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UNIVERSITY OF SOUTHAMPTON

FACULTY OF HEALTH SCIENCES

How paramedics manage and respond to patients experiencing mental health issues

by

Ursula Rolfe

Thesis for the degree of PhD

June 2018

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ABSTRACT

FACULTY OF HEALTH SCIENCES

Paramedic Practice

Thesis for the degree of Doctor of Philosophy

How paramedics manage and respond to patients experiencing mental health issues

Ursula Ilse Rolfe

Introduction

Mental ill-health is the largest single source of disability in the UK and approximately one in 4 of the UK adult population (some 7 million people) will have a significant mental health problem at any one time (McManus et al, cited in Mental Health Foundation, 2015). The ambulance service is often called upon to respond to people experiencing mental health issues. Statistical figures support the increasing demand for paramedics to manage mental health patients. Ambulance trusts dealt with an average of 16.1 emergency calls to the 999 ambulance service per minute (23 216 calls on average per day) in 2013/14 (NHS Digital, 2016). Between 2013/14, over 1.7 million adults accessed NHS services for severe or enduring mental health problems (NHS Digital, 2015). Simply put, the ambulance service is being inundated with calls and struggling to meet the demand and some of these demands concern mental health.

Aim

To observe and explain how paramedics respond to and manage patients experiencing mental health issues.

Methods

This study adopts an ethnographic approach, using qualitative methods of participant observation and semi-structured interviews. Twenty-one paramedics were observed over 240 hours during their frontline shifts on an ambulance within a single English Ambulance Trust. This was followed by 11 semi-structured interviews.

Results

Thematic analysis revealed that paramedics see mental health patients as being “like a black hole”. Paramedics say they only have “about 20 minutes of ‘there, there’” in them when managing these patients. Ironically, these quotes speak to the state of mind of paramedics and not their management of mental health patients. Paramedics managed their feelings by making use of humour, stereotyping and nostalgia. These behaviours were then analysed using Goffman’s ideas of presentation of self (1959), which uncovered that paramedics used humour to de-escalate emotional tension that arose during a mental health call and also used humour among themselves as a form of resilience. Paramedics also used stereotyping as a triage tool which served as a coping mechanism when managing mental health patients. These behaviours, which manifested through shared emotions, knowledge and tips, created a supportive mechanism in the form of a paramedic Community of Practice, where the ties of this paramedic community were strengthened.

Conclusion

This study has provided rich and detailed material to evidence how and why paramedics manage mental patients in the way they do and could therefore provide a platform for relevant future role players, such as ambulance trusts and higher education institutions, to initiate support and consider the future of paramedic practice in terms of managing mental health patients.

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Academic Thesis: Declaration Of Authorship

I, Ursula Rolfe, declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

How paramedics respond and manage patients experiencing mental health issues

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signed:

Date:

Acknowledgements

I dedicate this thesis to my beloved Omi and Opa, who I know would be so proud of this achievement. I also hope that this will show my son, Gabriel, who was only six months old when I started this journey, that anything is possible if you want to achieve it badly enough!

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Last but certainly not least – thank you to my partner Mark – for putting up with this long and sometimes difficult journey and to my mum who read this thesis from cover to cover.

Definitions and Abbreviations

Department of Health (DoH)

Ambulance crew – usually consisting of a paramedic and technician, or a double paramedic crew or a paramedic and an ECA.

Crisis Resolution and Home Treatment (CRHT)

Critical Appraisal Skills Programme (CASP)

Emergency care assistant (ECA) – these staff members are trained at a basic level to assist paramedics in their clinical work. They usually complete a 4 week course and are also blue light driver trained.

Emergency Department (ED)

Emergency Medical Service (EMS) – US term

General practitioners (GPs)

Health and Care Professions Council (HCPC)

National Health Service (NHS)

National Service Framework for Mental Health (NSF)

Paramedic – is protected in law, and can only be used by individuals who have successfully completed an approved programme of education, and are registered with the Health and Care Professions Council. (College of Paramedics Scope of Practice Policy)

Public Psychiatric Emergency Assessment Tool (PPEAT)

South West Ambulance Service Foundation Trust (SWASFT)

Technician – a title for ambulance staff who can work either autonomously, or as assistants to a higher skilled paramedic depending on the ambulance trust they work for. They would have completed a 12 week course and 3 weeks' blue light driver training.

United Kingdom (UK)

Welsh Ambulance Service Trust (WAST)

World Health Organisation (WHO)

Chapter 1 Introduction

1.1 Introduction to my research question

This chapter describes the background to my research as well as considering the complexities around defining mental health. The chapter continues with an overview of relevant policies, reports and guidance papers about mental health and then introduces the evolving role of the paramedic and how paramedic practice needs to adapt to meet patient demand. Next, organisational and educational factors are considered and how these concepts influence past and current paramedic care, situating managing mental health patients within the broader context of paramedic practice. The chapter concludes by presenting the aims and objectives of my research and the structure of the thesis.

1.2 Background

In 2008, the World Health Organisation (WHO) claimed that 450 million people were affected by mental, neurological or behavioural problems. More recently the WHO (2013) published a Mental Health Action Plan which confirmed that health systems have not yet adequately responded to the burden of mental health disorders and as a consequence, the gap between the need for treatment and service provision is a global challenge. However, defining the term “mental health” was complex and research for one particular definition lacked consensus. Often the term mental health was used as a euphemism for mental illness (Manwell et al, 2015). The WHO (2018) defined mental health as: “a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her own community.” This definition was perhaps more prescriptive than descriptive (Manwell et al, 2015) with an additional suggestion by Huber et al (cited in Manwell et al, 2015) that mental health should also encompass an individual’s ability to adapt and self-manage rather than achieving a state of complete well-being. In order to understand the core concepts of understanding and therefore defining mental health, Manwell et al (2015) undertook an international, multidisciplinary survey. Their results suggested that “any practical use of a definition of health will depend on the epistemological and moral framework through which it was developed, and that the mental and social domains may be differentially influenced than the physical

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domain.” For the purpose of this thesis, the WHO (2018) definition of mental health will be used but I will also refer to mental health “problems” and “issues” to denote illness, disability and challenges faced by people experiencing poor mental health.

Mental health problems are the largest single source of disability in the UK and make up 23% of this burden (DoH, 2011). It is estimated that about one in four of the UK adult population will have a significant mental health problem at any one time. This equates to more than seven million people (McManus et al, cited in Mental Health Foundation, 2015). One in 10 young people will experience a mental health problem (Mental Health Foundation, 2015). Nine out of 10 people with mental health problems experienced stigma and discrimination (Mental Health Foundation, 2015). Mental illness not only has a human and social cost but also an economic one, recently estimated at £70–£100 billion a year (Davis, 2013).

As frontline staff, paramedics are often the first responders to patients with mental health care needs (College of Paramedics, 2016). This includes acute emergency episodes (e.g. suicide attempts) and cases where chronic mental ill health is associated with other long-term conditions that precipitate ambulance calls (e.g. a suspected heart attack in a person who also suffers from depression). Paramedics do not diagnose mental health patients, but they respond to mental health calls as allocated by the ambulance triage system; or when a patient presents with symptoms relating to mental health, paramedics will make a note of these symptoms and use them to consider a differential diagnosis relating to a mental health disorder. Moreover, there is evidence that people with co-morbid mental health problems make greater use of health services (Laurin et al 2009; Jaing et al 2001, Himeloch et al 2004) including paramedic services. A recent study within the Welsh ambulance service (Morisson-Rees et al, 2015) revealed that mental health-related emergency calls comprised of 2 974 a month. This evidences that there has been a marked increase in patients experiencing mental health issues. In response to this, nationally, there is now a desire from policy makers and the NHS to ensure mental health has the same parity as physical health. This has been accompanied by policies, reports and guidance papers which will now be discussed in the next section.

1.2.1 UK mental health policies, reports and guidance papers

Several documents have outlined the national policy for mental health care and services. Mental Health Policy in England (2016) provided a brief summary of government policies introduced under the 2010–2015 Coalition Government, and those introduced under the 2015 Conservative Government, which outline the government's objective to give equal priority to mental and physical health. It referenced the Mental Health Crisis Concordat (2014) where national services and agencies involved in the care and support of people in crisis have agreed to improve how they work together to improve care. Of particular relevance to my study was one of the four main areas the concordat focused on – urgent and emergency access to crisis care – and the aim to ensure that a mental health crisis is treated with the same urgency as a physical health emergency. There were 27 national signatories to the concordat, which include the ambulance service.

Alongside the concordat, Closing The Gap: Priorities for Essential Change in Mental Health (2014) identified 25 areas for immediate change to improve mental health care under the following four themes: increasing access to mental health services; integrating physical and mental health care (a common theme across other policies); starting early to promote mental wellbeing and prevent mental health problems (paramedics could play an active role in flagging vulnerable patients and supporting the ones they see in practice); and lastly, improving the quality of life of people with mental health problems.

Ambulance services have responded to these policies by showing a greater awareness of the mental health issues that needed to be addressed. One example is the South West Regional Mental Health Joint Protocol (2015), which aimed to ensure that services provided to patients in a mental health crisis are managed in accordance with the Mental Health Crisis Care Concordat (2014). It also sought to ensure that patients who lacked capacity and refused advice or care, receive care that is in their best interests using the least restrictive means necessary.

Interestingly, one of the only documents about the mental health patient perspective on the care they receive from various services was a report published by the Care Quality Commission known as the Right Here, Right Now report (2015). This report was based on feedback from almost 1 800 people with experience of a mental health crisis, along with local area inspections looking at how services work together, surveys of service providers and a review of national data. The report found that the quality of care experienced by a person in crisis

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can vary greatly depending on where they are and what help they require. Many people also experienced problems getting help when they needed it, and found that healthcare professionals sometimes lacked compassion and warmth when caring for people who were having a crisis. Interestingly, general practitioners, ambulances and the police were all perceived to be more successful in providing caring and empathetic responses to people in a crisis. Most people reported that they came into contact with at least three different services when they had a mental health crisis. One in twelve (12%) said that they had come in to contact with between six and ten services and often one of these services was the ambulance trust.

The Five-Year Forward View for Mental Health: a report from the independent mental health task force to the NHS in England (2016) made a series of recommendations, which included parity between mental and physical health. Additional recommendations to be delivered by 2021 included providing mental health care to 70 000 more children and young people as well as new funding for acute hospitals to have mental health services in the Emergency Department (ED). Little reference was made to paramedics and how they could make an impact; however, the report did mention the need to support paramedic/ambulance staff in their own mental health resilience. Current policies and guidelines are ambitious, and some recognise the role of paramedics and acknowledge that they are going to be crucial to the provision of better care for mental health patients. My research seeks to contribute to the evidence about paramedic practice when managing patients experiencing mental health issues to provide support for paramedics in terms of education and creating a better understanding of the role paramedics are playing, and how this can be used to influence and direct patient care in the future. In order to do so, the development of the paramedic profession needs to be considered to contextualise the research and will be discussed in the section below.

1.2.2 The development of the paramedic profession and practice

The first UK “paramedic” started in the 1970s where voluntary ambulance staff began with extended training to take on a “paramedic”-type role. This expansion proved successful and after realising the need for more highly-trained ambulance staff, the Department of Health created a UK-wide pilot scheme in the 1980s which was adopted by all UK ambulance services (College of Paramedics, 2016). In the late 1980s there was a call for the recognition of formal payment for staff with an extended scope of practice and a move away from the volunteer role.

Although extended training was considered mainstream, ambulance trainers were concerned about the supporting knowledge base of these staff members, which prompted two higher education institutions to form partnerships with their local ambulance services to develop a degree in paramedic science in the mid-1990s. According to the College of Paramedics (2016), after the registration of paramedics with the Council of Professions Supplementary to Medicine (CPSM) in 1999, which was followed by the Health Professions Council (HPC), paramedics became the 12th group of health workers to become registered Allied Health Professionals (AHPs).

In 2000, the Joint Royal Colleges Ambulance Liaison Committee (JRCALC), in partnership with the Ambulance Service Association, created the Practitioner in Emergency Care (PEC) role, based on the recognition that the demands being placed on ambulance services had changed from a traditional view that all 999 calls represented hyper-acute emergencies to one where less serious “undifferentiated” primary care cases dominated the case mix (College of Paramedics, 2016). This expanded role included further education in patient assessment, history taking, clinical decision-making and advanced pharmacology. In 2003, the same year as the introduction of the regulatory body (then the Health Professions Council), the government published Ten Key Roles for Allied Health Professionals (AHPs) in order to formally clarify that AHPs, including “paramedics” should be the first point of contact for patient care. This meant that they would have the ability to order diagnostic tests, confirm differential diagnosis, prescribe medicines, discharge patients, make referrals to other appropriate care pathways, teach others and engage in health promotion for our client base (College of Paramedics, 2016).

Today, paramedics hold a variety of titles (see Figure 1 for the paramedic career framework) such as student paramedic, paramedic, specialist paramedic (roles in urgent and emergency, and critical care), advanced paramedic and consultant and director paramedics (College of Paramedics, 2016). More roles will emerge as paramedics become ever more present in the healthcare system, supported and enhanced with greater post-registration knowledge and skills, and enabled by academic graduate qualifications (College of Paramedics, 2016).

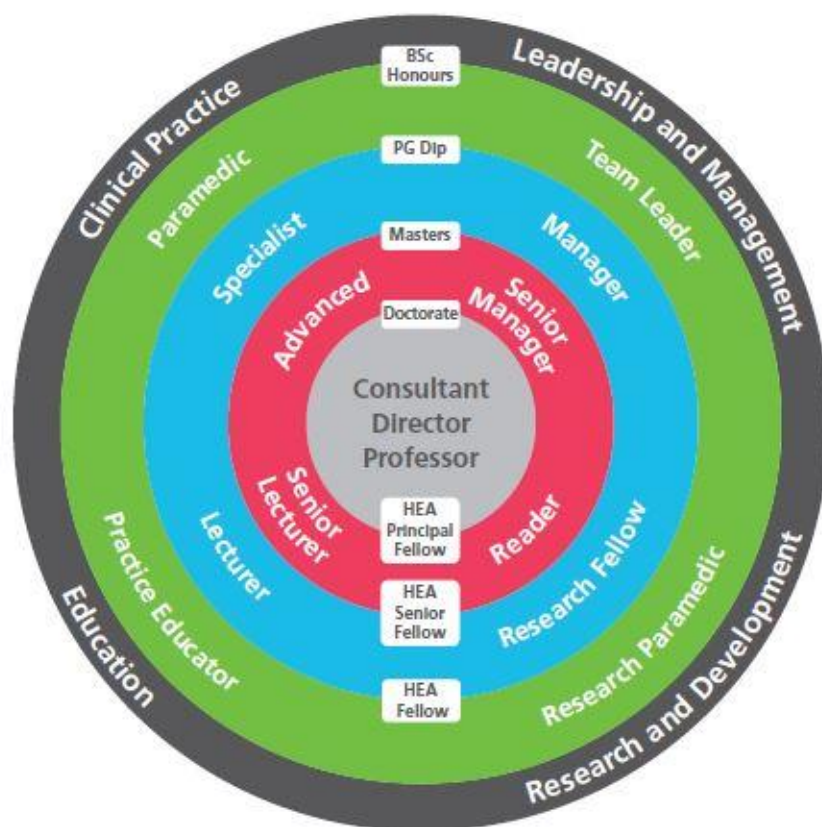


Figure 1: Paramedic career framework (Source: College of Paramedics, 2016)

In the past 40 years, the role of paramedics has gradually changed from an experimental idea to become well-established health care professionals within an evolving health care landscape. During their history, their main purpose has been to provide emergency care, as supported by the observations and interviews in this study and discussed in the previous chapters. However, their role is evolving and now includes assessment and management of patients who were traditionally treated and managed within the primary health care field, including mental health patients. The College of Paramedics (2016) added that the clinical scope of practice and operation for paramedics has changed radically and continues to evolve at a rapid pace, with greater emphasis on critical decision-making, treatment and management, with referral – if required – to an appropriate pathway of care rather than the historical focus on transportation to the Emergency Department (ED). However, when it comes to managing patients experiencing mental health issues, paramedics most often reverted to the traditional pathway of bringing patients to the ED due to the complexity and safety concerns that often accompany this patient group and this will be

evidenced and discussed in Chapters 4 and 5. This transition of roles required a shift in focus to a role that is more embedded in primary and urgent care as opposed to life-threatening and critical care – a role most of the older generation paramedics are still attached to and identify with.

The College of Paramedics (2016) reported that there was more emphasis now on critical decision-making and a greater responsibility to appropriately assess patients to enable effective, evidence-based decisions as to where patients should best be managed or referred within the healthcare system. However, mental health patients still presented a great challenge as evidenced in this study, with paramedics requesting more support and education from their Trusts. The clinical implications of these role changes are substantial; as discussed in Chapters 5 and 8; both in terms of staffing, retention, education and professional identities for paramedics, because these increasing responsibilities fall on their shoulders (College of Paramedics, 2016). Organisation and educational change also influence the care of patients experiencing mental health issues.

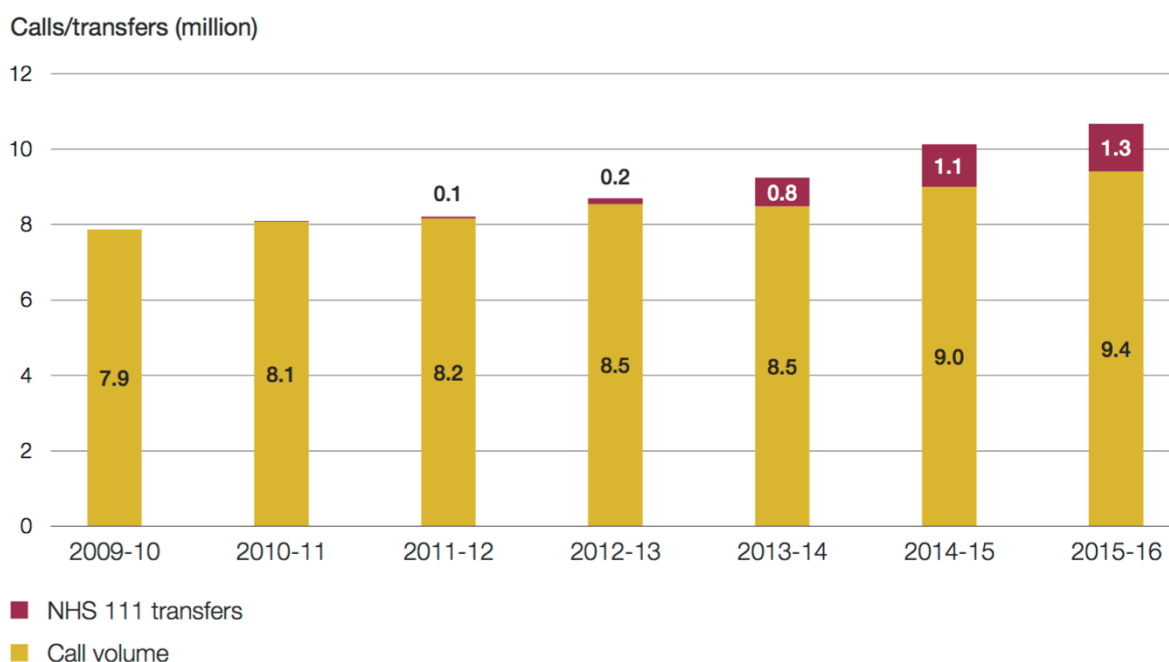
1.2.3 Organisational and educational change

In reality, this evolution in the role of the paramedic has been led by patient demand and reconfigurations within the wider National Health Service (NHS), particularly those that have affected general practice, including the amendments to the contractual obligations of general practitioners (GPs). All of these changes have taken place against a background of escalating 999 call volumes. There has been an increasing demand for ambulance services. Between 2009–10 and 2015–16 the number of ambulance calls and NHS 111 transfers increased from 7,9 million to 10,7 million – an average annual increase of 5,2% (as seen in Figure 2). Contributing factors include an ageing population and an increasing number of alcohol and mental health related issues (National Audit Office, 2017). The National Audit Office also added that ambulance trusts face resource challenges that are limiting their ability to meet the rising demand. In 2015, the paramedic vacancy rate was 10%, however, these numbers are now on the increase due to universities creating more paramedic cohorts (National Audit Office, 2017).

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Call volumes and NHS 111 transfers, 2009-10 to 2015-16

Demand for ambulance services has been growing by an average 5.2% a year since 2009-10



Notes

- 1 NHS 111 services became available nationally in February 2014.
- 2 Includes calls and NHS 111 transfers passed to the Isle of Wight NHS Trust.
- 3 Call volume data sourced from NHS Digital (2009-10 and 2010-11) and NHS England (2011-12 onwards).
- 4 In 2010-11 there were around 14,000 NHS 111 transfers.

Source: National Audit Office analysis of NHS England and NHS Digital data

Figure 2: Call volumes and NHS 111 transfers (Source: National Audit Office, 2017)

Health Education England has also set up a development programme to train more paramedics and to upskill current ambulance staff but there is no standard requirement for more mental health education. To meet the future workforce needs, the National Audit Office (2017) estimates that the NHS will need to recruit 1 800 to 1 850 paramedic trainees each year from 2016 to 2020.

The journey of paramedic “professionalisation” and the increasing power of representative organisations such as the College of Paramedics, means more inter-professional representation and profession development project work. One example of the College of Paramedics’ increasing influence is the recent development that paramedics have been granted the right to prescribe (College of Paramedics, 2018). Ironically, although this is a step forward on a professional level, the ambulance service is now under significant pressure to consider how to deliver training and education in this regard. It may also mean an increase in the NHS banding of paramedics from band 6 to band 7, which follows their nursing

counterparts. Since prescribing is regarded as an advanced skill, the Trust would need to increase the pay of paramedics who have this increased knowledge and added skill. In addition, staff retention in traditional ambulance roles are also becoming a challenge with paramedics striving for higher levels of education and then seeking more diverse and challenging work.

One of these diverse areas is primary health care, which is embracing paramedics as they are less expensive to employ than agency GPs and many have the additional autonomous experience which many primary health care nurses do not have. This is a step in another direction for paramedics in terms of moving away from emergency work as discussed in the previous chapters. However, as within the pre-hospital area, very little consideration has been given to how paramedics manage mental health patients in primary health care as well. It appears as though no matter which area paramedics are working in (frontline ambulance, critical care, primary health care or remote medicine), there remains very little research about how to support paramedics in managing patients experiencing mental health issues. As this study will show with frontline ambulance paramedics, there is a lack of support and consideration of the skills and experiences paramedics could positively use to contribute to the overall care of the mental health patients journey within the NHS is lacking. This leaves paramedics in the uncomfortable and precarious position of delivering care to a patient group they do not feel confident about, and with more and more patients experiencing mental health issues being taken to the ED, many of these mental health patients are not getting the type of care or support they need. These tensions and resulting behaviours in how paramedics manage mental health patients will be discussed in more detail in Chapters 5, 6 and 7.

From an educational perspective, the paramedic profession is now moving towards a degree BSc (Hons) profession and moving away from the original vocational training that probably more than half of its work force has as training background (HCPC, 2018). Although it can be argued that experience cannot be replaced, the profession is moving forward to support a higher degree of autonomy but little change in the working conditions. At the time of this study, 31 universities in the UK provided paramedic education. There are 13 regional ambulance trusts which include Scotland, Wales, Northern Ireland and 10 English trusts (Givati et al, 2017). What initially started as paramedics acting as volunteer responders to emergency situations has now evolved into a broader role where paramedics are managing patients as autonomous practitioners in a variety of settings. Interestingly, paramedics were traditionally trained and educated

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according to a “biomedical” approach where the focus was on considering the biological reasons behind an illness. Simply put, paramedics were taught symptom recognition which they could then relate to disease or illness and then manage and treat their patients accordingly. This also meant excluding social factors such as lifestyle, environment and economy. However, with the educational progression of paramedic education and training and the evolving needs of the patient, a bio-psycho-social model was adopted to take more relevant factors into consideration. This is where tensions rise when paramedics manage the wide variety of patients they come across because during an emergency situation where time is of the essence, a biomedical approach and managing patient symptoms until the patient is stable is often the more sensible approach. When paramedics manage patients experiencing mental health issues, greater consideration of the patient’s social and psychological factors need to be taken into account, as evidenced in Chapters 5, 6 and 7. This study observed and interviewed paramedics working for a local NHS ambulance service. However, the paramedic role continues to evolve in an attempt to meet the demands of the public (as evidenced in this study) as well as the wide variety of organisations they work for, namely ambulance and hospital trusts, GP surgeries and agencies, amongst others. Higher education institutes are now providing the educational support from level 5 to level 8 for these evolving roles either via modular courses contributing to a continued professional development portfolio or full degrees.

A profession that was heavily based on the emergency role of the paramedic, responding to life-threatening emergencies such as cardiac arrest, respiratory arrest and similar emergencies is now moving more towards a model based more strongly on urgent care, as shown in this study. Although the life-threatening emergencies still occur they are less frequent, with a higher demand for responding to more urgent care concerns such as coughs, colds, social issues and mental health problems. This study is not about whether the evolution of this role is right or wrong. Its primary remit is to consider and explain how paramedics manage mental health patients within this ever-changing environment. It will show that paramedics manage mental health patients using humour and stereotyping (in Chapters 5, 6 and 7) in order to mitigate the changes in their role that they have no control over. They use these skills as part of sharing knowledge and emotion, thereby strengthening the ties within their paramedic Community of Practice as discussed in Chapter 7. Paramedics cannot change the needs of their mental health patients and they cannot influence the organisations that require them to respond to these patients while feeling

unsupported and underqualified. This is why they need to employ supportive mechanisms as discussed in Chapters 5, 6 and 7 to ensure they can continue to adequately manage mental health patients. The next section will discuss the rationale for this study as well as the aims of objectives.

1.3 Rationale for this study

Paramedics operate within the remit of their local ambulance service trusts. The ambulance trusts respond to 999 and 111 calls. These calls are either immediately labelled as mental health, according to a triage scoring system based on the information the caller provides or paramedics get sent to a patient who then presents to them with symptoms which may be labelled as mental health problems. Some of these symptoms can include anxiety, depression, mania, etc. This study developed from my personal clinical experience of working for the South West Ambulance Service Foundation Trust (SWASFT) since 2009. In practice, I observed that paramedics responded to at least one patient with mental health symptoms, during a 12-hour shift. This figure does not include people with learning difficulties or dementia. This first-hand experience of the demand placed on paramedics inspired the proposed research which aims to contribute to the evidence base for frontline emergency care services and to the education of paramedics so that services to patients can be improved and paramedics can be supported in delivering this care.

Statistical figures support the increasing demand for paramedics to manage mental health patients. Ambulance trusts dealt with an average of 16.1 emergency calls to the 999 ambulance service per minute (23 216 on average per day) in 2013/14 (NHS Digital, 2016). Between 2013/14, over 1.7 million adults accessed NHS services for severe or enduring mental health problems, and 1.8 million people accessed specialist mental health services for adults in 2014/15 (NHS Digital, 2015). Simply put, the ambulance service is being inundated with calls and struggling to meet the demand. A recent report on the challenges ambulance services are facing (West, 2016) reiterated this increasing demand for ambulance services as well as the need to cut costs, with the result that patients were being compromised.

More specifically, two NHS Ambulance Trusts have examined the nature of the burden of mental health cases on their services. The Welsh Ambulance Service Trust (WAST) published findings about the volume of mental health emergency calls they received as mentioned in 1.2. The authors of this audit, Morisson-Rees

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et al (2015), claimed that in April 2012 WAST handled 28 328 999 calls, with 1642 (5.8%) recorded with a mental health condition code. In the random sample they found 164 (10.5%) calls related to mental health problems and estimated the volume to be 2 974 per month. Each category of mental health problem had a conveyance rate of over 80%, with the exception of anxiety (61.6%). The South West Ambulance Service Foundation Trust (SWASFT, 2015) published their audit about pre-hospital assessment and management of patients presenting in a mental health crisis and although this did not quantify the mental health calls made, it identified 243 clinical records in one year that fitted their criteria for a mental health crisis. This included overdose, hanging, self-wounding and other disorders such as anxiety and depression. Supporting this on a national level was a paramedic survey of the membership of the College of Paramedics (2014), which indicated that paramedics did not feel they had the necessary skills and knowledge to meet the needs of mental health patients, and that the services set up to help them (both patients and service providers) were not effective. Ninety-eight percent of respondents believed more education and training for paramedics in mental health conditions was necessary. They also believed that more research was needed to provide evidence of how paramedics are managing this patient group to identify the most appropriate care for patients and support paramedics in delivering this care. The survey results are summarised in Figure 3:

- 622 respondents (86%) stated they were familiar with sections 135 and 136 of the Mental Health Act 1983;
- Of the 613 respondents, 67% (414) stated they understood sections 135 and 136 of the Mental Health Act 1983;
- Of the 623 respondents, almost 98% (609) believed there should be more education and training for paramedics in mental health conditions – the highest component of which was for training on how to manage mental health patients safely (581);
- Out of the 457 respondents, there was no clear support for additional powers for paramedics through legislation with 267 (58%) in favour of being able to detain; 56% (255) in favour of being able to restrain; and 70% (322) in favour of being able to treat patients with mental health illnesses and conditions;
- While 83% (456 of the 546 respondents stated that paramedics were put at risk when dealing with mental health illnesses and conditions), there were a number of comments emphasising that the risk was no higher than the general level of risk encountered across all types of cases paramedics deal with;
- Of the 546 respondents, 94% (513) believed that the numbers of mental health cases were increasing.

Figure 3: Summary of College of Paramedic Survey (2014)

1.4 Research question and objectives

1.4.1 Aim

The aim of this research is to observe and explain how paramedics respond to and manage patients experiencing mental health issues in an NHS ambulance trust in England.

1.4.2 Objectives

1. To provide a unique and detailed description of paramedic practice through observation and interviews.
2. To use this detailed knowledge to identify challenges for paramedic practice and gaps in professional skills.
3. To understand where paramedics fit into the network of inter-professional services that provide support for mental health patients.
4. To share these findings to help identify ways to improve paramedic care and education.

1.5 Structure of this thesis

This study will begin by scrutinising the relevant literature relating to this research question in Chapter 2 and then discuss the methodology and methods used to gather data and analyse it in Chapter 3. Chapter 4 will introduce the field of study and explain initial data processing. Chapter 5 will provide a rich and detailed description of how paramedics manage patients experiencing mental health issues based on the collected observations and interviews. The data and underpinning theory have evolved in such a way that this study will then analyse and explain related findings based on individual paramedic behaviour and then move on to group or community behaviour (see Appendix A1 and A2). Chapter 6 therefore builds on Goffman's ideas around presentation of self (1959), showing how individual paramedics – at micro level – perform on different stages, using different props and costumes and how these performances influence how they manage patients experiencing mental health issues. Then Chapter 7 then moves away from the individual paramedic towards understanding how paramedics can be viewed as a Community of Practice (Lave and Wenger, 1991) at meso level, and what elements of their group behaviour can be understood using this theory. The concluding Chapter 8, situates the understanding of paramedic behaviour on a macro level while examining the development of the paramedic profession and

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practice. It explores the role of organisational and educational change looks to the future and what this study contributes to paramedic practice; concluding with a discussion around the limitations and recommendations derived from this study.

Chapter 2 Literature review

This chapter presents an overview of the evidence around the demand for mental health care services, suggesting that there has been a dramatic increase in recent years. However, due to the ethnographic methodologies used to study paramedic behaviours in this study, the broader sociological literature will be examined first. This will place this study in context in terms of the biomedical model and evidence-based medicine and it will introduce literature around the central concepts of emotion and emotional labour, which will create a platform for the key themes this study produced namely: humour, stereotyping and nostalgia. Following on from this, the breakdown of the data sources and the search strategies used for a more traditional literature review will be discussed. Then a review of the current practice of health care professionals and paramedics managing mental health patients in the UK will be analysed. Finally, alternatives to UK practices in managing mental health patients will be reviewed in terms of how this literature contributes or provides plausible alternatives to current UK practice, concluding with a chapter summary.

2.1 The broader sociological context

As briefly discussed in Chapter 1, the importance of how disease and illness are understood is closely linked with the boundaries and scope of responsibility associated with medical work (Farre and Rapley, 2017). Defining disease is based more on its physiology, for example, heart disease is based on physiological problems such as high blood pressure and occluded coronary arteries. But defining illness according to Farre and Rapley (2017) is slightly more complex and includes “the human experience of ill health” and in the case of this study, the experience of patients with mental health issues. The sociological perspective when considering health and illness can therefore not only be applied to experience and division of health and the institutions (such as the NHS) that provide care as discussed in Chapter 8; it can also help to explain the transactions and behaviours between individuals and society. These transactions are evidenced in Chapter 5 where two particularly compelling emotive categories – “they’re like a black hole” and “I’ve only got about 20 minutes of ‘there, there’ in me” are discussed. These are paramedic responses to the emotional demand they feel is placed on them when having to manage patients experiencing mental health issues. Chapter 6 explores these emotions and linked behaviours using the

ideas behind Goffman's presentation of self (Goffman, 1959). Chapter 7 then situates these behaviours within the context of a Community of Practice where shared knowledge, identity and emotion support the resilience of this paramedic group and support their sustainability. Therefore, including the sociological perspective within this study will enable me to explain and understand the interactions observed and analysed in this study and contextualise the aforementioned themes which evolved from the analysis.

Contemporary health care is dominated by evidence-based practice (Bendelow, 2010). Evidence-based medicine is based on making decisions on "the anticipation, rational calculation and attempted management of future hazards" (Bendelow, 2010). With this in mind there are also certain conceptual frameworks or ways of thinking about health care. The medical or biomedical approach has historically been the dominant model of medicine (Farre and Rapley, 2017) and therefore the approach paramedics have used to manage their patients. This conceptual framework focused on the physical or biological aspects of disease and was associated with a focus on diagnosis, cure and treatment of disease. Paramedics were, in the main, taught to recognise physical signs and symptoms and treat patients accordingly. For example, when paramedics attend to a patient who has breathlessness, they first rule out emergency-related respiratory and cardiac issues by assessing the patient's vital signs, which include pulse rate, respiratory rate, blood pressure, etc. There was and often still is very little consideration of possible non-medical reasons for the heart palpitations, for example, anxiety.

Patients requiring some form of mental health care input are not only increasing; their presentation, history and treatment can also be complex. It is this complexity that paramedics now have to manage. The biomedical framework divides the physical from the emotional and does not consider mental wellbeing. In the past, this divide between mental and physical health was reinforced by hierarchical divisions within medicine itself (Gabe and Monaghan, 2013). Conditions that were classified as a mental illness were stigmatised and marginalised. There is further literature that supports the notion of stigma and patient categorisation based on judgement by both in-hospital staff and paramedics and how this impacts patient care. Stigmatisation resulted in a more negative experience for patients. Paramedics, as well as other health care staff, often categorise patients according to their presentation. For example, a patient who has fallen will be categorised as a "fall" and a patient who has injured themselves will be categorised as "trauma". This categorisation will also be

described and examined in Chapters 4 and 5 of this study. Hughes (1980), in his earlier work, described how “typified pictures” of patients are built up during their ambulance journey to the hospital and how the description of these patients affected their care in ED. Interestingly, even in the 1980s, ambulance staff were labelling “genuine” accident and emergency cases, an area that will be discussed in later chapters. Hughes (1980) also deliberated about “other disvalued” patient categories such as “drunks” or “hypochondriacs” where the quality of patient care was affected, dependent on the handover description from the ambulance crew. The degree of uncertainty about what awaited paramedics after they received a call has not changed much, with later work building on the categorisation of patient as shown by Hillman’s (2014) ethnography, which examined the negotiation process between patients and medical staff over accessing emergency medical resources. Hillman (2014) provided an account showing how patients and their relatives helped to determine their placement into a specific category by staff. This categorisation was relevant in terms of how a triage system was used to prioritise patients according to clinical need. This had similarities to the triage system the ambulance services used to dispatch paramedics and prioritise the urgency of calls. Hillman (2014) concluded by discussing the growing emphasis on “self-responsible conduct” by patients, where they were expected to show awareness of their own management of their health and well-being (Hillman, 2014).

According to Rogers and Pilgrim (2014), physical treatments used to dominate modern mental health interventions because of the historical biological emphasis within the biomedical model. After much criticism of the biomedical model and its limitations in not addressing the psychological, behavioural or social impacts of disease and illness, another conceptual framework was suggested by Engel (cited in Farre and Rapley, 2017). The biopsychosocial model broadened the biomedical approach by considering psychological and social factors as well as biomedical factors in relation to ill health, and to look at the interactions of these factors when managing patients. Many modern illnesses, such as heart disease and cancer, have psychological (for example, self-esteem) and social (for example, poverty) components that should also be considered. Corman’s (2016) paper supports the relevance and complexity of including social factors with findings on the work on how paramedics assessed and cared for their patients on the front lines of emergency health services and how social, demographic, location, and situational factors shaped and organised their work. This paper was particularly relevant as it also acknowledged that the working landscape of

paramedics is changing. Corman (2016) added that the quality of the care paramedics provided to patients was often measured against approved protocols. He further described how paramedics tend to “trend” a patient, which allowed the paramedic to know if the interventions, or lack thereof, were beneficial or deleterious to the patient. Interestingly, Corman’s (2016) research found that trauma calls were more “black and white” because paramedics “treat what you see”; conversely “psyche” or mental health calls are more complex in nature therefore requiring a more complex response. Corman (2016) added that the social characteristics of patients mediated how paramedics interacted with them. This was another useful reference in terms of considering the needs and social characteristics of mental health patients. Corman (2016) concluded by saying that paramedics individualised their care according to their work settings and that this research begins to explain the socially-organised site in which that work occurred. Corman’s (2018) later paper examined how paramedics gave meaning to their work setting, their social conditions and the relations that “are central to their work practices”. Corman (2018) acknowledged that the work of paramedics was “understudied”, “forgotten” or “taken for granted entirely”. He felt that understanding paramedic work was important because paramedics are in a position to integrate care across otherwise fragmented care. Corman (2018) furthermore discussed how paramedics categorised their patients and appeared to be critical of the information they received from their dispatch centres. However, despite the prejudging of a call, much of the paramedic work was geared towards the “what ifs” of their work setting. Paramedics were therefore constantly preparing for all eventualities on their way to a call. Corman (2018) added that understanding this informs the work of those in managerial and administrative positions and highlighted the divide between those that work on the “frontline” – in ambulances – and those that managed staff from behind a desk. He concluded by highlighting the need for more research with regard to the hidden work of frontline workers in contemporary settings such as the ambulance service and how this work setting is influenced by the institution they work for. Interestingly, many of the patients observed within this study had psychological and social components that paramedics simply did not have the resources, time or training to manage, as evidenced in Chapters 4 and 5.

In light of the complexities discussed above in providing a more holistic approach to patient care and therefore moving away from the more traditional biomedical approach towards a more inclusive biopsychosocial approach, the psychological aspects in terms of the research question: how do paramedics manage patients

experiencing mental health issues also needs to be considered. Corman (2018) discussed the work of the paramedic above saying that paramedics prepare for eventualities on their way to a call. I believe paramedics need to not only prepare themselves physically, they also need to prepare themselves mentally and emotionally for a call. This is where the role of emotions played an important part in understanding why paramedics observed in this study used humour, stereotyping and nostalgia to manage mental health patients.

According to Bendelow (2010) emotions can be defined as “part of the consciousness that involves bodily feeling”. Therefore, emotions provide an important connection between the body, mind and society. Researching emotions in a sociological context supplies a context to behaviours and attitudes that will be considered throughout this study. The management of emotions is key when examining paramedic behaviours such as humour, stereotyping and nostalgia, as will be evidenced throughout this study. The concept of emotional labour was defined by Hochschild as “the induction or suppression of feeling in order to sustain an outward appearance that produces an emotion in others” (1983, cited in Gabe and Monaghan, 2013). This study will begin by describing two particular emotive categories: “they’re like a black hole” and “I’ve only got about 20 minutes of ‘there, there’ in me” in Chapter 5. These categories sum up a host of emotions paramedics feel when managing mental health patients.

Emotional labour is not a new concept to healthcare and has been applied to many settings, particularly nursing. There is also the sentiment that if emotional labour is a component of nursing practice then nurses should be made accountable for that care (Theodosius, 2013). Nursing care, like paramedic care has become increasingly pressured and increased workloads have led to greater emphasis on efficiency and physical clinical-based skills (Brunton cited in Gabe and Monaghan, 2013). This is when paramedics initiate behaviours such as humour, stereotyping and nostalgia, as coping mechanisms in response to the emotional demands of their work. Ideas from Goffman’s presentation of self (1959) are useful in explaining these behaviours, as discussed in more detail in Chapter 6. Furthermore, paramedics work within a Community of Practice, which also provides a support mechanism through shared knowledge, identity and emotion as explained in Chapter 7.

Returning to the biopsychosocial model, Gabe and Monaghan (2013) maintain this model did not fully address the “mind/body dualism” still compartmentalises care and management of patients. Moreover, Smith cited in Farre and Rapley

(2017) adds that the biopsychosocial model's scope was too generic, yet despite these criticisms, it is an improvement on the biomedical model and is a move in the right direction in terms of addressing more than just the physiological needs of patients. These conceptual frameworks will continue to evolve, as will the paramedic role as discussed in Chapter 8. And although paramedic education now includes more of the biopsychosocial model, there are still many paramedics, like their other healthcare colleagues, who remain "ill prepared to fully understand the connections between mental and physical health" (Gabe and Monaghan, 2013) as shown in this study. Having looked at these important distinctions between mental and physical health, the next section will show the data sources and search strategy for the literature review for how paramedics manage patients experiencing mental health issues.

2.2 Data sources and search strategy

A systematic search was undertaken as the basis for a narrative review. Although the aim was not to fulfil all the Cochrane criteria for a systematic review (Aveyard, 2010, p15) an adapted version of the Critical Appraisal Skills Programme (CASP, 2014) appraisal tool was used to critique the original research papers (see Appendix B1). A thematic approach as suggested by Thomas and Harden (2008) was used to integrate the literature.

I searched EBSCO, MEDLINE, CINAHL, Conchrane, BNI, Internurse, Science Direct, TRIP and Web of Science as well as Google Scholar from 2007 to 2018 to identify relevant published work. Key search terms included 'paramedic', 'mental health', 'mental health issues', and 'manage' (see Appendix B2). Initially this search resulted in 931 publications, but when adding the term "ambulance", the search was narrowed down to 57 (see Appendix B3). Literature was included and excluded according to its relevance to the research question and its associated objectives. Inclusion criteria consist of primary research, literature reviews, concept analyses, and any further studies relating to paramedics and mental health patients. Opinion pieces and case study reports were also considered in light of the little research available on this topic. Studies of paediatric mental health patients, those not available in English and studies about paramedics' own mental health were excluded. The time frame was limited to post- January 2000, which was the launch date of the National Service Framework for Mental Health (NSF) in 1999, which started a new era in mental health in the UK (McCulloch et al, 2003). The frame work spelled out national standards for mental health, what

they aimed to achieve, how they should be developed and delivered and how to measure performance in every part of the country.

The 57 papers identified were studied and only those relating to paramedics and how they were managing patients experiencing mental health issues were used. This dramatically narrowed down the results; leaving 19 papers for critical review. This search strategy resulted in an interesting mix of papers, many of them being international as shown in section 2.4. However, what was evident was the lack of UK evidence about how paramedics manage patients experiencing mental health issues. Another problem was the fact that many of the papers identified were opinion pieces and therefore not quality research. There were four primary research papers (Clarke et al, 2007; Roberts and Henderson, 2009; Aberton, 2011 and Prener and Lincoln, 2015). There was also one qualitative review (Rees et al, 2015) one case study review (Townsend and Luck, 2009) and three narrative reviews (Broadbent et al, 2007; Shaban, 2006 and Vibha and Saddichha, 2010) of qualitative literature.

2.3 UK research about health care professionals and paramedics managing mental health patients

The literature search showed that very little primary research has been undertaken in the UK about the role of paramedics and their management of mental health patients. However, one qualitative review by Rees et al (2015) focused on a particular area of mental health – self-harm. Rees et al (2015) used a meta-synthesis approach and included 12 papers to investigate paramedic and emergency staff perceptions about how they care for people who self-harm. This review reiterates that paramedics are often the first health professional contact following a mental health crisis and in this case, self-harm. Interestingly, none of the papers reviewed paramedic care for self-harm and Rees et al (2015) attributed this to the challenges of conducting qualitative research in the pre-hospital setting. Emergency care personnel saw themselves as preservers of life and self-harm was counter to this medical cases were seen as more legitimate and thus given a higher priority than self-harm cases. The review relied on translations and constructivist interpretations of paramedic studies from a wide range of contexts as none actually investigated paramedic care of self-harming patients. Metaphors revealed in this paper highlighted challenges in decision making and legislation and opportunities to improve care through

professionalisation and tailored education. Rees et al (2015) also commented on the difficulty paramedics had in making decisions within the current mental health legislation and compared this to the Australian paramedics mentioned in the study by Shaban (2005) discussed in section 2.4.

In 2015, an ambulance trust in the south of England released an audit on the pre-hospital assessment and management of patients presenting in a mental health crisis including deliberate self-harm (SWASFT, 2015). The audit examined how paramedics assess patients in a mental health crisis, self-harm, overdose or any other mental health condition in seven counties in the South West of England. It did not include patients presenting with physical issues caused by their mental health such as respiratory distress or chest pain due to anxiety. The audit provided data on origins of calls, in working hours/out of working hours, contact with mental health services, police attendance, suicides and conveyance. The mental health patient demographics within the audit included age, gender, and social situation/history, past medical history, alcohol abuse and illicit drug use. The audit supported the fact that paramedics were seeing an increasing amount of mental health patients, often with complex and multiple mental health issues. The most common mental health issues were depression, anxiety and self-harm. Eighty-four percent of patients were under the age of 50 with 66% reporting a previous mental health diagnosis. Thirty-six percent were under the influence of alcohol while 57% intentionally took sequential overdoses. The peak periods of being called out to this patient group were mainly out of hours (67%) but the majority of these patients also needed conveyance to the ED. However, this still means that 33% of these patients were seen in working hours (08h00–18h00, Monday to Friday) when mental health services and general practitioners (GPs) were available. Although the statistics provided by the audit were useful in terms of supporting the fact that paramedics are having to manage more patients experiencing mental health issues, the audit reiterates the need for more in-depth research into this field, again highlighting the gap this study is seeking to fill.

Following research in England, Welsh authors Morisson-Rees et al (2015) investigated the volume of mental health emergency calls in the Welsh Ambulance Service Trust and developing a pre-hospital mental health module of care. Their audit revealed that dispatch and on-scene condition codes underestimated the volume of mental health related emergency calls by nearly half. The audit concluded by calling for support for paramedics to assess and reduce transfers to emergency departments through access to pre-existing community care

provision. Although the audit provided interesting statistics, this work also suggested that more primary research needs to be done to support the development of practice and policy.

In turn, Elliott (2013) provided a reflective case study on the need for a national mental health pathway for paramedics. The role of the paramedic was not to diagnose a mental illness but to identify key indicators in mental deterioration and then signpost or activate an appropriate care pathway. A pre-alert similar to cardiac arrest would allow the mental health patient to be effectively triaged by a specially-trained mental health professional. This would increase positive working partnerships between mental health, ambulance and ED staff. Elliott (2013) concluded that there should be an investment in a national mental health clinical pathway where patients could be referred directly to Crisis Resolution and Home Treatment (CRHT) teams.

Moreover, the overview of Wright and McGlen (2012) echoed the research topic of Broadbent et al (2007) by looking at the use triage tools in mental health assessments. The aim of the piece was to help nurses understand how to use a structured assessment framework called the Public Psychiatric Emergency Assessment Tool (PPEAT). Wright and McGlen (2012) believed staff were overwhelmed in communities and hospital settings, thus their responses were often delayed. Staff needed to know how to communicate with mental health patients and be able to refer them to specialist knowledge and resources through accurate assessment. Wright and McGlen (2012) suggested that using the PPEAT can help practitioners to organise and structure the information they acquired during their patient assessment. Often information vital to a patient was not passed on when a patient was managed by many different resources such as the police, paramedics and finally the ED. Wright and McGlen (2012) claimed the use of the PPEAT could help nurses pass this vital information on to specialist mental health professionals, thus closing the gap between inter-professionals working together to treat mental health patients.

Conversely, Aberton's primary research study (2011), which included paramedics, examined the pathways of care in mental health emergency situations. The pilot study revealed the problematic nature of the work for professionals with a focus on pathways, decision making and social relationships. The study also uncovered the absence or inadequacy of existing pathways for practice. Aberton (2011) used 14 semi-structured interviews, six of whom were paramedics. The data was coded and revealed the uncertainty or non-existence of pathways and a lack of

training in mental health. Aberton (2011) concluded that caring for mental health emergency patients is an on-going process of “changing enactments which don't necessarily match fixed pathways” and used this finding as a counter argument for using triage tools.

Finally, the opinion pieces of Hawley et al (2011a, 2011b), written in two parts, claimed to offer a short guide to paramedics about the principles of initial assessment and management of mental health conditions. The first piece (Hawley et al, 2011a) asserted that the majority of mild to moderate mental disorders should be managed in primary care according to a stepped care model as recommended by NICE, (2010). The second piece (Hawley et al, 2011b) stated that there was no formula that could be universally applied to mental health patients. The authors concluded that experience and expert judgement was required to respond flexibly to features of each individual based on context, urgency, risk, time and resource. This echoed Aberton's (2011) assertion that “a mental health emergency is a fluid object”. In contrast, Elliott (2013) admitted that diagnosing mental health patients was not the priority of paramedics but that they should be able to identify signs of deterioration and activate or identify an appropriate care pathway. Elliot's (2013) suggestion that paramedics should activate an appropriate pathway fits in well with the UK Mental Health Crisis Care Concordant (Department of Health and Concordat signatories, 2014), however, not all mental health patients fit neatly into one pathway, as supported by Aberton (2011). In addition, literature about how police handle mental health patients echoes some of the findings above. Menkes and Bendelow's (2014) work examined how the police use of Section 136 in England and Wales and revealed that formal training in mental health varied greatly, as was the case with paramedics. And, in the same way as paramedics, the police recognised that mental health patients should be treated with compassion and acknowledged that they too would welcome more training in this field. Most importantly, Menkes and Bendelow's (2014) conclude their work by saying that the police were influenced by the availability of institutional and social support, and similar to paramedic sentiment discussed in later chapters, also saw themselves as the “last resort in caring for the people that nobody else wants to deal with”.

Current UK research highlights the need for more primary research about how mental health patients are managing in the community. It also acknowledges the complexity of these patients and the challenges they pose for paramedics who are often the first responders in a crisis or acute episode. Although some UK research suggests a mental health pathway or triage tools as a way forward, the

complexities of the mental health patients make their use problematic. Decision making in terms of managing mental health patients and the tensions this creates for paramedics is a theme that will be discussed in more detail in Chapters 4 and 5. The audits across large trusts support the fact that paramedics are seeing more mental health patients than before and this has an impact on their management and their evolving role. This impact and the evolution of the paramedic role is evidenced further in Chapters 6, 7 and 8. The next section will review the literature outside the UK in terms of managing mental health patients as mental health and its management is also recognised as a local concern.

2.4 Research about how paramedics manage mental health outside the UK

There is a global recognition, supported by the WHO's own constitution, which states that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2016). As an acknowledgment of the increasing concerns around mental health from an international point of view, the WHO's Comprehensive Mental Health Action Plan for 2013–2020 (2016) supports governments across the globe in preventing mental disorders, providing care and enhancing recovery. With this in mind, and with the knowledge that paramedics are educated and trained differently across the world, different geographical regions have published a variety of material about how their paramedics, or in the absence of paramedics, how their ED staff, are coping with the care and management of mentally ill patients. The North American literature provides commentary and some primary research supporting the need for more education and highlighting the disparity of current education and skills when managing mental health patients. This disparity in education is also a feature in the UK and will be discussed in further detail in Chapters 4 and 8. The most relevant empirical research on paramedics and patients with mental health issues comes from Australia and this focuses on the complex decision-making skills and judgements paramedics are faced with; mental health legislation and ethical issues; perceptions of the paramedic role and organisational culture and the use of triage tools. Elsewhere there is a more limited literature, with an audit from Germany and a narrative review from India that highlight the increase in mental health patients seen by emergency personnel. The international literature and some details about paramedic care provision in the different geographic locations, are reviewed in more detail in the section below.

2.4.1 North America

Montera's (2016) opinion piece suggested there is a role for a community paramedic in the treatment of mental health patients. The author believed that community paramedics are well-positioned to work with patients suffering from a mental illness and likened their role to "psychological first aid". Although only an opinion piece, the article recognised the struggle of mental health patients and their access to relevant services. It was also acknowledged that paramedics had very little training regarding the treatment of patients experiencing mental health issues in the US and that the curriculum of a community paramedic addressed this gap. Montera (2016) re-emphasised that mental health issues continued to rise in the US and that community paramedics could be part of the solution.

Similarly, the primary research paper of Prener and Lincoln (2015) echoed the sentiment that more training was needed within the emergency services (including paramedics) in helping to manage mental health patients and also emphasised the increasing number of mental health patients who relied on emergency services to help them. Prener and Lincoln (2015) analysed the way in which Emergency Medical Services providers interacted with people with mental illness and substance abuse problems. Unlike Montera (2016), the focus was on a small, private, urban emergency services, which are generally smaller in staff numbers and are dependent on patients being able to pay for their services. Data was collected in two phases. The first phase included observational data collected over a period of 48 hours using semi-structured observational data methods, while the second phase used 20 semi-structured interviews. All the data was collected by one author who used to work as a technician. Although a technician would have a certain level of insight into the role of emergency services after having practised at a technician level (thus not an autonomous or registered health professional), it could be argued that their level of understanding is limited by their clinical experience level. Codes were identified inductively while studying emergent themes and these themes were then explored by using computer software ATLAS.ti. The authors found that paramedics felt that their training was inadequate, supporting the points made by Montera (2016). Paramedics also felt unprepared for the "psych calls" and claimed that most of their knowledge about this patient group was learned "on the job". The paper added that there was a mismatch between job expectations and reality. Many paramedics felt they were specifically trained for "real emergencies" and yet many of the calls they attended – "every day health crises" actually included mental health and substance abuse problems. This mismatch between the reality of the job and the perceived ideal

job will also be examined further in Chapters 4 and 5. It was also not limited to geographic locations but appeared to be a growing sentiment within the paramedic profession. As previously mentioned, an additional drawback of the study by Prener and Lincoln (2015) was the small sample size within a private emergency service. There was also no consideration of the role of formal paramedic training and the informal socialisation when it comes to what paramedics often view as “psych calls”.

From the mental health patient’s perspective, the qualitative Canadian paper by Clarke et al (2007) researched how mental health patients using the emergency department (ED) reported their experiences. Although this paper focused on specialist psychiatric nurses, the results from this study can be applied to paramedics working within an emergency setting. Clarke et al (2007) examined eight focus groups (which included 27 clients, seven family members and five stakeholders) to determine their satisfaction with the care they received in regional EDs. These groups were facilitated by two of the authors. No tape recordings were used but instead notes on the sessions were used to identify the themes, which pose a question of the reliability of the study. Clarke et al (2007) claimed patients experiencing mental health issues were coming to the ED, as they had nowhere else to go. The focus of this study was on frequent users to the ED and the authors concluded that those with “nowhere else to go” ended up in the ED. A further limitation of this study was that it did not include infrequent users of mental health services or those who needed to use the ED only once; these are often the type of patients paramedics see frequently. In addition, the sample was exclusively urban with the authors adding that the data was biased towards negative experiences.

Ford-Jones and Chaufan’s (2017) commentary summarised the rising mental health call rates that paramedics are increasingly being required to respond to. They also acknowledged the disparities between paramedics when it comes to skill sets and the structure of the service they work for. But more importantly, they acknowledged the requirement for improved training and additional community mental health services to support this patient group, while highlighting that this alone was not enough and that a shift from the traditional biomedical model needed to be initiated to include a more psychosocial perspective. There was also additional reference to the role played by deinstitutionalisation with this patient group being expected to cope alone or within communities as some of the ethnographic texts support in Chapter 3.

These mental health communities lacked the staff, finance and infrastructure to truly help them.

In North America, it was recognised that paramedics in the traditional “999” ambulance role were not meeting the needs of mental health patients because of their training within the biomedical model. Clarke et al (2007) also reminded us that the ED department is not necessarily the most appropriate place for mental health patients to go to; a sentiment echoed by patients and paramedics alike in this study. Montera’s (2016) solution to the rise in patients experiencing mental health issues was to retrain paramedics in community paramedic roles and to meet the needs of mental health patients this way as suggested within a more biopsychosocial framework. Ford-Jones and Chaufan (2017) argued that it was not enough to improve the education of paramedics but that these issues needed to be addressed on a political and social level in order to prevent psychosocial crises rather than reacting to them. This reiterates the findings in the UK literature with the Mental Health Crisis Concordat (2014) initiating not only political involvement but social and interprofessional input. There continued to be acknowledgement around the training and the unpreparedness felt by paramedics when having to manage this patient group as well as the perception of their role as paramedics, something this study will examine from a UK perspective.

2.4.2 Australia

The most relevant research relating to this study is from Australia. With a continued focus on the role of paramedics, Shaban (2005 and 2006) looked at paramedics and how they used clinical judgement in dealing with mental illness. He used a discourse-historical case study as the primary methodology and applied ethnographic and discourse analytic techniques in the data analysis. The first data set included gathering and analysing “official” or “expected” accounts and standards of paramedic judgement and decision-making when dealing with mental illness problems. Data culminated in a variety of documents including legislation, letters, correspondence, guidelines, policy and pedagogical materials over a period of 15 years. After cataloguing and examining the data, Shaban (2005) initially used first-pass ethnographic analysis followed by historical-discourse perspective to describe findings as well as six semi-structured interviews. The qualitative review results of Shaban (2005) emphasised that paramedic roles were changing when it came to assessing and managing mental illness but how this happened was not known or thoroughly evidenced. Role confusion led to an explicit need for additional skills and training and a tool to

guide practice. He noted that routine mental health assessments are well-documented by psychiatrists, physicians and nurses, but not by paramedics. Paramedics said there was a gap in their knowledge and there needs to be recognition for the evolving role of a paramedic, this gap in knowledge is supported by evidence presented throughout this study. Shaban's (2006) review highlighted the absence of research into paramedic clinical judgement and decision-making around mental illness and suggested that additional exploratory research was needed. The identification of strategies from research to support a more effective, paramedic clinical judgement practice was also not attempted. Shaban (2006) called for additional training, preparation and clarification of practice and policy for dealing with different categories of the mentally ill, echoing the recommendations of the North American research and the feedback from paramedics within this study.

Reiterating the focus on the role of the paramedic, Townsend and Luck's case study review (2009) explored the increasing complexity of the paramedic role associated with changes to the mental health legislation in New South Wales, Australia. They used two legal cases to describe the changes to the New South Wales State mental health law (NSW, 2010). This new law allowed paramedics to transport patients directly to a mental health facility thereby relieving the burden on EDs. They added that there was a lack of understanding around the legal and ethical issues that surrounded decision-making skills in mental health treatment, something also touched on by Shaban (2006).

This theme around the role of the paramedic continued with the thematic analysis of Roberts and Henderson (2009) aimed at exploring perceptions of paramedics regarding their role, education and training and organisational culture and interaction with allied professionals when attending to mental illness. This paper used the South Australian Ambulance Service's clinical data to establish a quantitative measure and was followed by 159 surveys and three focus groups. The survey was analysed using descriptive statistics to compare paramedic perceptions of workload and time on scene with the quantitative data from the ambulance service's database. Thematic analysis resulted in four broad categories: the role of the paramedic; education, organisational culture and the working relationship with others. Some of these themes are applicable to this study and will be analysed further in later chapters. Roberts and Henderson (2009) believed that transportation and limited clinical intervention opportunities were the predominant features in their discussion. Their data also revealed a difficult working relationship with the mental health teams in comparison to the

police as also shown in Chapter 4. Another point of discussion was “time on scene” which often extended to beyond an hour. The authors concluded, similarly to Shaban (2005, 2006) and Townsend and Luck (2009), that more training and education was needed and that the poor perception of working relationships presented a possible barrier to creating coordinated care for mental health patients. However, the sample was limited to three months and the authors acknowledged the lack of generalisability in their findings.

Considering types of assessment and pathways of care, Broadbent et al (2007) conducted a narrative review around the use of triage tools for mental health care in the ED. They discussed the development of specialist mental health triage scales, which revealed an improvement in competence and confidence in the ED. The authors considered the lack of a national emergency triage for patients with mental illness in Australia. Broadbent et al (2007) also reviewed the importance of parity of care, something the Mental Health Crisis Concordat (2014) also emphasises. In order for patients with a mental illness to receive the same level of assessment and management as those with a physical injury or illness, it was necessary to use a triage scale that incorporated mental health descriptors this is also reviewed further in terms of the biopsychosocial model in the next section. The authors suggested that a national approach should be used for mental health triage scales and they reiterated the lack of training and ongoing education regarding mental health illnesses for emergency department staff. The review identified that using a mental health triage tool improved the competence and confidence of emergency staff in treating mental health patients. Unfortunately, paramedics were not considered in this study but it remains useful as a possibility that could be rolled out for paramedic practice.

Australia provided the most relevant research about how paramedics managed mental health patients with reference to the decision-making process and recognised that the role of the paramedic was evolving and that paramedics felt that there was a distinct gap in their training when it came to managing mental health patients. Broadbent et al (2007) felt a mental health assessment triage tool in the ED setting could aid in the care of this patient group. Most relevant was the change in the law to allow paramedics to transport mental health patients directly to mental health facilities, however, the success and effect of this change in practice remains unpublished. Australian authors did, however, add that more research in this specialist field was needed – something my study hopes to address.

2.4.3 Germany

Pajonk et al (2008) used a prospective cohort comparison audit to describe mental health emergency services in Germany. There was, however, a difference in the qualification and education of ambulance personnel in Germany compared to the UK. In Germany, ambulances are crewed by doctors and paramedics whereas in the UK, paramedics and technicians (lower clinical level, unregistered personal) crew ambulances. This distinction potentially distorted any similar findings on the provision and success of emergency medical services for mental health patients, however, this work emphasised the importance of mental health within emergency medicine. Psychiatric emergencies accounted for 10–15% of Germany's emergency calls, with psychiatry as the fourth most frequent emergency type in emergency departments (Pajonk et al, 2008). They noted that the rise in these psychiatric emergencies was not fully understood. Recommendations included training in risk assessment, treatment of suicidal behaviour and crisis intervention strategies.

2.4.4 India

A narrative review by Vibha and Saddichha (2010) also emphasised the importance of additional training for professionals within the psychiatric emergency services. The review compared the global burden of behavioural emergencies with the current situation in India, which included a focus on specialist groups: adolescents, the elderly and females as well as examining the management of and training for behavioural emergencies. The authors added that the complicated legislation in India increased the stigma of psychiatric illness and that an improved emergency service that was able to manage psychiatric emergencies would help. Further elements of stigma will also be explored in the next section. Although the review did not cite limitations, there was a lack of consistency in the population groups, with the omission of adult males, and similarly to Pajonk et al (2008), no definition of behavioural emergencies. Unsurprisingly, Vibha and Saddichha (2010) recommended that behavioural emergencies and their management could only improve if health service providers (also undefined), researchers and policy makers worked together – something the UK Mental Health Crisis Care Concordat (Department of Health and Concordat signatories, 2014) is also suggesting. Vibha and Saddichha (2010) reiterated the need for further research in this area in order to help formulate comprehensive guidelines.

2.4.5 Summary

Globally current research confirms that mental health and the demands it places on emergency services is on the rise, not only in the UK. In addition, there is acknowledgment in the commentaries and audits reviewed and through the limited primary research into the subject, that paramedics managing mental health patients is a complex issue. The empirical literature from Australia recognises that the paramedic role is evolving. Clarification around this role and the decision making processes and judgements paramedics undertake when managing mental health patients needs more support, not only via education but also from the other organisations they work with. Australian research has also evidenced the impact of changes to mental health laws and recognises the continued moral and ethical dilemmas paramedics often face when treating mental health patients. These tensions around the paramedic role are also apparent in the analysis presented within the later chapters of this study and my work echoes the findings and recommendations of Australian-led research. Although much of the American literature is commentary rather than empirically based, it offers the same findings: paramedics need more training and support and the role is evolving which creates a tension and identity crisis in many paramedics. One response to the increased demands on paramedics responding to mental health patients in North America has been the development of the role of a community paramedic. This newer role may support the needs of the mental health patient more than the traditional “emergency” role and similar roles have begun to be discussed in the UK following the Mental Health Crisis Concordat (2014). One study was identified from Germany, and another from India which did not focus on paramedics, but confirmed that the issues faced within their EDs are the same as those faced by UK EDs – more mental health patients are being admitted and more training is required in risk management by ED and pre-hospital care staff. Unfortunately, it is not clear exactly what training is needed because too little is known about how paramedics manage these cases. This study will start to provide empirical evidence of how paramedics manage patients experiencing mental health issues in the UK. It is therefore starting to fill the gaps identified in the research discussed above. It seeks to add to current research by identifying behaviours and responses paramedics use when managing mental health patients, thereby creating a platform for other ambulance trusts and organisations to understand and support paramedics and their mental health patients in the future.

Alongside this review of the clinical literature on paramedic work I also explored the sociological literature about mental health in order to understand the broader theoretical context for my study. In the following section, relevant sociological literature will be examined further and will be used to provide a broader context for this study, its themes and findings, as discussed in further chapters.

2.5 Summary

There is little literature on how paramedics manage patients experiencing mental health issues. What the review of the clinical literature has shown is that there is global awareness about the increase of mental health issues and the demand it places not only on paramedics but community mental health teams and the ED. The role of the community paramedic (Montera, 2016) has been developed in North America in an attempt to address the increasing demand for more mental health services and their literature reiterated a general lack of training in mental health and that most often, the ED is the “only place to go”. UK’s paramedic roles are evolving in a similar fashion with specialist paramedics being employed as primary health care practitioners working in the community alongside GPs. However, the education and training in mental health varied from county to county as well as higher education institutions. The lack of uniformity in education and training in the UK makes it difficult to assess where to benchmark what paramedics are being taught about mental health and what possible gaps in education could be.

States in Australia have moved beyond the role of community paramedics and legislative changes have been made to improve paramedic access to and care of this patient group (Townsend and Luck 2009). More empirical literature (Shaban 2005, 2006) also referred to the evolving role of their paramedics and how more training was needed to suit the changing needs of the population they care for. Broadbent et al (2007) also advocated for a mental health pathway to create parity of care alongside medical illnesses such as strokes and heart attacks. Interestingly, the UK’s Mental Health Act 2007 precludes paramedics from acting as advanced mental health practitioners and they are also unable to assist in sectioning a patient. The move to change this type of legislation from Australia’s perspective is something the UK should consider to spread the burden across professions.

While the audit from Germany has seen an increase in mental health patients (Pajonk et al, 2008), their emergency services have a dual doctor and paramedic

on board which increases the scope of care they can provide pre-hospitalisation, however, further education and more research about this topic was also suggested. The only services that provides paramedic and doctor roles in the UK are the air ambulance services. With the current state of decreasing GP numbers in the UK and the cost of having these professionals on ambulances or in response cars, this is not a viable option for the UK. However, a consideration around increasing the scope of paramedic practice has already been considered with paramedics recently being granted prescribing rights.

Conversely, a narrative review of India's mental health system (Vibha and Saddiccha, 2010) showed a need for new policies and legislation. Current practices and management of mental health patients has seen an increase in the stigma of psychiatric illness. The authors recommended an improved emergency service that is able to manage psychiatric emergencies. An improved emergency service in the UK in terms of triage protocols and expert mental health practitioners within the call centres could be a plausible suggestion.

This chapter has also provided additional sociological literature, which briefly discussed the complexity of health and illness and moved on the place this research in the context of conceptual frameworks when thinking about patient care. The more traditional medical or biomedical model (Farre and Rapley, 2017) was discussed in terms of its historical roots and how paramedics often adopt this approach due to their previous training and education. This approach has limitations especially in terms of managing mental health patients as their needs are not only physiological. There was also further discussion about the emergence of the biopsychosocial model (Farre and Rapley, 2017) and how this model included the consideration of psychological and social needs, not only in terms of the patient but also how paramedics manage their emotions by using humour, stereotyping and nostalgia as discussed in Chapters 4 and 5; as well as the concept of emotional labour illustrated by the emotive categories discussed in Chapter 5. These considerations support and provide a framework and context for what this study wants to achieve: examine and understand how paramedics are managing patients experiencing mental health issues, thus providing a much needed evidence base for future care of mental health patients and support for the clinicians who are managing them.

Chapter 3 Methodology and method

3.1 Introduction

Within health care research, a paradigm is defined as a system of beliefs about the nature of the world (Rubin and Rubin, 2005). There also needs to be an understanding of how a particular paradigm relates to epistemological and ontological standpoints. Broom and Willis (2007) define epistemology as the nature of knowledge or how we come to know certain things about the world. Ontology is what constitutes reality and how we can understand it (Rubin and Rubin, 2005).

My research study was located within an interpretive paradigm, which maintained that knowledge is socially constructed while reality is subjective (Rubin and Rubin, 2005). My research adopted a relativist approach which accepts the ontology that there is no single truth and that reality is created by individuals in groups – in this case, paramedics within a local National Health Service (NHS) Trust. Therefore, the epistemology (i.e. how paramedics manage mental health patients) will use methods that seek to discover underlying meanings, events and activities in order to answer the research question: How do paramedics manage and respond to patients experiencing mental health issues?

The interpretive paradigm supported ethnography as a methodology, using qualitative methods of participant observation and semi-structured interviews. Rather than trying to simply measure or categorise behaviour, this research aimed at focusing on understanding the paramedic's behaviour, their views about how they manage patients experiencing mental health issues and how they construct their reality by associating meaning with observed events and actions. As Rubin and Rubin (2005) succinctly explained: "interpretive research is about figuring out what events mean to research subjects: how people adapt and how they view what has happened to them and around them". Although interpretivism is criticised for its perceived subjectivity, the paradigm offered a deeper level of understanding owing to the level of detail and in-depth analysis offered by ethnographic methodology.

This methodology also enabled me to examine the social and culturally-embedded aspects of paramedic work and how these influenced the way paramedics manage patients experiencing mental health issues. Using participant

observation, this research observed group behaviour and individual experiences of interactions, and looked at work processes to identify patterns. It was not enough to observe; it was important to understand why actions occurred. My role within this research was as a participant observer, as a paramedic turned researcher, which offered a unique opportunity to observe and interview paramedics about how they manage mental health patients. Methodology and methods will be described in the next two sections. This will be followed by exploring the ethical issues associated with my research (including my insider role) and concludes by considering quality and rigour.

3.2 Methodology

Methodology is defined as a “theory of how inquiry should proceed, embracing philosophy, assumptions about validity and sometimes preferred methods” (Bazeley, 2013). In 3.1, the philosophical paradigm of interpretivism was briefly discussed. This research question lends itself well to qualitative research as it enables a rich understanding of experience and processes (Harper & Thompson, 2012). Parahoo (2006) believed that qualitative research design can provide an in-depth examination aimed at understanding social phenomena or behaviour (in this case, paramedics managing mental health patients). In using ethnography as a methodology, I pursued answers to questions of ‘how’ and ‘why’ as suggested by Green & Thorogood (2009). There was meaning attached to people’s experiences of situations as is the case in this research, about how paramedics manage mental health patients; and then how they understand this meaning (Pope et al, 2007).

3.2.1 Why ethnography?

The literal translation of ethnography means describing a picture about particular people (Lambert et al, 2011). There seems to be a variety of interpretations around the subject. Authors from Lipson (1991) to Agar (1996) and from Wolcott (1999) to Atkinson and Hammersley (1994) define ethnography from a philosophical paradigm to a way of collecting data.

Looking back at its historical roots, and then understanding more of its essence, ethnography has a rich history where the aim of social anthropologists was to provide a detailed account of cultures and lives in small tribes. Paramedics are a community in their own right, they have specific patterns of behaviour and language nuances that were observed within this study. This methodology also

encouraged a more holistic approach which focused on processes and relationships (between mental health patients and paramedics, relationships (at the scene of the call and more), connections (between crews in particular) and interdependency (on each other and on other services) (Denscombe, 2008).

Hammersley and Atkinson (2007) stated that ethnographic methods such as observations and interviews can be used to study social interactions, behaviours, and perceptions within groups (mental health patients), organisations (the NHS), and communities (paramedics).

Key features of ethnography include an emphasis on exploring the nature of a particular social phenomenon such as paramedics at work; a tendency to work primarily with “unstructured data”; a detailed investigation of a small number of cases and analysis of data that involves explicit interpretation of the meanings and functions of paramedic actions; the product of this analysis primarily takes the form of verbal descriptions and explanations (Hammersley and Atkinson 2007). This methodology also allowed me to immerse myself in this research setting, thereby generating a deeper and richer understanding of the actions and subtleties observed in paramedic practice.

Contributions by Hammersley and Atkinson (2007, 63–121) provided helpful guidance for my research methodology. What was particularly applicable was their reference to constructing “a working identity” (Hammersley and Atkinson, 69: 2007). Interestingly, as a paramedic doing research on paramedics, my identity was already set in a way I needed to be cognisant of, especially when behaving in a non-participant capacity. However, based on feedback from patients and public interest groups it was suggested that I should wear the recognisable green paramedic uniform and introduce myself as a paramedic researcher. Hammersley and Atkinson (2007: 158) also discussed the process of analysis adding that “analysis of data is not a distinct stage of the research”. This continual reflection on observations and field notes, even during the field work, and continually during analysis supports their supposition. Hammersley and Atkinson (2007: 209) also included new elements such as ethical regulations which will be described in more detail further on in this chapter.

Qualitative Research Methods in Mental Health and Psychotherapy (Harper and Thompson, 2012) also acknowledged “the intersubjective relationship between the researcher and the researched” (2012; 6) and the importance of “reflexivity”. Harper and Thompson (2012; 6) reminded me that reflexivity is “a slippery concept”. I became aware of the possible conflicting roles of being a researcher

and clinician or participant observer. As a researcher, I used personal reflexivity to evidence my awareness of my dual roles and how these influenced this study. To mitigate this, I also kept a journal and had regular meetings with my supervisors.

Being a paramedic and observing behaviour and in this case – paramedic practice – while having semi-structured interviews and informal discussions with paramedics, patients and other staff helped me understand the attitudes and experiences that were key to this study. Capturing their understanding ‘from the inside’ allowed for a deep understanding of paramedic practice. This immersive approach capitalised on my reflexive knowledge and experience of paramedic practice, not only drawing on my subjective knowledge of this world but also encouraged systematic collection and analysis of different types of data to challenge and extend interpretations.

Although there were a large number of journal articles published using ethnography in the medical field, there was very little ethnographic research about paramedics. In order to understand this methodology in more detail, I began to read several core ethnographic texts. To gain more insight into the application of ethnography, I concentrated on a classic medical cultural study by Becker et al (1977) *Boys in White*. This book was created in the context which took medicine as an object of study, creating a sub-field within US medical sociology called the sociology of medical education (Nunes and Barros, 2014). Becker et al (1977, 18) themselves note that the focus of the work “was on the medical school as an organisation in which the student acquired some basic perspectives on his later activity as a doctor”.

Although this book was based on the study of medical education, using ethnography, it provided a detailed description of the institution of the medical school. It could be argued that the ambulance service is also an institution in its own right with its own particular culture that influences how paramedics practice. The level of detailed observation and longevity of *Boys in White* (Becker et al, 1977) provides an excellent platform of a culture that was steeped in tradition and gender bias as well as exclusivity.

Making Doctors (Sinclair, 1997) sought to “debunk the popular myths of authority which surround the medical establishment”. He used Becker et al (1977) as a platform for his own findings acknowledging that “I shall validate the dispositions that I have derived from Becker’s perspective, first by analysing some more of his material to show their use as cognitive categories, and I hope their superiority

over Becker's perspectives" (1997, 34). Similar to *Boys in White*, *Making Doctors* made reference to the institution of medical school and its colourful history and in the same way as Becker et al (1977) this text also acknowledged a possible need for "radical revision of training" (1997, 321). These texts echoed some of the journey paramedic education has been going through. We started with a regimented, military-style training model similar to what is referred to in *Making Doctors* (Sinclair, 1977) and *Boys in White* (Becker et al, 1977). There is now a move away from this hierarchy of training towards education and changing the structure of education within the ambulance service by creating higher education degrees in collaboration with ambulance trusts to ensure a more rounded and holistic educational experience. What also added gravitas to *Making Doctors* (Sinclair, 1997) was the fact that the author was a doctor and a participant observer. This would have created a different set of research biases and preconceived notions about medical training compared to *Boys in White*. Sinclair was far closer to his subject than the authors of the aforementioned book were. These books encouraged me to understand the role around organisational culture and learning – themes which will prove relevant in this study.

I read more mental health-specific ethnographies such as *Asylums* (Goffman, 1968); *Making it Crazy*: an ethnography of psychiatric clients in an American community (Estroff, 1981); *A disability of the soul*: an ethnography of schizophrenia and mental illness in contemporary Japan (Nakamura, 2013) and Davis's (2013) *Communicating Hope*: an ethnography of a children's mental care team (Davis, 2013). *Asylums* (Goffman, 1968) was a text central to revealing the true nature behind psychiatric institutions. Mental health still has stigma attached to it and this text humanised the patients in a way that has not been done before his works were published. His revelations about how these institutions were run proved a great source of learning and understanding about how mental health patients are perceived and how this perception can also influence their care.

Making it crazy (Estroff, 1981) was an ethnography that described tensions between the requirements of the community and the rights and desires of individuals with mental health diagnoses. Interestingly Estroff (2003) wrote that on reflection and time "disparities between the vocabularies of psychiatry and mental health services with the lived worlds, desires, and sensibilities of c/s/x are more evident and more political in the present." Estroff (1995) also wrote openly and honestly about her thoughts on how ethnography and research into this field has changed over the past 20 years. She admitted that she would now take a more collaborative approach with the patients she wrote about. Estroff's

revelations from her own study reinforced my desire to ensure continued and open collaboration with the paramedics and patients within my study. She concluded by saying: “competing claims of authority and autonomy are part of nearly everything we do in the practice of mental health care. Whether you take the role of researcher or of practitioner... you will confront claims and counterclaims of varying intensity and dimension daily – if and how we respond to them and those that make them will in the end be as important an outcome of our work as any that prevails at present” (Estroff, 2003). This also reminded me to be reflexive about my role as a participant observer.

A Disability of the Soul: an ethnography of schizophrenia and mental illness in contemporary Japan (Nakamura, 2013) focused on a community living with schizophrenia that was supported and encouraged by Bethal House. Bethal House also concentrated on social integration as well as support to encourage employment and socialisation opportunities for those who lived in it. It also offered a financial boost for the surrounding community. This example of social integration and support was not often evident in the UK from the patients seen by paramedics. Nakamura was also reflexive about her own mental health and how that played a role in her life and in her research. This type of raw reflexivity encouraged me to “dig deeper” during my own reflexive practice.

Communicating Hope: an ethnography of a children’s mental health care team (Davis, 2013) was of particular interest as it focused on a provider of mental health support, which drew parallels with paramedics also being seen as providing mental health support within their remit. The author had a communications background and this was clear in the detail of analysis Davis showed in her chapters. Like Estroff (1981) and Goffman (1968), Davis’s ethnography included clinical and practice matters relevant to health care professionals working with mental health patients. There was a heartfelt yet scientifically valid account of mental health patients and their interaction with mental health practitioners.

These ethnographic texts were particularly influential in my thinking around ethnography as they provided a rich, detailed, personal and in-depth perspective around their subject matter. This made them memorable and thought-provoking in a way that was inspirational. Becker et al (1977) *Boys in White* revealed organisational and cultural influences within the medical school. This reminded me to keep reflecting on how the NHS and the Trust I did my research for could be influencing the practices I was witnessing. *Making Doctors* (Sinclair, 1997)

was written from an “insider” perspective – a doctor looking in on his tribe – and with prolific detail describing “the institution of medical school” which reminded me to consider the importance of training and education of paramedics, my experiences as a paramedic training officer and university educator and how this influences practice. *Making it Crazy* (Estroff, 1981) made me think about how I could immerse myself in the paramedic tribe from a different perspective – this time not only as one of the tribe, but also as a researcher. Her honesty about her findings and methods was inspirational. Texts by Nakamura (2013) and Davis (2013) detailed clinical practices around mental health which evoked comparisons to paramedic practices with this patient group. These texts provided the inspiration and starting block for how I wanted to present my own findings in an ethnographic way and also began my exploration around the paramedic community and its greater meaning within paramedic practice.

3.3 Method

Methods are the tools employed by a researcher to investigate a problem, these included participant observations and semi-structured interviews (Bazeley, 2013).

3.3.1 Data collection

Data collection for the first part of my study entailed participant observations of 21 paramedics, over 240 hours, during a variety of shift patterns over a period of five months in 2016. This was followed by 11 semi-structured interviews lasting approximately one hour per interview.

3.3.1.1 Ethnographic observations

Observational data following paramedics was collected over five months in 2017 (see Appendix C1 for a sample of the field notes). These shifts included observing paramedics on ambulances and single-manned rapid response vehicles. Seven paramedics were female and the remaining 14 were male, 10 were vocationally trained while 11 had graduated from university, all of them being frontline paramedics. In addition, 20 consented mental health patients and their carers/family were observed while they were being cared for by paramedics.

As well as direct observation, data included informal conversations with paramedics, mental health patients and their carers/relatives (with their consent) which naturally occur during observational fieldwork. The study covered different ambulance shifts (during weekends, on weekdays, days and nights), and response

modes (ambulance and rapid response vehicles) to capture variation and reflect the range of paramedic practice. Detailed field notes were taken during the observations and informal conversations.

3.3.1.2 Interviews

Eleven paramedics were interviewed in the year after the initial observations, using a semi-structured interview process (see Appendix C2 for a sample of the interviews). Interviews ranged from 60 to 90 minutes per participant. Out of the 11 paramedic participants, eight were male and three were female. Five were registered paramedics, three practised at specialist paramedic level, two paramedics were in educational roles and one paramedic was the mental health lead for the Trust. Six of the 11 participants were university graduates and five were vocationally qualified.

The aim of the interviews was to probe further and understand the thematic findings which emerged from the observations. Some of the participants were observed and this provided an opportunity to interview them about some of their behaviour in practice. Field notes from these observations were shared with the participants and then discussed in more detail. Other participants were interviewed to add perspective from a paramedic education and ambulance trust management point of view. The roles of education and management were codes that emerged from the observations. This prompted a more detailed discussion in terms of how paramedics were managing mental health patients and how education and management influenced this management. Each interview started with broad questions around mental health and managing this patient group. If the participants were previously observed, field notes about these observations were referred to and discussed in more detail. Behaviour such as the use of humour and stereotyping were also discussed as well as questions around the emotive categories of “I’ve only got about 20 minutes of ‘there, there’ in me” and “they’re like a black hole”. Participants were also encouraged to raise any other topics that they thought would be relevant to this research. There was a prompt sheet of questions (See Appendix D) to guide the process but these questions were not strictly adhered to because I did not want to hamper the natural flow of the conversation. Interestingly, when referring to paramedic practice the participants often referred to this as “ours” or “we” which reiterated the fact that they included me as a fellow paramedic. I was also aware of how this may have impacted on how I analysed and perceived some of the comments they made,

which is why the transcribed notes were discussed with my supervisors and I continued with my reflexive notes.

3.3.2 Implications of conducting research as a participant observer

Although this thesis has integrated reflexivity throughout its chapters, it is also important to specifically consider the implications of my role as participant observer or “insider” and how this status impacted on my findings. Goodwin et al (2003) said “in ethnography there is an understanding that the researcher is also the research instrument” and as such my role as an “insider” had methodological implications which needed to be considered. Conducting research as an “insider” was complex as I needed to consider not only my professional identity as a paramedic but also my identity as a researcher and my personal identity and how these roles would possible impact the data collection and findings of this thesis. As briefly discussed in section 3.3.1, I observed paramedics working for a local ambulance trust over five months and also interviewed paramedics a year after my field work. As a fellow paramedic, I was able to gain access to situations and conversations that a non-clinical researcher may not have been privy to, simply because the paramedics I was observing knew of my clinical background and saw me as one of their own. I was able to observe not only formal behaviours of paramedics when they were managing patients but also informal behaviours when paramedics were on breaks or shift changes. I continually practiced reflexivity as I needed to ensure I was constantly clear about my role as a researcher and not as a fellow paramedic. I also reminded paramedics of my role as a researcher regularly to ensure that there was no confusion. Peshkin (cited in Goodwin et al., 2003) referred to a researcher’s identity being both “enabling and disabling”. My identity as a researcher was enabled by my clinical background, allowing me to have access to the world of paramedics and how they managed patients experiencing mental health issues. I not only knew the system in which the paramedics worked but was also able to build a rapport with the paramedics due to a shared clinical background. After the paramedics completed their initial assessment of their mental health patients, I was then able to approach the patients, explaining my purpose and the details of the study. There were no incidents where a patient was not willing to discuss their experiences of being managed by paramedics; in fact they were eager to do so as also discussed in section 3.4.2. I had to be aware of my own clinical biases and practices, and reflected on these not only in my diary but also with my supervisors. To ensure “non-exploitative research” (Goodwin et al, 2003) I repeatedly highlighted my role

to the paramedics and patients I was observing and therefore also formally ensuring I had the participants' consent. I was fortunate that there was no incident where a mental health patient had become so unwell that I had to revert from researcher to paramedic. This possibility was discussed with the paramedic before we started the shift and it was also negotiated with the clinical lead of the Trust, working on the understanding that I would only be expected to change from researcher to clinician if there was a life-threatening situation that required extra clinical input and skill, a reasonable expectation of a healthcare professional. In addition to my roles as researcher and paramedic, I also needed to be aware of my own biases and behaviours when analysing the data. With continual reflexivity, I wanted to ensure I let the data "speak for itself" and this was helped with additional discussions with my supervisors and also sending some of the data to the paramedic participants as discussed in section 3.5.4. Although my "insider" role gave me access to this pre-hospital environment in a way that perhaps a non-clinical researcher would not have experienced, qualitative research will always have an element of subjectivity which is acknowledged throughout this study and discussed in further detail in Chapter 8. Being aware of ethical and practical implications as a participant observer was vital – having a "knowing responsibility" (Code, 1995) and this was something I reminded myself of when I was analysing the data, as discussed in more detail in Chapters 4 and 5. This "knowing responsibility" shaped the way I gathered my data, analysed it and reporting on it as evidenced in the remaining chapters of this thesis.

3.3.3 Recruitment procedures

I approached the Research and Development Department of the Ambulance Trust via telephone and follow-up e-mail. The Trust was already informally aware of this study because I was and am currently still practising as a specialist paramedic. I also work as a bank learning and development officer within the Trust. The Research and Development Department approved of the study, and senior paramedic operational managers were contacted for permission to send out and put up recruitment posters around relevant ambulance stations as well as to disseminate relevant paramedic information sheets. I then followed up interested paramedics with an e-mail and suggested a face-to-face meeting to answer any questions before joining the participant paramedics on their shift.

3.3.4 Data management

Miles and Huberman (1994, 428) suggested that data management starts with a “coherent process of data collection, storage and retrieval”. This chapter included discussions about the processing of the ethnographic field notes, observations over a five-month period, follow-up interviews and the data analysis process. These processes resulted in the findings which will be discussed in detail in the next chapter.

3.3.4.1 Processing ethnographic field notes and observations

Ethnographic research is a spiral process which involves what LeCompte and Schensul (2013, 27) define as recursive analysis – “a cyclical process of raising questions, collecting data to answer them, analysing the data, and the reformulating or generating new questions to pursue, based on previous analysis”. With my research question firmly in the back of my mind I recorded all my conversations, feelings and experiences in detail in a notebook during the 240 hours I spent observing paramedics managing patients experiencing mental health issues. Hammersley and Atkinson (1995) reiterated the importance of field notes as details are often easily forgotten. After every 12-hour shift I typed up my field notes and added additional notes as more ideas and thoughts emerged from transcribing my handwritten notes. These were then cross-checked to ensure no details had been mistakenly omitted. I also wrote a personal reflection after every shift as I felt I needed to voice my own feelings about my experiences in the field and also used it as a self-monitoring process. Sadler-Moore (2009) believed that as the fieldwork intensifies and data analysis becomes part of the transcription process, ethnographic notes evolve into analytical notes. Hammersley and Atkinson (1995) described this as reflexive ethnography.

3.3.4.2 Processing interview notes

The interviews were recorded and transcribed. The resulting transcribed notes were listened to numerous times during the stages of analysis. Where applicable, additional notes were made and then integrated into the analysis process. The aim of the interviews was to encourage an informal conversation about the research topic, leaving room for the participants to be able to talk honestly and reflectively about their practice. The participants were all keen to discuss areas related to the research question and I was grateful for their level of honesty and enthusiasm.

3.3.4.3 Analysing data

LeCompte and Schensul (2013) supported the idea of Hammersley and Atkinson (1995) that data collection and analysis can occur at the same time. Often, my transcribed notes and/or reflections raised more questions relating to the initial research question. The process of analysis will be discussed in detail in the next chapters.

3.4 Ethics

3.4.1 Ethics approval

The study proposal was peer reviewed by the Research Governance Office at the University of Southampton. A favourable ethical opinion has been obtained from London-Camberwell St Giles Research Ethics Committee (IRAS project ID number: 174606). NHS management approval has also been obtained through the SWASFT Research and Development department (see Ethics documents in Appendix E).

3.4.1.1 Informed consent

This research was overt and relatively unobtrusive and confidentiality, privacy and informed consent were paramount. Verbal consent was sought each time I entered the setting. Written consent was given when appropriate during the observation, once any medical emergencies were ruled out. Verbal consent was recorded for all the follow-up interviews. It was made clear to all the participants that they had the right to withdraw from the study at any time and that all data relating to them would be destroyed. Patients and family members were given time to consider their involvement. The participant information sheets provided advice about the capacity to consent and were informed by discussion with the paramedic team and carer/next of kin of patients as necessary.

3.4.1.2 Support for participants

The participant information sheets also gave participants advice on where to seek additional support if they needed it, for example, if a paramedic participant did not feel happy about the research process and the observation, they were given independent contact details of the local research and governance group as well as the Trust's research department.

3.4.1.3 Support for the researcher

Participant observation might have presented a small risk that my presence may impact on the care episode. I deferred to the instruction of the paramedics I was observing, for example, we agreed that I would introduce myself after they had assessed the patient and there was a tacit agreement between the paramedic and myself that the patient may fall within the mental health category. However, according to the paramedic crews I observed, my presence did not visibly impact on patient care. I adhered to my professional code of conduct as a registered health care professional (HCPC, 2016) where the safety and welfare of the patient always comes first. Issues of clinical risk or concern were discussed with the paramedic team and clinical supervisors as necessary. No serious ethical or professional incidents were witnessed during the field work. I managed strong feelings and responses to the episodes observed by diarising my feelings in a reflexive way and seeking support from my supervisors.

3.4.1.4 Anonymity and confidentiality

All data was stored and protected in accordance with the Data Protection Act and the University of Southampton Data Storage policy. Notes were handwritten and transcribed onto password and security protected files stored on university computers. Recorded interviews were saved on a password restricted folder. Patient information such as names and addresses and any other identifying information were not stored and all patients were referred to in an anonymised manner.

3.4.2 Participants and setting

There were two sets of participants: paramedics and mental health patients or their carer. Inclusion criteria for paramedics were proof of registration as a paramedic within the Trust. Paramedics received e-mails and saw posters displayed at their base stations about this research. They were then requested to e-mail me if they wanted to participate within this study.

I raised the fact that paramedics may find being observed uncomfortable although this is a common practice for training and clinical supervision. This was discussed before the start of a shift to ensure there is an agreement between the paramedic and the researcher on how to move forward. Ongoing consent was sought verbally during the shift to check that the paramedics were willing to continue to be observed.

The inclusion criteria for the mental health patient are supported by The Mental Health Act 1983 in 2007 (DoH, 2007), which defines a mental disorder as “any disorder or disability of the mind”. For the purpose of this research study I use the term “mental health issues”, to refer to a range of different acute health conditions including self-harm, attempted suicide and overdose, and chronic conditions such as schizophrenia, depression, bipolar disorder and anxiety. Dementia and severe learning disabilities are excluded as these have separate definitions, characteristics, and referral and treatment pathways.

Verbal consent for observation was sought at the scene when clinically appropriate – usually after the paramedic had completed their initial patient assessment. The patient was also informed that they could withdraw their consent at any point in which case the observations would cease immediately. Consent was followed up in writing and recorded during the follow-up interviews.

As a trained paramedic I am skilled in dealing with patients in emergency and urgent care situations. I was aware I also wanted my role as a researcher to be as unobtrusive as possible. Luckily there were no incidents where paramedic or mental health patient participants withdrew their consent. The agreement from the ambulance trust was that if there was a life-threatening priority one call that was in no way related to mental health and where it would be beneficial to the patient, I would act as an additional paramedic resource. All the paramedics who consented to this research were aware of my paramedic background. There were two incidents which had life threatening implications, once with an ailing paediatric patient in respiratory arrest and once with an adult in cardiac arrest. Neither of these patients were mental health participants. I discussed these incidents with my supervisors and also documented their impact in my reflexive diary. For the rest of my time in the field and after, I was able to observe and maintain my role as a researcher. In fact, after the paramedics had completed their initial assessment and I explained my role as a researcher and paramedic, patients consented to the study very readily and were eager to add their suggestions and comments about their care in general and how they experienced the care provided by paramedics. Patient and paramedic participants within this study were not shy to explain their experiences or perceptions of the care they received and delivered. This is discussed in greater detail in the Chapter 4. However, this “insider role” created potential for bias, and I therefore needed to critically examine my subjective views and understanding. As described above, I used continuous reflexive practices, kept a field diary and systematically documented my analysis, while monitoring and acknowledging my dual role as a

researcher and paramedic. As a practicing specialist paramedic I continued to discuss my research with other paramedics and also did follow-up interviews to add depth of understanding and analysis to my observations. I used regular supervision to check and validate my interpretations and continued to use these sessions to ensure rigour within this study.

3.5 Rigour

Rigour in research was defined as methodological soundness by Holloway and Wheeler (2002, 254). Lincoln and Guba (1985) suggested four criteria in pursuit of rigour and a trustworthy study: credibility; transferability; dependability and confirmability. Hammersley (1992) also discussed the importance of relevance. Each criteria will now be addressed individually.

3.5.1 Credibility

Shenton (2004) suggested that provisions can be made to ensure credibility. His first suggestion was adopting well-established research methods. In this study detailed and rich ethnographic participant-observer observations were used. Lincoln and Guba (1985) recommended “prolonged engagement” between the investigator and the participants. I was not only a practising paramedic, but also observed paramedics and how they managed mental health patients over 12-hour shifts during a period of five months and initiated follow-up interviews totalling more than 11 hours. Triangulation as suggested by Shenton (2004), involved the use of different methods which can include observations, focus groups and interviews. To ensure honesty in participants, all the participants approached were given the opportunity to refuse to participate. They were encouraged to be honest and my status as a researcher was emphasised. Shenton (2004) suggested opportunities for scrutiny and in the case of this study, several paramedic participants read Chapters 4, 5, 6 and 7 while Chapter 8 was also scrutinised by an educational and mental health lead paramedic and by the chairman of the paramedic professional body, the College of Paramedics. Their comments and feedback enabled me to consolidate some of my commentary. Furthermore, I had frequent debriefing sessions with my supervisors as advised by Shenton (2004). Shenton (2004) who emphasised the importance of “reflective commentary”. Meticulous diary notes and personal reflections were transcribed and read. I was constantly aware of my role not only as a researcher and also of how my paramedic qualification could influence this study. Patton cited in

Shenton (2004), believed that the credibility of the researcher is especially important in qualitative research. This research study evolved from my extensive clinical experience not only as a paramedic, but also as a university lecturer in paramedic practice and my continued involvement on a national level around paramedic education and mental health.

3.5.2 Transferability

Shenton (2004) stated that the results of a qualitative study must be understood within the context of the particular characteristics of the organisation. The organisation in question was the ambulance trust in which I have been a paramedic and training officer for nine years. This afforded me an in-depth knowledge and understanding about the trust and its priorities. Several factors can influence transferability: the number of organisations taking part; the number of participants, the number and length of data collection sessions and the time period of data collection (Shenton, 2004). This study took place in one section of a large ambulance trust, which included 32 paramedic and 26 mental health patient participants, observed over five months with 11 follow-up interviews. These small sample sizes are limitations of this study. However, the data supporting the concepts and findings of this thesis as described in Chapters 5 to 8 was also examined by paramedics working in other areas of the ambulance trust as well as by paramedics leading on the professional development of clinical practice at a national level. The descriptions and analyses within this study, resonated with those who read it, which supported the notion of transferability. Although this study took place within one trust – the paramedic participants are a subset of a larger group (the paramedic profession). However, the organisational culture of ambulance trusts remains similar as they are governed by national guidelines and processes. In addition, my own role as national mental health lead and trustee member of the national paramedic professional body, the College of Paramedics, has been instrumental in helping me to understand and question the direction of the future of the paramedic profession, its needs and areas for improvement – where mental health is an area with opportunities to develop and encourage change. My role also allowed me to sit on a variety of national, strategic paramedic education and professional development committees that discuss, among others, the management of mental health patients and how to align and improve the education and training of paramedics in mental health.

3.5.3 Dependability

Lincoln and Guba (1985) believed there are close ties between credibility and dependability. They argue that a demonstration of the former goes a long way in ensuring the latter. Shenton (2004) added that processes within the study should be reported in detail and include research design and implementation (as addressed in this chapter), operational detail of data collection (see section 3.3.1) and reflective appraisal of the project as has been discussed throughout this chapter and within the study itself.

3.5.4 Confirmability

Patton as cited in Shenton (2004) recognised the difficulty in ensuring real objectivity and that the intrusion of researcher bias was inevitable. But Miles and Huberman (1994) considered that key criteria for confirmability were the extent to which the researcher admitted their own predispositions. Every transcribed field note covering a 12-hour shift had a reflective diary entry about my own thoughts during the observations and how my beliefs and feelings may play a role in how I interpret or respond to these observations. The transcribed interview notes had additional annotations where reflexivity was required. I acknowledged that my role as a paramedic influenced how I analysed and interpreted the data, however, using ethnographic observation methods and also being a paramedic myself aided my access to the 'paramedic tribe' and deepened my understanding of the behaviour and processes that paramedics follow.

3.5.5 Relevance

Hammersley (1992, 2) asserted that relevance was not just a practical matter but more about the purpose of research. There were, however, a few aspects of relevance that Hammersley (1992, 73–76) highlighted, such as the importance of the topic and contribution to the literature. It has to be acknowledged that the topic of this study was borne out of personal clinical experience and could therefore be deemed relevant only to clinicians of a similar background. But this study has greater implications as managing mental health patients affects clinicians of all backgrounds as well as the patients themselves and their families. This study also looked at the interactions between paramedics and their patients and goes on to describe and explain the various coping mechanisms paramedics employed when managing this patient group. Therefore, making it relevant and applicable to a greater audience. Hammersley (1992, 73) added that “research

that confirms what is already known is of little value". The literature review of this study has already supported the fact that there is lack of knowledge and research about how paramedics manage patients experiencing mental health issues and therefore this research fills that gap. Lastly, this study has made a contribution to the knowledge of how paramedics manage this patient group thereby contributing to further debate and literature not only amongst clinicians but also among academics and those interested in the management of mental health patients.

3.6 Summary

This chapter has introduced the interpretive paradigm under which this study falls. It has discussed the merits and pitfalls of ethnography as a methodology as well as the justification and inspiration behind this methodology. Methods used to collect data, recruit participants and the management of this data was also considered in detail as well as the implications of conducting research as a participant observer. Lastly, ethics and rigour and how these were acquired and processed conclude this chapter.

Chapter 4 Introducing the field of study

4.1 Introduction

This chapter will discuss the initial process of analysis which led to my findings in Chapter 5. Spradley (1980) named three phases of data collection (descriptive, focused and selective) and they resonated well with my experience as a participant observer during my five months in the field (see Appendix F for the initial analysis process in more detail). However, these phases did not occur in succession but often simultaneously or interchangeably. Keeping in mind the LeCompte and Schensul (2013) reference to recursive analysis, I used these three phases to help me order my analysis. I began by outlining the descriptive analysis used to understand the complexity of paramedics working in the pre-hospital environment, and to help me develop more concrete questions relating to the research question. I then focused on processes and problems paramedics face while managing patients experiencing mental health issues. This chapter ends with the selective phase of the analysis, which explores in more detail how paramedics are managing this patient group.

4.2 My data

Ethnographic observation data was collected over five months with over 240 hours in the field. I went on 20 12-hour shifts and observed 21 paramedics (one double paramedic crew) on frontline ambulances and rapid response cars from January 2016 to the end of May 2016. Of the 21 paramedic participants, 14 were male and seven were female. In addition, 11 paramedics participated in 60–90 minute follow-up interviews a year later.

4.2.1 Descriptive phase of analysis

Spradley (1980) suggested that the descriptive phase was a general and open-minded approach asking broad questions. For me, there were two clear groupings I needed to examine at the outset – the characteristics of paramedic participants and patient participants.

4.2.1.1 Paramedic participants

The paramedics observed and interviewed had received training via two different pathways, either vocational training that started as an emergency care assistant,

progressed to technician and then paramedic. This type of training required working full time for the Ambulance Trust and completing short courses, usually over four years studying on a part-time basis. University education is more popular now, either foundation degrees, diplomas in higher education or BSc (Hons) degrees in paramedic science. These degrees are full time and require 750 hours' practical experience working under a mentor on a frontline ambulance. The educational classifications are shown in Table 1.

Table 1: Education levels of paramedics observed and interviewed

Gender	Vocational training	University education
Female = 10	1	9
Male = 22	14	8
Total = 32	15	17

4.2.1.2 Patient participants

During the 240 hours of observation, 26 patients experiencing mental health issues were seen and treated by paramedics. Twenty of these patients provided full consent and six did not have capacity to consent and had no advocate to consent for them or they did not want to take part in this study. Two patients under the age of 21 (both male), eight female patients and 10 male patients consented to this study.

The following characteristics of mental health participants were observed during fieldwork: time of mental health call, gender distribution, past medical history of mental health patient, previous formal mental health diagnosis and influence of alcohol.

During five months of fieldwork, the highest percentage of calls (25%) to mental health patients was between noon and 13h00 and another 25% were between 16h00 to 17h00. Interestingly, the only 'after hours' (defined in the ambulance service as between 18h00 and 08h00) call-outs were at 20h09 and 24h10. Types of mental health issues between noon and 13h00 included four males with issues including depression and anxiety, bipolar disorder and a history of self-harm and

attempted overdose, and one female with anxiety (undiagnosed but suspected as such by the crew and researcher). The mental health issues of the patients who called 999 between 16h00 to 17h00 did not vary greatly and included three males with depression and anxiety respectively, and one deemed to have no mental capacity according to his GP. The other two female patients had a history of anxiety and bipolar disorder. The two calls after hours were to a male with depression and a sleep disorder and to an intoxicated female who was suffering from bipolar disorder. Three of these patients also had a history of alcohol abuse and were intoxicated during the call. It should be noted that when a patient with mental health issues is intoxicated or there is a suspected drug overdose, the crisis team refer them to the ED as they cannot rule out organic causes and will not treat patients who potentially were under the influence of drugs or alcohol.

Looking at the gender distribution during the peak call times between noon and 13h00, four males and one female, called 999. Between 16h00 to 17h00, three males and two females called 999 and after hours, one male and one female made a call. Comparatively, the Mental Health Foundation (2016) provided statistics, which claimed that in England, women were more likely than men to have a common mental health problem and were almost twice as likely to be diagnosed with anxiety disorders. They added that in 2013, 6 233 suicides were recorded in the UK for people aged 15 and older. Of these, 78% were male and 22% were female (Mental Health Foundation, 2016).

Out of the 26 patients experiencing mental health issues observed in this study, the most prevalent medical condition in this study's patient group was drug overdose followed by stroke, diabetes and cardiac health issues. Drugs included use of heroin (n=2), cannabis (n=2) and alcohol abuse (n=3). Cardiac health issues included myocardial infarctions and chest pain and other included urinary tract infections (n=3), chronic pain (n=1) and malnourishment (n=2). I was unable to find a recognisable medical history pattern of statistical value within this patient group due to the small size of the sample and because the study's focus was more on the mental health condition rather than the patient's past medical history.

Nine of the 26 patients in this study had a formal mental health diagnosis in their case files or this was revealed by the patients themselves. Some of the formal mental health diagnoses included: depression and anxiety (and separately depression without anxiety and anxiety without depression), bipolar disorder,

schizophrenia, sleep disorder and a term called 'nervous breakdown' according to patient case notes or records. The most common formal mental health diagnoses were anxiety and depression. Many patients had a combination of the above diagnoses such as bipolar disorder and depression, anxiety or depression, and anxiety and sleep disorder. Finally, there were three mental health cases related to alcohol misuse in this study.

4.2.2 The focused phase of analysis

This phase was described by Spradley (1980, 34) as narrowing your perspective on processes and problems which are essential to your research question. Three things stood out in the data and they seemed to be important in how paramedics approached, managed and responded to mental health patients. The first was information before the 999 call. Before responding to any call, paramedics received information via a computer system called a mobile data head. This information was supplied to the paramedic crew via the ambulance control centre. I wanted to analyse whether the information received on the mobile data head had any impact on how paramedics manage patients experiencing mental health issues. Second was the use of supportive services, which included police, GPs, mental health crisis teams or community mental health teams. Paramedics often needed to consider how and when to refer a patient or consult about alternative management plans for the patient. From the discussions held in the crew room (noted within my field notes), paramedics often needed to use additional support services. Lastly, relationships between patients and their carers (often, family members) provided interesting information about the support mental health patients felt that had, or conversely did not have and how this influenced their need to call 999.

4.2.2.1 Information before the call

Paramedics received information from the control room about the patient they were responding to. Unfortunately, this information was not always accurate or reliable as seen from the excerpt below:

16h07: we were called to a 79-year-old female but were stood down within minutes of responding. 16h15: we were redirected to a 37-year-old female from 111. "If it's the shithole I am thinking of it's not going to be a normal job Ursh," said paramedic R as we sped to the job at high speed. 16h24: we arrived on scene and a man opened the door and led us inside a dark and cold small apartment. Paramedic R asked where the

patient was and the man turned around surprised, saying: “it’s me, I called...” “Oh ok, sorry, we were told it was to a woman,” said Paramedic R” – *field notes, Paramedic R*

Paramedics are trained to assess and treat a patient correctly and are aware of the fact that patients often omitted pertinent medical history or lied about their condition. Sometimes patients were embarrassed to share certain medical concerns or there was someone else present at the scene and they did not feel comfortable to share their medical history. Other times it was simply because they wanted to hide the truth.

Paramedics worked with what they saw in how the patient was physically presenting to them and then matched these physical observations to the information they received from patients. Sometimes there was a disparity between the two; other times both aligned. This was influenced by information on the mobile data head. At other times, the information was more clinically accurate, for example:

“17-year-old overdose” and “50-year-old overdose ... patient taken 40 tablets and is on floor” – *field notes 8 and 20*

Out of the 20 shifts observed and the 26 mental health calls described and attended to, five calls had accurate mental health information provided to the crew. The remaining 15 calls included more information about physical concerns such as a fall, shortness of breath, nausea and chest pain. Interestingly, once paramedics completed their initial physical assessment to rule out life-threatening concerns, many patients presented with physical symptoms such as breathlessness, tachypnoea and chest pain, but the causes were due to their anxiety and depression. Initially three patient participants agreed to follow-up interviews but when contacted later for these interviews, they declined.

4.2.2.2 Use of support services

Historically there has been a supportive relationship between the police and the ambulance service. See Appendix G on the protocol ambulance staff need to follow to request police back up. In the three cases observed where paramedics asked for police support, none was received. The reasons for this were unknown to the crew and to me. Interestingly, the paramedics showed no great concern about this:

“I then called the police but they refused to help because he was in his own house. Then I called the on-call clinical supervisor and told him about my patient. He said straight away the patient needed to be sectioned and he called the GP.” – *field note 1*

GPs were also under enormous pressure and time constraints. However, like all NHS staff there was an expectation to work and liaise with other support agencies; and paramedics were one of these agencies. Out of the six cases I observed where paramedics requested to consult with the patient’s GP or required their presence, there was only one case where the GP was uncooperative and refused to re-attend the scene. The reason for her refusal was because she had already been at the scene at 11h00 with a psychiatric nurse and the ambulance had only arrived at 17h00. The reason for the delay in our dispatch to the patient was unknown. The remaining five calls showed a positive and cooperative working relationship between the GPs and the paramedics.

A crisis resolution and home treatment (CRHT) team was a team of mental health professionals who supported patients at home during a mental health crisis. It included a number of mental health professionals, such as a psychiatrist, mental health nurses, social workers and support workers. Many CRHT teams were referred to as the crisis teams by paramedics. The feedback from paramedics about the crisis team varied as evident in the following excerpts:

“My first call was to the mental health crisis team, they refused to come out. They always do. They said I needed to transport him to hospital to rule out organic causes before they could get involved.” – *field note 1*

“What did crisis say?” asked the nurse clearly annoyed. “What they always say ...call an ambulance. They don’t care,” answered the paramedic. – *field note 20*

“It was one of those calls where everything went wrong no matter what we tried, but the good news is that the crisis team have been reported by the local hospital so maybe if they report it things will change?” – *field note 9*

However, patients were more positive about the crisis team as seen in the excerpts below:

“The crisis team said I could stay in a day hospital,” said the patient. “A&E can sort out a hospital stay after they sort out your tablet issue,” said the paramedic. – *field note 20*

“He [the patient] said that he was diagnosed with depression, which was really bad and had started feeling suicidal which is also why he was now under the crisis team for treatment. The crisis team suggested he increase his medications to triple the dosage.” – *field note 5*

This was another case of paramedics using other services to support their patient and where these services were not responding. There was no opportunity to observe the interaction between the two services during this study as the crisis team was not present at any of the 26 mental health calls observed.

4.2.2.3 Relationships between patients and their carers

As a paramedic, I found the relationships between people who were on the scene very telling, not only with regard to the call but also with regard to the patient. As a researcher, I wanted to see if I could find any links between the relationships patients have with their carers while paramedics are attending. Three typologies stood out for me: fraught relationships, relationships based on dependency and friendships. The most frequently observed were relationships based on dependency. Relationships based on dependency took many forms in the cases observed during this study. Some started with the role reversal of children looking after their parents as seen in the excerpt below:

“My daughter has seen me try to throw myself in front of a train. She saw me overdose. I was 21 when they diagnosed with me bipolar type 1 and depression.” I was watching the daughter while her mother recounted her medical history. She seemed concerned for her mother but not affected emotionally by what her mother was telling us. We guessed she had been privy to this type of situation many times before. In fact, she replied at one point with a humorous ‘Well mum, we didn’t like that window much anyway did we?!’ The patient continued with her history: ‘She [her daughter] saw me go to a mental health institution. She has had enough of this. My son hates me; he doesn’t talk to me ... Alcohol was my anaesthesia.’ – *field note 2*

It was clear that the patient's daughter had grown up with her mother's diagnoses. Despite the mother recounting her medical history and her daughter having to witness traumatic events there seemed to be genuine care and warmth between the two women. Sometimes the role of the carer had a negative effect on a relationship as shown below from this excerpt:

"Stop talking about that [the patient's desperate need to sleep], tell them why you need them," said the partner very irritably. "He forgets things," explained his partner. "I am worried about him; he hasn't been the same. I am his carer. They [the GPs] are not interested in helping him," he added. – *field note 15*

Sometimes dependency can be unhealthy for both parties as was the case in the following excerpt where 999 was called after a mother thought her 16-year-old son had overdosed on his antidepressants:

His mother was standing at the foot his [her son's] bed. "I am really worried about him," she said to us, "sorry I am talking about you while you are in the room darling [her son], but I don't know what else to do to help you," she said. "I suffer from bipolar disorder you see and I worry about him," she said to us. The patient kept pulling the duvet over his head when his mother spoke. The specialist paramedic asked the patient to explain what happened and why. The patient said he couldn't sleep and was always feeling tired and had felt tired for months. He was awake at 2am and decided to try something new. I just wanted to see if they [his antidepressants] would be different in powder form. "It's no big deal," he said sulkily. He [the patient] looked annoyed whenever his mother spoke to us. "I would have taken more if I wanted to hurt myself," he said again.

"He [the patient] keeps staying on the computer until late and I cannot get him off it. He won't come outside with me for a walk and I am worried he isn't going to school enough. He couldn't cope at the mainstream school so he was moved to this school," she explained looking really tired. – *field note 4*

Interestingly what this patient's mother did not know was that her 16-year-old son had been sneaking out of the house for weeks to smoke cannabis with his friends and that was why he was so tired. He also confirmed his mother's suspicions about not attending school by revealing to the paramedic that he

didn't want to go to school and had not been in a while. Because this conversation was confidential (the paramedic was duty-bound not to share this information as the patient was over 16 years old), the paramedic did not recount the details to the patient's mother. "If he was a danger to himself or to her I would have told her," said the paramedic to me.

Fraught relationships were apparent on two occasions. The partners of the patients were both very upset as seen in the following excerpts:

"I should take a photograph and show it to him. Never seen him this bad," said the partner. She looked very vulnerable and almost disorientated. "He can't handle drink," she said to me, "he isn't abusive but does end up hurting himself." – *field note 12*

The patient in field note 12 had a history of alcoholism and had fallen and been found unconscious by his partner. She called 999. After arranging transport for the patient, the paramedic completed a vulnerable adult referral form for the patient and the partner who had found him. Another similar call was to a suspected overdose after a young woman, who called 999 claiming her boyfriend had told her he had taken an overdose. When she went to his house, he had left the premises.

"On our arrival a young girl came running out, she was crying noisily and said that the patient had left. She told us the patient had called her and told her he had taken an overdose of tablets, she called for an ambulance and then came through five minutes later, but he had left already. She continued to cry and said that she was trying to call him but he was not answering. She then explained that she and the patient had had a fight. However, she would not explain what the fight was about. "It wasn't anything that would make him do this," she said rather defensively. – *field note 8*

Fortunately, the patient was found with his friend nearby and transported to hospital. This leads neatly into the strength of friendships. This excerpt was from the same call as above but this time with the patient and his friend:

While the paramedic was handing over to the nurse in the ED, I watched the interaction between the patient and his friend. The patient was sitting

in his chair occasionally checking his phone and more regularly brushing his long hair away from his eyes. His friend was pacing up and down the floor in front of the patient. 'I was gonna tackle you,' he said, 'but then it was your dad I saw, not you,' he said laughing somewhat hysterically. The patient laughed as well and then went with the paramedic to be handed over to the hospital. I asked him then if his friend had ever done this before. His reaction was very interesting. He became cagey and defensive. 'Best you ask him. I can't remember all the things he has done,' said the friend. – *field note 8*

This patient was found with his friend after a large group of his friends and his father called his mobile. They also went looking for him close to his home. This was where the ambulance crew was waiting. As we pulled up to where the patient was, we saw them hugging. It was obvious that the patient was glad to have his friend with him. His friend also accompanied him to hospital.

As seen in the examples above, the relationships that patients had with their family, carers or partners influenced how paramedics managed patients experiencing mental health issues. They could elaborate on past medical history or help paramedics to understand how they could help these patients. Conversely, their presence sometimes added more complicated dynamics to the call when paramedics realised that they needed to treat the patient and manage relatives or carers as well.

4.2.3 The selective phase of analysis

Spradley's (1980) final selective phase of analysis helped me narrow down and focus on two particular practices which then evolved into themes, namely humour and stereotyping. These themes showed how paramedics managed patients experiencing mental health issues. Paramedics used humour as a form of patient management and not just with mental health patients. Paramedic crews used humour among themselves as a form of debriefing and information sharing as well as emotion management. This was witnessed in observing crews interact with each other throughout the shift and at the station. Using humour with mental health patients helped to break down barriers and established a rapport between the paramedic and the patient that also acted as a tension breaker. Stereotyping was used in a slightly different way, this time as a form of triage in managing patients and resilience to help paramedics manage this patient group.

Paramedics used stereotyping or labelling to triage patients for example: “granny down” is labelling a falls patient; “paeds” is labelling calls to children, “drunks” refer to intoxicated patients, “arrest” as cardiac or respiratory arrest patients and “crazies” or “mad” label patients experiencing mental health issues. By using these labels, paramedics were able to prepare themselves for the call they were en route to. This echoed similarity to the stereotyping of patients in Becker et al (1977) *Boys in White*. In addition, using stereotyping helped paramedics to categorise patients, thereby helping them in their management of this patient group. When it came to mental health patients, paramedics used stereotyping prospectively when they received information about the patient on their mobile data heads; retrospectively and during conversation with each other. These stereotypical labels were not used during patient contact time. When comparing stereotyping labels across patient groups such as the elderly, paediatrics and mental health patients, these labels supported how paramedics considered their role in caring for these patients. If put along a continuum (see Figure 4 below) starting with “crazies” and “drunks”, followed by “granny down” and “paeds” in the middle with “arrest” and “trauma” on the right, paramedics considered the middle to right of the continuum as legitimate and ideal paramedic work. Veering towards the left of the continuum was considered as less legitimate work and it was felt that this was not part of their role as paramedics working for a frontline emergency service.

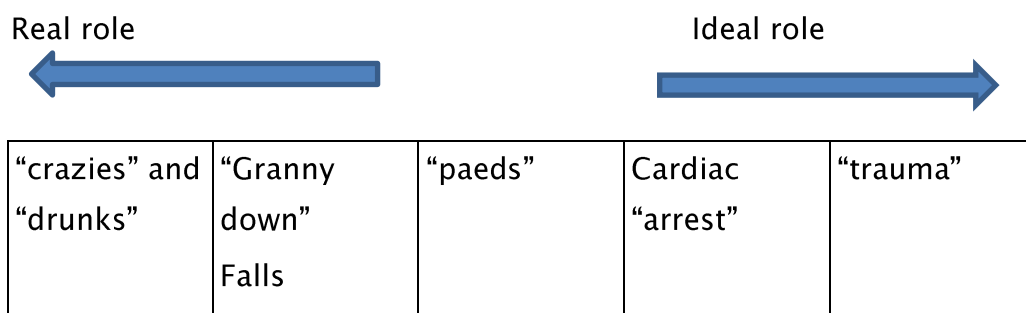


Figure 4: Ideal versus real role dependent on stereotyping labels

But, despite these two management strategies, managing this patient group remains a great source of frustration for paramedics. The following sections will show these behaviours or coping mechanisms in more detail, starting with humour.

4.2.4 Humour

The observations showed that paramedics used humour as a form of communication and management strategy with patients and patients often either initiated the use of humour during conversations with paramedics or responded to humorous quips and questions in kind. This resulted in the development of a typology, which included: humour initiated by the patient, humour initiated by the crew and humour between crews. The follow-up interviews support the use of humour but also highlighted that humour was used in different ways depending on the experience of the paramedic. Less experienced paramedics were more cautious when using humour with patients in particular, but the more experienced paramedics used it to great effect with patients. “Gallows” or “dark” humour was evident among all paramedics when they were talking to each other or sharing “war stories” about patients. It was also evident that humour was used as a management strategy as evidenced below.

4.2.4.1 Humour initiated by the patient

There were many instances where patients used humour when describing their own situations. An 85-year-old man had activated his care line after falling in his lounge. He was unable to get himself up again. As the paramedics arrived at his home, the care manager of the assisted-living home opened his door and the patient was found on the floor. He was unsure how long he had been there but was quick to reassure the paramedic: “I am a tough old cookie,” said the patient with a smile, “even on the floor!” Not only did this illicit a response from the paramedic in the form of a big smile, but the patient managed to also create a friendly and welcoming environment despite being on the floor. This echoes the work of Chapple and Ziebland (2004), which supports the “role that humour can have in easing difficult situations and expressing camaraderie”.

During another call, one paramedic admitted she did not know what to say to mental health patients. Interestingly, the patient used humour to describe his problem and made a point of trying to illicit a response from this paramedic. The paramedic found the patient sitting on the couch with his partner explaining what had happened. After the paramedic ruled out any pressing medical issues, the patient explained that he had trouble sleeping and had been ordering sleeping tablets off the Internet as his GP “refused to help him”. The paramedic asked about his sleeping patterns and the patient replied: “It’s earliness that really stresses me out,” he [the patient] carried on explaining. “I need an hour to make sense after waking up!” “Otherwise I just speak gobbledegook!” he said. The

paramedic laughed at this. “Ha! I made you laugh!” said the patient to the paramedic, looking pleased with himself. This banter immediately changed the dynamics between the paramedic and patient to a more comfortable atmosphere and made gaining a full medical history much easier.

Tremayne (2014) reminded us that laughter was a natural expression of emotion and promoted a more human and mutual connection between health care professional and patient. The patient did not stop there. Just before the paramedic was about to leave she asked if he would be ok with the plan they had discussed and asked if there was anything else she could do. It had been decided between the patient, his partner and the paramedic that he would attend an earlier slot for his already booked mental health assessment appointment and that if he fell again and injured himself, he would call 999. His reply before the paramedic walked out of his lounge was to smile and add while laughing: “I just need to sleep, maybe I should read my Keith Lemon book, he helps me sleep.” Again, the paramedic smiled and left the scene. I observed her smiling as she walked back all the way to the RRV. Paramedics benefited from the exchange of humour initiated by a patient as much as a patient benefited from being distracted or reassured with humour by the paramedic.

4.2.4.2 Humour initiated by the crew

It was evident from my observations and interviews that paramedics liked to amuse and distract patients as a way of managing them. Paramedics often struggled to see a physical difference manifest in their patient when their management strategy was more verbal. For example, reassuring and calming an anxious patient, rather than a physical intervention such as intravenous morphine for a patient in pain. Paramedics were used to seeing how an intervention made a difference to their patient. The subtlety of calming a distressed patient was perhaps not as obvious as relieving a patient of pain or giving a patient a drug to improve their breathing. Nevertheless, using humour was a way paramedics could reach a patient; again the difference was subtle but still proved to be effective. Whenever the use of humour by paramedics was observed, there was a positive response from the patient, sometimes simply a smile and other times with a humorous comment in their reply. Tremayne (2014) reiterated that humour could lead to a more personalised and holistic approach to patient care and this could result in the patient feeling comforted and cared for.

Was humour always used appropriately? With a few patients, as an observer, I sometimes felt unsure, however, the patients all responded well and with humour

of their own. One such example was when a paramedic responded to a patient with chest pain. After ruling out any emergency concerns, the paramedic started asking more details about the patient's medical history. The paramedic was also looking around the apartment and noticed some football paraphernalia. "You are a Pompeii fan?" he asked the patient. "If I knew that I would have walked back out again." As the paramedic said this, I wondered how the patient would react and felt slightly uncomfortable but the patient laughed and this set the tone for the rest of the positive interaction between the paramedic and the patient. Humour was subjective but no negative responses to paramedic humour were observed during my field work; but this is not to say such incidents never happen.

The interviews revealed a more obvious division about the use of humour between the experienced paramedic and the less experienced paramedic. Experienced paramedics use humour more, and it was part of their general management across most patient groups. Less experienced paramedics were more cautious when using humour, more so with patients and less so with each other. The interviews supported this notion but the observations showed that humour was used across all levels of experience. Perhaps because there was no calculated behaviour and being observed in practice showed true behavioural patterns. However, when questioned about the use of humour, more thoughtful and considerate answers were given, perhaps because of how humour and its use may have appeared inappropriate. After more prompting participants revealed their thoughts in more detail:

"We use humour because, we use gallows humour don't we? Dark humour, because the things we see, the normal public wouldn't be able to deal with, so that's why I think a lot of us are suffering from mental health ... So, we all suffer mental health, we are all on that spectrum of maybe, yeah darkness. So, I think we are quite good with mental health, because we sort of, maybe suffer with it ourselves, and we can relate to them." – *interview 4*

The above excerpt not only touches on why paramedics used humour but also explained that these behaviours were coping strategies particularly when it came to patients experiencing mental health issues and the susceptible nature of paramedics' own mental health. One paramedic pointed out that inexperience and confidence played a role in how paramedics used humour as an additional tool when managing mental health patients, but that it was a useful release when used between crews. The element of experience is repeated in the next excerpt:

“Experience, yeah. And also, I think when you’re newly qualified, you don’t want to push it too much whereas I think a lot of the old-school guys, they know and they don’t care what they say, not don’t care what they say, but they’ve got a bit more confidence, you know? Whereas I think when you’re new, you don’t want to risk getting a complaint or anything like that but I think a lot of the older-school guys are probably past it, they don’t care.” – *interview 5*

This excerpt was from a less experienced paramedic who felt that experience was a factor in using humour but there also seemed to be an added perception that experience led to caring less, which is not what was seen in my observations. The next paramedic agreed with humour being used depending on levels of confidence and experience as seen below:

“I’d agree with it. When I’ve worked with different people and you work with people who have been in longer who are more experienced, I think they’ve got the experience to read the situation better and gauge whether humour would work or whether being a bit calmer and – not saying humour’s insensitive but being a bit more kind of sensitive, sit down, calm approach. They can probably read the situation a bit better from experience and what they’ve dealt with before. I think they are probably more comfortable to use humour in those sorts of situations than I would be.” – *interview 3*

There was also acknowledgement from less experienced paramedics about the role of humour when managing mental health patients, and their approach remained more cautious as evidenced below:

“I may do [use humour] but I’d be very cautious with it because generally it gets their [mental health patients] back up. If they think you’re not taking something seriously, you just have to read the situation. Sometimes it can work, so if someone’s really aggressive and you deflate the situation a little bit by humour then fine, but you just need to be careful because humour is Okay but you just have to say the wrong thing and you’ll backtrack entirely.” – *interview 2*

Risk management was also a factor in dealing with this patient group. Less experienced paramedics were more risk averse and hence more cautious in their approach to their patient. Another paramedic added what was seen in my

observations as well, that the use of humour depended on the patient and the situation:

“I think that all depends on any patient, no matter who you go to, I think if it’s appropriate at that time, and you’re reading that patient very well, and they respond to humour, and their mood allows you to use humour, then that is okay to do so, providing it’s not humour at them, and humour just about something they find funny as well. Do you see what I mean? There’s humour and there’s degrading humour. I think you have to be careful of every given situation.” – *interview 9*

4.2.4.3 Humour between crews

Humour observed among paramedic crews was more prevalent than the exchange of humour between paramedics and their patients. One such example was observed in the following excerpt:

“In the crew room another paramedic approached me and asked if I was assessing the mental health of paramedics. I explained saying that I was observing how paramedics manage patients experiencing mental health issues, not assessing them or their mental health. ‘Good!’ he said. ‘We wouldn’t have jobs left if you were assessing our mental health!’ A few other crew members in the crew room sniggered at his comment.” – *general field note*

The most interesting element of this observation was the somewhat ironic and yet disguised with humour comment around the mental health of paramedics as opposed to how they manage patients experiencing mental health issues. Although saying: “We wouldn’t have jobs left if you were assessing our mental health!” was said in jest with supportive sniggers of other crew members who heard the comment. This comment echoed honesty but was not analysed further as it was not part of this research study. However, most commonly observed was the easy banter between paramedic crews regardless of rank as shown again in the excerpt below:

“The Duty Officer came downstairs and told the paramedic that he could get on an RRV: ‘that should get you sorted. It’s got a steering wheel and a clutch. It’s not an automatic so remember to use the gears!’ The paramedic was used to responding on the newer automatic ambulances and the officer enjoyed teasing him about this. The paramedic just laughed and invited me to follow him to the RRV.” – *field note 20*

The paramedic had to move from an automatic ambulance to a manual RRV. The officer immediately started to tease the paramedic. It was obvious that they knew each other well but interestingly the paramedic did not respond with the usual quick-witted response observed during other similar incidents, instead he laughed loudly. I continued to watch him after this exchange, as I was curious about whether the paramedic did not quite agree with the level of teasing from the officer, but he continued to smile after we walked away, and laughed loudly when he started the engine of the RRV.

The excerpt below supports earlier data analysis which revealed that using humour was a coping mechanism for paramedics, especially when they used it among each other.

“I think that’s a good thing really. I think the conversation between crews ... is fine and it’s fine to blow off a little bit of steam with a little bit of dark humour. I think that’s perfectly appropriate. I think though that as soon as you get to a job, a professional attitude then needs to come on and I do find occasionally, paramedics are a bit lacking in that sometimes. So, I think it’s a coping strategy for paramedics. I think, you know, it’s something that’s always been done ... but I think there’s recent evidence to suggest that actually it’s perfectly healthy, you know, and it shouldn’t be something that we are embarrassed to admit that happens. But I think it needs to be contained and kept professional and it needs to be not broadcast to, you know, to everyone. There are experienced staff that are exceptionally good at it.” – *interview 10*

The above excerpt reiterated the difference between experienced and inexperienced paramedics. This paramedic mentioned that experienced paramedics “are exceptionally good at it” with a hint of disparity. In a paper published by Kuiper (2012), which considered how humour fits within a resilience perspective, the author claimed that evidence reviewed within the paper suggested that there is an important role for humour and understanding resilience with particular reference to paramedics and stressful situations. Kuiper (2012) acknowledged that more research around this subject was required but also added: “Increased humour can contribute to the enhancement of positive life experiences and lead to a greater positive affect psychological well-being”. However, in a later study by Charman (2013) with a slightly different focus, the author suggested that humour is not just about resilience or coping. Charman (2013) published a study about the role of humour in relationships between

police officers and ambulance staff. She found that humour also functioned across occupational divides. "Police officers and ambulance staff draw from a mutually acceptable but culturally defined joke-book in the course of their work. The informal forces of humour appeared, ironically, to provide a means of enhanced interoperability between the two organisations but at the expense of other agencies involved within the emergency service field" (Charman, 2013). Interestingly, this was also clear from the interviews.

The next excerpt supported the idea that paramedics had a specific type of behaviour pattern that was used as a management or coping mechanism. All follow-up interview participants unanimously stated that the type of humour that paramedics use with each other is specific to the profession with the assumption that it would only be understood by those in the same profession. However, use of humour was not new to the health profession, but little had been written about paramedic use of humour which is why this typology was so valuable in this study.

"I think it's [humour] something very peculiar to paramedics, isn't it, it's a level of humour and the type of humour, I think. I'm not sure that it exists, in the same way, in other healthcare professionals. I think that was a huge coping mechanism for me. I remember a very inappropriate humour, which I think is a trademark of paramedics (laughter), this was when I was working in London, and we went to a cardiac arrest in an elderly gentleman, who had hanged himself with his dressing gown cord and died. It was obviously very sad, and we took him to hospital, but he died unfortunately, and we, I remember, we were all sitting around, there was like a bench outside A&E, and we were all sitting around having a cup of tea and the paramedic who had led was writing the paperwork and someone said, "Did anyone get the wife's name?" and, you know, someone went, "Oh, I think we'll just put down Widow Hughes," or something like that. Which is not even funny, and really inappropriate, but we absolutely rolled around laughing and I think that is just a coping mechanism, because it was really sad. This elderly gentleman had committed suicide, which is unusual in itself, and, you know, retelling that story to anyone, saying that's not even funny, never mind bad taste – but we were absolutely rolling around laughing and it was just a coping mechanism and we felt a bit better after it Yeah, it's very interesting, I think, yeah ... I don't know if that exists in nursing, for example. I'm not sure it does." – *interview 11*

Interestingly, paramedics also acknowledged that they use what they term as “inappropriate” humour among themselves and that it was a successful coping mechanism. This ‘dark humour’ was different from the humour used to deflate an emotive or hostile situation in practice. It was also different to the humour paramedics used as a tool to connect with their patients. As a paramedic and researcher, I constantly had to question what I knew as a paramedic and what I observed as a researcher. I acknowledged that when it came to humour, my own was somewhat dry and at times ‘dark’. Perhaps these facts contributed to how I interpreted the humour I observed among paramedics and if my background had been different, my interpretations may very well have been different as well.

Humour ran across all paramedic work, including managing mental health patients. There was no specific link between increased uses of humour with mental health patients above patients with other medical issues. Paramedics used humour to manage themselves and often resorted to using humour with patients. More rarely, and only on two occasions, patients initiated humour as a communication tool. In these particular cases, the patients were seeking to “lighten the mood” and “wanted to make you [the paramedic] laugh”. During the mental health cases observed in this study, there was time and opportunity for paramedics to develop a good rapport with their patients. This did not occur during a medical emergency, often because the patients were unresponsive and because the focus foremost is on providing life-saving treatment. However, humour was often used after emergency calls as a release valve or debrief when the crew had returned to the crew room. Another coping mechanism observed and discussed during follow-up interviews was stereotyping.

4.2.5 Stereotyping

The word stereotype stems from two Greek words: *stereos* meaning solid and *typos* meaning a model (Schneider, 2005). When applied to people, Schneider (2005, 8) believed that stereotypes were rigid and “stamp all to whom they apply with the same characteristics”. The most familiar use of the word referred to characteristics we applied to others based on their nationality, ethnic or gender groups. My research showed that mental health patients were one type of category. Abdou et al (2016) took this definition one step further, calling it healthcare stereotype threat, which they defined as the “threat of being personally reduced to group stereotypes that commonly operate within the healthcare domain, including stereotypes regarding unhealthy lifestyles and inferior intelligence”. Their study suggested that the healthcare stereotype threat

was associated with higher physician distrust and dissatisfaction with health care (Abdou et al, 2016).

Healthcare stereotyping by paramedics took on a specific form for mental health cases. Some of the most common phrases used by paramedics in the crew room when discussing mental health included: “those crazies are so annoying”; “we had to go from hospital to hospital with our crazy patient because no one wanted him and we didn’t know what to do; she was totally crazy, screaming and shouting – it was horrible”; “the other night we discussed whether we should get a dart gun and do a drive by with a Narcan dart with the amount of heroin overdoses that night”; “We have plenty of nutters here”.

Paramedics were not the only ones labelling mental health patients. There was a national drive to address the stigma that surrounded mental health. The Mental Health Foundation (2016) reported that people with mental health problems said that the social stigma attached to mental ill health and the discrimination they experienced made their difficulties worse and make it harder to recover. The Mental Health Foundation (2016) also acknowledged that there was a strong social stigma attached to mental ill health, and people with mental health problems could experience discrimination in all aspects of their lives.

Although a study by Abdou et al (2016) suggested that this type of stereotyping was associated with higher physician distrust and dissatisfaction with healthcare; the same cannot be said for paramedic care. In fact, according to the CQC Right here, right now Report (2015), paramedics and GPs were seen in the most favourable light by mental health patients, with ED staff, mental health crisis teams deemed the least favourable.

Although there was no evidence observed during this study that paramedics treated mental health patients any differently to any other patients they were managing, mental health patients were considered as complex by paramedics – they described these cases as: [the] “worst calls ever”; and “horrible calls to respond to because no one gives a shit.” Becker’s (1993) work on stereotyping and what medical students referred to as “crocks” has parallels to my observations. Becker (1993) explained that medical students used this term to stereotype “someone with psychosomatic illness” and a crotch “presented no medical puzzles to be solved”. Often paramedics felt that they could not help mental health patients as they did not consider them an emergency type call and did not have the knowledge or education to help them in any other way.

A study by Jeffrey (1979) on how medical staff typify “good and rubbish patients” echoed the sentiments of paramedics. Jeffrey (1979) stated that staff defined “good patients” in terms of their medical condition or symptoms. In his study, the medical staff defined “rubbish” patients as “the normal suicide attempt, the normal drunk ...” Similar to paramedics, staff in the study by Jeffrey (1979) felt uncertain about the existence of an illness if there was no therapy, or in the case of paramedics, drug or medical skill intervention, that they could provide. He added “this uncertainty fostered frustration ...”. A similar level of frustration was often discussed in the ambulance or crew room after attending to mental health patients. The interviews revealed continued patterns or practices observed in practice; stereotyping was a coping mechanism to manage patient groups with complex needs that did not fit neatly into a treatment pathway – mental health patients specifically. The participant below explained his reasoning for stereotyping:

“Paramedics are very good at switching off and I think that’s one of the other reasons why paramedics have so many mental health issues later on in their career or when they retire. It’s because it then affects them. They’ve been so good during their career at shutting it off.” – *interview 3*

His description of “switching off” showed a management strategy where paramedics depersonalised patients and categorised or stereotyped them, often according to their medication presentation. Another interview supported this notion:

“I think it probably depersonalises it so you’re not remembering the patient’s name or gender, you are kind of just – yeah ... So, it depends what information they give you. If it just says 23-year-old woman with depression, you probably kind of stereotype and go, oh, it’s someone with depression. Does that make sense?” – *interview 6*

Paramedics spend extended amounts of time on scene with mental health patients and as the observations evidenced, this could be up to four or more hours. This extra time took a personal toll on paramedics because the emotional connection they made with mental health patients seemed far more necessary than physical intervention. But added time also added to the stress paramedics were under because they knew their service was evaluated by time targets. Interestingly, stereotyping was done en route to the call so that paramedics could mentally create a management strategy before they arrived on scene, this helped them plan ahead and feel they could manage the possibility of the unexpected in

a more productive way. The element of surprise was something all paramedics enjoyed about their job, however, where possible, trying to plan ahead helped when the unexpected occurred. Sometimes removing feelings from the job was another reason paramedics stereotype:

“I’m quite guilty of that [stereotyping] actually. I think I’m quite a clinical person. I’m not overly always interested in the sort of, you know, feelings on reflection. I’m more interested in, you know, ‘What is wrong with the patient?’ ‘What can I do for that patient?’ ‘What could I have done better?’ ‘What could I do next time?’ And, ‘What did I do wrong?’” – *interview 10*

The clinical aspect, managing the physical symptoms, seemed to be the focal point for most paramedics when managing mental health patients. It was easier to focus on managing physical symptoms than managing emotional symptoms, as also evidenced in the observations. Below, this paramedic explains why:

“Yes, I think it is, I think stereotyping is human nature and I think, you know, it helps us to process things, to make sense of things ... I think it helps with resilience, absolutely, that kind of dehumanising aspect of it and to put things in boxes, so it can help with the diagnostics. What’s the treatment plan? But, I think stereotyping only becomes a problem, I might get shot for this, I think stereotyping becomes a problem when you’re not aware that you’re doing it and you act on those preconceptions, but that actually, having a stereotype is perfectly normal and helps us to make a quick decision sometimes about things, but if we’re aware that we are stereotyping and that there may be differences in this particular instance, and we’re open to that, I don’t see that as a particular problem. It’s to what extent as well, that having been diagnosed with a mental health condition, is a label. I’ve spoken to people who have had mental health problems and they’ve been given like six or seven different diagnoses throughout their lives, but their lives haven’t been that long, you know? So, is it useful giving someone a label of depression? Is that a useful thing or does that not matter, what matters is how we’re going to help this individual person feel better, and I would sway towards that.” – *interview 11*

This paramedic showed insight into how stereotyping could be perceived very negatively if there was a lack of awareness around its use. The interview supported what the observations have revealed, that stereotyping was used as a coping mechanism in managing patients and it was also a triage tool to use en

route to the patients to formulate possible treatment or management plans before arriving on scene.

4.3 Chapter summary

This chapter described the paramedic and patient participants in this study. It also described the processes of data collection and used three phases of analysis Spradley (1980) to organise and present the analysis. The descriptive phase examined characteristics of the paramedic and patient participants. The focused phase revealed how information about the call, use of support services and relationships between patients and their carers affected the way in which paramedics managed patients experiencing mental health issues. The final selective phase narrowed down two particular paramedic practices – humour and stereotyping – showing how paramedics used these to manage patients experiencing mental health issues. These practices, through continued analysis, evolved into themes and their role will be discussed in more detail in Chapters 6 and 7. Paramedics used humour as a form of patient management and not only with mental health patients, but the crews used humour among themselves as a form of debriefing and information sharing as well as emotion management. This was witnessed while observing crews interact with each other throughout the day and at the station. Using humour with mental health patients helped to break down barriers and established a good rapport between the paramedic and the patient, thereby also serving as a tension breaker. Stereotyping was used in a slightly different way, this time as a form of triage in managing patients and resilience to help paramedics manage this patient group. By using these labels, paramedics were able to prepare themselves for the call they were en route to. These echoed similarities to the stereotyping of patients in Becker et al (1977) *Boys in White*. In addition, using stereotyping helped paramedics to categorise patients, thus helping in their management of this patient group. When it came to mental health patients, paramedics used stereotyping prospectively when they received information about the patient on their mobile data heads; retrospectively and during conversation with each other. These stereotypical labels were not used during patient contact time. When comparing stereotyping labels across patient groups such as the elderly, paediatrics and mental health patients, these labels supported how paramedics considered their role in caring for these patients. There was a disparity between the ideal role (emergency work) and the real role (which included managing mental health patients) since the real role was the work paramedics were expected to do daily. The importance of role

perception or identification will be discussed in more detail in subsequent chapters. The next chapter will look at why paramedics manage mental health patients the way they do.

Chapter 5 “They’re like a black hole”, that’s why “I’ve only got about 20 minutes of ‘there, there’ in me.”

5.1 Introduction

This chapter will show how paramedics managed mental health patients based on rich sets of ethnographic data after five months of observations in the field and 11 follow-up interviews. As discussed in the previous chapters, paramedics are increasingly required to respond to and manage patients experiencing mental health issues. Literature and related mental health policies have shown that mental health calls to the ambulance service are greater than ever before (NHS Digital, 2016). Community mental health teams are under-staffed and under-funded (King’s Fund, 2018). Mental health patients often could not get an appointment with their GP or talking services when they felt they need support and as one patient aptly explained: “We know you [paramedics] will come, there is no one else”; this leaves the ambulance service to respond. However, many paramedics considered their role as responding to emergency calls, which included cardiac arrests, respiratory arrests and other life threatening conditions. To address these changing expectations of the public and therefore the ambulance trusts, paramedics were dispatched to a raft of calls that would not be defined as emergency calls. The reality of the paramedic role was fast evolving to include more primary care type calls – coughs, flu, headaches, medication renewals and non-acute mental health issues such as anxiety and depression. This study focused specifically on the mental health calls paramedics were frequently responding to. Data analysis in the previous chapter revealed two specific behaviours or coping mechanisms paramedics used when managing mental health patients: humour and stereotyping. In addition to these specific coping mechanisms, there were two emotive categories: “they’re like a black hole” and “I’ve only got about 20 minutes of ‘there, there’ in me”, which explained the overarching sense of frustration paramedics feel when managing mental health patients and show the reality of why these calls are very complex.

5.2 Examining emotions behind paramedic behaviour

What started off as two particularly compelling statements from my field notes: “they’re like a black hole” and “I’ve only got about 20 minutes of ‘there, there’ in me”, evolved into emotive categories within my data analysis (see Appendix H for further analysis process). These emotive categories helped me to understand the complexity of the way in which paramedics managed mental health patients. Although much paramedic work is practical, there are additional elements that influenced how paramedics managed their work, one of these elements was emotion, which manifested in various ways and will now be discussed in more detail.

Paramedics frequently and subconsciously slipped in and out of many implicit roles: their role as a clinician, their role within public health (health promotion and screening) and their professional role of maintaining competence. These roles often overlapped and became problematic when dealing with a patient group that did not fall into the “emergency cases” category. The paramedics I observed and interviewed offered a particular world view, but one that was extremely problematic. They felt they were there to treat emergencies and considered most mental health calls not to be real emergencies but rather calls that took up a lot of time and extra resources. Therefore, paramedics did not think that providing mental health care was legitimate within their role. They also claimed they did not have the skills to manage these patients, yet in practice they spent lots of time dealing with these cases – this was a paradox. Paramedics therefore had this ideal that they discussed and believed in – “we are there to treat ‘real’ emergencies”; “we are an emergency service”. However, despite believing that mental health patients did not fit into the emergency work they did, paramedics were spending over an hour at various scenes managing these patients, despite the time and performance pressures placed on them by the Trust. Mental health patients were rarely simple to manage as their complex social and mental health issues often required more input from specialist services such as the crisis team or community mental health services. There was, however, a clear tension between this ideal paramedic and the actual role they practised.

This tension between the paramedic’s actual role versus their ideal role lead to a conflicted discourse on the way paramedics managed patients experiencing mental health issues. Paramedics therefore came up with coping or management mechanisms to try to bridge the gap between their ideal role and their actual role. They did this by using humour as a communication tool to break down barriers

and a debriefing tool to manage emotive situations and by using stereotypes as a form of triage (as discussed in detail in the previous chapter). Paramedics labelled these patients as draining, that is, “they’re like a black hole” and they used humour as a form of resilience and structure for managing this patient group. There was also evidence of tension between what they said about their role and what they actually did.

Coding and thematic analysis helped to elucidate this tension between the ideal and actual role of a paramedic, thus understanding how they managed patients experiencing mental health issues. Paramedics worked to certain rules within their profession. Time was a big factor. Their time on scene with a patient was measured by the Trust they worked for and the Trusts were also under pressure to meet time-driven targets. There was also a lot of emotional labour in their work which was often forgotten and not acknowledged. Paramedics were result-driven in their practice. They were taught how to correct physical presentations in patients using a variety of practical skills and interventions. The following matrix showed how this tension between the ideal role versus actual role played out within paramedic practice and the elements that contributed to each role:

Table 2: The tensions contributing to the actual role of the paramedic versus the ideal role of the paramedic

Ideal elements of paramedic role	Actual elements of paramedic role
Physical	Emotional
Short time on scene	Prolonged time on scene
Autonomous practice	Heavy reliance on other support services
Education fit for purpose	Education gaps
Set work boundaries (clear clinical pathways)	Unclear work boundaries
Example of ideal calls: cardiac arrest, life-threatening asthma	Example of actual calls: panic attacks, falls, non-injury

The shift from treating life-threatening emergencies to managing more social calls within the paramedic role was the root of the frustration that paramedics felt when managing patients experiencing mental health issues. Their way of coping with this source of frustration was to use humour and stereotyping. The “black hole” metaphor described the frustration and disempowerment paramedics felt when they manage mental health patients.

Further ideas about mental health patients and how different crews managed this patient group was a discussion topic I raised during meal breaks at the station. I was curious to hear how paramedics thought about this patient group, away from their clinical role and away from patients. It was clear that ideas were being shared, “war stories” were being exchanged, or as Le May (2009) suggests: “anecdotes with a purpose” like a Community of Practice, which will be discussed in more detail in Chapter 7. Paramedics talked about their experiences with mental health patients and about things they have heard about. Each paramedic or crew member chipped in about their experiences managing this patient group. The atmosphere for this to occur in was relaxed and safe – in the ambulance crew room, over a cup of coffee or tea – sitting on couches. This was also where humour and stereotyping found a voice.

The two emotive categories “they are like a black hole”, and “I’ve only got about 20 minutes of ‘there, there’ in me” were reasons paramedics offered for the frustration they felt when managing mental health patients. Because of their training, paramedics were results-oriented and task-driven. When it came to mental health care, paramedics felt frustrated because they could not see tangible results like they would in emergency calls. Managing mental health patients was a complex and time-consuming task with far more emotional work compared to emergency calls which worked in a more structured way for paramedics: if a patient was not breathing, breathe for them; if a patient was in pain, give them pain medication – symptom, intervention, result. These types of interventions were the core of emergency work for paramedics and the results were visible in how the patient physically responded. With mental health patients, the responses were often not visible or very subtle. Paramedics were very aware of their own limitations as will be shown in later sections. They felt that they did not have adequate training to manage this group or adequate support to improve the care of these patients. This negative cycle of belief led to the “I’ve only got about 20 minutes of ‘there, there’ in me” response. Paramedics felt they had limited capacity to provide the emotional support mental health patients required. Ironically, despite this perception of their abilities, this study showed

that paramedics did spend extended time with mental health patients and that much of that time was providing emotional support, which led back to the feelings of “they’re like a black hole”. The two categories were inextricably linked.

Both categories also had other common features that tied them together. Firstly, the role of the paramedic was evolving. This was not only supported documents such as the publication of The Paramedic Curriculum Guidance (2015) which highlighted the move away from teaching focused only on emergency care but calls for a more holistic approach to patient care which included addressing social and mental health issues. The public was also reflecting a change as their calls to 999 were increasing which included calls that had mental health at its core. Paramedics, especially those who had been on the road for 5 years or more were struggling with the change in their role. More recent graduates were closely questioned at pre-session interviews or during open days about their understanding of the paramedic role today which helped to ensure a more realistic understanding of the role when they started their degree pathway. However, many of the paramedics observed in this study had been qualified for well over five years. In addition, this increased demand by the mental health patients for ambulances, affected paramedics and ignited feelings of disempowerment and frustration – fuelling the sentiments of both “they are like a black hole” and “I’ve only got about 20 minutes of ‘there, there’ in me”.

In response to this demand and change, paramedics adopted coping mechanisms which was to incorporate humour in their patient approach and with each other and to stereotype this patient group in order to manage them, as discussed in the previous chapter. Alongside the evolving role of the paramedic was their perception of their abilities to manage these patients. Many of the paramedics observed felt they ... “did not know what we [paramedics] were doing”. Follow-up interviews supported the disparity between the paramedics’ perception of their limited capacity to use “emotional labour” with mental health patients despite the observations showing that when they were on scene for an extended time, they did in fact reassure, calm and talk to these patients.

Another common feature to support the sentiments behind “they are like a black hole”, and “I’ve only got about 20 minutes of ‘there, there’ in me” was the role of support services in how paramedics managed this patient group. Throughout this study it was evident that paramedics did not feel they could provide the right care for their patients, and they were observed calling GPs, community mental health teams, the crisis team and the police for support. However, most often this

support was not available to paramedics and their patients. This added to their feelings of frustration and perception of their own limitations and using humour and stereotyping helped to alleviate these feelings. These two categories will now be evidenced with supporting observation and interview field notes.

5.2.1 “They’re like a black hole”

During the observations, paramedics talked about how the role of the paramedic is understood. The role was to respond to pre-hospital emergencies, stabilise patients for safe transport or refer patients to alternative services for care. However, this role changed and as supported by the observations and interviews in this study. Paramedics were increasingly being dispatched to patients who did not need life-saving interventions, such as mental health patients. Lifesaving interventions included carrying out advanced life support skills such as protecting an airway with an endotracheal tube, delivering drugs intravenously or intraosseously and carrying out defibrillation. Their role then evolved from applying urgent medical interventions to a less technical one such as using communication strategies to de-escalate stressful scenarios and creating a management plan for the patient that did not require physical intervention. This shift of the paramedic role was the root of the frustration that paramedics felt when managing patients experiencing mental health issues. An example of this frustration was highlighted by a paramedic during an observation. The paramedic had just transported a patient to the local Emergency Department (ED) after she had taken an overdose of her anti-depressants. She was known to the paramedic who had been called out to her before and she was known to the ED. After handover to the ED, the paramedic and I discussed mental health patients in more detail. He explained his thoughts as follows:

“These patients are like a black hole; we cannot treat them or see the results of good treatment. They get a ‘plaster’ [treatment by the ED] and then get sent out again and we don’t make a difference.” – *field note 20*

The “plaster” the paramedic referred to was the standard default response paramedics adopted with mental health patients – if it was not safe to leave the patient at home, they would take patients to the ED. However, paramedics were aware that the ED was not always the best option for this patient group. Paramedics also felt there should be more community support or a mechanism for direct admission to a mental health facility more suited to the needs of the patient as described below:

“We should have a mental health specialist we can call for advice or help. It’s far easier when they actually want to go to hospital. When they are compliant. Why can’t we take them directly to the mental health hospital in the area if they are so shit crazy? It’s so darn frustrating.” – *field note 7*

Paramedics also struggled to persuade patients to be transported to ED – the only safe alternative other than the patient’s home. This confounded the problem – mental health patients did not want to go to ED and paramedics could not leave them alone at home safely, making the ED their only alternative. This lack of choice for alternative care for patients compounded the levels of frustration paramedics felt when managing them. However, until there are alternative pathways to aid direct admission to mental health hospitals or referrals to community mental health teams, this management continued.

Interestingly, despite talking about the frustration they felt in managing this patient group, paramedics often spent a great deal of time persuading patients to accept treatment or transport under very demanding circumstances. One particular observation shift stood out in the way the paramedic managed to calm a patient in a stressful situation and despite being verbally abused and remained calm throughout:

The paramedic said, “We are here to help you, your GP says you need to go to hospital?” The patient looked at paramedic sharply and replied: “rather kill me, rather than take me to hospital. The doctor wouldn’t come here ... leave me alone! Release me and fuck off!” The paramedic knelt down near the patient but not close enough for the patient to be able to lash out and reach him. Quietly he said: “We are only here to help you”. – *field note 11*

In the above excerpt, the patient was deemed to have no capacity by an earlier visit from a GP and was potentially suffering from a severe Urinary Tract Infection, which was unconfirmed as he refused to let anyone near him. Despite the escalating verbal abuse and physical threats, the paramedic remained calm and kind and stayed on scene with the patient for the three hours. The patient believed that we were from the prison services and not the ambulance service. The paramedic showed the patient his uniform with “paramedic” clearly marked but the patient refused to engage and continued to be verbally abusive, lashing out with his walking stick as soon as the paramedic came too close. The paramedic felt very strongly that he could not simply remove the patient from his home without his permission: “I know the GP has been here but look at him [the

patient was sitting in his own faeces and was unwashed and partially clothed], I can't just take him and put him in the back of the ambulance. I wanted to convince him," explained the paramedic to me. After three hours of persuasion and reassurance the paramedic crew finally managed to take the patient to the hospital. This call illustrated what the "black hole" was like for paramedics, these patients were seen as requiring hours of effort and considerable patience – a lot of input and care without any visible positive results. The amount of time spent on scene with these patients was a recurring issue as shown below:

"The patient was becoming more upset though. 'Aw, bless you,' said the paramedic, touching the patient's shoulder. The patient didn't appear to have heard this and continued recalling his medical history. 'My chest is sore and I have pain down my arm,' he said. 'I am so confused,' he added crying in earnest. 'Don't worry, that's why we are here. We'll look after you, don't worry,' reassured the paramedic. 'I don't know what's going on,' cried the patient looking at the crew. 'Don't worry,' soothed the paramedic, 'it's ok.'" – *field note 19*

This patient was initially abusive to the crew when they arrived on scene. However, after the paramedic took the time to persuade and reassure the patient that he could help him, the attitude of the patient changed and the dynamic of the call changed to a calmer and collaborative nature. This call took well over an hour and placed the paramedic under great pressure to respond to the next call. The time it took to manage patients experiencing mental health issues was a common source of the frustration for paramedics. In addition, the paramedic sat, listened and reassured the patient in field note 19 and then delivered him to the ED where the patient again became agitated. This can be linked to the category of a "black hole" as the time taken to manage the patient did not correlate with any tangible results of a successful call.

Paramedics did not view mental health patients negatively because they had mental health issues, but more because they felt helpless and disempowered in how they managed these patients. "We don't know what we are doing half the time," said paramedic 6. This feeling of helplessness, which perpetuated the analogy of a "black hole" was echoed by all the paramedics observed and interviewed: "This was without a doubt the most frustrating call [to a mental health patient] of my career so far" – paramedic 1. The following excerpt reiterated the disempowerment paramedics felt when managing mental health patients:

“I was called to a 13-year-old girl, they thought she had tried to hang herself,’ he started explaining. ‘I asked control for back-up but they didn’t send any. I was really worried because I was on the RRV [rapid response car] and if she had really hung herself then I would need more help,’ he said with an air of resignation. ‘I arrived and her father had found her and cut her down. She had used crepe bandage but didn’t actually succeed at hanging herself,’ he said. ‘She needed help and in a response car I could not transport her,’ said paramedic 20. ‘I waited for two hours on scene and tried my best, but what could I do? She needed help. And if I left her at home she would do it again. She had visible self-harm scars on her wrist and had apparently tried to hang herself before...,’ he added. He couldn’t finish recalling the call as we were sent to our first call of the day.” – *field note 12*

The resignation used to describe what must have been an emotionally traumatic call for the paramedic was also telling. He recalled the experience factually but his feeling of helplessness was still apparent. This was not the only call of this nature he had to attend to.

Many paramedics believed that they should not be responding to mental health patients unless they received more education and training. Most saw mental health calls as the responsibility of mental health specialists such as mental health nurses, community mental health nurses working for the crisis team or advanced mental health practitioners. Often it was easier to blame the lack of support services in managing these patients as described below than to take responsibility for their care:

“We went to a patient who was self-harming. The crisis team told the patient to keep a self-harm box (they actually called it that) which has razors and cigarettes in it. They didn’t give a shit. They never do. She [the patient] was 15 years old. We took her to hospital and they probably just put a plaster on her and told her to go home. I was making myself sick by being so nice! And it didn’t make a difference. Her mum said the crisis team told her daughter to keep the self-harm box because taking it away takes away her choices.” – *Field note 20*

The sense of futility of managing this patient group was strong in the above excerpt. The paramedic felt the crisis team had not managed the patient properly and felt she had no alternative but to transport her to the ED. Note the comment: “I was making myself sick by being so nice! And it didn’t make a difference.” The

paramedic verbalised his efforts and didn't feel they amounted to anything tangible. Again, the category of 'they're like a black hole' – sucking up everything inside, came strongly into play. This was again reiterated in the follow-up interview:

“They're [mental health patients] draining, they're frustrating, because you can't get them the help that they need. It's getting better, now that I'm an ECP I do find that I've got more channels now so I do feel a little bit better since we last spoke, so I now feel like I'm starting to make better treatments, so that's nice, so it's becoming less frustrating; it's not that I don't like mental health, it's that I always found it really frustrating but it's becoming less now, because you do something. “Yes, the frustration seems to be that it's not about – it's not that paramedics don't want to treat – well some paramedics don't want to treat mental health because they don't think it's their job and that's fair enough, if that's what they feel but from what I've seen, the consensus about the frustration behind treating mental health is not that; it's the fact that they feel helpless because they want to be able to do something and they feel like they can't or don't do enough.” – *interview 5*

This participant had recently upskilled to specialist paramedic level (ECP). When she was observed a year ago she was still practising at paramedic level and she now felt having additional skills improved her patient care of mental health patients, making them “less frustrating ... because you do something”. All participants of the observations and follow-up interviews said that more education around mental health would improve their care and perhaps also the continued sense of disempowerment when it came to managing this patient group. This follow-up interview evidenced the difference in her attitude towards mental health patient care because of more education, adding that the frustration was based more around disempowerment than not wanting to manage mental health patients. The variety of mental health presentations and conditions paramedics saw also compounded their management of these patients.

The continued sense of disempowerment and lack of support added to the frustration paramedics felt even when they put their own safety at risk. This excerpt showed how a lone working female paramedic on a response car responded to a 15-year-old patient having seizures. Unfortunately, the information she received from the control room was incorrect and on her arrival

at the school, she was told the patient was threatening to kill everyone around him.

“The school called 999 and control sent me. I arrived there and was then told this 15-year-old was trying to kill everyone. Control sent me on the RRV – me! Instead of the police – on my own,’ she said with absolute incredulity. ‘But I wasn’t scared. The school had him [the patient] in a side room and restrained. They then locked me in the room with him while they watched from the room next door! I spoke to him and he was not interested in talking and could not remember anything. But the school told me that he had threatened to kill anyone he could get to. I felt sorry for him, he was a nice kid,’ explained the paramedic. ‘While I was still trying to talk to this kid, the armed police arrived. After I did! Then they stood with the teachers while I carried on talking to the kid – alone,’ she explained with even more exasperation. ‘They decided he needed to be sectioned. The kid was sweet. He didn’t know what he was doing. But they took him and I left the scene.” – *Field note 7*

The continued desire to treat patients despite conflicting information and personal safety and increased time spent on scene continued to be evident in this study. There were additional sources adding to the frustration levels of paramedics, thus emphasising the “black hole” analogy. One was that support services did not help paramedics manage mental health patients and this added fuel to the feeling that no one cared for these patients:

“We had to go from hospital to hospital with our crazy patient because no one wanted him and we didn’t know what to do; he was totally crazy, screaming and shouting – it was horrible.” – *field note 1*

Paramedics cannot refer a patient directly to a mental health facility or mental health community services. Their only alternative to leaving the patient at home was to take them to the closest ED. However, as the above excerpt shows, the ED did not always accept these patients. In the above excerpt, the paramedic crew went to a local ED but were told there were no mental health staff to support the patient and they were referred to another ED. Paramedics insist that their Trust did not support their care for mental health patients either:

“We deliver that care [mental health] with great difficulty. No one cares about those patients, especially not the Trust.” – *Field note 5*

These feelings were reiterated during the interviews and the complexity of managing these patients was explained:

“It’s very hard to fix their care. It’s very hard to help them. You can help them immediately saying, ‘Things are going to be okay’. You can help them medically, but mentally, it’s very, very difficult, because you haven’t always got time, as an ambulance service, to sit. You can try implement stuff, but you haven’t got time to sit and cater for their mental health needs, which is why they keep calling us, yeah?... You’re better off having an acute psychosis, like that young girl did, where I couldn’t leave her. I had to implement something that day. For other things [depression and anxiety], it’s very difficult to access that because there’s various channels, various routes. For instance, the crisis team won’t see somebody who is not known to them, yeah?” – *interview 9*

Paramedics also attended to repeat callers who had fallen through the system and had no alternative care, which led them to call 999. The patient below had been seen by her GP and was known to the ambulance service. The patient had abdominal pain, which the GP felt was psychosomatic but no treatment plan was in place to deal with this alternative diagnosis. The patient called 999 as she felt her GP was not listening to her. The patient insisted on being transported to hospital: “I called you to take me to hospital, that’s all I need you for,” said the patient. The paramedic had ruled out any concerning medical issues and then called the GP to discuss an alternative plan, as hospital admission was unnecessary. The GP reiterated the psychosomatic nature behind the patient’s concerns and insisted the patient was left at home. This put the paramedic in a difficult position. His patient wanted transport to hospital but did not fit any criteria for hospital admission and the patient’s GP insisted she stay at home. After a long discussion with the ever-increasing irate patient, the paramedic left the patient at home. Nevertheless, his feelings were evident once we returned to the ambulance:

“Do we keep batting her [the patient] off? Something needs to be done. It gets out of hand after a while. She wants to go to hospital. She will call again – this won’t stop,” he said. – *field note 14*

The paramedic knew this was not the last time they would be attending this patient and it added to the “black hole” analogy, as he was powerless to give the patient the support she needed to avoid calling for the ambulance repeatedly. Paramedics were results-oriented. They liked to see evidence of their treatment

so that they could adjust their management accordingly. However, as the paramedic above stated, managing mental health patients was complex and often resulted in feelings of helplessness and futility.

There was a constant comparison between the ease of treating physical conditions versus mental health conditions. This was reiterated every time by the fact that paramedics felt more comfortable treating conditions they could see some type of positive response to, for example, giving drugs to an asthmatic patient and seeing their breathing improve, or ventilating a patient because the drugs were not effective. Paramedics were more comfortable with the certainty of symptomatic treatment, because this was how they had been trained, as this participant explains:

“Yeah, if it’s a physical thing, then you can fix it, and you can monitor how you’re fixing it, like a tourniquet if they’re bleeding out. You know you’re putting a tourniquet on to stop the bleeding, and you’re doing a good job. How do you know that this person isn’t having a three-way conversation, disagreeing with you internally, externally accepting what you’re saying? Do you see what I mean?” – *interview 11*

Another incident in the field notes highlighted how paramedics managed mental health patients and why they behaved in a certain way. A specialist paramedic was dispatched in his RRV to a youngster suspected of having had an overdose. On arrival, he was met by the mother of the patient who had called 999 after discovering white powder next to her 16-year-old son’s bed. The patient was upstairs in his bedroom when the paramedic entered the house and was told why 999 was called. After a brief discussion with the patient’s mother, the paramedic decided to speak to the patient and suggested after a general overview that he speak to the patient alone for a while, while I went back downstairs with the mother.

After discerning no immediate threat to the patient, the paramedic came downstairs and had a talk with the patient’s mother about the next steps. The paramedic felt the patient did not need to be seen in the ED and he was also due to meet with the CAMS team later that morning. After also briefly speaking to the patient’s GP, the paramedic felt it was best for the patient to be left at home in the continued care of this mother. After spending an hour on scene, the paramedic and I returned to the RRV and he said the following:

“Ursh you gotta put that call in a box and shove it away, that family cannot be helped. It will only go one way” ... she [the patient’s mother] is projecting her mental health issues [bipolar disorder] on to her son. He is going to carry on using drugs [not known by the mother] and will end up dead or overdosed. She will carry on declining.” – *field note 4*

Several codes emerged from this field note. “Put that call in a box” suggested a literal meaning of containment and also a more metaphorical meaning, implying the paramedic was using “putting it into a box” as a coping mechanism. By putting this patient “into a box” the paramedic was able to move on from the call, thereby creating a patient–clinician boundary so that he could respond to the next call quickly and effectively. Getting more involved required more emotional labour and time.

“It will only go one way ...” described how the paramedic felt there was an inevitable road that this patient and his mother would travel. There was a feeling of futility and inevitable decline that added to the paramedic’s feelings of powerlessness and perhaps his own view of his input into this call – helplessness. Essentially all the paramedic did was take a detailed medical history, listen, advise and safety-net this call. There was no visible change in the patient because of any input the paramedic made. Often, in emergency situations, there was a tangible result to the actions paramedics undertook when treating a patient. In this case there was no obvious change in the patient’s circumstances as his problems were mental and not physical. The patient had not overdosed but he had tried to see what effect his anti-depressants would have if he sniffed them instead of swallowed them. The white powder his mother found next to his bed were his anti-depressant tablets which he had ground into a powder and sniffed.

“It will only go one way ...” was also another way of stereotyping or labelling mental health patients – since paramedics cannot help them, who else can? A deep sense of futility and helplessness was clear from this phrase. This paramedic was very experienced in primary health care, his past experiences in this sector added to his internal dialogue about mental health patients: “she [the patient’s mother] is projecting her mental health issues [bipolar disorder] on to her son. He is going to carry on using drugs [not known by the mother] and will end up dead or overdosed. She will carry on declining.”

The increasing need for paramedics to respond to mental health patients placed a new burden on the paramedic. They need to learn a different set of skills and also be more comfortable in managing conditions where responses were subtle or not

evident at all. This experience of living with uncertainty when paramedics managed mental health patients added to their sense of frustration and also contributed to the negativity they felt when they realised they needed to manage these mental health patients much better. The next excerpt described this well by aptly depicting mental health as the “invisible disease”:

“It kind of goes back to where we train and where we’re doing the job in that you have a problem and you know that the intervention you are doing is helping that person immediately and you can see the results. Whereas with mental health, it’s a longer process, isn’t it, to help somebody and we’re not going to see the immediate results – so, we don’t actually know. We assume we’re not helping the situation but you don’t know because you don’t see the outcome. What you say to them could actually trigger something to change them but you can’t see that so it’s almost like going down the lines of the invisible disease sort of stuff that you can’t see it, so is it there? Have you changed them? Have you helped them? We’re never going to know. There’s no follow-up whereas if you take a medical patient to hospital or a traumatic patient to hospital, you can go in later and find out, you can see immediately that day or the day after, did what you do help the situation. Where are they now? Whereas you can’t do that so you haven’t got any kind of closure, I suppose, on it.”– *interview 8*

A black hole has such powerful gravitational pull that it sucks everything into it, leaving no traces behind. This was an apt metaphor that described the frustration and disempowerment paramedics felt when they managed mental health patients. All paramedic participants in this study said they had very little support to help them in their management of mental health patients and they wanted more mental health education and specific mental health treatment pathways to help improve the care they delivered. A few paramedics added that the role of the paramedic needed to be revisited as most often mental health calls were not considered an emergency and their role in attending these non-urgent calls – with increased scene times and lack of support – added to their feelings of disempowerment feeding the notion that these patients are “like a black hole”. The follow-up interviews supported this as seen in the excerpts above. Paramedics described their frustration in terms of their own perception of helplessness. This was perpetuated by little or no feedback from mental health patients because they presented differently to patients with physical conditions. This feedback loop was key to learning about patient care and outcomes;

paramedics found the unknown and the perceived notion that they were not helping, uncomfortable. Patient care will not progress or change with these feelings ruling how paramedics managed this patient group. The interviews reiterated how paramedics managed patients – respond and treat symptoms. Perhaps learning how to live with this uncertainty and still feeling some sense of achievement as a profession is something that needs to be addressed when considering the future management of mental health patients by paramedics. Furthermore, paramedics were not only frustrated when treating mental health patients; they also did not feel they had the propensity to manage them. The next section will discuss why they felt this way and how this influenced their management of mental health patients.

5.2.2 “I’ve only got about 20 minutes of ‘there, there’ in me”

During an observation shift, a paramedic told me: “I’ve only got about 20 minutes of ‘there, there’ in me”. This quote made such an impact on me that I decided to explore it further. I recalled a lunch break in the crew room, when I was talking to a few paramedics about my research and a debate started around the role of 999 and how the public perceives paramedics. The discussion turned to how the 999 service is being abused and attempts by the NHS to educate the public about appropriate reasons to call 999, for example, a message entitled “please help us to help you, think before you call” (SWASFT, 2015). The paramedics were clear about when to call 999: the service was for a medical emergency – when someone is seriously ill or injured and their life is at risk. Medical emergencies included: loss of consciousness; an acute confused state; fits that are not stopping; persistent, severe chest; pain; breathing difficulties; severe bleeding that cannot be stopped; severe allergic reactions and severe burns or scalds. They did not include minor concerns such as “headache” or “backache”. Mental health issues were not considered emergencies, so paramedics suggested it was inappropriate to be called to a patient who was depressed. One paramedic summarised his own feelings like this:

“I disagree with all this ‘there, there’ business. It’s not our job. We are here to make them [patients] better and wiping their forehead or holding their hand won’t do that,” he said with conviction. I encouraged him to continue. “I’ve only got about 20 minutes of there, there in me – that’s it,” he said laughing. – *field note 18*

The “there, there” the paramedic was referring to was the time-limited amount of empathy, time and reassurance paramedics employed to calm and care for their patients. Most of the paramedics felt their role was more about responding to life threatening emergencies and using medical interventions to save the patient, rather than to sit for hours at a scene with a patient suffering from anxiety. Due to the nature of how paramedics perceived their job, the skills they believed were most important were those that saved a life (for example, drug interventions, CPR, ventilation and defibrillating). In a true emergency setting where there was a life-threatening injury or illness, paramedics first responded by using interventional skills to save the life. If the patient was revived, then “soft skills” such as good patient communication and caring were employed. There was more focus on fixing or correcting the physical problems than on the emotional problems and the emphasis only changed when the interventions were successful. With mental health patients, most often there was no physical intervention, only emotional support and this felt uncomfortable for many paramedics.

The follow-up interviews revealed that paramedics did not want to feel or admit to being emotionally compromised. The added complexity was sometimes the fact that paramedics could relate so well to their patients and this added to their feeling of vulnerability; making them feel the need to come across as tougher than they really were. The following paramedic explained it more detail:

“They’re [paramedics] thinking subconsciously that they need to defend against burnout, and that they’re worried about getting too involved emotionally with a patient because of the effect it might have on them, which you would expect. So, they’ve put up a sort of defence by saying, you know, publically almost that, “I’m not gonna do this and I’m gonna limit ... You know, I’m gonna ration, if you like, my empathy through self-preservation.” But, actually they are naturally quite empathic people. Despite their anxiety, they articulate that way about being drawn in ... being burnt out by being drawn in to emotive situations because that’s part of the job. Maybe it’s like a sort of, you know, a bit of flag-waving saying, “I don’t wanna let myself do this. I don’t wanna let myself be emotionally compromised.” But, actually they can’t help themselves because they are empathic.” – *interview 3*

Presenting a tough exterior helped paramedics cope with patients that affected them more than they would have liked to admit:

“We all went into this to never earn money. We all went into this to care, didn’t we? We all care. We go in there, and once we get absorbed into that patient’s needs, and absorbed into the patient’s crisis, rules and regulations, to a certain extent, and have at times, go out of the window because you’re absorbed. You want to help this patient. This is the reason we went into this. I think you get so emotional – I know you’ve got a small amount of time to build up a rapport, but once you get involved with this patient, and the mental health, and all the crises, and it’s flagged up to you, and it’s in your power to do the help, then you’re going to do it. If that is holding their hand, if that is reassuring and counteracting their anxiety needs, then you’re going to do whatever you do, because there’s nothing worse than leaving a patient. I always say to students, ‘You’re full of confidence. You’ve got confidence to sell. Go and sell it. Go in there, give them confidence, reassure them, and do not leave until they are reassured, yeah?’” – *interview 9*

However, the paramedic role was changing, as were the expectations of patients whose emotional needs needed to be managed and this was where paramedics felt they had limited capacity: “only about 20 minutes”. Although they felt limited in their emotional capacity to soothe and support mental health patients, the data showed this to be untrue. In most of the shifts observed, time on scene with mental health patients was often well over an hour; with these extended scene time calls, paramedics spent their time consoling or calming patients. This meant paramedics perceived their role in a certain way yet acted differently from their perception. The changing role of the paramedic was something I reflected on a lot during my time in the field as evidenced in the excerpt below:

“I am beginning to see that when paramedics are called to patients with physical problems [chest pain, shortness of breath] and a side-effect of this problem is stress or anxiety, then it is often ignored in order to deal with the physical issue first. Historically, paramedics are trained to respond to emergencies and a common response when I ask them about this is: “We aren’t counsellors or psychiatrists.” It begs the question, should we be treating the patient holistically and be supported by further education to do so, or should our focus remain on the physical, only noting mental health issues on our documentation and referring patients to supportive services and if so, which supportive services?” – *field note 6*

Three concepts were clear from this reflexivity, based on observations in the field: paramedics put the physical needs of the patient first; paramedics felt they were not trained or qualified to manage mental health patients; and the role of supportive services and how these services interacted could improve the patient experience and paramedic care. The following excerpt highlighted the focus being only on the physical condition (chest pain) as discussed in the previous section:

“The patient’s medical history included depression and anxiety but apart from that he was fit and well. ‘I worry about everything, you see,’ he added after explaining his medical history. During the banter between the patient and his friend, paramedic 14 had completed his observations and assessments. He had also done a 12-lead ECG to rule out any cardiac issues. He asked the patient directly if he ever had panic attacks before: ‘I get them twice a week usually, but if this is one it’s really taken it out of me,’ said the patient. ‘My chest is really sore,’ he repeated. Paramedic 14 asked for more details about this and sounded slightly frustrated. After noting the history and completing the physical assessment, paramedic 14 said the cause of the chest pain was anxiety and that he was going to leave the patient at home in the care of his friend ... – *field note 6*

The patient had chest pain but the cause was anxiety and not a cardiac problem. The paramedic was able to establish this through the medical history of the patient, doing an ECG (to rule out acute cardiac conditions) as well as interpreting how the patient presented to him. Although the paramedic diagnosed the patient with anxiety, he did not speak to the patient about how to manage the anxiety or consider referring the patient to alternative services. The paramedic felt he had ruled out life-threatening concerns and the patient could safely be left in the care of his friend and summarised it saying: “that was an easy one”. Easy because the patient did not need transport to ED and because no interventions were necessary; there was therefore no need for “only about 20 minutes of ‘there, there’.”

Another example of managing the physical needs of the patient above the mental health needs is described in the following excerpt. Here an RRV paramedic was called to a patient with severe back pain:

“She [the paramedic] finally got through to the GP for advice on pain management for the patient. She [the GP] sounded extremely annoyed and said she had spoken to the patient already and that it was completely

inappropriate to call 999, and she insisted she had told the patient this already several times ... She [the paramedic] then arranged an appointment with a nurse practitioner to prescribe additional pain medications if the patient could get there within 40 minutes.” – *field note 15*

The patient admitted that she had been calling the GP regularly and this was not the first time she had called 999. After more discussion with the paramedic about trying to manage pain levels the patient admitted that she felt unsupported and was struggling with her 11-year-old son. Holistically the patient had multiple problems: an acute flare-up of back pain, chronic back pain issues due to her obesity and concerns about being a single mother to her son. The only issue that was discussed with the paramedic was the acute back pain. After leaving the patient in the hands of her parents, who arrived while we were leaving, the paramedic commented on the call:

“It’s the kid I feel sorry for. Look at her, she is so big she won’t be able to look after herself, never mind him,’ she said with annoyance ‘He already has to do so much for her, it’s not right, he will suffer.’” – *field note 15*

These comments showed that the paramedic was aware of the underlying social and mental health concerns of the patient and her son, yet only addressed the physical aspect of the patient’s problems during the call. This referred back to the perception that paramedics did not believe their role was to be a “counsellor or psychiatrist,” hence the referral to a limited capacity in managing mental health and emotional issues.

Historically paramedics have been taught to respond to emergency situations where patients are in dire physical need for intervention. Often, under these circumstances, conversation was not a priority or a possibility if the patient was unresponsive. There was also a limited time paramedics could spend on scene with these patients as they needed the added interventions only hospitals could supply. However, these types of emergencies are now proving to be rarer, with the added change that the majority of calls are minor injuries or ailments, social or mental health-related calls which require not only a different mentality but also different training. The notion of being able to “sweep in and save the day” and then move on to the next patient to do the same is outdated. Patients require more time and input due to their increasingly complex medical presentations as

well as a lack of NHS resources and funding. The role of the paramedic has changed and this was how paramedics coped with the change:

“Most of us have trained to do the emergency side of it but you – you deal with what you’re given, don’t you? And the way mental health [problems] is growing, I don’t know, but you’re still dealing with somebody in an emergency situation. So, although we kind of say that maybe our capacity for that sort of job is lower or we dislike it more, I don’t know, but you’re still dealing with somebody in an emergency whether it’s their arm hanging off or whether they’re in a mental health emergency. I think ultimately, we’re still there to help people when they’re in desperate need and I think people probably say, and we’re probably all guilty of it, say those types of things to kind of just – kind of guard ourselves, I suppose, a little bit from being too emotional about it all ... There could be an element of that in that if you get like, I don’t know, if you’re a bit more open about how you enjoy or, kind of, enjoy helping people when they’re in a mental health crisis or have emotional problems, it will make you more emotional about it. So, it could be kind of a you are guarding yourself from the emotions behind dealing with it. Does that make sense?” – *interview 7*

While government policy such as the Five-Year Forward Plan (2015) and the Mental Health Crisis Concordat (2014) all supported an increase in education around mental health for all NHS services it seemed that this has not filtered down to the current frontline ambulance staff. This was evident during the observations as well: “We don’t know what we are doing half the time”, said paramedic 1; “They [MH patients] are people too and we can’t do anything for them,” added paramedic 19. “These patients are like a black hole; we cannot treat them or see the results of good treatment. They get a plaster and then get sent out again and we don’t make a difference,” said paramedic 20. Paramedic 7 blamed himself saying: “I am so shite with mental health patients, they deserve better than me.” These emotive quotes highlight the feeling of disempowerment, fuelling the sentiment of “only about 20 minutes of ‘there, there’” and “they’re like a black hole”.

Further to how paramedics perceived their management of mental health patients, all paramedics observed and interviewed in this study strongly commented that they should be able to access more support services for their patients as a way of improving their own care. A parallel part of support services

was having support from their own Trust. Almost all paramedics felt they should be able to admit their mental health patients to a mental health facility or hospital using a mental health pathway approved by the Trust. One paramedic reiterated this by saying “We need clear guidelines”. “There is nothing I can do for mental health patients. I don’t have the skills [education] or the back-up from other [support] services to help them,” he added. This was supported by another paramedic who said:

“We need to be able to admit them [mental health patients] to the local psychiatric hospital directly or they need to have a psychiatric ED.” – *field note 12*

As discussed in the previous section, paramedics believed that taking their mental health patients to ED was not in their patient’s best interest, and alternatives such as a community mental health centre or a psychiatric hospital for a patient who was in a mental health crisis were more appropriate facilities. This sentiment was supported by another paramedic observed on a different shift:

“We used to be able to take [mental health patients to the local mental health hospital] directly but now we must take them to ED. We can only take transfers there,” he explained. – *field note 3*

Interestingly, the Trust trialled direct admissions to the local mental health hospital a few years ago but stopped within the first two weeks of the trial as the mental health hospital had no beds left and felt many patients were taken to the facility inappropriately. The only alternative was for paramedics to take their patients to the ED.

Paramedics do care, as the above excerpt explains, but their caring used to be packaged into bite-size time portions where they could be easily managed because of the limited amount of time on scene and therefore less emotional input and reserve required. Now mental health patients and other social-type calls required more time on scene, more emotional engagement and also more careful consideration about how to manage patients with very little extra resources or alternative pathways to rely on. This is a change paramedics continue to wrestle with.

5.3 Chapter Summary

This chapter has used observational data and interviews to present how paramedics managed patients experiencing mental health issues. Two emotive categories emerged: “they’re like a black hole” and “I’ve only got about 20 minutes of ‘there, there’ in me” (also see Appendix I1 and I2 as supporting evidence presented at conferences in 2016). These categories evidenced the frustration levels of paramedics when it came to managing mental health patients and was linked to the changing role of the paramedic, the role of support services and the perception paramedics had about their capabilities and training when managing mental health patients. Pressure on the Ambulance Trust and their workforce added to the complexity of this study and the limited options of alternative care paramedics could provide for mental health patients led to them feeling that mental health patients “are like a black hole”. In addition, the increased demands paramedics faced which included being called to more and more mental health patients affected how paramedics perceived their ability and training to manage this patient group and they responded by saying “I’ve only got about 20 minutes of ‘there, there’ in me”. The next chapter will look at the micro level or the individual behaviour of paramedics, using ideas of presentation of self (Goffman, 1959) to explain behaviour patterns.

Chapter 6 Paramedic performance: exploring paramedics' presentation of self

6.1 Introduction

Chapter 5 depicted the role of the paramedic and provided a rich and descriptive account using participant observations and interviews to portray how paramedics responded to and how the perception of their role contributed to the way they managed mental health patients. This chapter will harness ideas around presentation of self as developed by Goffman (1959) to help understand why paramedics managed a patient group they considered to be “like a black hole” by using humour and stereotyping as coping mechanisms. This focus on the micro-level interactions of individual paramedics will provide a foundation for the next chapter, where the Community of Practice will be explored and how this shaped the way paramedics managed and responded to patients experiencing mental health issues.

6.2 Goffman's ideas about presentation of self in the sociological context

Before understanding how the concepts of self (Mead cited in Gecas, 1982) and presentation of self (Goffman, 1959) were relevant to how paramedics managed mental health patients, I felt it would be useful to frame this study within the broader context of sociology and used Figure 5 to help contextualise these ideas and the relationships between them. Sociology is broadly defined as the study of human behaviour and this PhD study used participant observations to study paramedic behaviour, analysing paramedic interactions with patients and with each other. The individual or micro level of paramedic behaviour will be analysed in this chapter. However, the group behaviour of paramedics will also be considered within the Community of Practice framework in the next chapter. This study also used the interactionist perspective to understand how paramedic interactions with mental health patients and each other influenced their management of this patient group. Two theories emerged from the interactionist perspective: the dramaturgical theory and symbolic interactionist theory.

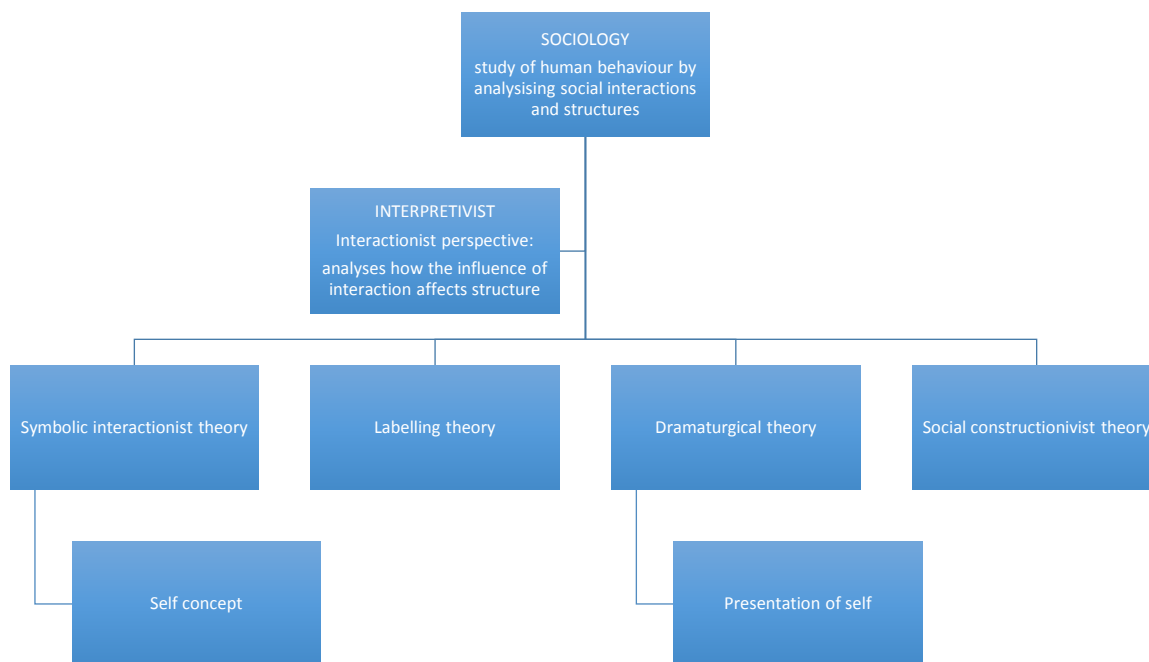


Figure 5: Situating self-concept and presentation of self within sociology
(adapted from Andoscia, 2018)

The dramaturgical theory emphasised that individuals made dramatic presentations and engaged in strategic actions according to a cultural script (Turner and Stets, 2006). In other words, paramedics used humour and stereotyping and believed that they only had “about 20 minutes of ‘there, there’” in them when managing mental health patients. This theory also focused on impression management and strategic behaviour which will be discussed in more detail later on in this chapter and Goffman’s presentation of self (1959) sits within this theory. Symbolic interactionist theory sits alongside dramaturgical theory and proposes that self was a motivating factor in encouraging certain behaviour. The function of interactions between people, institutions and groups and the symbols such as language, appearance and gestures shaped conceptions of the world around as well as performers within this world. Turner and Stets (2006) explained it as follows:

“The more that individuals have been able to verify self and identities in a situation, the more likely that identities, behavioural outputs, perceptual inputs, normative expectations, and sentiments about self, other, roles, and the situation will converge and reveal congruity.”

This study showed that there was a tension between the real role and ideal role of a paramedic and how paramedics perceived their role was often a factor in how

they responded to managing mental health patients. In fact, the few that considered mental health as part of their role experienced less tension and they made less use of humour as a coping strategy. As this chapter focuses on the micro level of behaviour, Goffman's presentation of self (1959) and ideas relating to self-concept were explored in more detail.

Goffman's seminal text, *The Presentation of Self in Everyday Life* (1959), used the metaphor of theatre to explain behaviour. These ideas proved useful in terms of explaining how paramedics managed mental health patients in certain ways. Three key concepts fall within Goffman's presentation of self idea: front stage, back stage and impression management. Although paramedics were not studied in their home environment, this study observed paramedics in their work environment and their interactions which supplied a rich description of how paramedics interacted. "Front stage" actions were those that were visible to the audience and part of the performance. In this study, front stage actions were the use of humour for an audience which consisted of mental health patients and their families or carers. From a research methods perspective, Goffman (1959) also used participant observation to access "back stage" behaviour. The back stage was where people's true feelings were apparent and a place where there was less performance for the sake of an audience. Here stereotyping, humour and nostalgia were used. Because this PhD study also used participant observation, access to paramedics' authentic thoughts and feelings were described as well as how they dealt with patients. In managing patients experiencing mental health issues by using humour and stereotyping, paramedics have created a coping mechanism that aided their own resilience. These coping mechanisms can also be described as behavioural patterns or props. Goffman's (1959) "impression management" term contended that each performance was a presentation of self and that specific impressions were considered for a specific audience. Impression management was the backbone of paramedic work. Paramedics were trained to appear calm, knowledgeable and in control under considerable stressful and unpredictable conditions. Interestingly, what this study revealed was that the paramedics acted in a measured, professional way when managing mental health patients on the front stage, however, what they really felt was underprepared, unsupported, frustrated and uneducated and this became apparent in their backstage behaviour. Using Goffman's concepts of front and back stage behaviour and impression management, helped to provide a theoretical construct to explain paramedic behaviour, therefore providing further structure to the data generated in this study towards answering the question: how paramedics manage

mental health patients. The next section reveals sub-themes that emerged from data analysis to support Goffman's notions of front and back stage behaviour and impression management during these performances.

6.3 Stages and performances

Using Goffman's ideas (1959), and building on the analysis from the previous chapters, several sub-themes emerged in terms of analysing the patterns and behaviours of paramedics seen during participant observations and follow-up interviews. The first sub-theme was real and imagined or ideal work. As discussed in previous chapters, there was a constant tension in paramedics between their real and ideal work. The second sub-theme was paramedic performance which was manifested in the way paramedics felt about their uniform and therefore their identity and how they managed the tension resulting from their work and their use of nostalgia to mitigate their feelings of frustration. These will now be discussed in more detail using Goffman's metaphors of theatre and concepts of front and back stage behaviour and integrating impression management into these stages during paramedic performances.

Stages within paramedic practice differed not only in so far as the geographical setting was concerned but also in the sense of particular moments (for example, when a calm patient becomes manic). The front stage can be in patients' houses, in the back of the ambulance or in a public area, depending on where the paramedics were dispatched. Interestingly, the ambulance had a dual role and was a front or back stage depending on the moment. It acted as a front stage when it had a patient in it as explained in excerpt 8: "I like to bring mental health patients into "my area" so that I can manage them in a safer space and I have more control in the back of my ambulance". It was even considered as a stage prop. However, the ambulance or response car and the crew room also acted as backstage when there were no patients aboard. It then became a space for paramedics to share their stories and complex or difficult calls, successful calls or a collective disgruntlement with the management of organisation they worked for, thus continuously reaffirming their Community of Practice. The response of patients to these different stages was variable and also largely dependent on their circumstances. If the patient was in crisis, the back of the ambulance was often seen as a confined and threatening space, especially if that patient did not want to be transported to the ED. It could also act as a positive location because patients felt reassured knowing that they were now in a safe place and en route to

receiving additional care. The front stage was an area where impression management included the “professional face” of the paramedic and where the audience, or in this case, the patient was reassured and listened to despite the contradictory emotions of futility and frustration felt by the paramedic and evidenced by back stage acting. I will begin with front stage performance because understanding how paramedics perform for an audience of mental health patients will help to answer the research question: how paramedics manage patients experiencing mental health issues. Backstage performance provides a more detailed view of what happens behind the scenes, therefore also contributing to the research question.

6.3.1 Front stage performance

Crucial to Goffman’s metaphor was the role actors wanted to convey. Paramedics who managed mental health patients wanted to provide the best and most appropriate care for their patients and this aligned with their identity and role – to provide treatment to patients in the pre-hospital environment. However, previous chapters have shown that despite this desire to provide the right care, paramedics felt frustrated and drained when treating mental health patients. Before they even started to “perform” or manage mental health patients, factors such as the tension between their ideal and real role were already coming into play, which was why they used certain scripts which contained humour to ensure that despite the way they felt, they still provided appropriate patient care. For a performance to start, certain elements needed to be in place. This study showed that paramedics were ready to “act” for their public audience on the front stage. They required props to do so effectively. These props included costumes, in this case uniform; and scripts which included nostalgic stories, and the use of humour. Their costumes or uniform represented their profession. Uniforms were one way of enacting professional boundaries in practice. According to Timmons and East (2011), uniforms were clear, visible symbols which made it easy for everyone to know where the occupational boundaries were. Timmons and East (2011) also added that there were very few papers written on uniforms as their main focus and none in relation to paramedic identity and uniform. Although not recent, Joseph and Alex’s work in 1972 (cited in Timmons and East, 2011) emphasised how uniforms are emblematic, indicate status and legitimacy, and suppress individuality. Spragley and Francis (2006) believed that within healthcare, uniforms generated strong emotional attachments and this was observed in this study as well. Paramedics work in a variety of roles which require

different dress codes, however, this study focused on paramedics who were working on frontline ambulances for a local trust and therefore they all wore green uniforms.

Role identity influenced how paramedics responded to mental health patients with the uniform acting as a protection against the work that paramedics were being asked to do – their real work. The green uniform also had other symbolic signifiers attached to it. The uniform itself is made of durable material and includes additional gear for different environmental hazards such as heat and cold, literally protecting the paramedic from the elements. The green uniform also signified a tribe working for the ambulance service and this created an expectation from the audience or patient – that paramedics would quickly arrive in an ambulance or response car and would treat and manage your condition. It also marked out the paramedic tribe and differentiated paramedics from others such as GPs, police, community members and patients. Paramedics created a certain “professional” impression for the patient, their family and carers as described in this excerpt:

“On the way to hospital, Paramedic 6 sat next to the patient alternatively writing notes and reassuring the patient by rubbing her shoulder. ‘You live and learn. You get through this alcohol shit and you can live again. You have a wonderful daughter and son,’ added Paramedic 6.” – *field note 2*

Here the paramedic was in a dual role, completing the required paperwork for the patient’s arrival in the ED and being empathetic and listening to the patient talk during the transfer to hospital.

Central to performance was impression management (Goffman, 1959). This is where impressions, including first impressions, come into play, as they can situate a person's identity. Goffman’s presentation of self (1959) considered ways in which individuals in work situations present themselves and their activities to others. Goffman (1959) also explored ways in which these individuals’ guided and controlled the impressions they form of themselves and the kinds of things they may or may not do while sustaining their performance. Cynically, Goffman (1959) stated that individuals offer performances and put on a show “for the benefit of other people”. Goffman (1959) reiterated that several factors influenced “acts” or performances, the setting, the appearance of the actors and the manner in which they present themselves. During front stage performance, the role of uniform and

how paramedics perceived their identity influenced their responses to mental health patients. And their manner was aided by the use of humour (as seen in the excerpt below), which ensured their role was performed as the audience expected it to be and this combated the feelings of “they’re like a black hole,” thereby ensuring that they had more than just 20 minutes of “there, there” in them.

“‘It feels like something is pushing against me, I have a bad back too,’ he [the mental health patient] said with tears streaming down his face. ‘Ha ha,’ laughed paramedic 27 loudly. ‘I know all about sore backs, that’s why I am swaying when I stand – don’t worry I don’t have music in my head!’ he added laughing loudly. The patient laughed too and started to look less anxious.” – *field note 18*

In this front stage performance, the paramedic engaged humour in an empathetic way to defuse the emotional tension of the call. The patient was initially crying but started to laugh as the paramedic employed humour. Goffman (1959) believed actors created impressions with language and body language. Paramedics created impressions by their expressions, in this case the expression of humour. However, as evidenced in the previous chapter, paramedics found their role frustrating and often felt helpless in terms of how they managed mental health patients. There was an internal conflict about how they perceived themselves in this role as seen in the following excerpts:

“‘We don’t know what we are doing half the time’ – *field note 5*; ‘This [mental health call] was without a doubt the most frustrating call of my career so far.’ – *field note 2*; ‘They [MH patients] are people too and we can’t do anything for them. And we can’t get the crisis team in or the GP because they never come,’ he said with some frustration in his voice.” – *field note 19*

The frustration that stemmed from paramedics feeling they were not helping mental health patients was a recurring emotion throughout the excerpts and throughout this study. Supporting this in the follow-up interview was an experienced paramedic, who saw mental health calls as a personal challenge. He described the paramedic role as:

“‘... a lot more social, a lot more mental health and a lot more probably urgent care calls. We tend to do a bit of everything and don’t specialise in one particular thing.’ His understanding of why there are more ‘social’ calls lies

with a generational attitude, 'I am sounding old now, but the younger generation want treatment now sort of thing ... People aren't always prepared to wait ... GP surgeries are overloaded and particularly out of hours are inundated so we end up getting pushed a lot of GP out of ours calls. They [patients] call us [999] for referrals. People say mental health is not our job but it probably is'." – *interview 1*

However, often the mental health calls that paramedics were being sent to as observed in this study were not allocated as emergency calls which meant responding at normal road speed and with no sense of urgency. Again the tension between the ideal role ("we are an emergency service") and the real role ("we now respond to falls, minor injuries, mental health and social calls") ensured that paramedics were performing on the front stage in an appropriate and expected manner, yet in reality paramedics did not feel confident about managing mental health patients. The scripts paramedics referred to depended on the patient and the experience of the paramedic. As also evidenced in the previous chapters, some paramedics used humour with confidence and regularity while other less experienced paramedic "actors" used it less frequently.

Understanding the persona of the paramedic lead to understanding why they behaved in certain ways and ultimately this helped identify why they managed mental health patients in the ways they did. In terms of this study, a paramedic's social identity was linked to their "first appearance" on the front stage when arriving at a mental health call. This study showed that paramedics also used humour to defuse tense situations to "lighten the atmosphere" and before arriving at calls they also stereotyped patients, for example, "going to a mental one again" or "it's an arrest", in categories as a triage and coping mechanism. But, how paramedics perceived themselves influenced how they were perceived by the patient during their performance. If paramedics acted confidently and used their props (humour) then their real feelings of frustration would not be known to the patient. Paramedics therefore acted as one character – as a health care professional dressed in the green uniform that aligned with their identity and signified their role as a health care professional. However, their feelings of frustration remained as an internal dialogue among paramedics when they were not performing for the audience. Their ability to discuss their frustrations and anxieties ensured they were able to continue a good front stage performance as they had an outlet for their true feelings later – during the back stage performance.

Goffman (1963) also paid particular attention to social identity in the context of his work on stigma and presentation of self. His ideas around social identity were helpful in terms of this study because how paramedics perceived themselves will help towards understanding their behaviours. Goffman (1963) wrote that:

“Society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories. Social settings establish the categories of persons likely to be encountered there ... When a stranger comes into our presence, then, first appearances are likely to enable us to anticipate his category and attributes, his ‘social identity’... The category and attributes he could in fact be proved to possess will be called his actual social identity.”

The paramedic social identity was therefore linked to their green uniform and their role and ironically this role was aligned to a service to call for an emergency. But Goffman (1963) also wrote that actors had a “situated identity”. Goffman (1963) felt this identity needed to be in place or “situated” before an interaction took place. Paramedics were in a situated identity when responding to mental health patients. This friction between their real and ideal role caused tension in their situated identity which is why they used humour and stereotyping as coping mechanisms. Therefore, front stage impression management comes with a heavy sense of duty, responsibility and autonomy that is often not understood by the public or other health care professionals:

“It’s that feeling of not ... of uneasiness and not knowing, uneasiness and probably helplessness, of knowing that this person [the mental health patient] needs some intervention, needs some help, but that that is not forthcoming and the services that are there to provide this help have not and are unwilling to see him, at that point, and that feeling of not being able to help someone makes me very uneasy, I think.” – *interview 11*

The nature of paramedic work also forced paramedics that were in conflict with their core beliefs, to revert to a nostalgic worldview but continued to act in their work world which included responding to an increasing number of mental health calls and this eroded their nostalgic world view. This nostalgia was seen during the back stage performance of paramedics and will be discussed in the next section.

6.3.2 Back stage performance

Back stage performance represented the actions of paramedics when they did not have an audience (Goffman, 1959). These back stage performances took place during meal breaks at their base station, time between calls and shift swap times. One underlying and common act during back stage performance was nostalgia. As a prelude to nostalgia, the tension between the real and ideal role spilled over onto the back stage performance as well. Nostalgia set up the difference between the real and ideal work – where paramedics longed for an ideal role yet acted in a real role. There was also a friction between the older and younger paramedic generation in terms of how they perceived their role. The more experienced paramedic had the historical experience of responding to mostly emergency calls and now had to cope with an evolving role that required them to deal with non-emergency work. The younger generation were coming into the service having to respond to emergency, urgent, social and mental health calls. This influenced how each generation reminisced. Many of the younger generation were swept up in the nostalgia of the older generation and their reference to the “olden days” and listened enthusiastically to these shared experiences even though it did not match their current experiences. This division was compounded by the lack of a defined role added to the complex acting back stage.

Nostalgia is defined as “a sentimental longing or wistful affection for a period in the past” (Oxford Dictionary, 2018) and has previously been examined in Health Services Research. McDonald et al (2006) wrote about the link between identity and nostalgia adding that “nostalgic idealisation of the past can be employed to demonise the present by those who seek to resist change”. The older generation of paramedics seemed resistant to change creating a sub-group of “others” within their own group. This influenced the younger generation of paramedics as well as the incoming students as they picked up on the divide between the older generation paramedics and those more recently qualified. How the younger and older generation perceived their roles also influenced the concept of their Community of Practice which will be discussed in the next chapter. McDonald et al (2006) commented about the role nostalgia had in “constructing, maintaining and reconstructing our identities”. Across all observations and interviews, the individual paramedic identity was very strong, there was pride in the title and pride linked to the work they found most valuable – “real emergency work”.

Nostalgia was not only evidenced by recollecting the “good old days” but in terms of the types of calls paramedics used to receive in “the good old days”. These

were defined as “true emergency calls,” such as life-threatening asthma, pulmonary oedema, hypoglycaemia, cardiac arrest and road traffic collisions, as a few examples. A study by McDonald et al (2006) described how medical staff drew on “nostalgic memories to present an alternative, competing version of the world” in order to challenge the change within the organisation. Although the older generation of paramedics were certainly nostalgic in their accounts, there also seemed to be a resignation to the change of the role, a reluctant acceptance, which was not the case in the younger generation. This was due to the difference in expectations and historical experience of the role. Strangleman’s (2007) work on nostalgia explored the tendency to look at the past for stability and “good work” as opposed to the “dirty work” referred to by Jeffrey (1979). Strangleman (2007) reiterated the importance of context when understanding the role of nostalgia and discussed the concept of loss in terms of employment and economic change. The findings of Strangleman (2007) were relevant to this study as some of the paramedics observed and interviewed very much depicted this sense of “loss” in their nostalgic accounts of the past. Understanding the context of the paramedic role as discussed so far and also the broader context of the paramedic profession helped me in answering this study’s question. Fifteen years ago, the role was certainly more focused on emergency with an added element of social and mental health calls. The newer generation of paramedics were expected to have a clear understanding of their role now which has become far more urgent, social and mental-health care related. A more recently qualified paramedic described how he perceived the paramedic role today as follows:

“I liked responding to those sort of life threats and stuff like that, but then obviously, coming into the profession quickly realised that actually it’s not about that. I liked the profession because I liked the diagnostic side of it ... You know, if it had stayed as it was traditionally where we just took everyone to hospital, it wouldn’t have been a career that interested me ... There’s usually some mental health. There are a lot of social problems and then obviously, there are the emergencies where people have immediate threats to life, but they’re more far and few between.” – *interview 10*

This interviewee was less nostalgic about the past, but he also touched on the traditional role and how there was less clinical autonomy and responsibility, which was why paramedics had to take patients to hospital more often in the past. Interestingly, this particular paramedic took his mental health patient to hospital as he did not feel it was safe to leave the patient at home. The older generation were nostalgic about the simplicity of the job, to respond to

emergencies, treat patients and refer them. Today's role was seen as far more complex with more clinical responsibility and autonomy. There is a growing acceptance that mental health calls are now a reality and that the ambulance service will continue to respond to these calls. To manage this real work, paramedics continued using nostalgia as well as humour and stereotyping. This excerpt summarised how paramedics understood that managing mental health patients was their real work but that did not change how they felt about managing them:

"We constantly relate what we do for physical health with mental health, so because we know we can fix things and we want to fix things because that is the kind of people we are, when we can't that's ... You are not going to educate the public, and so you need to change, instead of trying to move the services or move them, you need to move the services to meet their needs, and mental health is the same. You are not going to stop people dialling 999."

– *interview 2*

In addition, many paramedics felt that their role lacked more definition. It was no longer a role of being emergency responders, but more "a jack of all trades and a master of none", which clouded their situated identity (Goffman, 1963). A clear situated role was preferred which was why many paramedics have started to specialise in urgent care or critical care as these roles are far more defined and less general:

"The role of the paramedic nowadays is everything, whatever we just get sent to whereas before, I think it was a more defined role, years ago ... Again, mental health more of that than what we used to deal with years ago and we're doing more, I would say GP-type work with the 111-type calls we get so things like trauma, even cardiac and all this is just going, you know, it's just slowly disappearing." – *interview 6*

There was also the added pressure of minimising hospital admissions and keeping patients at home, this was highlighted by the Right Care, Right Place, Right Time initiative by SWASFT, a commission-funded agreement that committed the Trust to reducing admissions to EDs by 10% (SWASFT, 2010) as evidenced in the following excerpt:

"I think we're just expected to do absolutely everything, but then I think we always were but now to a bigger degree, so before we would see everybody and generally they'd go to hospital whereas now I think you see everybody and

you're expected to have a treatment plan for them, so I think that's changed, but I don't think you always need a treatment plan and I think in other Trusts you don't, but because it's so heavily advocated to keep someone at home, you're starting to treat a lot more people." – *interview 5*

The underlying message from all paramedics observed and interviewed is that they realised mental health calls were not going away but they also acknowledged that they would like to improve their care of this patient group, thus responding to the Right Care, Right Place, Right Time initiative (SWASFT, 2010). All paramedics in this study said they lacked the clinical skills and knowledge to meet the needs of their mental health patients. This was supported by the College of Paramedics survey (2014) where 98% of the respondents believed there should be more education and training for paramedics in mental health conditions. Interestingly, most of the paramedics interviewed also wanted more referral pathways or access to supportive services as they believed that understanding a mental health condition was beneficial but supporting the patient by referring them to other services within the community and therefore avoiding admission to inappropriate facilities such as the ED. The historical experience of the ideal job, which again was related far more to "life threatening emergencies" also fuelled paramedics' frustrations as shown in the following excerpt:

"We should have specialist paramedics (whatever they are now) on the car and leave the ambulance for real emergencies. Seamless care does not work ... we are being used as an urgent resource when we are trained for emergency care." – *field note 8*

This was a discussion during a meal break back at the base station. The reference to "urgent resource" signified the resentment that was brewing among paramedics about having to respond to calls they did not consider an emergency, as described in Chapter 5. Paramedics were regularly responding to patients who "cannot get an appointment with my GP" but felt they need to be seen by someone and often mental health patients called 999 as "I know you will come" and "no one else will listen". This resentment was evident in the interviews as well:

"We are not doing the job we are trained for, we are really not ... You see, we could be called to something totally different and people have got mental health, so I am probably seeing mental health an awful lot more, definitely a lot more than in the olden days. I don't mind going to mental

health, but going to some of the stuff, it's hard to be professional sometimes." – *interview 4*

The data gathered during the observations and interviews revealed that paramedics had certain common scripts when performing on the back stage which included humour and stereotyping. In addition, paramedic back stage performances also revealed that there was a lack of a defined role which added to the tension already existing between the real and ideal perception of the role and lastly, all of the paramedics observed and interviewed felt they lacked the skill and knowledge base to correctly manage these patients. How did this affect their identity and performance? The older generation of paramedics struggled more with their situated identity because of the nostalgic pull back to the "olden days" where care and management of patients was different. This is why they used props like humour as described by an experienced paramedic below:

"We use humour because we use gallows humour, don't we? Dark humour, because the things we see, the normal public wouldn't be able to deal with ..." – *interview 4*

When it comes to interactions between paramedics a different "act" becomes clear during back the stage performance; there was banter and the use of dark humour that not seen during patient care:

"In the crew room another paramedic approached me and asked if I was assessing the mental health of paramedics. I explained that I was observing how paramedics manage patients experiencing mental health issues but not assessing them or their mental health. 'Good!' he said. 'We wouldn't have jobs left if you were assessing our mental health.' A few other crew members in the crew room sniggered at his comment ... 'Malpractice makes perfect!' laughed the one paramedic with a gleam of mischief in his eye." – *field notes 2 and 19*

The use of humour and understanding it as a type of behaviour within Goffman's framework of Presentation of Self (1959) was further evidenced by work from Cain (2011) who explained the role of dark humour and "morbid" conversations in what she described "backstage behaviour" of hospice workers. Again, the tension between presenting a "professional face" versus a "sincere face" was evident in this paper and supported this study's observations and follow-up interview findings. Paramedics used dark humour among themselves but, they also used humour when managing mental health patients. Although these were

two different faces of humour, they were both used authentically and as a management tool, firstly for resilience and secondly to break down barriers when communicating with mental health patients. Goffman (cited in Cain, 2011) reiterated that backstage regions must exist to make the front stage behaviours possible. This study showed that paramedics used dark humour backstage, which enabled them to manage mental health patients with humour during their front stage performance. However, Cain (2011) believed that back stage areas were also sites of conflict, vies for power and attempts at influence, especially during times of organisational change. This study showed that the role of the paramedic was undergoing an evolution and this also impacted organisational response to this change, therefore increasing the need to use humour and stereotyping as props. The crew room as well as the front cab of the ambulance were backstage areas for paramedics to decompress, and where they were able to show their “sincere face”. The other prop, which was stereotyping, was also supported by the follow-up interviews and was only evident during back stage performances:

“I think it [stereotyping] probably depersonalises it so you’re not remembering the patient’s name or gender, you are kind of just – yeah ... So, it depends what information they give you. If it just says 23-year-old woman with depression, you probably kind of stereotype and go, oh, it’s someone with depression. Does that make sense?” – *interview 6*

The newer generation make less use of nostalgia and therefore also rely less on humour and stereotyping as explained in this excerpt:

“Experience, yeah. And also, I think when you’re newly qualified, you don’t want to push it [humour] too much, whereas I think a lot of the old-school guys, they know and they don’t care what they say. Not don’t care what they say, but they’ve got a bit more confidence, you know? ... Whereas I think when you’re new, you don’t want to risk getting a complaint or anything like that but I think a lot of the older-school guys are probably past it, they don’t care.” – *interview 5*

The use stereotyping during back stage performances was explained by a new paramedic as follows:

“... I think stereotyping is human nature and I think, you know, it helps us to process things, to make sense of things ... I think it helps with resilience, absolutely, that kind of dehumanising aspect of it and to put things in boxes, so it can help with the diagnostics, “What’s the treatment

plan? But, I think stereotyping only becomes a problem, I might get shot for this. I think stereotyping becomes a problem when you're not aware that you're doing it and you act on those preconceptions, but that actually, having a stereotype is perfectly normal and helps us to make a quick decision sometimes about things, but if we're aware that we are stereotyping and that there may be differences in this particular instance, and we're open to that, I don't see that as a particular problem." –

interview 11

Also relevant to this paramedic identity crisis was Stacey's (2005) work about finding dignity "in dirty work". Aligned to this was the older work of Jeffrey (1979), also discussed in Chapter 4 and his concept of "dirty work". Stacey (2005) revealed that workers identified three broad work constraints that influenced their ability to do a good job or experience their work as meaningful: overwork; increased risk (less inexperienced paramedics tended towards defensive practice and were very risk averse); and physical and emotional strain of the job (as played out through humour and stereotyping. However, participants in Stacey's (2005) study were also clear about rewards of the job, which stemmed from practical autonomy, skills building and doing dirty work. Stacey (2005) added that these findings supported evidence that workers found ways to manage risk, and as this study shows, paramedics used humour and stereotyping to manage patients thereby mitigating the internal battle about their role and identity.

Stacey's (2005) study referred to low-waged workers as well as unskilled, non-professionals which was in direct contradiction to paramedics in this study, however, what they both had in common was the "dirty work" defined by Stacey (2005) as "a highly stigmatised (dirty) occupation". Paramedic work is "dirty" in the literal sense due to the calls they had to deal with, which often included faeces, urine, blood and vomit. There was also a metaphorical element of their work that was "dirty" and this related more to the use of humour and stereotyping which were props or coping mechanisms paramedics employed. There were other parallels in this study that corresponded with the data from my study. Stacey's (2005) findings included a theme: "we're maids, overwork and added responsibility". This rang true with paramedics' accounts that they were being called to mental health patients as other more appropriate resources were no longer available. "Patients call us [999] as they know they will get a response of some kind, face-to-face or verbal, they don't get this from their crisis teams or their GPs", *interview 2*. As well as dealing with what is often

perceived and expressed by paramedics as “real 999 emergencies” and a situated identity they are comfortable with. Paramedics were expected to draw on a wider set of skills due to evolving patient expectations and service demands. They also acted as counsellors and social workers, both additional expectations that added to their labour and often created more anxiety when having to safety-net a mental health patient, thus creating a vortex where often they felt their only alternative is to take the patient to the ED. This back stage action mirrored but was more magnified than acting seen in practice and in front stage performance, specifically because the back stage had no audience and paramedics could reveal their true feelings without judgment.

But keeping up front stage acting was draining and therefore fed into the feeling of “they’re like a black hole”. To counteract this, paramedics managed their emotions back stage as described below:

“You just need time out, because it’s a drain ... I mean, they [mental health patients] are frustrating because you are not going to get anywhere with them to a degree, you don’t have long enough to sit with them and peel back the layers of the onions and find out what the cause is, because we’re pushed to come clear to do another job, so we don’t have time enough with them really. You know the only place to take them is ED half the time. If they are safe, you are going to get criticised there. Or, you leave them at the scene you are running the risk that they might harm themselves, and if you overlook something you are going to get criticised.” – *interview 4*

Back stage acting was more authentic and raw as Goffman (1959) believed. In the excerpt below paramedics revealed that they felt worn out and tired and as one paramedic aptly described as “... I’ve only got about 20 minutes of ‘there, there’ in me” to manage mental health patients as described below:

“They’re [paramedics] thinking subconsciously that they need to defend against burnout, and that they’re worried about getting too involved emotionally with a patient because of the affect it might have on them, which (?), you would expect. So, they’ve put up a sort of defence by saying, you know, publically almost that, ‘I’m not gonna do this and I’m gonna limit ... You know, I’m gonna ration, if you like, my empathy through self-preservation.’ But, actually they are naturally quite empathic people...Despite their anxiety, they articulate that way about being drawn in ... Being burnt out by being drawn in to emotive situations because

that's part of the job. Maybe it's like a sort of, you know, a bit of flag-waving saying, 'I don't wanna let myself do this. I don't wanna let myself be emotionally compromised.' But, actually they can't help themselves because they are actually empathic." – *interview 3*

Part of "impression management" was also managing emotions. Various studies have considered the importance of healthcare professionals managing their emotions and presenting a certain demeanour in a number of healthcare settings. Bolton's (2001) study focused on the "emotional work" of nurses and also referred to the changing organisational context of nursing in Britain. The findings of Bolton's study were relevant as she also used Goffman's concepts of "presentation of a socially acceptable face" in practice. Goffman's (1967) analysis of social interaction helped understand emotion and relied on the assumption that emotions were actively managed by people according to a set of rules of a particular situation. The rules for paramedics included the expectation of professional behaviour and appropriate care for patients. Goffman (1967) added that social actors move between being fully present and absent according to the signals they receive throughout encounters and rules learnt by being an active member in a community of practice. This provided a basis for understanding why paramedics used humour and stereotyping as tools when managing mental health patients and also why many of them felt "I've only got about 20 minutes of 'there, there' in me". The constant tension between portraying a "professional face in their uniform" and their personal feelings of frustration and futility because of the limitations they had in providing care for mental health patients was exhausting. Not only did they have to present a "professional face" to patients and to their organisation while these undercurrents were running beneath the surface, but this was also in contrast with how they interacted with each other during down time. Interestingly, Goffman believed that people do not switch themselves on and off but "glide from one performance of face-work to another, sometimes matching feeling and face with situation (paramedics with their crew mates and family) and at other merely maintaining face (paramedics managing patients)" (cited in Bolton, 2001). Bolton (2001) asserted that the presentation of the professional face required a combination of contradictory elements. This study shows that contradiction happens when paramedics are managing mental health patients. Bolton's (2001) study revealed that nurses were able to seek out "spaces" where they could find relief from having to maintain the professionally prescribed face. This "space" for paramedics was their crew room and personal time where they used humour and stereotyping as resilience tools. Bolton (2001)

believed that nurses' ability to overcome times of emotional stress with humorous episodes, as evidenced in this study too, "can actually work in the organisations' favour ... the use of humour allows nurses to redefine a stressful situation and carry on and do their job (Goffman, cited in Bolton, 2001).

The front and back stages also acted as a boundary between paramedics and their patients. These boundaries helped shape areas where in the back stage, paramedics could show their authentic selves and in so doing create a safe place where ideas were disseminated, calls were debriefed and a shared transfer of knowledge in a supportive and humorous way was observed. Goffman (1959) believed that "among members of the team, we tend to find solidarity, familiarity and secrets being kept". The solidarity and familiarity were elements of an evolving Community of Practice. He added "a tacit agreement is maintained between performers and audience to act as if a given degree of opposition and of accord existed between them (Goffman, 1959). Paramedics were often considered only as ambulance drivers with very little understanding around the depth of their autonomy and practice level. The increasing responsibilities paramedics carried in a changing NHS system, where budget and staff cuts directly impacted on services such as mental health, was often left to the ambulance service to then pick up the calls no one else wanted to deal with – "they [mental health patients] call the crisis team or their GP and get told they need to wait, they [patients] don't want to wait and they know when they call 999 we will come, even if it is just to listen." – *interview 3*. This added to the complexity of impression management in a "play" where the roles were constantly changing to meet the needs of the audience.

Alongside the front and back stages described above, and building on Goffman's (1959) ideas about presentation of self, I also believe paramedics have a "dressing room" and in the literal sense, their changing room at their base station. This was a transition area behind the front and back stages and represented paramedics as they were in their personal lives. In the "dressing room" paramedics get changed into and out of their uniform and here they made the transition by preparing for their performances on the front and back stages, or they had completed their shift and therefore their performance was over and they could change into their civilian clothes, shedding any props or scripts as they prepared to go home. This was an idea I would have liked to develop more but the parameters of this study did not include observing paramedics in their personal lives and therefore further analysis was not possible.

6.4 Summary

This chapter built on the detailed description of how paramedics manage mental health patients in Chapters 4 and 5 by using Goffman's ideas of presentation of self (1959) to show how paramedics used humour and stereotyping behavioural patterns when managing mental health patients. The chapter also introduced concepts front stage, back stage and impression management during both these performances and how paramedics performed on these stages with different scripts and props as shown in Table 3.

Table 3: Performances and stages describing how paramedics manage mental health patients

Performance		
Front stage	Back stage	Dressing room
<p>Stage: the ambulance, a patient's home, in public areas, any place where a patient is being treated by paramedics</p> <p>Impression management: for the sake of the audience</p> <p>Appearance: uniform</p> <p>Props: "soft approach" stereotyping and humour</p>	<p>Stage: the ambulance without patients in it, the crew room, the base station</p> <p>Impression management: for the sake of colleagues</p> <p>Appearance: uniform</p> <p>Props: stereotyping, dark humour, nostalgia</p>	<p>Stage: changing rooms at the ambulance base station</p> <p>No need for impression management</p> <p>Appearance: getting changed into uniform; or getting changed out of uniform</p> <p>No props necessary</p>

Impression management occurred during front and back stage. Underlying props in this chapter contributed to the performances observed on the front and back stages. During front stage performances the green paramedic uniform contributed to the identity of the paramedic and managing mental health patients influenced the situated identity of the paramedic thereby ensuring that they acted in a manner expected by the audience, their patients. The tension between the paramedic's real role which was managing mental health patients and their ideal role, being emergency-related calls was mitigated by their uniform. Their uniform serves a reminder of what role they had to play and they used props such as humour to ensure they kept to their script. During the back stage performance, which occurred during paramedic "down time", paramedics felt freer to voice their opinions regarding managing mental health patients and this was also an

opportunity to share knowledge and reinforce their Community of Practice. Although they were still in uniform, dark humour and stereotyping were used as props with one addition, the use of nostalgia. Nostalgia, in the same way as humour and stereotyping, helped the paramedics to voice the tension between their real and ideal roles. Nostalgia also acted as a unifier, where the older generation reminisced about the “olden days”, drawing the attention of the newer generation when recounting their stories. The final part of the act was what happened in the dressing room, the transition area where paramedics were either changing into their uniform or changing out of it at the end of their shift. Here, no props were necessary and there was no need to manage any impressions. This was not observed as part of this study yet using my own experience as a paramedic, I believe the private lives of a paramedic are just as relevant as their working lives in terms of the roles they have to play. Having the ability to remove their costumes (uniform) and not have to rely on a script or props creates a safe place for paramedics to unwind. In conclusion, this chapter focused on the micro level of paramedics managing mental health patients. We know the role of the paramedic is evolving and understanding how paramedics perceived their role in terms of managing mental health patients and knowing why they behaved in certain ways helped me to understand their behaviours and beliefs as a group or Community of Practice, which will now be reviewed in Chapter 7.

Chapter 7 A Community of Practice

7.1 Introduction

The previous chapter used Goffman's presentation of self (1959) to explain the various front stage and back stage performances of paramedics and why they used humour, stereotyping and nostalgia as coping mechanisms or tools when managing and responding to patients experiencing mental health issues. This chapter moves beyond the individual paramedic performance to look at paramedics as a group. It focuses on the sharing of emotions, tips and knowledge about how to manage mental health patients and discusses factors influencing this such as segments within the Community of Practice and boundaries that help define it. This chapter builds on the concepts of Communities of Practice to examine how being part of a community has an important influence on the way paramedics manage mental health patients. This analysis is used to underpin a further argument which is that paramedics are a distinct Community of Practice.

7.2 What is a Community of Practice?

Often considered the founders of Communities of Practice, Wenger and Lave (cited in Le May, 2009) describe a Community of Practice as:

“Groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their understanding and knowledge of this area by interacting on an ongoing basis ... These people don't necessarily have to work together on a day-to-day basis, but they get together because they find value in their interactions. As they spend time together, they typically share information, insight, and advice. They solve problems. They help each other. They discuss their situation, their aspirations, their needs ... over time they develop a unique perspective on their topic as well as a body of common knowledge, practices, and approaches.”

The observation and interview data showed that paramedics “shared a set of problems” around how they managed and responded to patients experiencing mental health issues and “interacted on an ongoing basis” while on the job, on station during break time and during shift change. They appear to be a Community of Practice. Wenger and Lave (1991) originally put forward that Communities of Practice were central to their situated learning theory which

proposed that learning involved a complex relationship between a novice and expert within a group. They highlighted the importance of being socialised into the practice and the ways group members developed an identity within that community (Wenger and Lave, 1991).

Some of the literature discussed in Chapter 2 also supported the premise of Communities of Practice in healthcare. Becker et al (1977) *Boys in White*, showed how medical students were institutionalised and influenced by their educational experience. Becker et al's (1977) ethnography also described details of the "medical student tribe" and its associated rituals, standards and efforts towards self-sufficiency. Although, the study by Becker et al (1977) was about a different profession, it also highlighted certain behaviours, rituals and ways knowledge was passed on and evolved through the Community of Practice. Similar behaviours seem to operate for paramedics. Sinclair's (1997) later work, *Making Doctors*, also linked apprenticeship learning to Lave and Wenger's (1991) concept of legitimate peripheral participation. Paramedic students and new staff members enter the paramedic Community of Practice as legitimate observers, following experienced paramedics on the periphery and as they work towards their own registration and autonomy they begin to move from peripheral participation to becoming members of the community.

Estroff's (1981) *Making it crazy*, focused on the psychological and social facets of mental health patients discharged from hospital and also suggested that patients formed their own Community of Practice in terms of coping mechanisms after being discharged with a focus on deinstitutionalisation, and concepts such as control and labelling. As this study has already demonstrated paramedics also used labelling or stereotyping as a coping mechanism within their community. Whilst Nakamura's (2013) *A Disability of the Soul: an ethnography of schizophrenia and mental illness in contemporary Japan*, focused on a community of individuals living with schizophrenia and how symptoms of their disorder (such as hallucinations and delusions) were embraced and accepted unlike in the "outside world". These individuals also formed a Community of Practice. Nakamura (2013) believed that this specific community thrived because of the acceptance of the symptoms associated with schizophrenia. This provided an interesting example from the patient perspective and how a Community of Practice was formed through lived and shared experiences and was therefore specifically understood by its members. These different analyses of Communities of Practice alerted me to similar features of the paramedic tribe. In what follows I

explore how ideas about Communities of Practice helped to explain the behaviours and practices of the paramedic community.

7.2.1 Why are paramedics considered a Community of Practice?

Historically, Communities of Practice were developed from the analysis of apprenticeship learning. Lave and Wenger (1991) observed how apprentices' learning depended on a situated and social process supported by interactions with others. Later, they developed the theory of Communities of Practice, which included three characteristics that proved useful for examining paramedics: domain, community and practice (Wenger, 1998). Domain was defined as a shared domain of interest with a commitment and shared competence that distinguishes members from other people (Wenger, 1998). In this study the domain was health care and the management of patients. The second characteristic was the community. Wenger (1998) defined the community as members who pursued their interests and engaged in joint activities, discussions and shared information. In this study, the community was the frontline paramedic who provided care in the pre-hospital health care setting. Paramedics shared an interest in treating mental health patients and they also shared competencies that were recognised by the Health and Care Professions Council as registered health care professionals under the protected title – paramedic (HCPC, 2016). The final characteristic defined by Wenger (1998) was the practice, in this case managing mental health patients, as explained in Figure 6. Paramedics are health care practitioners and they shared experiences (meeting up to manage a patient) through formal and informal meetings (in the crew room and between shift changes) and discussions, which occurred continuously throughout the periods of observation. They used these shared experiences to work on problem solving, in particular how to manage patients experiencing mental health issues.

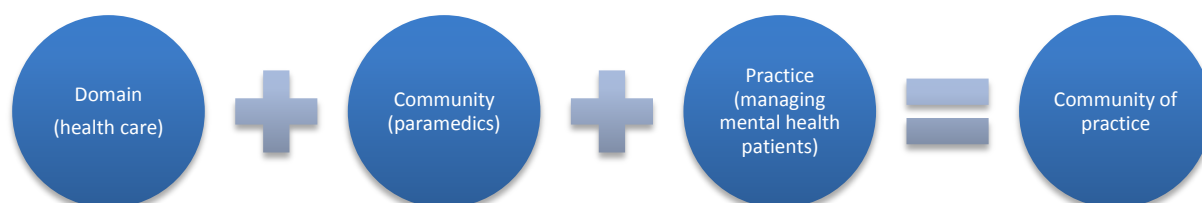


Figure 6: Evidencing paramedic community of practice

A key perception of Communities of Practice was that knowledge and therefore learning were embedded in cultural practice. In terms of this study, the way paramedics managed mental health patients was heavily based on the cultural practice of the profession. This culture included the use of backstage performances such as humour and stereotyping for reasons discussed in the previous chapters. Hoadley (2012) summarised this as: “knowledge equals practice in authentic contexts by communities”. The observations and interviews showed that paramedics shared their experiences about managing mental health patients during their ‘down time’ (when on a break or a shift change) back stage, as this provided them with a safe time and place to openly and honestly discuss their experiences as shown below, therefore also sharing ideas for future practice:

“We used to go to a regular self-harmer who knew exactly what she was doing. It was funny but when we transferred her to the local psychiatric clinic, she turned around to me and said: ‘your crew mate is crazier than I am, and that’s saying a lot!’ I loved that,” laughed paramedic 29. – *field note 18*

And the reply from another crew was:

“We also went to a patient who was self-harming. The crisis team told the patient to keep her self-harm box (they actually called it that), which has razors and cigarettes in it. They didn’t give a shit. They never do. She [the patient] was 15 years old. We took her to hospital and they probably just put a plaster on her and told her to go home.” – *field note 18*

These discussions and exchange of ideas about how paramedics managed mental health patients helped paramedics feel supported and also created an informal platform for the exchange of knowledge that was implemented in practice. As the paramedics listened to the conversation and then contributed to it, they became part of this community through legitimate participation, defined by a shared identity within the paramedic community that works on shared practice. Shared knowledge, identity and emotion supports this Community of Practice and will now be discussed in more detail.

7.3 Sharing within the Paramedic Community of Practice

Shared knowledge, emotion and identity were observed during front and particularly back stage performances using humour and stereotyping. Paramedics

shared these elements with each other, creating resilience and a supportive environment which in turn strengthened and underpinned their Community of Practice. Each element will be discussed in more detail to show how this occurred and why this helped paramedics manage mental health patients.

7.3.1 Shared knowledge

Cooper (2011) defined knowledge as an “adequate understanding of facts, concepts, and their relationship, and the basic foundation of information a person needs to perform a task”. This applied to paramedics in this study in terms of the understanding they had about mental health; creating a foundation of knowledge that helped them manage mentally ill patients. Cooper (2011) added that within Communities of Practice the interaction, support, and collaboration that takes place was initiated by knowledge sharing. Knowledge and the sharing of knowledge were drivers of, and served to strengthened the Community of Practice. In my data knowledge was shared during down time (back stage), either in the ambulance, between calls or at the station during a meal break or shift change. Paramedics were observed sharing their knowledge, often accompanied by humour and stereotyping during these exchanges. This helped create a sense of comradery and alleviated the feelings of futility and frustration that often accompanied the management of mental health patients. Shared knowledge acted as a coping mechanism and paramedics felt less isolated in managing this patient group, knowing that they had the support of their fellow community members, as illustrated in the following excerpt:

“I went to an overdose of Paracetamol. She [the patient] knows how the system works. I said we needed to take her to hospital and she said we needed to wait a while because the hospital only takes bloods after four hours. She had waited three-and-a-half hours before she called me. She told me she didn’t want to wait that long in hospital. She told me she would rather wait at home than in the ED even though she knew she had to go in. Can you believe that? There was nothing else I could do, I waited with her and then took her in to the ED,” explained paramedic 11 – *field note 11*

Another paramedic in the crew room answered: “It all goes in circles ... First we were allowed direct access to the mental health hospital and then they changed that. Now we can only take them to ED,” said another paramedic.

A third added to the conversation saying: “I have heard all this before,” answered a third paramedic – *field note 7*

This interaction shows mutual support but also shared knowledge about the behaviour of some mental health patients. In the first part of the excerpt the paramedic is talking about a frequent caller who “knows how the system works”. This kind of shared knowledge will help future paramedics prepare and manage this patient and others who display similar behaviour because they have knowledge of the background and can therefore also understand the behaviour. The excerpt then moves onto an alternative to taking patients to the Emergency Department (ED). A few years ago, the Ambulance Trust ran a pilot study for paramedics to admit mental health patients directly to a mental health facility, thereby cutting out the ED. Many of the “older” paramedics recalled this trial and felt it was a more suitable option than taking their patients to the ED. As discussed in previous chapters, many mental health patients did not need or want to go to ED. They needed talking therapy or specific psychiatric support and often related this to the paramedics managing them but with no alternative, paramedics have now returned to taking mental health patients to ED. The third part of the excerpt reminds us of the “they’re like a black hole” category, where the paramedic responds by saying he has heard this all before, thereby showing a sense of futility and cynicism around managing mental health patients. Without this knowledge exchange there is no outlet for frustration or the sharing of useful information within this Community of Practice, which makes exchanges like this the underpinning of the Community of Practice, thereby strengthening its ties.

Interestingly, another reference to alternative care (transporting directly to a mental health facility) and therefore shared knowledge was observed a few shifts later. The continued sense of frustration was once again highlighted in this excerpt:

“I had a 19-year-old patient last night (the last call of my shift) who had drunk bleach. She was a self-harmer. I didn’t think she had capacity, so I tried to get the GP to come out. She had massive scars on her arms and chest from self-harm,” Paramedic 12 explained.

Researcher’s note: I could see the crew were listening and another crew member standing behind Paramedic 12 replied: ‘I take patients directly to the local psychiatric hospital you know. I have the bed manager’s number in my phone,’ and he took out his mobile phone and scrolled down to show me his contacts.”– *field note 4*

In the above observation, the paramedic described a call she found frustrating as she felt her patient needed long-term support rather than being transported to the ED. The GP did not attend to the patient therefore the paramedic was left with either transporting the patient to the ED or leaving the patient at home. This would have been risky in terms of guaranteeing the patient's safety. The patient was then transported to the ED to mitigate this risk, but another paramedic felt that psychiatric specialist help would have been more appropriate for the patient and said as much in the excerpt. The other paramedic who was listening to Paramedic 12 responded by sharing an alternative – calling the bed manager at a mental health facility. The paramedic showed me the telephone number as if to prove the validity of his claim while Paramedic 12 watched. Both paramedics were from the same ambulance station. This sharing of knowledge and frustration lightened the burden felt by the paramedic recalling her patient and also added alternative ways of considering managing this patient for future reference. Sharing knowledge and therefore practice and even sources of frustration strengthened this Community of Practice as evidenced below:

“We can't take them into the ED because that's not the right place for them'. Interviewer: 'Why do you think it's not the right place for them?' Respondent: 'Because they haven't got time in the ED, they haven't got the specialists there. I would say probably nine times out of ten after 20 minutes they're going to get up and walk out and they're going to be more vulnerable then because they're going to be out in the street'.” – *interview 7*

Paramedics often voiced frustration that the default management of mental health patients was to take them to the ED. Many paramedics felt there should be alternatives such as a mental health “pathway”, meaning sharing knowledge, building the resilience of the Community of Practice and strengthening its ties. However, certain types of knowledge and how they are transferred also need to be understood in terms of knowledge retention and therefore continued shared practice, which answers the question how paramedics manage patients experiencing mental health issues. These will now be discussed in more detail.

7.3.1.1 Sticky knowledge and leaky knowledge

Knowledge was divided into two types, based on the work by Hoadley (2012) who believed that a Community of Practice was “an important theoretical construct that underlies a model of learning” and relied on the idea that knowledge was

enacted by a group of people over time in shared practices. Hoadley (2012) used the terms “sticky” and “leaky” knowledge which was apt in terms of understanding the transfer of knowledge within the paramedic profession as this influenced the way they managed not only mental health patients, but all patients. It also referred to the transfer of learning and knowledge across organisational boundaries. “Sticky knowledge” focused primarily on the challenge of moving knowledge inside organisations, for example, moving knowledge inherent in “best practice” from one part of an organisation to another – from the clinical managers to the frontline paramedics, thereby shaping practice. In terms of the Ambulance Trust this could be the clinical directorate publishing new clinical guidelines, for example, on cardiac arrest management, which paramedics on the frontline need to adhere to in practice. Sticky knowledge also referred to knowledge that stayed with the paramedic and this “stickiness” was aligned to how the paramedics perceived their role. If paramedics believed their role was to deal with emergencies, then knowledge about managing emergencies “stuck” and therefore this type of knowledge was valued more by paramedics. “Leaky knowledge” was the opposite and generally focused on the external and (as the term suggests) undesirable flow of knowledge. In particular, the loss of knowledge across the boundaries as evidenced below:

“And ... I think we [paramedics] just bumble along until it changes, because let’s face it, if we [paramedics] had a massive interest in mental health, we’d all be social workers” – *interview 9*

This loss of knowledge across organisational boundaries had a profound effect on patient care because of the lack of cohesive knowledge shared in a positive manner. Instead there seemed to be silos or segments of knowledge that were not shared and therefore lost when it came to alternative ways of managing mental health patients. This “leaky knowledge” terminology was also reiterated from a trust management perspective:

“... when we drove round all the EDs in the Trust, and we parked outside the EDs, we engaged paramedics in conversation just to try to find out, what is it in your local area that causes you the most concern? Which patients are those that you find most difficult providing the appropriate care for? And, every area in the Trust, the top two, either one or two was mental health. Other areas were, inappropriate calls from GPs, but mental health was up there in every single area of this Trust.” – *interview 2*

This excerpt shows that “leaky knowledge” is lost within an organisation and therefore impacts patient care. Paramedic managers asked staff about what concerns them most and mental health was listed as one of the significant concerns, yet the only way this knowledge was currently being transferred was through leaky channels, by sharing clinical experiences and giving tips to each other. Leaky knowledge was a feature of back stage performance and was not easily retained. Like sticky knowledge, leaky knowledge was also strongly linked to how paramedics perceived their role. If, like the more recently qualified paramedic, a paramedic believed that managing mental health patients was part of their role, then information about this subject area was retained for longer. Therefore, if paramedic knowledge around mental health was “leaky” this created “leaky practice”. This influenced how the next generation of paramedics will manage mental health patients. Paramedics are a naturally occurring Community of Practice whose knowledge influenced its culture. However, the shared knowledge was also influenced by the experience and educational background of the paramedics. The older generation of paramedics viewed managing mental health patients as not part of their role and therefore created leaky knowledge. Their model of learning – vocational – was heavily focused on emergency care and when responding to these patients with very little if any training on mental health, their sticky knowledge was based on emergency care. But, the newer generation – university graduates – proved that leaky knowledge can become sticky knowledge as mental health was included more and more in their education and they began to accept it as a part of their role. When asked whether managing mental health patients was part of the paramedic role this university graduate replied as follows:

“I would rather take responsibility [for managing mental health patients] myself as I said, as an autonomous person. But in order to do that, I would need more training in mental health. I would need more support and I’d need more referral pathways.” – *interview 10*

But this did not mean vocational paramedics cannot change their thinking or attitudes around managing mental health patients; it will take a change in the perception of their role as less of an emergency responder and more of a “jack of all trades”. As time progresses and university graduates take over in numerical terms, this leaky knowledge about how to manage mental health patients will eventually disappear and be replaced by sticky knowledge. The boundaries between these two segments influenced how the Community of

Practice functioned depending on which group was dominant. This often related to simple maths, if there were more vocational paramedics in a room, the shared knowledge related to their vast experiences and role perceptions which included how they perceived their roles as emergency responders. The same was true of the vocational paramedics except that they showed greater acceptance around how the role had changed, and that managing mental health patients was part of this new role. Sharing knowledge can help to transform “leaky knowledge” into “sticky knowledge” and humour helped to start this process. However, this study generally evidenced the thoughts and perceptions of vocational paramedics as they were higher in numbers. What was not observed was a discussion between an equal number of vocational and graduate paramedics or how students in either group would be influenced by this dynamic interchange. The next interaction that strengthened this Community of Practice was shared emotion.

7.3.2 Shared emotion

Shared emotion played a big role as a cohesive element within this Community of Practice. The back stage performance of paramedics revealed their true emotions about how they managed patients experiencing mental health issues. Here there was not an audience to please, just fellow paramedics to share true feelings with. Bendelow (2013, 68) discussed the concept emotion management by referring to Hochschild’s social theory of emotions. Particularly relevant to this research was the reference to “status shields”, which Bendelow (2013, 68) described as “socially distributed resources that people have for protecting their sense of self in various social situations”. Paramedics are using humour and nostalgia as these “status shields” through the process of sharing their emotions. Bendelow (2013, 69) also referred to a health capital model, which explained that individuals with more resources and fewer vulnerabilities may be less likely to perceive certain circumstances as stress-provoking. Some paramedics may have greater emotional resources to cope than others. Interestingly, and as previously quoted, one comment from a paramedic was: “We wouldn’t have jobs left if you were assessing our mental health”. This alluded to an underlying current about the fragility of paramedic mental health, and is a topic that is currently being researched and newly supported in practice. As Bendelow (2013, 69) added, responses to stressful situations, like managing patients experiencing mental health issues, are strongly influenced by socio-economic, environmental and as seen in this research, by cultural factors or the paramedic Community of Practice.

As Putman and Mumby (1993) further suggest: “Not only are emotions an integral part of learning to belong, they are also a crucial component of building a ‘community’”. Sharing emotions is a mechanism of release and often reflects the norms and values of a group. This study revealed the sense of frustration and futility paramedics felt when they managed mental health patients, borne out of a need to provide better care despite “resource-starved mental health services” (Bendelow, 2010) and therefore limited support and knowledge as evidenced in the following excerpt:

“...‘There is nothing I can do for mental health patients. I don’t have the skills or the back-up from other services to help them,’ he [the paramedic] said quite passionately.’ The reply from his paramedic colleague was: ‘We need clear guidelines,’ he said. While another added: ‘We need to be able to admit them [mental health patients] to the local psychiatric hospital directly or they need to have a psychiatric ED’.” – *field note 12*

Here one paramedic shared his frustration about the care he felt he delivered to mental health patients. His paramedic colleagues “endowed their knowledge and skills” as Le May (2009) suggested, and provided ideas around how this could be changed. Paramedics also empathised with one another, reinforcing the bonds they shared, thereby having a common platform to discuss difficulties and experiences:

“The other day he [a paramedic colleague] did four [mental health patients] on the trot, anxiety, mental health, hyperventilating, so that was quite high. I have not faced that, but that is quite high. Yeah, because you come back to the station like, quite deflated saying, ‘God, I can’t believe I got four on the trot’. You just need time out, because it’s a drain ... Probably because we can relate to them (laughing). I mean, they [mental health patients] are frustrating because you are not going to get anywhere with them to a degree, you don’t have long enough to sit with them and peel back the layers of the onions and find out what the cause is, because we’re pushed to come clear to do another job, so we don’t have time enough with them really. You know the only place to take them is the ED half the time. If they are safe, you are going to get criticised there. Or, you leave them at the scene you are running the risk that they might harm themselves, and if you overlook something you are going to get criticised.” – *interview 4*

This paramedic was referring to a colleague who he could empathise with in terms of feeling frustrated and mostly helpless when managing this patient group. He was on a meal break back at the ambulance station – a safe place to share emotions. By sharing their clinical experiences and associated emotions in managing patients experiencing mental health issues, they are not only reinforcing the ties of their Community of Practice, but also creating a supportive structure to ensure their resilience and longevity in the field. This resilience was buoyed by back stage performances of humour, stereotyping and nostalgia as described in the previous chapter. Wenger et al (2002) suggested that a major advantage of Communities of Practice was “emphasising interactions in a climate of mutual trust” as seen in many of the excerpts where knowledge and experience continued to be shared in downtime or backstage, which was considered a safe “climate of mutual trust”.

Mind set or attitude is influenced by emotion and is relevant to how paramedics manage patients experiencing mental health issues. When paramedics see mental health patients as “they’re like a black hole”, this re-emphasises the feeling of “I’ve only got about 20 minutes of ‘there, there’ in me”. As previously discussed, a way to combat these emotions was to use the back stage props of stereotyping, humour and nostalgia as described in Chapter 6. The excerpt below described the mind set of paramedics in terms of managing mental health patients:

“...‘You have got to understand the mind set of paramedics, particularly once they have been in [the ambulance service] a few years, their mind is in an emergency world, so everything, it’s a bit like the McDonalds culture, everything has to be done now and that is how our minds work because we are an emergency, so to us an emergency response is eight minutes or an hour at most, that is how we think. So, if somebody tells us they are providing a crisis intervention or an emergency duty team, the words in our head, consciously or otherwise, we kind of interpret that as, ‘They are going to come now then’ whereas the mental health world is much slower, and they consider an emergency response to be within 24 hours, and there is this clash of mind sets and you can’t gel that together’.” – *interview 1*

This mind set reflected the attitudes of some paramedics and influenced how they shared their emotion and therefore knowledge. Often sharing was based on negative experiences, but the negativity stemmed from frustration and the

need to want to deliver good care and this forged bonds between members of the paramedic Community of Practice. Wenger acknowledged (1998) that participation in social communities “is a complex process that combines doing, talking, feeling, and belonging. It involves our whole person, including our bodies, minds, emotions, and social relations (1998, 56)”. Shared identity and how this contributes towards strengthening a Community of Practice is discussed next.

7.3.3 Shared identity

Another element of a Community of Practice is a shared “identity defined by a shared domain of interest” (Wenger, 1998). This shared identity is also defined by a shared proficiency that distinguishes its members from others – paramedics are defined by their skills level and in this study by how they manage patients experiencing mental health issues. This shared identity is not new to this study and has been discussed in the previous chapter, more specifically how the perception of the paramedic role (and the tension between the real and ideal role) and therefore identity influenced the use of humour and stereotyping. This paramedic Community of Practice was influenced by how paramedics perceived their role as evidenced below:

“We aren’t counsellors or psychiatrists. It begs the question, should we be treating the patient holistically and be supported by education to do so, or should our focus remain on the physical, only noting mental health issues on our documentation and referring patients to supportive services.” – *field note 6*

Interestingly, Ranmuthugala et al (2011) reviewed whether Communities of Practice improved health care practice suggesting that they had a role in sharing information through shared knowledge, emotion and identity; reducing professional isolation and facilitating new processes. Wenger (cited in Egan & Jaye, 2009) argued that practice influenced identity because it is produced “as a lived experience of participation”. A sense of belonging and identity between members was crucial within a Community of Practice. Interestingly, Egan & Jaye (2009) also linked this sense of alignment with “professional socialisation” which they defined as the “gradual development and identification with a profession along with an accompanying commitment to the professional body” as evidenced in the behaviours and practices observed within this study. However, shared identity also produced boundaries in terms of paramedics versus “other” and

interestingly also segments within the paramedic workforce: university graduates versus vocational paramedics. These boundaries and how they influence the paramedic Community of Practice will be discussed in the next section.

7.4 Boundaries

Boundaries were defined as “a line which marks the limits of an area” (Oxford Dictionary, 2017). In terms of this study, boundaries were not geographical areas but more metaphorical in terms of restrictions or divisions in various forms. Wenger et al (2017) believed that boundaries were created between those who have been participating in the Community of Practice, in this case paramedics, and those who have not, others. Wenger et al (2017) proposed treating boundaries as potential learning opportunities. This study has shown that internal boundaries were being formed within the Community of Practice which influenced how paramedics managed mental health patients in the future.

7.4.1 “Old versus new” – Segments within the Community of Practice

The older work of Bucher and Strauss (1960) discussed the process approach, a model which the authors believed showed that there were a number of segmented groups within a profession which “tend to take on the character of social movements” and influenced transfer of knowledge. Bucher and Strauss (1960) added that these segments developed distinctive identities which influenced goals for the future. My analysis showed that there were two distinct segments within which the paramedic participants were observed and interviewed: university graduate paramedics and vocational trained paramedics, and often there is a tension between the two groups, as seen below:

“I think a lot of the younger paramedics now are getting the almost I am the God-type attitude. I’ve been picking it up with crews ... Maybe if you work with these people all the time you’re maybe not picking it up but because they back me up and just their demeanour and the way some of them walk in, it’s like, oh...” – *interview 2*

This paramedic recalled his feelings about the younger generation in terms of his perception of their attitude. His reference to these graduate paramedics acting with a “God-type attitude” referred to what he believed was an arrogant attitude that lacked respect for the older generation of paramedics. He felt his experience commanded respect and often the younger generation

would back up this experienced paramedic because he was a lone worker on a rapid response car, yet they did not act with deference to his clinical decision making and instead acted with a “God-like attitude”.

These sentiments were not in isolation:

“Because, our generation, we know how to deal with people. Like there are certain things I would say to you that I wouldn’t say to a 90-year-old lady, and we are very good at people skills. But, the newer generation, they are frickin’ shocking ...” – *interview 6*

Here the paramedic again highlighted thoughts about the graduate paramedics – “they are frickin shocking”. Each segment had a particular way of managing mental health patients. Although published over 70 years ago, Bucher and Strauss’s research (1960) remained relevant in terms of their findings around the development of segments or coalitions when considering these in terms of the paramedic profession. Interestingly, these segments were further divided into what Bucher and Strauss (1960) labelled “specialities”. With the evolution of the paramedic profession, what started to emerge were fields of speciality, similar to medicine and nursing. Bucher and Strauss (1960) also discussed relations these professions had with the lay public saying “these professional activities are not necessarily evidence of internal homogeneity and consensus but rather of the power of certain groups” (1960, 331).

Power also played a role within these segments. This power struggle was marked by a difference in education and training between the two paramedic “segments” and this influenced how they managed patients experiencing mental health issues. The graduate paramedics had come into the profession; however, they still found managing this patient group difficult and shared frustration with the older generation of paramedics. The younger generation also used humour and stereotyping back stage but with less confidence than the older generation. Nostalgia, as described in the previous chapter, was used by the older generation of paramedics and was effective in terms of sharing experiences from the past. Younger paramedics listened to these nostalgic recollections but it did not seem to alter their attitude towards their role, this was supported by the follow-up interviews. Nostalgia was useful for the older generation in terms of a fond recollection of events from a different era which created comradery and emotional ties. However, it did not solve the reason behind the nostalgic recollections – the struggle to accept the evolving role which included more mental health management and social calls and far less of the emergency calls

this generation was used to. In addition, the observations and interviews supported the view that the older generation of paramedics used tools such as humour and stereotyping more regularly and with greater confidence, mostly due to their extended experience on the frontline dealing with patients that often spanned a career of over 20 years. The excerpt below showed that the graduate paramedics believed experience mattered:

“Experience, yeah. And also, I think when you’re newly qualified, you don’t want to push it too much whereas I think a lot of the old-school guys, they know and they don’t care what they say. Not don’t care what they say, but they’ve got a bit more confidence, you know?” – *interview 3*

Unanimously both these “segments” or group were unified in their demand for more education around mental health with the vocational paramedics focusing more on referral opportunities or pathways while the university graduate paramedics wanted more clinical education around mental health diseases and disorders and how to manage them. Understanding these divisions within the community helped when considering boundaries and how they influenced the practices and behaviours within this Community of Practice. Egan & Jaye (2009) also suggested that boundaries provided a way to understand relationships between members of a Community of Practice. In addition to these segments there were also organisational and professional boundaries, these will now be discussed in further detail.

7.4.2 “Us versus them” – Organisational and professional boundaries

Throughout the observations and supported by the interviews, the paramedic Community of Practice demonstrated the placement of boundaries. There were organisational boundaries where paramedics felt there was no cohesive or clear guidance about managing mental health patients from the Trust; and they felt unsupported, which led to a mentality of “us versus them” as evidenced below:

“We’re never going to solve the situation ... but we can possibly try and ease it, but it’s frustrating as there are no real pathways and we’ve got no real access to mental health services.” – *interview 1*

The paramedic believed the Trust should create specific pathways including referral pathways to ensure paramedics had alternative options to taking the patient to the ED. The paramedics who were observed and interviewed also

believed the solution to managing mental health patients should be led by the Trust and the staff should be briefed accordingly:

“I think there’s definitely problems outside of house as well. And I actually think that better briefs need to be given to staff ...” – *interview 11*

However, Communities of Practice were not only defined by its members, in this case paramedics, but also by the shared ways in which they performed their work and interpreted events and how they viewed the organisation they work for. There was also the added pressure of the evolving role and expectations of a paramedic by the Trust and the patient as evidenced in the following excerpt:

“I think it’s getting too fast; I think we’re just expected to do absolutely everything, but then I think we always were but now to a bigger degree, so before we would see everybody and generally they’d go to hospital whereas now I think you see everybody and you’re expected to have a treatment plan for them, so I think that’s changed, but I don’t think you always need a treatment plan and I think in other Trusts you don’t, but because it’s so heavily advocated to keep someone at home, you’re starting to treat a lot more people.” – *Interview 5*

Many paramedics wanted to increase their skills and knowledge about mental health but did not feel they were supported in doing so:

“I would rather take responsibility myself as I said, as an autonomous person. But in order to do that, I would need more training in mental health. I would need more support and I’d need more referral pathways. People that I can speak to, specialists that I could speak to.” – *interview 10*

Paramedics also felt that no one was taking responsibility for this patient group which created professional boundaries that also influenced their management and treatment as they were left with very few alternatives:

“I made about eight telephone calls to eight different services and it was just going around. I think I even spoke to the pharmacy at one point because they were refusing to give out a medication without – everyone was just refusing to take responsibility and you think, you know, it was just so frustrating.” – *interview 8*

There were also blurred boundaries between paramedics and other supportive services in terms of who should take responsibility for a mental health patient

who, for example, did not need emergency medical intervention but was having a mental health crisis. Paramedics felt that they were not supported in providing alternative referrals for their patient, which led to resentment and once again an “us versus them” demarcation or boundary as described below:

“We are dogsbodies. We are a doormat to the NHS. I think when people don’t know how to handle things, like the GPs and nursing staff, they just tell people to phone 999 and they will deal with it. We are just doormats, we are not doing the job we are trained for, we are really not ... –

interview 4

Egan & Jaye (2009) also discussed the complexity around practice shaped by conditions outside the control of its members, such as lack of support from services such as the mental health crisis team. These boundaries continued to form over the responsibility of mental health patients including input from mental health crisis teams:

“My first call was to the mental health crisis team, they refused to come out. They always do. They said I needed to transport him to hospital to rule out organic causes before they could get involved.” – *field note 1*

Kislov et al (2011) reiterated that empirical research supported the notion of cultures and boundaries in healthcare. They reminded us that different healthcare professionals had different attitudes to organisational change that were embedded in their professional culture. Nurses, doctors and managers were used as examples. Professional identity seemed central to attitudes about organisational change and Kislov et al (2011) defined this as: “the relatively stable and enduring constellation of attributes, beliefs, values, motives and experiences in terms of which people define themselves in a professional role”. This study built on these notions of attitudes, beliefs about the role and experience, which showed that paramedics had a very strong sense of professional identity despite their evolving role as shown in the previous chapter about how uniform and identify factor into how paramedics manage mental health patients. In terms of attributes, motives and experiences, if we understand how and why paramedics managed mental health patients the way they did, we would have a better understanding about their behaviour and attitudes as a profession. This study has shown that paramedics are increasing the ties of the Community of Practice through shared knowledge, emotions and identity and that they use particular tools or props – humour and stereotyping – to build up their resilience. Kislov et al (2011) added that professional Communities of Practice tended to isolate

themselves from neighbouring professional communities. This was evidenced in the observations where there seemed to be a definitive “us versus them” mentality, especially when it came to interactions between the ED, crisis teams and the police. The following excerpt was an apt summary of how paramedics felt when they managed complex mental health patients and reinforced the boundaries that already existed based on professional qualifications:

“I had one [a mental health patient] the other day that was hard, but GP in-hours don’t know. They can’t necessarily come out. The hospital doesn’t want to know. Its [the patient is] under a mental health team, they’re stretched, they can’t send someone out. I’ve got to sit with them. Ah, it’s like walking up river against a current, and it depends on the severity of the patient’s needs to how much that current then flows and pushes you back, if that makes any bloody sense?” – *interview 9*

Lastly, subtle boundaries or segments existed between paramedics. This PhD study showed that humour and stereotyping were the tools and coping mechanisms paramedics used when managing mental health patients. This helped paramedics to stay resilient and assisted in breaking down emotional boundaries between each other and with patients. One paramedic described how paramedics created their own emotional boundaries:

“Paramedics are very good at switching off and I think that’s one of the other reasons why paramedics have so many mental health issues later on in their career, or when they retire. It’s because it then affects them. They’ve been so good during their career at shutting it off.” – *interview 2*

Paramedics also wrestled with their own emotional fallout when managing mental health patients:

“It’s that feeling of not ... of uneasiness and not knowing, uneasiness and probably helplessness, of knowing that this person needs some intervention, needs some help, but that that is not forthcoming and the services that are there to provide this help have not and are unwilling to see him, at that point, and that feeling of not being able to help someone makes me very uneasy, I think.” – *interview 11*

Egan & Jaye (2009) also discussed how boundaries were determined by clinical objectives. This PhD study showed there were no clear clinical objectives when it came to mental health patients. The category was too broad to fit within a single pathway and the patient group was so diverse that each patient needed individual

treatment plans. In addition, there was also very little community support for mental health patients and this was why the ambulance service was responding to these mental health related calls. A patient himself said as much: “there is no one else we can call” (patient quote from observations). Egan & Jaye (2009) reminded us that boundaries also needed to be considered in terms of legitimacy saying: “what is legitimate participation on the margins may not be so at the centre”. This was echoed by Hoadley (2012) who took the definition of Communities of Practice one step further and described it as “a constant process of legitimate peripheral participation”. Boundaries came in a variety of forms but could also be discernible by unique understandings (through shared knowledge, emotion and identity) and language (employing humour, nostalgia and stereotyping). Wenger–Trayner & Wenger–Trayner (cited in 2017) remind us that boundaries “hold potential for unexpected learning”. Wenger–Trayner et al (2017) added that trying to foster learning across boundaries can create learning opportunities. This remained true within this research, as both paramedic “groups” learnt from each other and therefore created a better understanding around the complex nature of managing patients experiencing mental health issues.

7.5 Summary

This chapter built on Goffman’s presentation of self (1959) to explain back stage performances, but this time in terms of a group – as a paramedic Community of Practice. This chapter then focused on the back stage behaviours that support and enhance this Community of Practice through sharing – of knowledge, emotion and identity. Sharing knowledge and learning was integral to the Community of Practice in terms of community identity and engaging in and creating knowledge which influenced practice. This study showed that paramedics learnt to produce a practice from a shared knowledge base through active participation and negotiation. The observations and interviews showed that this shared knowledge provided a platform for paramedics to work from and was divided into two categories: sticky and leaky knowledge. These types of knowledge were influenced by the perception paramedics had of their role; how they retained information as well as their educational background. The study maintains that mental health starts out as leaky knowledge due to the belief held by many of the older generation of paramedics that mental health should not be part of an emergency service. However, the graduate paramedics feel less ambivalent about mental health and therefore transform this leaky knowledge into sticky knowledge. As the profession evolves and the graduate paramedics

take over the role with the vocational paramedics either adapting or retiring, the “leaky” knowledge will evolve to become “sticky” knowledge therefore also influencing how the profession will manage and respond to patients experiencing mental health issues.

Both vocational and graduate paramedics shared frustration about managing mental health patients and use back stage behaviours – humour and stereotyping – as props to build up their personal and community resilience. Sharing the emotions linked to manage this patient group strengthens the ties with the Community of Practice which is also bound by a shared identity and augmented by a literal boundary – that of the green paramedic uniform. However, this shared identity is not without difficulty as there is a tension between the real and ideal role as perceived by all paramedics, but managed differently and in subtle ways.

The final concept discussed was boundaries. Boundaries were divided into two types: “old versus new” or segments within the Community of Practice and “us versus them” – organisational and professional boundaries. Segments were defined according to educational background – the university graduates (“new”) and the vocationally trained (“old”) paramedics. There were, of course, hybrid paramedics, some of whom started with vocational training and are now graduates, but they were not observed within this study. Interestingly, these educationally-driven segments also managed mental health patients slightly differently in terms of how they used humour and stereotyping. The university graduates used humour and stereotyping more cautiously than the vocationally trained paramedics. The university graduates also wanted more education in terms of mental health disease and disorder identification to improve their management of this patient group. The vocationally trained paramedics wanted access to more support services that they could refer their patients to for long-term care and used nostalgia as an additional back stage behaviour, fondly recalling the days when seeing mental health patients was not part of their role. Both segments, however, shared frustration about managing these mental health patients in terms of feeling helpless in giving them what paramedics perceived to be the wrong care – most often than not, taking the patient to the ED. They were also united in their view that they were working in isolation when managing mental health patients.

There were also organisational and professional boundaries between the Trust and the paramedics and other mental health services. Many paramedics felt they did not receive enough guidance or support from their Trust in terms of

managing mental health patients. The interviews and observations also revealed the perceived boundaries between these professions and how this influenced the management of mental health patients. There was very little support from mental health specialists (crisis teams and even GPs), which meant the patient had to go to the ED and could not be managed at home. In most cases this was not what the patient wanted, leaving the paramedic to negotiate an option they also felt was not in the best interest of the patient. Often there was a strong desire by the paramedic to follow a more proactive approach to avoid ED admission for the patient, but with no support from external sources this could not happen, leading to the repeated feeling of helplessness and feeling “they’re like a black hole”. As previously mentioned, this was linked to the feeling that “I’ve only got about 20 minutes of ‘there, there’ in me”. Ironically, paramedics were observed on scene holding the patient’s hand or reassuring them well past the hour mark, often for up to four hours.

This study showed that boundaries will continue to exist but with the evolution of the profession, the segments based on educational backgrounds will slowly start to dissolve as vocational paramedics retire or adapt, and graduate paramedics become the norm. This means there will be less discourse about mental health patients and their management as it will become part of the identity of the “new” paramedic. But, organisational boundaries will continue to exist within the changing expectations and delivery demands of ambulance services sending paramedics to mental health patients. Perhaps as Wenger–Trayner et al (2017) suggested, boundaries should be considered as a positive way for creating learning opportunities across them as we see how the concepts of knowledge and boundaries shape how paramedics manage mental health patients.

Chapter 8 Conclusion: ‘A profession in transition’

8.1 Introduction

This study has evidenced how paramedics manage and respond to patients experiencing mental health issues. Chapter 2 provided the literature review that supported a distinct gap in research around this subject area. Chapters 4 and 5 provided a description of how paramedics managed patients experiencing mental health issues. This was followed by Chapter 6, which harnessed ideas about presentation of self (Goffman, 1959) to understand on a micro level why paramedics behave the way they do. Chapter 7 built on this premise and looked at behaviours at a meso level in terms of functioning as a Community of Practice. This concluding chapter explores the contributions to knowledge and paramedic practice by identifying and understanding paramedic behaviours and the mechanisms that support these behaviours. Finally, this chapter looks to the future and what this study can contribute to paramedic practice and concludes with a discussion about the strengths, limitations and recommendations derived from this study.

8.2 Contributions to knowledge and paramedic practice

A patient’s journey within the NHS often starts with paramedics in the pre-hospital environment. With this comes the responsibility to have appropriate knowledge, experience and competence to provide fitting assessment and treatments and to begin the referral and management process if the patient does not require direct transport to the ED. The College of Paramedics (2016) recognised that paramedics were also increasingly being employed by organisations other than NHS ambulance trusts such as the armed forces, the independent and private sectors, primary and acute care trusts, GP services, minor injury units, tele-care services, and alternative care pathway provider services. Therefore, paramedics were not isolated from changes experienced in other healthcare settings. As reviewed in Chapter 2, the literature showed that there has been an increase in the incidence of mental health issues as well as acute and chronic illnesses, dementia, and end-of-life-care calls that paramedics are required to respond to (NHS digital, 2016). Traditionally, high-acuity medical

illness and traumatic injuries accounted for approximately 10 percent of emergency calls received by an emergency ambulance service, although serious trauma represents less than 1 percent of the 999 workload according to the National Audit Office (College of Paramedics, 2016). With this change in patient presentations from high acuity illnesses to more primary health related issues, paramedics have adopted coping mechanisms and behaviours in order to manage these diverse patients and these coping mechanisms will be discussed below.

8.2.1 Identifying paramedic behaviour patterns

This study has shown that there is a tension between the real role of the paramedic (responding to an increase in mental health calls, etc.) and the ideal role (responding to trauma and emergencies). The internal narrative that paramedics have can be summarised as the feeling that mental health patients were “like a black hole”. In response to these problematic cases paramedics would often say: “I’ve only got about 20 minutes of ‘there, there’ in me,” however the observations and follow up interviews conducted for this study showed the opposite. In fact, paramedics were regularly observed managing and reassuring mental health patients for up to four hours and there seems to be no indication after five months in the field that this will change. This tension around the role of the paramedic was previously raised by leading Australian research (Shaban, 2005), which highlighted the evolution of the paramedic role especially in managing mental health patients and how this lead to role confusion. Shaban (2005) also reiterated the need for more empirical research in light of the evolving paramedic role. Role tensions are not new in healthcare; much has been published about the changing role of nurses (Rasmussen et al, 2018). In order to address the increasingly complex needs of patients and organisation changes and pressures within the NHS, the nursing role has evolved. A nurse’s perception of their professional identity, as with paramedics, included how they saw themselves, their role and their practice setting. Tensions arose if these three elements were poorly aligned (Rasmussen et al, 2018). Paramedics, however, both nationally and internationally will have to continue to respond to these increasing mental health-related calls and this study has shown that paramedics in have adapted to their evolving role by using tools or performance props – humour and stereotyping in various ways.

The observations supported by the follow-up interviews were used to create a typology around humour: humour between patient and crew, humour between the crew and humour initiated by the patient as explained in Chapter 4.

Paramedics used humour as a form of patient management with mental health patients, and crews used humour among themselves as a form of debriefing and information-sharing as well as emotion management. This was witnessed by observing crews interact with each throughout the day and on station. Using humour with mental health patients helped paramedics to break down barriers and established a narrative between the crew and the patient who in some cases even initiated this humour themselves. Chapple and Ziebland (2004) wrote about how humour and its use eased difficult situations and supports solidarity, whereas Kuiper (2012) suggested humour played a role in encouraging resilience. Tremayne (2014) added that humour broke down barriers and led to a more individualised approach. Other publications around humour included its use between ambulance staff and police (Charman, 2013). Ironically, Charman (2013) explained that although humour encouraged “interoperability between the two organisations”, but added that it was at the expense of other professions. Humour within nursing was also used as a resilience tool (Bolton, 2001) and some nurses believed it helped make their working environment more pleasant but they avoided joking unless it helped the mental health of their patients and was therefore recognised as a “caring strategy” and as an opportunity for change (Chaffari et al, 2015). Taney et al (2013) described humour as a form of communication which had multi-dimensional value in cancer care and a large observational study found humour to be invaluable even in an end of life care setting, where researchers concluded that humour played an essential part in promoting team relationships and added a “human dimension” to care staff were providing not only to these patients but also their families (Dean and Major, 2008).

The second behaviour observed within this study was stereotyping. Stereotyping was used as a triage and resilience tool in managing all patients. Some of the stereotypes used included: “granny down” labelling a falls patient; “drunks” refer to intoxicated patients, “arrest” as cardiac or respiratory arrest patients and “crazies” or “mad” labelled patients experiencing mental health issues. These labels helped paramedics prepare themselves for the call and categorise the patient, thereby creating a management plan before reaching the patient. Interestingly, these stereotyping labels supported how paramedics considered their role in caring for these patients. Throughout the observations and supported by the interviews, there was a discrepancy between the ideal role (emergency work) and the real role (which included managing mental health patients) because the real role was the work paramedics were expected to do

daily. As discussed in Chapter 4, Abdou et al (2016) added that this created “a threat of being personally reduced to group stereotypes the commonly operate within the healthcare domain” often resulting in different levels of care. Abdou et al (2016) believed this encouraged physician mistrust and higher rates of dissatisfaction. Stereotyping may be a contributing factor to disparities in healthcare, however, Balsa and McGuire (2003) also acknowledged that very little research has been done to assess these mechanisms – something this study has addressed. Other studies about physician use of stereotyping, suggested implicit stereotyping amongst physicians, which showed biased diagnoses and treatments, even in the absence of the practitioner’s awareness or intent (Moskowitz et al, 2012). Chapter 5 used the observational data and interviews described in Chapter 4 and with continued thematic analysis two categories emerged: “they’re like a black hole” and “I’ve only got about 20 minutes of ‘there, there’ in me”. These emotive categories evidenced the frustration levels of paramedics when it came to managing mental health patients. Describing mental health patients as “they’re like a black hole” was closely linked to the changing role of the paramedic, the lack of support from specialist services such as the crisis team, GPs and the police and the perception paramedics had about their capabilities and training when managing mental health patients. Paramedics often felt their management of mental health patients was limited and this created the vortex of negative emotion resulting in the narrative: “I’ve only got about 20 minutes of ‘there, there’ in me”. When these categories were explored further in the follow-up interviews, paramedics strongly agreed with these sentiments because they summarised their feelings of frustration and futility when managing this patient group, but the paramedics also added that they did not want to feel or admit to being emotionally compromised. One paramedic even pointed out that their feelings of vulnerability could provoke a need to come across as tough or un-emotional, and this in turn resulted in the emotional reaction of “I’ve only got about 20 minutes of ‘there, there’ in me”. As discussed in Chapter 2, emotions and emotional labour (Bendelow, 2010) are strong underpinning concepts within this study. Emotional labour has long been discussed within medicine and particularly in nursing and was especially useful in explaining the skills and effort required of paramedics that are often invisible and undervalued. Understanding emotional labour through the lens of this study can support staff against burnout and other negative outcomes that paramedics face when managing mental health patients. As shown throughout this study, care and compassion still runs strongly in paramedic practice and despite saying how they feel, paramedics still spend up to four hours with mental health patients, showing

that although they verbalise their feelings of frustration and futility, their care exemplifies far more than “...about 20 minutes of ‘there, there’”. The next section explains these behaviours using ideas from Goffman’s presentation of self (1959) and the mechanisms of a Community of Practice.

8.2.2 Understanding paramedic behaviours

Getting to know the true sentiments of paramedics from this study, I was then able to use Goffman’s presentation of self (1959) ideas around performance on a variety of stages to understand how and why paramedics used stereotyping and humour as discussed in Chapter 6. Goffman (1959) introduced his theory of presentation of self using a metaphorical analogy that people are actors performing for audiences and that they use a variety of props and costumes. Goffman (1959) said actors performed on front and back stages and used impression management to manage the expectations of their audience. Goffman’s presentation of self (1959) has also been applied to nursing and describing the behaviour of staff in the operating theatre using space analysis (Tanner & Timmons, 2000). Tanner and Timmons (2000) found that the theatre department was “strongly a backstage area”, different to the findings of this study. In this study, the actors were paramedics performing for an audience of mental health patients. These paramedic “actors” performed on the front stage, dressed in their green uniform or using the acting metaphor “costumes”. This “costume” helped to create a specific impression for their mental health audience – that of a competent and confident health care professional. This was what the audience expected. Their uniform also served as a reminder of the role paramedics needed to fulfil to keep their audience happy. As discussed in Chapter 6, Timmons and East (2012) emphasised how uniforms indicated status and legitimacy and Spragley and Francis (2006) suggested that uniform also generated strong emotional attachments, as observed and discussed within this study.

The paramedic role was to provide treatment and management for their mental health patients but this did not alter their feelings about this patient group. As discussed in Chapter 4 and above, the role paramedics had to play for their audience – managing mental health patients’ needs – often differed from the role they wanted or needed to play, which was responding to and managing life-threatening emergencies. In order to ensure this tension did not impact their audience, paramedics used humour as a prop. However, during their back stage performance, which occurred without a patient audience and during down time

such as meal breaks or shift changes, paramedics acted differently and as Goffman (1959) would describe, they paramedics acted “authentically”. During their back stage performance, paramedics used darker humour and stereotyping with one further addition, nostalgia. Nostalgia, in the same way as humour and stereotyping helped these paramedics voice the tension between their real and ideal roles, therefore also functioning as a resilience tool. Nostalgia also acted as a unifier, where the older generation of paramedics recollected their “olden days”, drawing the attention of the newer generation when recounting their stories. McDonald et al (2006) acknowledged the link between identity and nostalgia and added that nostalgia helped to maintain and reconstruct identities. Strangleman’s (2007) work considered nostalgia as a way of looking at the past for stability. As there is tension and uncertainty around the paramedic role in managing mental health patients, paramedics looked at ways to feel more stable, using nostalgia as a coping mechanism. Interestingly, nostalgia also played a role in resistance on a political level, according to Batcho (2018). Nostalgia fortified resistance or struggle through shared identity and social bonds, counteracting loneliness and supported cognitive emotional coping as evidenced in Chapter 5.

Lastly, the final part of the paramedic performance act happened in what I called the dressing room. The dressing room served as a transition space where paramedics were either changing into their uniform, getting ready for their front or back stage performances, or paramedics were changing out of their uniform at the end of their shift. In this dressing there was no need for props such as humour or stereotyping and therefore there was no need to manage their impressions. Although dressing room behaviours were not directly observed as part of this study, my own experience as a paramedic supported the notion that there was an additional space where paramedics were free from the constraints of their front and back stage performances. I believe the private lives of paramedics are just as important as their working lives in terms of the roles they have to play. Having a space where they can remove their costumes (uniform) and not have to rely on a script or props, created a safe place for paramedics to unwind. By understanding how paramedics perceived and performed in their role and knowing why they behaved in certain ways, opened an avenue to explore how being a paramedic Community of Practice helped paramedics manage mental health patients as detailed in Chapter 7.

8.2.3 Identifying the mechanism that supports how paramedics manage mental health patients

The concept of Community of Practice is not new to healthcare and exists to enable people to share knowledge and to innovate and progress their practice as discussed in Chapter 7. In a recent systematic review by Barbour et al (2018), Communities of Practice were measured to investigate what impact they had on public health practice. The results cited that Communities of Practice supported a change in practice and networking opportunities, however, there were no studies to describe the impact of Communities of Practice on public health outcomes. This is something the paramedic Community of Practice evidenced in this study considers, as the mental health patient group falls within the larger public health remit.

The paramedic Community of Practice was supported and enhanced through the sharing of knowledge, emotion and identity as discussed in Chapter 7. Sharing knowledge and learning was integral to this paramedic Community of Practice in terms of their identity and engaging in and creating knowledge that influenced their practice and therefore their management of mental health patients. This study showed that shared knowledge provided a platform for paramedics to work from and was divided into two types: sticky and leaky knowledge. The study asserts that knowledge about mental health started out as leaky knowledge because many of the older generation of paramedics felt managing patients experiencing mental health issues should not be part of an emergency service. However, the graduate paramedics observed and interviewed, felt less ambivalent about mental health and transforming this leaky knowledge into sticky knowledge. As the profession continues to evolve, leaky knowledge will become sticky knowledge, thereby influencing how the profession will manage and respond to patients experiencing mental health issues.

Both vocational and graduate paramedics shared their emotional weariness about managing mental health patients and used back stage behaviours – humour and stereotyping – as props to build up their personal resilience. Sharing their feelings provided them with a mechanism to cope and therefore also strengthened the ties of their Community of Practice, which was bound by their shared identity. But this shared identity was not without difficulty and it manifested a tension between the real (managing mental health patients, fall–non–injuries and minor ailments) and the ideal role (responding to emergency calls) that was felt by all paramedics. As discussed in Chapters 5 and 6, graduate

paramedics used humour and stereotyping to manage patients but did so with considerable less confidence than the vocational paramedics who used both behaviours with regularity and confidence. When this was discussed in more detail during the follow-up interviews both segments felt that the subtle difference of employing humour and stereotyping was linked to experience and confidence levels. This segment was discussed further in terms of boundaries that also formed part of the functioning Community of Practice. This study furthermore showed that there were segments within the paramedic Community of Practice in terms of experience and educational background and there were also organisational and professional boundaries.

The segment of graduate versus vocational paramedics was also shaped by the educational requirements in terms of improving their care of mental health patients. Although both segments wanted to improve the way they managed mental health patients, they identified different educational support. University graduates wanted more education in terms of mental health problems, disorder identification and drug management to improve their management of this patient group. The vocationally-trained paramedics wanted access to more support services that they could refer their patients to for long-term care. Both segments were, however, united in their feeling that they were working in isolation when managing mental health patients and this is where the organisational and professional boundaries became evident.

Although specific pathways were provided by the Trust for mental health patients who needed sectioning, these patients were not attended to regularly; in fact, this study did not observe any patients who required sectioning during the five months of observational field work. Moreover, many paramedics felt there was no guidance or support from their Trust in terms of managing mental health patients with more prevalent conditions such as anxiety, depression and addiction. Some ambulance trusts have started working on alternative pathways, for example, Yorkshire Ambulance Service NHS Trust piloted mental health nurses within the 999 control room in 2014 (NHS Confederation, 2016). These mental health nurses helped triage patients and identified what support they might need, removing some of the frustrations paramedics felt as described within this study. Yorkshire Ambulance Service NHS Trust also piloted direct referral to a mental health team if a full assessment showed the patient had no medical need to go to hospital but a clear need for mental health support (NHS Confederation, 2016). Other ambulance trusts are pursuing similar avenues.

The interviews and observations also revealed professional boundaries between paramedics and other health care professionals such as GPs, the crisis team and the police. Further research into how police handled mental health patients by Menkes and Bendelow (2014) echoed the sentiments about the disparity in training paramedics received around managing mental health patients; where formal mental health training in the police force also varied greatly. The relationship between paramedics and other professional contributed to how paramedics managed and responded to mental health patients. During the observational field work and as discussed in more detail in Chapter 4, the crisis team and police were unable to support the paramedics who asked for their assistance. However, the reason for the crisis teams and police not responding when requested by paramedics was not examined further in this study. Without this type of support, paramedics often reverted to taking their mental health patients to the ED, which complicated things as this was often the very thing the patient did not want. In most cases there was a desire by the paramedic to take a more proactive approach to avoid ED admission for the patient, but with no support from external sources, this could not happen, leading back to the recurring feelings of “they’re like a black hole” which again linked into the mind-set that paramedics felt that “I’ve only got about 20 minutes of ‘there, there’ in me”. Ironically, as seen in the observations the opposite was true, with paramedics managing and reassuring their patients on scene for well over an hour. These boundaries are not necessarily permanent. The segments based on educational backgrounds will slowly to start to dissolve as vocational paramedics retire or adapt and graduate paramedics become the higher percentage in the workforce. This means there will be less discourse about mental health patients and their management as it will become part of the identity of the real role of the paramedic. Organisational boundaries will, however, continue to exist in response to the changing expectations and delivery demands of mental health patients.

This study has shown that paramedics use humour, stereotyping and nostalgia when managing mental health patients and this aids in their personal resilience but also fortifies the ties within their Community of Practice. This Community of Practice acts as a support mechanism, ensuring that paramedics can continue to manage and evolve with the needs of their patients. This is why this research matters; it provides a basis for initiating change in practice and supports the need for further education and training for a profession whose role is in transition and is required to evolve.

8.3 The study's strengths and limitations

8.3.1 Strengths

Impetus for this study was based on my personal clinical experience when managing mental health patients and also while supporting paramedics and paramedic students as a clinical tutor and university lecturer. As a participant observer in this study, I understood of the context of paramedic practice and was therefore able to use that knowledge to create and develop a research relationship between myself and the paramedics and patients I was observing. As discussed in more detail in Chapter 3, ethnography has the capacity to uncover undercurrents of relationships and behaviours as described in this study. Ethnography also has the ability to make explicit the unspoken rules and values of social interaction (Sharkey and Larsen, 2005) such as the use of humour and stereotyping and the feelings of “they’re like a black hole” and “I’ve only got about 20 minutes of ‘there, there’ in me” which act as emotional resilience mechanisms in order to help paramedics manage mental health patients with very little support and education. Ethnography allowed me to immerse into my field of practice during my five months of observation on frontline ambulances. Watts (2011) added that for this immersion to be achieved, the prolonged participation of the researcher in the life of a group is necessary with the role of participant observer achieved through developing empathy with the culture, values and behaviour of the group. Critics of participant observation question the ethics about this immersed researcher role. However, Becker (1970) believed that people do not maintain a “front” or an act for long and that what they are engaged in preoccupies them and is more important to them than the fact that an “outsider” is present. In other words, it could be argued that initially paramedics may have altered their behaviour in my presence, but as time went by they focused instead on the needs of their patients and my role as observer mattered less than the welfare and management of their patients. When discussing my research and gaining permission from the Trust to observe their paramedics, I was only expected to take on the role of clinical paramedic if we had a patient who had a life-threatening condition and it would benefit the patient and the crew to have an additional resource at hand. This happened twice in the five months of observations, once when we were sent to a cardiac arrest and once when a child had life-threatening asthma. On both of these occasions I continued with my own reflexive diary entries and also saw my supervisors to discuss these calls. We also did not attend to any mental health patients who met the inclusion criteria of this

study directly before or after these two incidents, which helped me to transition back into ‘researcher mode’.

Hammersley (2004) reminds us that “there is not a single valid description of a situation or culture. Descriptions ... simply represent those aspects of it that are relevant to the purposes motivating the enquiry”. I therefore acknowledge that there are no guarantees of validity whichever research instruments are used and that this qualitative research is therefore subject to pragmatic and practical decision-making. However, this should not detract from the fact that this study has provided a unique and detailed description of paramedic practice evidenced by observations and follow-up interviews as described in more detail in Chapters 4 and 5. This detailed knowledge was the used to identify challenges for paramedic practice and gaps in professional skills. These challenges include managing mental health patients despite paramedics feeling a real tension between their real and ideal roles as described in Chapters 5 and 6; managing this patient group with very little or no external or internal organisational support as detailed in Chapters 6 and 7 and managing their own feelings of frustration and helplessness as was demonstrated throughout the study. All paramedics who were observed and interviewed, identified gaps in their education and were keen to learn more in order to support these patients and each other. This study also identified two particular behaviours or skills used in paramedic practice that shaped the way paramedics managed mental health patients, being stereotyping and humour, and these have been discussed throughout the study. We can now also understand where paramedics fit into the greater network of the NHS. Paramedics feel they work in isolation and therefore employ nostalgia, humour and stereotyping within their Community of Practice. This strengthens their community ties through sharing emotions and knowledge and ensures their continued management of a complex patient group. Lastly, Chapters 4, 5 and 8 have received positive respondent validation from three respondents who were observed and interviewed in this study.

8.3.2 Limitations

This study took place in a single English setting, with a relatively small cohort of paramedics observed and interviewed. Out of the 21 paramedics observed, five have left the Trust and four have moved on to different sections of the Trust or changed roles. Out of the remaining 12 paramedics, eight agreed to follow-up interviews and three additional paramedics in managerial roles such as university and ambulance trust education and a mental health lead were interviewed.

Interestingly, the gender division leaned more towards male paramedics. However, when looking at managerial roles within the NHS Band 7 to 8 region, it remains male dominant. Education levels were similar with a mixed range of experience. The follow-up interviews were limited as patients and their carers were not interviewed. Although they consented to follow-up interviews during the observation phase, they did not consent when followed up a year later. Further studies investigating the impact and participation of mental health patients in the pre-hospital environment is therefore recommended.

In addition, my identity as a paramedic and therefore participant observer also played a role in how the interviews were structured and how some of the questions were posed. For example, I chose to say “how do you think *we* can ...,” including myself in the question as a paramedic as all the participants were already aware of my paramedic qualification and I believed it would help to create a sense of ‘togetherness’ and a shared sense of ownership and understanding. I also believed that by doing so, this would break down potential barriers and set the tone for a more honest and open conversation where I could push for frank answers or discuss situations with more candour. Conversely, because of this shared identity I needed to be aware of not making assumptions when interpreting the data from the interviews. I constantly reminded myself that my role in these interviews was first and foremost that of a researcher and then a paramedic. I also clearly reiterated that I was doing these interviews in a research capacity and that the participants could stop the interview or withdraw from it at any time as indicated in the participant information sheets.

I cannot deny that my role as a paramedic is what started this research in the first place, but constant awareness of the duality and complexity of being a participant observer by being reflexive and discussing the data with my supervisors and peers continued throughout every phase of my research including observations, interviews and data analysis addressing potential conflicts of interest. Reflexivity through all stages of this research process underpins my ethical conduct and Watts (2011) reminds us that where the researcher is the “instrument” and the “objects” of research are human beings, ethical, social and practical issues are inextricably linked.

8.4 Recommendations for practice

8.4.1 Paramedic practice and education

The requirement for paramedics to manage mental health patients is not going to change. If the current need for paramedics is any indication, the number of mental health patients calling 999 and 111 will only increase. It is therefore vital to use this study as an information basis to guide future paramedic practice. We now know what behaviours paramedics initiate to manage mental health patients. But will humour and stereotyping ensure sustainability and resilience in the long term? Paramedic practice needs to evolve where humour and stereotyping are no longer needed as coping mechanisms.

Mental health has recently come under the spotlight but the role of the paramedic and how paramedics can be supported in managing this patient group has yet to be clarified. Developments currently taking place in the paramedic workforce highlight several issues that should be addressed as a matter of priority. There is a clear need to continue progressing standardisation of education and training programmes, and moving towards professional regulation. Greater clarity is also needed in relation to both career structure (to take into account the likelihood of a more mobile workforce, between jobs, services and roles), and the role of the paramedic in relation to the broader health system. In an environment of workforce innovation with the development of new roles such as advanced paramedic practitioners (critical care and primary care) and paramedics prescribing, it is important to continue to redefine the scope of practice of the paramedic professional and to consider the range of potential career trajectories for paramedic graduates. In addition, an integrated, national approach to workforce planning is needed to ensure that future inflows to supply match with forecast demand. Addressing these issues will ensure that the paramedic workforce is included in current developments in health system and health workforce reform. One mechanism to address standardisation of education and redefining the scope of practice is through national working groups such as the NHS Clinical Commissioners' National Ambulance Commissioners Network and the Association of Ambulance Chief Executives. Both these national groups work together with other stakeholders to improve the treatment, referral and conveyance of people experiencing mental health crises. This study presented an evidence base showing how paramedics currently manage and treat mental health

patients thereby providing evidence-based practice which in turn can support change and support.

Mental health is a field of change and in the pre-hospital environment it represents all paramedic work if one had to view a patient holistically. It is no longer a “scoop and run” approach, but a treat and manage approach, with very little internal or external support as evidenced by this study. University graduate paramedics accept their evolving role which includes managing mental health patients and would therefore welcome further educational training and support regarding the treatment of these patients. Vocationally trained paramedics struggle more with the evolution of their role but also request more training, more specifically around referral pathways for mental health patients. The “new paramedic” witnesses both groups and can either side with one or the other but I believe that both roles have merit in what they require to improve care for mental health patients.

Lastly, the registrant body for paramedics – the Health and Care Professions Council (HCPC) – after national consultation in 2017, has agreed to a change in the threshold entry level to the paramedic register, which will now be raised to a BSc (Hons) degree. Vocational pathways and foundation degrees will no longer be enough to register as a paramedic. This means from 1 December 2018, the HCPC will not accept new applications for approval of paramedic programmes that are delivered below degree level and from 1 September 2021, they will withdraw approval from existing programmes delivered below the new threshold level (HCPC, 2018). These programmes will then not be able to take on any new students. Although this is good news in terms of the professional progression of paramedics, it creates complications around workforce requirements with ambulance trusts having to wait longer for paramedics to graduate. This does not help the current recruitment needs for paramedics. Fortunately, existing registered paramedics who do not have degree-level qualifications will continue to be registered.

Based on the observations and interviews, this study has identified the area of practice and education that needs more support. As this study focuses on how paramedics manage mental health patients the practice area has already been highlighted. Ironically, many ambulance trusts across the UK have started to work on support mechanisms around paramedic mental health. The College of Paramedics recently developed a Paramedic Mental Health and Wellbeing Steering

Group which works in partnership with the charity Mind and its Blue Light Programme (Mind, 2016). This steering group not only considers how to support paramedics managing mental health patients, it also looks to support paramedic mental health. Paramedics in this study have also been specific in their requests for further education. As previously described, there were two segments within the paramedic participants – university-qualified paramedics and vocational paramedics; remembering that hybrid paramedics (those who started vocationally and then went back to university were not observed but they certainly exist). University-qualified paramedics specifically want more education from the ambulance trusts and supporting universities regarding the most prevalent mental health disorders they see in practice: anxiety, depression, addiction, psychosis, bipolar disorder, schizophrenia. They explicitly requested more focus on the epidemiology of these conditions followed by their drug management. Hawley et al (2011a, 2011b) published a series of articles providing a guide for paramedics about managing mental health conditions, detailing mild to moderate mental disorders such as borderline personality disorder, antisocial personality disorder, depression and anxiety. However, this series was only available via subscription membership. Interestingly, vocational paramedics wanted more education and information from their ambulance trust about how to talk to patients about their conditions and then refer them to support groups – thereby supporting them in the community rather than transporting them to the ED. Both groups felt that with additional educational support they could improve their current care but the lack of support in practice was also a huge factor. This was evidenced repeatedly in this study with paramedics saying they worked in silos and felt isolated when managing mental health patients. This study will highlight these areas to ambulance trusts and education providers, supplying them with the evidence they need to support and improve the practice and education of their paramedic staff.

8.4.2 Future research

As a researcher this study has provided a platform for further research ideas. One of the limitations of this study was the lack of follow-up interviews with mental health patient participants. The perception of mental health patients on the care they received before being admitted to hospital would be of added value to the findings of this study. As mentioned in the previous section, paramedic mental health is receiving attention in terms of increased support from their ambulance trusts for talk-therapy support and identification of burn out, post-traumatic

stress disorder and other related conditions. Research initiatives working with other mental health organisations such as Mind have come up with some interesting findings. For example, the Blue Light Programme Research Summary (2016) evaluated the impact of mental health support for emergency services staff and volunteers in 2015 to 2016, which added that poor mental health was common within the emergency services, citing workload and management pressure as a major contributing factor. In light of this, paramedic resilience in the current workforce climate would be another area of research that could positively impact clinical practice and therefore patient care. There has also been a recent call for paramedics to participate in a local survey in the South West, which focuses on how much training paramedics need to deal with mental health incidents (Bournemouth University, 2018).

8.4.3 Policy

Four years ago, 22 national bodies involved in health, policing, social care, housing, local government came together and signed the Crisis Care Concordat (2014). Since then five more bodies have signed the Concordat, making it a total of 27 national signatories. The Concordat focused on four main areas: access to support before crisis point; urgent and emergency access to crisis care; quality treatment and care when in crisis and lastly; recovery and staying well. There was also a section on prevention and intervention that the Concordat built on but did not replace existing guidance (2014). In 2016, an evaluation of the Crisis Care Concordat implementation was published. The evaluation (Mind, 2016) reported that different areas were starting from different points in terms of crisis care provision and partnership-working, however, the fact that all these areas signed up was an achievement in itself. The momentum of the Concordat now seems to have slowed down and there is no indication that the work paramedics are doing in terms of managing mental health patients has been considered in terms of acknowledging the complexities they face as discussed throughout this study and how their practice could be supported and improved.

Following the Concordat, was Closing The Gap: Priorities for Essential Change in Mental Health (2014) which identified 25 areas for immediate change to improve mental health care under four themes: starting early to promote mental wellbeing and prevent mental health problems (as discussed in Chapter 2, paramedics could play a role in identifying vulnerable patients and supporting them in practice); increasing access to mental health services (the ambulance service was a point of access in terms of mental health patients calling 999); integrating

physical and mental health care (a common theme across other policies); and improving the quality of life of people with mental health problems.

The Five-Year Forward View for Mental Health: a report from the independent mental health task force to the NHS in England (2016) made additional recommendations to be delivered by 2021 included providing mental health care to 70 000 more children and young people as well as new funding for acute hospitals to have mental health services in the ED. The Mental Health Policy in England (2017) summarised the mental health policy since 2010, adding that NHS England also published Implementing the Five-Year Forward View for Mental Health (2016), which confirmed that the NHS had accepted the recommendations made in the Five-Year Forward View for Mental Health. The College of Paramedics has also been approached by the Mental Health Team at NHS England to submit recommendations on the future of mental health care to inform the development of a Long Term Plan for mental health. As the mental health lead of the College of Paramedics, I was able to contribute some of the findings of this PhD study to support this request. This Long Term Plan document was submitted alongside a bid to NHS England to support a Mental Health Development Programme on a national level. The bid proposed a three year project working with NHS England and the College of Paramedics to identify amongst others: undergraduate core competencies in mental health, existing workforce core competencies and an advanced clinical practitioner in mental health. The results of this bid remain outstanding at the time of the publication of this PhD study.

8.5 Summarising the contribution of this study

Mental ill-health continues to be the largest source of disability in the UK and approximately one in four of the UK adult population will have a significant mental health problem at any one time (McManus et al, cited in Mental Health Foundation, 2015). Around 100 000 adults were admitted to hospital with mental health problems at some point during 2015 to 2016 (Baker, 2017). In addition, one in six people reported having symptoms of a common mental health disorder which includes different types of depression and anxiety, panic disorders, phobias and obsessive compulsive disorder (Baker, 2017). Mental health issues are on the increase and frontline paramedics are increasingly expected to respond to these patients, yet feel unprepared and unsupported in doing so.

This study resulted from my personal clinical experiences not only as a practicing paramedic but also as a clinical tutor and university lecturer, where I had to

manage mental health patients myself, support fellow colleagues and teach and mentor paramedic students. Because of my clinical background, I used ethnographic methods of observation and follow-up interviews as a participant observer in order to explore how paramedics managed and responded to patients experiencing mental health issues.

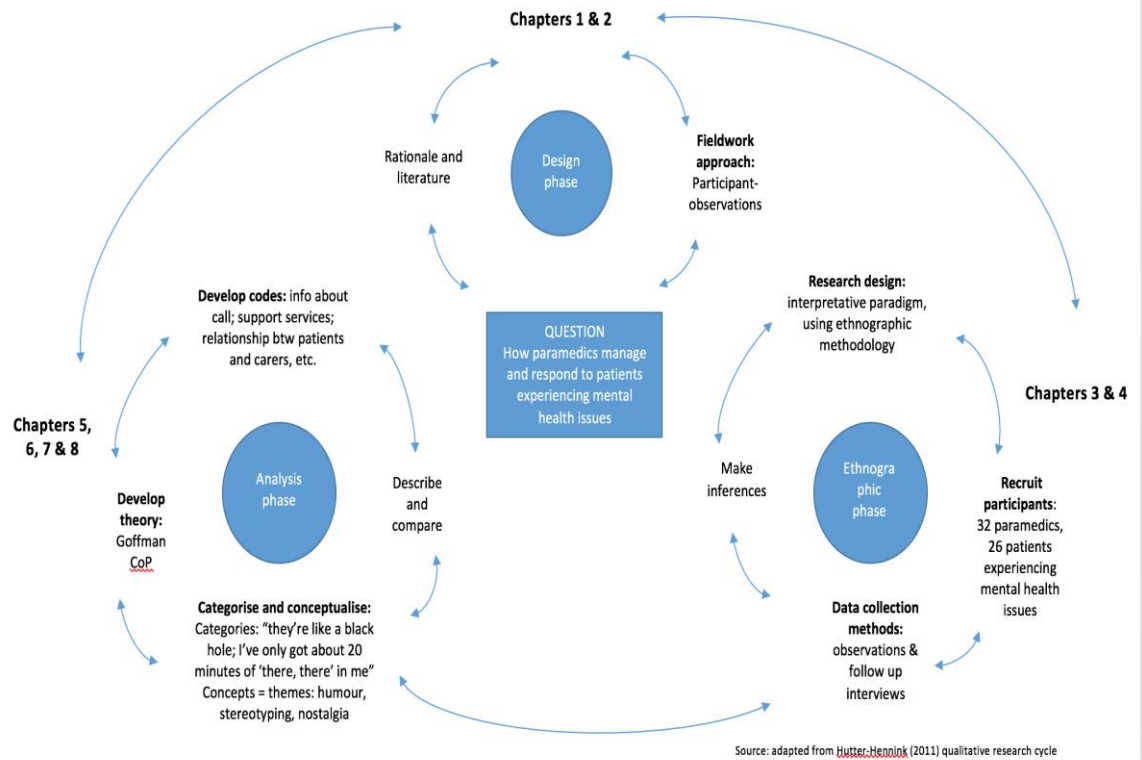
After five months of observing paramedics in the field and conducting follow-up interviews a year later, thematic analysis revealed areas that impact on practice and the future welfare of paramedics and their patients. Paramedics are expected to manage and respond to a wide range of emergency care needs, however, the role is evolving and much of the focus of their education is on serious emergency presentations, yet the 'bread and butter' routine work of the service entails responding to and managing mental ill-health and associated social challenges. Paramedics felt that mental health patients were "like a black hole" which left paramedics feeling like they only have "about 20 minutes of 'there, there'" in them to manage these patients. Ironically, these quotes speak to the state of mind of paramedics and not their management of mental health patients, which included observing paramedics reassure and care for mental health patients for as long as four hours when average times on scene should be around 30 minutes. Paramedics managed these feelings of futility and frustration by utilising specific behaviours such as humour, stereotyping and nostalgia when managing mental health patients. These behaviours were then analysed using Goffman's ideas of presentation of self (1959), which in turn uncovered that paramedics used humour to de-escalate emotional tension often present during a mental health call and also used humour among themselves as a form of resilience – to blow off steam. Paramedics also used stereotyping as a triage tool which served as a support mechanism when managing mental health patients. These behaviours, which manifested through shared emotions, knowledge and tips, created a supportive mechanism in the form of a paramedic Community of Practice, where they strengthened the ties of this paramedic community.

This study has provided rich and detailed material to evidence how and why paramedics manage mental patients in the way they do and could provide a platform for relevant future role players such as ambulance trusts and higher education institutions to initiate support and consider the future of paramedic practice in terms of managing mental health patients.

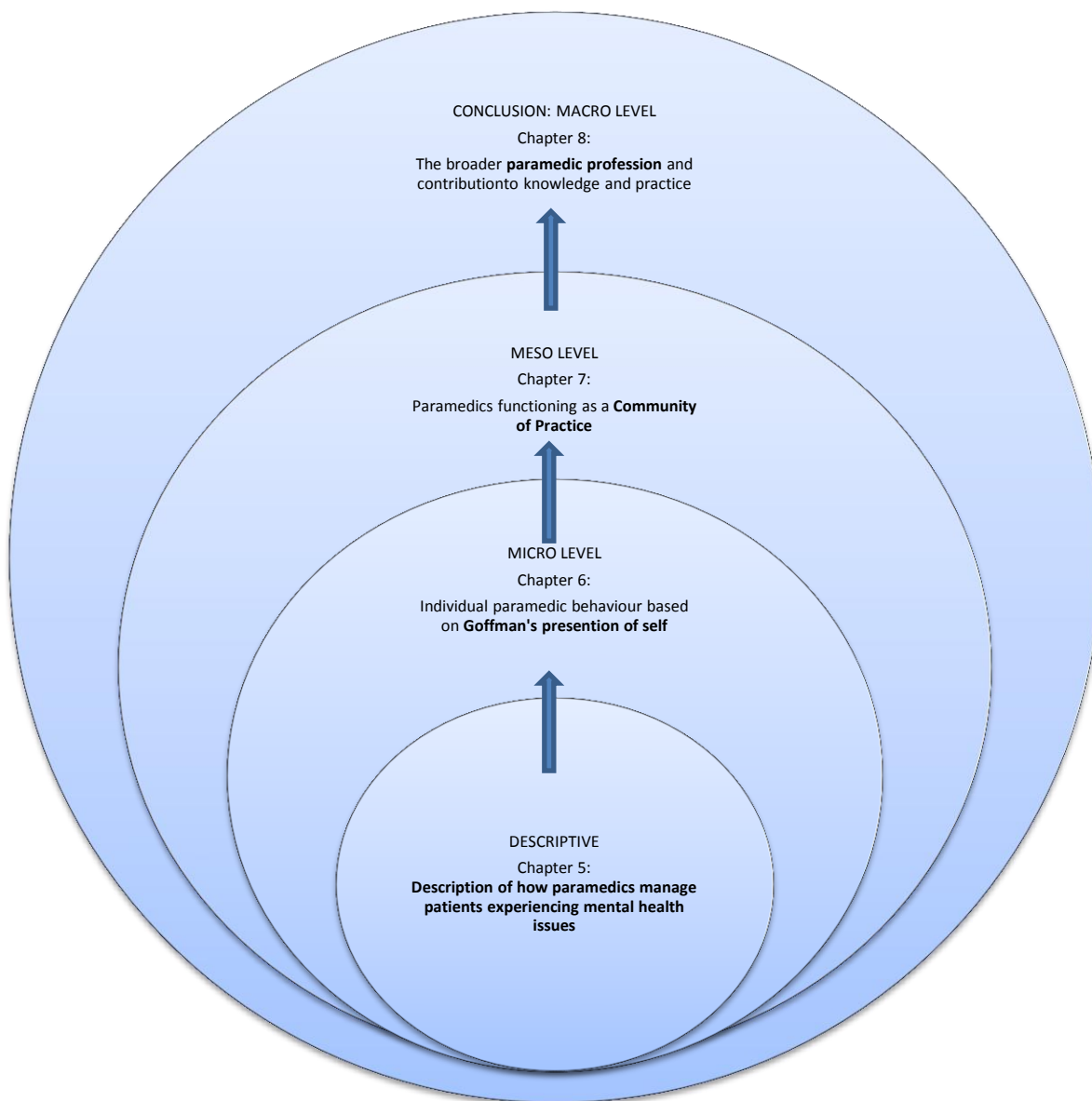
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Appendix A

A.1 Research cycle explained



A.2 Venn diagram showing progression and structure of Chapters 5, 6, 7 and 8



Appendix B

B.1 Summary of studies included in the literature review using CASP

Author, Title, Journal	Type	Was there a clear statement of aims of the research?	Is the qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between the researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Key findings and recommendations
Aberton, H 2011. Material enactments of care: Paramedic, police and mental health-related emergency calls. Unpublished, University of	Primary qualitative research	Yes	6 paramedics, 4 police, 4 hospital staff	Yes	Yes	Yes – semi-structured interviews	Yes	Yes	Yes	Caring for mental health patients is an ongoing process of changing enactments. A mental health emergency is a fluid object not singular or fixed, therefore a mental health pathway cannot address the complexities that mental health patients present.

Stirling.										
Broadbent et al. 2007.The development and use of mental health triage scales in Australia. <i>International Journal of Mental Health Nursing.</i>	Narrative review	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	A review of the development of specialist mental health triage scales reveals an improvement in competence and confidence of emergency department (ED) staff triaging patients with a mental illness but there is no national emergency triage of patients with mental illness in Australia. In order for patients with mental illness to receive the same level of assessment and management as those with physical injury or illness, it is necessary to use a triage scale that incorporates mental health descriptors. A national approach should be used for mental health triage scales. There is a lack of training and ongoing education on mental health illnesses for emergency department staff.
Clarke et al. 2007.	Primary qualitative	Yes	Yes – 8 focus	Yes	Voluntary response to	Yes	Yes	Yes	Yes	Many patients with mental health issues are coming to

Emergency department from the mental health client's perspective. <i>International Journal of Mental Health Nursing.</i>	research		groups (27 clients, 7 family members, 5 stakeholders		written invitation via ED, CMHT and self help groups					the ED as they have nowhere else to go. It is 'hoped' that if these patients had somewhere more suitable to go, they would make use of these facilities as opposed to going to ED. Respectful and holistic individual care was highlighted.
Elliot R 2013. Exploring the developmental need for a paramedic pathway to mental health. <i>Journal of Paramedic Practice.</i>	Opinion piece	Yes	Perhaps	Not in-depth	N/A	Yes	No	No	No	The paramedic role is not to diagnose a mental illness but to identify key indicators in mental deterioration and then signpost or activate an appropriate care pathway. A pre-alert similar to cardiac arrest would allow mental health patient to be effectively triaged by a specially trained mental health professional. This would increase positive working partnerships between mental health, ambulance and A&E staff. There should be an investment into a national mental health clinical pathway where patients

										could be referred directly to Crisis Resolution and home treatment (CRHT) teams.
Ford-Jones PC & Chaufan C 2017. A critical analysis of debates around mental health in the prehospital setting. <i>Journal of Health Care Organization, Provision, and Financing</i> .	Opinion piece	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	There is a rise in the call volume of mental health calls. It is not enough to request more education and training for paramedics or a better triage system. This piece highlights a requirement for policy change and the acknowledgement of deinstitutionalisation. The authors believe the paramedic perspective can inform a better understanding of what drives these psychosocial crises and that greater political and social engagement could act as a prevention strategy rather than a reactionary one.
Hawley et al. 2011a. Mental health in the care of paramedics:	Opinion piece	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	The aim of this article is to provide paramedics with a synopsis of common psychiatric conditions. The article also claims that the

Part 1. <i>Journal of Paramedic Practice</i> .										majority of mild to moderate mental disorders should be managed in primary care according to a stepped care model as recommended by NICE, (2010) (http://tinyurl.com/66yzx94)
Hawley et al. 2011b. Mental health in the care of paramedics: Part 2. <i>Journal of Paramedic Practice</i> .	Opinion piece	yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	A continuation of a previous paper which claims to offer a short guide to paramedics about the principles of initial assessment and management of mental health conditions. There is no formula that can be universally applied to this patient group. Experience and expert judgement is required to respond flexibly to features of each individual based on context, urgency, risk, time and resource.
Montera A 2016. The Community Paramedic's Role in Treating Mental and Behavioral	Opinion piece	Yes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	This article believes that community paramedics are well-positioned to work with patients with mental illness. The author likens their role to 'psychological first aid' by meeting the basic physical

Health Patients. <i>EMS World.</i>										needs and then the most basic of psychological needs of the patient.
Morisson-Rees et al. 2015. Investigating the volume of mental health emergency calls in the Welsh ambulance service trust (wast) and developing a pre-hospital mental health model of care for application and testing. <i>Emergency Medicine Journal.</i>	Qualitative audit	Yes	Yes – 10% electronically generated random sample of calls in April 2012	Yes	Yes	Yes	Multiple researchers over 3 different ambulance trusts	None mentioned	Yes	Both dispatch and on-scene condition codes underestimate the volume of mental health related emergency calls by nearly half. This audit provides potential to support paramedics to assess and reduce transfers to emergency departments through access to pre-existing community care provision.
Pajonk et al. 2008. Psychiatric emergencies in prehospital emergency medical	Qualitative audit	Yes	Yes – protocols of 2 emergency services	Yes	Yes	Yes	Yes	Yes	Yes	The study emphasises the importance of psychiatry within emergency medicine. Training on risk assessment, treatment of suicidal behaviour and crisis

systems: a prospective comparison of two urban settings, <i>General Hospital Psychiatry.</i>										intervention strategies should be provided within a multi-professional course for all those involved in psychiatric emergencies.
Prener & Lincoln 2015. Emergency medical services and 'psych calls': examining the work of urban EMS providers. <i>American Journal of Orthopsychiatry</i>	Primary qualitative research	Yes	Yes (4, 12 hour periods of observations and 20 semi-structured interviews)	Yes	Yes	Yes	Yes	Yes	Yes	Despite the frequent involvement of EMS with mental health patients and substance abuse problems, the nature and content of this still needs further research. The study found EMS providers had limited training and felt unprepared for psych calls. Discourse between every day reality and EMS preference of 'exciting' calls. Providers also described system-level challenges. Limitations of the study include, sample size, no examination of the role of formal training and informal socialisation of providers' view of psych calls. More research is

										needed.
Rees et al. 2016. Perceptions of paramedic and emergency care workers of those who self harm: a systematic review of the quantitative literature'. <i>Journal Of Psychosomatic Research.</i>	Qualitative review	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Paramedics are often the first health professional contact following self-harm, yet limited qualitative literature has explored this encounter. Metaphors revealed in this paper highlight challenges in decision making and legislation, also opportunities to improve care through professionalization and tailored education
Roberts & Henderson 2009. Paramedic perceptions of their role, education and working relationships when attending cases of mental illness. <i>Journal of Emergency</i>	Primary qualitative research	Yes	Yes – database, 74 surveys and 3 focus groups	Yes	Yes	Yes	No	Yes – peer reviewed	Yes	Mentally ill patients comprise a growing proportion of paramedic workload. Discrepancies between paramedic perception and information on the clinical database was mentioned but not explained. Education and training was mentioned with specific request for an assessment tool that allows same standard approach used for trauma patients.

<i>Primary Health Care.</i>										Thirdly, interagency relationship within mental health remit were looked at, some were considered effective by paramedics while others were not. More research is required in this field.
Shaban R 2005. Paramedic clinical judgement of mental illness: representations of official accounts. <i>Australasian Journal of Paramedicine.</i>	Case study	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Paramedic roles are changing when it comes to assessing and managing mental illness but how this happens is not known or thoroughly evidenced. This means there is role confusion which has led to an explicit need for additional skills and training and a tool to guide practice. Paramedics say there is a gap in their knowledge and there needs to be recognition for the evolving role of a paramedic. More study is needed.
Shaban R. 2006. Paramedics' clinical	Qualitative review	Yes	Yes	Yes	N/A	Yes	No	N/A	Yes	Absence of research into paramedic clinical judgement and decision-making of mental illness. This means

judgement and mental health assessments in emergency contexts: research, practice, and tools of the trade. <i>Journal of Emergency Primary Health Care</i> .										the impact of significant reform to mental health service provision to the emergency care and paramedic settings have been unexamined. Additional exploratory research is needed. The identification of strategies from research to support a more effective, paramedic clinical judgement practice has also not been attempted.
SWASFT 2015. Pre-hospital assessment and management of patients presenting in mental health crisis including deliberate self harm.	Qualitative audit	Yes	Yes – 243 records	Yes	Yes	Yes	No	No	Yes	Patients with depression, anxiety and alcohol dependence are becoming more prevalent. The ambulance service is seeing more of these patients. The majority of calls were (67%) were out of hours and the majority were transported to hospital. 42% of patients were under the influence of alcohol or drugs. The average age was 36 years and 84% were below 50 years. 66% of patients had previous mental health

										diagnosis. The audit recommends quality improvement work. It does not discuss how paramedics are actually coping with this patient group or how they are managing these patients,
Townsend & Luck 2009. Protective jurisdiction, patient autonomy and paramedics: the challenges of applying the NSW Mental Health Act. <i>Journal of Emergency Primary Health Care.</i>	Qualitative review	Yes	Yes	Yes	N/A	Yes	N/A	N/A	Yes	Examined legislative principles and ethical dilemmas faced by paramedics due to changes in mental health laws and increasing responsibility of paramedics towards this patient group. NSW Mental Health Act 2007 changed to make provision for paramedics to transport patients directly to mental health facilities, therefore relieving burden on EDs. Additional powers include: reasonable force, restraint and sedation for purpose of transport. Now practice is defensive. But again, very little research on the way in which paramedics deals with the clinical complexities of

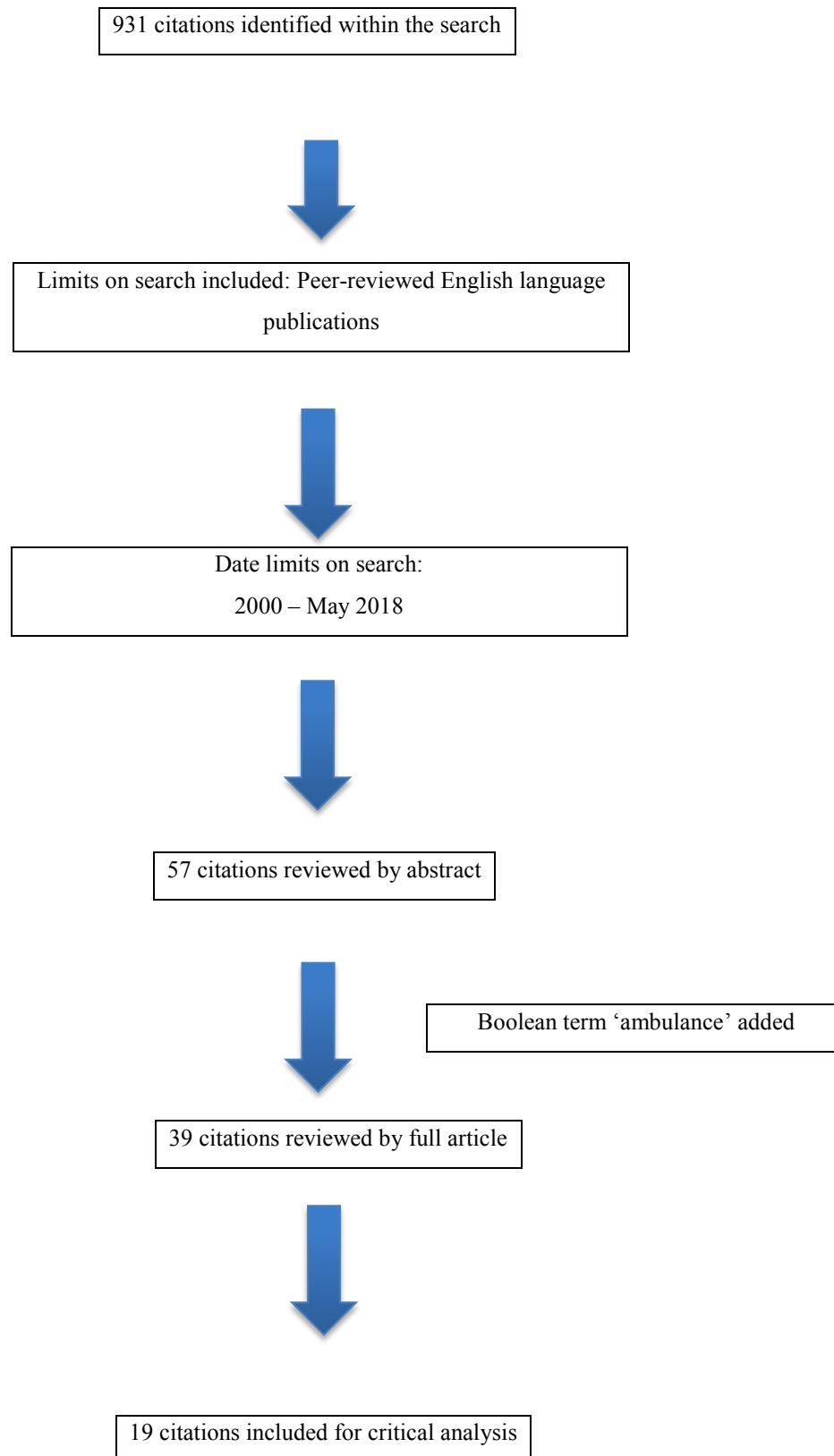
										mental health assessment and treatment. Further research is required.
Vibha & Saddiccha 2010. The burden of behavioural emergencies: need for specialist emergency services. <i>Intern Emergency Medicine</i> .	Narrative review	Yes	Yes	Yes	N/A	Yes	N/A	Not mentioned	Yes	Behavioural emergencies are a neglected area among all emergencies presenting to the emergency services. Along with the improvement of emergency services to deal with psychiatric emergencies, further research is needed in this area. There are also challenges to researchers and clinicians in terms of understanding the problems with regards to aetiology, consequences and services available
Wright & McGlen 2012. Mental health emergencies: using a structured assessment framework. <i>Nursing</i>	Opinion piece	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Staff are overwhelmed in communities and hospital settings; responses are often delayed. Staff needs to know how to communicate with mental health patients and be able to refer them to specialist knowledge and resources through accurate assessment. Using an

<i>Standard.</i>										assessment tool such as the Public Psychiatric Emergency Assessment Tool (PPEAT) helps nurses to use existing skills to ensure they can meet the needs of mental health patients who are considered vulnerable.
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B.2 Search strategy for literature review

Key concept	Alternatives	Combinations
Paramedics	Paramedic* Emergency medical technician* Emergency medical service* Hospital rapid response team Prehospital care	paramedic* or emergency medical technician* or Emergency medical service* or Hospital rapid response team* or Prehospital care
Mental health issues		mental health issue* or mental disorder* or psychiatric emergenc* or emergency
Manage	Mental health issue*	services psychiatric* or
Managing	Mental disorder*	psychiatr* or psychosocial
	Psychiatric emergenc*	
	Emergency services, psychiatric?	
	Psychiatr*?	
	Psychosocial	
	Manag*	
Ambulance		

B.3 Flowchart of review process



Appendix C

C.1 Field note sample

Excerpt from *field note 2*:

12am: We were dispatched to a woman who had 'fallen and put her head through a glass window'. As soon we received that information on our data head we all said the same thing: "this will be a mental health call". We are trained as paramedics to have a high index of suspicion. I thought it would be a mental health call because I person does not usually put her head through a glass window. I didn't ask Paramedic 6 or ECA 1 why they thought it was possibly a mental health call. 12.10am: We were greeted at the property by a neighbour who explained that the patient had been drinking and she had then also put her head through a window. He led us up the staircase to what looked like a property under renovation. There was a lot of building material and wood lying around as well as boxes and it was very cold within the property. When we reached the cold landing we saw the female patient (48 years old) sitting on the floor, blood on her face and a laceration above her right eyebrow. It was clear she was intoxicated or drugged as her eyes were unfocused and she was slurring her words and laughing and then looking into the distance as if she was seeing something we could not see. The patient was surrounded by three other women. One was the neighbours partner and the other two younger ones were the patient's daughter (17 years old) and her friend. All of them were trying to hold the patient upright and reassuring her that "everything was fine". Paramedic 6 gained consent to treat her and ruled out any physical emergencies but looking at her wounds, feeling her neck and spine and taking observations. ECA 1 stood back and watched and so did I. The patient admitted to drinking "355ml of vodka – which is really not very much for me". Paramedic 6 nodded and confirmed this with the patient's daughter who also nodded. "I saw a bright light," the patient slurred, "my gran was calling me, she said I must save my life, so I put my head through the window. My daughter has seen me try to throw myself in front of a train. She saw me overdose. I was 21 when they diagnosed with me bipolar type 1 and depression." I was watching the daughter while her mother recounted her medical history. She seemed concerned for her mother but not affected emotionally by the history her mother was telling us. Her face showed no emotion. We guessed she had been privy to this type of situation many times before. In fact she replied at one point with a humorous "Well mum we didn't like that window much anyway did we?!" The patient continued with her history: "She [her daughter] saw me go to a mental health institution. She has had enough of this." This is where her daughter wrapped her arms around her mother's shoulders and said "don't be silly mum, I am fine, they just need to take you to hospital to make sure you are ok. Remember you had a seizure." Interestingly we did not witness any medical seizures during the time on scene or on the way to hospital but the patient did wave her arms around dramatically and rocked while she was sitting. We did wonder if the daughter and neighbours thought that perhaps this was a seizure. "I am going into detox on Monday in Bristol and then spending 3 months in rehab. I have got funding for this," the patient explained. 12.40: We escorted the patient to the ambulance. She was able to walk with Paramedic 6 and ECA 1 by her side but was unsteady of her feet and continued to slur her words. In the ambulance Paramedic 6 asked her for more history about her alcohol problem. She didn't reply but instead said: "Did you know I have a PhD in Russian languages and both my children are very clever?" she asked me. I was sitting at the head end of the stretcher and Paramedic 6 was sitting near the feet filling out her paperwork. "My son is at Cambridge University. He hates me, he doesn't talk to me. And my daughter got all As. My Russian ex-husband is a danger to me. Alcohol was my anaesthesia. My daughter went to see him and she came back missing him but she sees how he destroys me. Its hard for her," she said. The patient rapidly changed the subject again and spoke about the incident again: "When I saw my gran [in the light] she called me to her. She wants me to come with her to die. But I need to to rehab. But I am so embarrassed by all of this. To be a burden." She laughs loudly and adds: "We hated that glass so we can change it now [more laughter] that's a dramatic way to change the glass!" The patient's medication included zopiclone (sleeping tablet), metformin (for type 2 diabetes), diazepam (treat anxiety disorders, alcohol withdrawal symptoms, or muscle spasms) and lamotrigine (for prevention of depressive episodes associated with bipolar disorder, BNF 2015). One the way to hospital Paramedic 6 sat next

to the patient alternatively writing notes and reassuring the patient by rubbing her shoulder. "You live and learn. You get through this alcohol shit and you can live again. You have a wonderful daughter and son," added Paramedic 6. 12.55am: "I overdosed at this hospital," as we pulled up outside the Emergency Department. "I can see her again...my gran she is there...[pointing to the back door of the ambulance]." The patient started waving her arms and rocking again. Paramedic 6 was brisk in her response: "now what are you doing that for? No need to rock like that, we are going to get you taken care of inside." The hospital accepted the patient and she was put into the holding bay. As she lay there she started to "fit" again by flapping her arms about and rocking her torso from side to side. The charge nurse shouted across from the admissions desk: "none of that nonsense here please". She asked a health care assistant to go and do observations on the patient and to tell her to stop being silly as she was not having seizures. Paramedic 6 smiled and whispered to me: "they don't take shit here!" And all three of us walked back to the ambulance.

C.2 Follow-up interview sample

Excerpt from follow-up interview 11

Respondent: I think most people who phone, with a mental health problem, probably do need someone to go out to them, it's probably right to, we are going to them, but perhaps some of the education is in how to walk away as well, and, you know, knowing you've done your bit. There's nothing more that you can do. This person is safe to be left alone and that's it, and I can walk away feeling happy that I've helped someone.

Interviewer: And I think that's where, so another theme that's come out is, it's another good quote, is, "They're like a black hole". So, what paramedics are saying, how I've interpreted that is that they're throwing everything that they have at this patient, except they're not seeing any feedback, whereas with a physical condition, you know, if someone's got an MI you put an ECG on them, give them morphine, give them aspirin and take them to the lab, but in between you can see, "Okay, on the ECG, have I made a difference or haven't I?" and then you do something else to evoke a different sort of outcome, if you know what I mean, whereas with mental health patients, the outcome is subtle, they can't, you know, talking to mental health patients is an intervention in itself, but it doesn't have the same result as giving someone a medication that you can see an actual, physical difference in their presentation, and I think that's frustrating.

[0:38:35]

Respondent: Yeah, yeah, yeah.

Interviewer: Because of how we are taught, because of what we are, we're sort of used to this, "Okay, so if they present as A and we do B, then we know the answer will be C, and if it isn't then we know what else to do in order to get that". Whereas, with the mental health patients, it's complicated because you're not getting the feedback that you often get with physical conditions.

Respondent: Yeah, yeah, absolutely and I think a lot of, when I think about, you know when you said, "Why did job stand out?" I think there's lots of jobs, mental health jobs I went to that stand out and it is that feeling of frustration that you can't help, where, in every other aspect of my work, I can help someone.

Interviewer: Yeah.

Respondent: But, in hindsight now, you know, I've realised that you can help people, that actually just talking to them and validating their feelings, being empathetic, is helping them, but you're not going to see that. They're not going to say, "Oh, thanks, I feel better now". They're probably not going to say anything and they probably won't realise they've been helped until maybe days, or weeks, down the line, you know, they think, "Actually, that paramedic was really nice and it helped me to kind of resource myself to kind of help with this problem". Might not come out of it, but, you know, to access help or whatever. So, I think the week that we run, I like, I like the stuff around communication and the service user coming in and talking about the way the paramedics have spoken to them and some that have been damaging to them, it could be some of them have been helpful, and the only difference is that people who are helpful are compassionate and nice and spoke to them like a human. I mean, one of the guys even says that he's an Arsenal fan, even one of the paramedics was a Tottenham fan and they joked about that for a bit and probably nothing to the paramedic, just the kind of jokes that we make, like to every patient, you know, anyone who's a football fan, I always make a joke about football, so it is absolutely nothing to us, but he remembers that years down the line. He remembers just someone being human to him and that helped him, and then I think, you know, perhaps education, for paramedics, is around either the little things you can do and when you walk away from them, you can be happy that you've, that you have helped them. You don't feel frustrated about this, you know, and the other interesting thing that we talk about is the recovery journey and kind of the cycle of recovery, and that everyone is on a different part of that cycle and if you can kind of work out where they are on that cycle, like you know if they're,

kind of, in the pre-contemplation phase, you can't help them. So, you know, that's it. You can't help them, they're going to need much more intervention until they get round the cycle a bit to wanting to help themselves. So, you know, I get frustrated when paramedics say, "We're needing more education on X topic," because, you know, there's not, there's just not kind of a bullet for this, but there ought to be little things we can do. The other question is, does teaching for mental health happen as a block? Is there even a unit in it? Or is it integrated throughout? My feeling is that mental health and physical health are so inter-related that probably it can make sense to teach paramedics, you know, to have mental health as integrated throughout their career, probably.

Interviewer: Yeah.

Appendix D

D.1 Interview topic guides

Paramedic Participants

Reintroduce self and exchange pleasantries

Ask participant where they would be comfortable to sit

Describe the purpose of the interview.

“Thank you for agreeing to participate in this follow up interview and for allowing me to observe you in practice last year. Should you have any questions, please stop me at any point so that I can answer them. I will now go through the consent form, which will ask you to sign if you agree to participate in this interview. Do you have any questions?”

Go through the information sheet and answer any initial questions.

Remind the participant of the study, and explain the consent form and explain each point they are required to sign.

Confirm understanding and ask the participant to sign the consent form.

Interview

Remind participant of confidentiality and discuss support mechanisms.

Describe the purpose and format of the interview.

Encourage questions and confirm understanding.

Start digital recording and conduct interview

Topic guides for paramedics:

Start off by asking paramedic to elaborate on role of paramedic – and what you do

Some suggested questions depending on how the interview develops:

- can you talk me through what you understand as a mental health call
- perhaps talk about recent mental health calls attended
- what do you think the role of paramedic is with MH calls
- interactions
- processes
- help and/or hinder aspects of call

Close of interview

Ask participant if there is anything else they would like to add?

Close the interview with thanks

Turn off the digital recorder

Close of meeting

Confirm participant has my contact number and email

Thank participant for their time.

Appendix E

E.1 Ethics documents

Health
Sciences

UNIVERSITY OF
Southampton

**A New Study to look at
How Paramedics Manage Patients— especially
those with mental health issues**

Do you want to influence future clinical practice?

This research aims to explore how paramedics respond to patients and manage their care needs – especially patients with mental health issues.

What are we doing?

The researcher will observe paramedics during their shift with particular attention to when you are treating patients with mental health issues. The researcher may all have informal follow-up conversations with you and your crew after the patient has been safely managed for more feedback on paramedic practice.

What will you get out of taking part in this research?

Be involved in supporting and changing the future of your paramedic practice. Evidence-based research has the power to initiate change!

Who are we looking for?

We are looking for paramedics who would be comfortable to be observed during their shift by a researcher who is also an experienced paramedic.

How do you get involved?

If you are interested in becoming involved and would like more information please contact Ursula Rolfe by email on ur1e13@soton.ac.uk

Health Sciences
www.southampton.ac.uk



Paramedic Participant Information Sheet

Study Title: How do paramedics manage and respond to patients with mental health issues

Researcher: Ursula Rolfe

Ethics number: 13765

Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

This research is towards a PhD qualification at Southampton University. The researcher is a paramedic who wants to know more about how to support and treat patients, especially those with mental health issues such as depression or anxiety. This research involves observing how paramedics work to identifying areas of good practise and improvement.

Why have I been chosen?

You have been chosen as a paramedic who sees and treats patients with mental health issues and who has experiences and views relevant to this research.

What will happen to me if I take part?

The researcher will be observing how you respond to and manage patients with mental health issues. You will approach your patient first and the researcher will introduce herself and the research when appropriate. She may take notes while observing your care and/or invite you to talk about your experiences if convenient.

Are there any benefits in my taking part?

Mental health is on the Government's agenda as a priority. Currently there is no research on paramedics and how we manage mental health patients. If this research identifies areas of strength and improvement it will be able to help support future paramedic practice with this patient group.

Are there any risks involved?

Your care of the patient will take priority over the research which will only involve observation and conversations or interviews as agreed between the researcher and you. If any discussions lead to topics that make you feel uncomfortable for any reason, the researcher will stop.

Will my participation be confidential?

Your participation will be kept confidential and not shared with health professionals. All data and consent forms will be stored securely to comply with the University of Southampton's Research and Ethics Policy and the Data Protection Act of 1998. Your details will be anonymised and will not be disclosed or shared with anyone without your expressed consent. In the very unlikely event of witnessing actions or omissions that bring harm, or have the potential to bring harm to patients, the researcher will be professionally obligated to bring these to the attention of your trust line manager in line with the Trust's policy on Code of Conduct.

What happens if I change my mind?

You have a right to withdraw from this research at any time without your legal rights being affected.

What happens if something goes wrong?

Please do not hesitate to contact the University of Southampton Research Governance Office on Rgoinfo@soton.ac.uk

25 November 2015 v2

What will happen to the results of the study?

The study will be written up as part of the researcher's PhD thesis. You will not be identifiable in any published results. The researcher will also disseminate the findings of this research through the ambulance trust and other publications.

Who has reviewed the study?

The study proposal has been peer reviewed by the Research Governance Office at University of Southampton. All research in the NHS is looked at by an independent group of people called a Research Ethics Committee. A favourable ethical opinion has been obtained from London-Camberwell St Giles Research Ethics Committee. NHS management approval has also been obtained.

Where can I get more information?

Please email Ursula on ur1e13@soton.ac.uk or call her on 07759453924 if you have any queries or wish to ask any further questions.



PARAMEDIC CONSENT FORM

Study title: How do paramedics manage and respond to patients with mental health issues?

Researcher name: Ursula Rolfe

Ethics reference: 13765

Please initial the box(es) if you agree with the statement(s):

I have read and understood the Information Sheet given to me (25 November 2015, Version 2) and have had the opportunity to ask questions about the study.

☐

I agree to take part in this research project and agree for my data to be used for the purpose of this study

☐

I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected

☐

I am aware that my conversations and follow up interviews with the researcher will be audio recorded and if I am uncomfortable with that I will ask the researcher to stop recording.

☐

I understand that, although no names or identifying comments will be included, anonymised direct quotes may be used in the write up of the study.

☐

Data Protection

I understand that information collected about me during my participation in this study will be stored on a password protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous.

Name of participant (print name).....

Signature of participant.....

Date.....

25 November 2015 V2

Patient Participant Information Sheet

Study Title: How do paramedics manage and respond to patients with mental health issues

Researcher: Ursula Rolfe

Ethics number: 13765

Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

This research is towards a PhD qualification at Southampton University. The researcher is a paramedic who wants to know more about how to support and treat patients, especially those with mental health issues such as depression or anxiety. This research involves observing how paramedics work to identifying areas of good practise and improvement.

Why have I been chosen?

You have been chosen as a patient who may have experiences or views relevant to this research.

What will happen to me if I take part?

The researcher will be observing how paramedics are responding to and managing you or your relative. She may take notes while observing care and/or invite you to talk about your experience if convenient.

Are there any benefits in my taking part?

The voice of mental health patients and their carers is important to inform paramedic work. Your involvement will provide valuable information that can influence how future mental health patients will be cared for by paramedics.

Are there any risks involved?

Your care will take priority over the research which will only involve observation and conversations or interviews as agreed between the researcher and you. If any discussions lead to topics that make you feel uncomfortable for any reason, the researcher will stop.

Will my participation be confidential?

Your participation will be kept confidential and not shared with health professionals looking after you. Your Paramedic Patient Report Forms and personal data outside the routine care team may be accessed by the research team. Direct anonymised quotes may be used. If you are chosen for follow up interviews, these interviews will be audio recorded and transcribed. Your details will be anonymised and will not be disclosed or shared with anyone without your expressed consent. All data and consent forms will be stored securely to comply with the University of Southampton's Research and Ethics Policy and the Data Protection Act of 1998.

What happens if I change my mind?

You have a right to withdraw from this research at any time without your legal rights or medical care being affected.

What happens if something goes wrong?

Please do not hesitate to contact the University of Southampton Research Governance Office on Rgoinfo@soton.ac.uk

In the unlikely event that something goes wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a

25 November 2015 v2



legal action for compensation against the ambulance trust but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate).

What will happen to the results of the study?

The study will be written up as part of the researcher's PhD thesis. You will not be identifiable in any published results. The researcher will also disseminate the findings of this research through the ambulance trust and other publications.

Who has reviewed the study?

The study proposal has been peer reviewed by the Research Governance Office at University of Southampton. All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee. A favourable ethical opinion has been obtained from London-Camberwell St Giles Research Ethics Committee. NHS management approval has also been obtained.

Where can I get more information?

Please email Ursula on ur1e13@soton.ac.uk or call her on 07759453924 if you have any queries or wish to ask any further questions.

Thank you for taking the time to read this information sheet.

25 November 2015 v2

Patient Consent Form

Study title: How do paramedics manage and respond to patients with mental health issues?

Researcher name: Ursula Rolfe

Ethics reference: 13765

Participant ID:

Please initial the box(es) if you agree with the statement(s):

I have read and understood the Information Sheet given to me (25 November 2015, Version 2) and have had the opportunity to ask questions about the study.

☐

I agree to take part in this research project and agree for my data to be used for the purpose of this study.

☐

I agree that the Paramedic Patient Report Forms and personal data may be accessed outside of the routine care team.

☐

I understand my participation is voluntary and I may withdraw at any time without my legal rights being affected

☐

I consent to my conversations and follow up interviews with the researcher being audio recorded.

☐

I understand that, although no names or identifying comments will be included, direct anonymised quotes may be used in the write up of the study.

☐

Data Protection

I understand that information collected about me during my participation in this study will be stored on a password protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous.

Name of participant (print name).....

Signature of participant.....

Date.....

25 November 2015 Version 2



Carer Information Sheet

Study Title: How do paramedics manage and respond to patients with mental health issues

Researcher: Ursula Rolfe

Ethics number: 13765

Please read this information carefully before deciding to take part in this research. If you are happy to participate you will be asked to sign a consent form.

What is the research about?

This research is towards a PhD qualification at Southampton University. The researcher is a paramedic who wants to know more about how to support and treat patients, especially those with mental health issues such as depression or anxiety. This research involves observing how paramedics work to identifying areas of good practise and improvement.

Why have I been chosen?

You have been chosen as a patient's carer who may have experiences or views relevant to this research.

What will happen to me if I take part?

The researcher will be observing how paramedics are responding to and managing you or your relative. She may take notes while observing care and/or invite you to talk about your experience if convenient.

Are there any benefits in my taking part?

The voice of mental health patients and their carers is important to inform paramedic work. Your involvement will provide valuable information that can influence how future mental health patients will be cared for by paramedics.

Are there any risks involved?

Your relative/patient's care will take priority over the research which will only involve observation and conversations or interviews as agreed between the researcher and you. If any discussions lead to topics that make you feel uncomfortable for any reason, the researcher will stop.

Will my participation be confidential?

Your participation will be kept confidential and not shared with health professionals looking after you. Your relative/patient's Paramedic Patient Report Forms and personal data may be accessed by the research team outside the routine care team. Direct anonymised quotes may be used. If you are chosen for follow up interviews, these interviews will be audio recorded and transcribed. Your details will be anonymised and will not be disclosed or shared with anyone without your expressed consent. All data and consent forms will be stored securely to comply with the University of Southampton's Research and Ethics Policy and the Data Protection Act of 1998.

What happens if I change my mind?

You have a right to withdraw from this research at any time without the legal rights or medical care of your relative/patient being affected.

What happens if something goes wrong?

Please do not hesitate to contact the University of Southampton Research Governance Office on Rgoinfo@soton.ac.uk

25 November 2015 v1

In the unlikely event that something goes wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the ambulance trust but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate).

What will happen to the results of the study?

The study will be written up as part of the researcher's PhD thesis. You will not be identifiable in any published results. The researcher will also disseminate the findings of this research through the ambulance trust and other publications.

Who has reviewed the study?

The study proposal has been peer reviewed by the Research Governance Office at University of Southampton. All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee. A favourable ethical opinion has been obtained from London-Camberwell St Giles Research Ethics Committee. NHS management approval has also been obtained.

Where can I get more information?

Please email Ursula on ur1e13@soton.ac.uk or call her on 07759453924 if you have any queries or wish to ask any further questions.

Thank you for taking the time to read this information sheet



Carer Consent Form

Study title: How do paramedics manage and respond to patients with mental health issues?

Researcher name: Ursula Rolfe

Ethics reference: 13765

Participant ID:

Please initial the box(es) if you agree with the statement(s):

I have read and understood the Carer Information Sheet given to me (25 November 2015, Version 1) and have had the opportunity to ask questions about the study.

☐

I agree to take part in this research project and agree for my data to be used for the purpose of this study.

☐

I agree that my Paramedic Patient Report Forms and personal data may be accessed outside of the routine care team.

☐

I understand my participation is voluntary and I may withdraw at any time without my or my patient/relative's legal rights being affected.

☐

I consent to my conversations and follow up interviews being audio recorded.

☐

I understand that, although no names or identifying comments will be included, anonymised direct quotes may be used in the write up of the study.

☐

Data Protection

I understand that information collected about me during my participation in this study will be stored on a password protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous.

Name of participant (print name).....

Signature of participant.....

Date.....

25 November 2015 Version 1

Appendix F

F.1 Initial analysis process

	Data	Paramedic participants		Mental health patient participants		
Spradley's descriptive phase	Number	21		20		
	Gender	Female 7	Male 14	Female 8	Male 10	Under 18 2 males
	Education levels	Vocational training 1	Vocational training 9			
		University degree 6	University degree 5			
	Time of call to 999			12h00–16h00 24h00–02h00	12h00–16h00 20h00–24h00	16h00 – 20h00
	Past medical history			Overdose Cardiac UTI Malnourished	Overdose Stroke Diabetes Cardiac Malnourished	Self-harm Overdose

	Former mental health diagnosis			Depression and anxiety Depression Anxiety Bipolar Self-harm Overdose Schizophrenia	Depression and anxiety Depression Anxiety Bipolar Self-harm Overdose Sleep disorder	Self-harm Overdose Anxiety Depression
	Alcohol			1	2	
Spradley's focused phase	Information about the call	<p>"41-year-old female with 'back pain, felt like back popping this morning'."</p> <p>"a woman who has 'put her head through a glass window'."</p>	<p>"P2 back up to a 'patient with a bad smell'."</p> <p>"37-year-old female from 111"</p> <p>"a woman 'having a psychotic episode'."</p> <p>"50-year-old overdose, crisis team do not know door."</p> <p>"76-year-old woman with a wrist injury."</p> <p>"60-year-old male patient who wasn't acting like himself."</p> <p>"a man without a fixed address who had been kicked in the head."</p> <p>"80-year-old male 'off</p>	<p>"41-year-old female with 'back pain, felt like back popping this morning'."</p> <p>"P2 back up to a 'patient with a bad smell'."</p> <p>"37-year-old female from 111"</p> <p>"a woman 'having a psychotic episode'."</p> <p>"a woman who has 'put her head through a glass window'."</p> <p>"50-year-old overdose, crisis team do not know door."</p> <p>"76 year old woman with a wrist injury."</p>	<p>"60-year-old male patient who wasn't acting like himself."</p> <p>"a man without a fixed address who had been kicked in the head."</p> <p>"80-year-old male 'off legs' and required transport and admission to the local hospitals Acute Medical Unit."</p> <p>"a 16-year-old who had a history of self harm and had taken an overdose of fluoxetine tablets."</p> <p>"a 53-year-old male patient with chest pain."</p> <p>"a 17-year-old overdose."</p>	

			<p>legs' and required transport and admission to the local hospitals Acute Medical Unit."</p> <p>"a 16-year-old who had a history of self harm and had taken an overdose of fluoxetine tablets."</p> <p>"a 53-year-old male patient with chest pain."</p> <p>"a 17 year old overdose."</p>			
	Use of support services					
	GP	<p>"The GP refused to come out to help as well as he said it wasn't an emergency. I called for an ambulance to back me up and after trying everyone else we decided to physically restrain him and take him to hospital."</p> <p>– FN 1</p>	<p>"The GP came out with a psychiatrist from the community mental health services at 11am today [it was 17h30 now]. The GP said they suspected some kind of infection as he had been sitting in his own faeces for a week and refused all care for a week. She said 'he has no capacity and is a danger to himself and needs to be admitted for an infection'."</p> <p>– FN 11</p>	<p>"The GP refused to come out to help as well as he said it wasn't an emergency. I called for an ambulance to back me up and after trying everyone else we decided to physically restrain him and take him to hospital." – FN 1</p>	<p>"The GP came out with a psychiatrist from the community mental health services at 11am today [it was 17h30 now]. The GP said they suspected some kind of infection as he had been sitting in his own faeces for a week and refused all care for a week. She said 'he has no capacity and is a danger to himself and needs to be admitted for an infection'." – FN 11</p> <p>"I am going to sue my GP</p>	<p>"The GP thinks tripling your does is what is causing you to feel unwell. So she will rewrite a prescription so that you can double your dose to 100mg over a week and then the following week you can go up to 150mg, is that ok lovely?" – FN 5</p>

		<p>“Paramedic 23 then suggested that she call the GP and make an appointment for the patient to receive pain medications. The patient agreed but said she was on the phone to the nurse practitioner and GP already and they said they would not see her.” – FN 15</p>	<p>“The GP thinks tripling your does is what is causing you to feel unwell. So she will rewrite a prescription so that you can double your dose to 100mg over a week and then the following week you can go up to 150mg, is that ok lovely?” – FN 5</p> <p>“They don’t do their job. We need to pick up their crap because they are ‘under resourced’ but so are we and no one cares. We then attend to mental health not urgent patients and can’t see the real emergencies.” – FN 20</p>	<p>“Paramedic 23 then suggested that she call the GP and make an appointment for the patient to receive pain medications. The patient agreed but said she was on the phone to the nurse practitioner and GP already and they said they would not see her.” – FN 15</p>	<p>surgery. They are not helping me. I need help. I need to sleep. I am so tired,” – FN 15</p>	
	<i>Crisis team</i>	<p>“My first call was to the mental health crisis team, they refused to come out. They always do. They said I needed to transport him to hospital to rule</p>	<p>“What did crisis say?” asked the nurse clearly annoyed. “What they always say...’call and ambulance’. They don’t care,” – FN 21</p>	<p>“What did crisis say?” asked the nurse clearly annoyed. “What they always say...’call and ambulance’. They don’t care,” – FN 21</p>	<p>“My first call was to the mental health crisis team, they refused to come out. They always do. They said I needed to transport him to hospital to rule out organic causes before they could get involved.” – FN 1</p>	
			<p>“it was one of those calls where everything</p>	<p>“They don’t do their job. We need to pick up their crap because they are ‘under resourced’ but so are we and no</p>		

		<p>out organic causes before they could get involved.”</p> <p>– FN 1</p>	<p>went wrong no matter what we tried but the good news is that the crisis team have been reported by the local hospital so maybe if they report it things will change?” – FN 5</p>		<p>one cares. We then attend to mental health not urgent patients and can’t see the real emergencies.” – FN 20</p> <p>“it was one of those calls where everything went wrong no matter what we tried but the good news is that the crisis team have been reported by the local hospital so maybe if they report it things will change?” – FN 5</p>	
	Police	<p>“I then called the police but they refused to help because he was in his own house.” – FN 2</p>	<p>“She [clinical supervisor] said we need to make clear to the police that this is a mental capacity act situation and not a mental health act and that we should not let ourselves be brow beaten.... “The police don’t like sectioning. They don’t like. But if we tell them its capacity then its easier for everyone.” – FN 10</p>		<p>“I then called the police but they refused to help because he was in his own house.” – FN 2</p> <p>“She [clinical supervisor] said we need to make clear to the police that this is a mental capacity act situation and not a mental health act and that we should not let ourselves be brow beaten....“The police</p>	<p>“they decided to update ambulance control about the patient absconding scene and asked them to update the police...there was no sign of the police.” – FN 8</p>

			<p>“they decided to update ambulance control about the patient absconding scene and asked them to update the police...there was no sign of the police.” – FN 8</p>		<p>don’t like sectioning. They don’t like. But if we tell them its capacity then its easier for everyone.” – FN 10</p>	
	<p>Relationship between patients and their carers</p>			<p>“She then became quite irritable with her 11-year-old son as he was not sitting quietly but eating a large amount of sweets. “Stop that and close the curtain,” she said to him curtly. He did as he was told. “No, no, not like that,” she shouted.” – FN 15</p> <p>“We were really worried, she was in such pain when we called,” said the patient’s mother. – FN 15</p>	<p>“I should take a photograph and show it to him. Never seen him this bad,” said the partner. She looked very vulnerable and almost disorientated...” He can’t handle drink,” FN 12</p> <p>“The neighbour was very surprised. “We all know he has had a problem for years but this is the first time he has asked for help or even admitted he needed help!” she said</p>	<p>“His mother was standing at the foot his bed. “I am really worried about him,” she said to us, “sorry I am talking about you while you are in the room darling, but I don’t know what else to do to help you,” she said. “I suffer from bipolar disorder you see and I worry about him,” she said to us.” – FN 4</p> <p>“He keeps staying on the computer until late</p>

			<p>"I was watching the daughter while her mother recounted her medical history. She seemed concerned for her mother but not affected emotionally by the history her mother was telling us. Her face showed no emotion. We guessed she had been privy to this type of situation many times before. In fact, she replied at one point with a humorous "Well mum we didn't like that window much anyway did we?!" The patient continued with her history: "She [her daughter] saw me go to a mental health institution. She has had enough of this." – FN 2</p> <p>"I asked the carer about her medical history. "I have no idea, I know she was in hospital a couple of months ago but I have no idea why," said the carer." – FN 3</p> <p>"she was also diagnosed with bipolar 12 months ago, and she was absolutely awful," she said. I was surprised by this remark. My surprise must have been visible on my face as she quickly added that she was in fact the patient's mother. "She was awful," repeated the patient's mother. "But since the diagnosis and medications I feel like I have my daughter back," she said with real feeling. "She used</p>	<p>incredulously." – FN 6</p> <p>"There was also a man on scene who said he knew the patient well and told us that she was a heroin addict but was also trying to quit and that she collected her methadone treatments. "This is no way to live, she can't carry on like this," he said. "Look at her," he said scathingly motioning towards the patient." – FN 16</p> <p>"When asking about the medical history in more detail from the wife she rolled her eyes and reassured us that he was normally fit and well but that he was a bit sensitive. "He can't cope with blood or sickness and fainted at the birth of our first</p>	<p>and I cannot get him off it. He wont come outside with me for a walk and I am worried he isn't going to school enough. He couldn't cope at the mainstream school so he was moved to this school," she explained looking really tired. He hasn't been to school for a few days now because he is so tired and I can't get him to go." – FN 4</p> <p>"young girl came running out, she was crying noisily and said that the patient had left. She told us the patient had called her and told her he had taken an overdose of tablets, she called for an ambulance and then came through 5 minutes later but he had left already. She continued to cry and said that she was trying to call him but he was not answering." – FN 11</p> <p>"An older man then came out of the house. He</p>
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				<p>to shit herself just to get attention and she used to fight a lot with the carers.” – FN 7</p> <p>“The carer then added that the house was a mental health assisted living facility and that the patient had been with them for 9 years. She was really concerned about the patient. “She has really regressed physically over the last few months. She has carers come in three times a day to her clean her and wash her. We can’t do that here for our clients. We cannot keep up with her physical deterioration. She is wetting herself all the time and we are not allowed to clean her up, we have to wait for her carer to come. She has no one else.” – FN 8</p>	<p>child,” – FN 5</p> <p>“His friend nodded in agreement. “I need to get back soon mate, you are going to get me divorced,” said the patient’s friend. The patient admitted to sometimes smoking cannabis and his friend was very surprised by this. “First time I heard this!” he said to us. “Fucking liar!” laughed the patient, “You know everything about me mate.” Apparently they have been friends for over 20 years and the camaraderie was visible between the two of them.” – FN 6</p>	<p>identified himself as the patient’s father and bought out empty pill packets. “I think these are what he took, they are his mother’s tablets and paracetamol. I cannot get hold of him on the phone,” added the patient’s father.” – FN 11</p> <p>“His friend was pacing up and down the floor in front of the patient. “I was gonna tackle you,” he said, “but then it was your dad I saw, not you,” he said laughing somewhat hysterically.”- FN 11</p>
Spradley’s selective phase	Humour					
	<i>Initiated by patient</i>	<p>“I am a tough old cookie,” said the patient with a smile, “even on the floor!” – FN 14</p>	<p>“I was born in 1942 and bathed in goat’s milk – that’s what they did back</p>	<p>“I was born in 1942 and bathed in goat’s milk – that’s what they did back then,”</p>	<p>“I am a tough old cookie,” said the patient with a smile, “even on the floor!” –</p>	

		<p>"Its earliness that really stresses me out," he carried on explaining. "I need an hour to make sense after waking up!" "I just speak gobbledegook!" he said. Paramedic 23 laughed at this. "Ha! I made you laugh!" said the patient to paramedic 23, looking please with himself." – FN 15</p>	<p>then," she explained. – FN 8</p> <p>"I just slipped when I tried to hang washing up," she explained. "my wrist hurts but I don't know when I hurt it," she giggled, "you don't know where its been – ha ha," she laughed loudly. – FN 9</p>	<p>she explained. – FN 8</p> <p>"I just slipped when I tried to hang washing up," she explained. "my wrist hurts but I don't know when I hurt it," she giggled, "you don't know where its been – ha ha," she laughed loudly. – FN 9</p>	<p>FN 14</p> <p>"Its earliness that really stresses me out," he carried on explaining. "I need an hour to make sense after waking up!" "I just speak gobbledegook!" he said. Paramedic 23 laughed at this. "Ha! I made you laugh!" said the patient to paramedic 23, looking please with himself." – FN 15</p>	
	<i>Initiated by crew</i>	<p>"We were offered tea and cake and paramedic 20 readily accepted: "we are waiting; it would be rude not to!" – FN 12</p> <p>"I don't need to get the narkan out, phew...saves me from signing out something else today!" he said laughing loudly. – FN 20</p> <p>"You are going up in the world [patient]," laughed Tech 2. Paramedic 16 and the patient chuckled at this even more. "We will take very good care of you ok?" – FN 8</p>	<p>"She then asked: "how much training do you do for this?" The ECA pithily answered: "We are always learning." – FN 11</p> <p>"You are a Pompeii fan?" he asked the patient. "If I knew that I would have walked back out again." The patient smiled and then laughed." – FN 18</p> <p>"It feels like something is pushing against me, I have a bad back too," he said with tears streaming down his face. "Haha," laughed paramedic 27 loudly. "I know all about sore backs, that's why I am swaying when I stand – don't worry I don't have music in my head!" he added laughing loudly. The patient laughed</p>	<p>"She then asked: "how much training do you do for this?" The ECA pithily answered: "We are always learning." – FN 11</p>	<p>"We were offered tea and cake and paramedic 20 readily accepted: "we are waiting; it would be rude not to!" – FN 12</p> <p>"You are a Pompeii fan?" he asked the patient. "If I knew that I would have walked back out again." The patient smiled and then laughed." – FN 18</p> <p>"It feels like something is pushing against me, I have a bad back too," he said with tears streaming down his face. "Haha," laughed paramedic 27 loudly. "I know all about sore backs, that's why I am swaying when I stand – don't worry I don't have music in my head!" he added laughing loudly. The patient laughed</p>	

			<p>too and started to look less anxious.” – FN</p> <p>“Cor, that is a big telly, its bigger than my sitting room!” exclaimed paramedic 27 – FN 17</p>		<p>too and started to look less anxious.” – FN</p> <p>“Cor, that is a big telly, its bigger than my sitting room!” exclaimed paramedic 27 – FN 17</p> <p>“I don’t need to get the narcan out, phew...saves me from signing out something else today!” he said laughing loudly. – FN 20</p> <p>“You are going up in the world [patient],” laughed Tech 2. Paramedic 16 and the patient chuckled at this even more. “We will take very good care of you ok?” – FN 8</p>	
	<i>Humour between crews</i>	<p>“Malpractice makes perfect!” laughed the one paramedic with a gleam of mischief” – FN 14</p> <p>“I’m billy no mates today, I forgot you were coming and don’t have an ECA to work with, but they [pointing up to the paramedic offices] have a plan.” – FN 20</p> <p>“This was met with general mirth by the 5 people crew members listening. “We don’t know what we are doing half the time”, one of the other ECAs replied. I was watching the reaction to this and everyone seemed to be nodding their heads in agreement.” – FN 1</p> <p>“I don’t know what to do with these patients either,” he</p>				

		<p>said, almost as an aside. – FN 13</p> <p>“You won’t get out with the crew now until, there are calls stacking and they wont even get back here unless they get their meal break – then they are not even guaranteed to have it here!” he laughed. “It’s just how things are now,” he said. – FN 12</p> <p>“Things were flying around in the back. We have to do the datix now because its dangerous, its dangerous!” said the other paramedic who had responded on blues and sirens to the hospital. – FN 14</p> <p>“Good!” he said. “We wouldn’t have jobs left if you were assessing our mental health.” A few other crew members in the crew room sniggered at his comment. – FN diary</p> <p>“The Duty Officer came downstairs and told paramedic 29 that he could get on an RRV: “that should get you sorted. It’s got a steering wheel and a clutch. It’s not an automatic so remember to use the gears!” – FN 20</p> <p>“You should have been here last night,” said Paramedic 11, “one of the paramedics spent 2.5 hours with a patient who drank a bottle of bleach and had to wait two extra hours for the GP to come out – who knows why, just take the patient to hospital!” she exclaimed. – FN 3</p>			
	Stereotyping	<p>“worst calls ever” We had to go from hospital to hospital with our crazy patient because no one wanted him and we didn’t know what to do; she was totally crazy, screaming and shouting – it was horrible.” – FN 1</p> <p>“they are horrible calls to respond to because no one gives a shit.” – FN 3</p>	<p>“I think we simply wore him down,” said paramedic 19 on the way to the ambulance to collect the carry chair. – FN 10</p> <p>“We used to go to a regular self harmer who knew exactly what she was doing. She’s calculated. It was funny but when we transferred her to the local psychiatric clinic, she</p>		

		<p>"She was clever, and she knew we couldn't section her. But she flirted with the police," explained paramedic 21. "I took her to hospital in my car because they [police] wouldn't take her," she shrugged nonchalantly. "She tried to befriend me but I said 'no silly games!' to her." – FN 13</p> <p>"The patient was fine too...just an overdose, nothing serious," she added before getting up and going to her next call. – FN 18</p> <p>"a woman who had 'fallen and put her head through a glass window'. As soon we received that information on our data head we all said the same thing: 'this will be a mental health call' – FN 2</p> <p>"we went to a patient who was self-harming. The crisis team told the patient to keep her self-harm box (they actually called it that) which has razors and cigarettes in it. They didn't give a shit. They never do. She [the patient] was 15 years old. We took her to hospital and they probably just put a plaster on her and told her to go home. I was making myself sick by being so nice! And it didn't make a difference. Her mum said the crisis team told her daughter to keep the self-harm box because taking it away takes</p>	<p>turned around to me and said: 'your crew mate is crazier than I am, and that's saying a lot!' I loved that," laughed paramedic 29. – FN 20</p> <p>"With these types of patients I like to get them in here [ambulance]. Into my world...If they kick off its easier for us to manage than to force them out of their house." – FN 11</p> <p>She was a self-harmer. I didn't think she had capacity so I tried to get the GP to come out. She had massive scars on her arms and chest from self harm. She looked like Frankenstein," Paramedic 12 explained.</p> <p>"They had a crappy start and live in a crappy area. There is only one way that will go," he added again. – FN 4</p> <p>"It all goes in circles, it's not like these calls are new to us. First we were allowed direct access to the mental health hospital and then they changed that. Now we can only take them to ED. And the crisis team is never around and always refuse to help us. Its swings and roundabouts," – FN 7</p>			
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		<p>away her choices." Another paramedic listening to us talking leaned in and said: "it's hurty time, that's what the box is for". – FN 20</p> <p>She was a self-harmer. I didn't think she had capacity so I tried to get the GP to come out. She had massive scars on her arms and chest from self harm. She looked like Frankenstein," Paramedic 12 explained. – FN 3</p> <p>"I went to an overdose of paracetamol. She [the patient] knows how the system works. I said we needed to take her to hospital and she said we needed to wait a while because the hospital only takes bloods after 4 hours. She had waited 3.5 hours before she called me. She told me she didn't want to wait that long in hospital. She told me she would rather wait at home than in ED even though she knew she had to go in. Can you believe that? There was nothing else I could do, I waited with her and then took her in to ED," explained the paramedic." – FN 7</p> <p>"We have plenty of nutters here," she said – FN 3</p>	<p>"you should have been with us yesterday Ursh. We were sent to a woman who was suicidal and delusional," – FN 9</p> <p>"He is sort of compliant as he is speaking to his friend," said paramedic 16 – FN 9</p> <p>"This guy was shit crazy." – FN 4</p> <p>"The other night we discussed whether we should get a dart gun and do a drive by with a narcan dart with the amount of heroin overdoses that night." – FN 20</p> <p>"we have had no nutters today yet – sorry!" – FN 9</p>			
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	<p>“They are like a black hole</p>	<p>“We should have a mental health specialist we can call for advice or help. Its far easier when they actually want to go to hospital. When they are compliant. Why can’t we take them directly to the mental health hospital in area if they are so shit crazy? It’s so darn frustrating!” – FN 7</p> <p>“On the way to hospital the paramedic sat next to the patient alternatively writing notes and reassuring the patient by rubbing her shoulder. ‘You live and learn. You get through this alcohol shit and you can live again. You have a wonderful daughter and son,’ added the paramedic. The patient then started waving her arms and rocking again. The paramedic was brisk in her response: ‘now what are you doing that for? No need to rock like that, we are going to get you taken care of inside [the hospital].’” – FN 2</p> <p>“We went to a patient who was self-harming. The crisis team told the patient to keep a self-harm box (they actually called it that) which has razors and cigarettes in it. They didn’t give a shit. They never do. She [the patient] was 15 years old. We took her to hospital and they probably just put a plaster on her and told her to go home. I was making myself sick by being so nice! And it didn’t make a difference. Her mum said the crisis team told her daughter to keep the self-harm box because taking it away takes away her choices.” – FN 20</p> <p>“The school called 999 and control sent me. I arrived there and was then told this 15-year-old was trying to kill everyone. Control sent me on the RRV – me! Instead of the police – on my own,” she said with absolute incredulity. “But I wasn’t scared. The school had him [the patient] in a side room and restrained. They then locked me in the room with him while they watched from the room next door! I spoke to him and he was not interested in talking and could not remember anything. But the school told me that he had threatened to kill anyone he could get to. I felt sorry for him, he was a nice kid,” explained the paramedic. “While I was still trying to talk to this kid, the armed police arrived. After I did! Then they stood with the teachers while I carried on talking to the kid – alone,” she explained with even more exasperation. “They decided he needed to be sectioned. The kid was sweet. He didn’t know what he was doing. But they took him and I left the scene.” – FN 7</p> <p>“These patients are like a black hole; we cannot treat them or see the results of good treatment. They get a plaster and then get sent out again and we don’t make a difference,” – FN 20</p> <p>“The paramedic said, “We are here to help you, your GP says you need to go to hospital?” The patient looked at paramedic sharply and replied: “rather kill me, rather than take me to hospital. The doctor wouldn’t come here...leave me alone! Release me and fuck off!” The paramedic kneeled down near the patient but not close enough for the patient to be able to lash out and reach him. Quietly he said: “We are only here to help you”. – FN 11</p> <p>211</p> <p>“I was called to a 13-year-old girl, they thought she had tried to hang herself,’ he started explaining. ‘I asked control for back up but they didn’t send any. I was really worried because I was on the RRV [rapid response car] and if she had really hung</p>
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	<p>"I've only got about 20 minutes of 'there there' in me"</p>	<p>"I disagree with all this 'there there' business. It's not our job. We are here to make them [patients] better and wiping their forehead or holding their hand won't do that," he said with conviction. I nodded encouraging him to continue. "I have only about 20 minutes of 'there there in me – that's it," he said laughing. – FN 13</p> <p>"I am beginning to see that when paramedics are called to patients with physical problems [chest pain, shortness of breath] and a side effect of this problem is stress or anxiety, then it often is ignored in order to deal with the physical issue first. Historically, paramedics are trained to respond to emergencies and a common response when I ask them about this is: "We aren't counsellors or psychiatrists." It begs the question, should we treating the patient holistically and be supported by educated to do so or should our focus remain on the physical, only noting mental health issues on our documentation and referring patients to supportive services. And if so which supportive services?" – FN 6</p> <p>"The patient's medical history included depression and anxiety but was otherwise fit and well. "I worry about everything you see," he added after explaining his medical history...During the banter between the patient and his friend, Paramedic 14 had completed his observations and assessments. He had also done a 12 lead ECG to rule out any cardiac issues. He asked the patient directly if he ever had panic attacks before: "I get them twice a week usually but if this is one its really taken it out of me," said the patient. My chest is really sore," he repeated...Paramedic 14 asked for more details about this and sounded slightly frustrated...After the history and physical assessment, paramedic 14 said the cause of the chest pain was anxiety and that he was going to leave the patient at home in the care of his friend...– FN 14</p> <p>"We need to be able to admit them [mental health patients] to the local psychiatric hospital directly or they need to have a psychiatric ED." – FN 12</p> <p>"We used to be able to take [mental health patients to the local mental health hospital] directly but now we must take them to ED. We can only take transfers there," he explained. – FN 3</p> <p>"He [the paramedic] explained that they had called the crisis team but they refused to come out and the patient absconded and lay herself across the train track. I asked if he thought the crisis team could have made a difference and he was very certain in his answer. He believed without a doubt that "they could have counselled the patient and that she would have been</p>
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		<p>admitted to the local mental health hospital instead of being left at ED and then left to try and kill herself again.” – FN 9</p> <p>“It’s not about knowledge, it’s about bums on seats....keep quiet and do your job and then go home to your family,” she said. – FN15</p>
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Appendix G

G.1 Protocol for ambulance staff requesting police assistance

Ambulance staff may request police assistance for patients who lack capacity under the following circumstances:

- Patients in need of emergency treatment who require restraint due to their threatening or violent behaviour (identified through DORA).
- Patients refusing emergency treatment and/or transport in their best interests where DORA has identified minimal restraint as being neither effective nor safe to be undertaken by ambulance staff.
- Patients who are at risk of causing further harm to themselves or others.
- Where there are other significant risk factors identified at the scene of the incident that prevent the patient from receiving treatment or transport to the hospital that is in their best interests.

Ambulance staff will request police attendance through the SWASFT Clinical Hub (Control Centre), informing clinical hub staff that police attendance is required for an emergency MCA incident, full details of the incident and the requirements of the police must be conveyed, additionally any significant risk information must be passed at this time.

Clinical Hub staff will contact police and state police attendance is required for an emergency MCA incident, full details of the incident and the requirements of the police must be conveyed, additionally any significant risk information must be passed at this time.

The police will respond to the incident as an emergency and grade the incident as a 1 or 2. Calls to the police will be assessed, graded and responded to as per force policy.

Following arrival of the police at scene, the ambulance staff will provide the police officers with the following:

- A brief history of the incident.
- Information relating to the clinical condition of the patient and the treatment or care required.
- A summary of the mental capacity assessment, highlighting the reasons why the patient is believed to lack capacity.
- A summary of what support is required by the police officer.

The ambulance staff and police officer will then work together, undertaking a joint dynamic risk assessment and agreeing a plan on how best to manage the patient in the safest, timeliest and least restrictive means possible. This will not be a formal written process but a supportive and collaborative discussion to ensure that both ambulance and police staff are engaged in the decision making process and agree the most appropriate course of action. The thought process and rationale should be recorded with due regard to the relevant ambulance and police documentary processes.

A patient's mental capacity can change over relatively short periods of time. Therefore, it may be necessary for ambulance staff to re-assess the patient's capacity at any time if there is a change in their behaviour or appearance. Assessments of capacity should be time and decision specific.

Ambulance staff will have responsibility for all decisions relating to the clinical treatment of the patient, including the most appropriate destination hospital.

Ambulance staff will agree with police the appropriate level and type of restraint to be used; taking into account the patients condition and any injuries, assessment or treatment required.

Protocol for police staff requesting ambulance assistance

Police officers are often the first agency at the scene of an incident and may have to deal with patients who require immediate clinical assessment or treatment.

Police officers should request an emergency ambulance where they believe the patient lacks capacity (or they have concerns over a patient's capacity) and are in need of emergency care within a private or public location. (Appendix 5, 6). This is of particular importance if any "Red Flag" is triggered (Appendix 3). Police officers will request attendance of an emergency ambulance through Police Control as per normal procedures.

Police Control will contact the appropriate SWASFT Clinical Hub and request assistance under the mental capacity act. The ambulance response will be determined based on the clinical need of the patient following initial telephone triage. Any life threatening emergencies (such as dangerous haemorrhage, chest pain, collapse or issues arising from restraint), will be provided with an eight-minute response. All calls outside of life threatening emergencies made following application of section 135 and section 136 will be categorised as a Green 2 call. This will automatically dictate a thirty-minute response.

Where a delay in ambulance response is advised, SWASFT Clinical Hub may advise the police to consider transferring the patient to hospital in an appropriate vehicle where the anticipated delay may impact on the patient and a joint risk assessment indicates that this is the most appropriate course of action and a suitable vehicle has been identified. Calls triaged as Green 2 may be diverted to a higher category of call if they are the nearest appropriate vehicle. Green 2 calls will only be diverted to Red 1 and Red 2 calls which are confirmed cardiac arrest or potentially life threatening calls.

Following arrival of the ambulance at scene, the police officer will provide the ambulance clinician with the following:

- A brief history of the incident.
- Information relating to their clinical concerns for the patient.
- A summary of the mental capacity assessment, highlighting the reasons why the patient is believed to lack capacity.
- A briefing on the risks and issues relating to the patient.

The police officer and ambulance clinician will then work together, reviewing the capacity assessment, completing a joint risk

assessment and agreeing a plan on how to manage the patient in the safest, timeliest and least restrictive means possible.

A patient's mental capacity can change over relatively short periods of time. Therefore, it may be necessary for ambulance staff to re-assess the patient's capacity at any time if there is a change in their behaviour or appearance. Assessments of capacity should be time and decision specific.

Ambulance staff will have responsibility for all decisions relating to the clinical treatment of the patient, including the most appropriate destination hospital.

Ambulance staff will agree with police the appropriate level and type of restraint to be used; taking into account the patient's condition and any injuries, assessment or treatment required.

Appendix H

H.1 Overall Data analysis table

<i>Process</i>	<i>Initial analysis</i>				<i>Subsequent analysis</i>		<i>Additional analysis</i>	
<i>Based on what data</i>	Observations				Observations and interviews		Observations and interviews	
<i>Analysis process</i>	Participant characteristics	Initial coding	Subsequent coding	Categories	Continuation of categories	Themes	Themes continued	Sub-themes
	Paramedics: Male Female Education level Clinical experience Mental health patients: Male Female Child	Time of mental health call Gender Past medical history of patient Previous formal mental health diagnosis Alcohol	Information before the call Use of support services Relationships between patients and carers	"I've only got about 20 minutes of 'there, there' in me" "They're like a black hole"	"I've only got about 20 minutes of 'there, there' in me" "they're like a black hole"	Humour: Initiated by patient Initiated by crew Between crews Stereotyping	Humour: Initiated by patient Initiated by crew Between crews Stereotyping Nostalgia	Real vs ideal role Performance Boundaries
<i>Theoretical support</i>	Based on Spradley (1980) see Appendix F				Presentation of Self Front stage Back stage Dressing room			Individual paramedic behaviour

		Communities of Practice Sharing knowledge Sharing emotion Sharing identity	Group paramedic behaviour
Conclusion	A paramedic profession in transition		

H.2 Continued analysis after upgrade viva

Subsequent analysis		Additional analysis	
Observations and interviews		Observations and interviews	
Continuation of categories	Themes	Themes continued	Sub-themes
<p>“I’ve only got about 20 minutes of ‘there, there’ in me”</p> <p>“I disagree with all this ‘there there’ business. It’s not our job. We are here to make them [patients] better and wiping their forehead or holding their hand won’t do that,” he said with conviction. I encouraged him to continue. “I’ve only got about 20 minutes of there there in me – that’s it,” he said laughing. – field note 18</p> <p>“They’re [paramedics] thinking subconsciously that they need to defend against burnout, and that they’re worried about getting too involved emotionally with a patient because of the effect it might have on them, which you would expect. So, they’ve put up a sort of defence by saying,</p>	<p><u>Humour:</u></p> <ul style="list-style-type: none"> - Initiated by patient <p>“I am a tough old cookie,” said the patient with a smile, “even on the floor!” – field note</p> <p>“It’s earliness that really stresses me out,” he [the patient] carried on explaining. “I need an hour to make sense after waking up!”</p> <p>“Otherwise I just speak gobbledegook!” he said. The paramedic laughed at this. “Ha! I made you laugh!” said the patient to the paramedic, looking pleased with himself. – field note</p> <ul style="list-style-type: none"> - Initiated by crew 	<p><u>Nostalgia</u></p> <p>Nostalgia set up the difference between the real and ideal work – where paramedics longed for an ideal role yet acted in a real role. There was also a friction between the older and younger paramedic generation in terms of how they perceived their role. The more experienced paramedic had the historical experience of responding to mostly emergency calls and now had to cope with an evolving role that required them to deal with non-emergency work. The younger generation were coming into the service having to respond to emergency, urgent, social and mental health calls. This influenced how each generation reminisced. Many of the</p>	<p><u>Real vs ideal role</u></p> <p>Paramedics therefore had this ideal that they discussed and believed in – “we are there to treat ‘real’ emergencies”; “we are an emergency service”.</p> <p>Paramedics labelled these patients as draining, that is, “they’re like a black hole” and they used humour as a form of resilience and structure for managing this patient group. There was also evidence of tension between what they said about their role and what they actually did.</p> <p>When it came to mental health care, paramedics felt frustrated because they could</p>

<p>you know, publically almost that, “I’m not gonna do this and I’m gonna limit ... You know, I’m gonna ration, if you like, my empathy through self-preservation.” But, actually they are naturally quite empathic people. Despite their anxiety, they articulate that way about being drawn in ... being burnt out by being drawn in to emotive situations because that’s part of the job. Maybe it’s like a sort of, you know, a bit of flag-waving saying, “I don’t wanna let myself do this. I don’t wanna let myself be emotionally compromised.” But, actually they can’t help themselves because they are empathic.” – interview 3</p> <p>“The patient’s medical history included depression and anxiety but apart from that he was fit and well. ‘I worry about everything, you see,’ he added after explaining his medical history. During the banter between the patient and his friend, paramedic 14 had completed his observations and assessments. He had also done a 12 lead ECG to rule out any cardiac issues. He asked the patient directly if he ever had panic attacks before: ‘I get them twice a week usually, but if this is one it’s really taken it out of me,’ said the patient. ‘My chest is really sore,’ he repeated. Paramedic 14 asked for more details about this and sounded slightly frustrated. After noting the history and</p>	<p>“We use humour because, we use gallows humour don’t we? Dark humour, because the things we see, the normal public wouldn’t be able to deal with, so that’s why I think a lot of us are suffering from mental health ... So, we all suffer mental health, we are all on that spectrum of maybe, yeah darkness. So, I think we are quite good with mental health, because we sort of, maybe suffer with it ourselves, and we can relate to them.” – interview 4</p> <p>“Experience, yeah. And also, I think when you’re newly qualified, you don’t want to push it too much whereas I think a lot of the old-school guys, they know and they don’t care what they say, not don’t care what they say, but they’ve got a bit more confidence, you know? Whereas I think when you’re new, you don’t want to risk getting a complaint or anything like that but I think a lot of the older-school guys are probably past it, they don’t care.” – interview 5</p> <p>“I think that all depends in any patient, no matter who you go to, I think if it’s appropriate at that time, and you’re reading that patient very well, and they respond to humour, and their mood allows you to use humour, then that is okay to do so, providing it’s not humour at them, and humour just about something they find funny as well. Do you see what I mean? There’s humour</p>	<p>younger generation were swept up in the nostalgia of the older generation and their reference to the “olden days” and listened enthusiastically to these shared experiences even though it did not match their current experiences. This division was compounded by the lack of a defined role added to the complex acting back stage.</p> <p>Nostalgia was not only evidenced by recollecting the “good old days” but in terms of the types of calls paramedics used to receive in “the good old days”. These were defined as “true emergency calls,” such as life-threatening asthma, pulmonary oedema, hypoglycaemia, cardiac arrest and road traffic collisions, as a few examples. A study by McDonald et al (2005) described how medical staff drew on “nostalgic memories to present an alternative, competing version of the world” in order to challenge the change within the organisation. Although the older generation of paramedics were certainly nostalgic in their accounts, there also seemed to be a resignation to the change of the role, a reluctant acceptance, which was not the case in the younger generation.</p> <p>“I liked sort of responding to those sort of life threats and stuff like that, but then obviously,</p>	<p>not see tangible results like they would in emergency calls. Managing mental health patients was a complex and time-consuming task with far more emotional work compared to emergency calls which worked in a more structured way for paramedics: if a patient was not breathing, breathe for them; if a patient was in pain, give them pain medication – symptom, intervention, result. These types of interventions were the core of emergency work for paramedics and the results were visible in how the patient physically responded. With mental health patients, the responses were often not visible or very subtle.</p> <p>In response to this demand and change, paramedics adopted coping mechanisms which was to incorporate humour in their patient approach and with each other and to stereotype this patient group in order to manage them, as discussed in the previous chapter. Alongside the evolving role of the paramedic was their perception of their abilities to manage these patients. Many of the paramedics observed felt they ... “did not know what we [paramedics] were doing”. Follow-up interviews supported the disparity between the paramedics’ perception of their limited capacity to use ‘emotional labour’ with mental health patients despite the observations showing that when they were on</p>
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<p>completing the physical assessment, paramedic 14 said the cause of the chest pain was anxiety and that he was going to leave the patient at home in the care of his friend ... – field note 6</p> <p>“Most of us have trained to do the emergency side of it but you – you deal with what you’re given, don’t you? And the way mental health [problems] is growing, I don’t know, but you’re still dealing with somebody in an emergency situation. So, although we kind of say that maybe our capacity for that sort of job is lower or we dislike it more, I don’t know, but you’re still dealing with somebody in an emergency whether it’s their arm hanging off or whether they’re in a mental health emergency. I think ultimately, we’re still there to help people when they’re in desperate need and I think people probably say, and we’re probably all guilty of it, say those types of things to kind of just – kind of guard ourselves, I suppose, a little bit from being too emotional about it all ... There could be an element of that in that if you get like, I don’t know, if you’re a bit more open about how you enjoy or, kind of, enjoy helping people when they’re in a mental health crisis or have emotional problems, it will make you more emotional about it. So, it could be kind of a you are guarding yourself from the emotions behind dealing with it. Does that make sense?” –</p>	<p>and there’s degrading humour. I think you have to be careful of every given situation.” – interview 9</p> <p>- Between crews</p> <p>“In the crew room another paramedic approached me and asked if I was assessing the mental health of paramedics. I explained saying that I was observing how paramedics manage patients experiencing mental health issues, not assessing them or their mental health. ‘Good!’ he said. ‘We wouldn’t have jobs left if you were assessing our mental health!’ A few other crew members in the crew room sniggered at his comment.” – general field note</p> <p>“I think it’s [humour] something very peculiar to paramedics, isn’t it, it’s a level of humour and the type of humour, I think. I’m not sure that it exists, in the same way, in other healthcare professionals. I think that was a huge coping mechanism for me. I remember a very inappropriate humour, which I think is a trademark of paramedics (laughter), this was when I was working in London, and we went to a cardiac arrest in an elderly gentleman, who had hanged himself with his dressing gown cord and died. It was obviously very sad, and we</p>	<p>coming into the profession quickly realised that actually it’s not about that. I liked the profession because I liked the sort of diagnostic side of it ... You know, if it had stayed as it was traditionally where we just took everyone to hospital, it wouldn’t have been a career that interested me ... There’s usually some mental health. There are a lot of social problems and then obviously, there are the emergencies where people have immediate threats to life, but they’re more far and few between.” – interview 10</p> <p>“We constantly relate what we do for physical health with mental health, so because we know we can fix things and we want to fix things because that is the kind of people we are, when we can’t that’s ... You are not going to educate the public, and so you need to change, instead of trying to move the services or move them, you need to move the services to meet their needs, and mental health is the same. You are not going to stop people dialling 999.” – interview 2</p>	<p>scene for an extended time, they did in fact reassure, calm and talk to these patients.</p> <p>Performance</p> <p>There was an internal conflict about how they perceived themselves in this role as seen in the following excerpts:</p> <p>“‘We don’t know what we are doing half the time’ – field note 5; ‘This [mental health call] was without a doubt the most frustrating call of my career so far.’ – field note 2; ‘They [MH patients] are people too and we can’t do anything for them. And we can’t get the crisis team in or the GP because they never come,’ he said with some frustration in his voice.” – field note 19</p> <p>“It’s that feeling of not ... of uneasiness and not knowing, uneasiness and probably helplessness, of knowing that this person [the mental health patient] needs some intervention, needs some help, but that that is not forthcoming and the services that are there to provide this help have not and are unwilling to see him, at that point, and that feeling of not being able to help someone makes me very uneasy, I think.” – interview 11</p>
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<p>interview 7</p> <p>"They're like a black hole"</p> <p>"These patients are like a black hole; we cannot treat them or see the results of good treatment. They get a 'plaster' [treatment by the ED] and then get sent out again and we don't make a difference." – field note 20</p> <p>"We should have a mental health specialist we can call for advice or help. It's far easier when they actually want to go to hospital. When they are compliant. Why can't we take them directly to the mental health hospital in the area if they are so shit crazy? It's so darn frustrating." – field note 7</p> <p>"We went to a patient who was self-harming. The crisis team told the patient to keep a self-harm box (they actually called it that) which has razors and cigarettes in it. They didn't give a shit. They never do. She [the patient] was 15 years old. We took her to hospital and they probably just put a plaster on her and told her to go home. I was making myself sick by being so nice! And it didn't make a difference. Her mum said the crisis team told her daughter to keep the self-harm box because taking it away takes</p>	<p>took him to hospital, but he died unfortunately, and we, I remember, we were all sitting around, there was like a bench outside A&E, and we were all sitting around having a cup of tea and the paramedic who had led was writing the paperwork and someone said, "Did anyone get the wife's name?" and, you know, someone went, "Oh, I think we'll just put down Widow Hughes," or something like that. Which is not even funny, and really inappropriate, but we absolutely rolled around laughing and I think that is just a coping mechanism, because it was really sad. This elderly gentleman had committed suicide, which is unusual in itself, and, you know, retelling that story to anyone, saying that's not even funny, never mind bad taste – but we were absolutely rolling around laughing and it was just a coping mechanism and we felt a bit better after it Yeah, it's very interesting, I think, yeah ... I don't know if that exists in nursing, for example. I'm not sure it does." – interview 11</p> <p>Stereotyping</p> <p>"Paramedics are very good at switching off and I think that's one of the other reasons why paramedics have so many mental health issues</p>		<p>Paramedics were regularly responding to patients who "cannot get an appointment with my GP" but felt they need to be seen by someone and often mental health patients called 999 as "I know you will come" and "no one else will listen". This resentment was evident in the interviews as well:</p> <p>"We are not doing the job we are trained for, we are really not ... You see, we could be called to something totally different and people have got mental health, so I am probably seeing mental health an awful lot more, definitely a lot more than in the olden days. I don't mind going to mental health, but going to some of the stuff, it's hard to be professional sometimes." – interview 4</p> <p>The constant tension between portraying a "professional face in their uniform" and their personal feelings of frustration and futility because of the limitations they had in providing care for mental health patients was exhausting. Not only did they have to present a "professional face" to patients and to their organisation while these undercurrents were running beneath the surface, but this was also in contrast with how they interacted with each other during down time.</p> <p>Paramedics were regularly responding to</p>
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<p>away her choices.” - Field note 20</p> <p>“Yeah, if it was a physical thing, then you can fix it, and you can monitor how you’re fixing it, like a tourniquet if they’re bleeding out. You know you’re putting a tourniquet on to stop the bleeding, and you’re doing a good job. How do you know that this person isn’t having a three-way conversation, disagreeing with you internally, externally accepting what you’re saying? Do you see what I mean?” – interview 11</p> <p>“It kind of goes back to where we train and where we’re doing the job in that you have a problem and you know that the intervention you are doing is helping that person immediately and you can see the results. Whereas with mental health, it’s a longer process, isn’t it, to help somebody and we’re not going to see the immediate results – so, we don’t actually know. We assume we’re not helping the situation but you don’t know because you don’t see the outcome. What you say to them could actually trigger something to change them but you can’t see that so it’s almost like going down the lines of the invisible disease sort of stuff that you can’t see it, so is it there? Have you changed them? Have you helped them? We’re never going to know. There’s no follow-up whereas if you take a medical patient to hospital or a</p>	<p>later on in their career or when they retire. It’s because it then affects them. They’ve been so good during their career at shutting it off.” – interview 3</p> <p>“I think it probably depersonalises it so you’re not remembering the patient’s name or gender, you are kind of just – yeah ... So, it depends what information they give you. If it just says 23-year-old woman with depression, you probably kind of stereotype and go, oh, it’s someone with depression. Does that make sense?” – interview 6</p> <p>“I’m quite guilty of that [stereotyping] actually. I think I’m quite a clinical person. I’m not overly always interested in the sort of, you know, feelings on reflection. I’m more interested in, you know, ‘What is wrong with the patient?’ ‘What can I do for that patient?’ ‘What could I have done better?’ ‘What could I do next time?’ And, ‘What did I do wrong?’” – interview 10</p> <p>“Yes, I think it is, I think stereotyping is human nature and I think, you know, it helps us to process things, to make sense of things ... I think it helps with resilience, absolutely, that kind of dehumanising aspect of it and to put things in boxes, so it can help with the diagnostics. What’s the treatment plan? But, I</p>		<p>patients who “cannot get an appointment with my GP” but felt they need to be seen by someone and often mental health patients called 999 as “I know you will come” and “no one else will listen”. This resentment was evident in the interviews as well:</p> <p>“We are not doing the job we are trained for, we are really not ... You see, we could be called to something totally different and people have got mental health, so I am probably seeing mental health an awful lot more, definitely a lot more than in the olden days. I don’t mind going to mental health, but going to some of the stuff, it’s hard to be professional sometimes.” – interview 4</p> <p>The constant tension between portraying a “professional face in their uniform” and their personal feelings of frustration and futility because of the limitations they had in providing care for mental health patients was exhausting. Not only did they have to present a “professional face” to patients and to their organisation while these undercurrents were running beneath the surface, but this was also in contrast with how they interacted with each other during down time.</p>
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<p>traumatic patient to hospital, you can go in later and find out, you can see immediately that day or the day after, did what you do help the situation. Where are they now? Whereas you can't do that so you haven't got any kind of closure, I suppose, on it." – interview 8</p>	<p>think stereotyping only becomes a problem, I might get shot for this, I think stereotyping becomes a problem when you're not aware that you're doing it and you act on those preconceptions, but that actually, having a stereotype is perfectly normal and helps us to make a quick decision sometimes about things, but if we're aware that we are stereotyping and that there may be differences in this particular instance, and we're open to that, I don't see that as a particular problem. It's to what extent as well, that having been diagnosed with a mental health condition, is a label. I've spoken to people who have had mental health problems and they've been given like six or seven different diagnoses throughout their lives, but their lives haven't been that long, you know? So, is it useful giving someone a label of depression? Is that a useful thing or does that not matter, what matters is how we're going to help this individual person feel better, and I would sway towards that." – interview 11</p>		<p>Boundaries</p> <p>- "Old vs new"</p> <p>My analysis showed that there were two distinct segments within which the paramedic participants were observed and interviewed: university graduate paramedics and vocational trained paramedics, and often there is a tension between the two groups, as seen below:</p> <p>"I think a lot of the younger paramedics now are getting the almost I am the God-type attitude. I've been picking it up with crews ... Maybe if you work with these people all the time you're maybe not picking it up but because they back me up and just their demeanour and the way some of them walk in, it's like, oh..." – interview 2</p> <p>"Because, our generation, we know how to deal with people. Like there are certain things I would say to you that I wouldn't say to a 90-year-old lady, and we are very good at people skills. But, the newer generation, they are frickin' shocking ..." – interview 6</p> <p>"Experience, yeah. And also, I think when you're newly qualified, you don't want to push it too much whereas I think a lot of the old-school</p>
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			<p>There was also the added pressure of the evolving role and expectations of a paramedic by the Trust and the patient as evidenced in the following excerpt:</p> <p>"I think it's getting too fast; I think we're just expected to do absolutely everything, but then I think we always were but now to a bigger degree, so before we would see everybody and generally they'd go to hospital whereas now I think you see everybody and you're expected to have a treatment plan for them, so I think that's changed, but I don't think you always need a treatment plan and I think in other Trusts you don't, but because it's so heavily advocated to keep someone at home, you're starting to treat a lot more people." – Interview 5</p> <p>"I would rather take responsibility myself as I said, as an autonomous person. But in order to do that, I would need more training in mental health. I would need more support and I'd need more referral pathways. People that I can speak to, specialists that I could speak to." – interview 10</p> <p>"I made about eight telephone calls to eight different services and it was just going around. I think I even spoke to the pharmacy at one point because they were refusing to give out a</p>
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			<p>medication without – everyone was just refusing to take responsibility and you think, you know, it was just so frustrating.” – interview 8</p> <p>“We are dogsbodies. We are a doormat to the NHS. I think when people don’t know how to handle things, like the GPs and nursing staff, they just tell people to phone 999 and they will deal with it. We are just doormats, we are not doing the job we are trained for, we are really not ... – interview 4</p> <p>The following excerpt was an apt summary of how paramedics felt when they managed complex mental health patients and reinforced the boundaries that already existed based on professional qualifications:</p> <p>“I had one [a mental health patient] the other day that was hard, but GP in-hours don’t know. They can’t necessarily come out. The hospital doesn’t want to know. Its [the patient is] under a mental health team, they’re stretched, they can’t send someone out. I’ve got to sit with them. Ah, it’s like walking up river against a current, and it depends on the severity of the patient’s needs to how much that current then flows and pushes you back, if that makes any bloody sense?” – interview 9</p>
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			<p>One paramedic described how paramedics created their own emotional boundaries:</p> <p>“Paramedics are very good at switching off and I think that’s one of the other reasons why paramedics have so many mental health issues later on in their career, or when they retire. It’s because it then affects them. They’ve been so good during their career at shutting it off.” – interview 2</p> <p>Paramedics also wrestled with their own emotional fallout when managing mental health patients:</p> <p>“It’s that feeling of not ... of uneasiness and not knowing, uneasiness and probably helplessness, of knowing that this person needs some intervention, needs some help, but that that is not forthcoming and the services that are there to provide this help have not and are unwilling to see him, at that point, and that feeling of not being able to help someone makes me very uneasy, I think.” – interview 11</p>
			
Theoretical support			

Individual paramedic behaviour		Group of paramedics' behaviour	
Presentation of Self		Communities of Practice	
<p>Front stage</p> <p>This study showed that paramedics were ready to 'act' for their public audience on the front stage. They required props to do so effectively. These props included costumes, in this case uniform; and scripts which included nostalgic stories, and the use of humour.</p> <p><u>Humour:</u></p> <p>These props included costumes, in this case uniform; and scripts which included nostalgic stories, and the use of humour. Their costumes or uniform represented their profession. Uniforms were one way of enacting professional boundaries in practice.</p> <p>"It feels like something is pushing against me, I have a bad back too,' he [the mental health patient] said with tears streaming down his face. 'Ha ha,' laughed paramedic 27 loudly. 'I know all about sore backs, that's why I am</p>	<p>Back stage</p> <p><u>Humour:</u></p> <p>"We use humour because we use gallows humour, don't we? Dark humour, because the things we see, the normal public wouldn't be able to deal with ..." – <i>interview 4</i></p> <p>When it comes to interactions between paramedics a different "act" becomes clear during back the stage performance; there was banter and the use of dark humour that not seen during patient care:</p> <p>"In the crew room another paramedic approached me and asked if I was assessing the mental health of paramedics. I explained that I was observing how paramedics manage patients experiencing mental health issues but not assessing them or their mental health. 'Good!' he said. 'We wouldn't have jobs left if you were assessing our mental health.' A few other crew members in the crew room</p>	<p>Sharing</p> <p>Knowledge</p> <p>Shared knowledge acted as a coping mechanism and paramedics felt less isolated in managing this patient group, knowing that they had the support of their fellow community members, as illustrated in the following excerpt:</p> <p>"I went to an overdose of Paracetamol. She [the patient] knows how the system works. I said we needed to take her to hospital and she said we needed to wait a while because the hospital only takes bloods after four hours. She had waited three and a half hours before she called me. She told me she didn't want to wait that long in hospital. She told me she would rather wait at home than in Emergency Department (ED) even though she knew she had to go in. Can you believe that? There was nothing else I could do, I waited with her and then took her in to ED," explained paramedic 11 – field note?</p> <p><u>Stereotyping</u></p>	<p>Boundaries</p> <p>- Segments "old vs new"</p> <p>"I think a lot of the younger paramedics now are getting the almost I am the God-type attitude. I've been picking it up with crews ... Maybe if you work with these people all the time you're maybe not picking it up but because they back me up and just their demeanour and the way some of them walk in, it's like, oh..." – interview 2</p> <p><u>Nostalgia</u></p> <p>These sentiments were not in isolation:</p> <p>"Because, our generation, we know how to deal with people. Like there are certain things I would say to you that I wouldn't say to a 90-year-old lady, and we are very good at people</p>

<p>swaying when I stand – don't worry I don't have music in my head!' he added laughing loudly. The patient laughed too and started to look less anxious." – field note 18</p> <p>Stereotyping</p> <p>"we now respond to falls, minor injuries, mental health and social calls") ensured that paramedics were performing on the front stage in an appropriate and expected manner, yet in reality paramedics did not feel confident about managing mental health patients.</p> <p>"going to a mental one again" or "it's an arrest", in categories as a triage and coping mechanism.</p> <p>Real vs ideal role</p> <p>Paramedics created a certain 'professional' impression for the patient, their family and carers as described in this excerpt:</p> <p>"On the way to hospital, Paramedic 6 sat next to the patient alternatively writing notes and reassuring the patient by rubbing her shoulder. 'You live and learn. You get through this alcohol shit and you can live again. You have a</p>	<p>sniggered at his comment ... 'Malpractice makes perfect!' laughed the one paramedic with a gleam of mischief in his eye." – field notes 2 and 19</p> <p>"Experience, yeah. And also, I think when you're newly qualified, you don't want to push it [humour] too much, whereas I think a lot of the old-school guys, they know and they don't care what they say. Not don't care what they say, but they've got a bit more confidence, you know? ... Whereas I think when you're new, you don't want to risk getting a complaint or anything like that but I think a lot of the older-school guys are probably past it, they don't care." – <i>interview 5</i></p> <p>Stereotyping</p> <p>"I think we're just expected to do absolutely everything, but then I think we always were but now to a bigger degree, so before we would see everybody and generally they'd go to hospital whereas now I think you see everybody and you're expected to have a treatment plan for them, so I think that's changed, but I don't think you always need a treatment plan and I think in other Trusts you don't, but because it's so heavily advocated to keep someone at home,</p>	<p>"We used to go to a regular self-harmer who knew exactly what she was doing. It was funny but when we transferred her to the local psychiatric clinic, she turned around to me and said: 'your crew mate is crazier than I am, and that's saying a lot!' I loved that," laughed paramedic 29. – field note 18</p> <p>"We also went to a patient who was self-harming. The crisis team told the patient to keep her self-harm box (they actually called it that), which has razors and cigarettes in it. They didn't give a shit. They never do. She [the patient] was 15 years old. We took her to hospital and they probably just put a plaster on her and told her to go home." – field note 18</p> <p>In the first part of the excerpt the paramedic is talking about a frequent caller who "knows how the system works".</p> <p>Nostalgia</p> <p>A third added to the conversation saying: "I have heard all this before," answered a third paramedic – field note 7</p> <p>Real vs ideal role</p> <p>"I had a 19-year-old patient last night (the last call of my shift) who had drunk bleach. She was a self-harmer. I</p>	<p>skills. But, the newer generation, they are frickin' shocking ..." – interview 6</p> <p>Nostalgia was useful for the older generation in terms of a fond recollection of events from a different era which created comradeship and emotional ties. However, it did not solve the reason behind the nostalgic recollections – the struggle to accept the evolving role which included more mental health management and social calls and far less of the emergency calls this generation was used to.</p> <p>Real vs ideal role</p> <p>"Experience, yeah. And also, I think when you're newly qualified, you don't want to push it too much whereas I think a lot of the old-school guys, they know and they don't care what they say. Not don't care what they say, but they've got a bit more confidence, you know?" – interview 3</p> <p>- Organisational "us vs</p>
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<p>wonderful daughter and son,' added Paramedic 6." – field note 2</p> <p>Role identity influenced how paramedics responded to mental health patients with the uniform acting as a protection against the work that paramedics were being asked to do – their real work.</p> <p>There was an internal conflict about how they perceived themselves in this role as seen in the following excerpts:</p> <p>"We don't know what we are doing half the time' – field note 5; 'This [mental health call] was without a doubt the most frustrating call of my career so far.' – field note 2; 'They [MH patients] are people too and we can't do anything for them. And we can't get the crisis team in or the GP because they never come,' he said with some frustration in his voice." – field note 19</p> <p>He described the paramedic role as:</p> <p>"... a lot more social, a lot more mental health and a lot more probably urgent care calls. We tend to do a bit of everything and don't specialise in one particular thing.' His understanding of why there are more 'social' calls lies with a generational attitude, 'I am</p>	<p>you're starting to treat a lot more people." – interview 5</p> <p>"I think it [stereotyping] probably depersonalises it so you're not remembering the patient's name or gender, you are kind of just – yeah ... So, it depends what information they give you. If it just says 23-year-old woman with depression, you probably kind of stereotype and go, oh, it's someone with depression. Does that make sense?" – <i>interview 6</i></p> <p>The use stereotyping during back stage performances was explained by a new paramedic as follows:</p> <p>"... I think stereotyping is human nature and I think, you know, it helps us to process things, to make sense of things ... I think it helps with resilience, absolutely, that kind of dehumanising aspect of it and to put things in boxes, so it can help with the diagnostics, "What's the treatment plan? But, I think stereotyping only becomes a problem, I might get shot for this. I think stereotyping becomes a problem when you're not aware that you're doing it and you act on those preconceptions, but that actually, having a stereotype is perfectly normal and helps us to make a quick decision sometimes about things, but if we're aware that we are stereotyping and that there may be differences in this particular</p>	<p>didn't think she had capacity, so I tried to get the GP to come out. She had massive scars on her arms and chest from self-harm," Paramedic 12 explained.</p> <p>Researcher's note: I could see the crew were listening and another crew member standing behind Paramedic 12 replied: 'I take patients directly to the local psychiatric hospital you know. I have the bed manager's number on my phone,' and he took out his mobile phone and scrolled down to show me his contacts." – field note 4</p> <p>"We can't take them into ED because that's not the right place for them'. Interviewer: 'Why do you think it's not the right place for them?' Respondent: 'Because they haven't got time in ED, they haven't got the specialists there. I would say probably nine times out of ten after 20 minutes they're going to get up and walk out and they've going to be more vulnerable then because they're going to be out in the street'." – interview 7</p> <p>- "Sticky vs leaky knowledge"</p> <p>"Sticky knowledge" focused primarily on the challenge of moving knowledge inside organisations, for example, moving knowledge inherent in 'best practice' from one part of an organisation to another – from the clinical managers to the frontline paramedics, thereby shaping practice.</p> <p>"Leaky knowledge" was the opposite and generally focused on the external and (as the term suggests) undesirable flow of knowledge. In particular, the loss of knowledge across the boundaries as evidenced below:</p>	<p>them"</p> <p>"I think there's definitely problems outside of house as well. And I actually think that better briefs need to be given to staff ..." – interview 11</p> <p>Nostalgia</p> <p>"We are dogsbodies. We are a doormat to the NHS. I think when people don't know how to handle things, like the GPs and nursing staff, they just tell people to phone 999 and they will deal with it. We are just doormats, we are not doing the job we are trained for, we are really not ... – interview 4</p> <p>"I had one [a mental health patient] the other day that was hard, but GP in-hours don't know. They can't necessarily come out. The hospital doesn't want to know. Its [the patient is] under a mental health team, they're stretched, they can't send someone out. I've got to sit with them. Ah, it's like walking up river</p>
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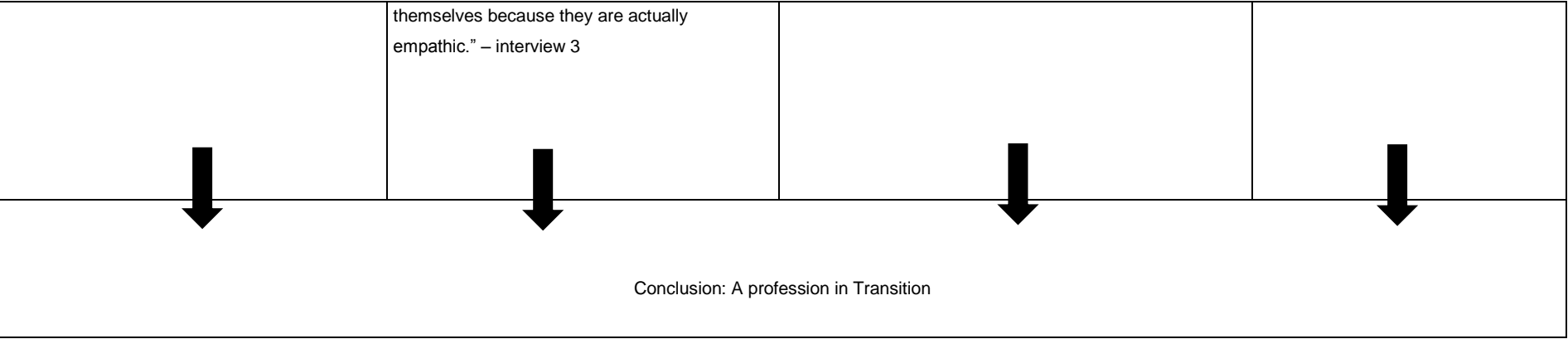
<p>sounding old now, but the younger generation want treatment now sort of thing ... People aren't always prepared to wait ... GP surgeries are overloaded and particularly out of hours are inundated so we end up getting pushed a lot of GP out of ours calls. They [patients] call us [999] for referrals. People say mental health is not our job but it probably is'." – interview 1</p> <p>Performance</p> <p>There was an internal conflict about how they perceived themselves in this role as seen in the following excerpts:</p> <p>"We don't know what we are doing half the time' – field note 5; 'This [mental health call] was without a doubt the most frustrating call of my career so far.' – field note 2; 'They [MH patients] are people too and we can't do anything for them. And we can't get the crisis team in or the GP because they never come,' he said with some frustration in his voice." – field note 19</p> <p>"It's that feeling of not ... of uneasiness and not knowing, uneasiness and probably helplessness, of knowing that this person [the mental health patient] needs some intervention,</p>	<p>instance, and we're open to that, I don't see that as a particular problem." – <i>interview 11</i></p> <p>Nostalgia</p> <p>"I liked sort of responding to those sort of life threats and stuff like that, but then obviously, coming into the profession quickly realised that actually it's not about that. I liked the profession because I liked the sort of diagnostic side of it ... You know, if it had stayed as it was traditionally where we just took everyone to hospital, it wouldn't have been a career that interested me ... There's usually some mental health. There are a lot of social problems and then obviously, there are the emergencies where people have immediate threats to life, but they're more far and few between." – interview 10</p> <p>"We constantly relate what we do for physical health with mental health, so because we know we can fix things and we want to fix things because that is the kind of people we are, when we can't that's ... You are not going to educate the public, and so you need to change, instead of trying to move the services or move them,</p>	<p>"And ... I think we [paramedics] just bumble along until it changes, because let's face it, if we [paramedics] had a massive interest in mental health, we'd all be social workers" – interview 9</p> <p>"I would rather take responsibility [for managing mental health patients] myself as I said, as an autonomous person. But in order to do that, I would need more training in mental health. I would need more support and I'd need more referral pathways." – interview 10</p> <p>Emotion</p> <p>"... 'There is nothing I can do for mental health patients. I don't have the skills or the back-up from other services to help them,' he [the paramedic] said quite passionately.' The reply from his paramedic colleague was: 'We need clear guidelines,' he said. While another added: 'We need to be able to admit them [mental health patients] to the local psychiatric hospital directly or they need to have a psychiatric ED'." – field note 12</p> <p>"The other day he [a paramedic colleague] did four [mental health patients] on the trot, anxiety, mental health, hyperventilating, so that was quite high. I have not faced that, but that is quite high. Yeah, because you come back to the station like, quite deflated saying, 'God, I can't believe I got four on the trot'. You just need time out,</p>	<p>against a current, and it depends on the severity of the patient's needs to how much that current then flows and pushes you back, if that makes any bloody sense?" – interview 9</p> <p>Performance</p> <p>"We're never going to solve the situation ... but we can possibly try and ease it, but it's frustrating as there are no real pathways and we've got no real access to mental health services." – interview 1</p> <p>There was also the added pressure of the evolving role and expectations of a paramedic by the Trust and the patient as evidenced in the following excerpt:</p> <p>"I think it's getting too fast; I think we're just expected to do absolutely everything, but then I think we always were but now to a bigger degree, so before we would see everybody and generally they'd go to hospital whereas now I think you see everybody and you're expected to</p>
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<p>needs some help, but that that is not forthcoming and the services that are there to provide this help have not and are unwilling to see him, at that point, and that feeling of not being able to help someone makes me very uneasy, I think.” – interview 11</p>	<p>you need to move the services to meet their needs, and mental health is the same. You are not going to stop people dialling 999.” – interview 2</p> <p>Real vs ideal role</p> <p>In addition, many paramedics felt that their role lacked more definition. It was no longer a role of being emergency responders, but more “a jack of all trades and a master of none”, which clouded their situated identity (Goffman, 1963). A clear situated role was preferred which was why many paramedics have started to specialise in urgent care or critical care as these roles are far more defined and less general:</p> <p>“The role of the paramedic nowadays is everything, whatever we just get sent to whereas before, I think it was a more defined role, years ago ... Again, mental health more of that than what we used to deal with years ago and we’re doing more, I would say GP type work with the 111 type calls we get so things like trauma, even cardiac and all this is just going, you know, it’s just slowly disappearing.” – interview 6</p> <p>“We should have specialist paramedics</p>	<p>because it’s a drain ... Probably because we can relate to them (laughing). I mean, they [mental health patients] are frustrating because you are not going to get anywhere with them to a degree, you don’t have long enough to sit with them and peel back the layers of the onions and find out what the cause is, because we’re pushed to come clear to do another job, so we don’t have time enough with them really. You know the only place to take them is the ED half the time. If they are safe, you are going to get criticised there. Or, you leave them at the scene you are running the risk that they might harm themselves, and if you overlook something you are going to get criticised.” – interview 4</p> <p><u>Nostalgia</u></p> <p>“... ‘You have got to understand the mind set of paramedics, particularly once they have been in [the ambulance service] a few years, their mind is in an emergency world, so everything, it’s a bit like the McDonalds culture, everything has to be done now and that is how our minds work because we are an emergency, so to us an emergency response is eight minutes or an hour at most, that is how we think. So, if somebody tells us they are providing a crisis intervention or an emergency duty team, the words in our head, consciously or otherwise, we kind of interpret that as, ‘They are going to come now then’ whereas the mental health world is much slower, and they consider an</p>	<p>have a treatment plan for them, so I think that’s changed, but I don’t think you always need a treatment plan and I think in other Trusts you don’t, but because it’s so heavily advocated to keep someone at home, you’re starting to treat a lot more people.” – Interview 5</p> <p>“I made about eight telephone calls to eight different services and it was just going around. I think I even spoke to the pharmacy at one point because they were refusing to give out a medication without – everyone was just refusing to take responsibility and you think, you know, it was just so frustrating.” – interview 8</p> <p>“My first call was to the mental health crisis team, they refused to come out. They always do. They said I needed to transport him to hospital to rule out organic causes before they could get involved.” – field note 1</p> <p>“It’s that feeling of not ... of uneasiness and not knowing, uneasiness and probably helplessness, of knowing that this</p>
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	<p>(whatever they are now) on the car and leave the ambulance for real emergencies. Seamless care does not work ... we are being used as an urgent resource when we are trained for emergency care.” – field note 8</p> <p>Performance</p> <p>Paramedics were regularly responding to patients who “cannot get an appointment with my GP” but felt they need to be seen by someone and often mental health patients called 999 as “I know you will come” and “no one else will listen”. This resentment was evident in the interviews as well:</p> <p>“We are not doing the job we are trained for, we are really not ... You see, we could be called to something totally different and people have got mental health, so I am probably seeing mental health an awful lot more, definitely a lot more than in the olden days. I don't mind going to mental health, but going to some of the stuff, it's hard to be professional sometimes.” – interview 4</p> <p>The constant tension between portraying a “professional face in their uniform” and their personal feelings of frustration and futility</p>	<p>emergency response to be within 24 hours, and there is this clash of mind sets and you can't gel that together’.” – interview 1</p> <p>Identity</p> <p>Performance/ Real vs ideal role</p> <p>“We aren't counsellors or psychiatrists. It begs the question, should we be treating the patient holistically and be supported by education to do so, or should our focus remain on the physical, only noting mental health issues on our documentation and referring patients to supportive services.” – field note 6</p>	<p>person needs some intervention, needs some help, but that that is not forthcoming and the services that are there to provide this help have not and are unwilling to see him, at that point, and that feeling of not being able to help someone makes me very uneasy, I think.” – interview 11</p> <p>Real vs ideal role</p> <p>“Paramedics are very good at switching off and I think that's one of the other reasons why paramedics have so many mental health issues later on in their career, or when they retire. It's because it then affects them. They've been so good during their career at shutting it off.” – interview 2</p>
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	<p>because of the limitations they had in providing care for mental health patients was exhausting. Not only did they have to present a “professional face” to patients and to their organisation while these undercurrents were running beneath the surface, but this was also in contrast with how they interacted with each other during down time.</p> <p>“They’re like a black hole”</p> <p>But keeping up front stage acting was draining and therefore fed into the feeling of “they’re like a black hole”. To counteract this, paramedics managed their emotions back stage as described below:</p> <p>“You just need time out, because it’s a drain ... I mean, they [mental health patients] are frustrating because you are not going to get anywhere with them to a degree, you don’t have long enough to sit with them and peel back the layers of the onions and find out what the cause is, because we’re pushed to come clear to do another job, so we don’t have time enough with them really. You know the only place to take them is ED half the time. If they are safe, you are going to get criticised there. Or, you leave them at the scene you are running the risk that they might harm themselves, and if you overlook something you are going to get</p>		
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	<p>criticised.” – interview 4</p> <p>“I’ve only got about 20 minutes of ‘there, there’ in me”</p> <p>Back stage acting was more authentic and raw as Goffman (1959) believed. In the excerpt below paramedics revealed that they felt worn out and tired and as one paramedic aptly described as “... I’ve only got about 20 minutes of ‘there, there’ in me” to manage mental health patients as described below:</p> <p>“They’re [paramedics] thinking subconsciously that they need to defend against burnout, and that they’re worried about getting too involved emotionally with a patient because of the affect it might have on them, which (?), you would expect. So, they’ve put up a sort of defence by saying, you know, publically almost that, ‘I’m not gonna do this and I’m gonna limit ... You know, I’m gonna ration, if you like, my empathy through self-preservation.’ But, actually they are naturally quite empathic people...Despite their anxiety, they articulate that way about being drawn in ... Being burnt out by being drawn in to emotive situations because that’s part of the job. Maybe it’s like a sort of, you know, a bit of flag-waving saying, ‘I don’t wanna let myself do this. I don’t wanna let myself be emotionally compromised.’ But, actually they can’t help</p>		
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Appendix I

I.1 Conference 1

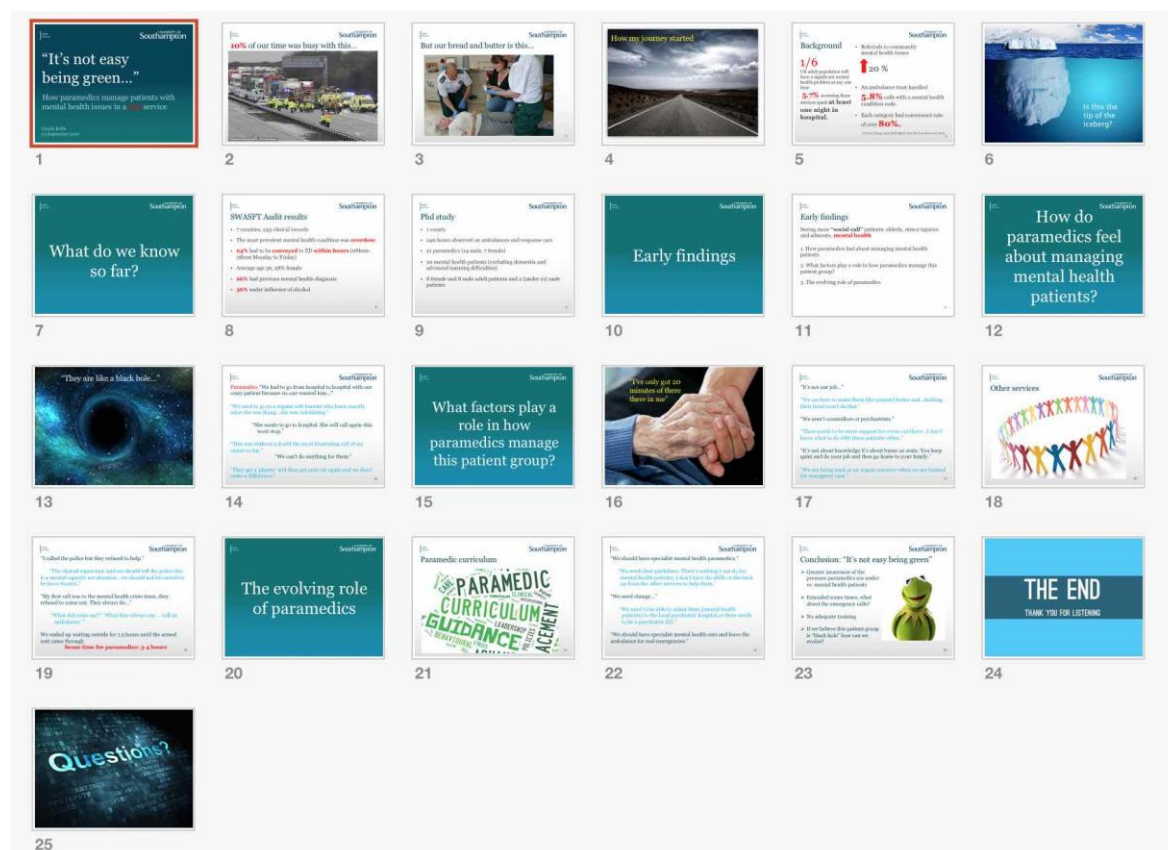
September 2016: Presenting my PhD research interim findings at BSA Medical Sociology Annual Conference, Birmingham September 8, 2016 – *Mental health calls in a 999 service, how do paramedics manage patients with mental health issues*

The presentation consists of 20 slides, numbered 1 to 20. The slides are as follows:

- Slide 1:** Title slide: "Mental health calls in a 999 service. How do paramedics manage patients with mental health issues? Ursula Riddle 8 September 2016".
- Slide 2:** "It's not all about this..." with an image of a busy road with emergency vehicles.
- Slide 3:** A landscape image of a road stretching into the distance under a cloudy sky.
- Slide 4:** Background statistics: "1/6 UK adult population will have a significant mental health problem at any one time", "5.7% scoring these services spent at least one night in hospital", "20% increase in referrals to community mental health teams", "5.8% calls with a mental health condition code", "Each category had conveyance rate of over 80%".
- Slide 5:** "Is this the tip of the iceberg?" with an image of an iceberg.
- Slide 6:** "What do we know now?"
- Slide 7:** "Operations Managers" with a map of South Western Ambulance Services (SWAS) area.
- Slide 8:** "SWASFT Audit results": "7 counties, 243 clinical records", "The most prevalent mental health condition was **overdose**", "64% had to be conveyed to ED within hours (0800-1800 Monday to Friday)", "Average age 36, 58% female", "66% had previous mental health diagnosis", "96% under influence of alcohol".
- Slide 9:** "This study": "1 county", "240 hours observed on ambulances and response cars", "21 paramedics (14 male, 7 female)", "20 mental health patients (excluding dementia and advanced hearing difficulties)", "8 female and 8 male adult patients and 2 (under 18) male patients".
- Slide 10:** "Developing themes".
- Slide 11:** "They are like a black hole..." with an image of a black hole.
- Slide 12:** "Patients": "Rather kill me than take me to hospital.", "TE tell you when I come out, I will remember...", "I don't know what's going on.", "Paramedics: 'We had to go from hospital to hospital with our crazy patient because no one wanted him...'", "We used to go to a regular self-harmer who knew exactly what she was doing... she was calculating.", "She wants to go to hospital. She will call again this week stop."
- Slide 13:** "Other services" with an image of a colorful DNA helix.
- Slide 14:** "I called the police but they refused to help because he was in his own house.", "The clinical supervisor said we should tell the police that this is a mental capacity act situation and not a mental health act... we should not let ourselves be heavy-beaten.", "My first call was to the mental health crisis team, they refused to come out. They always do.", "What did crisis say? 'What they always say... call an ambulance.'", "Scene time for paramedics: 3-4 hours".
- Slide 15:** "I've only got 10 minutes of there there in me" with an image of hands being held.
- Slide 16:** "It's not our job...", "We are here to make them [the patient] better and... holding their hand won't do that.", "We aren't counsellors or psychiatrists.", "There needs to be more support for crises out there... I don't know what to do with these patients either.", "It's not about knowledge it's about being on scene. You keep quiet and do your job and then go home to your family.", "We are being used as an urgent resource when we are trained for emergency care."
- Slide 17:** "Paramedic curriculum" with a word cloud including "PARAMEDIC", "CURRICULUM", "GUIDANCE", "LEADERSHIP", "ACCIDENT", "POLICE", "BEHAVIOURAL", "CRISIS", "ADULT", "CHILD", "MIND", "BODY", "SOCIETY", "CULTURE", "ETHICS", "LAW", "EVIDENCE", "RESEARCH", "TECHNOLOGY", "COMMUNICATION", "TEAMWORK", "PROBLEM SOLVING", "DECISION MAKING", "EMOTIONAL RESILIENCE", "STRESS MANAGEMENT", "CULTURAL AWARENESS", "DIVERSITY", "INCLUSION", "ANTI-DISCRIMINATION", "HUMAN RIGHTS", "SOCIETY", "CULTURE", "ETHICS", "LAW", "EVIDENCE", "RESEARCH", "TECHNOLOGY", "COMMUNICATION", "TEAMWORK", "PROBLEM SOLVING", "DECISION MAKING", "EMOTIONAL RESILIENCE", "STRESS MANAGEMENT", "CULTURAL AWARENESS", "DIVERSITY", "INCLUSION", "ANTI-DISCRIMINATION", "HUMAN RIGHTS".
- Slide 18:** "We should have specialist mental health paramedics.", "We need clear guidelines. There's nothing I can do for mental health patients. I don't have the skills or the back up from the other services to help them.", "We need change...", "We need to be able to admit them [mental health patients] to the local psychiatric hospital or there needs to be a psychiatric ED.", "We should have specialist mental health cars and leave the ambulance for real emergencies."
- Slide 19:** "Conclusion": "A hidden problem", "Paramedics have extended scene times", "No back-up", "No adequate training", "Evidence based research necessary".
- Slide 20:** "THE END. THANK YOU FOR LISTENING".

I.2 Conference 2

September 2016: Presenting my PhD research interim findings at 2nd Global Conference on Emergency Nursing and Trauma Care, September 24, 2016 – *It's not easy being green - an ethnographic study on how paramedics manage patients with mental health issues*



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