vital when the person presents with an altered consciousness level or thought processes. The physical, concrete and social information combine in the paramedics' assessment of the case as a psychiatric presentation.

The outward physical and behavioural observations

The physical observations included the patient's general demeanour, their discernible movements, actions and behaviour. Paramedics associated behaviour such as a rapidly changing mood, continual restlessness and agitated movements, and unpredictability, with psychiatric presentations. This meant they were always on guard and ready for sudden change. Paramedics acknowledged that what they observe in the patient's behaviour is dependent on what type of mental illness the patient is experiencing and if drug and alcohol use is involved. Not surprisingly, the focus of their assessment is directed at the physical and observable aspects of the patient's presentation, given the character of paramedic work, its positioning in 'emergency' care, and the short time frame the paramedics have with the patient as the following quotations demonstrate.

Adam
Case 12:
Initial interview

Constant moving and shaking, I mean he wouldn't sit still so constant things like that, he was pulling at his seatbelt the whole time, I guess that was getting a bit tight, that's alright, not yelling or anything but was getting quite frustrated with his seatbelt always going tight and when he went to get out his shoelace was undone and he appeared to be pretty upset about that so that shows some sort of signs of stress I think, just a little bit.

Robert
Case 7:
2nd interview

They keep moving around and they don't sit still. They're not making eye contact a lot of the time. I mean, it depends what obviously, mental health issue they've got, but it can be the other side where they're completely flat in the corner, depressed – don't want to make eye contact, don't want you to touch them, and don't want to have anything to do with this – you know, if they're suicidal or whatever the stage their at. But yeah, so, everyone's different and I don't think you can sort of generalise one – you know, they're all different. Some, you go there and they're manic, running around the place. Other ones are sitting quietly.

Robert recalled the difficulty of getting the patient to sit still, the continual movement and the difficulty in obtaining an accurate patient history. He mentioned the patient's 'insignificant' actions which suggests paramedics do observe the whole interaction with the patient but make an evaluation of what information is essential for their immediate provision of care and do not necessarily see the movements as symptoms of the mental illness.

Robert
Case 7:
2nd interview

They seem to be quite distracted a lot of the time. You know ... they would have been called there by ambulance, most people sort of pay attention. A lot of these people can be running around the house doing insignificant things that aren't really ... and it's hard to sort of get them to sit down, so you can get a good history from them.

Paramedics told of a wide range of sad and humorous behaviours they witnessed from a variety of cases they considered psychiatric presentations. Behaviours ranged from presentations involving hallucinations and delusions and their associated outward manifestations to closed communication with the patient. Paramedics described cases where the patient feared the paramedics and the police, held strong beliefs something was controlling them, and would not engage with the paramedics. Paramedics recounted stories of patients who were not forthcoming, 'rambling' and lacking coherence, and restrained and limited in their conversation. Paramedics described patients that were visibly upset, in distress, straining against the seatbelt and stretcher straps, and retreating into themselves.

Nathan
Case 13:
Initial interview

Every time he started talking, he started talking about other stuff that he became aggressive about, like his – he mentioned that he apparently was in a war somewhere or in some specific army overseas, and things like that, and that story changed a little bit as well and when he was talking about that he seemed to be a lot more aggressive and conscious of himself and would start sort of straining.

Robert
Case 7:
Initial interview

[What suggested that there may be more to this case than abdominal pain?]

Well just the way she was acting. Yeah the way she was sort of guarding it. And so, I offered her pain relief, so she got some methoxyflurane, and that seemed to help her. That settled her down a little bit, but that didn't take the pain away, and like, even now, you look at her now, inside the hospital and you can see that she's visibly distressed as well as her ongoing abdo pain. So, whether it's her medications need reviewing, or things have changed in her life where she needs reassessing.

Eye contact

Patient eye contact played an important role in the paramedics' assessment of the patient's degree of engagement and was a widely recognised behaviour. Paramedics noted if the patient's eye contact was sporadic, associated with targeted questions or if there was limited engagement and minimal or no eye contact. The patient's eye contact allowed paramedics to gauge how comfortable the patient was in their presence, their level of agitation, how distracted they are and whether the patient's mood was changing.

Adam
Case 12:
Initial interview

[Was there eye contact with the patient?]

… He did. He did when I asked him direct questions. I actually – a couple of times he sort of went into his own little world and I actually had to call him by his first name to get him to actually look at me and then when I started talking he'd look at me again so, yeah.

Robert
Case 7:
Initial interview

She was quite irritable, wouldn't make eye contact, fidgeting a lot, sort of nearly crying, nearly breaking into tears, quite distracted and going off on tangents and insignificant information all the time.

Evidence of self-harm and alcohol and substance use

Clear indications of self-harm or the effects of either alcohol, or substance use were a significant concern for paramedics. The description of alcohol being on the table next to the patient, the 'groggy' appearance and 'slurred speech' exhibited by the patient demonstrated the detail they singled out and how they incorporated what they saw and heard into their assessment.

Samantha, for example, found the patient's emotional response to the overdose she had taken, which didn't concern her, in comparison to the embarrassment she felt regarding the lacerations on her wrists, a surprise because both have implications in the way paramedics provide care. Samantha, in her estimation, considered the haemorrhage may be more directly a threat to life than the overdose depending on the amount and type of substance taken and the severity of the lacerations. The embarrassment towards the slit wrists Samantha could understand but found it difficult to comprehend why the patient differentiated

between the overdose and the lacerations when she considered both to have the same intent of self-harm.

Samantha
Case 14:
Initial interview

When we arrived she actually walked out to the ambulance and met us, had her bags packed so she was already organised and thinking and knew that she was going to the hospital, but also lacerated both her wrists though which she failed to mention when she made the call to the ambulance but she was quite embarrassed about that. She wasn't embarrassed about the overdose but quite embarrassed about her slit wrists. … She actually said 'look I'm really embarrassed about this'. She insisted on cleaning up the blood before she would let us take her away, she didn't want to come back to the house and see that. While the overdose wasn't concerning her, the lacerated wrists were.

Abigail
Case 15:
Initial interview

We actually went into the house before SAPOL got there, just knocked on the door and she answered the door and welcomed us in, obviously a little bit groggy and claimed to have had an overdose, unknown amount, not very forthcoming just that too many and also a bottle of champagne, there was obviously self inflicted wounds to one of her arms which when I asked about she did the night before, so it was just an ongoing issue but when asked wouldn't give any information about what was going on today or tonight.

Abigail's reference to the reluctance of the patient to tell her about what was happening reflects what I believe is the 'tell me what is happening now' nature of the information which paramedics concentrate on in their assessment. For obvious reasons the information is required for paramedics to make a clinical decision on how to help the patient in the immediate short term, but when dealing with individuals with an extensive history of a chronic condition the past history and the individuals story may be more critical for both short and long-term care.

Hallucinations, delusions and conversation

Patient hallucinations and delusions are narrated as objective descriptions of the statements made during the paramedic's time with the patient. Paramedics relied on what they could discern from the patient conversation and if they could validate that information with the immediate surrounds. The patient's history and conversation were the corner stone to unravelling the patient's story and current presentation. Reference to the patient's hallucinations and delusions came across as either an empathetic connection to what the paramedics were attending or an expression of not being able to relate and understand their patient.

Sonya
Case 16:
Initial interview

So when we went in there, knocked on the door, she was quite aggressive verbally, wouldn't let us in the house, wouldn't come out and talk to us, going on about someone in the roof, someone had been murdered or something, some blood or something in the roof cavity and she's like 'come back with a ladder and I'll let you in' because she wanted someone to go up and have a look at her roof cavity.

Emma
Case 3:
2nd interview

Well if you've got someone for instance, I went to a young man who was clearly unwell, just his body language was indicating that he just said he felt nervous to start with and then he stood up and just said 'I'm Jesus' and he was quite clear about that, and I said 'do you think you're Jesus?' 'Yes I do.' 'Ok.' 'Do you have a mental illness at all?' 'No, no there's nothing wrong with me, I'm just Jesus.' You know and he was young and I don't know whether he had a diagnosis of schizophrenia or whether he'd sought treatment. He was only late teens, early 20s living alone, clearly not managing at home.

Emma who was a mother herself, expressed a connection and sadness at this 'young lad's' plight. Her tone of voice became reflective and sad as she recounted the difficulty she experiences when trying to help children and young people in

situations where she considered issues of mental illness, neglect or abuse to be evident. She describes 'wanting to put her arms around them and help them'.

The coherence of the patient's story was complicated not only by changes in thought perception but in the disjointed and contextual nature of the conversation. The historical references and rambling nature of the conversations from patients made it difficult to determine if delusion or hallucination were involved or if they were referring to actual events. Troy mentioned the attempts he made to verify the information from his patient but the historical nature of the references made it almost impossible.

Troy
Case 9:
Initial interview

[patient conversation] *it was kind of fairly rambling, it didn't make a lot of sense to me so it was to do with an incidents that had happen in the past to herself and other people I think but details were a little bit hard to determine what the actual details were. She was saying it was kind of disjointed it didn't really flow that well. …it was all historical I couldn't verify it but she wasn't talking about anything at the minute so I don't think it was necessarily hallucinations but it may have included delusional.*

Tracy painted a picture of a patient who was hesitant, exhibited slurred speech, did not like the police, and was intent on continuing to drink.

Tracy
Case 5:
Initial interview

He refused to open the front door and he spoke to us through a closed glass window, just pulling aside the curtains because he's afraid of SAPOL. He doesn't like their attendance at all and really flares up and becomes violent. He just wanted to make sure that it was the ambulance that was there and once he'd identified us he allowed us into the house. He was slurring his speech and swaying on his feet and bumping into things as he was walking. He sat down at the table and continued to drink an alcoholic beverage.

Changes in the patient's conversation and body language could indicate the person was going to leave and seclude themselves. The 'disappearing person' was a significant and real concern for paramedics regarding the possibility of self-harm or harm to others, particularly if the patient locked themselves in their own room or in the toilet. The secluded patient became a logistical issue for paramedics when working in the community and in unfamiliar environments.

Abigail
Case 15:
2nd interview

They sometimes disappear out of the room, they just walk out into their room and shut the door, sometimes they lock themselves in the toilet, it's just body language as well and a lot to do with what they're saying and how they're saying it.

The details observed by paramedics indicated their heightened sense of surveillance and their ability to gather a large amount of contextual information. The problems occur during the filtering of this extensive contextual and social information to make appropriate clinical decisions in line with their role. The filtering process, by necessity, means the patient story is condensed and not complete for those involved in follow up care.

Identify changes in agitation and distress

The paramedics considered the ability to be able to recognise increasing patient agitation and distress as significant in keeping themselves and the patient safe. The variable amount of information from the patient and scene requires paramedics to have the skills to recognise signs and symptoms which indicate an escalation in self-harm behaviour, anxiety or agitation.

Samantha surmised there was an escalation of her patient's self-harming behaviour since the patient had taken drug overdoses on other occasions, but this was the first incident of her lacerating her wrists

Samantha
Case 14:
Initial interview

She had had previous overdoses before so I'm thinking that's normal behaviour, she'd never actually slit her wrists before, but for herself it's been an escalation of her presentation, so I think seeing that it's the first time that she'd done this that's the embarrassment and escalation.

Robert suggested it is usually straight forward to identify when a patient is becoming more agitated and distressed. An increase in the speed of the patient's speech, the ease to which the patient becomes distracted, loss of interest, and decreasing engagement were cues to the paramedics to become more alert. The need for safety and caution again became evident as Robert talked about never taking risks with people that are displaying signs of increasing agitation. He believed you must know your exits and be very aware of your position in relation to the patient. Gerry spoke of the 'up and down' behaviour of the patient and how

everyone positioned themselves at a distance just in case the patient became even more unpredictable.

Robert Case 7: 2nd interview	*You can obviously tell when someone's getting agitated. They'll start speaking faster. They'll get distracted. They'll start looking around, and they're not interested in what you've got to say. Listen to what they say, actually, is the thing – the key thing – listen to what they're saying to you. And never take any risks with people like that, I don't think. Always keep yourself at the door. Don't let them get in between your exit.*
Gerry Case 19: Initial interview	[Just what sort of things would you look for to indicate to you that there was a possibility of violence and behaviour that was escalating?] *How his stance is, if he's fidgeting and how he's looking, just general body language, tone in his voice, that kind of thing.* [Did that change at all?] *Sometimes, he was a bit up and down but everyone kept their distance back but then he'd just go jump on the bed and lie down and get back up so he was a bit all over the place.*

The obvious outward changes in the patient's demeanour and behaviour were easily recognised but Abigail considered it was the subtle signs which worried her more. She recounted when patients just get up and leave the room as a sign that the individual has 'just shut right down' emotionally. The situation then becomes much more complex and urgent.

Abigail
Case 15:
2nd interview

Sometimes it's a bit more obvious like when someone might arrive at the house, family or friend, ex, but the subtle changes, the ones I think in particular where they get up and leave the room without saying where they're going and they'll just go, and they don't even say to you to leave or anything they just disappear and that's probably more the ones I get a bit more worried about because they've just shut right down and I don't know what they've gone to do in their bedroom and obviously two paramedics are not going to force their way into a bedroom.

7.1.2 The measured observations

There was a distinction made by the paramedics between their observation of the patient and their behaviour to the measured observations – 'concrete measures', they perform. These measures were done in situations where the paramedic considered it necessary and the patient was willing for the observations to be made. In Rose's estimation paramedics generally will not do observations unless the patient has consented and the act of taking the vital signs would not increase the patient's distress or level of aggression.

Rose
Case 20:
2nd interview

We pretty much won't do them [observations] *unless they say so, if they tell me that I can do them then I'll do them or if I ask them but other than that I won't, I'll just leave them alone. If they look like they're going to ark up or be angry with me or get violent or not like me touching them or anything like that then I won't do them.*

Vital signs become increasingly important when the patient displayed physical signs and symptoms associated with the consequences of their self-harm. Samantha described the drowsiness of her patient and the lowered blood pressure associated with the haemorrhage and the overdose as a concern. She commented on how the

patient had made a point of telling her that she normally experiences low blood pressure, but not typically this low. This information provided Samantha with a baseline to judge the patient's current low blood pressure against as well as the current signs and symptoms she was observing.

Samantha
Case 14:
Initial interview

She did have a lower than normal blood pressure which could be a result of the haemorrhage and also the Endep that she's taken. She said she normally has low blood pressure though. She was starting to get a little bit drowsy when we arrived as well.

The unknown played a part in the assessment, especially with an overdose, where the amounts or type of substance taken by the patient might not be able to be ascertained. The paramedics combined information they obtained from the patient's conversation and history, the physical presentation with some educated guesses along the way to gain as complete a picture as possible. Abigail, as a case example, generated her assessment from the patient's tachycardia, enlarged pupils, drowsiness and the lowered GCS (Glasgow Coma Score)[9] to suggest that the patient has taken a considerable amount of serequel, diazepam and alcohol. She was unable to determine from the scene and the limited information from the patient the exact amounts. She reflected whether this was due to the altered GCS or the patient's reluctance to answer her questions or a 'bit of both'.

9. See page 132 for details on the Glasgow Coma Score

Abigail
Case 15:
Initial interview

Serequel, and diazepam and alcohol, but unknown amounts. There's a possible greatest amount (sic) of Serequel which could be up to 250 milligrams which would be the one making her tachycardic, then on top of that she's got the diazepam and alcohol, big pupils, so there is enough on board to suggest that she'd taken an amount, she was certainly symptomatic just the level of GCS was difficult to work out whether it was drowsiness from the overdose or whether she was just reluctant to answer questions, probably a bit of both.

Len recounted, in a short series of statements, the patient's vital signs with the associated measures he took to care for the patient. The lowered GCS and the patient's ability to maintain their own airway were his first priority. The third party nature of the information which Len is able to collect revealed the challenge for paramedics in obtaining adequate information and the reliance on other sources for their clinical decision making.

Len
Case 10:
Initial interview

Initial assessment of patient, GCS of 10, pupils were equal and reactive, airway was patent and self ventilating, resp [respiration] *rate of 20, sats* [oxygen saturation level in the blood] *100% on air and* O_2*, hemodynamically stable, strong regular radial, BGL 6.1 patient has subsequently, administered* O_2*, transferred onto the stretcher, IV access normal saline KVO and monitored on the way to hospital, history was obtained from the friend at scene.*

7.2 The scene

The situational information, the 'scene', was integral to paramedics overall assessment of the patient and their circumstances. This included the medications that the patient may be on, their appearance, and objective and subjective views of how well the person seems to be coping and looking after themselves.

Len
Case 10:
2nd interview

Something that paramedics do quite often and they'll always look down the medication side of things and do a bit of assessment of the scene and look for some reasoning as to why the person is in the situation that they're in.

Nathan
Case 13:
Initial interview

Never seen him before, no, his house was quite reasonably tidy, he looked like he lives there alone, not much stuff in the house, like it was minimal furniture and things like that, it was neat and tidy and yeah, nothing really else to be honest. We were just in there and the police took him out and lifted him straight on the stretcher anyway so it wasn't too long that we were in there getting him out.

Nathan's account of police involvement and the short length of time they were in the house belies how quickly he made an assessment of the patient's surroundings. The automatic surveillance of the environment as paramedics attend to their patients provided a wealth of information. Paramedics instinctively assess and make judgements on this information. Emma took the evaluation of the scene one step further. She made the judgement that the young gentleman, who was unable to manage activities of daily living and self-care, may be experiencing an initial episode.

Emma
Case 3:
2nd interview

I went into the house and the home was quite disrupted and he had a really big television and Foxtel but no furniture, no cutlery and no eating equipment and no food so you could tell from that that he clearly wasn't managing and his clothing was really poorly put together and his general hygiene was really poor. So whether this had been an initial presentation and he didn't have any medication because we couldn't find any and with someone like that it's all you can do.

Robert
Case 7:
2nd interview

Yes. I mean, it's hard to describe, I suppose but yeah, just the way the person presents, the agitated things, the heavy smoking – cigarette smoking – as I said, the house in disarray, multiple medication packets lying around as you're walking through the house, and you see medications, overflowing ash trays – all those sort of little telltale signs. Yeah, they're probably the main things.

Robert and Emma made indirect reference to the socio-economic circumstance of the patients they were attending. The reference to the big television with Foxtel, very little food and other essentials apparently within the house, and the overflowing ashtrays and medication packets all over the place carries with it an immediate impression of where the individual's money is being spent. These comments are potentially also value statements on how these patients have prioritised their lives.

7.2.1 The search and filling in the picture

In association with the information paramedics are directly being told by the patient, and what they observe in the immediate surroundings they conducted a search for answers. Paramedics felt it is within their duty of care to look for answers to gain a better understanding of the patient's situation. This was particularly evident when the patient was not forthcoming with information, the story from the patient does not seem to be consistent or logical, or in situations where the patient may be unresponsive due to an overdose or suicide attempt. For example, as Emma noted:

Emma
Case 3:
2nd interview

Have they got packets of medication sitting in their bin? If they've got a pack of 20 diazepam that's now empty, sitting in their bin or tucked under their bed, you know go and have a look, find out what else it could be.

Emma
Case 3:
2nd interview

Certainly and I'll look in peoples fridges and if it's full of mouldy food that shows that they can't, like just their basic functioning is poor. You know where are they getting their food from? It's certainly not out of that fridge because it's all mouldy and was there a time recently when they were able to shop or do they have someone who supports them and goes and does their shopping for them and perhaps put it in the fridge but they haven't had the ability to then utilise that food. You know why don't they have any cutlery, why don't they have any plates? Have they recently moved? You know and just through finding out you've then got other areas to ask questions. If you don't look you don't know which questions to ask.

In order to gain a comprehensive history paramedics take action that in other contexts would be an infringement of the patient's privacy and rights, but in the situation outlined above Emma believed it was necessary to gain the facts. As other paramedics stated it is essential for them to have as many facts as possible so they can provide care. Emma qualified her statements by saying they ask the patient's permission first, the search is specific to the person's health needs, and not a search into their private property. The statement 'If you don't look you don't know what questions to ask' sums up beautifully the way paramedics must take on the role of detective in order to read the scene.

Emma
Case 3:
2nd interview

[Are you comfortable when you're doing that sort of search in a person's private area, a person's private house?]

Oh we ask them, just say oh would you mind if we just go and have a quick look in your bedroom, we're just looking for, you know sometimes they'll say no but if you also think that they're not in their right mind and that you need to find out what's going on you know you're not looking at their private papers and stuff, you're not doing, it's not the FBI, we're not doing a thorough search. We are trying to ascertain why that person's unwell. We've been called to the house, we have a duty and I think that once again comes back to duty of care and part of your history finding.

Gerry
Case 19:
Initial interview

He said he'd taken, he wasn't sure but he said he'd taken four boxes, there was no evidence of four boxes anywhere, there was only one box and it looked like an old box as well, there was about ten tablets missing out of the box. We had a good look around and couldn't find any other boxes…. Just asked how many he's had, tried to get a clear answer, he wasn't compliant with our questioning at all anyway, he was telling us to go away.

[In those terms or more unpleasant terms?]

More unpleasant, but like I said we had a good look around and couldn't find any evidence of any more than that, checked the bins and around the place. We took him in anyway because of the threat, no evidence of other self harm; he had no shirt on so it was pretty easy to tell if he'd done any injuries to himself externally.

Len
Case 10:
Initial interview

The search also requires paramedics to consider the not so obvious places which individuals may hide or store things they may not wish to be found. The individual may intentionally hide or not disclose information or in their altered state not realise what they are doing. The combining of information from multiple sources assists paramedics to make an assessment and work out a plan of action.

Potentially, potentially it depends on when the script was filled and you can sort of have a bit of an educated guess as to how many should be left based on when the script was filled, some have been filled a month ago, so you would expect them to be partially empty, like some of them were filled yesterday and you wouldn't expect them to be completely empty, they give you a bit of a clue.

Abigail
Case 15:
2nd interview

Most of that time it's like I guess you resort back to, if your patient was unresponsive and that's really just looking around and having a look, normally with a significant overdose there are empty packets and sometimes they're hidden, sometimes they're in bins, they're not just in the lounge-room so you have a good look around. There is obviously the history of the phone call and why we were called, some evidence there to say that there was an overdose taken, whilst I didn't speak to the person at the surgery who called the ambulance service they've claimed that she's called and said she's taken an overdose so there's that history as well. Apart from that from what she said to have taken she was looking symptomatic, so it would give you an idea that she's taken a significant amount and not just one tablet. Bit hard when you've got alcohol combined with that.

Abigail pointed out that although you may have searched and can make an educated guess regarding the amount of substances consumed by the patient it may still be underestimated. This underestimation was possible due to the fact the patient may be able to tolerate large amounts of medication, which they have been taking for extended periods, that would normally knock others 'for a six'.

Abigail
Case 15:
Initial interview

… combined with alcohol it's difficult to work out how much because in the person who might normally have 15 milligrams or20 milligrams of diazepam a day that might not touch her but with a bottle of champagne and maybe she'd had a lot more. We just don't know what, the diazepam or the alcohol. What would knock me for a six might not if she's normally on it.

The 'search' can either confirm or counter the patient's story, but often the information remained incomplete and this could have an effect on the triage and follow up care once the patient arrives at tertiary care.

Abigail
Case 15:
2nd interview

…but when someone's not very forthcoming but they obviously want help, for us it's not really that difficult, they want to go to hospital and obviously it's just the obs and getting as much information as we can to help the hospital here.

7.2.2 History, history from others and social history

The patient's medical history completed the search for information. The amount of current and past history gained from the patient was dependent on the patient's willingness and ability to communicate, the circumstances, and the paramedic skills in eliciting a response. The complexities in gaining a history, the variability of the response from the patient, and the availability of information contributed to the underlying feelings of 'they can only do as much as they can'. The incomplete history added to the frustration of working with half the story, particularly when attending psychiatric presentations.

Nathan
Case 13:
Initial interview

It's hard to say, I don't know the guy so I don't know what his history was, whether he's been in an army overseas or not. ... I couldn't ascertain. Never seen him before, we've got no history on him at all so one of those tough ones, I guess to find out anything.

Joyce
Case 2:
2nd interview

[Do you think social history is important?]

Yes, it definitely is.

[How do you go about getting that social history?]

Well it depends, yeah like sometimes you're not going to be able to get that – with that patient it was probably hard because – he'd tell you a fair bit but he wasn't going to probably go in and say well you know today I don't really feel too socially acceptable today, like he – you just sort of gauge it – that one's a hard one, just with everything you see and what you do.

Abigail
Case 15:
Initial interview

Has done that [past history of overdose and cutting self-harm behaviour] *before and has done the wounds before, there's a history of that, other than that not forthcoming with any other information about history. … Nothing else that she was saying other than it looked like she had some reflux issues, just not forthcoming with any information. I asked if she had a history of depression and again depending on the question wouldn't really respond with an answer, but if I asked something simple I suppose, not much history, then she'd answer.*

The reliability of the patient's account and the continual need to rely on other sources to verify the history was significant to how readily the paramedics believed or took note of what the patient was actually saying.

Nathan
Case 13:
Initial interview

Ah, he said he took some alcohol and he just said he took some tablets, so he wasn't very specific initially and then he said 500 then 100 then he said 50 then he said 300 so his story kind of changed. There's tablet bottles there from different dates so it's hard to know how many actually he in fact had. He's conscious and alert so you know; he's obviously not taken enough to knock him out

The continual 'battle' in the search for answers implied a sense of we will listen but not take at face value the patient's explanation, but look for an objective means of verification. Although information from bystanders and family members was considered very useful the information needed to be taken in context and family members, if available, might not be privy to the full extent of their relative's problems.

Len
Case 10:
Initial interview

It helps when you have bystanders at the scene who know the patient and can indicate what their current issues are, as with this patient.

Jessica
Case 8:
2nd interview

I guess the whole picture, the whole, like, what the bigger story is, maybe – yeah I guess the issues of the bigger picture, maybe what's causing their underlying behaviour, if you can find that out, sometimes you can't other times there's like a family member or teacher or someone who lets you know and that makes you a little bit more understanding because you can sort of see where they're coming from a little bit better and I guess the other is there behaviour. It is normal – have we been out to them a hundred times in the last month or is this a first presentation for them, that sort of thing, and I guess a gut feeling as well.

Robert
Case 7:
2nd interview

But yeah, and then, obviously, you've got to use your own skill and knowledge to decipher what's good in it and what's bad in it, and whether it's just a disgruntled neighbour that wants them out of the place, or whether they are a risk to themselves or other people – so, yeah, but I think all information – the more information you can get, the better, and make up your own sort of decisions with that information.

Robert mentioned that the main focus of his assessment was to make some sort of determination as to whether the person was a threat to others or to themselves and using all sources of information is beneficial in achieving that goal.

The social history, although considered important, was secondary to the physical manifestations of the patient presentation. It was considered 'nice to know' once the actual reason for needing the ambulance and past medical history were obtained. Although the social history was not directly sought after the paramedics tended to use strategies which by their very nature obtained the patients wider social history. Emma used the phrase 'come into my office', referring to the ambulance, as a way to invite her patients into her confidence. Emma's technique of letting 'them talk' consciously opened up the conversation for the patient and created an environment where the patient felt safe. The result, as Emma's account showed, was greater detail and understanding of the woman's situation.

Emma
Case 3:
Initial interview

Oh it was pretty freely given [the history – her life story?]. *Yeah, she was a bit hysterical when we got in there but we do the usual routine – just say look come into my office and we'll come and sit down and once you've usually got them by themselves which is something I try and do you could've said look what's been happening and what's been going on, you usually get that information quite freely and just let them talk I suppose and worry about your obs* [observations] *and stuff a little bit later. … She has recently over the last week has also been home a lot more with her husband than what she normally has which has also helped to trigger these problems that she's having and these thoughts.*

Samantha
Case 14:
Initial interview

[Did she mention anything about her previous treatment or previous history?]

No just that she's been an inpatient really very recently and sort of felt that she'd been discharged a little bit early so hence the rebound I think.

Joyce
Case 2:
2nd interview

Yeah, sometimes and sometimes you just get someone who is agitated, you're not going to get that information – you just have to chat, if they just want to talk about being on the moon, then you just sit there and talk about being on the moon, there's nothing much you can do – that's telling in itself.

Paramedics also used the incoherent information from patients as part of their history taking and assessment. As Joyce noted, when a patient talks about the moon or other strange events, this was telling in itself and it was a matter of being able to sit and chat. She made the point that there is the realisation that you might not be able to get the social story from the patient and there are the feelings of not being able to do anything which you have to deal with.

Documenting objective history and observations

Documenting the patient's history involved two issues: the need to document what paramedics considered objective facts and not the subjective views they may place on the situation; and its importance to ongoing care. The social history, included in a condensed form in handover, appeared to be dependent on what paramedics could determine as verified, objective fact. Paramedics made a distinction between facts as verifiable and those facts relayed by the patient. The value placed on the information gained in the history related to its immediate importance to ongoing care, especially in terms of the amount and what type of substance had been consumed in instances of suspected overdose. Overdose and other medical conditions such as diabetes have significant implications in terms of the conscious state of the patient, maintenance of the patient's airway and breathing, the potential for deterioration in the patient's condition, and whether further resources are required.

Joyce
Case 2:
2nd interview

… but you can't also make assumptions either, so if it's not a solid fact there's no point putting it down because that's just us – it means that we're putting our opinion out there and we're not really suppose to do that, so that's why we write down – like of course we put down what they're wearing in case they abscond so then they have a description of what they're wearing and also oddly enough if they're wearing their underwear on their head, that might be fine perhaps but not quite right at the moment, it might be something more going on.

Abigail
Case 15:
Initial interview

Other things, just whether or not there's any history, what she's had and whether or not we're going to have someone who can walk or not whether we're going to need assistance to get someone out of the house, whether that's SAPOL or just another crew, but a poly-pharmacy overdose obviously with diazepam sometimes they can be walking and the next minute they can be unconscious and obviously keep in mind what other medical conditions are involved, she didn't have a history of diabetes or anything else that would cause the altered GCS or whatever, rule that out.

7.3 Complexity and comorbidity: a process of elimination and can we treat any underlying medical causes of the disturbed behaviour

Paramedics used a process of elimination in patient assessment. This involved searching for any physical explanation for the patient's altered states of consciousness (altered GCS) and altered behaviour. This took the form of a check list of other conditions and comorbidities which have similar clinical signs and symptoms which could be the underlying cause. For example conditions such as hypoglycaemia, hypoxia, dehydration, stroke, arrhythmias, head injuries and the added complexity of drug and alcohol use. This process was not simply a 'tick a box' procedure to eliminate other causes of 'inappropriate behaviour' but a way in which paramedics could methodically, constructively and practically assist the individual. The process was also characterised by what paramedics felt most able to address considering their training which is focused on the biomedical and resources available to them.

Len
Case 10:
2nd interview

Yes, I mean obviously you need to consider all other medical possibilities and there are lots of medical conditions which can cause identical symptoms to mental illness so, I mean you need to still do your normal assessment on the patient, neurological assessment and your base line Obs, blood sugar level, all of those sorts of things in order to rule out anything medical, and obviously you can't completely always rule out something medical.

Emma
Case 3:
2nd interview

Well I mean if you've presented with someone initially with someone who's agitated and they have a history of diabetes the first thing you'd be doing is popping some oxygen on them and you'd be checking their sugar levels you know and then if they have enough cognition to answer questions you can ask them questions and get them to have some glucose paste. But after that and you're rechecked their sugar level and it seems okay, they don't have an arrhythmia that would affect their conscious state, they're not hypoxic, there's nothing else to indicate, they haven't had a TIA (transient ischaemic attack) or a CVA (cardiovascular accident) , there's nothing else to indicate why their behaviour is inappropriate, you know you get the list of medications, you find out from family members what their behaviours often like and if they've been having some sort of acute or chronic psychotic episodes or are becoming chronically unwell then that is also something that would be a part of your assessment for sure.

Don focused on the possibility of being able to do something constructive for the patient and that by addressing the primary cause you might be 'successful' in removing the secondary effects. These statements suggested that in cases of mental illness by implication paramedics felt they could not do anything constructive except transport the person to further care.

Don
Case 1:
2nd interview

Yes, I mean if you can remove the acute problem, that – you might be successful in removing the secondary problems, so if it's possible and we can intervene and make a difference then sure.

The process of elimination of other physiological causes was complex and not straight forward. Joyce explained that the person may not even acknowledge or know they are ill and may tell you they are fine and yet need further care which means the search for the problem is not defined and cannot be easily pinpointed.

Joyce
Case 2:
2nd interview

It can be – it can be a bit more difficult because it's not just I have a sore stomach and this is what's happening, it can be so many things and for them they might feel normal and trying to get – you know – if they don't feel like there is anything going on it's kind of hard because you ask them questions and they will just say 'no I'm fine there's nothing wrong' (yeah) they might do that, but – you know so it is hard, but then just have to gauge how their conversation goes and if they follow it – just your interaction, you just put down how they are.

Len considered it essential that paramedics have foundational knowledge about psychiatric disorders and how they present; otherwise the process of elimination cannot even begin. He believed you have to know what you are witnessing and the alternatives to make a clinical judgement. This allowed for more accuracy, better outcomes and assists the person to gain the help that is appropriate.

Len
Case 10:
2nd interview

I think that's where you have to have an awareness of what the disorders are that they have and how they can interact and what sort of affects they may show as a result of it. I mean some conditions you may be able to rule out as a problem as far as displaying signs and symptoms similar to a mental illness but then others you might go 'Well no there might be something here we need to look at'. I had one job recently where a patient was, no history of diabetes, no history of diabetes provided but you know, they'd been detained due to abnormal, bizarre behaviour when they were having a hypo [hypoglycaemia].

Another example of the complexity which makes the assessment process more than just a tick box exercise is, as Sam described, the difficulty in defining what is 'psychiatric' when the characteristics can be mirrored or complicated by other conditions. He remarked how difficult it was to accurately code the event on their documentation when you have multiple comorbidities involved, there is essentially only one code for 'psychiatric presentations' with no delineation in presentation types and it became a matter of choosing the code which best fits. This created tension between the shorthand documentation for the case card and handover and the elaborated knowledge gained during the assessment by the paramedic. Ultimately this reduced the exercise to labelling. Sam also flagged the notion of self-protection and some of the 'old school' ways of dealing with patients, such as restraint and routine police attendance which reflected a lack of knowledge of the resources available. He believed paramedic attempt not to label someone, but it becomes an issue with trying to encapsulate the information for coding purposes and handover (*Sam – field notes, 13th May*).

‘Regulars’ and the presence of long-term comorbidities posed a particular challenge for paramedics. Kate stressed the need to remain open minded and to try and not get blasé even though you may have attended this person several times before. The individual may have a past history of underlying conditions such as cardiac or respiratory disease or diabetes, but the reason for attendance in the past has been related to their mental illness. On these occasions where the person had become physically ill as well it had resulted in a tragic outcome. What became evident in Kate’s story is all aspects of the person are essential to consider when conducting an assessment and paramedics cannot ignore both the mental and physical aspects of a presentation.

Kate
Case 17:
2nd interview

Yes it gets tricky to manage them from a purely mental health point of view because they do have the medical issues so even though you know that they’re ringing up and saying chest pain and they probably don’t have chest pain it’s just part of their mental illness, they do have cardiac problems so you can’t, you still have to go and assess them, you can’t just say it’s probably not your heart because they do have heart problems and they will one day die and you can’t just ignore that. It’s very, very difficult to manage in a different way, it would be good if there was a better way but I don’t know what that would be because they do really get sick. I went to one of our regulars north and the call came through sounding exactly the same as it always did but then at the end they said ‘well actually she’s blue and not breathing’, and we got there and she had actually died. So you know it will sound exactly the same when they’re not dying as when they are so you can’t, I don’t think there is any real way around it.

7.3.1 'Body' first

Paramedics' primary role, the emergency provision of care, featured prominently when they discussed how they prioritise their information and plan their actions. Paramedics believed they did not discount the psychological aspects of their patient assessment, but their major task was to address the 'body' and the psychological side of the equation is better dealt with by experts.

Robert
Case 7:
2nd interview

Well that's where you are getting the thorough history, and I mean, obviously, we can fix all the physical things – well try to, anyway – just as long as we can look after their physical side of it until they get to hospital, the – obviously, the people that are – the mental health teams can look after the psychological side of it. So, yeah but it is good to know obviously, for your own safety, and also, as a sort of a flag that can tell you why they've got themselves into this situation. So, whether it is alcohol abuse, drug abuse – yeah, I think it's probably a lot bigger than a lot of us expect,…

Kate
Case 17:
2nd interview

For me the first priority is their physical side in the initial phase if somebody is having a significant haemorrhage you know you can't really help their mental illness if they die so you have to deal with the physical side first but that's only in the first instance and if you get to a point where the danger there has passed, you've bandaged them or stabilised them in whatever way you need to then I guess mainly it comes back to the mental health side. It does get pushed as a secondary in the first instance but that's because we tend to deal with what's going to kill you now versus what's going to kill you later.

Abigail added a more detailed perspective which contributes to the way paramedics cope and manage when confronted with several interdependent and complex problems in the one individual. Paramedics layered their approach and managed not only what was immediate in its effect on the individual but what was familiar

and to an extent comfortable initially, then ‘work around’ the psychological aspects of the presentation.

Abigail
Case 15:
2nd interview

Most people want to sleep when they’re intoxicated, they don’t want to talk to anyone, when there’s other things going on I guess for us the psychological aspect is a health problem but we have to address what’s happening with their body first so if they do have airway problems, obviously if they do have airway problems they’re not talking to us anyway, blood pressure problems, all that, we do have to address all that and make sure they’re not having a hypoglycaemic episode. Then on top of that try and work around what’s actually caused this and do you want to talk about it. …

[Do you find that mental health assessment takes a back seat when you have to deal with other medical issues?]

I find, no, I find even with our normal cases, you know say we went to a chest pain and someone might be on Zoloft coincidentally, once we’ve adjusted it and we’ve addressed the chest pain and everything else I’ll say ‘does the Zoloft work for you, are you still feeling depressed, how’s that going’ and most of the time you get a good idea about how they’re coping, I’d say rarely they would actually say ‘yeah I need to talk to my doctor about that as well’, but for me when I see the whole history I certainly ask questions, not just about the psychological history but everything that’s on there.

Don aptly encapsulated the feeling of being in the pre-hospital setting, the expectation and urge to ‘fix the problem’, and to be able to constructively do something for the patient. Their role was to help the individual in their acute and immediate circumstance, but as Don states, in the majority of cases of mental illness they cannot offer any immediate intervention.

Don
Case 1:
2nd interview

I wouldn't say myths, I would probably say misconceptions, from a – from a paramedic point view and pre-hospital care, emergency situation, we get the – we always have an urge to try and fix the problem and most – more often than not with mental health we can't – no interventions that we can do can immediately fix their problem. … Again depression is something that we cannot acutely fix; we can't really do anything to help a patient out with that, really all we can offer is transport or referral to a mental health team.

The other major consideration was paramedics attend to psychiatric presentations when they appear to be at the 'end' or acute stage. As Robert suggested 'when everything has gone wrong' and they are seeing the final result in form of self-harm or assault.

Robert
Case 7:
Initial interview

We see it at the end stage, probably when everything has gone wrong. So, a lot of the time it's a thing that's been going on for weeks. Well we see the final crux when they've decided to self harm, or assaulted someone, or in their car and had a car accident, and that was, maybe the underlying cause of the car accident. So, they can co-present, I suppose with other conditions.

Collectively the challenge of trying to ascertain if there is an alternative reason for the altered behaviour, the pervasive view clinically that there is little in the way of care they can provide, and attending the patient when they are usually in the acute or 'end stage', all contributed to paramedics focusing on what they might actually be able to address.

7.4 Conclusion

This chapter has focused on the processes and priorities in assessment with the emphasis being on what paramedics see, hear, search for and how they use that information to address the patient's immediate needs. The chapter explored the concept of what paramedics consider 'need to know' and 'nice to know' information, how they attempt to eliminate any other possible causes of the disturbed behaviour, and how the entire assessment process is complicated when the patient is presenting with multiple comorbidities.

Chapter 8 continues the narrative with what is considered treatment, the strategies paramedics used to achieve their duty of care, the legitimate need for care and use of their services, the influence of past and present 'on-road' experiences, and current education.

Chapter 8

Findings part 2:
Assessment, assumptions and influences
(Section 2—assumptions and influences)

8.0 Introduction

The word 'treatment' has a certain connotation and meaning within the medical arena. The Oxford English Dictionary (1996) describes it as the 'the application of medical care or attention to a patient'. This definition aptly covers the way paramedics viewed 'treatment' and the limited or non-existent 'clinical hands-on treatment' or active care they felt they could provide when dealing with psychiatric presentations. This chapter explores the concept of treatment, the strategies paramedics use to achieve safe transport and care, how they meet their duty of care and some of the cultural assumptions and influences which directly and indirectly affect their actions.

8.1 Treatment: strategies, interaction and provision of care (Can we clinically provide care?)

8.1.1 The traditional role of emergency care versus changing practice

The traditional role of providing 'emergency care' stems historically from the St John Ambulances first aid training, the military, and in South Australia the Department of Emergency Services. The following question from Sonya exemplified

paramedics' focus on the immediacy of a problem, on the 'medical' evaluation of the patient and the practical application of care.

Sonya
Case 16
Initial interview

I didn't need to take obs, medically she's fine.

[How did you make that decision that she was medically fine?]

She had a GCS of 15, she knew what was going on, she was walking; she was talking fine, there was nothing to suggest that she had any issues with blood pressure or anything like that.

This traditional role remains a predominant guiding cultural philosophy, although there are significant moves in the ambulance service to principles of primary health care, aligning with other health professions, and gaining professional status as referred to in the literature review. This transition period from the provision of emergency care to a more primary care focus has created tension in how the traditional paramedics' role is reconciled with new expectations and expanded practice. These tensions created feelings of uncertainty when paramedics considered their predominant role was still the provision of emergency care, but are confronted by cases which are chronic in nature with no perceived tangible solutions. In these circumstances of no clinical hands-on solutions they felt a devaluing of their skills. In psychiatric presentations, paramedics resorted to strategies to safely transport the patient to definitive care which currently remains the ED. This provided a means to medically clear the patient and, in the light of limited community services available a pathway to mental health care.

Abigail
Case 15
2nd interview

That's why often when we are called to these cases I'll try and get them to go voluntarily and explain 'because of this we now have a duty of care, you've taken these tablets and you've already told me that you want to harm yourself and you want to die', some of them have a plan, some of them I guess have an experience before and they just tell you everything so we have no option, 'we can do this and you come with us voluntarily, if you don't then we have to get the police involved and it's not nice'. I'd say 60 percent of the time that works, another 20 percent on top of that the police turn up and they come with us because they go right I'll go with the ambulance and then the other 20 percent don't; they have to be physically moved.

8.2 Managing the consequences of patient actions and alternative strategies

Paramedics used the terms 'active treatment' or 'passive treatment' to refer to the extent of the clinical intervention provided to a patient. If 'treatment' was actually required it usually entailed the managing of consequences of the patient's actions. This entailed dealing with incidences such as overdoses, self-harm, and comorbid alcohol and substance use.

Adam
Case 12
Initial interview

Bandaged up his arm, tried to keep him calm and just put him in the back here. On the way he appeared quite anxious so we just tried to build a bit of a rapport, keep him calm …

Pain relief or oral diazepam, depending on the circumstances, are the most readily available pharmaceutical options paramedics have in South Australia. Further support was available to paramedics in the form of the mental health liaison within the Operation Centre, shift managers, team leaders, and ACIS. Paramedics could also request the assistance of an intensive care or extended care paramedic, who

can within their practice guidelines use midazolam[10] for sedation and finally the involvement of the police to assist in the transport of the patient.

Alternative strategies were often required to care for the person and achieve the paramedics' goal of safe transport to definitive care. Sonya recalled a situation where the police borrowed a ladder from the neighbours to check the roof space where the patient believed bodies had been stored after they were murdered. The patient up to that point had been refusing to let the paramedics and the police in to their residence until they agreed to check the roof. The delusion was a powerful influence in this case and once the roof had been checked the patient was willing to come for further care.

Sonya
Case 16
Initial interview

Anyway we thought it's not going to be easy so we actually organised for an ICP [intensive care paramedic] *to come down because we thought we'd probably have to sedate her. Meanwhile the cops, I don't know how they did it but they found a ladder in the next door neighbour's shed so she was quite happy to let us in. So we went in, they checked her roof cavity, she was fine with that, 'alright, I'll come to hospital'. So she was quite cooperative in the end. I don't know what would have happened if we couldn't have had a look in her roof cavity.*

Sonya's description demonstrated the balancing act paramedics continually try to navigate between the need to get the patient to hospital in the most effective way possible and the safety of the paramedics and patient. Hence paramedics are

---

10. Midazolam: increases the inhibitory effects of GABA throughout the CNS, resulting in anxiolytic, sedative, hypnotic, anterograde amnesic, muscle relaxant and antiepileptic effects.
    Source: Bryant, B, Bryant, BJ, Knights, KM, Salerno, E, & Knights, K 2010, *Pharmacology for health professionals*, Mosby. p. 313-317

continually adapting to the changing physical and emotional states of the patients they attend.

8.3 Keeping it calm and using diversion

A strong narrative came through the interviews of paramedics attempts to keep the patient as calm as possible. They took actions that avoided aggravating the situation or going against the patient's wishes, if the circumstances allowed. This approach changed when the patient refused paramedic direction or medically the patient was at risk. This placed the paramedic in a position where they had to intervene to meet their duty of care.

Nathan Case 13 Initial interview	*He was a bit aggressive as well so I really didn't do much for him at all and to be honest– just left him alone and kept him calm by not aggravating his situation.*

Philip reiterated these sentiments and stressed 'I do not want to increase the patient's agitation or distress and our main aim is to get the patient to the hospital where they can receive further treatment and specialist care'. Philip also alluded to what was considered a common occurrence where patients suffering mental illness appear to present to paramedics when in crisis or in the acute phase of their illness. These patients can present at points in their life where they are quite agitated, distressed and angry, hence 'I try and go softly, softly to encourage and get them to hospital' (Phillip, field notes, 11 August 2009).

Samantha was aware that the patient's physical condition might change due to the overdose, but clinically made the decision that it would be better to have the patient willing to go to hospital and deal with the situation if it started to deteriorate. This reduced the potential for the patient to refuse transport if she insisted on using the stretcher.

Samantha
Case 14
Initial interview

The only other really significant thing is that she didn't want to be on a stretcher, she didn't want to be a patient but she was more than happy to sit in the seat and come in the ambulance. Ideally because she'd taken an Endep overdose I would have much preferred to have her on the stretcher and monitor properly but she wasn't happy to play that game so you just go with what they're happy to do.

Adam recounted his attempts to try and keep the patient as calm as possible when he discovered the patient was still experiencing auditory hallucinations and delusions. This discovery very quickly changed the focus to possible risks if the voices were telling the patient to self-harm or harm Adam and his partner.

Adam
Case 12
Initial interview

I didn't want to go into it too much, I didn't know what they were telling him and what he was hearing, would that provoke him to have a sort of negative attitude towards us or anything so I just sort of said to him, are you still hearing the voices? How long have you been hearing them? And he explained to me and I said what have they told you? Oh, they told me to cut my arm, I said okay.

The paramedics described using diversion as a technique to try and maintain this sense of calm and their skills in observation to find common ground with the patient to build a rapport.

Adam
Case 12
Initial interview

…, yeah, just tried to keep him calm and happy and just talked to him about a few different things …

Nathan
Case 13
Initial interview

I think the only real strategy I used was more the approach of just keeping him calm and not aggravating the situation by asking him too many questions … he had a motorbike at his house so I asked him questions about that like that just to divert off other things that seemed to upset him.

Rose
Case 20
2nd interview

Find out their interests, you can usually tell their interests by walking in their house, …, so you can always talk to patients and use what they tell you pretty much to build a rapport. … Just sit and talk to them about things that they've already spoken to you about pretty much, or finding things in their house, like you can see pictures of places, diverting their attention and talking to them about those things.

The use of diversion, although a common tactic used by health professionals, is a useful strategy for paramedics in two respects. As a practical strategy diversion generally did not aggravate the patient or escalate the patient's distress or discomfort when there was little or no immediate support available for the paramedics. Diversion also provides a means for paramedics to achieve the goal of transporting the patient to further care. The use of diversion is effective, but paramedics walk a fine line between acknowledging the patient's need to talk about their problems and the need to try and manage the situation without creating further emotional and psychological stress.

8.4 Focusing on the relevant information

Paramedics regularly found themselves trying to reorient the patient to the relevant information they felt they needed for the patient's immediate care and their

handover to triage staff. The information paramedics required was either lost in a limited response from the patient or in the tangents of the patient's life story. Their focus, in the short term, was how useful is the information to the patient's direct care needs and what is the 'need to know' information for the handover. Paramedics discussed communication as a task and in terms of information gathering rather than as a tool to develop a relationship with the patient.

Robert
Case 7
2nd interview

I was listening to what sort of tangent things she was talking about. She'd start talking about her sons, or started going off on – I can't quite remember the ones, the specific details of them – but I'd let her go on with them for a little bit, … She was sort of almost losing herself, so it didn't seem relevant to the case or anything I needed immediately to do. So, I'd – you know, in a nice way sort of – yeah, I understand all that, and then I'd sort of bring her back into the information I wanted to find out about her.

Sonya
Case 16
Initial interview

I can't say I got a good story of what's been going on specifically because there's nothing I'm going to be able to do by hearing that information so we were quite happy just to get a basic story and go with that.

Sonya justified the almost minimal stance on the history obtained by explaining that in this case the mental health team knew her patient well, were in attendance and had been her case manager for a number of years now. Sonya also believed that the ACIS staff had already been in contact with the mental health liaison within the ED before they arrived at the hospital. The belief that the 'basic story' was sufficient and that the real work needed to be conducted by the mental health workers was summed up by Robert.

Robert
Case 7
Initial interview

But yeah, I mean there's probably a lot more to the story that I didn't go into about, and that's probably the mental health worker's job to find out what the real underlying issues are.

8.5 The interactions and actions

The interaction with the patient and the way paramedics presented their actions was essential to understanding how paramedics viewed their management of psychiatric presentations. Paramedic communication and their actions were seen as standard and not necessarily as 'active' treatment unless the situation required a longer period of engagement with the patient. Carl, when asked if communication was seen as treatment, believed the initial history taking and exploratory questions are a common process with every case, therefore not 'active' treatment. Once the reason for attendance and preliminary information was gained then Carl considered communication could become treatment. He thought communication was an important part of the ability to recognise signs and symptoms, and knowing what to look for (Carl, field notes, 25 March 2009).

The tools to gather the patient history and to maintain a safe, calm environment were all closely linked to making the patient feel as comfortable and reassured as possible.

Robert
Case 7
Initial interview

… just reassurance and making her feel comfortable, you know, being in the ambulance and around the ambos.

Samantha
Case 14
Initial interview

She needed a lot of reassurance about calling an ambulance was the right thing to do, that in terms of her presentation, the house was relatively tidy, her personal appearance, she's still taking care of her personal hygiene, so just reassured her that she's a little bit ahead of the ball-game at the moment.

The idea of spending time in just 'being' with the patient varied between those that perceived value in this process to those that were more focused on getting the patient to further care and getting the basic story. The majority conveyed being respectful to the patient, treating the patient as a human being, and maintaining what they considered a professional stance as a basic guide to their interaction with the patient. Others made further statements placing value on actions such as sitting with the person, not rushing, and taking the time to listen and acknowledge the person. Emma suggested that if she felt the situation was going to take time she would contact the dispatch centre to make sure that they knew they were going to be engaged in the case for a longer period of time.

Robert
Case 7
2nd interview

But yeah, sitting down, talking to them, and taking time, not rushing. A lot of the times they want to have cigarettes while they're talking to you.

Samantha
Case 14
Initial interview

[Do you think communication is actually a vital part of what you do?]

Yes. They need to feel that they are being listened to, they're being respected and that'll get them to call us again next time.

The perception of communication and time changed when paramedics were transporting psychiatric patients from regional and rural areas. Fran, who worked 'down south', considered that in regional transfer situations they have time to

communicate and develop a rapport with the patient. Their transfer time can be up to an hour, providing them with an opportunity to talk with and get to know the patient. Fran believed the key is to treat the patient no differently, accept that as a paramedic you tend to get the patient's life history, and to know when the patient doesn't want to talk. When asked how she knows when a patient does not wish to talk Fran identified cues such as the patient seems to turn away and answers with closed responses.

Fran didn't believe that the extended timeframe with the patient created a confronting or more difficult situation for paramedics and stated 'I don't have a problem with the patient telling me their life history' or dealing with difficult or emotional content of what the patient is saying. She considered she 'had been there done that' and it was all about 'life experience' (Fran, field notes, 4 April 2009).

Paramedics observed that the extended time to get the patient to hospital offered a means of judging the resource effort that the case entailed. Sue and Neil, as they were waiting to handover, stated they had spent over an hour trying to get this particular patient to come with them and eventually the police were required to step in. They were trying to complete the job and handover because they had already gone into overtime and would be late by the time they got back to the station (Sue & Neil, field notes, 18 January 2010).

The story behind a given case is important to understanding whether the paramedics felt they had the time to spend with the patient and has practical implications for operational matters such as overtime and their availability as a resource. The particular incident described above occurred around five-thirty in the evening, which is close to the completion of the paramedics' early shift. The patient, in his mid-twenties, had claimed to have taken an overdose and stated a past history of anxiety and depression with previous cannabis and methamphetamine use. The patient claimed that he had smoked only one joint to help cope with a recent relationship break-up. The patient could not be left at home under these circumstances and the paramedics' duty of care dictated that they transport the patient to hospital. Sue suggested that the relationship seemed to be a volatile one according to the patient's account of the relationship. Sue and Neil were concerned due to the patient's high heart rate, 150 beats per minute, and an apparent history of a heart condition. The high heart rate was accompanied by a high blood pressure and the patient was drowsy (Sue & Neil, field notes, 18 January 2010). In this case the paramedics were dealing with a significant situation in terms of the overdose with positive physical signs. After an hour of listening and trying to encourage the person to come to hospital it was time to instigate alternatives, in this case using the police and their persuasive powers to achieve the goal of getting the patient to hospital.

8.6 The broader social reasons behind the need for care

Paramedics reflected periodically on the wider psychosocial reasons behind the presentations they were attending. Robert thought that paramedics often attended individuals who needed social contact and someone to listen to their experiences. Robert implied paramedics may be the first and only contact the person has had with the health system for a long period of time. Paramedics were available when there is limited access to general practitioners or specialists, the ambulance service is available twenty four hours a day, and it provides an entry point for further care and hospital admission.

Robert
Case 7
Initial interview

I think, you know, she'd really wanted to tell someone about what was going on, so that was the thing, I think she just needed someone to be able to talk to, really, and just know that she's got all these other ongoing pressures. I'm probably the first contact she's had.

Samantha proposed the reason for their attendance was possibly due to inadequacies of previous treatment and it was a way for patients to say to others that they really needed help.

Samantha
Case 14
Initial interview

[Did she talk about the lacerations or the reasons why she had cut herself or the overdose?]

No she didn't sort of make any – didn't have any real explanation for that at all other than she's just not coping at the moment. She's had a very recent overdose so I'm thinking perhaps she didn't get quite the level of treatment from that episode and has thought perhaps if I take it a little bit further there'll be more intervention this time round.

Samantha viewed this case as a situational crisis. She mentioned that although the person was feeling as though they had reached rock bottom she was still managing 'small wins everyday'. She was managing to maintain her house, her personal hygiene, and was getting out of bed every day. Samantha felt it was important to focus on the small achievements that the person was making as a way of encouraging the person to consider not everything was at a complete loss. Recognition of the individual's ability to call for help, although even earlier would have been better, implied Samantha believed they have a role as an important resource for people. This reinforced the belief that paramedics are often attending these individuals when they are at crisis point, the support for individuals experiencing a mental illness was limited, and that there remains significant gaps in the support they receive.

Samantha
Case 14
Initial interview

The most important thing for her is that she has called early, it would've been even better if she hadn't felt the need to have those attempts like just recognised in herself she was having a situational crisis and called before having to do any of that, like just felt confident in herself enough to say I'm having a really shitty day, put her hand up and call without having to do all of this but at least she hasn't let it go too far, she hasn't let herself get really, really sick before she's given us a call.

Samantha felt that it was a sad indictment on the health system that a person needed to go to the point of self-harm to make themselves heard. The individual's self-confidence, their ability to recognise when they are becoming ill and when to call for help were significant in determining when and if the ambulance was called. The reluctance, the associated emotional distress, possible shame and guilt felt by

the individual, which could lead to a delay in asking for help creates impediments not only for the individual in receiving care but also for the ambulance service. The delay had direct implications for service delivery, the urgency of attendance and associated increasing complexity of the presentations which paramedics attended. Appropriate interactions with all, including the point of contact with the health system from primary, community based care to tertiary and specialist care, was viewed as an essential component to encouraging people to call earlier when in need.

Samantha
Case 14
Initial interview

I think with appropriate interactions with all, like the continuum of health care, people will start asking for help a bit earlier which is what they need to do.

Samantha considered herself as part of the wider health system and integral to providing care within that system. Samantha's commentary clearly expressed her expectation that appropriate assessment and care needed to be given at all levels of contact with the health system which, in her opinion, was not currently being achieved. Adam also hinted at the lack of cohesion in the health system by highlighting the lack of communication and respect he felt the patient and the paramedic crew had been subjected to by the nursing staff at a facility where they were attending a patient.

Adam
Case 12
Initial interview

[How long had he been hearing voices for?]

This presentation since about four-thirty this afternoon so about three hours, I'm not sure of his previous history, we got no real handover from the nursing staff. It was sort of like we've asked what have you done today, we've got all his notes and almost, you know, almost kicked us out the door, so yeah.

[So they didn't give any explanation?]

No, none at all, none at all, no it was more this is his injuries, can you take him to hospital? You know, he was quite agitated so basically we went okay, come on, do you want to come with us?

8.7 Theme 6: Is it genuine, assumptions and influences

The concept of 'is it genuine' came from the paramedics' use of the term to convey whether or not someone they attended was in legitimate need of emergency care, the immediate care provided in what paramedics consider a life threatening or potentially life threatening circumstances. They made a clear distinction between individuals who may need attention and care but could access that care in alternative ways, rather than through an emergency service and those that need their attendance. Particularly in psychiatric presentation the tension built between what was seen as legitimate versus non-legitimate care.

This section discusses how paramedics determine someone is legitimate; how they view those they believe are using their services in an inappropriate way, and the rationale behind those decisions. The paramedics' perception of their primary role and the assumptions they bring to the job affect their actions in this area. The

paramedics refer to their ‘life experience’, past and present ‘on-road’ experience, their education and external factors such as the media and colleagues as forming their understanding of mental illness and hence their views on legitimacy.

8.7.1 ‘Is it genuine?’ attention seekers, regulars and are we just a taxi service?

When paramedics began to talk about the need for care in terms of ‘genuine’, the legitimate need of their services, it was important to ask what do they consider legitimate, how do they define it, and how do they make those assumptions. In practical terms paramedics focussed on characteristics of the person’s behaviour as a baseline for deciding someone was ‘genuine’ or not ‘genuine’. They identified behaviours such as the lack of hallucinations or delusions and the more obvious signs and symptom associated with psychosis as an indication this was not an immediate crisis. The paramedics became suspicious and less inclined to consider the case genuine if the individual seemed to know the system intimately and knew the phrases which would lead to immediate attendance such as chest pain or shortness of breath. A less tangible, but important, concept which the paramedics talked about was the idea of the ‘sixth sense’, the underlying feeling of what you are seeing and hearing is not the full story, is misleading or not ‘genuine’. The paramedics ‘on-road’ experience, personal experience, their own understandings, and professional knowledge all contributed to the development of this tacit knowledge and what they considered a ‘true psychiatric presentation’.

The feeling of the individual not being 'genuine' did not alter the paramedic's duty of care, but presented a challenge when they were fatigued, near the end of the shift, attending in the early hours of the morning, when attending the 'regulars', or feeling like they were being used as a taxi service. At these times the perception of being used inappropriately as a service could alter their tolerance and professional demeanour. On those occasions when the paramedics felt the person was not in genuine need of their services they particularly felt a tension between what they should be available for and having to care for someone who is not in immediate crisis. This feeling of being squandered as a resource and possibly denying emergency services to others created frustration and concern.

8.7.2 The patients behaviour and knowing the system

This section explores more closely the aspects of behaviour paramedics' identified which suggested to them whether the individual is genuinely experiencing a mental illness. The paramedics described behaviour which was aggressive towards themselves and others and appeared inconsistent with the patient's story and observed circumstances.

Abigail
Case 15
2nd interview

Just her behaviour and her attitude towards it, she didn't seem to be taking it seriously, she was laughing, giggling, you know had some mates around that she'd been talking to at the beach, just thought it was a big joke. … The body language is more what I would call a pretend fixed glance to the right but when not paid attention to that disappeared and she would then get distracted and do other things and if I asked the right question then she would answer it.

Rose
Case 20
2nd interview

[How do you make that determination if someone actually is playing on it or is a genuine case?]

If you've been to them, like obviously they've got a history and COMMS will tell you they've got a history, sometimes they can make you think maybe. Like she's basically said to me 'I can't find my house keys right now so you guys are going to have to leave and I'll call you back when I've found them', so those sort of things are telling you she doesn't need an ambulance.

Paramedics emphasised that experience, 'intuition' and the 'gut feeling', which they acquired with time 'on-road', contributed to determining if the patient was a genuine presentation. Joey succinctly expressed what he felt was their course of action when asked about how they identify if someone is genuine or not genuine.

> *What they say and do and a gut feeling and experience, and it is not limited to psych cases.*
>
> *For some patients it is a matter of getting them in the ambulance and telling them to sit down and 'shut up', the personality disorders seem to be the hardest to deal with.* (Joey, field notes, 11 August 2009)

Paramedics stressed that they believed that some patients, the 'non genuine' kind, knew how to play the system. The patient knew what to say and which avenues to go through to get the ambulance to attend. Those individuals have an intimate knowledge of the system and seemed to use that knowledge to ensure that they got the ambulance to attend. Another cause for suspicion about the call and its genuineness was the continually changing story from the patient at the scene, during transport, and once paramedics got the individual to hospital.

Joyce
Case 2
2nd interview

I think it depends on – because you know you get the people that have mental health issues and then you get the ones that are attention seeking, the ones that are just – they know and you know they're done it so many times, they know the system, they know what to say, they know and when you get them to hospital they're going to say something completely different, like we don't treat them, so they let them out – they kick them out of the hospital and I think that and those people frustrate, really frustrate the paramedics, …

8.7.3 Are we the right people to help?

Peter described how individuals with mental illness and what was considered attention seeking tendencies are not really well served by the ambulance service; he felt they are not the right people to help them in the long term. He felt 'they're not stupid; they are just fucked up and take up resources'… which upon reflection he qualified by saying 'I have a lot of time and empathy for people with mental illness, if they are genuine, but a lot are attention seekers and are just fucked up human beings' (Peter, field notes, 2 September 2009). My personal reflection at the time on the harsh nature of the comments made by Peter at the beginning of our conversation was how these statements demonstrated the stigma and discrimination which surrounds mental illness. As we continued the conversation I realised the description was not said as an attack on these individuals, but was more a sad expression that the whole situation was against these individuals and was not reflected in his actions with those in his care. He described how the environment and the often horrendous situations these people have experienced have played a major role in their development. He considered they have had no guidance in how to have functional relationships; they have never been shown or

taught the tools or skills. Therefore the need for the social interaction is there but they do not know how to go about it appropriately.

> [Question and personal reflection: If the support networks were there and they were able to access it – would this change the need and therefore the demand placed on the service?]
>
> *It possibly would, but the services aren't there and wonder if they would have the skills or willingness to access the help and it is hard to change something that has such a hold on the person.*
> (Peter, field notes, 2 September 2009)

The conversation dealt with the difficulty in providing the appropriate care for people with complex backgrounds and presentations. The difficulty lay in getting the person to recognise that he or she needed help and how to encourage a willingness to search for and accept assistance. There was also the question of whether the appropriate resources are actually available.

8.7.4 How paramedics see their role

These small details suggests the frustration paramedics express were not only directed at the patients which they viewed could be better managed in alternative ways (the 'regulars'), but about the conflict between how they viewed their role, emergency provision of care, and the lack of support that seems to be available for individuals with mental illness.

Abigail
Case 15
2nd interview

There's a particular person down south that they call us, we pick them up, we take them to hospital, they get there, a haloperidol injection and they leave, and they walk home. There has to be a better way than calling an emergency ambulance to take this person to [local hospital]. *The police go, we go and they walk out and I just think there has to be a better way, doesn't there?*

Sonya
Case 16
2nd interview

[Do you find your frustration is with the actual person or with the system more?]

Both. You get the ones, we've got one down at [name of place] *that just, she pops pills every time, calls Life Line knowing that that will get her the police which will get us involved which will get her to hospital. I sort of get annoyed with her because you know she's just doing it for the attention and every time she's like 'I wish I was dead' and you start to feel sorry for her but you think if that's the case why do you keep doing this every day, why don't you just go out and get some help yourself if you're not happy with what the hospital is giving you, you know take responsibility for yourself. I can't really blame the hospitals. I mean they're pretty busy and they have a lot of other people they have to deal with and if they're seeing these people all the time as well they're getting frustrated with them as well. I mean obviously the system is not working for some people but you know they're doing the best they can.*

Sonya encapsulated the overwhelming feeling from those paramedics who felt people needed to take responsibility for their health and, especially for those not perceived as genuine, needed to be proactive in accessing help for themselves. Sonya closely associated the high workload within the emergency departments and specialist community services with the difficulty in providing extensive and ongoing support for those individuals experiencing a mental illness.

Sonya
Case 16
2nd interview

Basically if they don't want to look after themselves you can't expect a lot of it on our behalf you know, if they're not going to try, why are we? There's only so much we can do and if they're not going to pull the rest of it why do we bother trying then?

The added dilemma for paramedics when dealing with apparently 'recalcitrant' patients is how does the patient's behaviour factor into the empathy and care the paramedics are willing to provide.

To answer that question, the stark comparison between the comments from paramedics seemed to actually belie the care which they showed to their patients. As I got to know the paramedics throughout the observation period, they showed empathy and compassion in their actions with psychiatric patients. They would do small things for the patient such as the way that they seemed to advocate for the patient with the triage staff, the tone of voice and manner with which they addressed the patient when they were interacting with them, and there were those that tended to follow up and see the patient before they left the ED. There were cases where there was clear misunderstanding and dislike of psychiatric patients, but the overwhelming feeling was of one of trying to do the best they can and achieve their job with the safety and care of the patient in mind.

One of many incidences observed demonstrated this extended provision of care. Adrian told of a case which involved a patient who had seen the general practitioner with a history of major depression. Apparently the depression was originally from a work injury and a recent stressful event triggered the cycle again. Adrian said they

tried to get the full story from the patient, but the individual was not altogether forthcoming. The general practitioner arranged for the individual see a psychiatrist for further help. The doctor did not detain the patient at that time because they appeared willing to see a psychiatrist and acknowledged their need for help. Once at home, apparently shortly after seeing the general practitioner, the ambulance was called because the patient was threatening to kill himself. Adrian described the effort it took to encourage the patient to come with them and get help. Adrian believed the patient needed urgent care. The patient 'looked like shit, unkempt, not looking after himself' and was currently taking antidepressants which didn't appear to be working. During the conversation Adrian questioned whether the doctor should have detained the patient because although the patient was 'voluntary,' Adrian considered there was a high possibility of the patient leaving without assessment if not seen quickly and directed in the right way. I observed Adrian spending time just sitting and talking with the patient in the ED and he kept encouraging the patient to 'hang in there and stay'. Adrian went out to the arrival area to let his partner know the situation and to contact the Operations Centre. Adrian stated they (he and his partner) really didn't want to leave until they were sure the patient was going to be seen by the mental health liaison and doctors (Adrian, field notes, 23 July 2009).

There was a level of contention regarding to what extent paramedics saw their role in psychiatric presentations. Similar to the feelings expressed under the paramedics' concept of treatment, some viewed the care they provide in terms of practical

measures, a matter of 'load and go' and transport to hospital, while some made statements of empathy, time and care if they perceived the person as genuine. As Joey says, 'If the patient is assessed as 'genuine' then there is an understanding, compassion and empathy that goes with it' (Joey, field notes, 11 August 2009). Joyce talked about the relationship if the paramedic takes what the patient is saying as serious and real. She felt generally that most people she has worked with are usually pretty good with mentally ill patients, but she qualifies that with the exception of the 'regulars'.

Joyce
Case 2
2nd interview

…you have a healthy respect for the people that are in a true psychosis that are really hearing the voices and most people scoff at them, but as long as you take them seriously and accept what they're saying and show that, you usually have a good relationship with them.

Joyce
Case 2
2nd interview

But one side of the issue is psychosis if they're not too aggressive most people I think are okay with them, but I don't know, everyone I've worked with are usually pretty good with mental health patients, except for the regulars.

8.7.5 The reasons for the frustration and disconnection with psychiatric patients

Excerpts from my conversations with Abigail and Sonya demonstrated the frustration experienced by paramedics when they considered the individual they are attending is not what they consider a 'genuine' presentation. They reiterated the feeling of being a wasted resource, which stems in part from the focus on what they considered as their primary role, emergency provision of care, and for some

who considered they should be available for cases where they feel their skills can be used.

Abigail
Case 15
2nd interview

I had a person who was a claimed overdose, but could just tell. I think they got drunk down the beach and were saying they took this and this, 'oh no they didn't take an overdose' they were saying they were suicidal, you're stuck down the beach with a whole lot of gear, played the nice ambo and she thought it was a big joke and I thought, because we were going home to drop her dog home and thought she's going to get there and thanks for the lift see you later sort of thing, and she'd already had an ambulance out that day as well which she told me and she didn't go because she was embarrassed and didn't want to go to hospital. This girl was stoned as well and she thought the whole thing was a big joke and then she became quite rude and normally I would probably ignore it but I guess everyone has a different, you know you have bad days and I didn't do anything wrong but I certainly didn't ignore it, I got frustrated with her and ended up getting her to get out of the ambulance, we called the police, we took her up to [name of the hospital]*, they didn't even talk to her or assess her, I'd never come across her before… mean I could tell this was all fun and games for her which frustrated me because there are lot of people, genuine people out there that need it and there's also a lot of other emergencies out there and we're playing this game it just seemed.*

Abigail acknowledged that she has to act in good faith with what the patient is telling her and she is not in a position to judge, but when behaviour is abusive and unrealistic demands are made which do not relate to the direct care of the patient it begins to create a negative feeling.

Abigail
Case 15
2nd interview

…who am I to judge whether or not that's genuine or not, I can from a point of view of tolerating her behaviour, we're not going to get abused and she didn't want to cooperate with her personal details and yet she still wants us to take her dog home and do all this other stuff, the whole thing didn't sit well with me and I had never met her before, didn't know her name, my partner didn't, neither of us knew her, and went into [name of the hospital] *and they went 'oh so and so', and I said 'what's her history because this is what's happened today, I couldn't get out of her what's wrong, she's obviously under the influence and she's told me what she's had, there's no overdose but she's feeling suicidal' and that's when they said they've got a management plan for her.*

Clearly paramedics have difficulty in maintaining tolerance and patience with an individual who appears to have called an ambulance to get a ride home. Paramedics perceived that there is a fine balance between what they consider an appropriate use of themselves as a front-line emergency health service, and being publicly available and potentially open to what they considered abuse. This sentiment was shared by the ED staff as they also faced similar circumstances. There is a public expectation that the ED like the ambulance service is there to cater for everyone, available twenty four hours a day, is accessible and is open for potential abuse. This discussion with both nurses and paramedics stemmed from dealing with a packed emergency department where some presentations appeared not to require emergency treatment. Nurses and paramedics thought these patients would be more appropriately seen by their general practitioner or 24 hour medical clinics rather than waiting in the ED for extended lengths of time. The question comes to mind: why then are people accessing the ambulance services and emergency departments when the waiting periods for non-critical presentations are lengthy

and the number of presentations continues to rise? One story relayed by the paramedics and the nursing staff reflected on the possible rationale and abuse seen by the staff, particularly in reference to psychiatric presentations. They recounted an incident where a patient, well known to them all, calls the ambulance stating that they have chest pain. The patient is monitored and brought to the ED, where they are assessed and tests are begun. After about half an hour of being in the ED the patient states they are feeling alright and discharges themselves and apparently gets a taxi to a well-known night club area. Paramedics and the nursing staff indicated the ambulance trip halves the distance and cost of the taxi from 'down south,' but their duty of care requires the transport and care from both the ambulance service and the ED.

These sentiments were also clearly articulated by Marie who suggested that paramedic frustration and negative views come from previous negative on-road experiences and public perception. Marie argued that sections of the public did not understand the role of the ambulance service and paramedics. The public to an extent still view the ambulance as a 'taxi service' and paramedics as ambulance drivers and not as skilled health professionals in the pre-hospital setting. Although this view was expressed others still considered that in general they did not feel like a taxi service. They regarded being available and accessible as part of their role and responsibility and it was only on the odd occasion within their working life that they have felt like a wasted resource.

Abigail
Case 15
2nd interview

Using all these resources and again don't know what the patient's been like in the past, maybe they act all nice because we're all there but that does my head in. I guess that's the taxi side of it, the feeling, but the rest of the time we don't feel like a taxi, I think that's our job, that's our role.

When the paramedics considered that they were being misused or their role was not understood it created a situation where the tension built between the traditional expectations and the current reality of on-road paramedic skills and what they considered they are trained for (field notes, 22 May 2009).

This then raised the question as to what paramedics consider an 'emergency' and how they view the application of their skills. The paramedics classified the need for their 'medical attention' as a measure of what is considered an appropriate use of their skills and the sense of urgency or crisis that accompanies an 'emergency situation'. The difficulty they found with psychiatric presentations is that in the short-term what they can practically do for their patient is limited. They questioned whether 'managing' psychiatric presentations was within their capabilities, were they prepared to manage them, and were they a part of their role. Marie states, for example, 'Nothing in our blue or red kits that will help this person in regards to treatment and time with the patient, what can we do for this patient? Nothing tangible in the short time frame we are with the patient'. The impression from Marie's description is that she felt paramedics do not necessarily have the expertise and skills to deal constructively with the life history of the patient and that it was the role of others such as psychiatrist and psychologist (Marie, field notes, 22 May 2009).

8.7.6 Drug and alcohol use, fatigue and shift work

Drug and alcohol use in the patient was another major concern for paramedics. Paramedics deal with the consequences of drug and alcohol use as the presenting feature, but with the possibility of a mental illness as the underlying cause. This affects the provisional diagnosis and often leads to paramedics placing drug and alcohol use along the continuum of mental illness. In the context of the acute, pre-hospital setting with little accompanying information and access to further assessment to make a clear decision this tendency was understandable. The high incidence of the comorbidity of drug and alcohol use with mental illness and the increasing incidence of drug induced psychosis within the community creates a situation where the paramedics are trying to account for several possibilities. Matt, a paramedic with seven to eight years' experience, told of how it is difficult to determine whether the patient is a genuine 'psych' case, particularly if alcohol and drug use is involved. He recounted the difficulties in trying to work with the patient and develop a rapport when drugs and alcohol are on board (Matt, field notes, 21 October 2009). Abigail, in her second interview, described how there was no way the patient was going to be able to logistically get themselves and their belongings from the location back to their house, because of the effects of drug and alcohol use.

Abigail
Case 15
2nd interview

I know she had an ambulance out that day and her comments to me about what she told them; I thought well now at eleven o'clock you're down the beach, you've got your whole house here down the beach, no way because she was stoned and drunk she could hardly walk to get this stuff home plus the dog. I was saying 'so what's happened now, why have you called us now?' and this is where you don't get an answer, it took me ages to get an answer from her 'it's okay I'm not judging you, what has happened to make you call us now when you've had the ambulance out today already. Why have you changed your mind?' and that's when I start suspecting that she's not not coping but unable to get her gear home, certainly I'm taking on board that, eventually after probably a 20 minute conversation she said 'oh and I'm suicidal' just off the cuff comment.

Fatigue associated with shift work also decreased the paramedics' ability to tolerate individuals that they considered did not genuinely require their attendance. The paramedics acknowledged that sometimes it is just a 'bad day' and the high workload was having an effect, especially in the early hours of the morning, as both Abigail and Joey pointed out.

Abigail
Case 15
2nd interview

I don't know if it was I was tired, it was a night shift, … , I don't know but I didn't tolerate her at all and normally I'm very tolerant. You just don't know.

Time is a factor, in terms of being at the end of a shift or three a.m. in the morning when your level of tolerance and compassion changes.
(Joey, field notes, 11 August 2009)

Liam intimated that sometimes the paramedics' reaction is a personality difference with a particular patient and not necessarily the type of presentation. As he said 'some patients just get to you, that's when your partner can step in'. In these

situations working as a crew had benefits to patient outcomes and relieved some of the tension. Liam believed the level of tolerance was dependent on the nature of shift work, for example, whether the shift has been busy, the types of cases attended (how acute, what has been required, good or bad jobs), the time in the shift whether close to the end of the shift, early in the morning and the period in the roster, two day shifts then two night shifts (Liam, field notes, 2 October 2009).

8.7.7 The 'regulars'

The 'regulars' through frequent attendance engendered in the paramedics' feelings of conflict between their professional demeanour, their procedures and the feeling that their role is being abused. Liam talked of the frustration experienced with what appeared to be 'attention seeking' behaviour. Paramedics may see the person several times in a shift and 'you try to maintain a professional approach but difficult in these circumstances' (Liam, field notes, 2 October 2009). Sonya mentioned again a point raised by other paramedics—that part of the frustration is with the system. Paramedics put in the effort and achieve getting the patient to hospital when they know the patient is just going to be discharged and the cycle will start all over again.

Sonya
Case 16
2nd interview

It's definitely part of the job. I wouldn't say I feel uncomfortable but sometimes it's quite frustrating, especially ones that are regular patients that do the same shit every time, you know you have to take them to hospital and you know they're just going to get discharged, walk out and do the same thing, it gets very frustrating.

Joey raised another side of the argument where as a paramedic you may not think the person you are attending, the 'regular', needs to go to hospital, but in the case of 'regulars' it is hard to assess. The patient may have limited support systems and leaving them home may have poor outcomes and challenges the paramedic's duty of care. Paramedics also may face the situation that if they do not take them to hospital they are just as likely to see them later in the shift and taking them to hospital may save difficulties later on or for the next crew, especially the transition to nights from day shift (Joey, field notes, 11 August 2009).

As part of the organisation's way to manage regular callers who may not require their immediate assistance they will coordinate with other services and people involved with the patient to implement a plan of action. As Joyce outlined, this may involve a change in approach or dispatch category.

Joyce
Case 2
2nd interview

There is – we have a system where once they recognise that they are – just nuisance calling in a way – the ones that don't have anything wrong with them and don't take any of their drugs and don't – they just do it to have people come round and give them a bit of grief for doing it, we have a new methods now of dealing with them, we – our regional manager will work with their counsellor whoever it is, their case worker and then they'll work out a way whether we don't respond lights and sirens which is what the call for anyway – we don't do this or we talk in a certain way to limit the – so we do have plans in place for certain patients.

8.8 Assumptions and influences: what you see, general perception, what do others model, life experience and past and present 'on-road' experience

Paramedics reflected on what effect past and present experiences had on how they viewed mentally ill patients. Abigail reflected on the long-term influence which both a positive and a negative experience can have on the way the paramedic relates to patients with mental illness.

Abigail
Case 15
2nd interview

I can clearly remember my first manic patient. I was quite young; I joined when I was 19. I hadn't seen mania before and this person, at two o'clock in the morning, blaring music from their house. We arrived and there was like knives and axes in their garden, it was very strange obviously and the guy just came rushing out of the house going 'I've got abdo pain, I have to go to the hospital, my stomach hurts' and this guy was a Russian person, probably six foot something, and I was like 'oh okay, hop on the stretcher', and then very friendly, very manic in how quickly he was talking and I happened to mention to him, because he locked the wire door, but left the music on, so music was still going and it was two in the morning, and I said 'oh you probably really should've turned the music off because you might wake the neighbours and they might call the police', and as soon as I said police he went nuts, really aggressive, in my face, I was so scared I couldn't move, I couldn't talk and my partner pulled over. He calmed down, he saw how frightened I was and apologised and didn't realise, but for two reasons I didn't recognise the manic presentation, I hadn't seen it before so I wasn't really aware not to mention, that there might be trigger words as well with him. The big, big guy and back then I would've been about 19 or 20 and a lot smaller, I had no idea, I must've looked that scared to him because he said 'I've obviously scared you, I'm not going to hurt you or anything', he was just manic, he wasn't really aggressive but I just said this trigger word which was police, which often is the trigger word funnily enough because they have that role, we get to play the good guys most of the time.

During her approximately 12 years of service Abigail stated this incident had occurred within the first couple of years of her working life. The absolute fear which she felt was a long lasting memory, Abigail described how this was such an eye opening experience and influenced her sense of caution when attending unpredictable situations. The last comment from Abigail reflects that over time she viewed that paramedics, more often than not, have the opportunity to make a positive difference and play 'the good guys' in the majority of cases.

Kevin and Scott told a story which strongly demonstrated the effect that an adverse event, even indirectly, can have on paramedics when dealing with situations which involve mentally ill patients. Kevin and Scott, with both approximately 20 years' experience, retold a story of one of their 'regulars' who would often state she would kill herself. This particular patient had an extensive history of self-harm and would present with significant self-inflicted injuries. On this particular occasion she was on a road overpass threatening to jump. This incident occurred in a semi-regional area where the individual was well known to both police and ambulance personnel and they felt this was a significant change in her presentation. Kevin and Scott were really concerned at the time she really meant to carry through with her suicide attempt which was not 'normal' and wasn't consistent with her other presentations, something was not right. They managed to talk her down off the overpass and succeeded in getting her to come with them in the ambulance. They transferred her to the ED of a major hospital and stressed their concerns to the hospital staff. Approximately an hour to an hour and half later Kevin and Scott

heard over the radio that another crew was attending category A (lights and sirens) to a major trauma at the same location and they soon heard that it was the same person they had so recently taken to the ED. They later found out she had left the ED and had caught a taxi out to the same location, then jumped and had been hit by a truck. She had sustained broken limbs and major internal injuries, but they did not know whether she had survived. This incident had occurred approximately eight to ten years ago, but it was still dominant in their memories and considered a major event, as evidenced by their detailed account, obvious anger and sadness shown through their tone and body language.

One of the comments which seemed to be at the heart of the anger and sadness Kevin and Scott felt was the fact that they had managed to intervene initially and get the individual to care, but from that point the system seemed to have failed their patient. They questioned the resources available, the whole process, whether detainment was appropriate and why was it not instigated in this circumstance. Kevin and Scott echoed the feelings of other paramedics that the mental health system appears to fail far too often and individuals are not being provided with the care they need. Again the picture of high workloads in the ED prevented the paramedics directly blaming the hospital, but they questioned whether junior doctors and nurses have the training and experience to appropriately assess mental illness and whether these circumstances lead to early discharge without adequate assessment and follow up care (Kevin & Scott, field notes, 20 October 2009).

8.8.1 The emergency department: not the right place

The ED was strongly asserted by Liam as not the appropriate place for mentally ill patients in the acute phase of their illness. Liam argued that the ED is such a public place where the individual is exposed and vulnerable that the potential for stigma and discrimination increases. Liam described behaviour from others such as 'rubber necking' and the limited privacy and confidentiality afforded people within the ED as contributing to the individual's agitation and distress. Liam used the analogy of the way cardiac patients are treated: 'you do not see cardiac patients worked on in public view. They are taken and treated in a specific way in a resuscitation room or within a cubicle'. Liam queried how effective is treatment and care, even with the best intent, in the busy and chaotic environment of the ED. He reflected 'the "ideal" of equality, that everyone should be treated the same, but in reality people are not the same and have different needs and are not treated the same'. He argued that there is an overwhelming need for more community and specialist support services for both the individual and their families, so that they receive the appropriate care and do not have to be subjected to the ED environment (Liam, field notes, 2 October 2009).

The very public nature of the ED and the need to triage patients as they present challenges the health system when it comes to mentally ill patients. The individual may not be in an immediate 'life threatening' situation, but prompt assessment and provision of a calm environment to support the person may be difficult to manage. Both paramedics and triage staff alluded to the fact that there is an expectation to

assess and care for mentally ill patients, but there is only a small window of opportunity to carry this out and then to make decisions based on limited training. A prime example of the difficulty in triaging and keeping track of mental health patients in a busy ED occurred during the observation period. A patient was brought into the ED under Section 23 of the *Mental Health Act 1993* by the police. The police handed over the patient to the ED staff and then left once care had been handed over. The nursing staff were dealing with an extremely busy ED while trying to locate the patient's medical records. During this brief time the patient had exited the ED to have a smoke without informing the staff. The ED staff, once they realised the patient was not in the triage area, began trying to locate the patient. The patient was found outside the ED having a smoke accompanied by either a partner or someone from the mental health team. At the time it was not completely clear who was accompanying the person, but obviously in the short time that the mental health assessment and notes were being organised the triage staff had not been informed or lost track of where the patient was and who they were with. The patient was accompanied back into the ED and directed to a specific area so that full assessment and observation could be done. ED staff appeared relieved that the patient was found and the comment 'we didn't lose the patient' encapsulated that feeling (field notes, 2 April 2009).

8.8.2 'Life' experience versus 'on-road' experience

The 'on-road' experience and the system constraints only form one side of the story for paramedics. There was a clear distinction made between the 'on-road'

experience which played a part in developing their views and understandings of mentally ill patients to the personal 'life' experience which shaped paramedic actions.

Abigail
Case 15
2nd interview

[Do you think life experience influences your communication skills and understanding?]

Definitely, I think experience with actual cases and case types, but yeah definitely. I know when I was nineteen and doing this job I would've been, I know I was shocked at many jobs.

Abigail stated she challenges those few people she has worked with in her 12 years who, in her opinion, have been judgemental or mistreated the patient. Her empathy and strong convictions seemed to stem from her personal experience with friends who suffer from depression. She felt those experiences gave her some insight into the problems faced by those she was attending.

Abigail
Case 15
2nd interview

…what I've seen and I've got friends that suffer from depression … I would say that I don't see any ill-treatment or anyone being judgemental, when I've seen that a couple of times probably in 12 years I've certainly made my thoughts pretty clear on it, …

Samantha suggested she tried to base her actions on what she would want if she was in the same situation as the patient. The direct personal experience of mental illness may not be part of Samantha's background, but she has adopted alternative strategies to try and find a way of relating to the patient.

Samantha
Case 14
Initial interview

I think it's just experience with mental health patients, there's certainly no training for what a mental health patient wants to hear or needs to hear, it's just you do enough of them. And I think myself if I was having such a really, really shitty day I'd want to hear the things I was doing well, find the positive, reinforce the positive.

Abigail stated when she was new to the job she was confronted by situations that she found confronting, had no previous experience with and they were totally alien to her, but she felt she was working with good teachers and mentors. These were older paramedics who were supportive with extensive 'on-road' and personal experience. She believes what appears to be different in the current system is that two 'young ones' although well-educated are placed together. They have either very little or no personal or 'on-road' experience with dealing with psychiatric presentations and have no experienced mentors to help them through that period.

Abigail
Case 15
2nd interview

… but I had good mentors and good, I was working with older people and you know I could talk about it because they had seen everything, but you know often I'm seeing nowadays two young ones, well educated, but working together and there's no way between the two of them they could've seen a manic person to be able to recognise these things.

She acknowledged that all paramedics come to the job with different personal experiences and for those 'young ones' that are just starting in the job they may have relatives and family situations that afford them some understanding.

Abigail
Case 15
2nd interview

[So it's a real eye-opener?]

It is and I think there'd be young ones that have grown up with an illness in their family, they've lived with parents who had depression, I'm sure there are people that have had exposure that are young and so their life experience is different but I certainly agree that life experience is significant.

Similar observations and comments came from a couple of paramedics, John and Mark, who had been in the ambulance service for over 20 years. They believed that over the past 20 years they have seen a dramatic increase in the workload related to mental illness and 'on the job' experience was one of the best ways to learn. They used the phrase 'that sort of hands-on knowledge' which cannot be taught at university, to describe the development of the 'on-road' skills or being 'road ready'. They consider the role of 'life experience' was significant in how paramedics recognised, approached and dealt with psychiatric presentations. In their mentor role they found that depending on the level of life experience students out of university found it difficult to manage or converse with patients especially those with mental illness. They cited an example that as older paramedics, with life experience and just the basic provision of care and dignity for the patient, they were able to engage and develop a significant relationship with an older gentleman who they were transporting. The engagement from Mark and John allowed the gentleman to feel safe enough to tell them the whole story behind what was really wrong. This gentleman had been living with major nightmares and depression for what was approximately 41 years and Mark and John were the first people outside his wife whom he had told (John & Mark, field notes, 17 March 2009).

Another account from an older paramedic, Jack, who had been in the service for around 28 years, one of 'the old guys of the trade', expressed a high level of disgust with the way he had observed some paramedics deal with psychiatric presentations. He cited a case that had occurred around five to six years ago where he attended an older female with serious behavioural concerns. She was wandering around house not knowing where she was, virtually naked. She was continually turning on the gas oven. The family was present and was actively attempting to calm her. She was becoming increasingly agitated, disorientated and aggressive with the family. The major issue which made Jack angry was that a patient in this state had been attended and left by four other crews previously in that shift. Jack told of the family's distress that they couldn't convince the other paramedics to take their mother to care. The police had also apparently been in attendance to one of the previous call outs.

As retold by Jack, the reason outlined for not taking the older lady to care was that treatment and transfer had been refused and so the previous crews had 'ANR' (Ambulance Not Required) the case. The first steps Jack took were to communicate with the family, reassure them that they were taking them seriously. He then focussed on the patient, attempting to provide a safe and calm environment. He tried to communicate with the patient to reduce her level of anxiety and distress, but was not 'getting very far'. He gently but firmly explained to the patient that they could not leave her and she needed further care, while maintaining respect for the patient and their dignity. He eventually used the police to assist him to get her on to

the stretcher as gently as possible; they covered up her near naked body, kept quietly reassuring her and worked with her family to keep her calm as they transported her to the hospital. He considered it all in the approach and communication with both the family and the patient. He believed that in the 28 years he had been in the ambulance service he had not got a straight out refusal for care and transfer. He finished his story with the emphasis on compassion, care and respect for all the patients that they attend. One interesting aside to these stories was that as older paramedics they recognised the needs of the older patients that they attend. If the nature of the presentation allowed they would take the older patients to one of the city hospitals that specialises in caring for the older generation, returned veterans and their families. They considered it not a slight on the other major hospitals, but more a case of the hospital and its staff being more aware of the older generation's needs, had more time to adequately address those needs and a simple matter of workload (Jack, field notes, 17 March 2009).

The impression from these paramedics was that there appeared to be a lack of the basic feelings of service and care they seemed to have been instilled with when they started in the job. It appeared not as evident in the 'younger' generation and this generational phenomenon seemed to generate from the sense of traditional volunteer role versus a career pathway and tertiary based education.

Kate, in her second interview, nicely summarises the impressions that have come through from the paramedics in relation to life experience and how that plays a part in their assessment of psychiatric presentations.

Kate
Case 17
2nd interview

I think that certainly plays a big part in it but again it does come down to personality types and on life experience; the way that you've been brought up to think about mental illness has a huge impact on how you deal with somebody, with a patient with mental illness. Some people don't understand how somebody can have a mental illness, you know you get people that have the whole 'just get over yourself' kind of attitude because they've never been exposed to it in their personal life so they physically don't understand it, whereas some people they may have seen it in someone close to them or experienced it themselves and so they have a better understanding of it, but I don't think that is something that you have to have had to be empathetic and to understand.

8.9 Role modelling and the dangers of categorising

The role modelling and actions by others revealed both positive and negative attitudes towards psychiatric patients. Abigail outlines instances of mentorship that showed her constructive strategies to care for the patient suffering mental illness and identified the ways 'not to do things'.

Abigail
Case 15
2nd interview

I can think of many people I've worked with who I've learnt from and I've certainly seen how not to do things, they would go hey you know what, yelling and being rude to that person wouldn't have got us anywhere, being nice and understanding and listening takes a little bit more energy but at the end of the day we got them to hospital and we didn't need the police.

The behaviours, such as in the small details of checking the vehicle, tended to suggest to Abigail that both positive and negative actions are carried through from when they start on the job to both good and bad habits that continue into longer term practice.

Abigail
Case 15
2nd interview

I think a lot of it would depend on who they go out on the road with, what their attitude's like. A lot of the young ones might be influenced by who they're working with and I say that because that sort of shows in things as simple as checking your vehicle, so if they're influenced by that behaviour they're probably influenced by other behaviours as well, good or bad.

Abigail and Joyce proposed that a lot of the attitude and way a paramedic operates when dealing with psychiatric presentations not only comes from what was modelled when they were learning but also who they are currently working with as their partner.

Paramedics faced the challenge in some situations of being supportive of the partner that they are working with and finding themselves confronting behaviour that is not professional or appropriate. Operationally paramedics generally work in crews (two paramedics) that are with each other for long periods of time and work closely together in situations where there is an expectation of reliance on each other. Paramedics walk a line between trying to maintain good working relationships with their partners and having the confidence and experience to confront inappropriate or bad practice. The attitudes and behaviours ultimately affect the outcome for the patient and play a part in decisions to ANR a patient.

Joyce
Case 2
2nd interview

A lot of it probably has to do with the persons that you're with that's attending, because we have some people who just don't like it, some people sometimes treat them badly, you might be really driven with mental health patients, so a lot of things depends on the person.

Emma used strategies to try and maintain a good working relationship with her partner, but also allow her the time to work through the difficulties and decisions that are being made.

Emma
Case 3
2nd interview

I'll go oh I hadn't thought about that, well how about we go and check that first and then if everything's alright, and then you've also got an opportunity while you're filling out your paperwork to spend a bit more time with them and continue your assessment, that's always really good too.

The familiarity with patient and the location could inadvertently lead to assumptions regarding the individual and their current presentation. The paramedics were aware of the dangers in making too many assumptions when confronted with someone that is a 'regular,' or in categorising the person. They acknowledged it occurred although they tried to prevent it by taking every presentation as a new set of circumstances.

Tracy
Case 5
Initial interview

I've actually been to this patient before, in very similar circumstances, so as soon as this case was given and the location, I sort of assumed that it was the same patient.

Robert particularly mentioned that the time you become complacent is when the situation will change and come back and 'bite you in the bum'. The habit of categorising and judging was considered problematic and to be avoided.

Robert
Case 7
2nd interview

Because we're there for what, 15 minutes of that person's life – I don't think you can make any judgement, you only can go on what you get and do your best with what you've got at that time. I think, you probably actually, as soon as you get blasé is the time that it'll bite you in the bum, and that sort of stuff. And yeah, if you go in and say, I know someone's safe, or they're mad, or they're sad, or you know. So, I wouldn't. I think it's a bad habit to get into, if you start doing that sort of thing. If you're categorising, you're generalising too much because they're far more complex than that.

In a profession that uses codes, provisional diagnosis and descriptors of presenting complaints as part of its everyday work practices the habit of making a judgement and placing what they see and hear into a category becomes part of the culture. Therefore it must be difficult trying to suspend that habit when dealing with mentally ill patients or patients in general.

8.10 Education

There was a general consensus that paramedics do not manage psychiatric presentations well. The expression 'poorly' was often used in response to the question and one of the reasons given for this was a gap in their education. Carl made the point that although they do cover the foundation knowledge in their courses there appears to be limited and disjointed ongoing professional development and how to address it in the pre-hospital setting (Carl, field notes, 25 March 2009). Janice also believed strongly that the information paramedics received in university needed to be reinforced, expanded on, and clearly identified within the curriculum (Janice, field notes, 4 April 2009).

Len argued that in proportion to everything else they needed to know and are required to learn for their work then paramedics probably do get the basics. Paramedics in the pre-hospital setting are required to deal with a whole variety of presentations and it is hard to know extensively about all things. The curriculum by necessity is focussed on the management of life threatening conditions, which does not leave a huge opportunity to focus on all things in depth. This is where the continual professional development and 'on-road' experience becomes important to the consolidation of knowledge and ongoing learning.

Len
Case 10
2nd interview

If, no we probably don't get enough but it's probably proportional to everything else that we get that we need to deal with. I think dealing with mental health is something as well as one of those things that you just need to be exposed to, and see how people display signs and symptoms with various disorders and how to interact with them and how to deal with them. But, yes and it's one of those things that you can read a book and … I mean you can learn what all the signs and symptoms are, you can learn what the disorder is, you know all the patho-physiology of it is, what they think the latest theories on what's causing it and what medications they might be taking but I don't think, I mean everyone's different.

Another point which was raised by a small number of the paramedics like Jessica was in reference to receiving information about local networks and alternative strategies.

Jessica
Case 8
2nd interview

Initially in the degree I think we do and then we go out there and that knowledge sort of grows upon like we do so on so many cases that yes that knowledge does grow with experiences but yeah I do think we get a lot of – maybe we don't get enough information of the local other networks that we could use. Like we don't really – like we know ACIS but other than that we don't really know of any others in the area so maybe if we had a little bit of information on that that we could direct patients to places other than the emergency department.

Skills like communication, de-escalation techniques and a better understanding of what paramedics classed as personality disorders were common areas identified for improvement. To consolidate these skills and their practical application, 'on-road' experience was viewed as essential. This was after the basic understanding of signs and symptoms had been gained. As Kate said some of these skills come more naturally to some people than others and they are difficult to teach.

Kate
Case 17
2nd interview

As far as an assessment I think probably but just in communicating with them that's probably a difficult thing to teach, I think it's something you're either naturally comfortable with or not. Some people, I've noticed some people I've worked with are really, really good with talking to these people, myself generally I just allow them to talk and be empathetic and try not to downplay, you know like 'that's fine, everybody has down days', not say things like that, let them speak and if they ask me questions I'll answer them honestly. But yeah like I say that's not something I'm entirely comfortable with, I haven't had a lot of experience in it.

8.11 Conclusion

From the discussion in this section which details how paramedics conduct and think about assessment and some of the assumptions and influences which underlie the

process a number of key ideas emerged. These are: the significance of how they see their role; how the need to be objective and clinical measures guide their actions; the role of education and the value placed on 'on-road' learning; and the concept of legitimate and non-legitimate need for care. The strong relationships between perception of role and the need to provide active measures form a large part of the culture surrounding paramedics work with psychiatric presentations.

The story continues with the handover and document analysis in Part 3 which completes the linear journey through the paramedics' narrative of their work with psychiatric patients.

Chapter 9

Findings part 3:
Handover and case cards
(Section 1—Handover)

9.0 Introduction

This section explores the handover process and the documentation of the patient presentation by paramedics. Known as the case card, the documentation and verbal handover provided by the paramedics are the last steps in the narrative and actions of their work with patients suffering a mental illness.

The 'handover,' the verbal relay of information from paramedics to the triage staff, is more than just the transfer of patient details and care. Handover is conducted in a physical and social space which directly and indirectly shapes how, when and to whom handover occurs. The physical layout of the emergency department (ED), the triage system, and the way occupants of the space, nicknamed the 'fishbowl', use the area influences how information is relayed and received. Theme 7, '*Place and space'*, details impressions of the physical space from my observations, how the physical space is 'owned' by particular groups and how the workload of both paramedics and the ED staff enforce their own rhythm on to the handover process.

9.1 Handover: the place, space and information transfer

9.1.1 Theme 7: Place and space: the 'ramp' and the 'fishbowl'

Walking up the entrance way, the 'ramp' to the ambulance and public access area for the ED, the first thing I noticed was how small the area is which caters for such a large number of people. The flow, like a continuous stream, alternated from a trickle to a steady stream and finally becomes a torrent consisting of individuals from the public, hospital staff, ambulances and other services. There is a designated smoking area to the right where some of the patients and their families were sitting talking. The arrival area was surrounded by whitewashed walls with the helicopter landing area just a short distance away on the next level. The space was separated into ambulance bays where ambulances park, like a line of delivery vans, with their backs to the automatic doors which accessed the ED. The automatic doors opened into an airlock area where patients, depending on their condition, were transferred from the ambulance stretchers onto hospital beds. Preliminary trauma and cervical spine assessments could be performed in the airlock and if the patient required immediate care they could be taken straight through to the resuscitation rooms.

To the left of the main doors was the entrance for the general public to walk in to the ED to present for care and treatment. Inside the ED the triage area was filled with sights and sounds from patients to the left of you being attended to by medical staff in three cubicles with drawn curtains. The waiting room towards the back of the triage area filled with the low sounds of a flat screen television, and people in various states of waiting. The space required the negotiation of a pathway through

the patients on beds to reach the staff area. The staff area, the ‘fishbowl’ as it was known, sits as a horseshoe shape in the middle and to the right of the triage area, with its glass surrounds enabling observation of the busy space (Appendix J).

Facing the main entrance area in the ‘fishbowl’ was the triage window, a space where triage staff prioritise and book in patients as they arrive. The interaction between the public and hospital staff conducted through this small window began at this point. Initial allocation and triage priority occurred from an extensive list of codes, placed within easy reach on the counter, which covered all the major body systems. The ‘booking in’ system on the computer recorded the triage code and a brief two line description of the presentation and history.

The ‘fishbowl’ was the centre of activity, with the handover from paramedics to triage staff forming a part of this hive of motion. The ‘fishbowl’ had two access points, one near the front triage window and the other halfway along the side which directly accesses the cubicles and waiting room areas, both are swipe card access for security reasons, which regulates who has access to the space and when. Paramedics were given access into the area so they could conduct handover, book the patient in with the administration clerks situated towards the waiting room side of the ‘fishbowl,’ and complete their documentation. The space was accessed by a number of different groups, the major group being the nurses staffing the triage and the wider ED. Doctors, registrars and consultants were continuously moving in and out of the space checking patient notes and documentation, attending to

patients, discussing treatment needs and sharing information with staff. The whiteboard, positioned on the wall above the drug cupboard towards the inside back wall of the 'fishbowl' played an important role in the running of the triage area and communication between staff. It contained staff allocation during the shift and major contact details such as the medical registrar, shift coordinator, emergency consultant and registrar, and volunteer on duty. The whiteboard was used as a tool for notification of the arrival of critical cases and as a means of coordinating the resuscitation and trauma teams.

9.1.2 Ownership of space

Paramedics come and went from the 'fishbowl' as itinerant professionals who are in the space for brief lengths of time with an explicit purpose. The wider triage area and outside arrival area, the ramp, are spaces which were divided by a sense of ownership. The 'fishbowl' belonged to the nurses who were the dominant presence and front-line to both the public and the liaison between the patients, doctors and other health professionals. The wider triage area was neutral ground as everyone, including the public, were within this area performing their particular roles. The 'ramp' on the other hand was the paramedics' domain where they discussed cases, work challenges, organisational politics, daily life, and briefly caught up with other paramedics from different crews. This chatter and banter went on while paramedics prepared their stretchers, restocked the ambulance with linen, replaced oxygen cylinders, completed documentation and cleaned the ambulance if required (field notes, 27 May 2009). On a small scale I became involved in the activities and

everyday routine on the ramp as a way of getting to know the paramedics and for them to understand my purpose for being there. I observed the way the paramedics discussed patients with mental health problems they attended and how they interacted with triage staff. The ramp became the focal point of my interaction with paramedics.

One striking example of this ownership of the space was an incident which occurred between a paramedic and the nursing staff. A paramedic came into the 'fishbowl' and proceeded to sit down in the triage chair where the nursing staff register incoming patients. This particular area was where the initial direct contact with the public occurs. The triage nurse at the time was out on the 'floor' assisting with a patient. My impression was that the paramedic had sat down in the wrong spot and impinged on the nurses' domain. The nurses continued to work around the paramedic to access patient files and the two computers with admission and triage details. The nurses were not outwardly aggressive, nor did they say anything to the paramedic, but looked at the paramedic with surprised expressions and raised eyebrows, with silent communication between them. The paramedic did not notice the tension or the looks and continued to fill out the case card documentation. After around 10 minutes the paramedic asked in an impatient, brisk, and louder tone 'whose triaging' to a passing nurse who said that she wasn't quite sure as they were working in 'A side' of the ED. The paramedic then asked a senior nurse as she went by. The sarcastic reply was 'No, I'm not triaging. We're all illiterate didn't you know!' This was met with quiet laughter and slightly uncomfortable murmurings

from other staff that heard the comment. The paramedic, not quite sure how to handle the response, got up with an annoyed and slightly puzzled expression and moved to find the triage nurse who was just returning to the triage window and, not aware of the previous discomfort, greeted the paramedic. The resultant short, direct and abrupt handover from the paramedic illustrated how the relationship between paramedics and staff, influenced by this sense of ownership of the space, could potentially bias the sharing of information (field notes, 23 April 2009). As part of understanding the culture and actions of paramedics in dealing with individuals with mental illness, a sense of the physical space and social interaction with other professionals, especially at the point of handover, is important. It provides context, a picture of the physical and social barriers to the handover of information, and how paramedics identified with their role in the process.

Although the nurses on occasions outwardly demonstrated their ownership of the space, in general the sharing of space was accepted as part of the nature of their work. The small gestures, such as opening the doors to the 'fishbowl' for the paramedics and the banter that occurred between nurses and paramedics, reinforced the overall observation of a functional, cooperative, and collegial working relationship. The banter included comments between the nursing staff and paramedics of shared patient experiences, humorous incidents with patients and, depending on the relationship and familiarity between the paramedic and the nurse, more personal discussions. For example three nurses and a small group of four paramedics were joking that one of the student paramedics, an ED nurse who

had gone back to university to complete her paramedic training, had ‘switched to the dark side’ (field notes, 18 August 2009).

The feeling of ownership and the temporary nature of the paramedics’ presence in the ED affects the handover process. To meet the demands of the busy ED and the triage process paramedics condensed and funnelled the information so they could relay the relevant patient details in shorthand, using a concise and direct manner. The short interview with paramedics post-handover revealed how focussed the handover was on the medical stability of the patient and the extent to which the patients’ history and emotional responses had been summarised in comparison to the picture actually gained by paramedics at the scene and during transport. The medical stability and the condensed version of the patient’s presentation were all essential information, and often all that was required to fulfil the triage process, but it showed the funnelling process that both the nature of the work and the system enforced on the transfer of patients and information. The potential benefit of the detailed information obtained by paramedic whilst with the patient but condensed or lost during handover, cannot be underestimated.

9.2 Negotiation of space and time: the busy ED

The negotiation of space and time permeated the actions of the paramedics and the triage staff. The motion in the ED was continually negotiated depending on patient need, workload, and available space. This negotiation of space played an important role in the way work and handover was conducted throughout the shift. This was

particularly evident during one observation when a large cohort of doctors, nurses, paramedics, specialists, senior staff, and physiotherapists were all trying to function within the 'fishbowl' at one time. The small space was 'filled to capacity'. The staff and paramedics increasingly found it difficult to locate necessary information such as patient notes, complete or review patient documentation, and treatment. The increasing number of people within the space posed difficulties for accessing the drug cabinet, computers and booking in information, places to sit and discuss patients (standing room only) and bench space to write (field notes, 26 May 2009). Barbara, part of the senior nursing staff, recounted the separation the area engenders between the staff and the public and how the area was not conducive to current needs, bearing in mind the ED was built over 20 years ago.

Barbara
Case 17
ED interview

Definitely, I think our physical environment is terrible, I don't think it's conducive to anything. You've got your little silo, there's you, there's us, you've got this whole barrier and it certainly doesn't promote patient contact, doesn't promote contact with your colleagues, you're behind that glass barrier and I think as much as it is there for a safety mechanism I think it can be more adverse than being a good mechanism. Certainly like the amount of barouches and people and the activity, not just the patients but it comes down to medical staff, nursing staff, SAAS, SAPOL, getting everybody in that small area just becomes a nightmare. So yeah I think that whole layout is just not conducive to anything.

During one observation session I witnessed over 20 admissions in one hour and was told anecdotally that at times the staff managed over 80 admissions within an eight hour shift period. This increase saw staff trying to free up beds, attend to patients and get them seen as soon as possible, mange with limited opportunity for breaks

or detailed handover and information sharing (field notes, 17 June 2009). The constraints enforced by the space were evident when as part of the normal routine patients were moved in and out of the three cubicle spaces and resuscitation rooms which offered some privacy so that test and examinations such as electrocardiographs could be performed. One specific conversation between a doctor and nurse exemplified how care is negotiated around the use of space. The doctor enquired whether the patient had been given their medication, a suppository, which the nurse stated that they had not been able to give as yet. The doctor appeared a little taken aback and asked why, the nurse responded with slight frustration 'they hadn't been able to free up a cubicle yet and we're trying to get the space in either one of the cubicles or the resus [resuscitation] room' (field notes, 2 March 2009).

9.2.1 Peak times: the eleven and three rush ('you can almost set your clock by it')

Peak periods within the ED occurred at 11.00 am in the morning and the number of presentations steadily increased from then to the next rush at 3.00 pm. These peak periods felt like times of barely controlled chaos when ED staff were in full swing. The regularity of the peak periods was such that when the build-up of people seeking care began earlier it was noted by staff.

> *Bizarre we usually don't get this busy this early. Usually starts to build up around eleven.* (field notes, 29 June 2009)

The continual motion and fast pace in the ED during peak periods clearly had an exhausting and stressful effect on the nurses, doctors and paramedics. Comments from staff explained how this almost overwhelming influx of large numbers of complex and often high acuity patients affects their ability to keep track of and care for their patients. Descriptions of being 'flogged' and 'needing a drink after last night' from nurses and paramedics express the challenging nature of their work during these times. One nurse who had been on the evening shift described it as a 'hard shift, horrendously busy and major trauma, the resus rooms were in full use, I needed a drink after last night,' adding with an almost resigned tone that it is the norm 'you get that, no one died' and although it was a hard shift she stated 'they managed to keep it all together' (field notes, 11 June 2009). Similar sentiments were expressed by paramedics with phrases such as 'we were flogged last night' and 'crazy afternoon, continual calls, missed crib again, we were meant to take it two hours ago' (field notes, 26 August 2009).

The shift coordinator, a prominent presence, attempted to maintain the flow of patients from triage to the wider ED (sides A and B) and coordinate the admission or discharge of patients. The shift coordinators presence was vital when the workload increased with large numbers of ambulance arrivals and public presentations. One nurse commented as she was going past the senior staff that they, the staff in general, had not had a break and her body language expressed tiredness. Watching the resuscitation team I could see them trying to maintain their composure as they dealt with one major incident after another. During this period

the shift coordinator was discussing the situation with senior management while organising other staff to support and relieve the existing team. The clinical nurse coordinators came in to the triage area to assist as much as possible and mentioned to staff to document and keep track of overtime and loss of breaks. The comment, said on the side, that documentation is the 'only way 'they' [the management] will understand' exemplified the feelings of pressure and constant workload experienced in this environment which is not seen as being addressed by the hierarchy, the 'management'. The staff realised the constraints imposed by the physical environment of ED built to cater for a population which has grown substantially since its beginnings and the issues of staffing a frantic but restricted facility to cater for the increase in peak loads. The pressure and workload filters through to the triaging of patients to force the handover to be precise, to the point and a quick process with the potential to omit important data (field notes, 2 September 2009).

9.2.2 The paramedics: how they get the process done

Paramedics came into this environment with the intent of delivering their handover of the patient, completing their documentation and then moving out of the space back to the ramp and 'on road' again. In this busy environment these procedural, structured events were often disrupted and adapted to get the process completed. There were several ways that paramedics managed to work within this environment to achieve their goals. One of the more subtle strategies used was their body language. On several occasions I observed that the paramedics after waiting

patiently towards the side of the triage nurse, initially several steps away, would lean forwards and move their body closer to the triage staff and almost take over the personal space so that they could get the attention of the staff and complete their handover. On one particular occasion the paramedic had been waiting for almost 15 minutes before he stepped up to be heard. The paramedic had been watching the triage nurse trying to manage four new arrivals from the public, two significant inquiries from doctors regarding patients, and receiving handover from two other paramedics (field notes, 23 April 2009).

On other occasions, paramedics would let the triage nurse know they were there and would go and book the patient in with the clerks and continue to complete their case cards while staying close so they could give handover when possible. Gian felt that waiting and adapting was unavoidable and an integral part of the nature of the work for everyone.

Gian
Case 7
ED interview

I will try and ask them do they have an urgent case, if they're just sitting around waiting. And if they say no, well I'm happy for them to wait for a while, and I think, they're not unhappy to sit there for a bit and they can fill out their case card and then give a story. So, mutual understanding – I don't think there's any animosity about having to wait or being put in a queue. And that's just a fact of having high and busy workload. Someone has to wait at some stage.

During one of these peak times as eight ambulances arrived around midday I observed an intensive care paramedic begin the patient handover at the triage window then follow the triage nurse around the wider triage area continuing the

handover 'on the move' which was interrupted on multiple occasions due to the high workload (field notes, 21 May 2009). This phenomenon of 'handover on the move' was not uncommon and occurred not only between paramedics and triage nurses but between the different health professionals working in the triage area. The disruptive effect that workload had on the sharing of information was evident in the multiple times it often took to complete the handover which potentially had a negative effect on patient outcomes.

9.2.3 The communication and negotiation of the handover process

The communication and negotiation of the handover process was evident in the commentary between the triage staff and the paramedics. Comments from the triage nurse to the paramedic such as 'How acute are they?' 'Can they manage in the waiting area? and the acknowledgement of the paramedics through a 'hi, just be a minute' or nod of the head whilst in the midst of booking in several new arrivals, showed an acknowledgement of the paramedics and their presence. In return paramedics were very conscious of the pressures within the ED. Comments such as 'are you ready for me mate?' said in a friendly, kind and acknowledging tone by a paramedic who had been waiting patiently for the triage nurse, displayed an awareness of the increasing workload the nurse was currently under. In response the nurse gave a relieved look for the understanding to the paramedic and apologised for the wait (field notes, 10 June 2009).

Both nurses and paramedics continuously prioritised their patients both formally and informally; for example the paramedics tone and demeanour would become more dominant when the patient they were attending was considered more urgent requiring an expedited handover. The request for a primary survey and trauma review in the airlock or the request for a 'code black' (support from the hospital security and immediate attendance by medical staff) were illustrations of the paramedics pre-triaging to ensure a reduced timeframe between the patient handover and being seen. At one stage the paramedic providing handover quietly intervened to let the triage staff know that the patient had MRSA (methicillin-resistant S*taphylococcus Aureus*), a bacterial infection that can be easily spread, before the busy nursing staff got 'carried away' (field notes, 4 April 2009).

9.3 Availability of space and resources

The availability of beds and physical resources, such as staff numbers, played a role in the decision making within the ED. On one notable occasion triage staff were required to refuse beds to several members of the public because the ED was full to capacity and staff needed to prioritise on the basis of need and the resources available. As one staff member quietly said she would 'like to give them all a bed but they are just 'not sick enough' leaving the patients in the waiting room to be seen as soon as possible (field notes, 2 May 2009). This included mental health patients brought in by the ambulance, who were distressed but also needed to be prioritised on the basis of immediacy of the condition. Another example of prioritising available resources was when the paramedic was asked by the triage

nurse if the patient was able to ‘comfortably sit in the waiting room or do they need a bed?’ The paramedic responded with more detail regarding the patient’s presentation and he felt because of the circumstances the patient really did need a bed if it could be found (field notes, 8 September 2009).

During the busy periods staff would try and explain the estimated waiting period to people so the public could gauge, based on this information and the initial assessment performed by the triage nurse, whether they would wait. Patients’ vital signs and initial assessment were carried out by staff whether the patients were in the waiting room, on beds in the corridors or within the cubicles. The following quotation from field notes was typical of the way the staff managed the public expectations and triaged by need.

> *There are 15 people waiting ahead of you. I am quite happy to book you in, but letting you know that it will be a wait.* (Field notes, 8 September 2009)

One occasion stood out during observation which demonstrated the public discontent with the waiting period. The triage nurse was confronted by a spouse who, quite distressed and angry, described the ED as a ‘hell hole’ to which the nurse responded with barely controlled sarcasm ‘thank you for your courtesy. We are trying the best we can. We will try and follow up and get your husband seen as soon as possible’ (field notes, 2 September 2009).

During a quiet period in the early morning the ED staff were discussing that patients have been there for three days on both sides A and B of the department. The discussion raised a number of issues that all present, including paramedics, considered had a role in the delay and difficulties of providing ongoing patient care. These included the difficulty in finding available beds to transfer patients to more appropriate areas such as the hospital wards, or accessing alternatives such as regional hospitals, residential care, hospital at home options and community supports. The coordination of care was a full-time workload requiring continual negotiation with facilities, wards, families and patients. The expectations and misunderstandings by ward staff and specialists was a point of contention for the ED staff particularly over the difficulty in transferring patients from the ED to the wards. The ED staff questioned what makes 'them' assume it is better for the patient with complex needs to stay in the ED rather than being transferred to the wards. Unless the ward staff had worked within the ED the staff considered they did not understand the nature of the work and the limited resources and staff available to manage complex cases. One comment suggested that others assumed the ED staff had some 'magical skill' to care for the patient on a barouche in the corridor of the triage area when the patient was considered 'not stable enough for the ward' (field notes, 1 May 2009). One discussion between a consultant and doctor debated the decision whether to admit a patient or not. The discussion centred on the patient's stability and whether adequate support could be found out in the community. The clinical decisions took into consideration the hospital and ED's ability to accommodate the patient given overcrowding, space and staffing and

could this patient be managed in the community or at home (field notes, 17 June 2009).

Barbara summarised these barriers and the constraints the system places on the interaction between the paramedics and the triage staff. She identified the high volume of patient presentations, the access block within the system, not only providing triage but full patient care within the triage area, the staff skill mix, and the never ending workloads of the paramedics and the police as all affecting patient care and transfer of information.

Barbara
Case 17
ED interview

High volume coming through, the time limits that I think people feel that they're under to be able to process people through that triage area. The access block that we have, we do have that back-up of people at triage so we're not only triaging but then doing the full patient care out there. I guess also the skill mix, the nursing skill mix and stuff so if we've got junior staff out there and the senior staff are triaging and then trying to get the care done it becomes a barrier and people are trying to get information quickly and less attuned to the quality as to let's just process it through so it becomes more a data entry than a triage. I think things like even SAPOL sometimes and the things that are happening with SAAS so if there's a lot of stuff going on and SAAS have to off-load and get off quickly that can be a barrier, not common but there's obviously even dynamics amongst the people so if you've had a clash with someone before automatically there are barriers and things there that occur as well. I think there's geographical, there's interpersonal, there's restrictions amongst the disciplines as well, it's across a full gamut.

9.4 Relationships within the fishbowl

The relationships between different groups and individuals which flowed in and out of the 'fishbowl' operated in general as amicable and productive working relationships. Within the team there were closer relationships between nurses, doctors and paramedics that went beyond just working colleagues to outside friendships and social circles. One example of this supportive and reciprocal relationship I observed during the interaction between a triage nurse and a paramedic student who had not done handover before. The senior nurse listened closely to the student and gently directed the paramedic through the process. The nurse structured questions which encouraged the student to identify patient needs and communicate them. The nurse specified the details required in handover and the 'quirks' of the booking-in system. The senior paramedic supported from the sidelines with confirmation and detail if the student was not sure (field notes, 13 May 2009). I noted this interaction occurred during a quiet time in the ED which raised the question as to whether the same attention would be possible during peak times.

There were occasions when the working relationships were strained due to the busy circumstance. The transfer of an elderly patient by an ambulance crew was one incident which demonstrated the strained patience of both nursing staff and paramedics. The patient had been transferred from an independent living arrangement with significant mobility difficulties. The patient apparently had been referred to the hospital for assessment by the residential facility. The patient was

assessed and the decision was to get the patient back to residential care with pain relief. The nurse's interaction with the paramedic focussed on exactly why the patient was brought to the ED. The nurse queried what they could actually do for the patient and that residential long-term care staff should take the responsibility and the patient should not have been brought to the ED. The paramedic found herself having to defend the rationale for transport and was in a difficult position due to the information being handed over from another crew. Throughout the process the paramedic was trying to give as much information as she could based on what she knew (field notes, 13 May 2009). A second incident, involving a detained patient who arrived with two ACIS staff and two police crews, created a situation where the paramedic felt as though they were in the middle between the mental health staff, the police and the triage staff. The paramedic expressed his frustration with the transfer in a conversation afterwards. In his words they were 'trying to cater to everyone' and they saw their position as being forced to be the mediator and relay information between the different groups while only having half the story (field notes, 8 January 2010).

The description of the physical and social space forms a picture of the constraints, rhythms and workload which influences the handover and the way interaction is conducted. The transient nature of the paramedics' presence in the ED and the ever present awareness of the need for a brief but summarised handover all influence the detail and the structure of the handover provided by paramedics and how it is viewed by triage staff. In the instances of the transfer of patients with mental health

problems the complex negotiation of the social and physical space as mentioned above creates both structural and cultural barriers which have a negative effect on practice and potentially the ongoing care provided.

9.5 Theme 8: Handover

The handover from paramedics followed a consistent pattern which mirrors the way information is documented in the case card. The final findings chapter provides more detail and explores how paramedics document psychiatric presentations and the structure they use. As an overview, the handover begins with the reason for attendance and presenting complaint, then the past medical history. Don, for example, began with the patient's age and gender and the patient's past medical history of schizophrenia. He then spoke of the case as an 'ACIS instigated call as the patient was detained under the Mental Health Act'. This short summary often included brief details of the environment that the patient was found in. The handover proceeds to detail the physical presentation and any actions taken by the paramedic. Blake and Gerry, Case 18 and 19, illustrated how paramedics preface their account with a shorthand statement of how they found the patient 'on arrival,' followed by the vital signs and physical observations, particularly with a suspected overdose.

> *The patient a 40 year old male found sitting outside his house and appeared hot, sweaty, vague, confused and anxious. He apparently works in a timber yard and his friend is concerned and rang us. He has a GCS of 14, BGL 9.8, slightly high pulse rate and BP. There didn't seem any obvious medical or trauma reason for the presentation.* (Blake, Case 18, handover field notes)

He was detained. SAPOL in attendance. It took approximately one hour to get the patient in the ambulance. He has stated an overdose of 10 Herron Plus tablets (500 milligrams of paracetamol and 10 milligrams of codeine). The patient has a previous history of violence. The patient was abusive enroute and tried to undo straps. Apparently has been in prison. The patient during transfer had a brief decrease in his GCS, query whether this was an actual decrease of GCS or a feigning of a lowering of GCS. We looked for any medications to verify the type and amount taken by the patient and tried to match it with his statements. Four boxes found but an older box was the only one with any medications missing. (Gerry, Case 19, handover field notes)

9.5.1 Information received and information given: The process and the social history

Paramedics have the kind of access to people's lives which is afforded to very few others in the health field, and due to this privilege they have the opportunity to provide insight regarding the patients' circumstances which can greatly affect the patients' care and treatment outcomes. Barbara believed paramedics can provide the insight and contexts of the individual's life which might not be readily forthcoming from the individual.

Barbara
Case 17
ED interview

I think it has a really high level, you need to know why they came in, you need to know if they're in that home situation what that's like and it does give you a lot of input into the person that you're dealing with and it's really hard someone can just come up to triage and say 'I'm here and this is what's wrong with me', but certainly the information that you get from the paramedics pre-hospital gives you a lot more insight into that person and the home life and whether or not there are any other barriers that we're going to come up against, you know issues with children, anything like that that might be involved that we need to consider, and they're not things that are going to be declared independently by someone that's self-presenting so that sort of information is really vital.

From the paramedics' perspective, Abigail considers their assessment and overall impression as crucial to her patient's ongoing care, particularly for patients suffering a mental illness. She explained, as an example, the patient who may have a history of violence but has not demonstrated any aggressive or violent behaviour while with the paramedics. The approach taken by ED staff to the patient and their ongoing treatment could be directly dependent on how the paramedic describes the patient's behaviour and the impression they give.

Abigail
Case 15
2nd interview

I would walk in and say 'look they do have a history of that but they've been cooperative, they're not angry today', whereas if I didn't add that stuff to it they might get treated a little bit differently if I just said they've got a history of violence.

[So the extra information and the impression you give in handover is really important to how they might be treated or how quickly they may get seen?]

Yeah I think so as to how they might get treated I suppose, they're still going to get the medical attention but you need to be aware of that history as any staff member attending a patient, obviously if you start, I think if you start aggressively or too assertively or whatever with a patient you might then aggravate them and get a bad response and then security gets involved and you're not really achieving the best thing.

This illustrated the connection that paramedics and others make between mental illness, the potential for aggression or violence and their overriding safety and caution. It also demonstrates an understanding, as discussed earlier that paramedic handover has a significant effect on the patient's response and ongoing care.

On the other hand the handover process was described by Jill as sometimes akin to 'hitting your head against a brick wall' where she felt that what you have to say as a paramedic is not taken seriously and does not make any difference because they are 'just the transport service' (field notes, 28 January 2010).

The triage staff acknowledged that the process poses constraints on the depth of information that they and the paramedics can delve into during handover. The process is an initial evaluation and designation of urgency of care. Tim describes it as a 'quick process' and 'a very quick decision on the patient's situation'.

Tim
Cases 4 & 5
ED interview

Triage is a very quick process, which is a very quick decision on the patient's situation. But it is then followed up, we then go back to them, and take a history ourselves, and we will reflect back on the ambulance history and talk to the patient as well as relatives to get our story and we write a similar history to what the ambulance service, we form our own observations, we'll be doing ECG's and then we'll move into the investigative side of things, with bloods and things as well. So everything, it sort of grows. They've got often a very good … history of the situation.

Naomi, when asked the value of the social and contextual information regarding the patient, suggests that the social and more detailed history from paramedics may be more useful in an initial presentation and is of some use in the short term, but on busy days triage is aimed at being concise. This reinforces the proposition that the busy environment may prejudice patient care.

Naomi
Case 3
ED interview

Probably not, on a day like today triage is supposed to be quite precise. Perhaps, if initial short term but because she was a suicide attempt I gave her a priority 2 which meant that she'd had a history of absconding or violence or anything that would have helped me in that she should be seen within 10 minutes or at least taken through to a room quite urgently, like she'd be the most urgent patient to be taken through and that's simply not because of the medication she took, that's simply because she was suicidal and I didn't want her sitting out here getting upset, she was agitated which I wasn't handed over, I worked that out for myself.

Consistent with the need to deliver a concise handover with consideration primarily to the stability of the patient, the information from paramedics tended to focus on the brief story. They structured the handover to cover the salient features of the patient's presenting complaint, medications, the patient's history, and the observations in the shortest possible time-frame. Naomi and Jannie, both triage

nurses, mentioned the constraints of time both for paramedics and the ED staff as a factor which influences the exchange between them and paramedics. Naomi gave a candid impression of what she considered the paramedics are seeing and feeling when they walk in to give handover.

> **Naomi**
> Case 3
> ED interview
>
> *Because we're rushed for time and they just wanted to tell me, well not only they're rushed for time, I'm not saying they're trying to get out of doing a thorough handover. They can see I've got three other ambulances waiting, they can see I've got four patients lining up in front of me, they can see the personalities of the triage nurse getting flustered and they think I'd better be quick and concise here because I've been waiting here for 10 minutes trying to get my handover over, I've got to get back to my work, the triage nurse is going to get short with me if I go on and on and on so what can I tell her in the shortest possible time frame?*

Naomi noted, if times allows, she is happy to discuss and interact more with the paramedics so they can discuss the patient's circumstances in more detail.

> **Naomi**
> Case 3
> ED interview
>
> *And sometimes if we have a little bit longer and it's less busy I will get talking to ambulance officers and I will get a few more details out of them just because we're standing there together talking and then they'll go into what the social situations like at home, maybe any relatives that are with them.*

Jannie, as well as mentioning time, included the limited amount of information that the paramedics may be able to obtain as integral to whether or not a good handover can be achieved.

Jannie
Case 18
ED interview

We've only got a certain amount of time so that limits the handover. Also a good handover, the patient may not want to tell the ambulance officer enough information so then I don't get a lot of information because it's not passed on, so it can often be, especially with mental health patients not giving enough information.

From the perspective of the emergency staff, paramedics generally provided a proficient handover, but noted areas that could be expanded upon. Consistent with others in the health field some paramedics were more aware and able to give a more detailed handover than others, as Peggy succinctly states

Peggy
Case 10
ED interview

There's some [paramedics] *that you don't* [get enough information from] *and you have to start pulling like teeth but the majority of them I would say they're very good*

Barbara and Tim, in particular, mentioned the paramedics' ability and skills to describe the event, the environment the patient was found in, and the medication details as specific strengths. Also the example provided by Tim of the motor vehicle accident demonstrated the use of a familiar template of knowledge and assessment and transferring it to other areas of practice.

Barbara
Case 17
ED interview

I think most are quite good and I think most do give the information that you want, I think there's always some areas where people can expand on.

Tim
Cases 4 & 5
ED interview

They've got often a very good history of the situation. Some are better than others obviously but that does help us and certainly their account of the event and how they pick them up is very useful. For instance if it's a motor vehicle collision, then it will tell us the state of the vehicle, how much damage is done to the vehicle, to give us a good idea of injuries we could encounter. The same sort of thing goes with this type of patient.

Tim
Cases 4 & 5
ED interview

The paramedics are usually fairly thorough at looking for patient medications, getting that sort of information already. Sometimes it's not picked up, but usually it is picked up if there is an overdose involved.

The areas identified by ED staff which could be expanded upon involved more detail regarding the patient's behaviour and affect, the patient's demeanour before and during transport especially if they have been bought to the ED under Section 23 of the *Mental Health Act (1993)*, and where possible more detail regarding the patient's environment. Barbara recounted how the observational assessment of the patient's body language and behaviour is a key element to being able to make some sort of judgement regarding what to expect when they continue the care within the ED.

Barbara
Case 17
ED interview

I think more so like the affect of the patients, so are they withdrawn, quiet, do they look like they're hallucinating, gazing, whatever it might be, just any of those indicators, were they pacing at the scene, were they really agitated before handled, were they just standing there letting someone put them in the handcuffs. Just that sort of information as to how they were before they actually got onto the bed would be a good indicator as to how they're going to be when we take those cuffs off.

Naomi's account suggested the paramedic included the fact this case was a suicide attempt as an afterthought and her slight frustration showed with the comment 'that was pretty much all I was told'.

Naomi
Case 3
ED interview

All I was told when she came in is that she'd taken an overdose of 40 Temazepam and 6 Panadol and the time she'd taken them and then I asked – and then I was told that it was a suicide attempt and that she'd had a previous suicide attempt in the past and the ambulance officer said that she felt that she was at risk of absconding which was good information to have. … I asked if she had a history of depression and she said yes and that was pretty much all I got told.

Naomi pointed out that paramedics sometimes did not articulate why they had gained a particular impression of a patient which left her with a feeling of subjective rather than objective assessment being handed over. The example she cited was the paramedic had stated the patient was an absconding risk, but with no accompanying reasoning behind the impression or statement.

Naomi
Case 3
ED interview

A little bit more information so that the triage nurse wouldn't just take the point of view, it was like an opinion that they handed over to me, not really any subjective or objective information about the patient that I could then use to make my own assessment. Like she could have explained to me that the reasons why she thought she was an absconding risk and perhaps the triage nurse would not necessarily take those opinions on board and would like some concrete evidence as to why she thought she was a risk; … agitated, she's distressed, she's told me that she's going to leave or something more concrete may have been helpful.

This rationale for an action was often the point at which the triage staff would need to prompt and elicit further information from the paramedics.

Barbara
Case 17
ED interview

I guess sometimes, especially when they're Section 23s quite often it's just that they're a Section 23 and not why and that's the information that I want to know. So sometimes that's the stuff that you end up having to prompt and elicit out of people as opposed to they're Section 23 and they're here, so you know the reasons behind it, but most of the time it's quite good.

9.5.2 The limited information from the scene and the acknowledgement from ED staff

Manni and Barbara both considered that although the paramedics varied in the amount of information they were able to provide was due to the circumstances rather than the value placed on the patient's broader social and mental health history. They believed most triage staff acknowledged that the logistics and nature of mental illness can create hurdles for paramedics when trying to obtain a comprehensive history. This was particularly relevant for the acutely unwell patient who is unable to provide their history or articulate what is happening to them. This inability to provide a history which can assist in their care poses a challenge for all health professionals especially in the pre-hospital environment.

Manni
Case 12
ED interview

Not always, and yeah, I don't think that there is all that much they can do because with acute psychotic patients, it all depends on the circumstances they're found in, so they're wondering around naked in the street, it's very hard to get history.

Paradoxically the hospital may have far more detailed patient history due to prior attendance by the patient than the paramedics, which makes important clinical decisions harder to achieve.

Barbara
Case 17
ED interview

It's difficult to say, not all the time because I think if they've got a patient who's particularly unwell from a psychiatric point of view there often isn't any history but we've probably got the history here so we sometimes have more information than them in relation to background and social situation. So I think it's a difficult one, I don't think that they can always give the social situation, sometimes they might give us some information about the scene that they picked them up from saying that it's a particularly unkempt place or there were faeces on the floor or something like that, but that's about it from social-wise unless the patient can give them history themselves or there's family present.

Other issues involved the secondary information transfer to paramedics from sources such as residential care facilities, ACIS or the police, and the physical location of the patient which may be the street or a location other than their home environment. Sebastian commented on how difficult it must be for paramedics to be able to gain an accurate picture from the scene if they are not in the lead role and the secondary nature of the information which paramedics are able to provide if they have received the handover from other sources such as ACIS (Sebastian, Case 1, ED interview).

Leonie considered that the limited information can be a major barrier to being able to provide a comprehensive and detailed handover, but the limitation is out of the paramedic's control; they do the best they can and work with what they can obtain.

Leonie
Case 19
ED interview

I think the main barrier is that paramedics don't have any background on the person when they pick them up but that's like anything isn't it really.

[So the missing history, the missing information?]

Yeah but there's nothing you can do about that if the patient can't give it to you, it's the same with any sort of medical condition, if somebody collapsed in the street we wouldn't know anything about them, so it's the same set of thing.

Leonie
Case 19
ED interview

I think it was, the only thing that could've been more helpful was possibly the amount of Codeine and the exact amount of Panadol but it was difficult with somebody like that to give exact amounts, so they did the best that they could've done in that situation.

The triage staff accepted that on occasions information was given on the 'doorstep,' as paramedics were bringing in a patient, which generally only happened when the paramedics did not have the opportunity to radio through a notification. A notification was generally given in advance by the paramedics in cases of either extensive self-harm which required the trauma or resuscitation rooms and medical teams to be on standby or in the case of aggression or violence where the ED needed to be prepared and security arranged, a 'code black'.

Leonie
Case 19
ED interview

Normally we do get enough information, sometimes it can be on the doorstep but that's because the patient's situation can change really quickly, so they might've been in an ambulance and suddenly become aggressive so that makes it difficult if the ambulance was on the road it's a bit difficult for that as it is with any situation. If they're almost at their destination they can't always notify.

Tim
Case 5
ED interview

He was obviously requiring code black and that was done fairly quickly on arrival. You could see that he needed to be assisted because of his aggression and he'd been coughing and spitting at the police and paramedics. …I think it's a quick decision if someone is that uncompliant, and because SAPOL is also in attendance that really the protection of staff and for the protection of the patient … just so we could calm him down.

Tracy, the paramedic who attended the patient that Tim above was referring to, felt frustrated with trying to manage the patient only to have the police wheeling the disturbed patient through to triage where other ill patients on beds were suddenly confronted by a large gentleman yelling and screaming. She was philosophical that these types of patients and situations 'keep you on your toes' and the police did not realise the consequences of bringing the patient from the airlock area through to the triage area. She told me the main reason that she was not able to radio through to organise the 'code black' was she was working with a new paramedic intern who did not know the procedure and she was busy trying to manage the patient with the police and was not able to mentor the process (field notes, 27 May 2009).

Tracy
Case 5
Initial interview

Otherwise it would normally be called in a 'code black' and they'd be waiting for us in that handover section, as it was the patient was wheeled straight through because SAPOL didn't know any better and I was distracted so the handover didn't occur as it normally should.

9.6 The police, 'detained' patients and the handover

Another significant consideration to the handover process was the transfer of a patient either due to a detainment order in the community by the mental health

teams or by the police under Section 23 of the *Mental Health Act (1993).* Barbara summarises how the triaging of a patient may be influenced due to the Memorandum of Understanding between the police, Department of Health and the Ambulance Service where police are required to stay with the patient until they have been seen by an ED doctor, ideally within a 30 minute time frame.

Barbara
Case 17
ED interview

I think the only difference that I would use between the voluntary and the involuntary is probably the Mental Health Act and legislation that goes around it in the way that they're triaged. The only one thing that I would from a triage perspective be looking at differently is if it was a Section 23 then because of the Memorandum of Understanding having the police release within the thirty minutes, so even if someone was extremely compliant and could be a four or a five which would not necessarily be, if they were coming in as a Section 23, but they would automatically be a three or above just because of that MOU, but any other reason for them being here even if they were detained it would be solely triaged on their mental health presentation, so you know their flight risk, their level of agitation and that sort of stuff so not, nothing else in relation to them being voluntary or involuntary.

Leonie noted the process for the ED if they are confronted by someone who needs to be 'specialled' or they have concerns about potentially aggressive or violent behaviour.

Leonie
Case 19
ED interview

Yes, it depends when you mean detention it depends if they've been detained in the community or they're under a Section 23 from the police which is two different things. If they're with the police then the police will stay with them until they're seen by a doctor which makes it a little easier. Either way we'll probably flag it to the shift coordinator and tell them that there's a patient that has been violent to the ambulance officers and may need to be specialled in the future, so we just let them know. If we were particularly concerned about somebody then obviously we'd call a code black which is our violence or personal threat code. We could also get a security guard to stand by without them being detained if we were all particularly worried about them. If we're told that somebody's coming in who's particularly aggressive then we can have a team of security guards standing by.

Jannie stated that when a patient is brought in to the ED under Section 23 the triage process almost becomes redundant because 'you know they [the patient] are going to be triaged at a high level and your main aim is to get them inside and seen'.

Jannie
Case 18
ED interview

Generally if they're detained you know they're going to be a priority two and we want to get them into a compartment as soon as possible so we can get a guard or a nurse to special on them, a lot of the information I don't necessarily need because half of my decisions are made, I need to make them a high priority and I need to get them inside. If they're very violent that's important so we can then put them into resus and try and sedate them but if they're compliant and happy to go with the flow I just want to get them in and I'm not really too fussed about much of the other information.

Peggy, a triage nurse, imagined that the police may, on occasions, be another hurdle for paramedics to contend with out in the field. She considered that the ED staff work reasonably well with the paramedics and from her point of view if the paramedics are contending with an aggressive patient then they are there to

support them. They will willingly organise the resuscitation room or a quiet secure area for the patient and the security support if it is required. They will juggle workload and space to try and accommodate the patient's needs. In her opinion the difficulty arises when the police are reluctant to 'section' the individual and the paramedics have to convince the police to 'section' the patient so that it is safe.

Peggy
Case 10
ED interview

But once they're [the patient] *'sectioned' the police have to stay with them but you find police are now more reluctant to 'section' where as I've had paramedics say we've had to talk them into 'sectioning' them so it's safe and because they don't want to have to stay until they've been seen by a doctor so I almost sometimes like it's us and the paramedics versus the police sometimes, because I can understand that they want to get back out on the road but when you've got the paramedics saying look you really need to section this person um yeah it's a bit rough.*

Jannie, on the other hand, put the relationship between the ED staff, the paramedics, and the police more bluntly. She considered the relationship to be fairly cohesive between ED staff and the paramedics, but she describes a blurring of the boundaries with the police. In her experience she found the police sometimes do not want to relinquish their responsibility and they antagonise the situation.

Jannie
Case 18
ED interview

I think it's more cohesive between the ambulance officers and us, the police kind of often overstep their mark, they often bring a patient in to us, they're a Section 23 so once they're seen by a doctor and they're [the police] *told to go they don't really need to hang around, but they often hang around, hit them or try, they kind of antagonise a bit because they want to see what's going on, they won't let us take over and it's now our responsibility in a sense, so there's a little blurring of the boundaries because of resus and they will be trying to hold the patient down when really it's not their responsibility, it's ours, they kind of sometimes, they do cross over the mark, they want us to look after so they don't stop what they're doing, they continue. Sometimes you have to say 'no, settle down, you don't need to do that, it's our role'.*

The interaction between the paramedics, ED staff and police, and their role expectations, play a crucial part in understanding the actions of paramedics and how they operate within the cultural and system constraints.

9.7 The double check by the ED staff

Legally the ED staff are required to do their own assessment of the patient for triage and the more in-depth assessment for ongoing care.

Peggy
Case 10
ED interview

You need to, legally we need to have to do our own assessment, on our charts we have areas of presenting complaints so what has happened before coming into hospital and then there is an area of our own assessment so there is the assessment from the ambos, what has been given by the ambos and then our own.

The triage staff tried to sight the patient during handover to get an impression of the patient allowing them to connect the information from the paramedic to what they were observing. Naomi, from her own observation of the agitation and distress

of the patient, suggested that the paramedic's assessment of the patient being an absconding risk might have been 'a little bit more subjective rather than objective'.

Naomi Case 3 ED interview	*I just looked at her sitting on the bed and she looked agitated and she was crying and I thought well she's quite distressed, she's definitely a priority 2 and perhaps the information that she was an absconding risk could have been a little bit more subjective rather than objective.*

Although Naomi considered the absconding risk to be perhaps lower than the paramedic believed she still included the possibility in her clinical decision-making and actions. She moved the patient into a cubicle for privacy, a quieter place to try and reduce the stress on the patient, the added benefit of closer observation and made it harder for the patient to exit.

Naomi Case 3 ED interview	*I actually moved her position. She was brought in and the only place available to put her at the time was on the bed in front of the door so I moved someone else out of the bay and put her in the bay one for her privacy because she was distressed and because it was harder for her to exit should she consider that. So that prompted me to move her which was probably better for her, I could keep a close eye on her and if I saw that she was escalating then I could do something about it or go over and talk to her myself or speak to the staff inside about coming to get her.*

Jannie identified the patient's 'non-verbals' as central to what she was looking for when she first sights the patient during the handover process. She expressed the belief that the 'non-verbals' give you a clearer picture of the individual and they 'don't lie'.

Jannie
Case 18
ED interview

Yeah, I normally try and sight the person so I can see what their non-verbals are telling me because that can often tell you a lot more than what they actually say, what they say and what they do non-verbally can be two different things, and they'll lie verbally but they generally don't lie non-verbally.

She added that the paramedics may not necessarily pick up on those non-verbal signals to handover for a number of reasons. The short period of time the paramedics are with the patient or the situation itself may limit what paramedics can determine regarding non-verbal cues from the patient. It may also be a case of paramedics not being attuned to the 'non-verbals,' or new to the job and still learning to be able to assess for these non-verbal clues.

Jannie
Case 18
ED interview

They may not see them or notice them in the short period of time they have them or the situation they're in or they may not be terribly aware of some of the non-verbals that they could be putting off, they might be quite new at their job so they're not always able to see them.

Jannie described two quite separate processes for her assessment from the initial triage assessment, a process which involves managing a number of competing priorities, and being able to manage a more comprehensive assessment in a more settled environment.

Jannie
Case 18
ED interview

Assessing them initially is completely different to assessing them after they've been triaged and stuff because initially there are often a lot of other problems going on, they want to be seen straight away and they want to get that across and all those types of problems when you're triaging, it's hard to get to their main problem whereas when you're assessing them after they've been triaged they're often a lot more settled.

9.8 The judgement and the regulars

The final section of the narrative of handover focusses on the effects on handover on judgement, and the consistent presentations of the 'regulars' who have long-term and chronic mental illness.

Naomi expressed a commonality in the undercurrent of judgemental attitudes from paramedics, nurses and doctors when it comes to dealing with individuals who are suffering a mental illness. She makes a point of saying that it is not everyone who is judgemental or who is misunderstanding, but enough is said in the commentary which suggests a preconceived view of these patients.

Naomi
Case 3
ED interview

There are, as with other nursing staff and doctors there are a lot of the judgemental attitudes and judgemental comments put in, not with everyone, but with some people will sort of start the handover out with 'this person's a fruit loop' or 'this persons a this' or 'it's Jo Blogs again' and you know him he was here yesterday and the day before and the day before which is useful information to know but perhaps not in that manner.

In Barbara's opinion there is the trap of becoming complacent and developing what she described as 'an in-ground fast-tracking mechanism' for those patients who are frequently seen by the ED.

Barbara
Case 17
ED interview

Yes, I think you do become more complacent, you certainly do have that 'they were here yesterday, it was the same sort of thing' almost like an in-ground fast-tracking mechanism that you have, but I guess it's really important and I'll say it to the new triage staff that every presentation is a new presentation, you can be aware that they're here often but there's always going to be something new that comes out of it or potentially that will come out of it so you certainly do become a bit laissez-faire with it all.

Hayden described the shorthand handover for 'regulars' as 'she or he's back again and that's about it' (Hayden, Case 14, ED interview and field notes). His general impression is that this shorthand, in most cases, is not meant as derision or to single out the person but as a simple statement of fact and a condensed version which is used in cases well-known to all. He went on to say he will always ask if there is anything different or changed in the presentation and was conscious of the need to make sure the follow-up assessment is comprehensive. He acknowledged this shorthand may be an issue with new or less experienced triage staff who are not privy to the details of the individual or less conscious of the need to ensure sufficient follow-up care. He considered there may be the possibility of bias and a false impression but believed the triage system, which requires details of the presentation first then personal details, and their own assessment responsibilities countered this.

Jannie, from her own observation, depicted the attitude and transfer of information from paramedics to triage staff regarding 'regulars' as minimal and as though they had little interest in the patient.

Jannie
Case 18
ED interview

To me their body language tells you a lot with the regulars, they'll just come and sit and are not terribly interested, just say 'they've come in, they're depressed, the story', they're not willing to give you much more than 'they're feeling depressed and want to kill themselves', whereas a patient that's not necessarily a regular we get a whole lot more information. … also sometimes with your ambulance officers they just don't like the patient so they just can't be bothered. You get that feeling that they're [the patient] *wasting my* [the paramedics] *time; I shouldn't be having to do this type of thing, some of the ambulance officers.*

She described the attitude as depending on a number of factors such as 'their day, their workload, whether they can really be bothered or not', and whether they are caring for what they consider to be an individual who is 'more just a PD [personality disorder] as opposed to a mental health problem we can treat'. She viewed the paramedics as generally meeting their duty of care, but it is just the 'ones they get annoyed with that they might not go to all lengths to make sure everything's alright with them' (Jannie, Case 18, ED interview).

Barbara provided more insight into the system of rotating people through different areas of the ED to reduce the frequency of exposure for triage staff and to give them 'time out'. Education, reorientation and a focus on service provision were all strategies used in an attempt to prevent the complacence and tiredness experienced by staff with patients who frequently present to the ED.

Barbara
Case 17
ED interview

Like we do now rotating people through the different areas so they're not getting that continual bombardment and ongoing, not just from mental health clients but everything, that whole bombardment and then the re-presentations and things and then you sort of build up that wall I guess, so rotating through the different areas and having time out of those areas certainly that gets them away from 'well I saw them last week' and they miss that frequency of people coming through. I guess the main strategy that I do see is that education and almost like continual re-orientation of staff to presentations and people and customer service, the whole gamut of things.

For paramedics the ability to be able to have respite from the 'frequent flyers' is only possible through their roster of four days on and four days off. Alternatively they can work as a team and sometimes the partner can step in to share or take on the care of the patient if the situation requires. The team leaders, shift coordinators and consultations with mental health liaisons or hospital staff were also possible measures although not immediately on the scene could assist with assessment and plans of actions.

9.9 Conclusion

The 'handover' of patients suffering a mental illness occurred within a physical and social environment which included the interaction between paramedics and the ED staff. Handover was not simply a process of relaying information, but was influenced by factors such as patient workload, physical space, the negotiation of space and time, the relationship between individuals, structural and organisational constraints, and the value placed on the information gained. To conclude this section the quotation from Barbara leaves an important notion for paramedics that

although the work they do becomes focussed and routine the familiarity should not distract from the importance of what they do and that she hoped they recognise this.

Barbara Case 17 ED interview	*Maybe not, I'd had to think that they did and I guess it would be the same as anyone in that you just become quite familiar with your own work and what you do and how it is important to yourself, I'd like to think that they did but same as anything sometimes I think you just become quite laissez-faire I guess and you're quite comfortable in getting the information that you need for your area of work and I guess it just carries on in every area of work, but yeah I like to think that they did know how important it was.*

The final findings chapter, the document analysis, continues the themes of role expectations, the value placed on knowledge, the summarising of that knowledge and the expectation of care and treatment which have been established by the interviews and observational data and how that is translated in the major legal document for the paramedics, the case card.

Chapter 10

Findings part 3:
Handover and case cards
(Section 2—case cards)

10.0 Introduction: the case card (the patient report form)

The SA Ambulance Patient Report Form, known as the case card, is a structured legal document that details the observations, assessment and treatment provided on- scene and during transport by paramedics. The case card, at present, is the only form of written documentation which in conjunction with the verbal handover supplies information to hospital staff and the ambulance service.

The case card (appendix K), a two-sided form, consists of specific sections. The front section outlines patients' details, dispatch and arrival information (time, dispatch code, priority code), attendant (paramedic) identification and signature, destination information, motor vehicle accident section, primary survey, and organisational codes that designate what type of patient presentation has been attended. The other side of the case card is an open section which includes assessment and treatment provided by the paramedics and summarises the key features of the case. A separate table at the bottom of this section is used to record observations such as vital signs, treatment provided, any notable event, and drug administration details. This section of the case card conveys information regarding the patient's

home environment, community (street, family home, mates place), initial patient presentation, and vital information regarding what the person says and does and how they respond to paramedics, to other emergency staff and to mental health staff.

The case cards contributes to understanding how paramedics document and impart the information they gain pre-hospital to other health professionals and complements the knowledge gained in the interviews and from observation of handover. The data also adds to the knowledge surrounding the pre-hospital culture specifically when attending cases deemed to be related to mental illness. This chapter explores the de-identified data gathered from the case cards, using the headings in the document itself as the framework. The chapter covers information regarding the presenting complaint, past and current history, on-arrival and on-examination data and an overview of the observations recorded.

10.1 Presenting complaint

The presenting complaint summarises what paramedics identified as the main reason for their attendance. Using a word or shorthand expressions that are generally well known within the health industry, the presenting complaint was established from what the patient states and from the history gained at the scene. The presenting complaint along with the ambulance service codes provides paramedics, the organisation and others with a way to characterise the case.

The presenting complaint for 19 of the 20 cases collected for this study ranged from those identified as psychosis, anxiety, mental health, 'detained' patient, through to self-harm, overdose and lacerations. One case card (case card 9) was not able to be obtained for logistical reasons.

Table 10.1 documents the presenting complaint, as written by the paramedics, and the attendance of either the police or the mental health teams.

Table 10.1 Presenting complaint and SAPOL or ACIS attendance

Case	Presenting complaint as documented on case card	SAPOL (SA Police) and mental health team involvement
Case 1	Detained pt; non-compliant with medn	ACIS and SAPOL
Case 2	Psychosis	SAPOL
Case 3	Prescription	
Case 4	Bipolar episode – major mood swings	
Case 5	ETOH + tramadol OD	SAPOL
Case 6	Mental Decompensation	Community Mental health Team SAPOL Escort
Case 7	Abdo pain	
Case 8	↑ Anxiety / depression	
Case 9	Unable to be obtained due to logistics.	
Case 10	prescribed O/D	
Case 11	Paracetamol O/D	SAPOL
Case 12	Multiple Forearm Lacs	
Case 13	Benzo OD	SAPOL gained access
Case 14	Endep OD	
Case 15	polypharmacy OD – prescribed	Surgery called SAAS and SAPOL after being contacted by the patient
Case 16	mental health	Southern mental health organised visit with SAPOL and SAAS
Case 17	Detained Pt	Patient in SAPOL custody on arrival and SAPOL escort enroute
Case 18	Anxiety, Dyspnoea	
Case 19	threatening self harm	SAPOL
Case 20	Psychiatric	

A number of terms were used on the case cards in specific contexts. A ‘detained’ patient refers to a patient that has been transported to hospital by the ambulance service where the decision has been reached that further assessment and care was required for the safety of the person and others. At the time of the study paramedics were practising under the *South Australian Mental Health Act 1993* which did not provide the legal powers to the ambulance service to act on these decisions directly. The police were legally required to carry out the provisions under Section 23 of the Act. The paramedics and police often worked together in making these decisions and although the paramedics at that stage did not have the legal responsibility they often directed the decision (Roberts & Henderson 2009). On occasions, if the patient had been seen by the mental health team and a detention order was in place the term ‘detained’ referred to these orders. The new *South Australian Mental Health Act 2009* which came into effect in July 2010 changed the powers that paramedics have in regards to these decisions. Under the new act, the paramedics are considered authorised officers. This entails a number of provisions and powers one of which is the concept of taking someone into ‘care and control’ to convey safely to further care. Two of the 19 cases stated ‘detained patient’ as the presenting reason for attendance. Eight out of the 19 cases used terms directly related to mental illness such as anxiety, mental health and psychiatric. One of the

eight was identified as threatening self-harm, but had called *healthdirect Australia*[11] and stated that he had taken an overdose.

The terms OD and ETOH (ethanol and OH, oxygen hydroxyl group) are shorthand for suspected overdose and alcohol intoxication. Paramedics identified these cases as relating to mental illness because of statements made by the patient or by others that indicated intended self-harm or a past history of attempts at self-harm in conjunction with diagnosed mental illness. Seven of the 19 cases were designated as overdose and alcohol related. The final two case cards collected described multiple forearm lacerations and the other case identified abdominal pain as the presenting complaint.

As a statement of the case, the presenting complaint was only the beginning of the story. The past history and current history recorded the patient's past and present medical circumstances and current events which led to ambulance attendance. This information, typically documented after the presenting complaint, offered insight into the social and situational contexts of the patient.

10.2 Past history and current event/history

As suggested in the interviews and observations, gaining a patient history can be complicated by a number of factors. One major issue is the presence of

11. *healthdirect Australia* is the collective trading name for the National Health Call Centre Network Limited (NHCCN Ltd) and those of its contractors who provide nationwide access 24 hours a day, seven days a week to healthcare triage, health advice and health information. http://www.healthdirect.org.au/about-us/about-healthdirect-australia

comorbidities, either drug and alcohol related or medical conditions such as hypertension, asthma or in one case intellectual and cognitive disability. Table 10.2 details the past history and current history or event as documented by the paramedics.

Table 10.2 **Past history and history/current event**

Case	Past history	History/Current event
Case 1	Schizophrenia, Hypertension	56 y.o. male [male symbol] seen by ACIS & SAPOL today detained as pt is off psych & anti hypertensive med^{n} & is delusional. Pt is voluntary.
Case 2	diagnosed bipolar disorder, cancer of the testes and batteries in the lower intestine	Current History of cutting arms and overdose (o/d) Wake up wanting to die today. Kicked window in care facility and SAPOL was called – has drunk a bottle of sherry.
Case 3	depression	This 41 y. o. female (symbol for female) has had problems over last 1/12 controlling her self harm ideologies, local GP has introduced zyprexia over last 7/7 which pt states makes her feel worse, less controlled. Discharged from [abbreviation for local hospital] 10 days ago still feeling suicidal according to daughter. Today has consumed approx 40 temazapam and 6 panadol with alcohol. Daughter called SAAS. Consumed medications @ approx 13.30.
Case 4	Intellectual Disability, Cerebral Palsy, Bipolar, Epilepsy	Staff at local Community Care ctr [centre] have been monitoring this pt for last 4-5/ 52 for ↑ agitation & issues with flat mates, culminating in inappropriate public behaviour – e.g. swearing, lashing out & yelling. Pt states he has been unwell with cold in last 5/7. Staff have gradually ↑ his med^{n} dose in consultation with LMO last few days also. Does not appear to have helped & staff also say pt has had ↑ frequency of absence seizures last 5/7
Case 5	Neck injury. Headaches	Pt had called his social worker stating he had OD on tramadol + alcohol. SAAS & SAPOL called.
Case 6		35 y.o male [male symbol] with hx of Schizophrenia. Pt has been drinking ETOH [alcohol] lately and refusing to take his anti psychotic meds. Pt seen today by the community mental health team who recommended further r/v.
Case 7	Bipolar	went to McDonalds for coffee. Felt unwell @ 11.30pm - ↑ pain abdo – nausea. Nil vomiting.
Case 8	Schizo-affective disorder, asthma, bronchitis, depression, Angina	59 yo female (female symbol) pt states her schizo-affective disorder is getting worse, symptoms of tiredness, anxiety, depression are increasing. Pt helped by valium PRN. Pt is worried that she will become suicidal
Case 10	depression, previous O/D, Hernia	42 yo male (male symbol) from home address. Pt found collapsed & unresponsive in the back yard of his home →SAAS. Friend stating pt has been drinking ETOH & taken an O/D of prescribed medications (? after lunch)
Case 11	Hepatitis, Bipolar, Cardiac stent x1, Angina, ↑ Cholesterol, Hypertension, Chronic back pain, PTSD	54 y.o. male [male symbol] lives alone. States between 1600 -17.30 today consumed 100 x 500mg paracetamol with 4 pints beer. Pt states desire to end life, depressed due to recent marriage failure. Called SAPOL because he felt dizzy → Sect 23. SAAS called.

Case	Past history	History/Current event
Case 12	IDDM [insulin dependant diabetes mellitus], unable to assess	39 y.o male [male symbol] Hx of auditory hallucinations since 16.30 this pm. Voices in his head told him to cut his arm with razor. Approx 1800 this pm cut R) forearm multiple times. BGL has been high for approx 1/52.
Case 13	? Depression	44 yo male [male symbol] today been drinking wine, rang family / friends to say ‘goodbye’ + stated he was going to end his life. SAPOL gained access to property to find Pt sleeping in bed. Empty bottles of Antenex + Alepam next to bed.
Case 14	Depression, Anxiety, ? liver damage → previous OD	Pt felt suicidal took approx 40 Endep tablets and cut both wrists at approx 1130 hrs. SAAS called 1320.
Case 15	- ? depression, ? previous OD	25 y/o female poor history due to GCS + not forth coming with information - ? called surgery →surgery called SAAS + SAPOL - Pt took unknown amount of 5mg Diazepam and up to 250mg of Seraquel → pt states she took ‘too many’ 1hr prior to calling. Unable to clarify further → unknown if a couple or a handful. - Pt also consumed 1x bottle of champagne - Self inflicted superficial wounds ® forearm done last pm - Unknown what issues surround today’s events
Case 16	Asthma, Schizophrenia	43 yo female living with male friend, regular contact with Southern Mental Health. September 09 taken off schizophrenia meds, been coping well until [approximate sign] 2/52 started using methamphetamines causing psychosis; hearing voices, paranoia. Southern Mental health called pt this am to check on mental health, concerns raised, organised to visit pt with SAPOL / SAAS with detained papers
Case 17	Schizophrenia, multiple admissions to [name of inpatient unit]	- ? y.o. female [female symbol] found in Coles supermarket looking for knives & stating she wants to kill herself. SAPOL & SAAS called
Case 18	Nil * smoker (moderate), alcohol ++ lately	40 yo male has been having relationship issues lately, Pt has been drinking heavily and has been quite anxious at times and living with a work mate. Today Pt was acting somewhat bizarrely, vague when questioned and saying he was breathless.
Case 19		42 male history of violence, detention, personality disorder Called health direct and said he had taken an O/D of Herron + (500mg Paracetamol + 10mg Codeine).
Case 20		72 y o lady, hearing voices through the TV, believes the queen has hurt her dog, believes the queen is controlling her life, won’t let her out of the house.

The past medical history (PHx) of the patients encountered in this study included conditions such as schizophrenia, depression, bipolar disorder, anxiety and previous overdoses. Schizophrenia or schizo-affective disorder was recorded in the past history of four of the 19 cases. Depression or a query of depression was found in six cases and bipolar disorder was included in four of the collected cases. The instances where there was no clear past history indicated under the heading the information was written within the current event. In two cases the paramedics placed a query regarding depression and anxiety in combination with a query of possible overdose, and in one instance the past history was not able to be assessed.

The record of history or current event, typically, started with the age of the patient or some acknowledgement that age was considered even if the information was not able to be obtained. The ages ranged from early twenties to an elderly lady that was in her early seventies. The gender of the patients was documented usually in the same line of text in the case card as age. There were eleven males and six females. Two cases did not explicitly state the patients gender and it was not clear from the past history or current history whether they were male or female.

The history, in a few sentences, specified the reasons for ambulance attendance and provided brief details of the information paramedics gathered from the scene. This information covered details such as the situational and social information surrounding the event. It alluded to the circumstances leading to the event and information passed on to paramedics by other sources. Case 16 provides a good

example of the social and immediate history condensed into a few sentences that is characteristic of the history.

> *43 y.o. female living with male friend, regular contact with Southern Mental Health. September 09 taken off schizophrenia meds, been coping well until ≈2/52 started using methamphetamines causing psychosis; hearing voices, paranoia.* (Sonya: Case 16)

Informants, other than the patient, who provide paramedics with information included individuals such as workmates, surgery and care facility staff, friends, family, and the Southern Mental Health Team. This information included whether the ambulance operations received the information from a third source, or who had called on behalf of the patient. Other information outlined in the history covered the attendance of other services, previous history of violence, alcohol or drug use, self-harm and altered perception. The attendance of either the police or mental health teams was documented specifically with the added information if the patient was detained under *The Mental Health Act (1993)* or conveyed under Section 23 of the *Act* by police. Paramedics also noted whether the patient was voluntary or involuntary and non-compliance with medications, as demonstrated in Case 1.

> *56 y.o. ♂ seen by ACIS & SAPOL today detained as pt is off psych & anti hypertensive med^{n} & is delusional. Pt is voluntary*. (Don: Case 1)

Any known previous history of violence was documented along with the initial information regarding the presences of alcohol and possible drug overdose. Intoxication and or possible overdose was either stated by the patient or suspected

by the paramedic from what they observed at the scene. In Case 19 Gerry documents that the patient has a history of violence, past detention and personality disorder.

> *42 male history of violence, detention, personality disorder. Called health direct and said he had taken an O/D of Herron + (500mg Paracetamol + 10mg Codeine).* (Gerry: Case 19)

Self-harm and associated injuries or stated intentions from the patient that they are going to harm themselves and a desire to die featured often in the history section on the case card. Self-harm behaviour was noted in three cases to be association with auditory hallucinations. To complete the initial picture of the case the presence of auditory hallucinations, visual hallucinations or delusions were also recorded on the case card. Adam, Case 12, offers an example of how both self-harm and altered perceptions were recorded within the case cards.

> *39 y.o ♂ Hx of auditory hallucinations since 16.30 this pm. Voices in his head told him to cut his arm with razor. Approx 1800 this pm cut R) forearm multiple times. BGL has been high for approx 1/52.* (Adam: Case 12)

Under a separate heading in the case card, but related to the history, is the recorded information regarding the patient's medications. The list of medications, if it was obtainable, was generally placed under the patients past medical history. The medication list was inclusive of medications for mental illness, comorbidities such as asthma, hypertension and pain relief medication.

Table 10.3 **Medications**

Case 1	Case 2	Case 3	Case 4	Case 5
arapax, olanzapine (not compliant)	Betamin, Seroquel, Megafol, Efexor (Ventafoxin), Metoprolol	Cymbatta, Olonzapine (zyprexia), arapax	Carbamazepine , Valpro, Zipfasadone	tramadol
Case 6	Case 7	Case 8	Case 9	Case 10
Risbendome	Elanzopine (wafer) panadene Forte	amoxicillin, spirva, symbicort, ventolin, Zocor, valium, GTN		Diazepam, Serepax, Panadol, Ergotamine
Case 11	Case 12	Case 13	Case 14	Case 15
GTN, Liptor, Coversyl , Noten, Oxycontin		Antenex 5mg, Alepam 30mg	Endep	Diazepam, Seraquel, Topiramate, Valpo, Zyrteo
Case 16	Case 17	Case 18	Case 19	Case 20
Ventolin, Prozac	unknown	Nil		Declofenac, Panadiene Forte

The next stage of the case card noted what the paramedics found on arrival at the scene and on examination of the patient.

10.3 On arrival (O/A) and on examination (O/E)

The ‘on arrival’ and ‘on examination’ data documented where the patient was situated and their position when the ambulance crew arrived on the scene and the assessment of the patient.

The ‘on examination’ information generally followed the process and principles of the primary and secondary survey. The primary survey outlines the systematic process of checking for danger, response, airway, breathing and circulation. The measuring of vital signs and the secondary survey examines the patient for physical trauma and systematically goes through the body systems to determine, as far as possible in the pre-hospital environment, any underlying reasons for the patient presentation. Paramedics look for issues such as a low blood sugar level (hypoglycaemia), signs and symptoms associated with changes in the central nervous system, the cardiovascular system, the respiratory system and gastrointestinal system. They also document any patient-reported tenderness and pain, any obvious bruising, bleeding or lacerations, and changes in mobility and range of motion. These processes form the basis for clinical decision-making and judgements that paramedics make on scene. Table 10.4 details the on arrival and on examination information from the case cards.

Table 10.4 **On arrival and on examination**

Case	On arrival	On examination
Case 1	Pt walked out to ambulance, ACIS & SAPOL present.	Pt Alert & orientated – GCS 15, appears well perfused BP 250 / 150, HR 116, strong & regular radial pulse Pt sat en route with ^{o} changes, ^{o} evidence of delusions, denies hallucinations & … with pt. ^{o} aggression, pt appears quite reasonable
Case 2		Wearing a black beanie, black/dark blue shirt and dark jeans Intent on dying today States he is hearing voices – voices telling him to harm himself to die Moments where … [name of patient] was aggressive but calmed down – cooperative with Q'S [questions]. Injury from kicking in window Able to follow conversation Skin warm and dry *wants to call father and sister
Case 3	– pt outside of house with daughter	CNS [central nervous system] – A/ O [alert and orientated] GCS [Glasgow coma score] 15 skin pink/ warm/ dry CVS [cardio vascular system] – BP 140/80, HR 80 irregular Resp. – rate 18 NAB [nil abnormalities detected]
Case 4	pt & client care manager walked to ambulance. Pt compliant.	Cons, A&O [alert & orientated] x 3. Pt. having wide variations in emotional state. Mild unproductive cough. Afebrile. Good limb strength. ^{0} headache, ^{0} nausea. Rest of body NAD. No violence or aggressive behaviour enroute.
Case 5	Pt came to door 2 x Malamute dogs in house. Pt speech slurred. Pt swaying on feet. Pt non compliant. History of violence- pt known to us – carried in past	CNS: Pt complains of severe headaches. Stated wanted to stay at home and die. Refused to come out of house or put dogs away. Pt required detaining by SAPOL + removed by force from house. Pt coughing & spitting at SAPOL + staff using verbal aggression + attempting to resist detention CVS: NSR. Skin hot & flushed. Resp: Pt shouting & yelling. Holding breath intermittently or else hyperventilating.
Case 6	Pt sitting on the lounge	Pt alert and initially co-operative but suddenly became aggressive after being advised of detention. Pt uncooperative and abusive during T/F. Delusional thoughts noted during initial conversation. Pt refused physical obs. Bruises and cigarette burn marks noted on pt's both arms. Pt handcuffed during t/f with SAPOL escort. Form 1 + 15 ?
Case 7		Blocked Bowel last 3/7 – opened bowel this am soft abdo – Nil masses Lower quadrant. Pain Bi-lat [bilateral pain] Nil chance of pregnancy Pt states Pt has anxiety from

Case	On arrival	On examination
Case 8		Pt states her symptoms are increasing due to lice infestation. Pt states she can not bear ' to face the washing machine' anymore as she washes everyday to get rid of the lice. Pt unable to sleep etc. Pt saw GP yesterday. States symptoms have increased since then. Pt states she is worried about 'having a break down'. Pt also states the lice ↑ her breathing difficulty, which ↑ her anxiety.
Case 10	Pt (L) lateral on ground, friend in attendance	Response - GCS 10, PEARL (2+) Airway ✓ Breathing – Bilateral A/E ✓, RR 20 & shallow, Sats 100% on air & O2 Circulation – HR 80 (weak regular radial), BP 90 / 70 (supine), skin pale (diaphoretic ?), ECG sinus rhythm with occasional unifocal PVC's; peaked T waves. ^{o} Vomiting , ^{o} incontinence, BSL 6.1 mmol Friend stating Pt intoxicated & taken polypharmacy O/D including Panadol (unknown amount), Serepax (? 25 x 30mg), Diazepam (? 50 x 50mg) & Ergotamine (? amount). Abrasion evident L iliac crest – no other obvious injuries O/E Enroute: Obs stable, pt haemodynamically stable (GCS 12)
Case 11	Pt ambulant, speaking with SAPOL	GCS = 15 cons A + O [alert & orientated HR = regular Skin = pink, warm, and dry. RR = 18 unlaboured - pt c/o RUQ [right upper quadrant] pain consistent with chronic hepatitis pain, nil new pain tonight. Pt c/o feeling dizzy + nausea
Case 12	[sitting stick figure] on bed, staff I/A [in attendance] attending to wounds	multiple superficial lacs to (R) forearm. Varying from 2cm – 5cm in length. No active bleeding A & O, reg radial pulse, normal respiratory effort, constant shaking in hands L) = R) appears anxious. Denies pain. States still hearing voices. BGL 18.9mmol
Case 13	Pt [lying down stick figure] in bed	Pt became GCS 15 post painful stimulus skin pink warm dry Pt verbally aggressive enroute @ times Init [initially?] physically aggressive with SAPOL Stated he has taken ≈ 300 diazepam tablets today.
Case 14	Pt walked to ambulance with bag	50 yo male [male symbol] pt post Endep OD + lacerated wrists Reports previous medication overdoses in recent past (approx 1/12 ago) Deep 6cm lacerations to both wrists haemorrhage controlled, minimal blood loss. Dressed by SAAS … Movement strength + sensation distal to injury. Pt walked to ambulance, reluctant about stretcher → happy to sit in seat Pt reports 'not coping' at moment

Case	On arrival	On examination
Case 15	Pt met SAAS @ door	– Conscious GCS 14 Alert but confused conversation, vague Skin well perfused dry Tachycardic HR 125 → sinus tachycardia c/o abdo pain → ^{0} nausea ^{0} other complaints
Case 16	pt verbally aggressive, would not allow entry to premises, would not come out to speak with Southern Mental Health. Paranoid that someone's in the roof cavity	CNS – GCS 15, A & O, aware time /place but paranoid about hearing voices. Resp – NAD Skin – pwd [pink warm dry] Pt unpredictable in past, violent towards SAPOL / SAAS, ICP [intensive care paramedic] back up for possible sedation but not required, pt cooperative in the end, calm & non aggressive en-route
Case 17	Pt in SAPOL custody, detained	Conscious, orientated, stating repeatedly that she wants to die. Pt refused all assessment from SAAS, refused to answer questions Pt agitated enroute. SAPOL escort
Case 18	Pt sitting on ground outside mates house	GCS 14 – vague answers to questions PEARL (size 6) Skins flushed moist perfused Hypertensive 180 / 90 ECG Sin tachy L1 –III Reg radial pulse RR 16 BSL : 9.3 mmol/l
Case 19	On arrival – Pt aggressive & abusive to SAPOL & SAAS	Approx 10 tablets seem to be missing from packet. Pt also intoxicated approx 10 x 375ml bottles @ scene. Pt threatened to kill himself once SAPOL left. Pt section 23 by SAPOL. ≈ 60 m [minutes] required to get patient to come with SAAS to be assessed in hospital. No obvious injuries on pt. Obs not taken due to violent nature of pt.
Case 20	pt initially non compliant with persistence pt then became compliant wanting to get arm looked at	CNS – GCS 15 A + O, PEARL, pt denies any chest pain. Pt states has pain in (L) arm that she has experienced for 6 weeks CVS – pt pink + warm, HR strong + regular, BP 130/P Resp – NAD – good rise + fall, Nil SOB Pt states queen has been hurting her dog's, channel 7 talks to her through the TV and people are passing through her body are pulling @ her organs – as per ACIS.

10.3.1 On arrival: the scene—the patient

When paramedics arrived at the patients home they were likely to find them anywhere from the front door and entrance of the premises, to sitting on the ground, waiting outside the residence or lying on the ground in the yard, or inside their home. Details on the case card included whether ACIS or the police were in attendance and whether there was aggressive or abusive behaviour towards the service providers who were present. A few words often accompanied the summary of where the patient was found in regards to whether the patient was compliant or non-compliant, 'detained', and the patient's voluntary or involuntary status. The other key features of the on-arrival information included the presence of relatives or others that could provide a source of information, whether or not the patient walked to the ambulance, and other physical or situational information that could potentially affect the ability of the paramedic to fulfil their duty of care.

The following two examples highlight the 'on scene' factors that paramedics were contending with:

> *Pt came to door 2 x Malamute dogs in house.* (Tracy: Case 5)
>
> *Would not allow entry to premises, would not come out to speak with Southern Mental Health. Paranoid that someone's in the roof cavity.* (Sonya: Case 16)

The on-arrival data created a picture, in a few words, which conveys the situation attended, position of the patient and the environment surrounding the patient.

10.3.2 On examination: seen, heard and measured

The following sections detail the observational data that paramedics recorded whether it is from what they saw, heard or measured. The patient's GCS as a measure of consciousness and patient vital signs were generally documented at the beginning of this section. The patient's appearance and any injuries followed by information regarding potential overdose or intoxication with the patients affect and behaviour as a final aside to the documentation.

GCS and observations

The *on-examination* data routinely began with data associated with the assessment of the central nervous system with the GCS and whether the patient was alert and orientated as a starting point. The majority of the cases were considered a GCS of 15, conscious, responsive, alert and oriented. If the GCS was lower than 15 then there was an accompanying rationale, for example vague responses to questions or change in responsiveness due to alcohol or overdose. One case specifically stated that the GCS was *15 post painful stimuli*. Also the paramedics if they deemed necessary detailed the pupil response to light and their size, evidence of possible head injury or drug related effects related to the central nervous system. As part of the paramedics secondary survey of the cardiovascular system they documented the patient's skin colour, if the patient was perfused (pink, warm and dry), and if the patient was diaphoretic. The pulse and blood pressure were obtained if the circumstances allowed. If the basic set of observations were not obtained then the reason was linked to the inability of gaining the cooperation of the patient and their

subsequent refusal or the aggressive or violent nature of the patient. Although the vital signs could not be measured and documented for these patients the paramedics noted that the patient was conscious, talking and in some cases swearing at the paramedics. A conscious, talking patient has a least an open airway, is breathing and receiving enough oxygen to vital organs to maintain their conscious level, heart rate, and blood pressure.

A description of the patient's respiratory rate was easier to obtain because physical contact with the patient was not required, it could be observed from a distance. The respiratory rate was generally included in the *on-examination* data or in the observation chart. In two cases the cardiac monitor was used to give the paramedics further information regarding the activity of the heart. One showed sinus tachycardia and the other showed a sinus rhythm with the occasional unifocal premature ventricular contraction and peaked t-waves. The later was specifically more detailed cardiovascular assessment due to the patient presentation and the information given to the paramedic of a polypharmacy overdose related to attempted self-harm and possible suicide attempt.

The notation NAD (nil abnormalities detected) was used to indicate that the paramedic had assessed at some level the area of concern and had found no obvious changes or deviations from what is considered within 'normal' range, function or appearance. For example, the notations from case twenty and case four both use NAD, nil or '0' to denote no evidence of change:

Resp – NAD – good rise + fall, Nil SOB (Rose: Case 20)
^{0} *headache,* ^{0} *nausea. Rest of body NAD.* (Frank: Case 4)

Table **10.5** provides an overview of the observations documented by paramedics.

Table 10.5 Observations

Case	**Observations**								
	Time	**Pulse**	**Resp**	**Blood pressure**	**Cap refill**	**SpO2**	**GCS total**	**Pupils L +/- R +/-**	**Pain /10**
Case 1	1300	116	18	250 / 150	2		15		
Case 2	Attempted to do obs but Pt became aggressive								
Case 3	1410	80	18	140/80			15		0
	1420	80	18	140/p			15		0
Case 4	1100	70	18	140/p	2	N/T	15		
Case 5	1255	94	22			100	15		
Case 6									
Case 7	1425	80	18	100/65		99	15		9
	1440	83	18	100/p		99	15		
Case 8	1255		18		2		15		
Case 10	1504	80	20	90/70	2	100	10	2+ 2+	UTA
	1525	70	20	100/p	2	100	11	2+ 2+	UTA
	1535	70	20	100/p	2	100	12	2+ 2+	UTA
Case 11	1800	88	18	130/p	2		15		
Case 12	1900	80	18	125/p	2		15		
Case 13		86	16	120/p	2		12		0
Case 14	1340	90	18	90/p	2		15		0
Case 15	1436	125	20	130/80	2		14	6+ 6+	
Case 16									
Case 17									
Case 18	1620	130	16	180/90	2		14	6+ 6+	0
Case 19	1340		20				15	2+ 2+	
	1450						6		
	1456						15		
Case 20	O/A	70	16	130/p	2		15	2+ 2+	0

Appearance and injuries

The appearance of the patient was specifically noted in one case which described the patient's attire as 'wearing a black beanie, black/dark blue shirt and dark jeans' (Joyce: Case 2). The other references to appearance commented on the patients overall physical and behavioural presentation such as 'appears anxious' (Adam: Case 12) and 'pt walked to ambulance, reluctant about stretcher - happy to sit in seat' (Samantha: Case 14).

In conjunction with appearance and observations the paramedics documented any injuries found and any treatment given to manage those injuries. The severity and type of injury varied across the cases.

> *Injury from kicking in window* (Joyce: Case 2)
>
> *Bruises and cigarette burn marks noted on pt's both arms* (Trevor: Case 6)
>
> *multiple superficial lacs to (R) forearm. Varying from 2cm – 5cm in length. No active bleeding* (Adam: Case 12)
>
> *Deep 6cm lacerations to both wrists haemorrhage controlled, minimal blood loss. Dressed by SAAS* (Samantha: Case 14)

Overdose and alcohol

Overdose and intoxication were comorbidities and major considerations in a significant number of the cases. The presence of suspected overdose and /or alcohol focused the paramedics efforts in determining what substances were taken,

how much was taken, and when it was taken. The history and *on-examination* data combined to provide the whole story in regards to the amount and what was taken by the patient. The *on-examination* data tended to detail the amount of what was taken or what was found in the process of examining the scene. Gerry and Len, case nineteen and ten, illustrated how the paramedics gathered the information and how they documented it.

> *approx 10 tablets seem to be missing from packet. Pt also intoxicated approx 10 x 375ml bottles @ scene.* (Gerry: Case 19)

> *Friend stating Pt intoxicated & taken polypharmacy O/D including Panadol (unknown amount), Serepax (? 25 x 30mg), Diazepam (? 50 x 50mg) & Ergotamine (? amount).* (Len: Case 10)

Affect and behaviour

Observations and GCS assessment initially completed, the *on-examination* data featured aspects of the patients affect and presenting behaviour. One key aspect was whether or not the patient appeared agitated or aggressive, which followed with the description of the aggressive behaviour if it occurred. The paramedics noted aggressive behaviour such as the patient was spitting, swearing and shouting at SAPOL staff and paramedics, physical aggression towards the police and verbal aggression towards paramedics, and any past history of violence. It was also clearly noted if the patient was not aggressive enroute or a noted past history of aggression or violence did not eventuate in the current presentation.

Other characteristics of the patients behaviour written into the case cards were statements from the patient involving the wish ‘to stay home and die’, threats and intent to kill themself, and reports of ‘not coping’ at the moment. Statements by the patient expressing the presence of delusions or hallucinations, often auditory in nature (hearing voices or ‘paranoid about hearing voices’) were documented.

Case two is one specific example were Joyce documented the auditory hallucinations in these terms:

> *States he is hearing voices – voices telling him to harm himself to die.*
> (Joyce: Case 2)

Rose, case twenty, describes the patient’s delusions as:

> *Pt states queen has been hurting her dog’s, channel 7 talks to her through the TV and people are passing through her body are pulling @ her organs – as per ACIS.* (Rose: Case 20)

One case expressly noted that there was nil evidence of delusions and the patient denies hallucinations although the patient had been seen by ACIS and SAPOL and was detained. An added comment by the paramedic in this particular case was the patient appeared quite reasonable.

The level of cooperation with questions posed by paramedics and the nature of the patient’s answers linked to the overall impression of how coherent and connected

the patient was to their present situation was also included on the case card. Impressions such as ‘delusional thoughts noted during initial conversation’ (Trevor: Case 6) and ‘vague answers to questions’ (Blake: Case 18) or ‘confused conversation’ (Abigail: Case 15) were documented.

The level of cooperation and the police

In regards to compliance and what events occurred on the scene paramedics recorded the actions needed to be taken to convey the patient to further care. They described instances such as the patient being handcuffed and conveyed with a police escort to patient being removed by force from their home. One case described what seemed to be a case of the police having to return to place the patient under section 23 of *The Mental health Act*, due to the patient threatening to kill himself once they originally left. The paramedic specifically noted it took approximately sixty minutes to get the patient to agree to come to the hospital for further assessment.

Another case describes the patient as unpredictable in the past and previous violence towards both the police and paramedics. In this case the paramedics had requested intensive care paramedic backup for possible sedation of the patient. It eventuated that the sedation was not required and the patient was cooperative in the end and ‘calm & non aggressive en-route’ (Sonya: Case 16).

The *on-arrival* and *on-examination* data described in a summarised, condensed fashion where the patient was attended, how they were found and what was seen, heard and measured by the paramedics in their assessment.

The last section of note in the case card is the treatment and event section. This section briefly encapsulates the actions taken by the paramedic during the case. Paramedics summarised information that was of concern in relation to the physical assessment of the patient and the treatment provided, for example, oxygen, the use of the cardiac monitor or administration of methoxyflurane (an inhaled pain relief). They included details if they were accompanied by the police or others and again if the patient was detained. The position of the patient as they were transported and the overall ability to do observations were also referred to in this section.

10.4 Conclusion

In the limited space provided on the case card, the paramedics summarised the major presenting features of what they observed and measured. This document is the written link between pre-hospital care and ongoing tertiary care, where decisions in regards to patient care can be determined based on the information provided within this document.

The structure of the case card provides a consistent framework for paramedics to follow and segments the information into specific categories. The history and *on-*

examination sections afforded the greatest scope to paramedics to describe the information they identified as relevant to the patients presentation.

The history and *on-examination* data identified the importance of the primary survey, the presence of aggressive or violent behaviour, the involvement of alcohol and other substances, and the incidence of intended or actual self-harm as priorities for paramedics.

10.5 Summary of the major themes

The narrative developed as a linear case history through the findings chapters identified key areas of culture and practice. Conceptually, these themes and their relationship to the paramedic world can usefully be represented as a funnel structure. In Figure 4 the top of the funnel illustrates the amazing amount of social, contextual and physical information that paramedics are confronted with at the scene. The themes are shown cascading into the top section of the funnel (the pre-hospital world) to represent how they inform, construct and provide meaning for paramedic actions during the processing of that information to produce the packaged, 'shorthand' triage. By necessity the nature of emergency care, both pre-hospital and within triage, deals with the present and immediacy of care. After triage the lower half of the funnel broadens to depict the expanded information requirements by those involved in the longer term care of these individuals such as mental health teams. Ironically those involved in the ongoing care of these individuals may need to recover or rediscover the social and contextual information

originally gained by the paramedics which had been condensed for triage. At present the way the system operates and the current norms provide minimal means for paramedics to preserve and relay the rich social and contextual information which they have unique access to.

Each of the themes plays a major and complementary part in understanding the culture of how paramedic identify, assess and manage psychiatric presentations in their practice. The concept of role and role expectations as the overarching driver of action creates a dynamic for paramedics where they are operating in a dualistic situation, juggling the conflict between what is socially and personally expected of their role and the changing direction of their practice. Throughout the paramedics stories they set value on what was considered ‘need to know’ knowledge versus ‘nice to know’ knowledge. The ‘need to know’ knowledge relates to information pertaining to the patient which allows the paramedic to make their clinical decisions and meet their role and duty of care responsibilities, such as presenting complaint, past medical history and current medications. The ‘nice to know’ knowledge is the broader social, environmental and contextual information which in the moment does not directly influence treatment or action. The concept of emergency care which informs their role focuses their approach and assessment on the physical and immediate presentation and its associated information. As mentioned in the findings paramedics describe their education as providing the foundation for their practice, but it was limited in the area of mental health and mental illness.

The theme legitimate versus illegitimate need for care, 'are they genuine', developed from the paramedics' description of how little they feel they can do clinically for mentally ill patients. The role expectations of being able to provide immediate care, to 'fix' the problem, creates the uncertainty of whether practically they are the best people to help the individual suffering a mental illness.

The physical environment and the patient presentation had bearing on what the paramedics do and how they approached a psychiatric presentation. Paramedics work in an environment which is constantly changing and unpredictable which means they use both prescriptive processes and strategies developed from experience to cope and manage this uncertainty. Two major means they used to control this sense of uncertainty is to consider the associated risks, approach with caution and safety, and to use means to assess for compliance to direction.

To place these findings in the wider context of mental health work and how roles are constructed in other parts of the health professions particularly in the ED, mental health nursing, and psychiatry it is useful to mention the sociological idea of 'fringe work'. The conceptual label of fringe work refers to activities that are perceived as outside a given groups 'normal' routine work that is set by policy agenda (de la Cuesta 1993, p. 668). Fringe work is an attempt to supply what is needed in a system by mobilising resources to meet demand and is considered by that group of as not 'common or standardised' (de la Cuesta 1993, p. 668). In this situation the paramedics are working within specified policy and procedure

structures like dispatch, ‘case card’ documentation, and handover which favour the immediacy of care and short duration of attendance, but are caring for presentations which are chronic in nature and require more complex care. As mentioned in the literature review the experiences of ED staff with those presenting with mental illness highlights the pressure generated on existing resources, that time becomes a factor due to workload and key performance indicators such as measures to reduce bed-block and waiting times and triage protocols, and the significant environmental and design limitations of the ED. There is also a significant difference in the conceptual understanding of recovery and patient care trajectories which affects the way mental health work is performed (Marynowski-Traczyk & Broadbent 2011; Weiland et al. 2011). Paramedics work with similar constraints in the community relating to limited resources, time, and external pressure to meet key performance indicators. General nursing and medical staff all mention their limited expertise in the area of mental health and the lack of professional development and education within the area (Shaban 2009; Marynowski-Traczyk & Broadbent 2011; Weiland et al. 2011).

What is considered fringe work can vary between organisations and the professionals working within that service. The value placed on technical provision of care, those acts which require skills in hands on clinical actions or use of equipment, which by their nature engender a specific social network and way of thinking (event driven) tended to be classed as the ‘real’ or valued work (non-fringe work) by those who work in the emergency field (Nurok & Henckes 2009, p. 506). Although surgical

or immediately life threatening emergencies were argued to be more highly valued in the work of emergency medical professionals a case which was complex and intellectually challenging was also seen as valuable. These cases allowed the experienced practitioner to demonstrate mastery and competence, but could alternately cause the less experienced to feel as those they had lost competence and a hold of the attributes of calm and composure to cope with any situation (Nurok & Henckes 2009, p. 508). Mental health work challenged paramedics concept of what is a valued case and their application of clinical ‘hands-on’ care, but although in this study mental health was ‘fringe work’ as in they felt they could not provide active treatment it was acknowledged as a significant part of their workload.

The discussion chapter brings together these findings, explores what each means in the context of the paramedic changing role for the care of psychiatric presentations, and how the role is being redefined by the national and state agenda for professionalism.

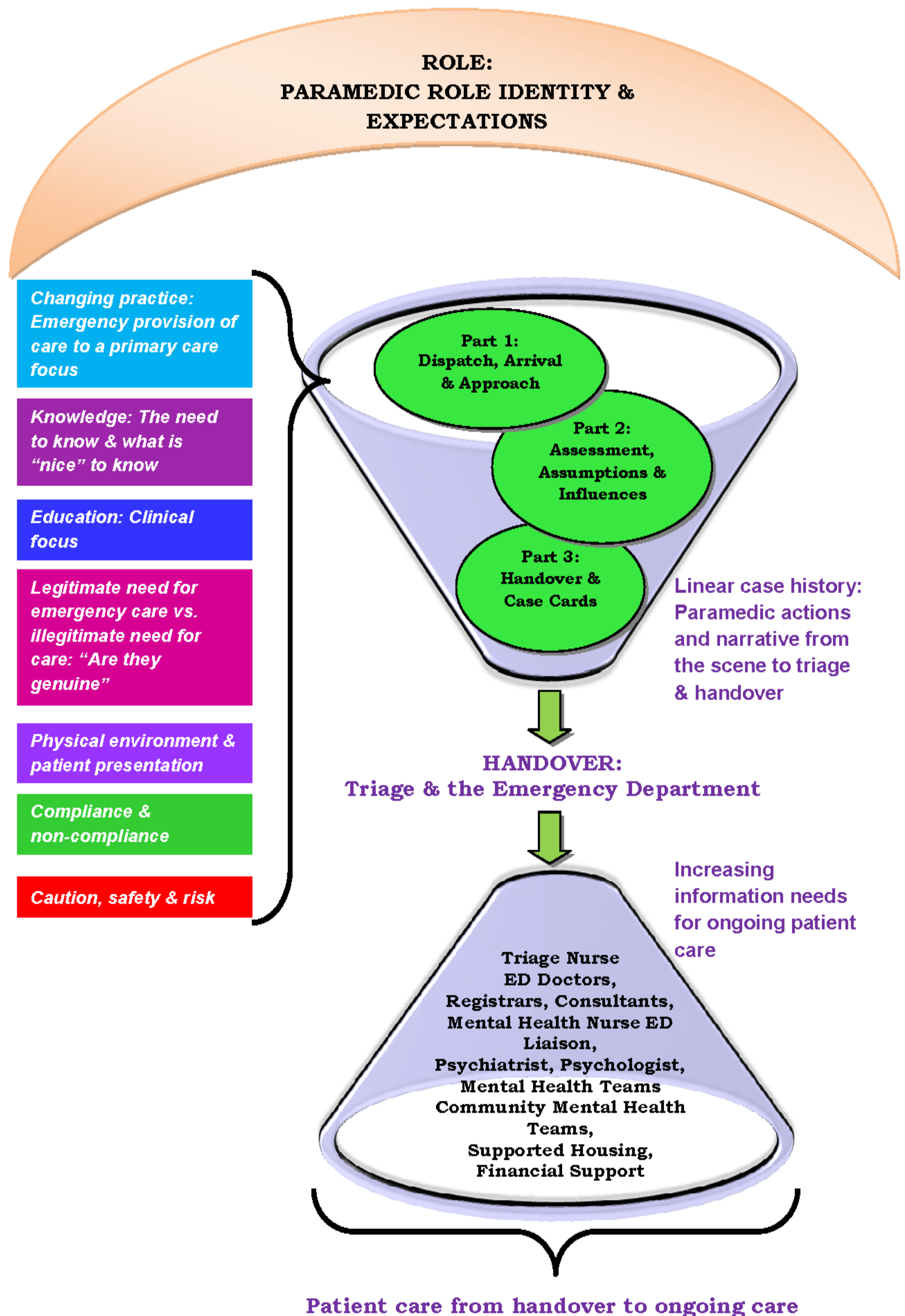


Figure 10.1 **Overview of the findings: The nature of information collection and delivery**

Chapter 11

Discussion

11.0 Introduction

Throughout the findings the concept of role, role expectations and role identity feature as prominent social constructs underpinning the culture of paramedic work with people with mental health problems. The paramedic narrative is built around what is considered both organisationally and culturally as their primary role, the provision of out-of-hospital emergency medical care.

This discussion is constructed using the characteristics of the cultural environment which governs paramedic practice (figure 11.1). The base layer summarises the major themes in the thesis which then form the foundation for the theoretical constructs developed in the second layer. The second layer identifies the relationships and activities found within these themes. The highlights within the themes of the base layer emphasise the major issues that were evident and generated by the data. The first two boxes summarise the themes of traditional versus changing role expectations and the organisational structures and procedures that guide paramedic actions. From these themes developed the concepts of transition work, which describes the in-between world that paramedics operate within, and the scaffolding, which focuses on industry constraints. The next theme deals with the paramedics' socially constructed personal and professional identity.

Thwarted identity encapsulates the concept of paramedics balancing their personal and professional expectations with public expectations and 'on-road' reality when caring for those with mental health problems. The unpredictable nature of the work environment and the need to control the unpredictable has direct links to the dominance of outcome-focused management strategies and paramedics preparing for the 'what ifs'. These lead to the paramedics attributing an identity to those they treat and taking actions which assume control.

Paramedics are essentially caught between the traditional episodic care which dominates emergency medical care and the increasing demand for longer term care. Longer term care for, the context of this thesis, refers to the extended time paramedics are involved with caring for those with mental illness and the complex nature of their presentations. At both national and state level the peak body representing paramedics (Paramedics Australasia) advocates for increased clinical skills to manage people in need within their homes, to providing greater access to alternative pathways of care, and hospital avoidance (Australian College of Ambulance Professionals 2011, p. 13). These expectations currently create tension when paramedics feel they are not equipped with the skills or resources to meet these directives. Existing in this *transitional* space between two worlds requires paramedics to be open to a change in what they have constructed as their professional identity. At present, the social construction of their identity to provide immediate care is *thwarted* by the 'on-road' environment and paramedic

perception of not being able to provide that care, unless there is a physical consequence of the mental illness such as drug overdose or self-harm.

Contributing to paramedics being between two worlds is the organisation's procedures and structures and the nature of their work environment. The *scaffolding* explores how paramedics navigate the gap between national and state level expectations and existing organisational structures. At present these structures are designed to meet the needs of acute, episodic care and are only beginning to adjust to the changing public demand. As part of the nature of their work environment, paramedics prepare for the 'what ifs', which places personal risk and caution high on their priorities. The heightened perception of risk and the need to control the unpredictable through outcome-focused management strategies reinforces actions that assume control and attribute a certain identity on those the paramedics treat.

In sum, these relationships and actions are framed in terms of role, role identity and role expectations, as the central overarching theme, and linked to my methodological stance of symbolic interactionism and social constructivism.

The discussion begins with defining the concept of 'role' and how that is generated from professional identity and expectations. To understand role the context of pre-hospital work and the definition of 'emergency' needs to be included as the prelude to discussing each theme and the links between them.

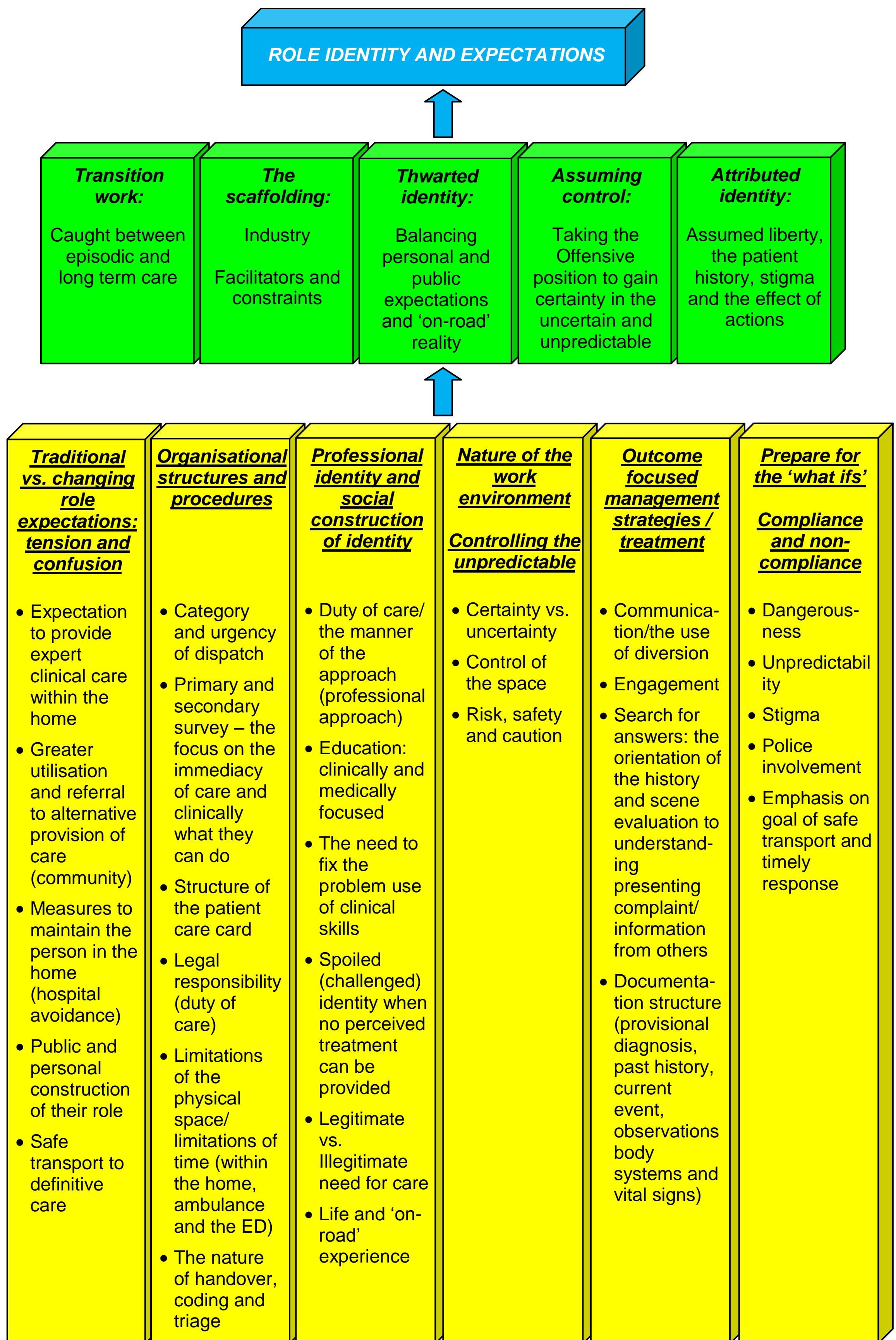


Figure 11.1 **Discussion overview**

11.1 Defining role

Biddle (1986, p. 70) suggests that role theory has been aligned historically with theoretical orientations from sociology and social psychology. Symbolic Interactionist Role Theory, one of five orientations contributing to the development of role theory, places the individual, in this case, the paramedic, at the centre of the development of their social roles. This defines both the social position, for example as a trusted profession, and the expectations (the scripts) which are held for paramedics. According to Turner the interactionist approach defines the term 'role' as:

> *a comprehensive pattern for behaviour and attitude that is linked to an identity, is socially identified more or less clearly as an entity, and is subject to being played recognisably by different individuals.* (Turner 2006, p. 234)

Concepts of role and role theory seek to understand how individuals, who inhabit particular social positions, are expected to act and interact within the social group and with the people they encounter. Turner (2006, p. 223) describes role theory as dealing with the 'organisation of social behaviour at the individual and collective level'. Role theory explores how individuals construct their expectations of themselves and others and is premised on what Biddle (1986, p. 68) describes as the most important characteristic of human social behaviour: 'the fact that humans beings behave in ways that are different and predictable depending on their respective social identities and the situation'. He divides role theory into three major components which are distinct in their contribution to understanding how

individuals acquire and act the role they inhabit within a given context. The triad of concepts, as Biddle refers to them, are described as the patterned and characteristic social behaviours (the role), parts or identities which are adopted by social participants (the social position), and scripts or expectations for behaviour which are collectively understood by the group and abided to by the performers (the expectations) (Biddle 1986, p. 68). Similarly, Turner suggests that when exploring the concept of role through an interactionist perspective it assumes that:

> *the patterning of behaviour that constitutes roles arises initially and recurrently out of the dynamics of interaction and that statuses and positions arise to place roles in a social organisational framework.*
> (Turner 2006, p. 236)

Biddle alludes to three ways that role theorists construct the concept of role expectations. One view is to consider expectations as *norms* or standards of behaviour which are prescriptive in nature. The second is to define expectations as *beliefs* which acknowledge the subjective possibilities of expectations. The third constructs expectations as *preferences* or *attitudes* which suggest a considered stance and choice in decision making. Despite these differences the majority of role theorists agree that expectations are the major generators of roles; expectations are learnt through experience and awareness of what a given role entails (Biddle 1986, pp. 69-70). Expectations involve both informal and formal guides to behaviour including those cultural norms and beliefs which define paramedic actions.

Paramedics have a defined social position in the provision of out-of-hospital emergency medical care which has associated patterned routines, policies, standard operating procedures, and responsibilities. These collectively provide a backdrop to the role of being a paramedic and contribute to the formation of their identity (i.e. their social position). The socially portrayed and real nature of paramedic work adds to the existing structural, organisational and educational parameters to define the expectations of out-of-hospital emergency medical care and the group understanding of their role.

11.2 Defining ‘emergency’ and the context of pre-hospital work

One significant concept which informs paramedics’ expectations of their primary role is the traditional construct around what is considered an ‘emergency’ and ‘emergency care’. In 1991, the International Federation for Emergency Medicine defined emergency medicine in the following way:

> *Emergency medicine is a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of episodic undifferentiated physical and behavioural disorders; it further encompasses an understanding of the development of prehospital and inhospital emergency medical systems and the skills necessary for this development.*

Although this is an older definition it is still used on both the International Federation and Australasian College for Emergency Medicine websites and in their

policy and resource listings. The use of the term behavioural disorders with no reference to mental health or illness within the definition suggests the tendency to label the individual as a set of behaviours rather than an underlying, legitimate illness.

The term ‘emergency’ conjures a specific and powerful meaning for those dealing with physical disorders (Clark 1982, p. 76). Clark suggests the term implies that a ‘major dysfunction threatens the viability of all or part of the organism; and there is the assumption that this dysfunction will continue unless acted upon’. The term, logically derived from practice and empirical observation, can be categorised in context of individual events and body systems. As these events occur in an observable and measurable way the action to treat or manage these events can be prescribed. This enables structures, organisations and procedures to be developed to address these ‘emergencies’. Clark found that the concept of ‘emergency’ is useful to determine the need for technical intervention, ‘but is inappropriate in the more ambiguous cases where *ad hoc* non-emergency categorizations supervene’, such as the use of broad categories such as psychiatric (Clark 1982, p. 76). The goal of most emergency medical services is either to provide treatment, with the aim of stabilising or alleviating the presenting condition, or take the next step of organising timely and safe transfer of the patient to definitive care. This is in line with Clark’s concept of providing technical intervention and the conventional understanding of ‘emergency’.

Mental illness, however, does not easily fit into traditional medical and surgical constructs and is not measured or assessed in the same manner as traditional physical observations. In cases of mental illness the scene time can be extended, the chronic nature of these conditions often require long-term treatment, and the limited resources available leave the paramedics in a situation of being the primary care provider and the access point for further definitive care. This enforced change of expectations leaves the paramedic in a position where their traditional construct of emergency care is challenged. Mental illness is particularly difficult in the out-of-hospital arena where comorbidities complicate the clinical picture of a patient and there is limited access to resources to eliminate underlying biological causes of disturbed behaviour. The use of alcohol and other drugs in conjunction with mental illness particularly makes the clinical picture for paramedics difficult.

11.2.1 Comorbidity: Drug and alcohol use in conjunction with mental illness

The complex and severe clinical profiles with which these individuals present pose significant issues for the paramedics as they juggle caring for someone who is suffering the effects of the drugs they have taken, with caring for someone displaying signs and symptoms of mental illness.

> *Dual diagnosis is an increasing challenge, particularly in acute mental health settings. Of note, substance misuse, in combination with mental illness, is an important predictor for violence and aggression.*
> (Mills et al 2009, National Drug and Alcohol Research Centre)

As illustrated in Chapters 7 and 8 substance use becomes the primary concern for paramedics and is generally not differentiated from the mental illness. In light of the dual nature of these presentations it is not surprising paramedics have the tendency to place drug and alcohol use within the same continuum as mental illness. However, to be considered a 'psychiatric case' the alcohol and/or substance use is usually associated with stated self-harm intent in the form of an overdose or with an extensive past history of diagnosed mental illness.

The comorbid presentation of mental illness and substance use may affect whether the paramedics can safely transport the individual to care, or interferes with the ability to stabilise the patient. This is where police involvement becomes an added dimension for the paramedics and the patient. In South Australia, The Mental Health and Emergency Services Memorandum of Understanding (2006, 2010) acts as a guide outlining the roles and responsibilities of the ambulance service, police and the mental health teams in these circumstances. At the time of this research the paramedics were operating under part 5, Section 23 of the *Mental Health Act (1993)* which left the conveyance decisions within the police's jurisdiction with the paramedics as adjuncts providing the ambulance as the means of transport. In reality, the conveyance decisions were often made as a result of consultation between the paramedics and police, with the paramedics unofficially taking the lead role.

Once the patient is conveyed to the ED, under the terms of the Memorandum the responsibilities of the ED staff are to have the individual seen within 30 minutes so that the police can be released to their other duties. The consequence of this is that ED staff tend to triage as urgent to meet the 30 minute time guide for the police which may not actually reflect the actual urgency of the case. The effect of this mechanistic and process driven approach to the system is that the patient may not be appropriately triaged, as the triage category is already predetermined, and tends to support a reluctance to convey the patient due to operational concerns. The resultant consequence, as shown in this study, is that paramedics find themselves in a position of advocating to the police to get the person conveyed under Section 23.

The new South Australian *Mental Health Act (2009)* significantly changes the role of the paramedics, with increased responsibilities regarding the care and conveyance of individuals with a mental illness. As a topic of discussion, due to its upcoming implementation at the time of the study, the paramedics raised concerns about the implementation of the new Act (2009), how it was going to affect them operationally, and the implications for their education.

11.3 Transition work: Caught between episodic and long-term care

The position in which paramedics find themselves means they are required to perform '*transition work'*, a combination of acute care and the beginnings of long term care, which is unique and particularly demanding in cases involving mental

illness. Closely linked to *transition work,* are the organisational structures and procedures, *the scaffolding*, and the professional and social construction of the paramedics' identity: a *thwarted identity* in the case of psychiatric presentations. These social structures and ideas play a major role in either facilitating or placing boundaries and constraints on how paramedics enact their everyday work. The following section explores the relationship between transition work, the scaffolding and thwarted identity and their contribution to paramedic culture.

11.3.1 Traditional versus changing role expectations: tensions and confusion

The transition from traditional constructs of ambulance work to meet changing public and organisational demands has created a gap between 'on-road' reality and stated professional expectations. The Productivity Commission (2010) found that ambulance services attended 2.93 million incidents nationally. Australian ED data showed that 84% of patients in triage category 1 and 47% of patients in triage category 2 arrived by ambulance. This is significant as psychiatric presentations are generally triaged within these categories. At a state level the ambulance service is committed to delivering expert patient care, clinical intervention and patient transport to over 1.6 million people across the state. During the period 2008 to 2009, the number of ambulance responses to incidents across the state increased by 8.2 % (SA Ambulance Service 2011). Paramedics Australasia argues that these national and state figures show the significance of the Emergency Medical Services (EMS) sector to peoples' lives and the community, with the average Australian

needing EMS care up to 16 times in their lifetime (Australian College of Ambulance Professionals 2011, p. 9). These expectations of widespread provision of emergency care and meeting targeted response times, which currently follow former 'scripts' (the collectively held expectations of behaviour) designed around statistically measured response times for physical trauma and transport compared to 'messy' and ill defined 'psych callouts', have created a conflict between service provision and the actual 'on-road' reality. In this thesis the conflict between service provision and 'on-road' reality was evident in the medical focus of the documentation, the tendency to load and go, and the tangible feelings experienced by paramedics of being of limited use to the patient.

The peak national body, Paramedics Australasia, is working towards national paramedic registration, recognition as a profession, and advocates greater involvement within the health system. This national push to be recognised as a profession creates further uncertainty in their role expectations (their scripts). The gap between stated expectations and the reform agenda at all levels creates conflict for paramedics as their role transitions from an essentially treatment and transport oriented medical model of service delivery to an increasingly primary health and community based model of care.

> *These one-dimensional role perceptions arise from the early beginnings of EMS based mainly on transport and emergency responses to public safety and life-threatening events. But the functions of EMS have undergone a sea change. The role of paramedics has evolved swiftly until today they are the primary practitioners in the delivery of advanced out of hospital emergency medical care*. (Australian College of Ambulance Professionals 2011, p. 9)

The gap between stated expectations and 'on-road' practice reality demonstrated in this thesis can be understood in terms of the paramedic trying to exist between two worlds, one of the expectations to meet changing demand and the other the current 'on-road' environment they operate within. In line with the tenets of ethnography and the exploration of culture used in this thesis, the anthropological concept of 'liminality' or the idea of paramedics being in a 'contradictory practice location' captures their social position when attending those with mental health problems.

As described by Victor Turner (1987, p. 4-5) 'liminality' depicts a dynamic process involving the transition of a person from one state to another, particularly in reference to rites of passage established by local customs, laws, conventions and ceremonies. Turner argues that if we consider our basic model of society as people existing in a structured world consisting of culturally defined positions, for example, that of child, adolescent, and adult, then the liminal period between these different positions can be viewed as an interstructural event. Turner cites Arnold van Gennep's work on '*rites de passage*' to describe the three phases, separation, margin (limen), and aggregation, which characterise the transition from one state to another. Separation denotes the symbolic actions that indicate detachment of the individual or group from their previous position in the social structure or from existing cultural conditions. As the ties to previous roles and cultural expectations are removed the individual or group find themselves in an ambiguous position where existing roles no longer apply and they have yet to establish themselves in

their new social position. They become structurally 'invisible' in society. The last phase, aggregation, occurs when the individual or group has transitioned to a new stable position with clearly defined rights, obligations and expectations of behaviour. He suggests that these transitions are not restricted to movement between established societal positions but can include new and evolving cultural norms, beliefs, and statuses.

The concept of liminality is now more commonly being used to explain a more static dynamic where a person exists or gets 'stuck' between two worlds (Higgott 1997, pp. 170–171). Existing between the new and the old without actually being able to either move forward or go back is akin to the paramedics not being able to stay in the traditional space of emergency care, because of demand, and not being able to move completely from the domain because it is still an essential part of their practice.

As demonstrated in this thesis, the role of paramedics is being redefined as expectations influence practice. The expanded scope of practice includes the advent of extended care paramedics (ECPs), paramedic practitioners, and the move to tertiary based education. The changing role direction is also being driven by the national debate on the move to national registration; becoming a recognised health profession; the inclusion of EMS in national health care policy and utilisation of paramedics in rural and remote areas to support local health provision. This move to community and primary based care, as stated by the Australian College of

Ambulance Professionals 2011 report, promotes the use of paramedics in extended care mode in hospitals and clinics whilst filling in the gaps in community health care provision. This extended role has the added benefit of maintaining the paramedics' skill base and is gaining recognition with the recent advent of the International Roundtable of Community Paramedicine (IRCP).

The move to primary based care is not only being driven by the recognition of changing demand but also the increasing workload in comparison to resource availability being experienced in all sections of the health system. This disparity between workload and resources is especially evident in the area of mental health as demonstrated in the research outlined in the literature review. The challenge for ambulance organisations as they find themselves filling the gaps in community care is to work towards implementing primary care ideals which in reality pose major structural, educational and cultural shifts. The thesis describes how paramedics currently are caught in this lag period between the present public demand and the ambulance organisations' current service provision. This lag period is particularly evident in the limited options, other than the ED, available for paramedics when they are expected to provide alternative treatment pathways. In essence as the organisations attempt to meet these new demands paramedics default to what they can currently achieve; they act to maintain and operate within norms that are familiar to them, even when dealing with the mentally ill. These actions can be viewed as the paramedics being in two different liminal spaces. The first liminal space, the inability to provide comprehensive care due to structurally and

educationally imposed limits, is what Beech (2011, p. 286) might describe as the intersection of structure and the individual agency where he suggests liminal practices occur. He describes 'self-identity' as the internalised view of self and that people seek to keep a particular expression of self when faced with external social pressures which aptly links to the second liminal space of operating within familiar norms and practices, thus gaining certainty from the uncertain (Beech 2011, p. 286).

11.4 The scaffolding: industry constraints

Social interaction and social life is not only made up of interaction between groups and individuals but is shaped by the structures that we operate within such as the workplace, community organisations, governments and formal social groups. Emergency Medical Services are structured to provide what is considered the mainstay of their work, the provision of 'emergency' medical care. As shown in the thesis paramedics work within various social structures, such as clinical governance, policy and procedure guidelines, international and national recommendations, which all operate at various times as both facilitators and constraints on how they practice.

11.4.1 Organisational structures, procedures and professional boundaries

The thesis has articulated that the relationships and actions of paramedics are significantly governed by how organisational structures prescribe their role through policy and operating protocols. This in turn affects their actions and communication

with other parties. As discussed earlier, the Medical Dispatch System is designed to prioritise calls for assistance based on urgency and whether the event is life-threatening or potentially life-threatening. The dispatch follows a strict structure and is guided by detailed protocols. The Patient Report Form (the 'case card' or 'patient care card') also uses a specified format which arranges the information based on body systems. These systems work well for trauma and life-threatening conditions, which are time critical, but have limitations when dealing with complex chronic presentations such as mental illness. They enforce an increased value on the immediate and medically focused information from the patient and tend to minimise the importance of the patient's broader social and mental health. They also create a 'funnel' effect into what is seen as relevant to their immediate provision of care and handover. The design of the system focuses on response times and the paramedics' availability for urgent calls for assistance and by default highlights the difference between the dispatch information and what paramedics ultimately find at the scene. These systems ultimately influence how information is collected, documented and reported, as demonstrated in the example of the case card and handover findings from Chapters 9 and 10. The overriding organisational structures do not easily lend themselves to adaption and paramedic culture tends to reinforce actions which follow their traditional role leading to a 'load and go' process to achieve safe transport.

Chapter 3, the theoretical chapter in this thesis, deals with Mead's construction of meaning and knowledge at an individual level, but from the findings the importance

of organisational structures became very evident. To understand the influence of these social structures on action and behaviour Stryker (2008, p. 19) suggests a modification of Mead's view of the constructed nature of social life. Social life not only recognises the significance of self in relation to the development of social behaviour but also the feedback of social process into the self and social interaction. Stryker (2008, p. 19) proposes a greater emphasis on the importance of society in shaping the self which in turn shapes the social interaction. Using this framework, society is composed of organised systems of interactions and role relationships, with complex differentiated groups, communities and institutions. The ambulance service, paramedics, the ED staff and the patients make up these complex, interrelated and interacting differentiated groups within this study. This way of viewing the interaction of social structures with the development of the self creates social life as taking place in relatively small networks of role relationships. These relationships can be interrelated and independent of one another, sometimes isolated and insulated from one another and sometimes not, and sometimes cooperative and sometimes conflicting. This reframed view emphasises social structures as patterned interactions and relationships which are durable, resistant to change, and have the capacity to reproduce themselves (Stryker 2008, pp. 19–20).

The durable and generic nature of the paramedics approach to their patient and their structured assessment acts as the basis for their interaction with those they treat. The difficulty for paramedics is when confronted with those who need care

based on a different type of relationship, for example based on a therapeutic relationship which is the dominant practice in mental health. This change in the patterned relationships no longer provides the solid foundation for social interaction that the paramedics are routinely trained in and accustomed to. This is one factor which leads to the disconnectedness they feel when attending these patients.

The need for care, or the perceived lack of the need for emergency care, is integral to the paramedics' patterned way of interacting with those they attend. This was particularly apparent in this thesis in Chapters 7 and 8 regarding patient assessment and compliance, the need for legitimate care, and the perception of 'attention seeking' behaviour. The notion of genuineness can potentially challenge the clinician's feelings of worth, again placing the paramedic in a liminal state of not fulfilling their perceived role but needing to meet their duty of care. As Hill eloquently states, challenge to, or lack of validation, as a clinician has the potential to lessen the value placed on the patient and the care provided.

> *Patients who fail to validate clinicians' sense of themselves as effective professionals, who threaten their control, and/or who create fruitless work are all subject to being labelled "bad patients".* (Hill 2010, p. 2)

The notion of patient genuineness is significant for paramedic practice because it is rarely challenged due to the lack of routine feedback regarding patient outcomes. This lack of feedback reinforces the perception because the complete picture of the

care required to support the patient is not routinely provided to paramedics. Education and continuing ongoing professional development in the area of mental health plays a vital structural role to support cultural change. It also provides a way to combat these notions and misconceptions.

11.4.2 The influence of organisational structure and policy: the gap between national and state direction and 'on-road' reality

Throughout the thesis paramedics continually referred to their duty of care and the practicalities of transport, rather than providing treatment to those with mental illness. The paramedics described the reality of not being able to clinically provide care because it is outside their scope of practice and current systems are not designed to support it. There remains an expectation that paramedics will manage and care for those with mental health problems with limited resources and support. As stated in the SA Ambulance Service Annual Report 2008–2009 (2010) key reform directions involve an expectation of increased level of expert medical interventions within the community and in people's homes, increasing clinical decisions around alternative care pathways and reducing the pressure on the hospital system.

> *A key part of the ambulance reform agenda is delivering increased expert medical interventions within the community and in people's homes without transporting them to hospital. Long-term, this will see the number of patients being transported to hospital level out or even decrease as more patients not requiring hospitalisation are directed to more appropriate clinical pathways….Further, patients who call an ambulance and do not require immediate treatment will increasingly be directed to other health care providers such as GPs. This is designed to reduce unnecessary pressure on the hospital system and ensure emergency resources are available to respond to emergencies.* (SA Ambulance Service, June 2010)

As indicated in the thesis, for these key reforms to take place the paramedics have to be supported to envision their role as more than dealing with the immediate and physical presentations of illness, with the associated professional development that this entails. This would include greater access to mental health resources and treatment alternatives rather than the ED. The availability of alternative pathways for individuals with mental illness is limited as there are still significant gaps between the provision of community services and demand as demonstrated in Chapter 2, the literature review. As stated by the Department of Health and Ageing there have been 'increased demand pressures for mental health care right across the health sector, particularly for acute and emergency care' (Department of Health & Ageing 2010). Consumers and carers, and indeed the findings of this study, all consistently point to these problems as needing urgent attention.

Contributing to the paramedics being in a liminal state between 'on-road' experience and organisational expectations is the current national debate regarding their role and the gap in practice. The narrative in this thesis demonstrated that in cases of mental illness paramedics find it difficult to work in the broader framework of primary care provision and revert to operating within the traditional 'emergency' role. Paramedics Australasia (2011) argues that while the concepts of prevention and broader health care roles are contained within the EMS job description and within the paramedic skill set, many policy makers at a local, state and federal level, including governing councils and service providers, still hold the perception of an ambulance and its crew responding to an emergency and taking the patient to

hospital. For example the National Health and Hospital Reform Commission (NHHRC) *Health care agreements and performance benchmarks* (2008), which uses the term 'emergency' almost exclusively in the context of hospital-based services, the word 'ambulance' appears only twice referring to a transport vehicle, and that the term 'paramedic' does not appear at all (Australian College of Ambulance Professionals 2011). This narrow perception of their role results in key performance indicators continuing to remain focused on response times and emergency service parameters. This leaves other important indicators of health care outcomes neglected and contributes to the lack of value given to this broader role.

11.4.3 How to define and develop the professional boundaries

This thesis demonstrated that the paramedics' professional identity is linked to their ability to provide immediate clinical care. The move to registration and the transition of the EMS role means that currently defining what exactly a paramedic is and what their professional boundaries are is becoming more difficult. In an environment where there is increasing expectations of person-centred community based care, with the inclusion of consumers in the development of policy and service provision, flexibility in work practices has become mandated. This flexibility is influencing the expectations of 'on-road' practice and how the paramedic role is being defined now and in the future. The emphasis on the needs of service users tests existing professional power bases and boundaries and mandates the use of multidisciplinary collaborations (Nancarrow & Borthwick 2005, p. 898).

Paramedics, as an emerging profession, are in the process of trying to codify these professional boundaries. Nancarrow and Borthwick (2005, p. 901) suggests that to maintain or take hold of professional boundaries organisations use strategies that protect their perceived areas of control while campaigning to expand or establish their expertise in other areas. They describes this process as a socially collective act which aims at ensuring the emerging profession's status and position in society. Defining the distinct areas of expertise for out-of-hospital EMS work through the gaining of professional status and a national curriculum maintains the identity of paramedics as 'hands-on' and active in care. By maintaining the focus on acute care it allows them to be aligned with emergency medicine, a high status profession. This alignment is beneficial for the recognition as a profession and is vital for the provision of emergency medical care, but may fail to recognise the rapidly changing demands of the out-of-hospital and community settings that now dominate, especially in the area of mental health.

Another structural and policy factor which influences paramedic practice is that statistical datasets related to EMS, patient health care and occupational classifications are inconsistent or are not comprehensive enough to evaluate patient outcomes from the initiation of care pre-hospital (Australian College of Ambulance Professionals 2011). Two important consequences of this lack of comprehensive data are inaccurate workload data regarding psychiatric presentations and the difficulty of providing comprehensive feedback mechanisms for patient outcomes. This was clearly demonstrated time and again in this study.

This lack of feedback has significant implications for paramedics working 'on-road' as demonstrated in the story told by the two older paramedics who managed to talk down a patient from an overpass only to hear over the radio that she had managed to get back there to jump off the overpass and sustained massive trauma. Even eight to ten years later they still did not know whether she had survived. This lack of feedback potentially has a depressive effect on the paramedics own mental wellbeing and may increase their cynicism regarding how useful they are in these circumstances. There is also the potential that this lack of feedback fosters anger and resentment, a negative view of those with mental health problems, and is therefore one of the drawbacks to being in this liminal state.

The stated commitment to provide increased expert medical intervention within the community and in people's homes is directly at odds with what paramedics reported in this study that they practically can do, and what they perceive they are able to do when dealing with patients who have a mental illness. Paramedics consider safe transport and getting the individual to further care as essentially their major contribution to assisting these patients. The findings clearly indicate that the majority of paramedics do have compassion and empathy for these patients, but are frustrated that they cannot provide the immediate 'hands-on' care which validates their presence and which is in line with how they see their role. There were statements and observations which demonstrated prejudice, misunderstanding, and disconnect with psychiatric patients but these were mainly directed towards the 'regulars' who the paramedics found tested their tolerance.

This leaves them with a feeling of not being able to meet their own, the organisations, or the public's expectations of what they do.

In this current environment, as their role is being redefined, there is a level of uncertainty surrounding these expectations and conflicting realities. Paramedics, to manage these conflicts, resort to their training, experience and their perceived role of dealing with the immediate and physical trauma, which is then applied to 'messy' psychiatric situations. Among the paramedics some valued their role as someone who could be there for the patient, while others were more focused on being available for the next 'true' emergency. They often felt more like a taxi service when attending patients with mental illness, rather than valued for their clinical skills. This lack of recognition and use of their clinical skills contributes to this sense of existing in a liminal state, between positive action and being just a transport service.

11.4.4 Education

In this study, the limits in mental health education provided to paramedics also posed a challenge to being able to provide expert clinical care in the community. The education which paramedics receive regarding mental health and mental illness lacks further review and continued professional development, unlike other areas of their practice. In this ethnography, ongoing professional development was considered limited, disjointed and focused on the control of the patient rather than providing the paramedics with alternative strategies to improve patient outcomes. Another fundamental issue is their education, by necessity, must cover a large

amount of information. Paramedics by the nature of their work are required to manage a wide variety of presentations which makes it increasingly difficult to cover all possibilities in extensive detail. The paramedics are moving into the realm of being *generalised* specialists, in pre-hospital care, which to date has meant a reliance like other health professions on comprehensive and consistent professional development. This includes appropriate supervision for clinical development for those new to the profession. As shown in the findings clinical mentorship is a critical issue for the ambulance service. Providing leadership, teaching and supervision roles are significant to how paramedics learn to care for someone with a mental illness. The development of appropriate behaviour and skills is very reliant on 'on-road' experience, which requires the effective provision of these mentoring roles. At present a crew, comprising of a senior paramedic with two to three years experience and a recent graduate, may lack the needed experience and expertise to appropriately make clinical decisions when confronted by a complex case involving mental illness. This leaves the paramedic in an in-between world, a liminal state, of having to deal with the situation but with limited experience to draw upon.

Changes in education

In the last five years there have been moves to address the need for greater training and resources in the area of mental health. The ambulance service has developed, in consultations with the mental health sector, mental health liaisons within the Emergency Operations Centre (EOC) to assist with the coordination of mental health resources for emergency presentations and expert advice for paramedics

when needed. Although the Assessment Crisis Intervention Service (ACIS) teams are available as a resource, paramedics rarely utilise them and the interaction only occurs when the paramedics have been called to transport a patient. The Mental Health and Emergency Services Memorandum of Understanding (2010) clearly outline the roles and responsibilities of each signatory to the Memorandum: SA Health, SA Ambulance Service, Royal Flying Doctor Service and South Australia Police. The Metropolitan Adult Mental Health Services as part of their role and responsibilities are to provide 24-hour service provision in the metropolitan area to ensure that mental health consumers in crisis are assessed and treated according to need. They are required to have support systems in place to respond to request for assistance from the other signatories as soon as possible and provide a statewide consultation and liaison service. These are ideal goals but in reality are difficult to implement when the services themselves are struggling to meet demand and 'on-road' there appears to be a lack of understanding of each other's expectations. These relationships with the ACIS teams need further research to understand the barriers to multidisciplinary collaboration and how that could be addressed in practice. The recommendations in the final chapter propose some strategies that might aid towards greater collaboration with the mental health teams.

As shown the organisational expectations and broader social structures operate to shape paramedic identity, but are only one aspect which contributes to their concept of role. The following section deals with how identity is formed by the balancing of personal and public expectations with on-road reality. The section

explores why certain identities are attributed to those paramedics treat, and why they assume control.

11.5 Thwarted identity: Balancing personal and public expectations and 'on-road' reality

This thesis shows how paramedics continue to identify with and operate along the traditional construct of emergency care, which includes seeing themselves as active in providing treatment and being available for life-threatening events. These socially constructed expectations influence their care of psychiatric presentations and how their traditional expectations and sense of identity is challenged by their work. Currently this leads to what is essentially a thwarted sense of role, identity and purpose which leaves them again in a liminal state. The term *identity* as defined by Stryker and Burke (2000, p. 284), in the symbolic interactionist tradition, is constructed as the 'meanings that persons attach to the multiple roles they typically play in highly differentiated contemporary societies'. The paramedics' identity is constructed by the public, media, and their own culture in terms of being heroic, as active agents providing care during a crisis, doing work that is repugnant, has inherent risks, is trauma focused, and unpredictable.

11.5.1 Psychiatric patients as anti-heroic work

Media and social portrayal of ambulance work as heroic dominates, with pictures of patients requiring urgent attention and frantic action from paramedics to manage life-threatening conditions. Paramedics themselves are portrayed as 'streetwise',

staccato speaking and as having limited interaction with hospital staff. Reynolds (2009, p. 31) suggests these portrayals rarely depict the true nature of paramedic work and the strategies used by paramedics to deal with the demands of the job. This thesis has illustrated that the reality for paramedics when dealing with someone who is mentally ill is often that the care they need to provide is not in line with these portrayals and expectations. The patient is often in crisis, but not in the traditional sense of requiring urgent care or frantic action to manage life-threatening conditions. Instead the care needed is in terms of time, communication, preliminary basic mental health assessment, and resources to support the patient in accessing appropriate care. This is particularly evident as paramedics face changing care needs in the community with an aging population, higher incidents of chronic illness and mental illness where the traditional skill sets are being challenged (Roberts & Henderson 2009). This socially constructed perception of what a paramedic is and what they do (the hero), is at direct odds to the type of work they are required to perform with mentally ill patients. Again leaving the paramedics in a liminal state of doing what they can but not valuing their contribution.

This thwarted or devalued sense of purpose relates to the perceived lack of clinical ’hands-on’ care they are able to deliver. The validation and worth of the paramedic’s contribution is not readily or easily recognised by themselves or the wider community. The contribution cannot be immediately measured by what they consider objective, observable, positive changes in patient presentation or reinforced by follow-up information on patient outcomes. As a result the

paramedics recognise that these cases are difficult, and to use their own words, they generally manage them poorly. The language used by the paramedics to describe mentally ill patients, such as the terms ‘attention seeker’ and ‘regulars’, and the evident disconnection with psychiatric patients demonstrated the lack of value paramedics attributed to their own contribution to the care of these patients. The ability to empathise and meet the needs of mentally ill patients requires a willingness to connect with the patient and the ability to assist the person in a ‘hands-on’ clinical manner. The value attributed to action is again based on the traditional construct of emergency care, but in instances of mental illness the value comes in the time spent with the individual, the ability to be with the person, to listen, and an aptitude to provide a safe environment for the patient to tell their story. These skills are often negated by the sense of their own urgency in their work, the need to meet response times, the wanting to be available for others who are sicker, and conflicts with the ‘load and go’ imperative to get the individual to further care.

11.5.2 Ambulance work as risky and repugnant: safety and caution first

Paramedics work in an environment that is ever changing, chaotic and often imposes its own limitations and challenges. The need to constantly adapt and ‘read’ the changing environment leaves the paramedic with a sense of uncertainty particularly with psychiatric presentations. There was a strong narrative from the paramedics in this study on risk, caution and safety that goes hand in hand with the

varied environments they encounter. To gain a sense of control and certainty paramedics focus on establishing a safe environment for themselves and the patient, which is a process that is practical and within their control and gives their presence meaning and purpose. Obtaining this sense of control may benefit the paramedic and the patient in a practical and clinical sense, but it also acts to negate feelings of a lack of purpose, and their ability to do useful clinical intervention. These acts reduce the paramedics' sense of loss of role and identity, their 'thwarted identity'. Their sense of control and purpose focuses on medically stabilising the patient by dealing with any physical consequences of the mental illness, such as an overdose, while making further judgements as to whether the patient is a continued threat to his or her own safety or the safety of others.

11.6 Attributed identity: dangerousness, legitimate vs. illegitimate need for care, assumed liberty in gathering the history, stigma and consequences of action

The situations paramedics face 'on-road' often pose significant risk to their safety. These real and potential hazards, as reported in the findings of this thesis, potentially threaten their personal safety. The unpredictable nature of dealing with someone experiencing a mental illness and the perception of dangerousness reinforce paramedics' actions which are based on preserving personal safety and a fear of the potential for violent or aggressive behaviour. This *attributed identity* to those paramedics treat is closely related to issues of stigma and discrimination

regarding mental illness, but is also a social act to protect the paramedics in the nature of the work they do.

11.6.1 Risk, caution and safety

Campeau (2008, p. 289) suggests paramedics are socially aware and use risk assessment not only for physical hazards but also as a means to assess for the potential threat from others. This heightened awareness of personal risk means that paramedics are very conscious of the possibility of a patient 'arcing' (sic) up, becoming aggressive, and possibly violent. This results in personal safety and caution being placed as a high priority in their management of not only mentally ill patients but all patients. This was evident by the way the paramedics referred to *getting a feel for the patient*, asking them if they have any weapons, and the attitude of 'you have called us, get in and we will get you to hospital', the 'load and go' option of care. Although this focus on personal safety could mean the patient's needs are discounted, the majority of paramedics involved in the study saw the assessment of danger as fundamental to being able to help the patient in the long term.

Strategies for scene safety: Campeau's 'what-if strategy', rationalised self-interest and trading of patient care and scene safety.

In this study the idea of dangerousness, as a potential hazard and a social construct, when attending psychiatric presentations was intrinsically linked with the paramedics' approach and assessment of the individual. According to Campeau (2008, pp. 292–293) the three strategies paramedics use to achieve scene safety are

the ‘what-if strategy’, rationalised self-interest, and trading of patient care and scene safety. The ‘what-if strategy’ involves the continual assessment for the worst case scenario and keeping these potential hazards in the forefront of their clinical decision making. This involves the paramedics’ recognising hazards, developing situational awareness and taking action in a changing environment.

11.6.2 The concept of dangerousness

The ‘on-road’ environment, past experience of being in a threatening situation or being subject to violence, and cultural reinforcement, perpetuate the prevailing sense of caution which governs the paramedics’ actions and their notion that psychiatric patients are dangerous. The media, public, and the paramedics’ own portrayal of mental illness as being linked to violence and aggression serve to support and influence the way they care for psychiatric patients. The difficulty for those dealing with individuals with mental illness is that the research into mental illness and violence is complex and poses several moral, ethical and interrelated questions (Rogers & Pilgrim 2005, pp. 205–207). These questions are not easily answered nor does it give paramedics a definitive way of predicting behaviour. Paramedics, like other health professionals, are faced with the overriding necessity to act in a manner that protects their personal safety, is within their duty of care, but without the immediate back up of specialists, other staff, security or police.

Until the 1990s the link between mental illness and violence was not clear in the research evidence (Pilgrim & Rogers 1999, p. 180). In a national epidemiological

survey on alcohol and related conditions from the United States the data showed that severe mental illness alone was not statistically related to future violence (Elbogen & Johnson 2009, p. 152). In Elbogen and Johnson's sample of 34,653 participants they found that severe mental illness did not rank among the strongest predictors of violent behaviour. They suggest that people with severe mental illness were not at increased risk of perpetrating serious violent acts and that their results are at odds with public perceptions.

> *Instead, the current results show that if a person has severe mental illness without substance abuse and history of violence, he or she has the same chances of being violent during the next 3 years as any other person in the general population.* (Elbogen & Johnson 2009, p. 152)

Recent research from Markowitz (2011, p. 40) however describes a situation where there is an acknowledged increased risk of violence from someone with a mental illness. He cites community epidemiological studies that suggest violent behaviour was found in 25% of those who met the Diagnostic Statistical Manual criteria for a mental disorder, compared to 2% of those with no mental disorder, but he also goes on to discuss the difficulty in measuring such relationships and the complex nature and influence of other social factors on behaviour. Markowitz stresses that although there is a correlation with active psychotic symptoms and increased potential for violence there is also the increased risk of the person with severe mental illness being subject to violence, committing suicide or being the victim of homicide (Markowitz 2011, p. 40).

Markowitz (2011) and Pilgrim and Rogers (1999) argue that it is difficult to identify and predict common signs and symptoms which would indicate potential for violence. Although they acknowledge that research has shown that if the individual is experiencing aggressive command hallucinations (voices directing the person to act in an aggressive way) or delusions which are frightening with threatening content then the potential for violence increases. They also argue the need to examine the broader social and individual circumstances of the person to be able to make links and understandings of the potential for violence. They list issues such as violence in the family, coexisting mental illness and physical illness, multiple disorders, co-existing drug and alcohol use/problems, socioeconomic status, and the treatment or lack of treatment already received as interrelated factors when examining the link between mental illness and violent or aggressive behaviour (Pilgrim & Rogers 1999; Pilgrim & Rogers 2005; Elbogen & Johnson 2009; Markowitz 2011). These interrelated factors tend to be a common occurrence in the cases attended by those who work in the community or emergency services, including paramedics.

Another factor to consider regarding violence and dangerousness is that although public understanding of mental illness has broadened, paradoxically there has been an increase in the public association of mental illness with dangerousness, violence and unpredictability. One explanation is the media portrayal of violent events and mental illness which may have led to the misunderstanding of the actual risk (Markowitz 2011, p. 39). Markowitz argues that the increased perception of

dangerousness has the effect of increasing stigma, discriminatory behaviour, social rejection and isolation, which can result in decreased options for housing, employment, social networks and supportive therapeutic community treatment. These social and life supporting activities act as a protective factor and reduce the potential for violence and are therefore crucial (Markowitz 2011, p. 42). Understanding the broader social context of the individual to be able to gauge risk adds weight to the need for paramedics to be aware of and evaluate not only the immediate patient presentation and environment, but also the broader history, the 'lifestory', of the person. This information can be used not only to establish as far as possible a safer environment for themselves but also for the patient and those who are treating the person at all stages of care.

11.6.3 Stigma: mental illness and spoiled identity

Stigma cannot be ignored as a subconscious or, as evidenced by some of the statements recorded in this thesis, a conscious influence on how paramedics deal with individuals with mental illness. The theme of legitimate and illegitimate need for care and the views on the 'regulars' demonstrate both a tainted understanding by paramedics of what mental illness is and the individual's ability to be able to help themselves. The paramedics' use of the terminology 'genuine' and wanting to be 'available for true emergencies', which again is a reflection of the contradictory practice position and liminal state they are in, demonstrates a number of assumptions regarding the character of persons with mental illness. The term implies that the individual was not in real need of their services, is not in crisis, but

is not strong enough to seek help for themselves, has less value than those with other more immediate concerns, and is better served by others. Although these assumptions may be directed primarily towards the ‘regulars’, the paramedics use what they consider a professional approach to be able to meet their role expectations. Their approach often had mixed results and potential consequences for the patient, but paramedics were often limited by their scope of practice, legal parameters and what alternative resources were available to them.

Goffman (1963) in his works on stigma and the concept of spoiled identity identifies stigma as a social construct where groups and individuals in society are categorised by common features, attributes, and characteristics. He views these categorisations as serving the purpose of almost shortcutting the social interaction because there are established notions regarding the nature of those who inhabit a particular category. Along with these notions are established expectations of how those in a particular category will act and interact with those around them, such as expectations of how paramedics will behave and interact, as well as how someone with a mental illness is perceived to act and react.

> *Society establishes the means of categorizing persons and the complement or attributes felt to be ordinary and natural for members of each of these categories. Social settings establish the categories of persons likely to be encountered there.* (Goffman 1963, p. 2)

Stigma is then defined by Goffman (1963, p. 3) as an ‘attribute that is deeply discrediting’. The discrediting attribute can be when either those we come in

contact with do not hold with the expectations of a given group which we assume them to be a part of, or they possess characteristics which make the individual different, or not considered within the social norm. Often those that are stigmatised, according to Goffman (1963, p. 14) are labelled without any interaction or evidence regarding the person's actual character. Ultimately they are blamed for their condition which is seen as intrinsic to their personality. The paramedics' perception of personality disorders as manipulative, with its strong moral tone, and a drain on the system, shows how the attributed discredited characteristics of an individual influence their actions and is seen as intrinsic to the person. Goffman (1963, p. 3) stresses that stigma is about relationships and context which was evidenced in this thesis by the acceptance of those who were truly considered to be suffering a mental illness and those that were considered to be wasting the ambulance resources and should find help elsewhere.

Horsfall (2010, p. 450) suggests that three distinct components seem to be required to fulfil a model of stigma. The first is 'an accessible mainstream negative stereotype'. For example, the perception that people who are mentally ill are dangerous provides the basis for the stigmatising behaviour. The second is that a person is provided with evidence of behaviour which confirms their belief the person is mentally ill, or the stigmatiser just believes the person is mentally ill without any basis for that decision. Thirdly there is avoidance, mistreatment, or discrimination against the person. Horsfall (2010, p. 450) argues this view of stigma is oversimplified as it relies on social labels and constructs, perceptions, cognitive

understandings and overtly discriminatory behaviour. The element she considers is missing is the element of emotion and how that is intrinsic in how both the stigmatiser and the stigmatised act and react. This element of emotion can be clearly seen when paramedics discussed how they find regulars draining, frustrating and a challenge to their professional manner when they know the '*ones that are regular patients that do the same shit every time'* (Sonya: Case 16, second interview).

Goffman's idea of spoiled identity can be attributed to both paramedics as well as those experiencing a mental illness. Goffman (1963, p. 67) refers to the act of 'placing' an individual into a social identity or personal identity as being an act of *cognitive recognition*. Through this act of identification, whether it relates to the defining features of mental illness, and the outward presentation of those characteristics, or personal and professional creation of the paramedics professional identity and role, there is a conscious perception of what those identities entail. When these identities are created the person placed in a particular category, either rightly or wrongly, is treated and viewed in a particular way which can reinforce behaviour or challenge the person's own construct of who they are. For people with a mental illness this is the attempt to get the recognition that their illness is only a part of who they are and not their whole being, and for paramedics it is trying to reconcile what they see as their role, and what they can actually achieve when attending people with mental illness.

Closely related to the idea of preparing for the worst case scenario is the idea of rationalised self-interest. In situations where the conflict between providing patient care and personal or crew safety arise, whether the risk is real or perceived, paramedics emphasise their role as 'rescuers', which Campeau defines as the rationalisation of self-interest (Campeau 2008, p. 293). The emphasis in the findings on patient compliance, assuming control, and outcome focused management strategies demonstrates the paramedics attempts to create a safe working space for themselves and maintain their role as 'rescuers'.

11.6.4 Rationalised self-interest and trading of patient care and scene safety

The work place reality for paramedics is that if they are injured, threatened, spat on, kicked, and punched at by patients they cannot perform their role. Under these circumstances they cannot provide timely or effective care, and hence cannot meet their own expectations. Although these situations appear to be in the minority they stand out for paramedics and result in a very strong assessment of personal risk at the scene and during transport of psychiatric patients. This practice results in placing a high priority on measures which manage or avoid an escalation of risk.

Campeau contends that, allowing for real physical risk, in interactionist terms, if the paramedic was unable to deliver needed patient care, they are not meeting their own expectations of competence. This strategy to maintain their practice as competent, able to do the job, is in line with the concept of ambulance work as

heroic. Campeau aligns this process of maintaining and establishing a competent image with Mead's concept of the recognition of self (2008, p. 293). This recognition of self and their social position becomes a part of how they construct what is professional behaviour when caring for someone who is mentally ill. This professional behaviour centres on the paramedics' duty of care. In difficult situations where the need for further care is not obvious or easily recognised, as in the interactions with those individuals paramedics consider 'regulars', the paramedic maintain their identity of 'self as competent' by resorting in most instances to the option of transporting the patient to the ED.

11.7 Assuming control: taking the offensive position to gain certainty in the uncertain and unpredictable

In placing risk in context for paramedics, an explanation of the complex nature of the patient presentations they encounter also needs to be taken into consideration. Paramedics can be confronted by incoherent, erratic, bizarre, emotional behaviour, and patient behaviour which is devoid of any connection to others and their surroundings. The behaviour in itself may not be threatening or confronting, but leaves the paramedics in a situation where their actions are not clear cut or prescriptive. Their actions may be dependent on the patient being able to connect to what is happening around them. The restless, agitated, and what was referred to as 'attention seeking' behaviour, displayed by patients challenges the paramedics ability to carry out their duty of care. It also confounds their capacity to make clear decisions because the history is often incomplete or not freely available. The result

is that paramedics construct strategic ways to get the individual to further care, for example the use of diversion, suggesting other medical reasons for the need for hospital care, and trying to identify common threads to develop a rapport. They may resort to the support of the police, use the threat of the police, or, as they describe, give the patient the option to come the *easy or the hard way*. They also use their organisational resources such as the backup of intensive care paramedics, shift or team leaders. In other words the paramedics meet the imperative of establishing control of the situation.

11.7.1 Compliance

The concept of 'compliance' was used by the participants in this study to frame the interaction between the paramedic and the patient in two different ways. Paramedics used patient compliance to measure potential risk, but they also used it as a means to control the scene which places them in a position of power over the patient. The person's willingness to follow direction was used by the paramedics to gauge the potential risk when at the scene, and in the confined space of the ambulance. The degree of compliance also informed their decisions regarding the resources that needed to be mobilised, preferably sooner rather than later. The term compliance also has practice implications regarding the involuntary conveyance of the person by the police and the ambulance service to further treatment under the legal framework of *The Mental Health Act (1993*). This involves a power relationship between the individual and the paramedic and ultimately the police, which can potentially result in a negative experience of care for the patient.

Defining power and the relationship between the patient and the paramedic

The terms compliance and adherence have come under sustained criticism without offering further insight other than the relationship between health professionals and patients is based on a framework for how patients ought to behave (Bissell et al. 2004, p. 851). The concept of power and who holds the ability to make the decisions regarding a person's mental state and their ability to make rational choices regarding their own care, in the out-of hospital environment, rest with the first responders, the paramedics, and the police. This places them in a position to dictate what ultimately happens or does not happen to the individual once called to the scene. To understand this relationship the concept of power needs to be defined. Power is defined by Torelli and Shavitt as:

> *an individual's relative capacity to modify others' states by providing or withholding resources or administering punishments.*
> (Torelli & Shavitt 2010, pp. 703–704)

They describe this notion of power as originating in a very self-centred, individualised goals orientated culture, but argue that more recent research has demonstrated that power holders can operate in a more communal and beneficial manner, taking the needs of others into account.

> *In contrast, communal-oriented people, or those disposed to respond to the needs and interests of others, behaved in ways aimed at benefiting others over themselves.* (Torelli & Shavitt 2010, p. 704)

The meaning and purpose of power for a given culture emerges out of the how the concept of power is socially constructed and nurtured.

> *Power is instrumental for achieving culturally nurtured goals. Because those goals differ by culture, the views of power as a tool for achieving culturally specific goals should differ as well. Accordingly, some cultures foster a conceptualization of power as something to be used for advancing one's personal agenda, and hence maintaining and promoting one's powerful status, whereas others foster a concept of power as something to be used for benefiting others.* (Torelli & Shavitt 2010, p. 704)

Within the paramedics' role prescription, their duty of care, the need to meet response times, the legitimate use of their service, and their ability to treat at the scene effect how paramedics consciously or unconsciously used their position of power. The paramedics oscillate between the self-directed use of power when trying to meet their own responsibilities and the more communal-orientated model when the trying to meet the needs of the patient. The other consideration in this relationship is the mismatch between the current orthodoxy and the dominant discourse within mental health of the recovery model and the instrumental clinical practice driven culture of the paramedics. The recovery model (Hungerford et al, 2012) , which is based in the empowerment of the individual and their ability to set their own goals, and the individual's right to choose their own care pathway, is at odds with the short, immediate care provision structure of emergency medical services. This mismatch leads to the paramedics being and feeling constrained, not necessarily understanding the principles of the recovery model which their patient

might be espousing, and not being able to provide the support and resources to meet the ideals of the recovery model.

The notion of insight

Compliance is also closely linked with the notion of insight (the patient's awareness and understanding of their illness) which informs the paramedics' clinical decision making regarding the individual's threat to themselves or others. According the Rogers and Pilgrim (2005, p. 154) the notion of insight has three significant problems. They suggest that the notion of insight is defined in a circular way where insight means there is agreement between the patient and the psychiatrist on a given diagnosis. The concepts of sanity and madness are socially agreed constructs and a breakdown in this shared notion usually means that the interaction between patient and health professional, in this case the paramedic, becomes an issue of the more powerful party making the decisions. This unequal interaction can mean the patients may lose their right to refuse treatment. For example, paramedics, placed in a position to make a judgement on whether the person is a threat to themselves or others and working with the police, are in a powerful position to dictate and control the individual's choices. Although the paramedics believed that the use of the police and Section 23 of the *Mental Health Act (1993)* was a last resort, they never the less deferred to their duty of care by involving police assistance to provide conveyance to the ED as an effective way to control the event.

The second concern with the notion of insight is that the nature of mental illness is conceded by professionals to be often episodic. Taking this into account the question arises of how does the mental health professional, let alone a paramedic, with less expertise in the field, make judgements on when a person is aware (has insight) and when is a person not aware (Rogers & Pilgrim 2005, p. 154). Paramedics rely on the patient's outward expression of emotion such as self-harm intent, any behaviour that they categorise as demonstrating a break with reality, and signs of the person not coping with daily activities and self care, to make a clinical decision whether further care is required. Although paramedics are privileged with access to the person's home, which few other health professionals have, their impressions can be an incomplete view of the person's overall ability. The paramedics have only a short time with the patient, have differing views on how valued their presence is for the patient, and the usefulness of the social history obtained at the scene. This does affect their determination of the person's awareness (insight), and how best to address this lack of insight in the out-of-hospital environment with limited resources.

The third challenge to the idea of insight is what does it 'actually mean in terms of cognitive and social competence?' (Rogers & Pilgrim 2005, p. 154). Treatment compliance, particularly for paramedics, is one of the defining features of insight, and resistance to treatment could be seen as irrational and indicating that the person is not sufficiently competent to make decisions. This could be a misjudgement according to Rogers and Pilgrim (2005, p. 154) and adherence to

treatment on its own is not enough to make a clinical decision on the person's ability to make considered choices, especially when allowing for the side effects of psychiatric pharmacological treatments. The findings show the paramedics unfortunately have to make these decisions on a person's cognitive understanding in order to judge whether transport to further care is required. These decisions are made with little time available to them, in an area not well covered in their training, and considered outside their role and scope of practice.

The discussion on compliance framed the paramedics actions as an issue of power and their judgement on insight (*attributed identity*), but also placed compliance as a logistical consideration and a form of control. The issue of logistics and control leads naturally to the question of space and workplace, and how paramedics make these areas safe and more certain for their practice, particularly in cases dealing with mental illness.

11.7.2 Gaining control of the physical and social space

The findings showed that paramedics were intensely aware of the spatial and 'ownership' of the workspaces they function in, such as the scene, the ambulance and the ED. McCorkel (1998. p. 230) describes work spaces as comprising of both physical and conceptual spheres that are interdependent and socially constructed. She suggests that the scene in an emergency, a normally routine space, then becomes the paramedics' defined place of work for that moment in time. The space is now characterised by high-intensity, deliberate, and exclusive activity regardless

of its previous characteristics. Campeau (2008) expands on this concept of space by stating that not only do paramedics have to manage a work space that is not predetermined but he believes 'they must accept the location where they find a patient as their working area and adapt themselves and the environment around the patient accordingly' (Campeau, 2008, p. 288). This adaption is seen in the paramedics' use of strategies to control the physical and social space they operate in, in order to give them a sense of certainty in a distinctly uncertain environment.

11.7.3 The activities in the physical and social space: the use of continual monitoring

To adapt to this uncertain environment paramedics begin by controlling the activities that take place in the space immediately surrounding the patient. Implicit in this control is the evaluation of potential danger, of any circumstances which might impede successful transport or care of the patient. This evaluation fits, as Campeau suggests, the concept of continual monitoring (Campeau 2008, p. 299). The process of continual monitoring in an ever changing environment presents several challenges for paramedics. The paramedics have to be aware of the physical space, which presents its own set of potential dangers and logistical concerns, such as cluttered rooms with limited space to treat the person, the presence of bystanders and their behaviour, and then the actions that need to be taken to assist the patient and potential treatment concerns. Workplace monitoring generally can be well defined for physical trauma and medical presentations, but for 'messy' psychiatric presentations the potential complications and difficulties cannot be as

well defined. For example, how many entry and exit points are there for the paramedics if they have to move quickly from the scene, does the person have access to prescription or non-prescription medications in the case of self-harm, or can the individual lock themselves in one of the rooms of their residence, and there is always the spectre of rapidly changing behaviour.

The findings of this study support Campeau's description of continual monitoring, but also offer a cultural perspective of the differences and similarities when monitoring was applied to psychiatric presentations. The way paramedics described their approach to the scene, the techniques they used to reduce the patient's distress, how they worked towards getting the person to definitive care, and the avoidance of actions that made the situation worse were all indicative of the use of continual monitoring. In practice, the management of space and the patient tended to lead to and promote the use of the 'load and go' philosophy. The principal goal of 'load and go' being the quick and safe transport to further definitive care as a practical and strategic way to manage the event and the patient. Again the paramedics' identity is constructed around the practical application of care and use of skills. Resorting to only being able to provide safe transport, although significant and an important aspect of their role leaves a gap or thwarts their application of the more advanced skills that they use in other situations.

11.7.4 The trading of responsibility

Campeau (2008) separates the workspace into what he considers two separate spheres of activity, one the patient and the other the environment. Paramedics manage the competing demands from these two areas by trading of the amount of attention given to one or the other. Paramedics also seek to optimise their on-scene efficiency by coordinating and combining the activity between patient and environment whenever the opportunity arises (Campeau 2008, p. 299). The trading of responsibility between the patient and the environment becomes an interaction between the need to get the individual to further care and the search for as much ‘relevant’ information as possible. This was particularly evident when the paramedics required information in relation to a stated overdose.

In these circumstances the paramedic crew would take different responsibilities, using team work to manage the patient’s direct care needs while conducting a search for medications to gather as much history as possible from alternative sources. The process of searching the scene, history gathering, and the relevance and value placed on the information found, all substantially affected the trading of responsibility. For example, when the information was predominately the ‘life-history’ of the patient and not directly related to immediate care. The social history was considered ‘nice to know’ but not necessarily ‘need to know’ and therefore by the very nature of the value placed on the information was either not documented or condensed for handover. This in the long term has the potential to affect the ongoing care and follow up provided to the patient by those in the mental health

sector. In practice, paramedics swapped the principal attending role when the patient was not responsive to one or the other of the paramedics in the crew. This sharing of the load was a strategy to assist the paramedics to deal with a complex patient presentation, to reduce the potential of getting frustrated with the patient, and to increase the chances of developing an effective rapport with the patient to achieve their goal of transporting the patient safely to further care. The significance of the paramedic crew sharing the attending role is that it acts as a protective mechanism for the paramedics, allows them to establish control in an environment where they rely on each other to perform their job, and implies an expectation that the crew is able to get the patient to further care. The expectation that some form of action can be taken has implication on how rosters, crew partnerships, and operating resources are allocated and dispensed.

11.8 Collateral (continual) monitoring and how it relates to Mead's symbolic interactionism

Campeau (2008, p. 300) associates the process of collateral monitoring by paramedics and trading tasks at a scene to Mead's concept of mind or mind action and 'the consideration of one's self as an object of reflection'. This means that paramedics in the act of monitoring establish where they are positioned both physically and 'socially' in relation to what is occurring at the scene. During this interaction they become the reference point for all the activity at the scene. This influences how they move and interact within that environment and with the patient. Mead's concept of mind suggests that thought, action and knowledge are

borne out of interaction, and are social acts. As a social act paramedics are building knowledge every time they approach a scene, as the importance attributed to being 'road-ready' and the value placed on skills learnt 'on-road' attest. The social act of interacting with the patient displaying behaviour which is confusing, perceived as attention seeking, and contrary to paramedics' expectations, interrupts routine operating processes and forces paramedics to adapt. The interruption and consequent enforced adaption creates an incomplete and disrupted social interaction. The disruption in the connection between the paramedic and the person with a mental health problem again enforces a reliance on what they know, leaves the paramedic with limited options, and an incomplete fulfilment of their role. Descriptions of being likened to a taxi service, feelings of frustration with the mental health system, and statements from paramedics along the lines of 'we don't manage them [*psychiatric presentations*] well' are evidence of this. Paramedics are also in the unenviable position of routinely not receiving feedback and follow up on the patients they attend. They have to, in most cases, actively seek out the patient outcomes requiring the paramedic to have an active interest and desire for that information. The argument could be made that psychiatric presentations do not necessarily engender interest or follow up which leaves a gap in the important feedback system for their practice. The alternative situation is that, as described in this thesis, the individual walks out of the ED even before the paramedics have completed their paperwork. This leaves the paramedics questioning their role, usefulness, and asking whether out-of-hospital emergency medical services are the most appropriate services for those with a mental illness.

This thesis adds to existing literature regarding the role and provision of mental health care by other health professionals by demonstrating the similarly contextual nature of pre-hospital work in this area. The thesis demonstrates that the social and organisational challenges found in the ED and the lack of community mental health care, with its accompanying frustrations, are mirrored to some extent in the pre-hospital setting. The lack of value placed on the 'medical' rather than the 'true emergency' and the stigma and discrimination found in the negative attitudes by health professionals in both the general and mental health field (Ross & Goldner 2009; Rogers and Pilgrim 2010; Hazelton et al. 2011; Weiland et al. 2011) was also evident. The lack of value was revealed in the way paramedics considered legitimacy of care, the primacy given to medical documentation within the case card, and the 'load and go' philosophy of care. The difference in the pre-hospital setting is in the isolation that paramedics feel when they are confronted by those in the community, with limited access to support, and the challenges with the redistribution and redefining of mental health care into the community and primary care settings.

11.9 Conclusion

The concepts of role, role expectations and thwarted identity are integral to understanding the conflicts, tensions and cultural landscape when exploring paramedic practice and psychiatric presentations. Paramedics' understanding and construction of their role defines how they go about their work and what gives their practice meaning. The traditional construct of emergency provision of care becomes

problematic when trying to establish expectations and actions in cases of mental illness, when broader skill sets and knowledge are required.

To add to this complex picture, the issues of risk, safety, stigma and compliance directly and indirectly affect the way psychiatric presentations are approached, managed, and documented. The perception of dangerousness and the need to control the scene in case of the unpredictable constrains as well as guides paramedic actions.

Finally the structures and policies which surround out-of-hospital EMS provision are moving towards professional recognition and broader practice expectations which currently paramedics ‘on-road’ are finding difficult to reconcile in the case of attending someone with a mental illness.

The final chapter explores recommendations and future areas of research that have been generated from this cultural exploration of paramedic practice.

Chapter 12

Conclusion and Recommendations

12.0 Introduction

The provision of care to those with mental illness in the community is complex and demanding. The significance of this thesis is that it demonstrates how paramedics are currently caught between the provision of traditional acute care and the provision of longer term care, *transition work*, for psychiatric presentations. The discussion outlines how the changing expectations and demand place paramedics in a conflicting position and challenges their sense of role and their identity. This thesis reveals how operationally there is a gap between changing role expectations and 'on-road' reality which paramedics are continually trying to negotiate when attending psychiatric presentations. Acknowledging that paramedics exist and will continue to function within the two worlds of acute and transitional care allows their culture to be viewed as caught in a contradiction of conflicting demands and expectations. Unfortunately this also means that there is no easy solution and that these issues will remain as an integral part of the operational world of the paramedic for the foreseeable future.

The potential benefits to future organisational and professional development from understanding paramedic culture are:

- the documenting and understanding the actions and attitudes of paramedics when attending psychiatric presentations. This understanding can assist in developing targeted training and guide the review of current policy and guidelines to better address the needs of the patient and the paramedics.
- the identification of the social, organisational, and personal practices which either enable or hinder paramedics when attending psychiatric presentations.
- the documenting of strategies used by paramedics' 'on-road' to function when dealing with the complex psychiatric presentations. This would enable targeted support or change to be implemented at a structural, resource and educational level.
- to inform change in education, policy, clinical practice and resourcing to support paramedics in meeting the high demand and patient outcomes in this area of their practice.

The following recommendations explore changes in organisational structure and operational practices, education and curriculum development, and multidisciplinary collaboration which aim to reduce the role conflict experienced by paramedics when attending psychiatric presentations.

12.1 Recommendations

The complex interaction between role expectations and 'on-road' reality when paramedics attend psychiatric presentations means that any recommendations need to consider the paramedic, the patient, organisational structures, the broader mental health system, and education. The following recommendations target greater collaboration and communication with the mental health sector, on-going paramedic education and curriculum development, and alternative reporting and documentation methods. These recommendations aim to assist paramedics in navigating the care of those with mental illness, providing a clear structure for collecting and relaying the valuable information they obtain, and suggesting inclusions within the curriculum to generate greater understanding of mental illness.

12.1.1 Collaboration and communication with the mental health sector

The Emergency Operations Centre (EOC), as part of a joint initiative with Mental Health, provides a statewide mental health triage service where specialised nurses provide a centralised emergency response for mental health patients. The centralisation of the Assessment Crisis Intervention Service (ACIS) in South Australia creates opportunities for direct collaboration regarding patient care, knowledge sharing, links to future e-health systems, and policy development. The establishment in 2007 of the mental health liaison within the EOC and the ambulance service mental health transfer teams have begun to address some of the

resourcing issues that paramedics face ‘on-road’ when attending psychiatric presentations. These roles have the potential to be expanded to increase the expert support available to paramedics during attendance and transfer of mentally ill patients. To gain an organisational understanding of how these roles could be expanded there needs to be a targeted evaluation of the interaction between the mental health liaison and the paramedic emergency crews. There also should be an evaluation of the potential for the mental health transfer teams to be available on a broader basis for emergency crews. These evaluations would also give an indication as to whether the expanded role would be financially viable and of benefit operationally.

There are a number of ways that the support offered by the mental health liaisons could be expanded. These include more staffing within the EOC at peak attendance times, further coordination with the existing ACIS teams, coordination with existing mental health liaisons within emergency departments, and the development of an ‘on-road’ role with paramedics. To develop the expanded role the dispatch and case data from the ambulance service needs to provide a clear picture of the workload in this area and be matched with hospital data to accurately depict patient diagnosis and outcomes. The data also needs to include, as far as possible, comorbidities to create a broader understanding of the complex nature of these cases for future resource planning. Understanding how paramedics are or are not utilising the mental health sector support is an area in need of further research. This further

research would provide the evidence for a more coordinated response and how it could be implemented.

In the area of knowledge sharing there is potential for further collaboration with the mental health sector on the development of curriculum and professional training for both the paramedics and the mental health teams. The cross discipline development of teaching material and provision of professional workshops should enable a greater understanding of the practice constraints and operational structures each works under. This joint collaboration potentially develops greater ties between the two sectors and should foster not only understanding at the management level, through the South Australian Memorandum of Understanding (2010), but creates a practice context for both paramedics and mental health professionals.

This joint collaboration may include mental health professionals joining paramedics and vice versa in their respective workplaces. The sharing of workplace experience should provide an appreciation of each other's clinical practice and the different means of providing care to those with mental illness. Logistically there are workload and staffing limitations which may prohibit the sharing of workplace experience, but it might be achievable on a limited basis e.g. an exchange every three to six months. There are also ethical, legal and financial considerations before the exchange could be implemented, such as the safety of the mental health staff within the ambulance and occupational health and safety requirements. Other considerations which may

pose challenges to an exchange programme are patient confidentiality and information sharing, the boundaries of the observer role and how concerns regarding practice are addressed, and whether the patient is willing to have others present. Although there may be difficulties in the implementation of an exchange the benefits would be significant. The exchange would add to the paramedics' clinical experience by observing and participating in alternative strategies of caring for someone who is mentally ill. The exchange would also provide a broader understanding of the limits existing within the mental health system and encourage ties with mental health professionals. The mental health clinicians would benefit in the same way by experiencing what paramedics contend with in their clinical practice including the challenges of providing the immediate and the transitional care for those with mental illness.

The following set of recommendations attempt to address the issues regarding the loss and funnelling of information from the scene to the handover, the lack of value placed on the individual's broader social history, and the documentation a modified mental health assessment. The recommendations explore the possibility of integrating into the existing patient report card a modified mental health assessment or generating a specific document exclusively dealing with psychiatric presentations. The recommendations also suggest the development of a system of direct reporting by paramedics to the mental health liaison as well as to triage staff.

12.1.2 Organisational structure and protocols: alternative to the patient report card

The thesis demonstrates how the dispatch and the patient report card (the case card) are by necessity focused on a structured way to report the assessment and care of trauma, life threatening medical conditions, and prioritising the ambulance response. These structures, although useful, do not give the paramedics a comparable guide for documenting psychiatric presentations or the opportunity to expand on the information they gather during their attendance. To improve this process a section devoted to a modified mental health assessment could be included on the case card or developed separately as a guide for paramedics. As a template Shaban (2009, pp. 125–127) suggests a Mental Health Assessment Tree and an Individual Mental Health Assessment Guide which was adapted from Yellowlees (1997) 'Psychiatric assessment in community practice' published in the *Medical Journal of Australia*. These guides follow existing mental health assessment structure with modification to fit the pre-hospital setting. These guides encourage a descriptive account that would be directly provided to the mental health teams or emergency department mental health liaisons. The guide outlines the major features of a mental health assessment including appearance, behaviour, conversation, affect and mood, perception, and cognition, but also other aspects such as patient dangerousness, patient insight, patient judgement and rapport. Patient dangerousness includes evidence of self-harm, threat of harm to themselves or others, and suicidal or homicidal thoughts, feelings or beliefs. The patient judgement and insight encourages the paramedic to consider whether the patient is

able to make decisions regarding their own care and safety. The assessment of patient dangerousness and insight are two areas which may be challenging for paramedics to assess accurately because, as shown in the thesis, the short amount of time and the limited training paramedics have make these assessments problematic. Two further areas which I believe are integral to encouraging paramedics to value and document the social context of the patient is the patient's social networks and a detailed description of the scene. The existing information gained from the current sections on the case card are still relevant and essential as a basis for ED triage, but would be enhanced by the targeted assessment for those with mental illness.

A consistent standard of documenting psychiatric presentation and the provision of that documentation to the mental health liaison within the ED creates an environment which fosters direct reporting. This more detailed account of the mental state of the individual pre-hospital, depending on the circumstances, can be relayed to the ACIS and the community mental health teams as an adjunct to their existing patient (consumer) information. The direct sharing of the pre-hospital documentation as a standard procedure generates links to the mental health sector and fosters the assessment and care of those with mental illness in paramedic culture. The documentation also creates an audit trail which could be used in clinical governance to establish a routine feedback system for paramedics in this area of their practice. As shown in the thesis paramedics are not routinely given

patient progress feedback or detailed clinical practice feedback which would assist them in this area of their practice.

Education is critical as a foundation for paramedics to be able to carry out a modified mental health assessment and to effectively document them. Further education for paramedics creates opportunities to challenge held beliefs, broaden understandings of mental illness, and involve individuals with lived experience in the development of realistic and relevant case studies.

12.1.3 Education

The paramedic participants in this thesis raised concerns particularly around the lack of ongoing professional development regarding mental health and mental illness. The majority of participants felt that, as a general rule, paramedics do not treat psychiatric presentations as effectively or with the best outcomes as possible. They recognised the limits of what they can achieve, but believed they would benefit from greater training in how to manage psychiatric presentations in the pre-hospital setting. Particularly required is further education regarding the different types of mental illness and their acute presentation with effective strategies to safely care for them. The thesis showed that paramedics have difficulty in reconciling the chronic nature of mental illness with its associated 'lack of change in their regulars' and their continual attendance. They have an expectation of treating the individual and having some sort of resolution to their care. They find that those who present with long term care demands are not within their traditional role

expectation or within the current focus of training. The difficulty in tailoring training in this area is making sure that the paramedics value the wider context of mental health care, including both the long term treatments and community care, so that it fosters an understanding of the episodic and long term nature of these disorders. The inclusion of current mental health reform, the principles of the recovery, and challenging the stigma and discrimination associated with mental illness are critical to mental health curriculum but are most useful when connected to relevant and realistic case based scenarios.

The addition of case based scenarios is in line with the 'hands-on' nature of the rest of paramedic training and provides a practical application of the skills needed within this area. Case simulations that develop skills in communication, rapport building, and the recognition and assessment of individuals who have a mental illness encourages critical appraisal of and reflection on their practice. The inclusion of simulation activities in professional workshops and undergraduate curriculum which replicate the experience of mental illness, such as auditory hallucinations, provides insight for those who work in the health sector. Consumer consultation and participation in the development of the simulations and case studies adds realism and accuracy to the curriculum and training. It also develops ties with those who have direct expertise in mental health and illness.

The addition of mental health clinical placements for paramedics would also provide an opportunity for practice development. Although coordinating

appropriate clinical placements for students is a challenge at both a state and national level, due to the increasing numbers of paramedic students and the staffing of clinical facilitators within industry, mental health care placements can provide an alternative environment for developing skills such as assessment and communication. Currently, employed paramedics are offered opportunities to develop and maintain their skills, such as canulation and intubation, in the ED and other applicable areas. The same opportunity should be offered in the mental health sector. Another major challenge to greater mental health content in professional development is the education and training required to cater for the wide variety of presentations paramedics attend. Mental health and illness education is competing with areas such as anatomy and physiology, trauma, cardiac and respiratory care, pharmacology, and practice development. Similar to all other health professions decisions are made regarding what is included, how detailed and what are the core components for their particular fields. These decisions then affect what professional development is required and how that is structured to support those who work in the health industry. According to the *SA Ambulance Service Annual Report* (2010–11) the data regarding incident types across the state resulting in patients transported, patient transfers (34.7%) are the largest component of paramedic workload. Second to transfers in workload is medical and general (24.9%) with cardiac third and other trauma fourth (10.7% and 9.2% respectively). The current report does not clearly delineate attendance to psychiatric presentations. Psychiatric presentations may be documented under neurological (8.9%), medical and general (24.9%), other trauma (9.2%) or overdose

(2.4%) if self-harm is involved. As mentioned previously there is the need to clearly report and collect data on workload in this area. Detailed and accurate data regarding attendance to mental illness allows ambulance services to make informed decisions regarding training and resourcing. The data at present suggests that trauma and emergency presentations are a significant but not the overwhelming area of care that paramedics are attending. Areas such mental health care and age care are increasingly significant components of their practice and require the same in-depth attention in education and professional development.

12.2 Limitations

The thesis focused ethnographic account of the provision of paramedic care in a specified geographical area and at one location which is in line with the tenets of a focused ethnography, but gives the thesis a context based in time and locality. Therefore the issues raised in the narrative are not intended to be generalisable, but offer insights into paramedic practice within this context. These insights may be transferable to other localities and contexts or be adapted to fit the local context, but need to be viewed in light of their social and cultural context. The cultural issues raised in the narrative are a basis for further research and provide ambulance services and paramedics with a template to explore these issues in their own areas.

Another consideration is the limitations imposed by the field itself on the ability to follow up paramedics and ED staff for interviews and the interruptions in data collection due to work requirements. The length of time in the field and the

paramedics' willingness to give of their time enabled these limitations to be overcome in the majority of cases.

12.3 Conclusion

The recommendations from this ethnography have focused on the need for greater collaboration with those in the mental health sector, structural changes that would create a system of direct reporting and more comprehensive documentation, and additions to education that would support paramedics in their clinical decision making. This thesis provides not only a documented account of paramedic culture surrounding how they care for those with mental illness, but identifies areas of further research. Key areas of further research from this thesis are:

a. the relationship between paramedics and mental health teams,
b. the relationship between paramedics and the police,
c. an exploration and comparison of the mental health education provided nationally and internationally to out-of-hospital emergency medical services,
d. the introduction and evaluation of a modified or specific form for psychiatric presentations pre-hospital,
e. an observational study of 'on-road' practice with psychiatric presentations,
f. a retrospective evaluation of the workload in this area at both a state and national level, and finally, but by no means the least,

g. the consumer voice needs to be heard with personal accounts of how they have experienced the care provided by paramedics.

The following quotation from one of the paramedic participants concludes this thesis because it succinctly identifies one of the reasons for doing this research and echoes the sentiment that we have to many people that are suffering and do not receive adequate care. Those who work in the community and in the provision of out-of-hospital EMS are privy to this suffering and often provide the first contact or gateway to further long term care. Therefore their actions matter.

> *There's lots of issues affecting mental health at the moment and it's not just mental illness, there's things that cause depression and anxiety and the society as a whole is disintegrating and for a lot of people who require the support they're slipping through the gaps, lots of them and they're slipping through the gaps really early on in their life.* (Emma, Case 3)

Appendix A

Paramedic Participant Information Sheet

Professor Eimear Muir-Cochrane
Chair of Nursing (Mental Health Nursing)
School of Nursing & Midwifery
GPO Box 2100
Adelaide SA 5001
Tel: +61 8 8201 5907
Fax: +61 8 8276 1602
eimear.muircochrane@flinders.edu.au
http://nursing.flinders.edu.au/
CRICOS Provider No. 00114A

Paramedic Participant Information Sheet

Title: The identification, assessment, and management of psychiatric presentations by paramedics within the community.

To Paramedics,
You are invited to participate in research which examines paramedic clinical practice in relation to psychiatric presentations. The research is being conducted through the School of Nursing & Midwifery, Flinders University. Participation is voluntary, you have the right to withdraw from the research at any stage, limit the information provided or decline from answering particular questions posed.

Why do we need this research?

- To gain an understanding of what your work involves when attending psychiatric presentations.
- To provide an opportunity for your perspective to be documented.
- To document how you use your clinical skills to manage situations that can be complex, challenging and are becoming a greater part of your role since deinstitutionalisation.

Who do we need and when will the study start?

- Paramedics who transport patients to the Flinders Medical Centre.
- Cases that have been assessed by you and designated as psychiatric presentations.
- The study will commence **March 2009** and be run over **8 to 10 months.**

Objectives:

The five objectives of the research are:
1) to examine how paramedics identify and assess patients with psychiatric presentations.
2) to examine what strategies paramedics employ to manage patients with psychiatric presentations.
3) to explore how paramedics document psychiatric presentations.
4) to examine the transfer of information and ongoing care of patients from paramedic attendance to the emergency department.
5) to uncover the clinical practices, gaps and challenges in the transition of care.

Methods:

How data will be collected

- Data will be collected through interviews, non-participant observation of patient handover and from case cards.
- The study will be based at the Emergency Department (ED) of Flinders Medical Centre.

inspiring achievement

What your participation involves:

- Observation by the researcher during patient handover
- **Initial interview:** approximately **5 to 10 minutes duration after handover**
- **Second interview:** approximately **30 minutes**. The researcher will travel to you to conduct the interview.
- The second interview will be organised within two weeks of the initial interview at a time and place that fits with your availability

What the interviews & observation will cover:

- Observation of handover will focus on what type information was provided during handover, how it was provided and to whom.
- The interviews will focus on 1) how and why this patient was identified as a psychiatric presentation 2) what clinical decisions were made during the care of this patient 3) what factors and thinking influenced the care provided and 4) how was the care provided communicated to the emergency department staff.

Consent

CONSENT FORMS can be filled out by e-mail or via return paid envelopes which will be provided in information packs available at stations within the research area. Written consent is sought prior to the interviews and observations taking place so if you wish to be involved in the study please return the consent form in the reply paid envelope or by e-mail. A recruitment phase will occur from the beginning of March to Mid April where no interviews or observations will occur, but I will be getting to know paramedics and asking if you are interested in the research and if you are willing to participate.

Please contact Louise Roberts by phone or e-mail if you have any queries about the study or would like to take part. If you do not wish to be involved or approached to participate in this study please indicate this via phone or e-mail.

All interviews and records will be kept confidential and no information which could lead to your identification will be released, except as required by law.

Unfortunately we are not able to pay you for participation in this study, but **goodies and refreshments** will be provided. Your participation will contribute to the development of knowledge in this area with the aim of improved clinical practice.

If you have any queries, concerns or need further information please contact:

Researcher:
Louise Roberts, Bachelor of Health Sciences (Paramedics) (Hons.)
School of Nursing and Midwifery, Flinders University
Work Ph: **(08) 8201 5135**
Mobile: **0407 720 573**
e-mail: **robe0187@flinders.edu.au**

OR **Principal Supervisor:**

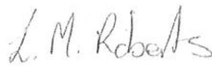
Professor Eimear Muir-Cochrane
Chair of Nursing (Mental Health Nursing)
School of Nursing & Midwifery, Flinders University
Work Ph: **(08) 8201 5907**
Mobile: **0434 374 573**
e-mail: **eimear.muircochrane@flinders.edu.au**

If at any stage your work or the research process causes you distress then we encourage you to contact The SA Ambulance Staff Wellness and Assistance program for general support. The contact details are Mr Cliff Pinkard on 0407 600 264

Complaints:

This study has been reviewed by the Flinders Clinical Research Ethics Committee. If you wish to discuss the study with someone not directly involved, in particular in relation to policies, your rights as a participant, or should you wish to make a confidential complaint, you may contact David Van der Hoek FCREC, at the Flinders Medical Centre (8204 4507) or email research.ethics@fmc.sa.gov.au.

Thank you for your time and anticipated involvement in this study on behalf of:



Louise Roberts & Professor Eimear Muir-Cochrane
Research Higher Degree Candidate Principal Supervisor

3

Appendix B

Consent to Participation in Research—Paramedic Participants

SOUTHERN ADELAIDE HEALTH SERVICE / FLINDERS UNIVERSITY
CONSENT TO PARTICIPATION IN RESEARCH
PARAMEDIC PARTICIPANTS

I, ...
(first or given names) *(last name)*

give consent to be involved in the research project :

The identification, assessment, and management of psychiatric presentations by paramedics within the community.

I understand the nature and purpose of the research project and what my involvement entails. This has been explained to my satisfaction by **Louise Roberts, Research Higher Degree Student, Flinders University** and my consent is given voluntarily.

I acknowledge that the details of the following have been fully explained to me, including the nature of my participation, the commitment involved, privacy and confidentiality matters and the anticipation of length of time of my participation.

1. Observation of handover of patients identified as psychiatric to emergency department staff at Flinders Medical Centre.

2. Participation in an initial interview directy after handover of approximately 5-10 minutes.

3. Participation in an in-depth interview of approximately 30-40 minutes duration, which will be organised in consultation with the researcher.The interview will occur within a two week period following the initial interview.

4. Interviews will be audio recorded with my knowledge and consent.

5. The non identified section of the case card will be photocopied with my and SA Ambulances consent to identify areas of communication and the type of information communicated.

I have understood and am satisfied with the explanations that I have been given.

I have been provided with a written information sheet.

I understand that my involvement in this research project may not be of any direct benefit to me and that I may withdraw my consent at any stage without affecting my rights or the responsibilities of the researchers in any respect.

I declare that I am over the age of 18 years.

Signature of Research Participant : .... Date: ....

I, ... have described to ....
the research project. In my opinion he/she understands the explanation and has freely given his/her consent.

Signature: .... Date: ....
Status in Project: ....

Appendix C

Flinders Medical Centre Emergency Department Staff Participant Information Sheet

Professor Eimear Muir-Cochrane
Chair of Nursing (Mental Health Nursing)
School of Nursing & Midwifery
GPO Box 2100
Adelaide SA 5001
Tel: +61 8 8201 5907
Fax: +61 8 8276 1602
eimear.muircochrane@flinders.edu.au
http://nursing.flinders.edu.au/
CRICOS Provider No. 00114A

Flinders Medical Centre Emergency Department Staff Participant Information Sheet

Title: The identification, assessment, and management of psychiatric presentations by paramedics within the community.

To Flinders Medical Centre Emergency Department Staff,

You are invited to participate in research which looks at paramedic clinical practice in relation to psychiatric presentations. The research is being conducted through the School of Nursing & Midwifery, Flinders University. Participation is voluntary, you have the right to withdraw from the research at any stage, limit the information provided or decline from answering particular questions posed.

Who do we need and when will the study start?

- Emergency department staff who receive handover from paramedics in relation to cases they have assessed as psychiatric in nature.
- Emergency department staff who have direct involvement in the initial care of that patient within the emergency department
- The study will commence **February 2009** and be run over **8 to 10 months.**

Objectives:

The five objectives of the research are:

1) to examine how paramedics identify and assess patients with psychiatric presentations.
2) to examine what strategies paramedics employ to manage patients with psychiatric presentations.
3) to explore how paramedics document psychiatric presentations.
4) to examine the transfer of information and ongoing care of patients from paramedic attendance to the emergency department.
5) to uncover the clinical practices, gaps and challenges in the transition of care.

Methods: How will data be collected?

- Data will be collected through interviews and non-participant observation of patient handover.
- The study will be based at the Flinders Medical Centre Emergency Department (ED)

What your participation involves

- Observation by the researcher during patient handover.
- **10-15 minute interview which will be audio taped.**

inspiring achievement

What the interview & observation will cover:

- Observation of handover will focus on what type of information was provided during handover, how was it delivered and to whom.
- The interview will focus on the following areas 1) how was the case presented 2) how relevant was the information 3) what was the initial care within the ED 4) how was the information used in the ongoing care and 5) is the information from the case card read and used by the ED staff in planning care.

Consent:

Consent forms will be provided with reply paid envelopes within an information pack in the ED. Written consent is sought prior to the interviews taking place so if you wish to be involved in the study please return the consent form in the reply paid envelope. Consent will be double checked at the beginning of each session of data collection.
Please contact Louise Roberts by phone or e-mail if you do not wish to be involved or approached to participate in this study

All lists used by the researcher to track interviews and records will be kept confidential and no information which could lead to your identification will be released, except as required by law.

Unfortunately we are not able to pay you for participation in this study. Your participation will contribute to the development of knowledge in this area and the aim of improved clinical practice.

If you have any queries, concerns or need further information please contact:

Researcher:
Louise Roberts, Bachelor of Health Sciences (Paramedics) (Hons.)
School of Nursing and Midwifery, Flinders University
Work Ph: **(08) 8201 5135**
Mobile: **0407 720 573**
e-mail: **robe0187@flinders.edu.au**

OR Principal Supervisor:
Professor Eimear Muir-Cochrane
Chair of Nursing (Mental Health Nursing)
School of Nursing & Midwifery, Flinders University
Work Ph: **(08) 8201 5907**
Mobile: **0434 374 573**
e-mail: **eimear.muircochrane@flinders.edu.au**

If at any stage you are distressed by the interview or research process or need to discuss a case then please contact the Employee Assistance Program through Davidson Trahaire for general support. Contact number 1300360364.

Complaints:

This study has been reviewed by the Flinders Clinical Research Ethics Committee. If you wish to discuss the study with someone not directly involved, in particular in relation to policies, your rights as a participant, or should you wish to make a confidential complaint, you may contact David Van der Hoek FCREC, at the Flinders Medical Centre (8204 4507) or email research.ethics@fmc.sa.gov.au.

Thank you for your time and anticipated involvement in this study on behalf of:

Louise Roberts
Research Higher Degree Candidate

&

Professor Eimear Muir-Cochrane
Principal Supervisor

Appendix D

Consent to Participation in Research—Emergency Department Staff Participants

SOUTHERN ADELAIDE HEALTH SERVICE / FLINDERS UNIVERSITY
CONSENT TO PARTICIPATION IN RESEARCH
EMERGENCY DEPARTMENT STAFF PARTICIPANTS

I, ...
(first or given names) *(last name)*

give consent to my involvement in the research project :

The identification, assessment, and management of psychiatric presentations by paramedics within the community.

I acknowledge the nature and purpose of the research project, especially as far as they affect me, have been fully explained to my satisfaction by **Louise Roberts, Research Higher Degree Student, Flinders University** and my consent is given voluntarily.

I acknowledge that the details of the following have been explained to me, including the nature of my participation, the commitment involved, privacy and confidentiality matters and the anticipation of length of time of my participation.

1. Observation of handover of patients identified as psychiatric by paramedics.

2. Participation in an interview after handover and initial interview with paramedics, of approximately 10-15 minutes.

3. Interviews will be audio recorded with my knowledge and consent.

I have understood and am satisfied with the explanations that I have been given.

I have been provided with a written information sheet.

I understand that my involvement in this research project may not be of any direct benefit to me and that I may withdraw my consent at any stage without affecting my rights or the responsibilities of the researchers in any respect.

I declare that I am over the age of 18 years.

I acknowledge that I have been informed of support networks through the participation information sheet and prior to the interview process in the event of distress or discomfort due to the research process.

Signature of Research Participant : .... Date: ....

I, ... have described to ....
the research project and nature and effects of involvment. In my opinion he/she understands the explanation and has freely given his/her consent.

Signature: .... Date: ....

Status in Project: ....

Appendix E

Paramedic and Emergency Department Staff Interview Guides

Interview Guide

Initial Impressions

Interview 1 : Questions For Paramedics

'On the Ramp' (time 5 -10 minutes)

1) Tell me about the case?

Follow-up questions

1) What was the rationale behind your use of the code 'psychiatric' for this patient?
2) What influenced the decision to transport the person to the emergency department?
3) How was the information about this patient gathered to make your clinical decision? (e.g. observation, history, bystander information) and what was the main source of that information?
4) Were there any factors at the scene or during transport that affected the way you approached or the care you were able to provide for this patient?
5) What strategies or treatment did you use in the care of this patient?
6) Were other crews, the police or ACIS (Assessment Crisis Intervention Service) needed at any stage? If so when were they required and why?
7) Was sedation required? If so when was it needed and how was the clinical decision made?
8) What information was important to communicate in the handover to the emergency department staff?
9) How do you think your handover was received?

Detailed Discussion

Interview 2 : Questions For Paramedics

(30 – 40 minutes)

1) How did you make the clinical decision that the patient you are attending is a 'psychiatric' presentation?
2) What did you take into consideration when you arrive at the scene? (Factors such as Operation Centre information, information from family or bystanders, physical indicators at the scene, movement / sound or other sensory information).
3) Were there any scene or environmental factors that influenced the way you approached and assessed the patient? If so in what way did they affect the approach and assessment?
4) What were the initial steps in your management of this patient?
5) How did clinical practice guidelines and training influence the care and treatment given to this patient?
6) What information were you aiming to obtain from the history or what was the main focus of your history taking and in this particular case who did you obtain the history from?

7) How does the information you obtain from the history influence your clinical decisions and what provisional care you implement?
8) If you are unable to obtain a history or information how does that effect your clinical decisions and the perception of the case?
9) What signs and symptoms did you identify during your assessment and how significant were they in the determination of this individual as a psychiatric presentation?
10) In this case was a risk assessment needed?
11) What are your major considerations when doing a risk assessment and how do you relay that information if required?
12) Were there other conditions / diseases / trauma that required attention? If so how did they affect the assessment and care?
13) What priorities did you establish from the assessment and the rationale behind those decisions? (e.g. what resources were needed, treatment priorities, urgency for transport)
14) What strategies did you use to treat / manage and care for this person and why?
15) How did communication play a role in the management of this individual?
16) What were the significant factors involved in making the clinical decision to transport this individual to hospital and were there alternative options available?
17) Were other resources needed to assist in the case? (e.g. Use of friends and family, intensive care paramedic / team leader or shift manager backup, ACIS / Hospital consult support)
18) Was sedation or restraint used? If so what were the reasons behind the use of restraint?
19) If chemical restraint was used how much was given?
20) What were the implications of using restraint and sedation?
21) What do you consider are the barriers and challenges in the provision of care to psychiatric patients from pre-hospital to hospital care?
22) Why do you see them as gaps or barriers in the system?

Interview Guide
Interview : Questions For Emergency Department Staff

1) How was the case presented to you by the paramedics during handover?
2) What type of information was communicated by the paramedics?
3) How relevant was that information?
4) Was there any further information that could have been useful if the paramedics were able to obtain it?
5) At this initial stage do you think the patient will be admitted? If so, why do you think the likely outcome will be to admit this patient?
6) How was this information used in the planning of ongoing care for this patient?
7) Do you use the information from the paramedic case card or from verbal handover to communicate with other members of the emergency department staff what the initial presentation of this patient was?
8) What initial care was commenced within the emergency department?
9) What do you consider are the barriers and challenges in the provision of care to psychiatric patients from pre-hospital to hospital care?

Appendix F

Paramedic Participant Details

Paramedic	Gender	Age	Years in service	Education	Pseudonym
Paramedic 1	Male	20–25	3.5	Degree	Don
Paramedic 2	Female	30–35	5	Diploma	Joyce
Paramedic 3	Female	40–45	4	Degree	Emma
Paramedic 4	Male	40–45	21	Degree	Frank
Paramedic 5	Female	30–35	10	Degree	Tracy
Paramedic 6	Male	25–30	1	Degree	Trevor
Paramedic 7	Male	40–45	13	Degree	Robert
Paramedic 8	Female	20–25	5	Degree	Jessica
Paramedic 9	Male	35–40	6	Diploma	Troy
Paramedic 10	Male	30–35	8	Diploma	Len
Paramedic 11	Male	30–35	7	Degree	Andrew
Paramedic 12	Male	25–30	4	Degree	Adam
Paramedic 13	Male	25–30	5	Degree	Nathan
Paramedic 14	Female	25–30	5	Degree	Samantha
Paramedic 15	Female	30–35	12	Degree	Abigail
Paramedic 16	Female	20–25	2	Degree	Sonya
Paramedic 17	Female	25–30	7	Degree	Kate
Paramedic 18	Male	30–35	9	Degree	Blake
Paramedic 19	Male	30–35	6	Diploma	Gerry
Paramedic 20	Female	20–25	2	Degree	Rose

Appendix G

Duration of Case Interviews

Case	Interview 1	Interview 2	Ed staff interview
Case 1	00.12.24	00.32.42	00.11.34
Case 2	00.13.23	00.42.45	00.13.40
Case 3	00.06.23	01.17.13	00.06.30
Case 4	00.09.59	01.05.10	00.12.52
Case 5	00.06.34		00.12.52
Case 6	00.07.24	00.14.06	
Case7	00.10.44	00.35.70	
Case 8	00.04.28	00.30.09	00.09.30
Case 9	00.04.03	00.47.48	
Case 10	00.07.00	00.38.37	00.07.16
Case 11	00.09.09	00.32.57	
Case 12	00.05.50	00.18.21	00.05.07
Case 13	00.04.23		
Case 14	00.06.38	00.56.27	00.06.12
Case 15	00.08.58	00.56.27	
Case 16	00.04.58	00.32.07	
Case 17	00.08.30	00.32.38	00.14.27
Case 18	00.06.00		00.10.28
Case 19	00.08.06	00.26.08	00.06.56
Case 20	00.10.27	00.32.12	00.02.25

Appendix H

Observation Overview

Month	Day	Date	Start time	Finish time	Hours
February	Thursday	26/02/2009	11.30.00	17.30.00	6.0
	Friday	27/02/2009	13.00.00	18.00.00	6.0
March	Monday	2/03/2009	10.00.00	16.30.00	7.5
	Tuesday	3/03/2009	09.00.00	14.30.00	5.5
	Friday	6/03/2009	08.15.00	16.00.00	8.0
	Wednesday	11/03/2009	11.00.00	13.00.00	3.0
	Monday	16/03/2009	14.00.00	17.00.00	3.0
	Tuesday	17/03/2009	12.00.00	17.30.00	4.5
	Saturday	21/03/2009	17.00.00	21.00.00	4.0
	Wednesday	25/03/2009	11.30.00	18.00.00	6.5
	Thursday	26/03/2009	10.30.00	15.30.00	5.0
	Sunday	29/03/2009	16.00.00	18.00.00	2.0
April	Thursday	2/04/2009	09.30.00	15.00.00	5.5
	Saturday	4/04/2009	09.00.00	15.30.00	6.5
	Tuesday	14/04/2009	12.30.00	16.00.00	3.5
	Thursday	23/04/2009	11.30.00	17.30.00	7.0
	Saturday	25/04/2009	17.00.00	21.00.00	4.0
	Thursday	30/04/2009	12.00.00	17.00.00	5.0
May	Friday	1/05/2009	12.30.00	19.00.00	6.5
	Wednesday	6/05/2009	13.00.00	15.00.00	2.0
	Wednesday	13/05/2009	10.00.00	15.30.00	5.5
	Thursday	21/05/2009	11.00.00	18.30.00	7.5
	Friday	22/05/2009	13.15.00	19.15.00	6.0
	Tuesday	26/05/2009	12.30.00	17.00.00	4.5
	Wednesday	27/05/2009	09.30.00	15.30.00	6.0

Month	Day	Date	Start time	Finish time	Hours
June	Monday	1/06/2009	13.00.00	16.30.00	3.5
	Wednesday	10/06/2009	13.30.00	20.00.00	6.5
	Thursday	11/06/2009	08.00.00	13.30.00	5.5
	Friday	12/06/2009	14.00.00	21.00.00	7.0
	Sunday	14/06/2009	13.00.00	16.00.00	3.0
	Wednesday	17/06/2009	09.30.00	16.30.00	7.0
	Tuesday	23/06/2009	10.30.00	13.30.00	3.0
	Monday	29/06/2009	10.00.00	14.30.00	4.5
July	Wednesday	1/07/2009	11.00.00	17.00.00	5.0
	Friday	10/07/2009	15.00.00	22.00.00	5.0
	Saturday	11/07/2009	17.00.00	20.00.00	3.0
	Tuesday	21/07/2009	11.00.00	17.00.00	6.0
	Thursday	23/07/2009	12.00.00	18.30.00	6.0
	Friday	24/07/2009	10.30.00	19.30.00	9.0
	Wednesday	29/07/2009	12.00.00	15.00.00	3.0
August	Monday	3/08/2009	15.00.00	19.00.00	4.0
	Wednesday	5/08/2009	12.30.00	17.30.00	5.0
	Tuesday	11/08/2009	11.00.00	14.30.00	5.5
	Friday	14/08/2009	14.00.00	19.30.00	5.5
	Monday	17/08/2009	13.30.00	17.00.00	3.5
	Tuesday	18/08/2009	13.00.00	17.00.00	4.0
	Wednesday	19/08/2009	09.00.00	13.00.00	4.5
	Friday	21/08/2009	17.00.00	21.30.00	4.5
	Wednesday	26/08/2009	12.00.00	17.00.00	5.0
	Sunday	30/08/2009	16.00.00	22.00.00	6.0
September	Wednesday	2/09/2009	12.00.00	18.00.00	6.0
	Tuesday	8/09/2009	14.30.00	17.00.00	2.5
	Wednesday	9/09/2009	09.00.00	14.00.00	5.0
	Saturday	12/09/2009	18.00.00	22.30.00	4.5
	Thursday	17/09/2009	11.00.00	15.00.00	4.0

Month	Day	Date	Start time	Finish time	Hours
	Friday	18/09/2009	17.00.00	20.30.00	3.5
	Sunday	20/09/2009	12.30.00	17.30.00	5.0
	Thursday	24/09/2009	11.00.00	14.00.00	3.0
October	Friday	2/10/2009	10.30.00	15.00.00	4.5
	Wednesday	7/10/2009	10.30.00	12.30.00	2.0
	Tuesday	20/10/2009	12.30.00	16.30.00	4.0
	Wednesday	21/10/2009	11.30.00	16.30.00	5.0
	Monday	26/10/2009	13.00.00	17.00.00	4.0
November	Wednesday	5/11/2009	10.00.00	15.00.00	5.0
	Monday	9/11/2009	12.00.00	15.30.00	3.5
	Friday	13/11/2009	13.30.00	18.30.00	5.0
	Saturday	21/11/2009	16.00.00	20.00.00	4.0
	Wednesday	25/11/2009	13.00.00	16.00.00	3.0
	Monday	30/11/2009	11.00.00	14.30.00	3.5
December	Friday	4/12/2009	14.00.00	17.00.00	3.0
	Thursday	10/12/2009	10.00.00	13.30.00	3.5
	Friday	18/12/2009	15.00.00	18.00.00	3.0
January	Wednesday	6/01/2010	12.30.00	17.00.00	4.5
	Friday	8/01/2010	11.00.00	18.00.00	7.0
	Monday	11/01/2010	15.00.00	19.00.00	4.0
	Wednesday	13/01/2010	14.00.00	20.00.00	7.0
	Thursday	14/01/2010	11.00.00	18.00.00	7.0
	Friday	15/01/2010	13.00.00	18.00.00	5.0
	Monday	18/01/2010	13.30.00	18.30.00	5.0
	Tuesday	19/01/2010	12.00.00	16.00.00	4.0
	Thursday	21/01/2010	12.30.00	17.30.00	5.0
	Friday	22/01/2010	12.30.00	19.30.00	6.0
	Monday	25/01/2010	12.00.00	17.00.00	5.0
	Thursday	28/01/2010	12.30.00	18.30.00	6.0
Total hours					**407.0**

Appendix I

Field notes

11.00 - 11.30.
→ Bed management info.
→ pt location / Discharge protocol
— Dr/nurse info sharing → planning operation protocol / workload logistics
— hierarchy communication
— situational info.
→ pt nurse interaction
11.30 - 12.00.
— triage history / pt paramedic handover
sits down next to triage nurse

Figure I.1 **Field notes sample 1**

1.30 - 2.30pm.
→ informal conversation with Paramedics.
1) point - Frustration / negative because of previous experience
2) believed they are due to the perception of ambulance service as 'Taxi Service'
3) the pt is not needing their medical attention 'not emergency'
4) There is nothing in their blue / red kit that will help the person.
5) time with pt - how can they do anything

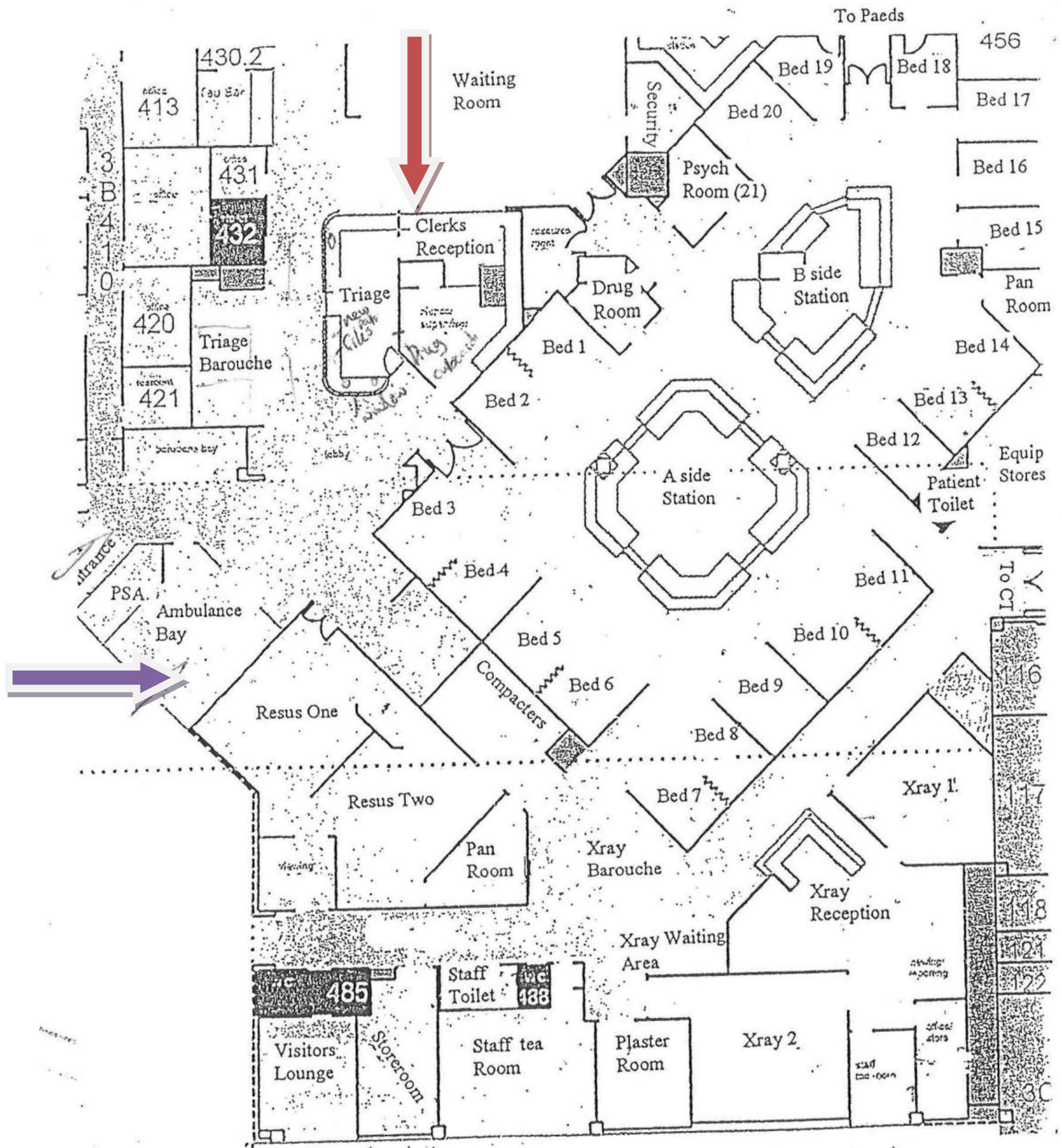
Figure I.2 **Field notes sample 2**

Date	Time	Observations	Impressions
Mon. 2/3/2009	10.00–1600	• The flow of patients from the entrance area to the triage desk, around to the Clarks and depending on the presentation whether they sit in the waiting room or go into cubical or on bed in the triage area. The security area is to the back of the waiting area with entrance to A & B side areas of the emergency department. Volunteer Cafe run at the front of the triage area for staff and waiting patients with access for staff from the same floor and other areas. • 2 entry points to Triage Staff Area (the ‘fish bowl’) one to the side facing the entrance area going into side B of the emergency department and one in the middle – direct access to the waiting area and the 3 cubicle areas for the patients requiring close observations. • Triage window for patients to talk to triage staff through – two computers either side to allow patients to be booked in – ‘ follow the blue line around to the Clarks and finish booking in’ – or paediatrics – follow the yellow duck feet to our paediatric area and someone will help you there’ • White board with names of staff and contacts for different areas – e.g. medical registrar, shift coordinator, emergency consultant and registrar, volunteer, staff roles and areas for notified (consultation/ arrival of critical case – resuscitation team or trauma) • Initial allocation and triage priority – extensive triage code list that staff use to enter and prioritise patient care and information of patients condition.. • Doctors, Nurses, Paramedics – access to area for documentation, handover, writing up notes and sharing information on patient care.	• Entrance – public, staff, patients all walk through the area – constant flow through of traffic and people. Corridors and bed areas within sight and sound of everyone. • Confidentiality and patient privacy – waiting room • Small area – not a lot of room for working and accommodating care of patients. Triage major point of contact between public and staff – major interaction point between paramedics, nurses, and doctors. • Reference to priority and triage scale to guide clinical decision making and imputing data – almost a constraint to further information and used as a beginning point – Triage definition and its role in the ED • Needs of documenting and sharing the notes – tracking exercise (patients and notes) – triage nurses follow patients – use strategies to recognise and track who is who – appearance, presentation, particular feature, or with others determine who is who and who has gone where

Figure I.3 **Field notes: transcribed with reflective notes**

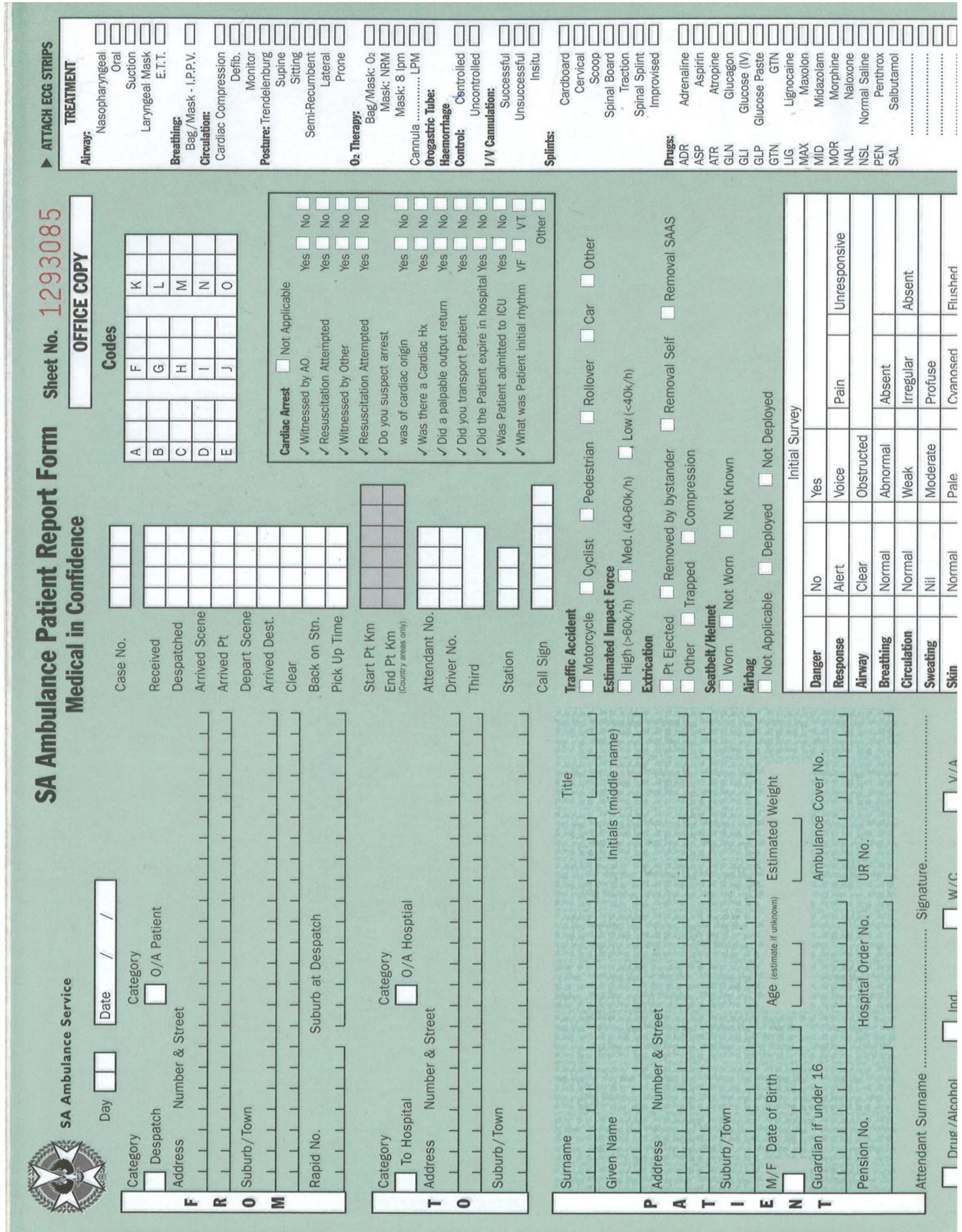
Appendix J

Emergency Department Floor Plan



Appendix K

SA Ambulance Patient Report Form
(The Case Card)



SA Ambulance Service

SA Ambulance Patient Report Form
Medical in Confidence

Sheet No. 1293085

OFFICE COPY

Day | Date / /

FROM

Category: Despatch | Category: O/A Patient
Address Number & Street
Suburb/Town
Rapid No. | Suburb at Despatch

TO

Category: To Hospital | Category: O/A Hosptial
Address Number & Street
Suburb/Town

PATIENT

Surname | Title
Given Name | Initials (middle name)
Address Number & Street
Suburb/Town
M/F | Date of Birth | Age (estimate if unknown) | Estimated Weight
Guardian if under 16 | Ambulance Cover No.
Pension No. | Hospital Order No. | UR No.
Attendant Surname .... Signature....................................
Drug/Alcohol | Ind. | W/C | V/A

Case No.
Received
Despatched
Arrived Scene
Arrived Pt
Depart Scene
Arrived Dest.
Clear
Back on Stn.
Pick Up Time
Start Pt Km
End Pt Km (Country areas only)
Attendant No.
Driver No.
Third
Station
Call Sign

Codes

A	F	K
B	G	L
C	H	M
D	I	N
E	J	O

Cardiac Arrest Not Applicable
✓ Witnessed by AO — Yes / No
✓ Resuscitation Attempted — Yes / No
✓ Witnessed by Other — Yes / No
✓ Resuscitation Attempted — Yes / No
✓ Do you suspect arrest was of cardiac origin — Yes / No
✓ Was there a Cardiac Hx — Yes / No
✓ Did a palpable output return — Yes / No
✓ Did you transport Patient — Yes / No
✓ Did the Patient expire in hospital — Yes / No
✓ Was Patient admitted to ICU — Yes / No
✓ What was Patient initial rhythm — VF / VT / Other

Traffic Accident
Motorcycle | Cyclist | Pedestrian | Rollover | Car | Other

Estimated Impact Force
High (>60k/h) | Med. (40-60k/h) | Low (<40k/h)

Extrication
Pt Ejected | Removed by bystander | Removal Self | Removal SAAS
Other | Trapped | Compression

Seatbelt/Helmet
Worn | Not Worn | Not Known

Airbag
Not Applicable | Deployed | Not Deployed

Initial Survey				
Danger	No	Yes		
Response	Alert	Voice	Pain	Unresponsive
Airway	Clear	Obstructed		
Breathing	Normal	Abnormal	Absent	
Circulation	Normal	Weak	Irregular	Absent
Sweating	Nil	Moderate	Profuse	
Skin	Normal	Pale	Cyanosed	Flushed

▶ ATTACH ECG STRIPS

TREATMENT

Airway: Nasopharyngeal, Oral, Suction, Laryngeal Mask, E.T.T.
Breathing: Bag/Mask - I.P.P.V.
Circulation: Cardiac Compression, Defib., Monitor
Posture: Trendelenburg, Supine, Sitting, Semi-Recumbent, Lateral, Prone
O_2 Therapy: Bag/Mask: O_2, Mask: NRM, Mask: 8 lpm, Cannula .... LPM
Orogastric Tube:
Haemorrhage Control: Controlled, Uncontrolled
I/V Cannulation: Successful, Unsuccessful, Insitu
Splints: Cardboard, Cervical, Scoop, Spinal Board, Traction, Spinal Splint, Improvised

Drugs:
ADR Adrenaline
ASP Aspirin
ATR Atropine
GLN Glucagon
GLI Glucose (IV)
GLP Glucose Paste
GTN GTN
LIG Lignocaine
MAX Maxolon
MID Midazolam
MOR Morphine
NAL Naloxone
NSL Normal Saline
PEN Penthrox
SAL Salbutamol

Presenting Complaint | Allergies | Comm Diseases

PHx - Past History   Hx - History   O/A - On Arrival   O/E - On Examination   Med'n - Medication   P△ - Provisional Diagnosis

Direction of Impact   X = Patient

A Abrasion
B Burns
C Contusions
D Dislocation
F Fracture
H Haemorrhage
L Laceration
N Numbness
P Pain
S Swelling
Pa Paralysis
W Weakness

Time	Pulse	Resp	Blood Pressure	Cap Refill	SpO_2	GCS E V M	GCS Total	Pupils L +/- R +/-	Pain /10	Treatment / Event	Drug	Dose	Route

Eye Opening:
4 - Spontaneous
3 - To Speech
2 - To Pain
1 - NIL

Verbal Response:
5 - Orientated
4 - Confused Conversation
3 - Inappropriate Words
2 - Incomprehensible Sounds
1 - NIL

Best Motor Response:
6 - Obeys Command
5 - Purposeful Movement
4 - Withdraws
3 - Flexion to Pain
2 - Extension to Pain
1 - NIL

1 Pinpoint   4   7 Dilated

Capillary Refill:
02 - Under 2 seconds
01 - Over 2 seconds
00 - Nil

10560/06/04

References

Ambulance Victoria 2012, *Ambulance Victoria 2011–2012 annual report*, viewed 20 January 2013, www.ambulance.vic.gov.au

Australian College of Ambulance Professionals 2011, *Enhancing patient outcomes: Improving the pathways of care through clinical engagement and collaborative action*, pp. 1-19.

Australian Institute of Health & Welfare 2011, *Australian hospital statistics 2009-10*. Health services series no. 40. Cat. No. HSE 107, AIHW, Canberra.

Australian Institute of Health and Welfare 2008, *Australia's health 2008*. Cat. no. AUS 99, AIHW, Canberra.

Beech, N 2011, 'Liminality and the practices of identity reconstruction', *Human Relations,* vol. 64, no. 2, pp. 285-302.

Berger, P & Luckmann, T 1966, *The social construction of reality: A treatise in the sociology of knowledge,* Open Road Integrated Media, New York.

Biddle, B 1986, 'Recent developments in role theory', *Annual Review of Sociology*, vol. 12, pp. 67-92.

Bissell, P, May, C & Noyce, P 2004, 'From compliance to concordance: barriers to accomplishing a re-framed model of health care interactions', *Social Science and Medicine,* vol. 58, pp. 851–862.

Blumer, H 1969, *Symbolic interactionism: perspective and method*, Prentice Hall, Englewood Cliffs, New Jersey.

Boser, S 2007, 'Power, ethics, and the IRB dissonance over human participant review of participatory research', *Qualitative Inquiry,* vol. 13, no. 8, pp. 1060-1074.

Bredo, E 2001, 'Reconsidering social constructivism: the relevance of George Herbert Mead's interactionism', in *Constructivism in Education: opinions and second opinions on controversial issues,* D Philips (ed.), National Society for the Study of Education, pp. 127 -146.

Brewer, J 2000, *Ethnography*, Open University Press, Buckingham, UK.

Bruce, M, Seeman, T, Merrill, S & Blazer, D 1994, 'The impact of depressive symptomatology on physical disability: Macarthur studies of successful aging', *American Journal of Public Health,* vol. 84, no. 11, pp. 1796-1799.

Bruffaerts, R, Sabbe, M & Demyttenaere, K 2008, 'Emergency psychiatry in the 21st century: critical issues for the future', *European Journal of Emergency Medicine,* vol. 15, no. 5, pp. 276-278.

Burr, V (ed.) 2003, ‘What is social constructivism’, in *An introduction to social constructivism*, Routledge, London, pp. 1-12.

Campeau, A 2008, 'The space-control theory of paramedic scene-management', *Symbolic Interaction,* vol. 31, no. 3, pp. 285-302.

Cassar, S, Hodgkiss, A, Ramirez, A & Williams, D 2002, 'Mental health presentations to an inner-city accident and emergency department', *Psychiatric Bulletin,* vol. 26, no. 4, pp. 134-136.

Cheek, J, Shoebridge, J, Willis, E & Zadoroznyj, M 1996, *Sociology and health: social theory for health workers*, Longman, Melbourne.

Clark, I 1982, ‘Psychiatric emergency: concepts and problems of organisational structure’, *Sociology of Health and Illness*, vol. 4, no. 1, pp. 75-85.

Crotty, M 1998, *The foundations of social research: Meaning and perspective in the research process*, Sage Publications Ltd, London.

Cuff, E, Sharrock, W, Francis, D (ed.) 1990, *Perspectives in sociology,* 3rd edn, Routledge, London.

Curry, J 1993, 'The care of psychiatric patients in the emergency department', *Journal of Emergency Nursing: JEN: official publication of the Emergency Department Nurses Association,* vol. 19, no. 5, pp. 396- 423.

De La Cuesta, C 1993, ‘Fringe work: peripheral work in health visiting’, *Sociology of Health & Illness,* vol. 15, no. 5, pp. 665-682.

De Laine, M 1997, *Ethnography: theory and applications in health research*, MacLennan & Petty, Sydney Australia.

Deegan, MJ 2001, ‘The Chicago School of ethnography’, in P. Atkinson, A. Coffey, S. Delamont, J Lofland & L, Lofland (eds) *Handbook of Ethnography*, London, Sage, pp. 11-25

Denzin, N 2000, 'Interpretive Interactionism ', 2nd edn, Sage Publications, California.

Denzin, N & Lincoln, Y 2008, *Strategies of qualitative inquiry,* 3rd edn, Sage, Thousand Oaks, CA.

Department of Community Safety 2012, *Annual report 2011–12*, Queensland Government, viewed 20 January 2013, www.communitysafety.qld.gov.au

Department of Health and Ageing 2010, *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the National mental health strategy 1993-2008*, Commonwealth of Australia, Canberra, ACT.

Department of Health and Ageing 2000, *National action plan for promotion, prevention and early intervention for mental health*, Commonwealth of Australia, Canberra, ACT.

Department of Health, Government of South Australia 2011, *The Annual Report of the Chief Psychiatrist of South Australia 2010-2011*, Dr M Honeyman, Chief Psychiatrist, Government of South Australia, SA Health.

Desjarlais, R, Eisenberg, L, Good, B & Kleinman, A 1995, 'Mental illness and psychiatric services', *World mental health*, Oxford University Press, New York.

Elbogen, E & Johnson, S 2009, 'The intricate link between violence and mental disorder: results from the national epidemiologic survey on alcohol and related conditions', *Archives of General Psychiatry,* vol. 66, no. 2, pp. 152-161.

Eppling, J 2008, 'First encounters: a psychiatric emergency program', *Journal of Emergency Nursing: JEN: Official Publication of the Emergency Department Nurses Association,* vol. 34, no. 3, pp. 211-217.

Fetterman, D 2009, *Ethnography: step-by-step*, Sage Publications Inc., Thousand Oaks, California.

Fish, S 1990, *'How to recognise a poem when you see one' Ways of reading: anthropology for writers*, 2nd edn, Bedford Books of St Martin's Press, Boston, pp. 178-191.

Fiske, A 2002, 'Using individualism and collectivism to compare cultures – a critique of the validity and measurement of the constructs: comment on Oyserman et al. (2002)', *Psychological Bulletin*, vol. 128, pp. 78–88.

Fletcher, J, Pirkis, J, Bassillios, B, Kohn, F, Blanshki, G & Burgess, P 2009, 'Australian primary mental health care: improving access and outcomes', *Australian Journal of Primary Health*, vol. 15, pp. 244-253.

Geertz, C 1973, *The interpretation of cultures*, Basic Books, New York.

Gergen, K 1985, 'The social constructivist movement in modern psychology', *American Psychologist*, vol. 40, pp. 266-275.

Goffman, E 1963, *Stigma: notes on the management of spoiled identity*, Prentice-Hall, Englewood Cliffs, New Jersey.

Goodenough, W 1971, *Culture, language and society*, Menlo Park, California.

Gostin, L & Gable, L 2004, 'The human rights of persons with mental disabilities: A global perspective on the application of human rights principles to mental health', *Maryland Law Review*, vol. 63, no. 20, Wayne State University Law School Research Paper no.08-31, pp. 1-104.

Grbich, C 2007, *Qualitative data analysis: an introduction*, Sage Publications, UK.

Guba, E & Lincoln, Y 1994, 'Competing paradigms in qualitative research', in *Handbook of qualitative research*, 2nd edn, pp. 163-194.

Hammersley, M 1992, *What's wrong with ethnography?: methodological explorations*, Psychology Press, Routledge, London.

Hammersley, M & Atkinson, P 2007, *Ethnography: principles in practice*, 3rd edn, Taylor & Francis, Routledge New York.

Hazelton, M, Rossiter, R, Sinclair, E & Morrall, P 2011, 'Encounters with the 'dark side': new graduate nurses' experiences in a mental health service', *Health Sociology Review,* vol. 20, no. 2, pp. 172-186.

Henderson, J & Fuller, J 2011, '"Problematising" Australian policy representations in responses to the physical health of people with mental health disorders', *Australian Journal of Social Issues*, vol. 46, no. 2, pp. 183-203.

Heslop, L, Elsom, S & Parker, N 2000, 'Improving continuity of care across psychiatric and emergency services: combining patient data within a participatory action research framework', *Journal of Advanced Nursing,* vol. 31, no. 1, pp. 135-143.

Hickie, I & McGorry, P 2007, 'Increased access to evidence-based primary mental health care: will the implementation match the rhetoric?', *Medical Journal of Australia,* vol. 187, no. 2, p. 100-103.

Higgott, R & Nossal, K 1997, 'The international politics of liminality: relocating Australia in the Asia pacific', *Australian Journal of Political Science,* vol. 32, no. 2, pp. 169-186.

Hill, T 2010, 'How clinicians make (or avoid) moral judgments of patients: implications of the evidence for relationships and research', *Philosophy, Ethics and Humanities in Medicine,* vol. 5, no. 11, pp. 1-14.

Holmes, A, Hodge, M, Lenten, S, Fielding, J, Castle, D, Velakoulis, D & Bradley, G 2006, 'Chronic mental illness and community treatment resistance', *Australasian Psychiatry,* vol. 14, no. 3, pp. 272-276.

Horsfall, J, Cleary, M & Hunt, GE 2010, 'Stigma in mental health: clients and professionals', *Issues in Mental Health Nursing,* vol. 31, no. 7, pp. 450-455.

Hoyle, S, Swain, A, Fake, P & Larsen, P 2012, ‘Introduction of an extended care paramedic model in New Zealand’, *Emergency Medicine Australasia*, vol. 24, pp. 652-656

Humphrey, N 1993, *A History of the Mind*, Vintage, London.

Hungerford, C, Hodgson, D, Clancy, R, Jones, T, Harrison, A & Hart, C 2011, *Mental health care: an introduction for health professionals,* John Wiley and Sons Australia Ltd, Australia.

International Federation of Emergency Medicine, viewed 16 November 2011, <http://www.ifem.cc/>.

Joyce, C, Wainer, J, Piterman, L, Wyatt, A & Archer, F 2009, ‘Trends in the paramedic workforce: a profession in transition’, *Australian Health Review*, vol. 33, no. 4, pp. 533-540.

Kalucy, R, Thomas, L & King, D 2005, 'Changing demand for mental health services in the emergency department of a public hospital', *Australian and New Zealand Journal of Psychiatry,* vol. 39, no. 12, pp. 74-80.

Katz, A & Fox, K 2004, *The process of informed consent. What’s at stake*?, Boston Children’s Hospital, Boston.

Kendall, E, Muenchberger, H & Catalano, T 2009, ‘The move towards community-based rehabilitation in industrialised countries: Are we equipped for the challenge?, *Disability and Rehabilitation*, vol. 31, no. 26, pp. 2164-2173.

Kessler, R, Demler, O, Frank, R, Olfson, M, Pincus, H, Walters, E, Wang, P, Wells, K & Zaslavsky, A 2005, 'Prevalence and treatment of mental disorders, 1990 to 2003', *New England Journal of Medicine,* vol. 352, no. 24, pp. 2515-2523.

Knott, J, Pleban, A, Taylor, D & Castle, D 2007, 'Management of mental health patients attending Victorian emergency departments', *Australasian Psychiatry,* vol. 41, no. 9, pp. 759-767.

Kvale, S & Brinkmann, S 2009, *Interviews: learning the craft of qualitative research interviewing,* Sage, Los Angeles.

Lamb, H, Weinberger, L & Decuir, W 2002, 'The police and mental health', *Psychiatric Services,* vol. 53, no. 10, pp. 1266-1271.

Langlois, A 2011, ‘Political research and human research ethics committees’, *Australian Journal of Political Science*, vol. 46, no. 1, pp. 141-156.

Larkin, G, Beautrais, A, Spirito, A, Kirrane, B, Lippmann, M & Milzman, D 2009, 'Mental health and emergency medicine: A research agenda', *Academic Emergency Medicine,* vol. 16, no. 11, pp. 1110-1119.

Larkin, G, Claassen, C, Pelletier, A & Camargo, C 2006, 'National study of ambulance transports to united states emergency departments: importance of mental health problems', *Prehospital and Disaster Medicine,* vol. 21, no. 2, pp. 82-90.

Larkin, G, Smith, R & Beautris, A 2008, 'Trends in US emergency department visits for suicide attempts, 1992-2001', *Crisis: The Journal of Crisis Intervention and Suicide Prevention,* vol. 29, no. 2, pp. 73-80.

Long, D, Hunter, C & Van Der Geest, S 2008, 'When the field is a ward or a clinic: hospital ethnography', *Anthropology and Medicine,* vol. 15, no. 2, pp. 71-78.

Markowitz, F 2010, 'Mental illness, crime, and violence: risk, context, and social control', *Aggression and Violent Behaviour,* vol. 16, no. 1, pp. 36-44.

Marynowski-Traczyk, D & Broadbent, M 2011, ‘What are the experiences of emergency department nurses in caring for clients with a mental illness in the emergency department?’, *Australasian Emergency Nursing Journal*, vol. 14, pp. 172-179.

McCorkel, J 1998, ‘Going to the crackhouse: critical space as a form of resistance in total institutions and everyday life’, *Symbolic Interaction,* vol. 21, no. 3, pp. 227–52.

Mclean, N & Marshall, L 2010, 'A front line police perspective of mental health issues and services', *Criminal Behaviour and Mental Health,* vol. 20, no. 1, pp. 62-71.

Mead, G 1934, *Mind, Self and Society*, University of Chicago Press, Chicago.

Mental Health Council of Australia 2010, *National health and hospital networks, COAG and mental health reform: position paper*, Mental Health Council of Australia (MHCA), Canberra.

Mental Health Council of Australia 2009, *Mental health, housing and homelessness in Australia*, Mental Health Council of Australia (MHCA), Canberra.

Mental Health Council of Australia 2006, *Time for service*, Mental Health Council of Australia (MHCA), Canberra.

Mills, K, Deady, M, Proudfoot, H, Sannibale, C, Teesson, M, Mattick, R & Burns, L 2009, *Guidelines for the Management of Co-occurring mental health conditions in alcohol and other drug treatment settings*, National Drug and Alcohol Research Centre, University of New South Wales, Australia.

Mitchell, A, Malone, D & Doebbeling, C 2009, 'Quality of medical care for people with and without comorbid mental illness and substance misuse: Systematic review of comparative studies', *The British Journal of Psychiatry,* vol. 194, no. 6, pp. 491-499.

Morphet, J, Innes, K, Munro,I, O'Brien, A, Gaskin, C, Reed, F & Kudinoff, T 2012 'Managing people with mental health presentations in emergency departments – A service exploration of the issues surrounding responsiveness from a mental health consumer and carer perspective', *Australasian Emergency Nursing Journal*, vol. 15, pp. 148-155

Mulhall, A 2003, 'In the field: notes on observation in qualitative research', *Journal of Advanced Nursing*, volume 41, number 3, pp. 306-313.

Murphy, E & Dingwall R 2007, 'Informed consent, anticipatory regulation and ethnographic practice', *Social Science & Medicine*, vol. 65, pp. 2223-2234.

Nancarrow, S & Borthwick, A 2005, 'Dynamic professional boundaries in the healthcare workforce', *Sociology of Health & Illness,* vol. 27, no. 7, pp. 897-919.

Nurok, M & Henckes, N 2009, 'Between professional values and the social valuation of patients: the fluctuating economy of pre-hospital emergency work', *Social Science & Medicine,* vol. 68, no. 3, pp. 504-510.

O'Meara, P. Tourle, V. Stirling, C. Walker, J. Pedler, D 2012, 'Extending the paramedic role in rural Australia: a story of flexibility and innovation'. *Rural and Remote Health*, pp. 1-13, viewed 28 January 2013. http://www.rrh.org.au/articles/showarticlenew.asp?ArticleID=1978

O'Neil, P 2002, 'Good intentions and awkward outcomes: ethical gatekeeping in field research', in W Van Den Hoonaard (ed.), *Walking the tightrope: Ethical issues for qualitative researchers*, University of Toronto Press, Toronto, pp. 17-25.

Olasoji, M & Maude, P 2010, 'The advent of mental health nurses in Australian general practice', *Contemporary Nurse*, vol. 36, pp. 106-117.

Orygen Youth Health Research Centre 2009, *Orygen Youth Health Research Centre Submission to the Senate Inquiry into Suicide in Australia*, Melbourne University, Melbourne Health and the Colonial Foundation, pp. 1-8.

Paramedics Australasia 2011, *The Forgotten Health Profession: A commentary highlighting the omission of paramedics and paramedic services from national health care policy considerations*, Paramedics Australasia, pp. 1-12.

Parker, M 2007, 'Ethnography/ethics', *Social Science & Medicine,* vol. 65, no. 11, pp. 2248-2259.

Patel, V, Araya, R, Chatterjee, S, Chisholm, D, Cohen, A, De Silva, M, Hosman, C, Mcguire, H, Rojas, G & Van Ommeren, M 2007, 'Treatment and prevention of mental disorders in low-income and middle-income countries', *The Lancet,* vol. 370, no. 9591, pp. 991-1005.

Pilgrim, D & Rogers, A 1999, *A sociology of mental health and illness*, Open University Press, New York, USA.

Phillips, D 1997, 'How, why, what, when, and where: Perspectives on constructivism in psychology and education', *Issues in Education*, vol. 3, no. 2, pp. 151-195.

Plummer, K, (ed.) 1991, *Symbolic interactionism, Volume 1 and 11: Classics and contemporary issues*. Hants, UK.

Prince, M, Patel, V, Saxena, S, Maj, M, Maselko, J, Phillips, M & Rahman, A 2007, 'No health without mental health', *The Lancet,* vol. 370, no. 9590, pp. 859-877.

Prior, L 2003, *Using documents in social research*, Sage Publications, London.

Queensland Government, Queensland Health & Queensland Ambulance Service 2007, *Queensland Ambulance Service Audit Report*, Government of Queensland, pp. 1-244, viewed 10 August 2012. http://www.ambulance.qld.gov.au/publications/pdf/FinalReport.pdf

Reynolds, L 2009, 'Contextualising paramedic culture' in *Paramedics in Australia: contemporary challenges of practice,* eds. P O'Meara & C Grbich, Frenchs Forest, N.S.W., Pearson Education, Australia, pp. 28-43.

Rock, P 2001, 'Symbolic interactionism and ethnography', *Handbook of ethnography,* Sage Publications Ltd, London, pp. 26-38.

Roberts, L & Henderson, J 2009, 'Paramedic perceptions of their role, education, training and working relationships when attending cases of mental illness', *Journal of Emergency Primary Health Care (JEPHC), vol. 7, issue 3, 2009 – Article 990317.*

Roberts, L, Henderson, J, Willis, E & Muir-Cochrane, E 2012, 'The challenges of gaining ethics approval for ethnographic research in the pre-hospital setting', *Journal of Psychiatric and Mental Health Nursing - Manuscript ID JPM-11-011.*

Rogers, A & Pilgrim, D 2005*, A sociology of mental health and illness,* 3rd edn, Open University Press, McGraw-Hill Education, Berkshire, England.

Rosenberg, S, Hickie, I & Mendoza, J 2009, 'National mental health reform: less talk, more action', *The Medical Journal of Australia*, vol. 190, no. 4, pp. 193-195.

Ross, C & Goldner, E 2009, 'Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature', *Journal of Psychiatric and Mental Health Nursing*, vol. 16, pp. 558-567.

S.A. Ambulance Service and the Government of South Australia: S.A. Health 2010, *S.A. Ambulance Service Annual Report 2008-2009,* June 2010.

S.A. Ambulance Service and the Government of South Australia: S.A. Health 2012, *S.A. Ambulance Service Annual Report 2010-2011*, March 2012.

Saukko, P 2000, 'Between voice and discourse: Quilting interviews on anorexia', *Qualitative Inquiry*, vol.6, no. 3, pp. 299-317.

Saxena, S, Thornicroft, G, Knapp, M & Whiteford, H 2007, 'Resources for mental health: Scarcity, inequity, and inefficiency', *The Lancet,* vol. 370, no. 9590, pp. 878-889.

Schmidt, T, Atcheson, R, Federiuk, C, Mann, N, Pinney, T, Fuller, D & Colbry, K 2001, 'Hospital follow-up of patients categorized as not needing an ambulance using emergency medical technician protocols', *Prehospital Emergency Care,* vol. 5, no. 4, pp. 366-370.

Shaban, R 2009, 'Paramedics and the mentally ill' in *Paramedics in Australia contemporary challenges of practice,* eds. P O'Meara & C Grbich , Frenchs Forest, N.S.W., Pearson Education, Australia, pp. 112-133.

Shaban, R 2005, 'Paramedic clinical judgment of mental illness: Representations of official accounts', *Journal of Emergency Primary Health Care,* vol. 3, no. 4. pp. 1-10.

Shaban, RZ 2004, 'Mental health and mental illness in paramedic practice: A warrant for research and inquiry into accounts of paramedic clinical judgment and decison-making', *Journal of Emergency Primary Health Care,* vol. 2, no. 3, pp. 1-9.

Shafiei, T, Gaynor, N & Farrell, G 2011, 'The characteristics, management and outcomes of people identified with mental health issues in an emergency department, Melbourne, Australia', *Journal of Psychiatric and Mental Health Nursing,* vol. 18, no. 1, pp. 9-16.

Singh, B & Castle, D 2007, 'Why are community psychiatry services in Australia doing it so hard?', *Medical journal of Australia,* vol. 187, no. 7, pp. 410.

Sheather, R 2009, 'Challenges in paramedic practice', in *Paramedics in Australia contemporary challenges of practice,* eds. P O'Meara & C Grbich , Frenchs Forest, N.S.W., Pearson Education, Australia, pp. 62-83.

Silverman, D 1993, *Interpreting qualitative data. Methods for analysing talk, text and interaction*, Sage Publications Ltd., London.

Silverman, D 1985, *Qualitative methodology and sociology*, Gower Publishing Co., Aldershot, UK.

Smith, V 2001, 'Ethnographies of work and the work of ethnographers', in *Handbook of Ethnography,* eds P Atkinson, A Coffey, S Delamont, J Lofland & L Lofland. Sage, Thousand Oaks, California.

South Australian Social Inclusion Board 2007, *Stepping up: A social inclusion action plan for mental health reform 2007-2012*. South Australian Social Inclusion Board, pp. 1-111.

Spradley, J & McCurdy, D 1988, *The cultural experience: ethnography in complex society*, Waveland Press Inc., Prospect Heights, Illinois, USA.

Stryker, S & Burke, P 2000, 'The past, present, and future of an identity theory', *Social Psychology Quarterly,* American Sociological Association, vol.63, no. 4 pp. 284-297.

Stryker, S 2008, 'From mead to a structural symbolic interactionism and beyond', *Annual Review of Sociology,* vol. 34, no., pp. 15-31.

Tedlock, B 2003, 'Ethnography and ethnographic representation', in *Strategies of qualitative inquiry*, vol. 2, pp. 165-213.

Thornicroft, G, Tansella, M & Law, A 2008, 'Steps, challenges and lessons in developing community mental health care', *World Psychiatry,* vol. 7, no. 2, pp. 87-92.

Torelli, C & Shavitt, S 2010, 'Culture and concepts of power', *Journal of Personality and Social Psychology*, vol. 99, no. 4, pp. 703-723.

Turner, RH 2006, 'Role theory', in *Handbook of sociological theory*, Springer Science & Business Media, New York, USA, pp. 233-254.

Turner, V 1987, 'Betwixt and between: The liminal period in rites of passage ', in Betwixt *& Between: Patterns of masculine and feminine initiation,* Mahdi, L, Foster, S, Little M*,* Open Court Publishing Company, pp. 3-22.

van Nieuwenhuizen, A, Henderson, C, Kassam, A, Graham, T, Murray, J, Howard, L & Thornicroft, G 2012, ‘Emergency department staff views and experiences of diagnostic overshadowing related to people with mental illness’, *Epidemiology and Psychiatric Sciences* , pp. 1-8, viewed 12 November 2012. <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=8719360>

Waddington, D 1994, 'Participant observation', in *Qualitative methodology in organizational research: A practical guide,* Sage, London, pp. 107–122.

Weiland, T, Mackinlay, C, Hill, N, Gerdtz, M & Jelinek, G 2011, ‘Optimal management of mental health patients in Australian emergency departments: Barriers and solutions’, *Emergency Medicine Australasia*, vol.23, pp. 677-688.

Weller, J, The Right to Health: The Convention on the Rights of Persons with Disabilities 2011. *Alternative Law Journal*, vol. 35, no. 2, 2010; Monash University Faculty of Law Legal Studies Research Paper No. 2010/32. Available at SSRN: http://ssrn.com/abstract=1935746.

Westwood, B & Westwood, G 2001, 'Multi-presenter mental health patients in emergency departments-a review of models of care', *Australian Health Review,* vol. 24, no. 4, pp. 202-213.

Wolcott, H 1999, *Ethnography: A way of seeing*, Altamira Press a division of Rowman & Littlefield Publishers Inc., Maryland, USA.

Wolcott, H 1990, ‘Making a study ‘more ethnographic’*, Journal of Contemporary Ethnography*, vol. 19, no.1, pp.44-72.

World Health Organisation (WHO) 2001, *The World health report: 2001: Mental health: new understanding, new hope,* viewed 20 January 2010, <http://www.who.int/whr/2001/en/whr01_en.pdf>

World Health Organisation (WHO) 2004, *The global burden of disease: 2004 update,* viewed 15 August 2009, <http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update full.pdf>

World Health Organisation (WHO) 2005, *Mental health: facing the challenges, building solutions. Report from the WHO European Ministerial Conference*. Copenhagen, Denmark: WHO Regional Office for Europe.

Wolff, A 2008, 'Development of a psychiatric crisis stabilization unit', *Journal of emergency nursing: JEN: official publication of the Emergency Department Nurses Association,* vol. 34, no. 5, pp. 458.

Yellowlees, P 1997, Psychiatric assessment in community practice', in *Medical Journal of Australia Practice Essentials – Mental Health*, Australian Medical Publishing Company, Sydney.