

Perceptions of mental illness by paramedics: a photo-elicitation study

By

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The Charles Sturt University Human Research Ethics Committee approved this research, protocol number H18168.

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Signature of Supervisor

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Abstract

Objectives

This project aims to amend the paucity of knowledge in this subject area and proposes an alternative way of researching perceptions about mental illness among paramedics. It will offer a unique contribution towards a fuller understanding of paramedics' perceptions of mental illness. Understanding current perceptions of paramedics will, in turn assist policy-makers and educators in knowing how to respond to people with mental illness and in determining what educational and other interventions should be taken to strengthen this aspect of practice. Another expected outcome to inform further research, paramedic education and paramedic policy development.

Methods

This project draws from the methodology 'postmodern emergence' and photo-elicitation. Photo-elicitation is considered to connect 'core definitions of the self to society, culture and history.' Two semi-structured interviews were conducted with each research participant. After the first interview, I the researcher made a photograph in response to dialogue from that meeting. The second interview will involve showing the photograph (photo- elicitation) to the participant as a way of generating and expanding ideas about paramedic perception of mental illness.

Results

Analysis of the collected materials (transcripts, photographs and research journal notes) occurred in a way that is reminiscent of Carter: 'a double movement of decontextualisation and of recontextualisation, in which new families of association and structures of meaning are established.' This is similar in intention to Somerville's method of dismantling and re-assembling her journal notes, transcripts, photographs, in order to 'create a new product from the research'. Both these formulations were used to facilitate the emergence of new associations (inventions) and 'knowing' about the perception of mental illness amongst paramedics. What emerged were 'families of association' that related to paramedic practice, including: *aporia* and *phronesis* across all levels of paramedic practice, nuances and complexities of mental illness classification in paramedicine and the pertinence of communication and autonomy for individuals with mental illness in emergency care.

Conclusion

This study identifies and explores varied perceptions of paramedics in relation to their management and treatment of individuals with mental illness. Factors such as *aporia* and *phronesis* across multiple levels of paramedic practice, nuances and complexities of mental illness classification in paramedicine and the pertinence of communication and autonomy for individuals with mental illness were discussed and considered here. Further research into paramedic management of mental illness from a practice-theoretical perspective would be a valuable topic for future research.

Keywords: paramedicine; perception; mental health; mental illness; prehospital care; photo-elicitation; postmodern emergence.

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Glossary

Perception: Explores the subjective nature of perspective and its inseparable relationship to experience. As individuals, we are physically and emotionally shaped and reshaped over time, which, in turn mediates our experience of the world, our place in it and an ever-evolving sense of self (Coppersmith 2018).

A belief or opinion often held by many people and based on how things seem (Cambridge University press 2018).

Mental illness: Mental illness is a broad term that refers to a collection of ailments or disorders, in the same way that heart disease implies a group of illnesses and disorders affecting the heart. A mental illness is a health problem that significantly affects how a person feels, thinks, behaves, and interacts with other people. It is diagnosed according to standardised criteria (Department of Health 2018).

Paramedic: A Paramedic is a health professional who provides rapid response, emergency medical assessment, treatment and care in the out of hospital environment (Paramedics Australasia 2018).

Photo-elicitation: Photo-elicitation is the implementation of incorporating images or any other type of visual representation in an interview and asking the participants to comment on them. The images may be produced by the participants or may be provided by the researcher. The main purpose of photo-elicitation interviewing is to record how subjects respond to the images, attributing their social and personal meanings and values. The meanings and emotions elicited may differ from or supplement those obtained through verbal inquiry (Harper 2002, pg. 1).

Introduction

The number of cases involving mental illness being treated by paramedics is increasing (Roberts & Henderson, 2009; Shaban, 2015), yet research has not yet identified how paramedics actually feel about a person who has mental illness (Prener & Lincoln, 2015). The complex nature of mental illness manifestation, as well as the demanding role of the contemporary paramedic within Australia, highlights the importance of paramedics not being familiar with the protocols and treatment strategies for the treatment of mental illness, they must also hold suitable beliefs and attitudes about mental illness in order to treat individuals with mental illness effectively. The growing rise in acute mental health emergency care has not been matched by research on how paramedics feel when treating individuals with mental illness. Consequently, there is inadequate knowledge to inform paramedic education and policy.

The limited amount of research on perception and even stigmatization of mental illness that is available comes from the functionalist paradigm - see, for example, Roberts and Henderson (2009). That is, researchers have tended to apply methodologies that are based on highly quantitative approaches with a relatively narrow scope. This may lead to new and significant understandings of perception and mental illness being overlooked. This project drew from an alternative way of researching perceptions about mental illness among paramedics an arts-based approach was taken. The benefit of an arts-based approach comes from the fact that photography and art-making are considered to be prestructural (Rolling, 2010, 107 pg.107); they facilitate an understanding of the 'relationship between what we know and what we believe' (Rolling, 2010, p. 107). A fuller understanding of this in relation to how paramedics perceive mental illness will allow for more relevant professional development programs for paramedics, more effective education and research about mental illness in undergraduate and postgraduate university-level paramedic programs, and more specific clinical protocols for the treatment of

mental illness by paramedics. This project provides a unique contribution towards gaining this fuller understanding of paramedics' perceptions of mental illness.

Literature review

In order for treatment to be applied appropriately paramedics do not only need to be familiar with the protocols and treatment strategies for the management of mental illness, they must also hold appropriate beliefs and attitudes about mental illness. There is only limited research exploring paramedics' attitudes toward mental illness, and indeed there is a paucity of contemporary research about the involvement of paramedicine in mental health-related incidences more generally (Roggenkamp et al. 2018, pg. 400). This is of concern since the number of people with mental illness treated by paramedics is increasing (Roberts & Henderson, 2009; Shaban, 2015).

My search strategy was challenged by to the limited availability on literature in this research topic, specifically related to Australian paramedics. I utilised the databases 'Scopus' and 'Primo Search' and searched through individual paramedicine related journal databases including 'Paramedics Australasia,' as well as government websites such as 'Paramedics NSW', which outline the current legislation that applies to paramedicine in NSW. The subject headings and keywords that I used, included: 'paramedicine Australia,' 'ambulance and depression,' 'paramedics perception,' 'paramedic attitudes,' 'emergency services and self-harm,' 'pre-hospital care and paramedicine,' 'paramedics' perception of mental illness,' 'paramedicine and mental health' and 'perceptions of mental illness in emergency care.' These searches yielded very little, which is a reflection on the scarcity of research being conducted in this area. Here, I will discuss what research is available pertaining to 'paramedics perception of mental illness' and present this from five key perspectives. These perspectives include, but are not limited to, paramedic scope of practice, historical

pertinence, education, training and policy.

Shaban (2006, pg.2) identified that the paramedic's role and objective in assisting the mentally ill within the wider context of health care has not been fully recognised or acknowledged. The limited published research in this topic suggests that the value of out-of-hospital care by paramedics and for individuals with mental illness in a societal and cultural context is not fully appreciated (Ford-Jones & Chaufan 2017, pg 3). However, the deficiency in research magnitude and scope has limited reform to mental health service provision and to paramedic education policy (Ford-Jones & Chaufan 2017, pg 4). Improving current research opportunities with a particular focus of mental illness in paramedic emergency care settings will improve education, training and policy in safeguarding quality and accountability of caring for the mentally ill (Shaban, 2006, pg.11). This, in turn, will positively influence the confidence and preparedness of paramedics in identifying, evaluating and managing mental illness.

Factors influencing paramedics capacity to deal with individuals with mental illness has been identified by Ford-Jones and Chaufan: 'inappropriate use of paramedic services for mental health and other psychosocial issues, insufficient paramedic mental health training, the deinstitutionalization of mental health patients without proper compensatory community mental health services, and an overemphasis on biomedical, to the detriment of psychosocial, aspects of health during the training of paramedics' (2017, pg. 3). It is important to also note that within the contemporary emergency medical service paradigm, paramedics are under accelerating pressure to expand their scope of capabilities in order to meet the demand of a complicated array of health and medical conditions (Raven et al. 2006). This heightened pressure to perform complicated tasks is exacerbated by the fact that only one to two paramedics (maximum) attend each emergency call (Thompson and Dowding 2002, pg. 5). Additionally, Shaban (2005), in investigating the clinical judgement and decision-making regarding mental illness in the out-of-hospital setting, emphasised that in terms of the management of people who are mentally ill in an out-of-hospital

setting, paramedics felt 'considerable uncertainty and both personal and professional distress' (Shaban, 2005, pg 8). The rise of this disposition can be considered to be due to an assortment of fractured institutional structures such as 'poor education and training, lack of integration with wider mental health services and infrastructure, rapid role expansion, increased complexity of mental illness' (Shaban, 2005, pg. 8). These are all factors that may influence paramedics' perception and consequently their management of people with mental illness.

Shaban also notes that paramedics commonly relying on 'intuition' and 'experience' focused only on 'physical assessments' of the individual's condition (Shaban 2005, pg. 8). It may not be surprising, then, that due to the 'mental' nature and the uncertainty of a presenting complaint within the context of mental illness, paramedics who participated in Shaban's study reported that commonly they implemented a policy 'taking them all to hospital' (Shaban 2005, pg. 8). This was irrespective of the fact that the condition may not have warranted such action. Similarly, Roberts and Henderson (2009, pg. 8) established that paramedics viewed their primary role in relation to attending cases of suspected mental illness as 'transportation' and that 'mental illness is a secondary consideration.' Put another way, the organisational culture highlights a 'load and go' practice, which is reference to the tendency of paramedics to deliver urgent transport to a hospital's Emergency Department (Roberts and Henderson 2009, pg. 10) due to 'time restraints' and the limited amount they can do treatment-wise for people with mental illness. In fact, Shaban (2005) found that terms used by paramedics, such as 'care' and 'transport' were interrelated - the act of transporting the patient to the hospital was considered to be 'treatment'. In turn, if the act of transporting the patient did not occur the paramedics considered this a 'failure' in management of the individual. All of this highlights an insufficient clinical policy framework and inadequate practices that are likely to be related to a lack of mental illness education in paramedic practice.

Shaban (2005) also identified that the paramedic's assessment of the individual with mental illness is highly influenced by the assurance of physical safety (Shaban 2005, pg. 8). Paramedics have described a need to 'persuade' patients to attend hospital

via the use of 'artful rhetoric and persuasion' (Standcombe and White 2003, pg. 3) in an effort to successfully and safely transport individuals with mental illness to hospital. Further, Roberts and Henderson (2009, pg.8) note that the 'perception of mentally ill patients are potentially a risk to the safety of the paramedic'. There is also an awareness that mental illness may not present with disturbed or violent behaviours (Roberts and Henderson 2009 pg. 9) but preparedness for that outcome is considered to be warranted. An example of this perception is identified in one of Shaban's focus groups:

I think safety is of paramount concern with mental illness, possibly more so than with other complaints and certainly your preparation and awareness of potential or unpredictable situations is heightened when attending a case with mental health issues. Considering access and egress regardless of the mental health complaint is important for paramedics' safety. Focus group 2, 2005

Shaban (2006) notes that there is a lack of research that explores paramedic's approach to treating individuals with mental illness, and Roberts and Henderson (2009) reiterate this within the context of paramedic development and training programs. The ability to learn and communicate effectively in order to establish rapport with patients were noted as 'key features to managing patients with mental illness' (Roberts and Henderson 2009, pg.10). Of course factors such as time limitations and the intricacies of individual mental illness presentations can impact treatment regimens and can undesirably affect rapport. Education and increased awareness of specific mental illness 'classifications' would positively impact the treating outcomes that occur in the pre-hospital environment. Roberts and Henderson (2009) echoes this view:

Greater awareness of types of behavioural abnormalities More emphasis on crisis interventions and counselling techniques. Further work on assessments" Survey, Roberts and Henderson, 2009

The apparent ineffectual nature of paramedic education in regard to mental illness is not surprising when investigating the phenomenon through an historical lens. Within an historical context, other health occupations such as medicine, including psychiatry and nursing possess a more linear progression when it comes to researching mental illness (Shaban 2006, pg.2). Paramedicine has not had rigorous advancement in knowledge related to this topic, which, may negatively impact quality of care. This may be exacerbated by inconsistent models of paramedic education throughout the latter half of the 20th century. The relatively recent transition from on-the-job training to the pre-employment option of a full time Bachelor's degree at a university (O'Brien 2014, pg. 1) could be a signpost of weakness in regard to the differing educational approaches of 'job-readiness.' Additionally, the absence of professional paramedic registration may have had some indirect influence on the progress of conducting detailed and comprehensive research in paramedicine, specifically research in regard to mental illness.

Paramedicine is no longer a profession that lies on the fringe of psychological health care. The dynamic social and cultural changes that underpin mental illness and psychological disorders have in turn shifted the social responsibilities and relevance of contemporary paramedic services. The Senate Community Affairs References Committee's Inquiry into the Accessibility and Quality of Mental Health Services in Rural and Remote Australia (2018) highlights aspects of pre-hospital care as well as the lack of current research in this topic area. The Inquiry was set up to highlight the need and urgency to: 'identify the areas where further information and research is needed to guide policymaking in the delivery of mental health services in rural and remote Australia' (pg. 5). The report identifies that Emergency Departments are one of the main locations where individuals seek treatment for mental illness. A current report from The Australian Institute of Health and Welfare states that in 2016-17, the rate per 10,000 population of mental illness-related Emergency Department presentations of patients living in metropolitan areas was the lowest, while patients in rural and remote areas was the highest (pg. 8). Not surprisingly, the Senate Community Affairs References Committee (2018) is currently conducting an ongoing inquiry into the accessibility and quality of mental health services in rural and

remote Australia. 'Australians struggling with mental ill health already have the odds stacked against them finding access to mental health services,' notes Committee Chair Senator Rachel Siewert (2018). According to NSW Mental health commission (2014), a skilled and sustainable workforce is at the heart of the long-term plan to strengthen mental health care in NSW. In 2012-13, over 129,000 people in NSW received a specialist mental health service either within a hospital or in the community. The NSW Government states it has: 'committed overhaul of mental health care service delivery, with a \$115 million boost to mental health funding over three years' (pg. 2). Irrespective of this funding, there is still a vast disconnect for individuals accessing mental health services. Suicide is the leading cause of death in Australia for people aged between 15 and 34 years - psychiatric disorders reduce life expectancy; for men approximately 16 years and women by 12 years. Nine thousand people are admitted to NSW hospitals for intentional self-harm each year and forty five per cent of Australians will be affected by mental illness at some point in their life (pg.4).

An exploration of the general nature of the mental health workforce within Australia also highlights paucity of much needed research: 'it is an area of research that continues to be hindered by a lack of good data' - However, the challenges that the mental health workforce faces is acknowledged and supported by researchers from a number of Australian universities (pg. 10). The Senate Community Affairs inquiry (2018) elucidated the implications of why accessibility to individuals with mental health illness can be challenging. The concept of societal attitudes plays an important role in 'whether people access mental health services at all, and if they do, the types of services they use' (pg. 10). For example, factors such as: 'attitudes to mental health services; the root causes of stigma and discrimination; and the strategies and interventions that are most effective with different cultural groups, geographic distributions and ages (pg. 10).' Researchers within Social Science and Biomedical Science faculties of universities have a role to play in exploring these issues. The pertinence of this addressing these notions surrounding attitude and perception is relevant to this research.

The Senate Community Affairs Inquiry (2018) also addresses the cultural shifts and ideals about mental illness. According to Dr Fiona Shand:

If we want to be really serious about saving lives, we need to focus on strategies that have been proven to work, not simply rolling out awareness campaigns. Hope is not a strategic plan ... if we look to the research evidence from here and overseas, there are clear strategies that have been proven to reduce suicide. Only some of these are currently in use in Australia, and implementation tends to be scattered and disproportionate to their impact ... we know that no single strategy will solve this incredibly complex issue, and what is needed is a combination of strategies targeting both the individual and the population (page 9).

The present-day demand for high quality healthcare in Australia is an important, even vital, topic. However, the World Health Organisation (WHO) dismisses the quality and delivery of healthcare, especially within the context of mental illness. The WHO (2011) has estimated that in high-income countries 35-50% of people living with mental illness do not receive appropriate mental health treatment. As a result of the deficit of mental health services, there is a direct impact on emergency medical services (EMS) such as paramedicine (Ambulance NSW 2013). Not surprisingly, Roggenkamp et al. (2018), in their study of 'mental health-related presentations to emergency medical services', found that incidents involving mental illness represent 1 in 10 EMS callouts in Victoria. In addition, NSW Ambulance (2018) note that 100,000 people per annum who call triple zero require mental health care. This equates to 15% of the total triple zero callouts. Due to the decentralisation of mental health services, hospital Emergency Departments have become 'the primary site for crisis care and intervention' (Roberts and Henderson, 2009, pg. 2) and paramedics increasingly face obstacles in caring for the mentally ill as a result of this decentralisation (Ford-Jones & Chaufan 2017, pg. 4). This results in an even more substantial growth of Emergency Department attendees. Moreover, there is not a recognised criterion for classifying mental health-related presentations in the out-of-hospital setting (Roggenkamp et al. 2018, pg. 400). Despite this, paramedics are

expected to manage an array of complex mental illnesses presentations.

There are discrepancies in paramedic legislation in New South Wales (NSW) and Ambulance NSW policy, which could also be a catalyst in regard to confusion for paramedics dealing with individuals and mental illness. The available research from Australia on this topic derives mostly from Shaban, who comes from a Queensland (QLD) perspective, whilst Roberts and Henderson (2009) come from a South Australian (SA) perspective. Nonetheless, their evaluations with regard to policy and legislation in the paramedic paradigm are not dissimilar to the ambiguity within current NSW frameworks.

Policy in regard to paramedic interaction with patients with mental illness is an important topic when looking at it from a legislative standpoint. Paramedics, not dissimilar to other health professionals, must respect patient autonomy. However, under the Standard Operating Policy of Ambulance NSW and the NSW Mental Health 2007, section 20 (1) notes that an 'An ambulance officer who provides ambulance services in relation to a person may take the person to a declared mental health facility if the officer believes on reasonable grounds that the person appears to be mentally ill or mentally disturbed and that it would be beneficial to the person's welfare to be dealt with in accordance with this Act.' This section grants paramedics the power to apprehend an individual on the basis of prima facie for the person's own protection from serious harm, or the protection of others. Accordingly, and in allowing the individual to attain their right to civil liberties, Section 68 (a) of the Mental Health Act notes 'people with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given'. It is stated in the Standard Operating Policy of Ambulance NSW that the choice to deny a patient with mental illness their civil freedoms and transport them to hospital against their consent 'must be guided by Section 68 (f) of the Act which states that - any restriction on the liberty of patient and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances.'

Contemporarily, the NSW Police Force Memorandum of Understanding (MoU) of 2018 highlights a 'grey area' in relation to the treatment and transport of individuals with mental illness. An amalgamation of the provisions from the Mental Health Act 2007 (NSW) and the Mental Health Forensics Provisions Act 1990 (NSW) provides legislative guideline for the NSW Police Force and the NSW Ambulance Service when dealing cooperatively with individuals with mental illness. However, the language between each profession differs when defining what constitutes a person with mental illness. The NSW Ambulance assessment of an individual with mental illness is based on 'reasonable grounds for believing that care, treatment or control of the person is necessary' (Mental Health Act 2007) and for the NSW Police, the individual just needs to 'appear mentally ill' (Mental Health Forensics Provisions Act 1990). This varying language and difference in the standard of assessment of mental illness is due to the NSW Ambulance paramedics having some mental health training. However, the implications of the MoU (2018) in relation to paramedics is that there is now a legally binding framework that can enforce a paramedic to transport an individual to hospital on the basis of police assessing an individual with mental illness (Mental Health Act, Section 22). The MoU states:

The most appropriate means of transport for a patient requiring clinical monitoring or clinical intervention is an ambulance... police vehicles are an undignified method of transport and their use should be limited to situations which pose a threat to public safety which cannot be safely managed within the resources available to other agencies. Lengthy journeys in police vehicles potentially expose people to increased risks i.e. clinical deterioration and adverse climatic conditions (pg.12-13).

In addition, clinical disagreement in the context of whether the person is mentally ill can also ensue, yet legislatively the paramedic is obligated to take the individual to hospital. The disjuncture of language in policy for paramedics does not aid in the treatment strategies for individuals with mental illness. Additionally, amendments to the mental health legislation in NSW indicate the heightened complexities of paramedics' role and responsibility in assessing, treating and managing patients with mental illness. Paramedic's within Australia are frequently the first responders to

emergency calls for assistance with mental illness (Roberts 2007). In response, the NSW government made an amendment to the Mental Health Act (2007) to help paramedics transport patients directly to a mental health facility instead of the hospital Emergency Department, firstly to ease the burden of Emergency Department resources and secondly to support paramedic time management with recurring mental health call outs. This amendment in the legislation highlights the need for more research into paramedicine and individuals with mental illness.

An improvement in the efficiency of management of patients with mental illness has been sought in Western Sydney through the joint NSW Ambulance/ Western Sydney Local Health District/Ministry of Health initiative that commenced in December 2013. Known as The Mental Health Acute Assessment Team (MHAAT), it includes a specialist paramedic and a mental health nurse who are sent to specific mental illness-related incidences that have been identified through a triple zero call. This concept directs patients who call triple zero with either acute or non-acute mental health concerns to mental health facilities instead of hospital emergency departments. Of course, this measure does not allow paramedics to diagnose or implement treatment plans, which is only accessible through a more qualified mental health practitioner. The combination of expertise and professional capabilities in assessing individuals with mental illness enables these individuals access to the most appropriate care in an effectual manner in conjunction with decreasing emergency transport to the Emergency Department (Ambulance NSW 2013). This progressive initiative in Western Sydney sets a significant precedent for future paramedic policy and treatment strategies for individuals with mental illness.

A significant professional amendment to paramedicine more generally is fervently overdue. The implementation of professional registration with AHPRA in 2018 for paramedicine can provide safeguards for individuals with mental illness (Paramedicine Board of Australia 2018). The continuance of professional registration will necessitate ongoing professional advancements, resulting in further training and education in recognising and responding to individuals with mental illness. Furthermore, an impartial professional registration body would give an individual who identifies that they were improperly apprehended or treated by a paramedic an

independent body to which they can state their concerns.

The intricacies and difficulties that paramedics in Australia face in the treatment of individuals with mental illness have been explored here from paramedic education, safety, historical pertinence, contemporary legislation and policy perspectives. In assessing the literature, an array of idle institutional barriers that let the paramedic profession down have been identified. While Research Australia's Senate Community Affairs Inquiry (2018) has sought to highlight some of the ways in which researchers can help address and confront the growing mental health crises in Australia. The evaluation of present mental health resources and their accessibility to people from all socio-economic backgrounds is also required: 'while the requirement for action is clear, what should be done is less obvious' (Australia's Senate Community Affairs inquiry 2018). Paramedic infrastructure, protocols and management strategies for the treatment of mental illness have to be continuously mandated to keep up with the fluctuating nature of mental health demands. Society cannot neglect the significance of paramedics and their advanced scope of practice, given the incessant demand of the complicated array of mental health conditions they receive, treat and assist every day. Thus, research regarding paramedic's attitudes and perceptions toward individuals with mental illness is warranted.

Photo –elicitation

Memory and perception is a strange faculty. The sharper and more isolated the stimulus memory receives, the more it remembers; the more comprehensive the stimulus, the less it remembers ... the thrill found in a photograph comes from the onrush of memory (Berger 1992, pg. 192).

Put simply, photo-elicitation is the insertion of a photograph or photographs in an interview as a way of generating knowledge that may not otherwise be accessible. The inclusion of photo-elicitation as research method in this project was based upon the notion that photo- elicitation can enlarge the possibilities of conventional empirical research (Harper 2002, pg. 1).

Zaltman and Coulter (1995) explore the notion that employing photographs as verbal prompts is a particularly useful method as memories are stored, not as words, but as mental pictures. John Collier (1957) concluded that the benefits of photo-elicitation are a more structured, focussed, expansive interview where participation is accelerated, more involving and more energetic. Research participants may also consider topics they would not normally consider (Blinn and Harrist, 1991). As the researcher I took photographs as part of the interview process because this approach is 'regarded as a powerful and credible tool for revealing and understanding the human world ... it provides multiple ways of understanding the complexity and variability of human experience' (Higgs and Cherry, 2009, p.8). Photographs are effective research tools because they trigger memories and require cognitive processing to determine the embedded meaning (Zaltman 2003).

The origins of photo-elicitation are interestingly quite similar to my contemporary topic of research. In the mid-1950s, photographer and researcher John Collier examined mental health in changing communities in the Maritime Provinces in Canada (1957). Collier's study in relation to the influence of environmental factors

on mental health outcomes proved to be a catalyst for research in the following decades as this method made it conceivable for the team of researchers to confront and challenge prior assumptions about the communities they were investigating (Bates et al. 2017, pg. 461).

Photo-elicitation, although a seemingly simple idea, provides almost endless possible variations. According to Rose (2007 pg. 241) there are a small number of rudimentary stages to the photo-elicitation process:

1. The initial interview with the participants. This interview does not include photographs or any visual stimuli. The focus in this interview is on the specific research topic and other pertinent questions related to the research.
2. This second step contains two possible options. After the initial interview the participants or interviewees can take pictures representing their experience in relation to the topic at hand. Or on the other hand, the researcher takes the photos based on their interpretation of the first interview, which is what took place for this honours project.
3. The photos are developed. Before the participant meets the researcher again reflective writing and thinking about the representation of the photograph takes place. This is applicable for whoever took the photographs, both the researcher and the participant. Blinn and Harrist (1991, pg. 189) note that taking a moment and implementing reflexive thought and consideration concerning the photograph is advantageous in formulating the successive stage of the photo-elicitation process.
4. The researcher conducts the second interview with the participants, discussing the detail of the photographs at length. This beginning stage of the interview is crucial in exploring and clarifying what the photographs represent to the participant. Talking through the content of the photos, the participant and the researcher begin to disentangle emerging themes and ideas that are relevant to the research topic at hand.
5. After the interview has taken place, interview data, including transcripts and the photographs are interpreted. This qualitative approach of analysis is

flexible in its approach, e.g. arts-based analysis or conventional social science techniques can be implemented – whatever is appropriate for the specific research at hand (Rose 2007, pg. 241 and 242).

An underlying argument for using photo-elicitation here is that it can be used for representing ideas and can influence what people are able to say about an idea. A pertinent challenge of interviewing as a method is participants being hesitant to discuss abstract concepts. This is where photographs become a useful tool in allowing research participants to feel more calm and comfortable. The photograph acts as a mediator, facilitating the participant to speak and communicate more about personal or even intimate topics.

The photograph or photographs can function as an ‘anchor point or as a springboard’ (Fenton and Baxter 2016, pg.37). Depending on the topic, research participants can have difficulty expressing their thought processes, ideas and experiences, so a springboard can be useful. In such cases, photo-elicitation can serve as a safety net for the participant as well as the researcher. Photographs in the interview setting can be used not only to direct conversation but also to stimulate the participants cognitive recall (memory) in a way that standardised questioning may not (Bates et al. 2017, pg. 461). The introduction of visual stimuli within the interviewing process can change the tone of the interview-taking place too. There is a potential to prompt emotional associations to memory and perception, therefore providing a more meaningful account by the research participant (Kunimoto 2004). The employment of photo-elicitation can act as an entry point for the participants – as the burden is not on the participant to come up with a response completely on their own, they can depend on the photograph to help them shape their answer or dialogue (Bates et al. 2017, pg. 461). There may also be specific topics or themes which participants are conscious of, which in may fact relate to this is the particular information the researcher is looking for – it is here that the photographs aid research participants in clarifying their ideas and points of view to the researcher conducting the semi-structured interview.

Bates et al. (2017) argue that photo-elicitation's: 'flexibility and power could elicit data that challenge traditional explanations of psychological phenomenon by relinquishing some of the power to participants and facilitating the elicitation of deeper, richer participant driven data.' To put this more broadly, the researcher acquires a 'phenomenological sense' (Harper 1986, p. 23) of the photographic content and what it represents to the participant – allowing for a 'contemporary and refreshing' (Bates et al. 2017, pg. 461) alternative to conventional qualitative research techniques.

Photography can act as bridge between two worlds. Harper (2002) notes that: 'Photographs may lead an individual to a new view of their social existence.' However, it is the multiplicity and deconstruction of photographic conventions that can expose concealed realities and experiences. Challenging the conventions of photographic portraiture or direct depictions of individuals can occur through strategies such as visual obscuring, cropping, highlighting, or fragmenting in order to disorient the participant (Bates et al. 2017, pg. 461). Additionally, while some of the works might be considered definitive and direct, some images may not include representations of the human body at all but instead convey a more abstract and non-figurative portrayal that may have been removed from their original context in order to explore perspectives on identity and the self, the expression of personal perception, psychology, community and society. Indeed, that is the approach taken here.

Taking this discussion about the benefits and relevance of photo-elicitation one-step further, Harper (2002) notes: 'Unlike many research methods, photo- elicitation works (or does not) for rather mysterious reasons.' It is the enigmatic nature that surrounds photography allures a deeper part of the human consciousness than the traditional 'words-alone' interview structure. As the researcher, I desire to capture the uncomfortable and the profound but also the mundane and the minimal. Harper states: 'Photographs appear to capture the impossible: a person gone, an event past.' The usefulness and validity of photo-elicitation is seemingly more beneficial in

research that is interpretive rather than positivist and conventional. This may, perhaps, be due to how perception and recall is enhanced by photographs and the particular quality of the photograph itself that is used in the research process. Put simply: 'That extraordinary sense of seeming to retrieve something that has disappeared belongs alone to the photograph, and it leads to deep and interesting talk' (Harper 2002, pg. 23).

Methodology

The primary philosophical and theoretical framework that underpins my research methodology is Somerville's concept of 'postmodern emergence' (2007). The ontological foundation of postmodern emergence, according to Somerville: 'is a response to two decades of critique of ethnographic practice following the "crisis of representation" (Denzin and Lincoln 1994) and feminist poststructural re-imaginings of self-other relationships' (Somerville 2008, pg. 214). The postmodern emergent methodology's primary objective concentrates on the 'undoing of self,' and 'the irrational, messing and unfolding' nature of 'becoming self' - It examines the ways in which 'the undoing of the self-constituted relationally in the research act is a necessary condition for the generation of new knowledge' (Somerville, 2008, pg. 216) for the qualitative and art-based researcher.

I take the ontological position that knowledge itself does not pre-exist; it is not a fixed entity (Guillemin, 2004). Karan Barad's concept of diffraction reverberates here: 'The space of possibilities does not represent a fixed event horizon - nor does it represent a homogeneous, fixed, uniform container of choices' (Barad, 2007, pg. 246).

Postmodern emergence reveres spaces of unknowing, silences, the irrational nature of 'becoming,' the disjuncture of liminal space and the iterative manner of research engagement. Pati Lather explores this iterative process: 'I support the goal of deconstructing binary oppositions, the necessity to keep things in process, to

disrupt, to keep the system in play, to set up procedures to demystify continuously the realities we create, to fight the tendency for our categories to congeal' (Lather 1991, p. 5). It is through iterative practices such as reflection, repetition, annotation that the 'new' emerges. Multiple approaches of expression are integrated in postmodern emergence, such as photography, dance, writing, stories, paintings, interviews and so forth. The dynamic nature of these creative forms is a vital for iterative practice, representation, and creation of new ways of knowing.

In an effort to extinguish some of the embedded granules of subjectivity in qualitative research, Somerville identifies a 'necessity' for 'emergence.' The notion of the 'liminal' is a precondition for 'emergence' because it is the 'time and space betwixt and between one context of meaning and action and another' (Turner, 1982, p. 113). Somerville aligns postmodern emergent ontology with the liminal, 'a space of becoming in between one state of being and another, acknowledged by researchers as working at the limit, the edge of self' (Somerville, 2007, pg. 240). Paul Carter echoes the significance of the liminal in his text, 'Material thinking' (2004). Carter, however, uses the term, 'the gap,' noting that this space in-between is not an 'empty interval' – the properties that manifest itself within this 'gap' would seem to be critical in order to create and subsequently promote a non-linear form of knowledge. Material thinking in its essence is this non-linear form and/ or structure: 'boundaries between inside and outside are ill defined' (Carter, 2004, pg.4).

Barad drives further into the theoretical underpinnings of knowledge acquisition, uniting ontological and epistemological framework models into a single concept and phrase, 'onto-epistem-ology' (Barad, 2003). Barad's rationale for this combination is the irrelevance of separatism in obtaining knowledge: 'we do not obtain knowledge by standing outside of the world; we know because 'we' are of the world' (Barad, 2003). The practices of 'knowing,' 'being' and 'becoming' are not isolatable. As the researcher, I am inherently part of the knowledge in its 'becoming' or 'emergence' in order to create meaning.

Additionally, Somerville explores the creation of meaning in response to the relationship to the parts:

These multiple creations are naïve in the sense that although they may be subject to the erasure of deconstruction, they are produced and valued in and of the moment, a pause in an iterative process of representation, engagement and reflexivity... These naïve forms are the means by which we display and engage with the ongoing products of our research (Somerville, 2007).

The significance of creating meaning that is fluid, adaptive and responsive is crucial in this research. Somerville explores this further through the concepts of: 'wondering and undoing' (2007, p. 52), a process that can be aligned to 'unknowing' in transformative learning and an acknowledgement of the undisciplined self (2008, pp. 212–214). The undisciplined self is integral in the process of emergence in this research. The dynamics that exist within the process of emergence are not mutually exclusive; there is a direct relationship to place and the sensory responses that inhabit a specific moment. This process that facilitates the making of new knowledge, requires me, as researcher to ultimately inhabit and know in a way that is aligned with the self being vulnerable and open to the fluidity of the process of 'waiting in the chaotic place of unknowing' (Somerville, 2008, pg. 209).

Postmodern emergence, as theorised by Somerville: 'moves outside the boundaries of the conventions of academic knowledge production.' Carter notes that 'creative research' and the articulation of ideas and meaning can be understood due to the: 'irreducible heterogeneity of cultural identity, the always unfinished process of making and remaking ourselves through our symbolic forms (Carter, 2004, pg. 13).' A groundswell of deconstruction, creation and conditional representation that exposes space for creativity to occur, whatever the desired mode of expression, asserting the process of these concepts and allowing them to come into being. Drawing from Somerville for his own research, John Rae notes: 'Postmodern

emergence offers a means for thinking differently about health services' creativity; if the research had not been attuned to the possibilities of emergence, opportunities for generating new knowledge may have been missed' (Rae 2018, pg. 218).

The ontology of postmodern emergence incorporates elements of our 'ontogeny' or our past self-history. Somerville identifies the pertinence of this:

Who we imagine ourselves to be, and our embodied relationship with others ... a reciprocal relationship with objects and landscapes, weather, rocks and trees, sand, mud and water, animals and plants, an ontology founded in the bodies of things.

There is a vibrant myriad of aspects that humans have indirectly or directly selected to use in the: 'process of becoming-other to ourselves' - a co-existence, a dynamic relationship of constant alteration and transformation with inanimate objects and technologies where subjectivities are fluid, where, as the researcher, I can purposefully manipulate and influence, such as paper and words, a camera, paints and brushes, and a 'Mac' notebook. This idea of representation is explored in Barad's book, 'Meeting the Universe Halfway' (2007). This post-humanist interpretation explores the: 'differential categories of human and non-human' and how the limitations are constantly stabilized and destabilized within the context of representation.

The notion of postmodern emergence and features of post-humanist theory are a new and innovative approach when it comes to scholarly examination. As the researcher, these methodologies support a reflexive style of inquiry that I have chosen to utilize; it goes beyond the traditional limitations of biomedical science and positivist research and offers an important and new way of exploring paramedics' perception of mental illness. Postmodern emergence and posthumanism deserve careful consideration and an opportunity to be further inspected as research theories. In an effort to conclude and in accordance with Barad, I believe it is apt to

identify that: 'Practices of knowing and being are not isolatable, but rather they are mutually implicated ... Humans do not simply assemble different apparatuses for satisfying particular knowledge projects but are themselves specific local parts of the world's ongoing reconfiguring and dynamic structuration (Barad 2003, pg. 829).'

Methods

The application of photography as a method of inquiry can extend the manifestation of meanings that may not be accessible in words alone. Collier (1986) illuminates this: 'the informational and projective character of photographic imagery makes this process possible. They can function as starting and reference points for discussions of the familiar or the unknown' (pg.99). The creation of meaning and fresh ideas can then be translated back into words 'through inhabiting the space between visual and verbal representations and meanings' (Somerville 2012 pg. 18).

In this project it is I, the researcher, who creates and takes the images that become 'the basis of discussion, interviews, and/or analysis' (Knowles & Cole 2008, pg. 47) and help me to 'elicit or provoke other data' (Knowles & Cole 2008, pg. 48). This is where I can enter the 'liminal' and 'unknown spaces' getting back to Somerville and Carter, in order to produce and manifest new knowledge and new ideas pertinent to paramedics' perception of mental illness.

In creating the images, no set process was taken, I did not try to force an image. Most poignantly, I took them whilst pertaining attending to other errands, but still with interviews fresh in my mind. Although the images were a priority, they did not take up an entire day, but were quickly executed in the midst of a busy day, doing jobs around the house, or walking the dog. I did this because creativity in life, I thought influences art and putting pressure on myself to create a photograph in unyielding conditions was not going to be productive. Indeed, I also realised that the concept of mental illness is constantly woven into everyday acts. There is no separatism between mental illness and human existence. They're part and parcel.

I chose the silver tone shade of photograph purely due to the feeling that it evoked a sense of complexity and beauty. The two tone image also invites interpretation for the participant.

Early on in the research process when I writing and thinking about the theory regarding photo-elicitation, I was expecting to show the participant one or two photographs. However in the midst of the photography process, one or two photographs did not feel sufficient enough in regard to my creative intentions at that time. All five photographs were shown to the participants in the second interview in order to generate new ideas about their perceptions of individuals with mental illness.

During and after interviewing three paramedics who had diverse experiences with individuals with mental illness, I could see that they valued the photographs that were presented to them. There was no hesitation or questioning of photo-elicitation. Indeed, there was a warm acceptance by the participants of the fluidity of the process, especially in the second interview when looking and thinking about the photographs that lay in front of them. A disposition of open mindedness was present in both interviews by all participants. I learnt quite quickly that I should not hold any expectation or assumptions about participants' creative capabilities or how their personal interpretation would unfold. Fittingly, Hatch denotes: 'Learn to take nothing for granted [and avoid] searching for one right answer, or believing that everyone thinks or should think as you do' (Hatch 1997, pg. 46).



Teddy, 2018, silver tone photograph, A1



Stairway to heaven, 2018, silver tone photograph, A1



The divide, 2018, silver tone photograph, A1



Precursors of thought, 2018, silver tone photograph, A1



A town exposed, 2018, silver tone photograph, A1



Clotheslines, sunrises and sertraline, 2018, silver tone photograph collage, A1

Participants

Participants were selected through purposive sampling, which was employed in order to 'yield the most information about the topic under investigation' (Leedy & Ormrod, 2005, pg. 147). In reference to this, Gentles (2015) notes that: 'Purposeful sampling is probably the most commonly described means of sampling in the qualitative methods literature today' (pg. 1778) and Patton (2015) postulates the pertinence of purposeful sampling in qualitative research by stating: 'the logic and power of purposeful sampling lie in selecting information-rich cases for in-depth study. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry ... Studying information-rich cases yields insights and in-depth understanding' (pg. 264).

Attention of sample size is important, but of primary concern here are ontological assumptions, Blaikie (2018) notes that: 'there are no necessary connections between the form of data and the type assumptions that can be adopted' (pg. 639). The ontological and logic of inquiry in this project work towards the 'generation' of knowledge, rather than, say, the generalisation of findings to broader populations.

Recruitment

An email request for participation was sent from my supervisor, Mr. Lyle Brewster, a paramedic, to members of the paramedic profession. The three participants responded were practicing paramedics with varying levels of expertise and situated in different practice locations both rural and metropolitan representation. Consent was obtained from all participants to participate in the research and there was an opportunity to confirm or re-negotiate consent during the research project. Participants were also able to withdraw from the project.

The fact that I am removed and quite separate to the paramedic profession leaves me, researcher, as an impartial component to the project. I possessed no preconceptions of a profession that may influence interview questions or image making. This separation, one may say, leaves me in a fascinating position, 'betwixt-in-between', as I am not a full-time remunerated academic researcher and not a professional paramedic. The disposition of taking risks was consequently heightened, perhaps the point where interactions with participants were more relaxed which may have attracted more information from the research participants than I would have otherwise.

Interviews

Two semi-structured interviews took place with each of the three participants. The location for these the Charles Sturt University, Bathurst campus, or by telephone. Where interviews were performed over telephone, I posted the images to the participant before the second interview took place.

The interview style had a relaxed conversational tone. In line with this semi-structural interview approach, I responded to the research participants' answers to the preceding questions, implementing 'reflective listening' in order to generate as much relevant information as possible.

The objective of the semi-structured interview is that it allows a non-directive discourse where the communication between the researcher and the participant is in the form of open conversation. I approached each interview with four or five key questions that aligned with the main research topic, and for the second interviews, photographs were presented to allow for 'flexible elaboration' (Lapenta 2004, pg. 59). This flexibility of the semi-structured interview complemented the approach of the photo-elicited interview.

The pertinence of this conversational style of interviewing allowed the participants and myself, the researcher, to 'talk with each other, interact, confront other ideas

and opinions, pose questions and give answers, get to know about others' experiences, learn about the world we live in, construct and learn about almost all of the social world that surrounds us' (Lapenta 2004, pg. 59). I worked to constantly remember the purpose of the interview, especially within the research topic about 'perceptions of mental illness by paramedics', perceptions being an intrinsic component to the investigation. All this helped to carefully obtain narratives from the participants 'with respect to interpreting the meaning that a specific area of experience has for them, and becomes a careful questioning and listening approach with the purpose of obtaining knowledge about that phenomena' (Lapenta 2004 pg. 60). There was almost an intimacy here, as the process involves an implicit sharing of considerations and understandings of social roles and identities. Table 1 lists examples of interview question and prompts.

Table 1. Examples of questions and prompts that were used in interview the first and second interviews.

<u>First interview</u>	<u>Second interview</u>
<p>What experiences have you had with mental illness?</p> <p>What does that make you think about mental illness?</p> <p>How prepared do you feel for mental health call outs?</p> <p>Does this impact other parts of your life?</p> <p>Taking a step back and thinking about your training and education and even the first 12 months on the job, do you feel you were adequately prepared for mental health call outs.</p> <p>How do you use you experience with mental illness in your role?</p>	<p>So what are your first thoughts regarding the photographs?</p> <p>Do photos contradict each other, in a sense, or they kind of help each other?</p> <p>Does anything link in with our first interview, to you, in any sense?</p>

Analysis

The notion of 'data analysis' here is different from positivist or functional paradigms and is aimed at the creation or generation of new knowledge. Within the realms of creative research, including postmodern emergence and also Carter's 'material thinking' (2004), art 'begins as a social relation' and is transformed by the artist before returning it to the social domain (pg. 10). A similar thing can be said of text, Lapenta (2004) acknowledges an issue that I find relevant to discuss: 'conversation, which might be characterised by an ordinary conversation style, is transformed and somehow denatured in an academic text or presentation, in an academic style that shares very little with its original style of production (Lapenta 2004 pg. 62). Standing (1998) also elucidates:

However equal the methods of access and interviewing, we, as researchers, still hold the real power when we take the interviewee's private words into the public world of the academia. It is in producing the written text, research report, journal article, book, presentation, that we have the most power' (Standing 1998 pg.189).

This constant and dynamic interplay of dualisms – the alternative consideration and analysis of data and the subsequent translation onto the archetypal form of academic text is a fascinating process. In qualitative research, it is acknowledged that the researcher is the primary element when it comes to data collection, analysis and interpretation. This is why Somerville's postmodern emergence provides such an innovative and useful lens when it comes to qualitative arts-based research. Postmodern emergence, within the context of analysis: 'examines the ways in which the undoing of the self-constituted relationally in the research act is a necessary condition for the generation of new knowledge ... ontology, epistemology and processes of representation are co-generating and co-generative in and of this process (Somerville 2008, pg. 214). Somerville reflects on her own analysis:

Meaning is dynamic and constituted intertextually between the various elements of the performance or representation ... there is a proliferation of representations in journal notes, interviews and transcripts, new and old photographs, paintings, drawings, storytelling's and maps. These are dismantled and re-assembled to create new productions from the research, each time working between the logics and poetics of the research, between the images and the rational meanings that are assigned to them (Somerville 2012, pg. 9)

The data that have been gathered in this project include the photographs I made after the first initial interviews with the three participants and the transcripts from both the first and second interviews, including the notations that I made on the transcripts. Additional materials that are pertinent include notes from my research reflection journal as well as photographs I took of the interview setting. There was a constant iterative assertiveness that allowed for insights into the complexities and contradictions. This is similar in intention to Somerville's (2007, pg. 239) method of dismantling and re-assembling her journal notes, transcripts, photographs and so forth, each time she 'create[s] a new product from the research' (Somerville, 2007, p. 239).

These formulations enabled new 'families-of-association' (Carter 2007, pg. 15-16) about the perception of mental illness amongst paramedics to emerge. From this dynamic and self-motivating process of de-contextualising/ re-contextualising, reflection on data, obtaining families of association and structures of meaning, emergence of insight and critiquing what is 'known' new knowledge starts to take shape, as Somerville (2007) notes: 'a moment in a broader generative process when researchers take note and respond, a radical turning point (Somerville, 2007, pg. 228). Carter (2007) elucidates the notion of 'decontextualisation in which the found elements are rendered strange, and of recontextualisation, in which new families of association and structures of meaning are established' (Carter, 2007, p. 15-16). This echoes the way I approached analysis of these materials. In examining the diverse forms of data that I collected, I challenged arguments and ideas and I explored

ambiguities and contradictions, and observed the complexities and dichotomies in the data as a crucial aspect in analysis.

Reflexivity

The inclusion and pertinence of reflexivity in my research is imperative in the expression and understanding of the ongoing re-construction of meaning (Lapenta 2004, pg. 47). Reflexivity, as described by Finlay: 'is thoughtful, conscious self-awareness. Reflexive analysis in research encompasses continual evaluation of subjective responses, intersubjective dynamics, and the research process itself' (Finlay 2002 pg. 532). Reflexivity is fundamental to qualitative research (Finlay 2002, pg. 531) because in qualitative research "meanings are seen to be negotiated between researcher and researched within a particular social context' (Finlay 2002, pg. 531).

Carrying out reflexive analysis can be a challenging process, as personal experiences and perceptions can be complex, multifaceted and sometimes uncomfortable. I believe reflexive analysis and research is interlinked with a sense of vulnerability for the researcher, as certainty and mistakes such as implementing wrong or ill-equipped strategies or choosing an unfitting questions have to be honestly acknowledged. I believe that as a researcher you recognise early on in the reflexive process that you have to be committed and be prepared for these potential oversights (Finlay 2002, pg. 541). Contrarily, it is feasible for academics to engage in reflexive analysis and receive an incredible amount of 'scope, depth, richness, and flexibility that reflexive analysis offers ... voicing the unspoken can empower both researcher and participant. As more researchers grasp the nettle, the research in the future can move in new, creative directions' (Finlay 2002, pg.544).

Rae, in his arts-based research, configured a reflexivity matrix representing the organisation of reflexivity - pre-research, data collection and data analysis stages:

‘The cells forming the matrix, that is, this intersection of thought about research stages and levels of objectification, raised questions about the investigation’ (Rae 2018, pg. 219). As Rae and Green (2015) noted: ‘a systematic approach to reflexivity, such as the reflexivity matrix, is a good place to start any research project, especially for newcomer qualitative health researchers (pg. 96). I found this matrix useful as form of personal connection and association with the research project, especially in the pre research stage and during the months prior to the interviews. Table 2, based on the work of Rae and Green (2015) lists the key prompts that I used to facilitate reflexivity.

Table 2. Reflexivity matrix.

Pre – Research position of the subject
1. How do your broader motivations affect your reason for conducting this research?
2. Where do your interests and conflicts of interest lie within the relevant literature and its interpretations?

Figure 1. *The boardroom*, 2018, silver tone photograph.



Photography was implemented as a reflexive tool. I took photographs of where the interview was going to be conducted (before the participant arrived). Miller, Carson and Wilkie from *The Reflexive Photographer* highlights: 'that a photograph rarely stands alone. When we look at a photograph we're interested not only in the photograph itself, but in the photograph and its context. The image has a relationship to its maker, to the viewer, to the time and place it was made - and to how it is being 'consumed.' David Gauntlett (2007, pg. 29) also notes that 'making or looking at a work of art encourages reflection upon ourselves and our place in the world', which aligns with Somerville's, 'critical power of place', as she explores the concept of place noting that 'these naïve forms are the means by which we display and engage with the ongoing products of our research ... within the conceptual framework of place, a postcolonial pedagogy of place and methodology of

postmodern emergence are proposed as the basis for a critical qualitative research' (Somerville 2012, pg. 1).

These images were taken in the environment where the interviews took place. Coming into this vicinity with enough time to settle, stop and think about the questions and photographs for the second interview proved to be a 'warming' and interesting process. The picture titled, *The boardroom*, was taken before an interview occurred and helped me to take in the larger context of this research. The significance of an individual walking into a boardroom and seeing five large A1 prints could be quite daunting I imagined. However, the topic and issues at large regarding individuals with mental illness seem to allow the size of the presented photographs to seamlessly blend in with the boardroom energy. This energy, formal and unvarying in nature - yet through the interview process it became a vulnerable and exposed place where candid information was exchanged. Similarly with the image, *Can you hear me? I'm on speaker*, the image of a telephone, reminded me of the distance and the vast area paramedic's cover within Australia. Although the telephone is still and seemingly vacant or non-agential vitality, the important and vivid conversation that transpired through this object goes beyond the normal conversational subjects one may have 'day to day' with, for example a loved one or friend. This notion inspired me to capture it as a photograph for research purposes. The photographs are silver tone in colour, I chose this colour as it's aesthetically pleasing and can be interpretive of nature.



Figure 2. *Can you hear me? I'm on speaker*, 2018, silver tone photograph

The first question from the matrix asked me to think about the broader motivations for this research. This was indeed crucial in self-reflection, not only within the context of this particular Honours project but self-identity in general. The complexity that arose from this seemingly simple question became emotionally prolific, due the fact that spiritually and physically I had begun something that I knew needed to be addressed. What came into clearer focus for me was the topic of mental illness in conjunction with me entering the world of paramedicine, an arguably undervalued and misunderstood profession especially, within Australia. The notion that I had this opportunity to 'dive into' academia, conduct and perform research, not only for me but also for the community and for others, sustained me during the project. I realized that intrinsically, on a deeply broad level the process of research and learning is a part of my biological and emotional 'tapestry'. How do I know this? It is a facet of my authentic self, seemingly irrelevant to the object of research itself; examination into the unknown can be quite an emotive process as I can feel all the

cells in my body scream with satisfaction. My body and my mind become electric, which I took to be similar to Gauntlett's discussions around creativity – scholarly inquiry for me is 'something that is felt' (Gauntlett 2011, Pg. 79). Gauntlett further reflects my disposition by noting: 'this unusual experience gets the brain firing in different ways, and can generate insights which would most likely not have emerged through directed conversation.' I reflected that the possibility to conduct research is a privilege and it is what I want to do for the rest of my life. My interest in a general sense stems from the personal urge to deconstruct normality. To have an opportunity to dissect and learn about concepts and interpretations that underpin societal realms as well as question architects is an honour and opportunity.

What were also considered were my interests (and conflicts of interest) that lie within the literature during the pre- research stage. Very early on into the process I dived deeply into the new relatively new realm of art-based research. I read deeply and thought about Somerville's postmodern emergence (2007) as well as Carters material thinking (2004), amongst others like Gauntlett's 'Making is connecting' (2011) and recent articles on posthumanism. I had no preconceptions of art-based theory or photo-elicitation for that matter, but I knew a lot about photography and my personal inclination to take photographs was undoubtedly a 'given' for this research. As I kept reading and thinking about these creative philosophies and arts-based theories my urge to them justice in this project grew stronger and stronger. I also knew that this collision of worlds, the biomedical paradigm and qualitative arts-based research, was something to prepare for. Initially explaining my intentions of and for this project around the dinner table was no easy feat, yet I thrived in the challenge in the pursuit of being able to simply articulate the nature of this project, and I continue to do so. As I had no presumptions about this particular research topic, reading the relevant literature, every article, book or component of research had some value. As a novice researcher, one must read and analyse the good and the bad to know how to define what is useful and what is not.

In addressing the question: 'Perceptions of mental illness by paramedics?' I was instantly put in a very interesting position because there was very little research in this topic to act as a precedent. The three main authors in the literature that

captured my attention early were Shaban, Roberts and Henderson. Their studies in paramedicine and mental illness were conducted in Australia, which for me was an important aspect in this research. In observing the paucity of research, I as much as possible wanted to keep it within an Australian context. This Australian lens, I believe allows for clarity for not only this research but for future research. In conjunction with this it links back to the overall objective of the project, which is creating a dialogue about mental illness in paramedicine within Australia, something that is deeply needed.

The arts-based element of this research opens up entirely a discussion of concepts that would have been perhaps taken for granted – for example, the binary stereotypes of paramedicine and also mental illness have been teased out an alternative expression of these rigid concepts can be powerful. This re-conceptualisation of concepts and ideas can occur through theoretical platforms such as Somerville's postmodern emergence and Barad's posthumanism opening up a whole new approach to paramedicine research epistemology.

The ethical considerations of this research should also be acknowledged. The Charles Sturt University Human Research Ethics Committee approved this research, protocol number H18168. This research project ensued with the informed consent of all the interested participants. All participants pre, during and after written consent was given had the option to decline participation in the study and could withdraw at any time. Consent forms and Participant Information Sheets were given to all prospective participants. The participants who were interested signed consent form, which were returned to me, the primary researcher, before any interview took place. There was no deception or coercion toward research participants at any time. The participants' names, or workplace, will not be made public. This was expressed to them fully and coherently before each of the interviews.

The participants throughout the interview process were valued. The topic of mental illness is profound and complex therefore all exchanges with them was respected and appreciated. In the analysis process, every attempt was made to represent their views as accurately and as soundly as possible. There was no distress throughout the

interviews. Participants' sense of relief and gratification in speaking about this important issue within their profession was obvious.

Results

In considering, questioning and exploring the interview transcripts a rich assortment of 'families-of-association' (Carter 2007 pg. 15-16) emerged from the data. These included dispositions of helplessness and un-preparedness to deal with mental illness presentations, the divided worlds of mental health professionals, contemporary paramedic policy, and the importance of autonomy for patients who have presenting characteristics of mental illness, and the impacts of organisational structure in paramedicine. Indeed, the results that are discussed here expose the different levels of complexity and intricacies within this profession when it comes to not just the perceptions that paramedics hold regarding mental illness, but also the treatment of individuals with mental illness.

Helplessness and non-preparedness

The notion of helplessness and non-preparedness was a primary issue that arose and developed across all three interviews. This sense of helplessness stemmed, it seemed, from very individualistic and personal experiences across the entirety of the participants' education and induction into their working professional life as a paramedic. Irrespective of the internal conundrum of helplessness for these participants, when it comes to attending prospective mental illness related 'callouts', the prevalence and sheer volume of work speaks for itself, this was identified by Participant 1 who stated:

Anywhere between 20% to 50% of that workload would've been mental health, dependent on location or time of year. So, yeah – so, I've experienced all forms of mental health. Everything from an anxiety attack right through to a psychotic break, schizophrenic episode, people who have suffered self-harm, self-abuse, abuse from others, physical harm, physical damage ... suicide, completed suicide – yeah, anything you want to name.

Participant 3 added:

Nobody is immune to any mental health I think probably if 99% of the population were honest mental health is part of like and we probably all experience some form of poor mental health and some stage in our lives regardless of where you live or what you do.

All participants considered the sentiment of non-preparedness in a general context, one participant noted:

Some days, you really just feel like you're banging against a wall, because you want to do the best for your patient, you can see your patient is struggling or suffering, but from what you're doing at the scene to going to help, there's this like wall you're trying to punch through, and it's like there's nothing there, and it's like, what's the point, sort of thing, you want to just sit down and have a cup of tea with this person and have a chat for a couple of hours and you think you'd probably do more good than them sitting there being frustrated in a waiting room or a holding area, not receiving any help, and then not being listened to, no one being empathetic, no one considering their plight or their individual circumstance ... I wish there was like a silver lining, but there currently isn't.

Participant 1 added further value to this notion:

To summarise it it's limited, and you feel frustrated because of the limitations that are either placed on you, resources that are not allocated to you, education and training that's not provided. You have to seek your own, like I did a mental health first aid course, and that was a whole day, and it was way better than anything we'd done, like you just, really, like, it's like the veil is lifted from your eyes and you go, oh, okay, that makes a lot of sense, I mean why haven't we covered that, like if we'd done something like that, even just at university or training ... You sort of become quite cynical, I suppose, I like to call it realistic, because you, as ambos are notorious for being problem spotters, we see the issues, that's part of our make-up, as well, what we're trained for. So, you see the issue in the situation of the training you receive as being something that's this is covering them from an insurance point of view, as a legality, okay well, we've done some mental health training that, here you go, so when a mental health job goes really awry, they can say, well, you received this training, and here's you signed off on it, so you and the trainer, whoever did it, get pulled before a tribunal and you get raked over the coals. You do feel a bit, sort of like you're just treading water.

The notion of paramedic education, more specifically 'theory' versus practical experience was the most apparent aspect when it came feeling helpless as a paramedic when dealing with individuals with mental illness. The disconnect between training and education is outlined by Participant 1:

I feel very prepared but at the same time, not prepared at all in that the training and education I received was certainly not up to standard for the job that we actually do. So, there's a complete disconnect between the training they've provided and education.

Participant 2 adds:

I just think that there are certain aspects of the job that you can't learn in a theoretical manner. So no, I think that there are a lot of aspects of how we work with people with mental health issues as paramedics that I think it's impossible to learn in a classroom setting. The only way you learn it is to go out and actually do the job ... from a university perspective, it's probably very difficult to teach without actually exposing people to the – to people suffering from those mental illnesses on a day-to-day basis. But, it's something that definitely needs to be done.

The participants strongly articulated that there is no singular solution to this apparent aperture in theory versus experience. Participant 2 proposed this:

I guess what I'm trying to express is I don't think you can prepare solely theoretically or solely on the job. I think if I went out as a vocational entry paramedic, I think you'd struggle a bit ... it's really valuable to review cases, like in the classroom, that have happened and to certainly become knowledgeable about as you said the legislation and basically the rules that define how we practice. I think it is just a case of developing more experience, going to more jobs, seeing how other people carry themselves.

Participant 3 added:

It's a very practical, very hands-on job, and I think the students are disadvantaged. They don't get a lot of exposure throughout their – through your degree – and you know, I mean they don't even do a placement on road in the first year, it's usually not until halfway through or the second half of second year, before they actually go in the ambulance, and even then, they probably – you know, in total, probably only do about eight weeks over the last two years.

The complexities of practice and on-the-job proficiency in relation to dealing with patients with mental illness was also highlighted - as there is indeed no definitive answer in dealing individual mental illness symptomology, as one participant notes:

Jobs that are just like physical trauma where someone's come off a bicycle or had a car crash or something like that, even though you could do five broken arms in a month, every one of those would have different contexts and circumstances. But comparatively it's a broken arm. You've got a sequence of things that you deal with. When it comes to the mental health side of jobs it's tricky because you're negotiating essentially with another human being. Not that you're not in trauma jobs, but I mean when the focus of the issue, the reason that you're there is the mental health and the mental wellbeing of the patient, there are a lot of skills mainly in communication and negotiation that you only develop by doing it I think...The only thing I'd think of saying is that I think there's – I don't think that there's any job that I've been to that doesn't involve some sort of mental health, not mental illness, but mental health aspect to it. I think the more experience that people can get, the better.

Indeed, communication in this profession is obviously imperative. As outlined by one participant, in order to effectively communicate to patients and establish a sense of rapport takes time, and is not something you can purely learn in a classroom setting:

Participant 3 notes:

I think just that exposure and seeing how other people communicate, how other people de-escalate and those sorts of skills, I think is good ... we work in an industry that's all about people, and the only way to become good at it, I think is by that exposure at the time. You can't teach someone how to talk to someone, and we discuss that quite a lot – quite a lot. And I don't know how, in this three-year degree, they run, I don't know how they can do that, other

than just providing more opportunity for them. And it might be working in a mental health facility for a placement.

Interwoven with these notions of non-preparedness were feelings of self-reproach and accountability towards patients, as reiterated by participant 1:

I feel bad for our patients because we're not as well equipped as we could be – should be. There's obviously levels of frustration there as well because you know that you're going to – if that person is profoundly unwell, you're going to feed them into a system that will not provide the kind of long-term health ... We're here to help people and in a lot of cases, we can – we can do that quite completely. I mean, as in we can assess, ... and assist them and then bring them to the help they need if it's a trauma or medical case. You can actually start them down the path to get them fully back to health, and that is not something that you can do with a mental case.

The divided worlds of mental health professionals

The detachment between mental health professionals and mental health resources was also raised. According to the participants there is a disjuncture between paramedics who work on 'the front line' of mental health care and other mental health specialists. This frustration was considered due to the overt differences in professional ethos when it came to treating individuals with mental illness, impacting the level of care for the individual. As participant 1 noted:

No one's taking a keen interest in mental health from the perspective of where we're at, as you say, on the front line. And there's nothing translating down to it. Even clinical psychologists are sort of looked down upon by other

medicos because they're very academically orientated and sort of – And when I say medico – like a PhD or MD – of another medical field. They're not working with the people in the field as much. They sort of – unfortunately from our point of view – from our perspective we don't have any dealings with those psychologists. We just deal with the mental health nursing team who themselves are doing exactly what we're doing – they're putting a band-aid on a broken leg. They are just about crisis mitigation at the time.

Another participant added:

Community mental health teams are great, and if we had ten times that number, we probably would be doing okay. But we don't. So, paramedics fill that nine out of ten gap. So, we're the ones going into their homes and we see their situation, and we understand what they're dealing with right now.

Participant 1, interview 2:

There's been some higher profile cases recently of mental health patients being turned away from certain health facilities that are designates mental health units which are ... - they are in no equipped to be that, but the government has decided they are. And those people have unfortunately left those facilities feeling acutely unwell, having been told nothing can be done for them that night and they've gone home and unfortunately committed serious heinous crimes resulting in death.

Contemporary Paramedic policy

The implementation of a current Memorandum of Understanding (MOU) in 2018 aligns NSW Health and the NSW Police enabling them to respond and work together in order to effectively and efficiently treat individuals with mental illness. Reflecting the amended Mental Health Act 2007, the MOU was raised concerning the effective treatment of individuals with mental illness within an emergency care context.

Participant 3 states:

There's been some conflict between us and the police. It's very dependent on who's on. We had one of the senior operational police here, a couple of years ago, it was very, very against any police involved, and we had a couple of big issues that caused a bit of a rift between us and the police. That sort of settled down after a while. That person moved on, and things sort of settled down ... But we've seen sort of an increase again, recently, and in fact, I did a job only two weeks ago where we had a mother and son, and the son has some behavioural issues, he has ADHD and has all sorts of other issues around that. He gets a bit violent. He lives with his mother and his grandmother. His behaviour escalated to the point where his mum just lost all rational ability to cope and to manage the situation. So, we were called, and it was probably about forty minutes out of town, so it was quite a lengthy trip, and it was a very, very busy day for us. And so, we got out there and assessed the situation. The police were already on the scene. And we ended up transporting the patient, the son, with us, who, the son was only twelve, and as we were leaving, I said to the police; look, what's happening with mum? And they said, look, we're actually thinking about scheduling her. By the time we got the son out to the car, we're chatting to him and getting ready to go, one of the other police came out and, actually said we've scheduled mum, can you organise another ambulance to come. And it certainly wasn't appropriate for us to take her with him in the same ambulance.

In this circumstance, the proliferation of mental illness presentations over the past decade has indeed correlated with the current paramedic and mental health legislative changes in NSW.

Participant 3 identified these changes over time:

Probably over the last five to ten years, since I've been in this job, the increase in mental health and associated presentations, I think we've definitely seen that, a huge increase. And I think, too, since we had the transition with paramedics being able to detain people under the Mental Health Act, brought a new scope of practice, and probably a bit more of a focus on formal assessment and assessment tools, and then, obviously, all the legislation around mental health, being able to search and detain people.

Another participant addressed this topic also:

You know, and it's interesting, when I look back to, even when I first started in the job, a lot of the time we'd be up at the hospital with a patient, and the police would come in with a patient, you know, they'd scheduled or whatever, and it was just never an issue. We would often get called, but it was never an issue. Having said that though, the flip side is, when I've been on scene with mental health patients and things have escalated and we've needed them, they've certainly always been helpful.

The importance of autonomy for patients who have presenting characteristics of mental illness

The importance and relevance of patient autonomy with individuals presenting with a mental illness was raised. Indeed, the notion of applying and allowing patient autonomy is circumstantial and may not be appropriate for every individual

presenting with mental illness symptomology. However, implementing the approach of patient autonomy, the participants felt that they had a more constructive sense of management and success with the treatment outcome. As participant 1 states:

I think a lot of the time interestingly I think again you know not saying I'm the paramedic of the universe but I think a lot of the time when dealing with this but take a particular patient cohort as we touched on last time – I think a lot of the – a lot of your success with these sorts of jobs is the way you approach it and the way you manage it and I think a lot of the time I will have a conversation with these patients around the fact that you know identifying that we are viewing their behaviour is not appropriate and asking them if they think their behaviour is appropriate or not – and a lot of the time I find once you identify where they're at in relation to whether they think their information is inappropriate or they acknowledge their behaviours or they acknowledge that they need something to help them to calm down.

The comparative notions between physical versus mental ailments and the importance of autonomy and successful communication were also identified.

Participant 3 adds:

I think it's really important – I think any patient – medical, surgical, trauma, whatever – if you are in a position where you can have the conversation with the patient. I think a lot of times people come unstuck – it's like when you see paramedics go to cannulate a patient – they put a tourniquet on and chances are the patient may or may not know what's coming but then suddenly the paramedic just does their thing and whacks in a cannula and then they wonder why the patient gets upset with them or stroppy with them – when they do put the cannula in they pull away or you need to take that time to explain and I think this particular patient cohort is exactly the same.

In conjunction with the importance of patient autonomy, challenges and contradictions about what is or should be deemed a mental illness presentation

surfaced. For the participants, perhaps due to the sheer prevalence and workload of mental health call-outs, the perception of mental illness versus bad behaviour was discussed. This notion of 'being quick to label' individuals presenting with mental illness was considered, Participant 3 noted:

I kind of can't help but think, as a society, we're very quick these days to label or – just trying to think, the best way of wording it – I think we're very, very quick to label someone's behaviour ... Now, whether that's in an attempt to excuse, or justify, or rationalise that behaviour, I don't know, but we seem to have become very quick to put a I just can't help but think that there's a large percentage of the population that are just poorly behaved.

Participant 1 adds:

People can be poorly behaved – it doesn't mean they have got a mental health condition. It certainly doesn't mean they need to be medicated. It quite often means that through probably no fault of their own they have had no sort of boundaries set to any of their behaviours... They have had no consequences for their behaviour so you know it's no different to a lot of the jobs we go to where people are teenagers in certain areas we go to who speak appalling to you. Who you get called to because they have been witnessed to do something or they may be intoxicated or under the effects of drugs or whatever, and you get there – but that's just how they talk because there is no boundary – boundaries haven't been set by anyone.

This development of 'being quick to label' individuals presenting with mental illness was further represented by Participant 1 (interview 2):

We seem to have become a bit soft in the sense that – like, even last week, we transported a young bloke last week – and when I say young man, he was in his early twenties – I don't think – he had had a bit of a blue with his girlfriend, he had said a couple of things that perhaps, you know – I didn't get

the feeling from him that he was, actually going to follow through and do anything to harm himself... I've seen a transition again, certainly with the increase in awareness and legislative responsibilities around mental health patients, we've seen that big focus from a police perspective on the decriminalisation of mental health, which I completely understand, but as a result, now I find with the interpretation mental health, we're probably called a lot more frequently than we used to be, to the point where, if anyone demonstrates any sort of behavioural abnormality.

Comparatively, Participant 2 identified the fact that mental illness goes beyond the notion of behaviour, labelling or diagnoses – instead mental health and mental illness is a holistic and nonbinding concept.

I think the amount of mental health issues in the community is vastly underreported. And I think, I definitely think that it's – the appreciation of that's getting better in the community as time goes by. But I certainly wouldn't advocate the idea that mental illness looks like anything in particular. It's just everyone.

Impacts of organisational structure

The complex organisational structures in paramedicine seemed to influence participants' perception of how mental illness should be treated. The nuances of leadership and management can impact the way paramedics work and administer care to individuals with mental illness. As Participant 3, (interview 2) stated:

I think when we as an organisation are struggling a bit at the moment is because we have a senior executive leadership team who have been very proactive in the last sort of 3-4 years in putting things into place to support our mental health thing and a lot of support stuff is done, but the problem is

that they are up here and they're quite vocal about all the good stuff they are doing, but down here where people are out on the road face to face with things they're not feeling that, and I think that's where there has been a whole lot of stress and a whole lot of issues I think we've still got a long way to go but what organisation doesn't? I think there is probably only 2-3 organisations around the world that are progressive and everyone is happy ... as an organisation we've got a lot of policies and procedures in place that are written around systems and support services and transparency but I think we've still got a long way to go into actually putting a lot of those into practice, particularly at the operational frontline and I think there's a lot of confidence that needs to be built in in our frontline managers. I think that when that happens I think it will prevent a lot of horrendous jobs.

Participant 1 emphasised this concern also:

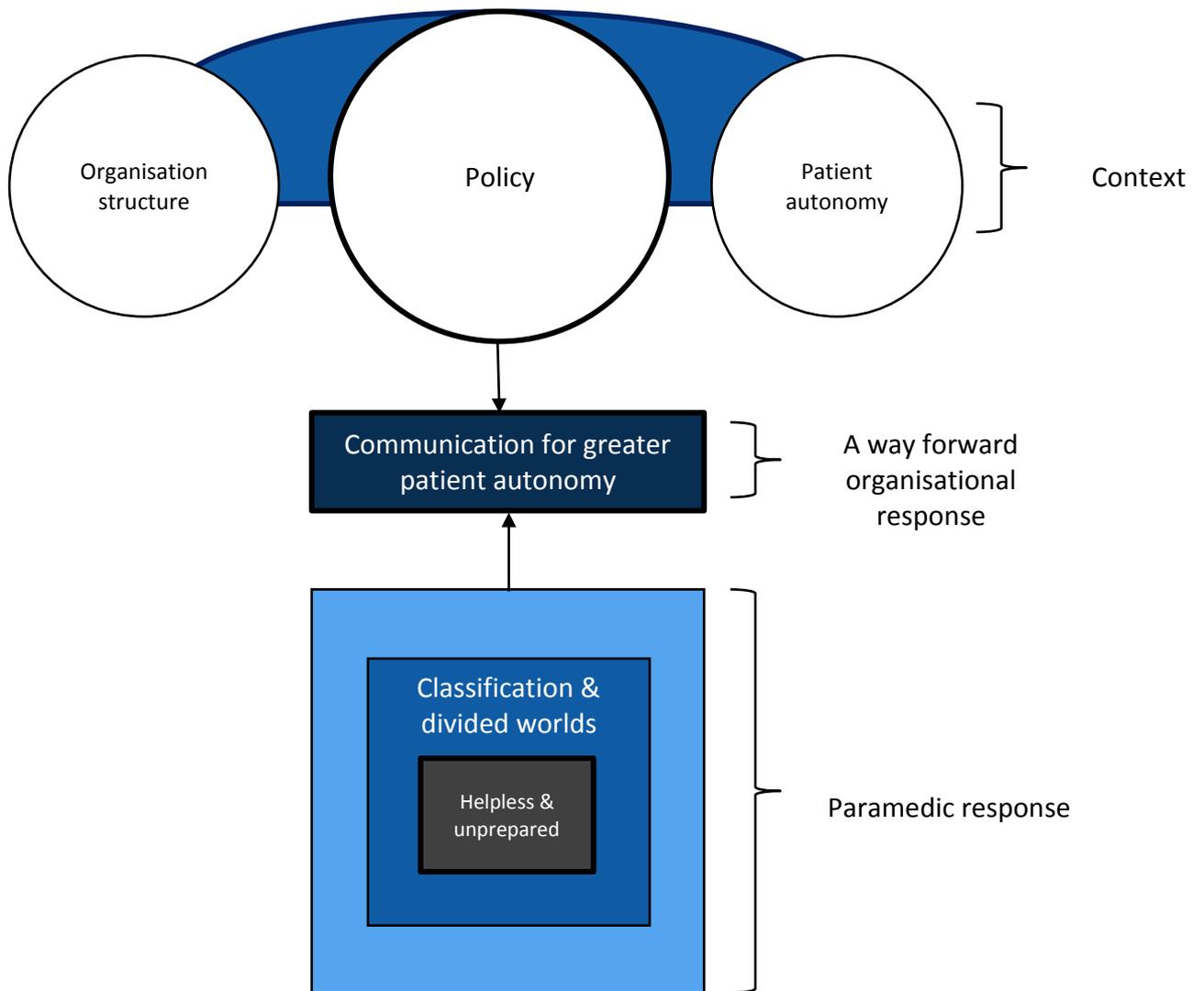
To say that there's a system in place is almost a joke sometimes ... We can put them in contact with people who have more training than we do, and try and get them into the system that we currently have, to get them the help that we can.

The general feeling of paramedics working in and providing care for individuals in a mental health system that is under-resourced.

Discussion

The participants in this research project contributed to increasing the awareness and understanding the perceptions of mental illness in paramedicine. The two-stage interview photo-elicitation process allowed for and facilitated the participants 'undoing of the self, constituting relationally in the research act as a necessary condition for the generation of new knowledge' (Somerville, 2008, pg. 216). The primary ideas that were 'generated' from were: helplessness and non-preparedness, the divided worlds of contemporary paramedic mental health policy, the importance of autonomy for patients who have symptoms of mental illness, and impacts of paramedic organisational structure. In 'untangling' and working *with* these ideas, issues around the intricacies of manifestation, presentation and forms of mental illness will be discussed, the notions of *aporia and phronesis* will be invoked, and from there the importance of communication and autonomy for individuals with mental illness in emergency care will be considered. This will help to depict and explain the fuller picture (Figure 3) of a paramedic's engagement with people who have mental illness.

Figure 3. Model representing paramedics' responses to mental illness, context and the way forward.



Aporia and Phronesis across all levels of paramedic practice

The perceptions that were conveyed by the paramedic participants included a varied dichotomy of personal dispositions within practice amidst treating patients with mental illness. These perceptions included the need for more education in the treatment of people with mental illness. One should note, of course, that educational and theoretical preparation cannot, in themselves, prepare an individual in dealing with presentations of mental illness in real time; these presentations all individualistic and unique. Further, these concepts of theory versus experience are not mutually exclusive; they are entangled within a complex and ever-evolving field of professional practice and relates very much to one's preparedness for practice and agency.

This notion of non-preparedness was reinforced by Roberts and Henderson who noted in their research that paramedics: 'currently felt their education is limited and does not prepare them, by their own standards, to adequately address this client groups needs' (Roberts and Henderson, 2009 pg. 13). Roberts and Henderson (2009) further identified that paramedics: 'viewed that they apply skills to the management of psychiatric presentations well, but not to their own satisfaction, in the absence of what they perceive as adequate training, and no doubt, additional education and training would provide a better understanding of the value of their work in attending these cases (Roberts and Henderson, 2009 pg. 13). Indeed, the notion of paramedic education, more specifically, 'theory' and practical experience was the most prominent aspect when it came feeling helpless as a paramedic when dealing with individuals with mental illness. The disconnect between training and education is outlined by Participant 1:

I feel very prepared but at the same time, not prepared at all in that the training and education I received was certainly not up to standard for the job that we actually do. So, there's a complete disconnect between the training they've provided and education.

One might also consider that helplessness as a paramedic when faced with an entire spectrum of suffering is perhaps an inevitable occurrence and it could be argued that no amount of education will completely alleviate that – there must be more. The concept of *phronesis* is pertinent here - *phronesis* is associated with: 'practical knowledge and practical ethics' or 'practical wisdom' (Flyvberg 2001, pg. 56-57), or as Dunne notes, *phronesis* is an 'action oriented form of knowledge' and 'irreducibly experimental in its nature' (Dunne 2005, pg 375-376). Linked to *phronesis* is the notion of *aporia*, which can be described as: 'unresolvable dilemmas and uncertainties—as a characteristic of the work of professional practice' (Kinsella and Pitman 2012, pg. 87). Bill Green linked *phronesis*, *praxis* and *aporia* in order to articulate the guiding principles of professional practice. *Praxis* is frequently interconnected in with *phronesis*, as 'good action' or 'investing in practice with a good moral dimension' (Green 2009, pg. 10). *Aporia*, in this formulation, refers to 'the confrontation in ones practice with unresolvable problems or paradoxes and links directly into notions of 'responsibility' and 'decisions' (Green 2009 pg.10). Green (2009) also notes that: 'all decision-making, even that which is, properly speaking mundane, or 'practical' is haunted' by *aporia*. With respect to the notion of practice itself, Polkinghorne (2004) defines practice as: 'primarily engaged action or activity' or 'activity aimed at accomplishing a variety of tasks' (Polkinghorne 2004, pg. 6) – or as Green (2009) notes: 'a common emphasis on doing-ness' (pg.7). In professional practice there are always moments of unpredictability and decision making when one must act, when the way forward is not clear, or more radically, is uncertain (Green 2009, pg. 11-12).

The notion of uncertainty in paramedic practice related to mental illness tended to resurface within the interview process as the participants were discussing their treatment strategies and perceptions of individuals with mental illness.

Highlighting these personal uncertainties, or *aporia*, was an understanding of the complexities surrounding mental illness on all levels within the paramedic structure. To illuminate this disposition further, the metaphor of Schön's swamp explains the nature of practice quite vibrantly: 'In the varied topography of professional practice, there is a high, hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solution through the application of research-based theory and technique. In the swampy lowland, messy, confusing problems defy technical solution' (Schön, 1987, pg. 3).

What does the process of *phronesis*, a possible response to *aporia*, look like in paramedic professional practice? An explanation given by a participant alluded to the discourse between *phronesis* and *aporia* from the position of personal hindrances that impact paramedics who are working on the front line in professional practice:

Some days, you really just feel like you're banging against a wall, because you want to do the best for your patient, you can see your patient is struggling or suffering, but from what you're doing at the scene to going to help, there's this like wall you're trying to punch through, and it's like there's nothing there, and it's like, what's the point, sort of thing, you want to just sit down and have a cup of tea with this person and have a chat for a couple of hours and you think you'd probably do more good than them sitting there being frustrated in a waiting room or a holding area, not receiving any help, and then not being listened to, no one being empathetic, no one considering their plight or their individual circumstance ... I wish there was like a silver lining, but there currently isn't.

In considering this, Arthur Frank (2004) notes: 'to reflect enough that maybe, eventually, a kind of practical wisdom will develop that can never be fully articulated but is felt as a guiding force' (Frank 2004, pg. 57). It is the art of communication and the acceptance of these hindrances that can evoke a power in professional practice. Joy Higgs broadens this understanding by inviting the belief that 'professional practice is characterized by the absence of certainty' (Kinsella and Pitman 2012, pg. 15). Higg's examination on the nature of *phronesis* is based upon the: 'pursuit of wise practice and the generation of practical knowledge' (Kinsella and Pitman 2012, pg. 15). Higgs extends this idea by elucidating the notion that: 'practice is the precursor of knowledge. Practitioner observation, reflection, and experience bring together actions and ideas that are enacted in wise practice' (Kinsella and Pitman 2012, pg. 15).

The identification of factors by Ford-Jones and Chaufan (2017) reverberate this uncertainty, for example the inappropriate 'use of paramedic services for mental health, deficient paramedic mental health training' (pg. 1). This notion of uncertainty ties back into the nuances within the mental illness paradigm and calls to question whether an individual should be treated or not treated by a paramedic.

This absence of certainty was conveyed through the experiences of one of the participants who stated:

To summarise it it's limited, and you feel frustrated because of the limitations that are either placed on you, resources that are not allocated to you, education and training that's not provided. You have to seek your own, like I did a mental health first aid course, and that was a whole day, and it was way better than anything we'd done, like you just, really, like, it's like the veil is lifted from your eyes and you go, oh, okay, that makes a lot of sense, I mean why haven't we covered that, like if we'd done something like that, even just at university or training ... You sort of become quite cynical, I suppose, I like to call it realistic, because you, as ambos are notorious for being problem

spotters, we see the issues, that's part of our make-up, as well, what we're trained for.... You do feel a bit, sort of like you're just treading water.

It is the act of embracing rather than avoiding *aporias* that goes against the quest for certainty in professional practice, rather than embracing 'the messiness of practice' (Kinsella and Pitman 2012, pg. 15). This 'messiness' was described by a participant who notes that there is simply nothing that can be done about the theoretical versus practical disparities in paramedicine when learning and engaging about individuals with mental illness:

I just think that there are certain aspects of the job that you can't learn in a theoretical manner. So no, I think that there are a lot of aspects of how we work with people with mental health issues as paramedics that I think it's impossible to learn in a classroom setting.

The notion of incorporating the uncertain is reiterated by Derek Sellman who identifies that: '*phronesis*, closely related to wisdom, is the virtue that enables us to judge what it is we should do in any given situation.' The individual and their competence in professional practice should stem 'emergent self-awareness or self-revelation' (Sellman 2012, pg. 17). Sellman argues that: 'an expanded understanding of competence, one that includes *phronesis*, is necessary if practice is to be more than the mere routine application of technically derived protocols or algorithmic responses to the complex issues facing practitioners in everyday work environments' (Kinsella and Pitman 2012, pg. 17). This is the position that paramedics reside in everyday, the complexities of treating individuals with mental illness is and cannot be rigid in its nature.

Kinsella and her colleagues distinguish an interesting paradox, which is that the measure of professionalism and professionalisation go hand-in-hand with procedural direction and decorum. Therefore, limitations in professional practice and its affiliates may hesitate in acting autonomously in specific situations that require application of professional discernment. Furthermore, the inherent risk of implementing '*phronesis* and holding practitioners accountable for practical wisdom

in contexts that may not support it ... is that practitioners may face a double bind, where they are blamed for a failure of agency at the personal level, when the issues may well be structural and systemic' (Kinsella and Pitman 2012, pg. 17). Most pertinently, however, a cultivation of '*phronesis*' in professional paramedic education and practice, especially regarding mental illness may encourage and promote paramedics to create a dialogue, in order to share, discuss and document the *aporia* of practice with one another and with emerging paramedics to feel safe and protected in discussing the complexities and ambiguities of practice. As Dunne notes, *phronesis* is 'the cultivated capacity to make particular judgement calls resourcefully and reliably in all the complex situations they address' (Dunne 2005, pg. 376). Perhaps, authentic and sustained change in the culture and ethos of paramedicine may induce a stance that embraces *phronesis*, and *aporia*, positively impacting the way individuals with mental illness are conceptualised and treated by paramedics.

Nuances and complexities of mental illness classification in paramedicine

An underpinning aspect of effectively treating individuals with mental illness in emergency care is the ability to discern the intricacies of manifestation, presentation and form of mental illness. Paramedic practice and the ability to communicate and deal with individuals from all forms society are imperative in enabling and retrieving efficient treatment. This widespread exposure to individuals at their most vulnerable is almost exclusive to paramedics. Instant and immediate access to people's personal homes and accessibility to public and private environments within society is a facet of paramedicine that makes it unique from any other profession.

In considering this, the dynamics of bio-psycho-social aspects of mental illness are still being understood within paramedicine. This alludes to Roberts and Henderson (2009) who note that education and increased awareness regarding specific mental

illness 'classifications' would positively impact the treating outcomes that occur in the pre-hospital environment. Schmid Jelscha (2017) studied the complexities of mental illness classification from a philosophical standpoint, identifying and exploring the 'notion' of 'disordered existentiality' (2017, pg. 485). More precisely, Jelscha described how mental illness 'is conceptualized as the disturbance of a person's existential structure, the process of which leads to a becoming explicit of the otherwise implicit dynamical structure that constitutes a person's experience' (Jelscha 2017, pg. 485). George Graham's, 'The Disordered Mind' (2010) also explores the notion that mental disorders cannot be understood purely as neurological disorders; however, others suggest that they cannot be comprehended without any reference to the neurological (Summers 2012, pg. 941). This is quite pertinent as the participants in this research had divergent ideas about 'what is mental illness?' specifically within the realm of identifying bad behavior as a mental illness. As explained here by a participant:

People can be poorly behaved – it doesn't mean they have got a mental health condition. It certainly doesn't mean they need to be medicated. It quite often means that through probably no fault of their own they have had no sort of boundaries set to any of their behaviours... They have had no consequences for their behaviour so you know it's no different to a lot of the jobs we go to where people are teenagers in certain areas we go to who speak appalling to you. Who you get called to because they have been witnessed to do something or they may be intoxicated or under the effects of drugs or whatever, and you get there – but that's just how they talk because there is no boundary – boundaries haven't been set by anyone.

This notion can be drawn back to Jelscha who described the interrelationship of mental illness and behaviour: 'to be disordered in one's existentiality thus means to be disturbed in the performance and interplay of structural elements that condition our being-in-the-world' (Jelscha 2012, pg. 486). This disturbance of an individual's existentiality indeed heightens the complexities of mental illness categorisation, as Jelscha notes: 'Suffering from mental illness then means a disruption of a person's

process of interpretation and thereby of his/her possibilities to realise herself accordingly ... A case of mental illness is not sufficiently characterized by conceiving of the sufferer as an object falling under the category 'ill' or as 'having dysfunction x', but rather as an existence with personal experiences and as the result of a process of self-interpretation' (pg. 489). Graham (2010) reiterates: 'in giving a simple answer to this quandary', he notes, 'not all somatic diseases are biologically clear and distinct, and normative judgments are pervasive even there, so there may be no clear line between mental disorders and somatic diseases' (Summers 2012, pg. 941).

Indeed, mental illness can change how an individual experiences the world around them; there can be a disruption in personal abilities and aptitudes and a nonsensical view of how existence can be made meaningful and significant. For example: 'a person experiencing a manic episode can be attributed a dysfunction in attention-sustaining or focusing-execution, however, this does not grasp how it is for this person to live in her experiential reality and this affects her interpretation' (Jelscha 2017, pg. 489). In addition, clinical disagreement in the context of whether the person is mentally ill can also ensue, yet legislatively the paramedic is obligated to take the individual to hospital. The disjuncture of language in policy documents for paramedics does not aid in the treatment strategies for individuals with mental illness; this was alluded to by Participant 3 when describing a mental health callout that was attended to.

We drove away talking about the job after and it was just really interesting because I thought I know a lot of people would have just gone – okay we don't know exactly what's happened but someone has suggested that you have made threats to harm yourself – we are now going to take you to hospital to get a mental health assessment. I think we did a mental health assessment on her and I was quite satisfied and the police were satisfied too that she wasn't a threat to herself – yet there was that element of emotional distress because of the payment issues and that's a stress in itself.

Similarly, the complexities of paramedic discretion when it comes to when dealing with a mental health callout was further identified:

We transported a young bloke last week. When I say young man, he was in his early twenties – I don't think – he had had a bit of a blue with his girlfriend, he had said a couple of things that perhaps he shouldn't of said– I didn't get the feeling from him that he was, actually going to follow through and do anything to harm himself. But he had said that that's what he would do. And the police had arrived. They had assessed him. They wanted us to come and assess him. And there kind of seems to be this – you know, what if – you know, what are the odds here?

Even speaking to him, I don't think he needed to go to hospital, I don't think he needed to go to an acute emergency department. Perhaps he just needed to talk to someone just to get some support and perhaps get some tools to help with the issue, you know, okay, look, I'm not feeling great. My girlfriend and I are having a bit of trouble. You know, she's under a bit of pressure from her family. I'm feeling that pressure. I just think there are a lot of occasions that we perhaps are over cautious, and the trouble is, I think, as I was saying before, I think when you actually do then see those people that really do need it – and I've transported patients to hospital before, who have been seen in the ED and discharged, that I've had real concerns about. And I can't help but think they're processed through the system very, very quickly.

Mental illness as described by Jelscha (2017) is, 'a disturbance of practical involvement in the world, deriving from a shift in the experiential structure and manifests in the aggravation or, in severe cases, in the malfunction of interpreting oneself in the world' (pg. 488). Consequently, this concept of 'disordered existentiality' and its connotations for an individual's interpretation of reality can be understood by the notion that living through and experiencing mental illness means to exist in a modified or altered way.

It is important to clarify that the phenomenon of mental illnesses functions to distinguish specific illness from one another for diagnostic purposes via The Diagnostic and Statistical Manual of Mental Disorders (DSM-5). These descriptions of mental illnesses within the DSM-5 are a guide to the indicators of mental illness within the subjective understanding of an individual.

However, the concept of 'disordered existentiality' interprets the structure of human experience, facilitating the 'identification of what is disordered or disturbed by mental illness' (Jelscha 2017, pg.488) and so does not fit comfortably with the DSM-5 approach. This leaves the question 'what is it that is disturbed throughout the experience of mental illness?' According to Jelscha, it is, 'the structure of human existence itself' (2017, pg. 488). That is to say that to experience mental illness is to be human – it is intrinsically attached to the human experience. This was further elucidated by one of the participants, who thoughtfully stated:

I certainly wouldn't advocate the idea that mental illness looks like anything in particular. It's just everyone.

Nonetheless, it remains ambiguous as to what extent active mental illness symptomology versus the judgment induced by the application of having a 'mental illness' label can incite or influence an individual's conduct. As Martinez et al. (2011) notes: 'a person bearing a mental illness label may also influence behavioral tendencies' (pg.4). Harris and Fiske (2006) propose that mental illness labels may influence mentally ill behavior (Martinez et al. 2011, pg. 3). However, this has no influence on paramedic perception regarding labels within the context of mental illness, as one participant noted:

I kind of can't help but think, as a society, we're very quick these days to label or – just trying to think, the best way of wording it – I think we're very, very quick to label someone's behaviour ... Now, whether that's in an attempt to excuse, or justify, or rationalise that behaviour, I don't know.

This notion also opens up avenues into the issue of over-diagnosis. Mental illness doesn't discriminate in where it can manifest. Epidemiological studies show diversified outcomes of prevalence of mental illness. Therefore, the over diagnosis in clinical practice rather than an actual increase is assumed to be the catalyst here.

Examining the supposition of over-diagnosis in mental illness reveals a diagnostic dilemma exclusive to mental illnesses and disorders and this dilemma is felt acutely in paramedic practice. According to Merten et al. 2017: 'contradictory to somatic ailments, mental illnesses cannot be, 'detected by genetic, neuronal, or physiological correlates. However, they're produced via a research-supported consensus of expert-defined groups of feelings and behaviours described in diagnostic manuals like DSM-5 or the International Classification of Diseases' (pg. 2). Furthermore, according to Dean (2017): 'given the increase in the prevalence and chronicity of depression, it isn't surprising to find that during the years 1992–2002, the suicide rate rose by 35% in adults ages 35–64, and by 60% among women ages 60–64' (pg. 6). This is exemplary of the high workload of mental health callouts that was described by a participant in this research:

Anywhere between 20% to 50% of my workload would be mental health, dependent on location or time of year.

All of the complexities surrounding mental illness in paramedic practice and the classification and/or particular expression of mental illness are an underpinning aspect in successfully treating individuals. The ability to discern the intricacies of mental illness manifestation, presentation and form is imperative in retrieving effectual paramedic management and treatment.

The pertinence of communication and autonomy for individuals with mental illness in emergency care

Paramedic emergency health care delivery is multifaceted and requires its practitioners to have extensive knowledge and expertise. With the continual advancements in knowledge with a primary focus on professional practice and treatment outcomes, the art of communication perhaps goes more unnoticed than not as an intrinsic skill in treating individuals with mental illness within paramedicine. As Frederickson (2013) notes: 'it is the ability to cultivate genuinely positive social sentiments from the inside out' (p. 96) that acts as the foundation for positive and successful encounters. The notion of a paramedic having: 'feigned concern, forced and insincere, can be as detrimental as no concern at all. Sincerity and earnestness, in the effort to create a healing encounter, are critical to the efforts' success (Raphael-Grimm 2015, pg.6).

Individuals thrive through positive relationships irrespective of how long the encounter. As Frederickson notes: 'Positive interactions are the essence of our happiness' (Fredrickson, 2013). It is this notion of connection that can decrease the feeling of isolation in the community, especially for those who are suffering with in a mental illness in their most vulnerable time of need. There is perhaps nothing more vital than for individuals to feel connected, supported and understood when they're in an exposed and vulnerable state. As Theresa Raphael-Grimm notes: 'Much of healing happens in encounters, even brief ones, where two people share a moment of authentic concern and human connection, where the patient experiences a sense that his or her suffering matters to the clinician and that the clinician is joining with the patient in attempting to alleviate that suffering' (2015, pg. 6).

When an individual who is suffering from a mental illness has an encounter with a paramedic, as Ferruci reports, they should have: 'every opportunity to experience the healing power of our full attention, to feel valued, cared for, respected, and understood' (Ferrucci, 2006). Of course, this is not always the case, even paramedics

with best intentions can overlook or undermine these opportunities. Such attitudes moreover result in an increase in the patients suffering. As Daniel Goleman highlights: 'A prerequisite to empathy is simply paying attention to the person in pain' (Goleman, 2013).

The notion of effective communication in paramedicine was also raised by Shaban (2006) who noted that there is a lack of research that explores paramedic's approach to treating individuals with mental illness. Roberts and Henderson (2009) expand on this point by identifying that the ability to learn and communicate effectively in order to establish rapport with patients was noted as 'key features to managing patients with mental illness' (Roberts and Henderson 2009, pg.10).

The benefits of efficient communication between paramedics and individuals with mental illness with regard to management and successful treatment outcomes was described by a participant who noted:

I think it's really important – I think any patient – medical, surgical, trauma, whatever – if you are in a position where you can have the conversation with the patient. I think a lot of times people come unstuck – it's like when you see paramedics go to cannulate a patient – they put a tourniquet on and chances are the patient may or may not know what's coming but then suddenly the paramedic just does their thing and whacks in a cannula and then they wonder why the patient gets upset with them or stroppy with them – when they do put the cannula in they pull away or you need to take that time to explain and I think this particular patient cohort is exactly the same – look there's absolutely undoubtedly that percentage of this patient group that you are not going to be able to have a rational conversation so you need to make that decision but I think you know communication is imperative.

Effective paramedic-patient communication in association with education and training can be a vital aspect in identifying, acknowledging and correcting misunderstandings and applying new ideas around mental illness. For the individual who's suffering from mental illness, the notion of having an open dialogue with a paramedic is in itself part of an effective treating strategy, as alluded to by one of the participants who pertinently stated:

You want to just sit down and have a cup of tea with this person and have a chat for a couple of hours and you think you'd probably do more good than them sitting there being frustrated in a waiting room or a holding area, not receiving any help, and then not being listened to, no one being empathetic, no one considering their plight or their individual circumstance.

Fittingly, the notion of open communication in paramedicine can indeed help in the creation of a safer environment for both parties. The utilization of communicative techniques and rapport development would be beneficial, as the individual who is in need will not feel isolated or defenceless, therefore the risk of violence or calamity when in an emergency care situation is diminished. This also may encourage a paramedic to raise this issue with their paramedic co-workers, which could help reduce the risk of crisis escalation in an emergency setting. This notion of paramedic safety is a pertinent contemporary issue within the Australian emergency care setting (Maguire 2018). Furthermore, Gudde et al. (2015) notes that: 'there's connection between issues like people not having their needs identified and met, inconsistency in relation to rules and staffing and controlling staff behaviour and subsequent aggressive incidents' (pg. 28). One of the participants discussed the significance of open communication and communicative techniques as method of de-escalation in the management of individuals with mental illness:

From my practice, I'm lucky to have had a considerable exposure to mental health patients in the past, and I suppose, naturally, you develop a way of de-escalating and making that connection with these patients. And so, you know, very, very rarely have I ever had to, actually schedule someone, in fact, I could probably count on one hand the number of times I've had to schedule

someone. I've only ever pulled the physical restraints out twice, and once, on one occasion, I've put them on the bed, but didn't actually need to use them. And as far as chemical sedation, you know, I could probably, again count on one hand the number of times I've had to do that. I've worked, however with a lot of people, who have probably aggravated the situation.

This perception leads into the discussion of autonomy for individuals with mental illness in a paramedicine context. According Al-Azzawi (2016): 'The national policy strategy and health service providers within Australia are now beginning to facilitate a paradigm shift towards a de-stigmatised, recovery-based model to addressing mental health issues in Australia, which emphasises the self-determination' (pg.7).

According to Grant Gillet (2012): 'Autonomy is a key concept in contemporary ethics and particularly the ethics of mental healthcare'. However, in a more general context, the question of whether individuals who possess characteristics or symptomology of mental illness and whether they should be allowed to make important decisions that affect their well-being is a complex subject.

There are many ways of interpreting this predicament, as Gillett notes: 'autonomy as an ethical value can function as the legitimization of what is effectively a search and disable policy aimed at those who are differently oriented in the human life-world' (Gillet 2012, pg. 233). In addition, 'for many, experiences of marginalization have caused a re-evaluation of the values around which their lives are organized and that distances them from an all-in conception of reason-governed action in terms of the choices regarded by most as normal rather than pathological' (Gillet 2012, pg. 233). There are two things at play here; the notion of autonomy for an individual with mental illness illuminates the intrinsic complexities of a basic human right, and evidence based practice. The collision of these two worlds yields a very complex ethical dilemma. As Bertolotti et al. (2014) identifies: 'the question of when, if ever, a person's mental state justifies not respecting their wishes concerning some aspect of their medical care is a place where the interplay between psychiatric diagnosis and rationality is brought into sharp relief. In this context, judgments concerning diagnosis and rationality have serious consequences in terms of legal recognition and

fundamental rights to liberty and bodily integrity. It is therefore an area where the issues discussed above take on particular legal and ethical significance' (pg.100). Comparatively, Jane Heal (2012) argues: 'that whilst acknowledging that discussion of the nature of autonomy might enrich our understanding of some ethical and political issues, she claims it may be methodologically inappropriate and unhelpful in thinking about how, in practice, we should relate to people with mental disorders and mental illness' (pg. 4). Derek Bolton and Natalie Banner similarly bring attention to the obstacles of autonomy for individuals with mental illness, asserting that 'a mental illness is an internal limitation to autonomy' (2012, pg. 94). However, within the context of paramedic perception, the concept of patient empowerment was discussed as a fundamental part of the management when it came to treating individuals with mental illness.

Questioner: So patient empowerment is crucial?

Participant: Absolutely, I think it plays a big part in managing these sorts of patients (presenting with mental illness) but – and also too – there is so many new types of medications – you just can't keep up with what's coming out. Communication is key.

Thus, the act and implementation of an open dialogue: 'allows all parties involved to feel empowered, informed and active in the recovery' (Al-Azzawi 2016, pg.22). The dynamics of communication and patient autonomy does not only aid in improved outcomes for individuals with mental illness who are being treated by paramedics but also has impact in regard to patient and paramedic safety. Effective and empathetic communication can indeed de-escalate pressure and tension which in essence allows both the individual and the paramedic to be more perceptive and understanding to each other's needs and requests.

Limitations

Although this research is progressive and open ended in its nature, it has a number of limitations. The sampling method of purposive sampling resulted in a relatively small number of participants (noting that the beneficial aspects of purposive sampling in qualitative research was discussed above). In relation to the practice of photo-elicitation, several ethical concerns arose. Due to the nine month duration of the project, I decided that photographing people would become problematic because additional ethics approvals were required. Photographing non-human and abstract forms did not easily allow for full creative freedom, which is an integral aspect to arts-based research and methodology. Nevertheless, this initial quandary transpired into an interesting aspect of the research, the descriptions of mental illness and the related notions that arose from the first interviews with the paramedics allowed for a more imaginative, probing and non-binary representations of the concepts discussed, creating a more thought-provoking tone for the second interview where these photographs were employed.

Future topic for research

The concepts discussed here have been loosely woven into the notion of 'professional practice.' An exploration of paramedic management of mental illness from a practice-theoretical perspective would be a valuable topic for future research.

Conclusion

This research identified the diverse paramedic perceptions of individuals with mental illness. The complex nature and manifestation of mental illness as well as the varied skillset of the contemporary paramedics allowed for an interesting and diverse examination of the pertinent families of association that related to paramedics' perceptions of mental illness and practice implications. The notion of *aporia* and *phronesis* across all levels of paramedic practice, especially regarding mental illness, highlights the relevance and need to cultivate these concepts within professional paramedic education and practice. These notions may embolden and support paramedics to create a dialogue with each other, allowing the complexities and ambiguities of practice to be acknowledged and revered. Further, the nuances and complexities of mental illness classification in paramedicine, which identified that an underpinning aspect of successfully treating individuals with mental illness in emergency care is the ability to discern the intricacies of manifestation, presentation and form of mental illness was recognised and illuminated. Finally, the pertinence of communication and autonomy for individuals with mental illness in emergency care was identified as a key factor in identifying successful treatment outcomes for individuals with mental illness. The art of communication 'allows all parties involved to feel empowered, informed and active in the recovery' (Al-Azzawi 2016, pg.22). The dynamics of communication and patient autonomy do not only support improved outcomes for individuals with mental illness who are being treated by paramedics but also has impact in regard to patient and paramedic safety. The data presented in this study allows for a greater understanding of paramedics' perception of mental illness in order to create a dialogue, inform further research initiatives, paramedic education and paramedic policy development. Additionally the incorporation of the biomedical paradigm and arts-based research has been a positive experience here.

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