

2015

Emergency Department Registered Nurses' conceptions of recovery for mental health consumers: a phenomenographic study

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Recommended Citation

Marynowski-Traczyk, Donna Therese, Emergency Department Registered Nurses' conceptions of recovery for mental health consumers: a phenomenographic study, Doctor of Philosophy thesis, School of Nursing, University of Wollongong, 2015.
<http://ro.uow.edu.au/theses/4438>

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**Emergency Department Registered Nurses' Conceptions of
Recovery for Mental Health Consumers: A
Phenomenographic Study**

by

Donna Therese Marynowski-Traczyk RN, BN (Hons)

Submitted in the fulfilment of requirements

For the award of the Degree

Doctor of Philosophy

University of Wollongong

School of Nursing

Faculty of Science, Medicine and Health

April 2015

ABSTRACT

Mental health reforms have changed the Australian health care landscape, altering the location of mental health services and impacting their accessibility. A consequence of the restructuring is that people who are experiencing a mental health crisis often access mental health care through the Emergency Departments of general hospitals. Registered Nurses, many with no formal mental health training, often care for consumers as part of their daily practice. The Emergency Department is now an integral link to both mental health inpatient and community services and has a significant role in supporting the optimal transition of consumers between services.

Recovery underpins contemporary mental health care in Australia, and a recovery oriented approach has been formally adopted into policy within national, state and territory governments and is firmly embedded in mental health services. However, in the healthcare sector there exists disparity in the meaning of recovery. Within the Emergency Department environment the dominant and generally accepted medical meaning of recovery encompasses a return to normal function and cessation of symptoms. This notion is very different to recovery as it is understood by people with lived-experience of mental illness, which acknowledges the deeply personal and individual journey of engaging in a meaningful life, while facing the challenges that may occur when living with a mental illness.

Recovery means different things to different people depending on the lens through which it is viewed. This research aimed to understand how Registered Nurses working in the Emergency Department conceptualise recovery for people who are experiencing mental illness.

II

This study used a phenomenographic approach and utilised individual in-depth interviews with fourteen participants. The iterative analysis of the data resulted in the elucidation of six discrete categories of description representing the critical variation that exists in the participants' collective understanding of the phenomenon of recovery. The categories of description that were identified for Emergency Department Registered Nurses' conceptions of recovery were - recovery not occurring; seeking help from the Emergency Department; getting through the acute mental health crisis; referral to other areas of mental health care; implementing strategies for ongoing care, and living in the community. The categories of description are presented as a phenomenographic outcome space that expresses the logical relations existing between conceptions. This structure maps this relationship within three hierarchical levels, as conceptualisations of recovery progress through levels of increasing complexity and understanding.

Research findings conclude that Emergency Department Registered Nurses have limited cognisance of the meaning of recovery for people with a mental illness, and their conceptualisation of recovery predominantly remains bound to the dominant medical notion of recovery. This research adds to the body of knowledge, as this is the first study to identify and describe Registered Nurses' conceptualisations of recovery as it applies to people who are experiencing mental illness within the Emergency Department.

III

Declaration of Originality

I, Donna T. Marynowski-Traczyk, declare that this thesis submitted in fulfilment of the requirements for the award of Doctor of Philosophy, at the University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

(Signature)

Donna Marynowski-Traczyk

21st April, 2015

DEDICATION



For my sons

Table of Contents

ABSTRACT.....	2
List of figures	11
List of tables.....	12
Appendices.....	13
Publications and presentations emanating from this research.....	14
Publications	14
Conference presentations	14
Publications and presentations by the researcher that have informed this research ...	15
Acknowledgements	16
Glossary of terms	17
Conventions used throughout this thesis.....	18
CHAPTER ONE: INTRODUCTION	1
Research Genesis	1
Background	2
Research Aim.....	5
Research Question.....	5
Rationale and Significance of the Study	6
The Structure of the Thesis	6
CHAPTER TWO: ENGAGEMENT WITH THE LITERATURE.....	9
Introduction	9
The Historical Roots of Recovery	9
Clinical Recovery.....	17
Personal Recovery.....	23
Elements of Personal Recovery	35

Hope	35
Connectedness	36
Empowerment	38
Active sense of self	39
Barriers to Recovery	42
Recovery as an Outcome Versus Recovery as a Process	49
Recovery as an outcome	49
Recovery as a process	53
Mental Health Care in Australia	55
Mental Health Care in Australian Emergency Departments	68
Summary	81
CHAPTER THREE: THE RESEARCH APPROACH	83
Introduction	83
Qualitative Research	84
Phenomenography	85
Origins of Phenomenography	88
Epistemology and Ontology	90
Conceptions	93
Categories of Description	97
Outcome Space	98
Rationale	99
Research Rigour	100
Credibility	101
Transferability	104
Dependability	105

Confirmability	105
Ethical Considerations	106
Respect	107
Research Merit and Integrity	108
Justice	109
Beneficence	110
Research Sample	111
Participant Recruitment.....	111
Participants	112
Participant Numbers.....	118
Data Collection.....	121
Pilot Interview	121
In-depth Interviews	122
Data Analysis	129
Stage 1: Familiarisation.....	133
Stage 2: Condensation.....	133
Stage 3: Comparison	134
Stage 4: Grouping	135
Stage 5: Articulating	136
Stage 6: Labelling	137
Stage 7: Contrasting	137
Summary	137
CHAPTER FOUR: FINDINGS	139
Introduction	139
The categories of description identified for ED RNs' conceptions of recovery	141

VIII

Summary	174
CHAPTER FIVE: DISCUSSION.....	176
Introduction	176
Recovery does not occur	178
Stigma	183
Recovery is ‘seeking help from the ED’	193
The evolving role of the ED	194
ED RNs’ mental health literacy	202
Language supporting recovery	204
Recovery is ‘getting through the acute mental health crisis’	207
The focus on emergent care	208
Psychiatric advance directives	218
Recovery is ‘referral to other areas of mental health care’	226
The Emergency Department environment	228
Mental health assessment and management.....	234
Mental health education and training	237
Length of stay in the ED	240
Recovery is ‘implementing strategies for ongoing care’	244
Discharge planning.....	245
Community services and support	249
Recovery is ‘living in the community’	253
Functioning and normality	256
Psychotropic medication and staying well in the community.....	259
Summary	263
CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS.....	265

Limitations	267
Recommendations	269
Final Statement	273
REFERENCES	274
APPENDICES	308

LIST OF FIGURES

Figure 1: Australian National Health Priority Areas	62
Figure 2: Mental health-related emergency department occasions of service in public hospitals, 2008-09 to 2011-12.....	69
Figure 3: First and second order perspectives	93
Figure 4: The component parts of an experience	96
Figure 5: Participants' age	114
Figure 6: Geographic distribution of participants	115
Figure 7: Map of Australia superimposed over the United States of America and Canada	116
Figure 8: Participant gender	117
Figure 9: Years of experience as an Emergency Department Registered Nurse	118
Figure 10: Phenomenographic view of relationality	130
Figure 11: Seven stage cycle of data analysis	132
Figure 12: The outcome space for ED RNs' conceptions of recovery	140
Figure 13: The position of category of description One within the outcome space	168
Figure 14: The position of categories of description Two and Three within the outcome space	169
Figure 15: The position of categories Four and Five within the outcome space	171
Figure 16: The position of category of description Six within the outcome space.....	173
Figure 17: Prevalence of mental disorders in the Australian population.	185
Figure 18: The structures of the experience of stigma.....	189
Figure 19: The position of category of description Two within the outcome space.....	194
Figure 20: The position of category of description Three within the outcome space...	208
Figure 21: The position of category of description Four within the outcome space.....	227
Figure 22: The position of category of description Five within the outcome space	244

LIST OF TABLES

Table 1: Differences in the concepts, language and values within the recovery and the medical models.....	22
Table 2: Recovery themes in consumer narratives	25
Table 3: Consumers, healthcare providers and policy makers' perspectives on recovery	27
Table 4: Recovery processes	29
Table 5: Characteristics of the recovery journey	30
Table 6: Stages of recovery	32
Table 7: Recovery themes	34
Table 8: Language that hinders recovery and recovery focused alternatives	48
Table 9: Key Australian reform policies and documents.....	66
Table 10: Mental health-related emergency department occasions of service in public hospitals, by episode-end status, 2008-09 to 2011-12.....	71
Table 11: ICD-10 codes for mental and behavioural disorders	72
Table 12: Examples of sample sizes in phenomenographic studies	120
Table 13: Models of emergency psychiatric services to Australian emergency departments	196
Table 14: Components of recovery that are supported by psychiatric advance directives	222

APPENDICES

APPENDIX 1: STAGES OF RECOVERY INSTRUMENT	308
APPENDIX 2: MEDIA RELEASE BY THE HON PETER DUTTON MP.....	312
APPENDIX 3: CQUNIVERSITY AUSTRALIA, HREC APPROVAL LETTER.....	313
APPENDIX 4: UNIVERSITY OF WOLLONGONG HREC APPROVAL LETTER	315
APPENDIX 5: PARTICIPANT INFORMATION SHEET	317
APPENDIX 6: CONSENT FORM	319
APPENDIX 7: EMAIL TO MEMBERS OF THE COLLEGE OF EMERGENCY NURSING AUSTRALASIA	320
APPENDIX 8: DOMAINS WITHIN THE PRACTICE STANDARDS FOR THE EMERGENCY NURSING SPECIALIST.....	321

PUBLICATIONS AND PRESENTATIONS EMANATING FROM THIS RESEARCH

Publications

Marynowski-Traczyk, D, Moxham, L & Broadbent, M 2013, 'A critical discussion of the concept of recovery for mental health consumers in the Emergency Department.', *Australasian Emergency Nursing Journal*, vol. 16, no. 3, pp. 96 –102.

Marynowski-Traczyk, D, Moxham, L & Broadbent, M 2012, 'Recovery and mental healthcare: views of ED nurses', *Australian Nursing Journal*, vol. 20, no. 2, p. 42.

Marynowski-Traczyk, D, Moxham, L & Broadbent, M 2011, 'Improving care in the ED', *Australian Nursing Journal*, vol. 19, no. 4, p. 36.

Conference Presentations

Marynowski-Traczyk, D, Moxham, L & Broadbent, M 2014, 'Mental health care and recovery within diverse practice domains', paper presented at the *40th International Australian College of Mental Health Nurses Conference: Honouring the past, Shaping the Future*, 7 – 9 Oct, Melbourne, Australia.

Marynowski-Traczyk, D, Moxham, L., & Broadbent, M 2013, How ED nurses conceptualise recovery: a phenomenography from Australia, paper presented at the *Horatio, European Psychiatric Nursing Congress: Stepped Care Provided by Psychiatric Nurses in Different Parts of the World*, 31 October–2 November, Istanbul, Turkey.

Marynowski-Traczyk, D, Moxham, L, & Broadbent, M 2013, Enhancing the health and well being of people with a mental illness through recovery in the emergency department; paper presented at the *International Council of Nurses 25th Quadrennial Congress: Equity and Access to Health Care*, 18–23 May, Melbourne, Australia.

Marynowski-Traczyk, D, Moxham, L, & Broadbent, 2012, Recovery in the Emergency Department: Can consumers expect recovery to intertwine all areas of mental health care provision? *ACMHN 38th International Mental Health Nursing Conference*, 3–5 October, Darwin, Australia.

Publications and presentations by the researcher that have informed this research

Marynowski-Traczyk, D & Broadbent, M 2011, ‘What are the experiences of emergency department nurses in caring for clients with a mental illness in the emergency department?’, *Australasian Emergency Nursing Journal*, vol. 14, no. 3, pp. 172–179.

Marynowski-Traczyk, D & Broadbent, M 2011, Mental health in the ED: the tide is changing, time to swim between the flags; paper presented at the *ACMHN 37th International Mental Health Nursing Conference*, 4–7 October, Gold Coast, Australia.

ACKNOWLEDGEMENTS

This thesis has been a wonderful journey and it has been made possible through the contribution of many special people that I would like to acknowledge and thank.

My deepest gratitude goes to my family; thank you for your love and support. To my amazing sons, thank you for your understanding and patience during the years that I have dedicated to this thesis. To my wonderful parents, thank you for your encouragement and unfaltering belief in me. Dad, even though you are not here with us today, I know that you are proud.

I would like to express my heartfelt gratitude to my two exceptional supervisors, Professor Lorna Moxham and Dr Marc Broadbent. I am privileged to have had such outstanding supervisors whose academic expertise, guidance, insightful feedback and ongoing support made this PhD journey an incredibly rewarding experience. Professor Moxham inspired me throughout this experience, thank you for sharing your wisdom, knowledge and enthusiasm. Dr Broadbent was there from the very beginning of my studies. He encouraged me and believed in me, and I am very grateful.

To the Emergency Department Nurses who participated in this study, I would like to express my appreciation and gratitude for giving your time to share your thoughts and experiences which made this research possible.

GLOSSARY OF TERMS

ACRONYM	TERM	DEFINITION
ABS	Australian Bureau of Statistics	Australia's national statistical agency.
CAT	Crisis and Assessment Team	An outreach service based in the community for acute mental health assessment and treatment
DSM	Diagnostic and Statistical Manual	The Diagnostic and Statistical Manual of Mental Disorders is the standard classification system for mental disorders produced by the American Psychiatric Association. The DSM-5 is the version currently in use within Australia
ICD	International Classification of Diseases	The International Classification of Diseases is the standard diagnostic tool for epidemiology, health management and clinical purposes. The ICD-10 is currently in use in Australia
ICD-10 AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification	This version of the International Classification of Diseases has been modified to serve Australian needs and to support the national collection of data relevant to the health of the Australian population
ICD-9 CM	International Classification of Diseases, 9th Revision, Clinical Modification	This version of the International Classification of Diseases is an adaption created by the United States of America National Center for Health Statistics.
MHC	Mental Health Commission	The Mental Health Commission of New South Wales was established to monitor, review and improve the New South Wales mental health system.
PAD	Psychiatric Advance Care Directive	A written document that describes what treatment a person does or does not want if at some time in the future they are judged to be incapacitated from mental illness
PEC	Psychiatric Emergency Centre	A mental health service co-located within the Emergency Department

CONVENTIONS USED THROUGHOUT THIS THESIS

The following conventions are used throughout the thesis:

- P = participant
- *italic text* for quotations from participant interviews
- “double” quotation marks for added emphasis
- **bolding** for the name of the categories of description

Consistent with the language of recovery the term ‘consumer’ is used throughout this thesis when discussing people who are currently, or have been, consumers of mental health services. “Person first” descriptors which are also used include “individual”, “person” and “people with lived experience”. The researcher acknowledges and respects that many people living with mental illness also chose to be identified as clients or service-users, and indeed some don’t mind the word ‘patient’.

Throughout this thesis the researcher is referred to in the third person; however an exception is made within Chapter One. In this instance the first person and the use of ‘I’ is made when the worldview of the researcher is presented.

CHAPTER ONE: INTRODUCTION

The goal of the recovery process is not to become normal. The goal is to embrace our human vocation of becoming more deeply, more fully human. The goal is not normalization. The goal is to become the unique, awesome, never to be repeated human being that we are called to be. (Deegan 1996, p. 92)

Research Genesis

As a Registered Nurse working in a mental healthcare setting, I am cognisant of the meaning of ‘recovery’ as it is understood by people who are living with mental illness. Recovery underpins contemporary mental healthcare, and I am privileged to support consumers on their personal recovery journey as part of my daily practice. In addition, as an Australian university graduate with a Bachelor of Nursing and a first class honours degree, I also have knowledge, experience and a professional appreciation of the medical notion of recovery. This concept of recovery is embedded in the general nursing curricula in Australia and is one that has a deep and long tradition and dominance within the general healthcare environment.

My interest in consumers’ navigation through the healthcare system during their recovery journey motivated me to explore the starting point of the consumers’ experience. This is often a general hospital Emergency Department (ED). I wondered then, given that the ED is the portal into the mental health system (Broadbent, Moxham & Dwyer 2014), what staff who work in this environment thought about recovery from a mental illness perspective. This led me, as part of my Nursing Honours Degree, to undertake a Phenomenological study to explore ED nurses’ experiences of caring for mental health consumers in the ED.

A comment, which resonated deeply, was made by a participant in my honours degree:

‘... I guess that there is an element of frustration there, you don’t see the recovery’,

This seemingly innocuous comment, from a member of the healthcare team who was providing front-line care and treatment to people with mental illness, raised even more questions. Not only were questions swirling, but the comment also caused me to ponder, from a philosophical perspective, about the different meanings for the word ‘recovery’ that coexist within the healthcare environment. Completing the honours, working as an RN, and observing and participating in consumer recovery struck the spark that was the catalyst inspiring me to further explore this concept through a doctoral degree.

My honours study used phenomenology, an approach to uncover experiences, but my interest had now both broadened and deepened into understanding how RNs conceptualise a phenomenon; in this instance recovery in the ED. Examining how Registered Nurses (RNs) practising within this general healthcare domain, conceptualise a consumer’s recovery at this juncture in their personal recovery journey, is presented in this PhD thesis.

Background

‘Recovery’ means different things to different people and the lens through which recovery is viewed can impact on the way in which recovery is conceptualised. Recovery for people experiencing mental illness is understood as a unique individual journey and a personal process in which hope, empowerment and personal choice support a person’s commitment to living a meaningful life (Shepherd, Boardman &

Slade 2008). This journey has no endpoint and each recovery journey is as unique as the person who is experiencing the mental illness (Deegan 1993).

This understanding of recovery by people with lived-experience of mental illness is very different to the generally accepted medical/clinical meaning of recovery as it is understood within the general healthcare domain. In contrast to personal recovery, clinical recovery is understood as objective and observable (Slade 2009a) and maintains a narrow focus on a person's symptomology. These two different notions of recovery have developed from different histories and have distinct perspectives and goals (Bellack 2006), and the coexistence of the disparate meanings is relevant for mental health consumers who access health services in times of crisis. This is discussed in greater detail in chapter two.

Recovery as a subjective personal process both 'belongs to' and is 'owned by' the consumer who is the expert in his or her own experience. Personal recovery continues with or without the presence of the symptoms of mental illness and the limitations that can purportedly occur (Anthony 1993). However, clinical recovery, which is based on pathology and focuses on the amelioration of symptoms, is assessed and rated by the expert healthcare professional (Slade 2009a). 'Recovery' in this context becomes a clinical opinion rather than a subjective experience.

Mental health reforms that have occurred within Australia, and indeed globally, have changed the healthcare landscape in many countries. A corollary of the reforms, particularly within Australia, has been the significant change in the location of mental healthcare service provision and also the way in which these services are accessed

(Morphet et al. 2012). The mainstreaming of what have historically been separate and independent mental healthcare services into the general healthcare system is a central tenet of the reforms (Commonwealth of Australia 2013). Therefore, people who are experiencing mental health crisis and/or distress, and who are seeking access to specialist mental health services, must now do so through general hospital EDs (Broadbent, Moxham & Dwyer 2014).

The notion of recovery as it is understood by people who experience mental illness, and the delivery of mental healthcare services that are recovery oriented, are now embedded in mental health service provision in Australia and within Australian national policy. This includes The Roadmap for Mental Health Reform 2012-2022 (Council of Australian Governments 2012), and the National Framework for Recovery-Oriented Mental Health Services 2013 (Australian Health Ministers Advisory Council 2013b).

However, mental healthcare, and general healthcare such as that provided in the ED, are very different. Each healthcare domain has its own culture and practices. Generalist RNs working in the ED provide care for people with mental illness as part of their daily practice; however they may have no formal mental health training and therefore may not have the level of mental health knowledge and attendant skills that will enable them to provide optimal care to this population (Plant & White 2013). Importantly as the focus of the ED environment in which they work is on physical injury and illness, they may have limited knowledge of personal recovery and recovery oriented care that is at the forefront of consumer expectations (Marynowski-Traczyk & Broadbent 2011).

As the ED provides mental health crisis assessment and management can it, and in fact should it, be part of a consumer's personal recovery journey? Contributing to this conversation is the notion of the ability of healthcare professionals, such as RNs, to facilitate recovery-oriented care in the ED, and to support consumers in their recovery. This thesis contributes to this conversation in its examination of how the recovery journey may be challenged by the coexistence of the different notions of recovery within this healthcare environment. Therefore, an area of particular significance to mental health consumers, who present to the ED and may be transitioning between service sectors, is the disparity in the meaning of recovery within the two diverse healthcare domains.

This is further complicated by an inevitable tension that exists due to the differences in the concepts and language inherent within each of the contrasting understandings (Roberts & Wolfson 2004). This dichotomy may impact the care that is provided by ED RNs to this vulnerable and disadvantaged group. The implementation of the research aim that was guided by the research question contributes to the gap in literature.

Research aim

The aim of this research was to understand how Registered Nurses working in the Emergency Department conceptualise recovery for people who are experiencing mental illness.

Research question

What are Registered Nurses conceptualisations of recovery as it applies to people who are experiencing mental illness within the Emergency Department?

Rationale and significance of the study

The mental health of Australians is a significant issue, as nearly half of all Australians will experience a mental illness at some point during their lives (Council of Australian Governments 2012). People who are experiencing a mental health crisis, and present to the ED, experience care provision that is delivered with a predominantly medical focus. The traditional medical model informs this healthcare environment and also the generally accepted clinical meaning of recovery. This is at odds with the meaning of recovery as it is understood by people with lived-experience of mental illness and who have unique care needs that are not confined to the constructs of wellness and/or cure that is embedded in general healthcare.

The findings from this research elucidate the differing conceptualisations of ‘recovery’ as they are understood by RNs who work within the ED. In turn, such findings can impact on practice and professional development which may facilitate optimal healthcare outcomes and have positive impact on the lived-experience of people experiencing mental illness.

The structure of the Thesis

This thesis is organised into six chapters.

Chapter One outlines the motivation for the study, introduces the background and presents the rationale and significance of the study. The research aim and the research question, which guided this study, are also presented.

Chapter Two presents an engagement with the recovery literature relevant to this research. The first part of the chapter discusses the historical roots of the concept of

recovery and the emergence of the contemporary understanding of recovery. This is followed by a discussion of the two disparate meanings of recovery within healthcare; clinical recovery and recovery as understood by people with lived-experience of mental illness. The chapter concludes with an examination of mental healthcare within Australia, and within Australian general hospital EDs.

Chapter Three outlines the qualitative research approach of phenomenography and details the applicability of this approach to effect this study's aim in understanding how Emergency Department Registered Nurses conceptualise recovery for people experiencing mental illness. The recruitment and selection of participants, ethical considerations, data collection and data analysis are also presented. In addition, the chapter is further strengthened by describing the strategies used to facilitate research credibility.

Chapter Four presents the findings of the phenomenographic study which are comprehensively detailed in chapter three. Achieving the aim of the research led to the discovery of six categories of description. These contribute to the detailed understanding of the critical variation in the collective understanding of recovery. The relationship between the categories is presented as an outcome space as is methodologically accepted.

Chapter Five discusses the findings that have emerged from this study. In this respect, the findings are examined and analysed with regard to the relationship that these findings have with the current body of literature.

Chapter Six presents the conclusions that have arisen from the findings of this study. This final chapter summarises salient aspects, and details the implications and recommendations for nursing education and practice, and of care and treatment related to service delivery. Integral to this are implications for consumers in the ED. Recommendations for future research are also outlined. This chapter concludes with the acknowledgement of the study's limitations.

CHAPTER TWO: ENGAGEMENT WITH THE LITERATURE

Introduction

This chapter presents an engagement with the literature on recovery for people experiencing mental illness. The recovery literature is extensive; however no literature could be identified within the expansive discussion that could elucidate how emergency department (ED) nurses conceptualise the concept of recovery as it applies to people with mental illness. This significant gap in the literature strengthens the justification for the researcher's phenomenographic exploration within this thesis, of ED registered nurses' conceptualisation of recovery for people with mental illness.

The chapter begins with an explication of the historical roots of the concept of recovery and the subsequent emergence of the contemporary understanding of recovery in mental healthcare and treatment. The two disparate meanings of recovery within the literature will be discussed, and personal recovery as understood by people with lived-experience of mental illness will be presented. Mental healthcare within Australia will be examined and contemporary mental health reforms will be discussed. The chapter concludes with a discussion of mental healthcare within Australian EDs.

The Historical Roots of Recovery

The concept of recovery in mental illness can be traced back over 200 years to Philippe Pinel (1745-1826), a highly regarded eighteenth century French physician (Davidson, Rakfeldt & Strauss 2010). Pinel advocated the humane treatment of the mentally ill and Pinel's *traitement moral* was based on the determination to 'govern by wisdom, rather than to subdue by terror' (Pinel 1806, p. 207, cited in Davidson Rakfeldt & Strauss 2010). Pinel's treatment of people with mental illness, who at that time were

labelled insane, was based on humanity and kindness and advocated treatment regimes that were individualised to the specific patient (Piddock 2001). Furthermore, Pinel believed, contrary to the beliefs of the time, that ‘madness’ was curable and that recovery was possible. His address to the Society for Natural History in 1794 contained an ‘implicit appeal for respect, if not even admiration, for this population of formerly despised and dispensable people’ (Davidson, Rakfeldt & Strauss 2010, p. 25).

The concept of recovery can also be linked to other initiatives occurring in psychiatry, such as England’s York Retreat (Slade et al. 2012). William Tuke (1732-1822) established the York Retreat in 1796 and is credited with founding England’s first moral treatment asylum, pioneering new humane treatment of the insane (Davidson, Rakfeldt & Strauss 2010). The treatment of the inmates at the Retreat consisted of moral management in a pleasant and calming environment, and inmates were encouraged to take personal responsibility for their behaviour (Charland 2002). Roberts and Wolfson (2004) maintain that a clinical philosophy and practice that centred on compassion and hope of recovery was established by the Tukes at York over 200 years ago, and occurred due to the criticism of psychiatric practice at that time. It became a model of care around the world that called for more humane and psychologically based approaches for people experiencing mental illness.

The contemporary understanding of recovery for people with a mental illness can be traced back to the 1930s, when the psychiatrist Abraham Low (1891-1954) founded one of the first self-help mental health groups called ‘Recovery Inc’ in 1937 in Chicago Illinois (Ochocka, Nelson & Janzen 2005; Sowers 2005; Welsch Jensen & Wadkins 2007). However, the current concept of recovery really started to emerge in the 1980s.

This 'modern' notion of recovery for people who were experiencing mental illness was impacted by the convergence of two influential developments; firstly, the consumer/survivor movement which elucidated the personal experiences, narratives and perspectives of people who had first-hand experience of mental illness, and secondly, the empirical knowledge that was gained from longitudinal outcome studies of people with severe mental illness (Anthony 2000; Davidson & Roe 2007; Ellis & King 2003; Gordon 2013; Turner-Crowson & Wallcraft 2002). These are now explained in greater detail.

As alluded to above, the contemporary concept of recovery had its roots in the United States of America (USA) in the consumer/survivor movement (Davidson et al. 2005; Ramon, Healy & Renouf 2007; Roberts & Wolfson 2004; Stickley & Wright 2011). This began in the 1970s (McLean 2003) and built upon the Civil Rights movements of the 1960s in the USA (Hall, Wren & Kirby 2013). Marginalised groups were joining forces for change (Frese & Walker Davis 1997), and the organisation of the groups of ex-patients was influenced by the black, gay, and women's liberation movements (Schiff 2004; Tomes 2006).

Deinstitutionalisation, a process which facilitated the movement of care for people with mental illness from traditional institutional care to community-based services (Kelly & McKenna 2004), occurred in the 1960s and 1970s in the United States. Deinstitutionalisation is thought to have laid the foundations there for the emergence of a recovery vision for mental health services (Anthony 1993; Bonney & Stickley 2008). People who had been hospitalised for mental illness and shared a common

experience rallied for change and sought to regain their rights, which they felt had been denied (Chamberlain & Rogers 1990). Anthony (1993, p. 11) states that:

The seeds of the recovery vision were sown in the aftermath of the era of deinstitutionalization. The failures in the implementation of the policy of deinstitutionalization confronted us with the fact that a person with severe mental illness wants and needs more than just symptom relief.

In addition, it is argued that the concept of recovery was also informed by the addiction movement (Davidson & Roe 2007; Sterling et al. 2010). ‘Recovery’, is in fact a foundational concept within Alcoholics Anonymous (AA). Established in the United States in 1935 (Munetz & Frese 2001; Shepherd, Boardman & Slade 2008) AA is a worldwide peer program in which individuals support each other to maintain sobriety through participation in group meetings, and sharing hope, experiences and strengths (Streifel & Servanty-Seib 2006). The notion of recovery in this context focused on individual empowerment and promoted a move away from attributing blame for the condition on the individual. This philosophy is consistent with elements that are associated with the current notion of recovery as understood by consumers living with a mental illness. Furthermore, the 12-step programme established by AA related to the thought processes of individuals with an addiction and encouraged personal responsibility. This resonates with ‘recovery’ as it is understood within contemporary mental healthcare (Sowers 2005), where personal responsibility involves people taking responsibility for their own wellbeing and the decisions that they make (Slade 2013). Prior to the contemporary understanding of recovery, severe mental illnesses were viewed as ‘harbingers of doom’ (Corrigan & Ralph 2005, p. 4). However, in the 1980s people with lived-experience of mental illness began to challenge the prevailing ideas of chronicity and limited hope (Sterling et al. 2010), and consumers/survivors began

to write about their experiences (Deegan 1988; Houghton 1982; Lette 1988; Lovejoy 1982; Unzicker 1989). The elucidation of their experiences of living with a mental illness was the platform for the discussion of the emerging concept of recovery (Anthony 1993), and challenged the prevailing belief that if a person developed a mental illness, such as schizophrenia for example, there was no hope.

At the time when people began writing about their experiences, there was a paucity of scientific and professional literature on the phenomenon of recovery. Patricia Deegan, herself a consumer, is an independent consultant who specialises in researching and lecturing on the topic of recovery and the empowerment of people diagnosed with mental illness. She argued that recovery was different to rehabilitation and maintained that perhaps recovery was a concept that was difficult to define due to the fact that the phenomenon of recovery is so fundamental. Deegan (1988, p. 12) posits that: 'Although the phenomenon will not fit neatly into natural scientific paradigms, those of us who have been disabled know that recovery is real because we have lived it'.

With the emergence of the consumer/survivor movement, people living with mental illness insisted on moving away from the role of passive participant in mental health services to that of informed consumers of services working in collaboration with mental healthcare professionals (Kopelowicz & Liberman 1995). Personal narratives, such as those provided above, that were articulated by the very people who experienced the challenges of living with a mental illness, provided affirmation of the existence of recovery. These recovery stories are positioned as 'quest narratives' (Ridgway 2001, p. 340), which facilitate discovery and reveal new pathways by which people who have experienced mental illness can navigate their life journeys. The quest

narrative can provide people with the courage and determination to face the challenges of living with a mental illness and the voice to impart their unique and personal stories (Ostrow & Adams 2012).

Swarbrick (2006) argues that it was the first-person narratives written by Deegan (1988) that were influential in the recent paradigm shift towards recovery. Frese and Walker Davis (1997) argue that personal accounts of the lived-experience were not a new phenomenon and they were being written early in this century, an example being the autobiography written by Clifford Beers (1876-1943). Beers was a former patient in the United States of America who was institutionalised for three years as the result of an attempted suicide. Throughout the period 1900 to 1903 Beers was hospitalised at the Connecticut State Hospital and also at Stamford Hall and The Hartford Retreat (Parry 2010). His seminal publication, *A mind that found itself* (1908), brought attention to the plight of people experiencing mental illness who were institutionalised during this time, and was the impetus for raising public concern about the treatment and care of such people. Beers was the founder of the mental hygiene movement, which was one of the earliest consumer advocate health reform movements in the United States (Frese & Walker Davis 1997).

While Deegan and others with lived-experience of mental illness were articulating their experiences, there was also a shift occurring in the long-held beliefs regarding long-term outlooks for people with severe mental illness. In 1893 the German psychiatrist Emil Kraepelin (1856-1926) introduced the concept of dementia praecox (which subsequently was named schizophrenia), and this had a significant long-term impact on psychiatric nosology (Ion & Beer 2002). Indeed, Watson (2012) argues that

the biomedical model of mental illness, which for numerous reasons still dominates today, had its roots in Kraepelin's research. The notion of extremely poor outcomes characterised serious mental illness as progressively deteriorating in course with a hopeless and pessimistic prognosis (Bellack 2006; Brennaman & Lobo 2011; Munetz & Frese 2001). This classification contributed to the perpetuation of negative perceptions and a pessimistic outcome in serious mental illness, and reinforced the expectation that people would not, in fact could not, recover (Ahern & Fisher 2001; Andresen, Oades & Caputi 2011; Corrigan & Ralph 2005; Kruger 2000; Watson 2012). This facilitated the maintenance of the myth of incurability (Amering & Schmolke 2009; Karon 2007).

In spite of the accepted and entrenched views of a life without hope and a certain downward spiral, increasing evidence was supporting the knowledge that people with a severe mental illness were not destined for the prevailing assumption of decline and chronicity, but rather could, and do, lead meaningful lives (Andresen, Oades & Caputi 2011). The findings of longitudinal studies suggested that people who had schizophrenia showed improvement over time (Bleule 1974; Ciompi 1980; Huber et al. 1980; Tsuang, Woolson & Fleming 1979). The studies that contributed to the changing mind-set included the International Pilot Study of Schizophrenia sponsored by the World Health Organization (WHO). This large-scale cross-cultural collaborative project in 1966 involved nine countries. The aim of the study was to position the methodological groundwork for future research in schizophrenia and other functional psychiatric disorders (Sartorius, Shapiro & Jablensky 1974). Given that

opinions were slow to change it is reasonable to suggest that its aim was partially achieved.

Another significant study was the landmark Vermont longitudinal study by Harding et al. (1987a; 1987b). This research, conducted between 1955 and 1982 in Vermont, United States of America, examined the long-term outcomes of a cohort of 269 patients who were described as having chronic schizophrenia. This group of people participated in a comprehensive rehabilitation programme and planned deinstitutionalisation. Two to three decades after the commencement of this study, one half to two-thirds of the study cohort were 'rated as considerably improved or recovered' (Harding et al. 1987a, p. 722). These findings further challenged the assumptions that remained prevalent regarding the course and long term outcomes of severe mental illness. Furthermore, longitudinal studies documented over the last three decades have consistently demonstrated that the course and outcome of serious mental illness is heterogeneous (Bellack 2006; Davidson et al. 2005). Lieberman et al. (2008) suggest that due to the individualised nature of mental illness that heterogeneity recognises, recovery should be defined in relation to specific heterogeneous domains. These domains include cognitive or vocational functioning, as this can facilitate the connection between 'hope and recovery with important advances in the science of the brain' (p. 487).

As posited by Davidson et al. (2005), the convergence of the two developments alluded to, that is the consumer/survivor movement and longitudinal outcome studies, has been a contributing factor in why the term 'recovery' has different meanings to different people. The following discussion will highlight how the two meanings of recovery occur within the recovery literature; the subjective and personal understanding of

recovery by those with lived-experience of mental illness, and the clinical understanding of recovery (clinical recovery) rooted in the traditional medical model dominant within the Australian healthcare system.

Discussion will be confined to these two conceptualisations of recovery; however, it is acknowledged that the use of the term ‘recovery’ is prominent in many other fields and recovery as a phenomenon is not confined to the medical or mental health fields. The term ‘recovery’ is used in many diverse areas and numerous disciplines and, as identified by Brennaman and Lobo (2011) includes, but is still not limited to, computing, maritime matters , sports, politics, industry and law.

Clinical Recovery

The traditional illness model defined mental illness as a problem that was ‘primarily a defective chemical mechanism in the patient’s brain that needs to be repaired by the expert’ (Fisher 1994, p. 913). Within the scientific literature, the disease and the associated reduction or elimination of symptoms is generally the perspective from which the term ‘recovery’ is viewed (Bellack 2006). An individual’s return to pre-morbid levels of functioning is included within the scientific or clinical conceptualisation of recovery, and a good outcome with regard to mental illness is viewed in terms of cessation of symptoms, and consequently no further need for hospitalisations (Ahern & Fisher 2001).

Mental illness, as viewed within the constructs of the medical model, is the same as physical illnesses (Ahern & Fisher 2001). This model of care and treatment maintains a narrow focus on the reduction of symptoms; focusing interventions for people

experiencing a mental illness based on their incapacity and deficiencies (Swarbrick 2006). Within the clinical conceptualisation of recovery there is a preoccupation with symptomology, and Munetz and Frese (2001, p. 36) argue that the medical model is viewed ‘as stamping out hope by implying that biology is destiny and as emphasizing an external locus of control’. Therefore the traditional clinical view of recovery, dominant within the general healthcare system, is not conducive to instilling hope. Furthermore, the legacy of chronicity in mental illness can reinforce dependency, as people living with mental illness can be viewed as powerless against a fate that is inherent within the illness itself (Braslow 2013).

Slade (2009a) maintains that the clinical meaning of recovery has four main elements:

1. Clinical recovery is an outcome or a state, which is generally dichotomous.
2. It is observable and is objective, not subjective.
3. Clinical recovery is rated by the expert clinician and not by the consumer.
4. Recovery is invariant across individuals.

(Slade 2009a, p. 35)

Paley (2002) contends that, as the medical model was driven by Cartesian dualism, it therefore perpetuates ignoring the mind. Cartesian dualism is credited to the French philosopher Rene Descartes (1596-1650) who proposed that the mind and body were two distinct entities. At that time in history this dualistic stance was greatly needed as the prevailing religious views of the mind-body relationship were impeding the progress of medical science, and dualism facilitated demythologising the body. Descartes’ philosophy, and the view that science was the legitimate path to knowledge,

was strengthened by the success that occurred in scientific method. It is argued that mind-body-dualism determined the biomedical model, which viewed people as biological organisms, and attributed disease to a physical or chemical occurrence requiring physical or chemical intervention to correct the deviation from biological norms. Consequently, definition of health and what it means to be healthy became understood as the absence of disease (Mehta 2011).

Duncan (2000) argues that scepticism can exist regarding explanations for illness that are not biological in nature, because they can be viewed by people as unscientific and illegitimate. Cartesian dualism continues to be prevalent in the field of health care today as medical knowledge that has developed over the last three centuries has been built on the biomedical model (Mehta 2011). However, and significant in mental health care, Cartesian dualism disregards the complex relationship that people have with their environment. Within the mental health field this results in people continuing to be removed from their context, and placed into defined categories of mental illness (Pretorius & Segal 2000).

The two major nosological systems that are used to classify a mental illness are the World Health Organization's (WHO) International Classification of Diseases (ICD) and the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) (Rajiv 2010). The ICD is a clinical diagnostic tool; however it is said to also serve an important global epidemiological function and to monitor the incidence and prevalence of diseases and health problems. The ICD is a dynamic document, continually under revision. The current version of the ICD is the ICD 10, with ICD 11 due to be released by 2017 (WHO 2015). Similar to the ICD, the

DSM is also regularly revised. The APA replaced the DSM IV-TR and released the fifth edition of the DSM, the DSM-5, in May 2013. It acknowledged the collaborative contribution of health care professionals, patients and their families as well as the general public (APA 2014). There is a large discourse surrounding the DSM. Summerfield (2002, p. 915), contends that the diagnostic classifications are not value-free and argues that ‘What comes to be presented as psychiatric knowledge is as much constructed as discovered’.

Furthermore, Lovell (2010) suggests that the validity of the diagnoses contained within the ICD and DSM would be improved through the incorporation of the subjective experiences of those who are living with mental illness.

Within the medical model a hierarchy exists in which the clinician is positioned as the expert and the consumer takes the role of passive recipient of treatment (Andresen, Caputi & Oades 2013; Chamberlain 2005; Hensley 2012; Mizrahi, Humphreys & Torres 2009; Walker 2006). This hierarchical relationship is strengthened linguistically, because the discourse used in this model perpetuates the view that a consumer has a pathology requiring expert treatment and interventions by the clinician to facilitate returning the consumer to a state that is considered “normal” (Walker 2006). Even today, language like “case manager” is used with people who live with a mental illness. As argued by Our Consumer Place, an Australian consumer resource centre run by consumers in Melbourne Victoria, a common statement articulated by consumers is that ‘I’m not a case and I don’t want to be managed!’ (Our Consumer Place 2013, p. 49). The overarching aim of any health care professional or health care organisation is to help people to recover; however there is incongruity between the

meanings of recovery within the healthcare sector. As a result, a person's recovery can mean two very different things depending on whether one views mental illness through a clinical/medical lens or from the unique personal view of the mental health consumer, that is the person with lived-experience. As a consequence of the differences in the concepts and language that are acknowledged and established within the two contrasting understandings of recovery, there exists an inevitable tension (Roberts & Wolfson 2004). The disparity in language and values of the two perspectives (Roberts & Wolfson 2004, p. 40) is presented in Table 1:

Table 1: Differences in the concepts, language and values within the recovery and the medical models

Recovery-oriented model	Medical model
Distressing experience	Psychopathology
Biography	Pathography
Interest centred on the person	Interest centred on the disorder
Pro-health	Anti-disease
Strengths-based	Treatment-based
Experts by experience	Doctors and patients
Personal meaning	Diagnosis
Understanding	Recognition
Value-centred	(Apparently) value-free
Humanistic	Scientific
Growth and discovery	Treatment
Choice	Compliance
Modelled on heroes	Underpinned by meta-analysis
Guiding narratives	Randomised controlled trials
Transformation	Return to normal
Self-management	Expert care coordinators
Self-control	Bringing under control
Personal responsibility	Professional accountability
Within a social context	Decontextualised

Munetz and Frese (2001) contend that the medical model can be viewed as paternalistic, emphasising a person's limitations rather than focusing on their potential for growth. The emergence of personal recovery and contemporary recovery approaches have facilitated an alternative for consumers that changes the focus from the dependence and deficits embedded in the clinical model, to embracing self-determination and empowerment (Australian Health Ministers Advisory Council 2013b). There is no test that is able to demonstrate that mental illness exists, and the primary basis for the diagnosis of mental illnesses is the individual's self-report which is given to a clinician to make the determination. Given the subjectivity of the phenomenon, mental illness is thought of as an experience, and so understanding mental illness should always emphasise the subjective experience of the person living with mental illness (Slade 2009a).

In contrast, personal recovery is very different to clinical recovery. This definition of recovery as it is lived and affirmed by people with lived-experience of mental illness, and as understood and practised in contemporary mental health care, will now be discussed.

Personal Recovery

In the 1990s the concept of recovery was being explored, and research on recovery was proliferating. Turner (2002, p. 29) over a decade ago suggested that 'people are being introduced to a word, an idea, a set of values, a philosophy for life, a political stance and a doctrine for change'.

Within the literature, definitions began to emerge as researchers attempted to define what recovery was and what it meant for those with lived-experience. Anthony (1993, p. 18) argued that ‘The vagaries of recovery make it a mysterious process, a mostly subjective process begging to be attended to and understood’.

With the emergence of the concept of personal recovery and its growing integration into policy and practice, the shadow of the dominant and generally accepted medical meaning of recovery has continued to contribute to the confusion regarding the understanding of this contrasting subjective meaning. Furthermore, there is linguistic confusion because the clinical understanding of the word ‘recovery’ was also already established in everyday discourse (Braslow 2013), and continues to be linked to the word ‘cure’ (Davidson 2005; Roberts & Wolfson 2004), or ‘a return to a state of wellness’ (Rickwood 2004, p.1). As stated in the Merriam-Webster Dictionary (2013) recovery is:

- the act or process of becoming healthy after an illness or injury : the act or process of recovering
- the act or process of returning to a normal state after a period of difficulty
- the return of something that has been lost, stolen, etc

Personal recovery is not about cure nor is it a return to a pre-illness state, and it is certainly much more than just the management of symptoms. Recovery is a process that is a holistic, deeply personal and individual experience of engaging in a meaningful life. Patricia Deegan (1997, p. 20) illustrates this when she says ‘One of the biggest things I have had to accept is that recovery is not the same thing as being

cured'. Deegan articulates an understanding of recovery that incorporates facing the challenges of living everyday with a mental illness, which may involve the presence or absence of symptoms, and viewing recovery as a journey and not as a destination or a cure.

Recovery narratives are a valuable resource and they challenge the master narrative of decline and chronicity (Ridgway 2001). The analysis of consumer narratives has elucidated many common recovery themes. An examination by Ridgway (2001) of four early consumer narratives, Deegan 1988, Leete 1989, Lovejoy 1982 and Unzicker 1989, reveals eight general themes, which are outlined in Table 2 (Ridgway 2001, pp 337-339).

Table 2: Recovery themes in consumer narratives

Consumers understanding of recovery
The reawakening of hope after despair
Breaking through denial and achieving understanding and acceptance
Moving from withdrawal to engagement and active participation
Active coping rather than passive adjustment
Means no longer viewing oneself primarily as a person with a psychiatric disorder and reclaiming a positive sense of self
Moving from alienation to a sense of meaning and purpose
A complex and non linear journey
Not accomplished alone- the journey involves support and partnership

The definition of recovery is as diverse as consumer experience. There is no concise universally shared definition of recovery, or unequivocal consensus on what the term 'recovery' means (Aston & Coffey 2012; Bellack 2006; Bonney & Stickley 2008; Cleary et al. 2013; Davidson & Roe 2007; Farkas 2007; Kogstad, Ekeland & Hummelvoll 2011; Onken et al. 2007; Slade, Adams & O'Hagan 2012). Moller and McLoughlin (2013) contend that the concept of recovery is undergoing constant development and the shaping of the definition of recovery is continually evolving. However, within the recovery literature and in mental health policy, a widely cited definition of recovery is by Anthony (1993, p. 15) who suggests that recovery is:

...a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.

Recovery is a unique and personal journey for every individual, with the meaning of recovery being idiosyncratic (Aston & Coffey 2012). Despite this, there are common elements that consumers identify as integral to their recovery journey (Glover 2012) and core personal and existential components of recovery agreed upon by many researchers (Kogstad, Ekeland & Hummelvoll 2011).

To examine the different ways in which recovery in mental health was conceptualised Bonney and Stickley (2008) conducted a review of the British literature. Three stakeholder groups contributed to the study; consumers, health care providers and policy makers. Six central themes were identified from the analysis of over 170 papers. The central themes were examined from the perspectives of the different stakeholder groups and, although there was a consensus that the provision of quality care promotes

recovery, defining recovery and how it should be delivered differed between the stakeholder groups. The six central themes are described as identity, service provision, the social domain, power and control, hope and optimism, and risk and responsibility. These are now summarised from the three stakeholder perspectives (Bonney & Stickley 2008, p.142-148) and presented in Table 3.

Table 3: Consumers, healthcare providers and policy makers' perspectives on recovery

	Consumers	Health care providers	Policy makers
Identity	Recovery involves redefining one's identity and is a transformative process of the reconstruction of one's sense of self	Recovery involves the reconstruction of a sense of self	Recovery involves people experiencing wellbeing, which can occur even during crisis
Service provision	Recovery is not about cure, or services emphasising maintenance and relapse prevention. Consumers are experts of their own experience and consumer led services are fundamental to facilitating recovery	Interventions to promote motivation and compliance and adherence to treatment	Efficacy and outcomes are becoming a priority. The ultimate objectives of services are improved outcomes or maintenance for service users
The social domain	Recovery involves participation as a valued member of society and living a meaningful life free from stigma and discrimination with equal access to opportunities	Becoming a valued member of society leading to reintegration and recovery and occupational identity	Social inclusion and citizenship. The importance of employment. People can experience well-being even within crisis

Power and control	Recovery involves empowerment and self-responsibility and consumers need to have choices and be involved in the planning and implementation of services.	The recovery journey is undertaken through empowerment, with a gradual transfer of responsibility; implementing a user-led perspective	Placing power with service users, some service users may not welcome the ‘colonization’ of recovery territory by health care professionals
Hope and Optimism	Hope and optimism for the future are integral a consumer’s recovery journey, and a necessary and vital aspect is that others hold hope too.	The restoration of hope and the belief in one’s ability to recover is thought to be instrumental to recovery	Focus away from symptoms and pathology, focus on strengths and uniqueness. Identifying unrealised potential and conveying hope and optimism
Risk and responsibility	The ability of the consumer to take risks can be a catalyst for change and preventing failures and risk-taking can be a barrier to recovery.	Assist a person to meet his or her needs to avoid fostering dependence; the importance of being enabled to take risks on the recovery journey	Anticipate, prevent crisis and reduce risks; mental health services should not focus too much on safety or social control

Leamy et al. (2011) completed a systematic review and narrative synthesis of the literature on personal recovery. Ninety-seven papers from thirteen different countries including Australia and the United States were reviewed. The dominance of literature on recovery that originated from the United States was emphasised. The review identified five prevailing recovery processes (Leamy et al. 2011, p. 448). These are presented in Table 4:

Table 4: Recovery processes

Recovery Processes
<ul style="list-style-type: none">• Connectedness• Hope and optimism about the future• Identity• Meaning in life• Empowerment

The process of ‘Connectedness’ involves consumers being part of a community, having relationships and being supported by other people. ‘Hope and optimism’ encompass the consumer’s belief that recovery and having dreams and aspirations like everyone else are possible. ‘Identity’ includes developing a positive sense of identity and overcoming stigma. ‘Meaning in life’ includes quality of life and consumers having purpose and goals in life, and the process of ‘Empowerment’ enables consumers to take control of their lives, focusing on their strengths (Leamy et al. 2011).

In addition, Leamy et al. (2011) described thirteen characteristics that captured the complexity of recovery and were identified as being integral to a consumer’s recovery journey. The characteristics illustrate that recovery is an individual, multidimensional

and ongoing process that has no set time-frame. Each person's recovery is unique. The fundamental characteristics of recovery (Leamy et al. 2011, p. 448) are presented in Table 5:

Table 5: Characteristics of the recovery journey

Characteristics of recovery
<ul style="list-style-type: none"> • Recovery is an active process • Individual and unique process • Non-linear process • Recovery as a journey • Recovery as stages or phases • Recovery as a struggle • Multidimensional process • Recovery is a gradual process • Recovery as a life-changing experience • Recovery without cure • Recovery is aided by supportive and healing environment • Recovery can occur without professional intervention • Trial and error process

Andresen, Oades and Caputi (2003) propose that there are four psychological processes reported by people with lived-experience, and by examining their personal narratives the authors identified these as being 1: finding hope 2: re-establishment of identity 3: finding meaning in life and 4: taking responsibility for life and wellbeing. In addition, a model of recovery was put forward encompassing five stages of recovery, and it is suggested that this model validates the lived-experience of consumers, and also provides a means for both consumers and healthcare workers to understand the process of recovery. The five stages of recovery (Andresen, Oades & Caputi 2003, p. 591) are outlined in Table 6:

Table 6: Stages of recovery

Stages of recovery	
STAGE ONE: Moratorium	A stage of hopelessness, despair and self-protective withdrawal.
STAGE TWO: Awareness	The realisation that recovery is possible
STAGE THREE: Preparation	Being aware of strengths and also limitations and developing recovery skills
STAGE FOUR: Rebuilding	Focusing on taking control of one's life and establishing goals which are meaningful to the individual.
STAGE FIVE: Growth	Having the sense of control, being future-focused and living a meaningful life

Glover (2012) also suggests a five-stage model of the recovery processes that people go through on their recovery journey. As with other models, this one also emphasises the consumer's personal control. The five stages are described as: passive to active sense of self; hopelessness and despair to hope; others' control to personal control and responsibility; alienation to discovery; and disconnectedness to connectedness.

Ralph (2000) argues that recovery is comprised of dimensions that are related to internal and external factors. Internal factors are described as those which are found within the consumers themselves, and external factors relate to the support and interconnectedness with others. There is a complex and dynamic relationship between the characteristics of the individual and the environment, and this interconnection is said to facilitate recovery; however, it may also inhibit the process of recovery (Kerr, Crowe & Oades 2013; Onken et al. 2007). Recovery does not occur in a vacuum and is not an individual solitary process, but rather a process that is impacted by supportive environments (Onken et al. 2007). Furthermore, Jacobson and Greenley (2001) describe the internal and external conditions of the recovery process as reciprocal conditions. Central to the internal conditions, such as experiences and attitudes, are key elements that include hope and empowerment. Within the external conditions that may facilitate the recovery process, the key elements include a positive culture of healing, and services that are recovery oriented. Onken et al. (2007) suggest that recovery be viewed within an ecological framework incorporating both the individual's life context and the environment. Therefore all elements of recovery involve the dynamic interaction between the two.

Mancini (2008) put forward another perspective on the common themes identified within the literature. He argues that the broad set of recovery themes, which are presented in Table 7, are conducive to facilitating recovery and incorporate both internal and external conditions.

Table 7: Recovery themes

Recovery Themes
<ul style="list-style-type: none"> • Identity formation: mental illness is one facet of a more differentiated self • Autonomy/self-agency: greater capacity for self-initiated action • Hope: renewed sense of possibility • Supportive, healing relationships: professional and personal • Enhanced role functioning: employment, parenthood, etc

A longitudinal study by Spaniol et al. (2002) investigated the experiences of recovery of twelve people living with mental illness. Findings of this research suggest that there are three phases that people progress through on their recovery journey. The first phase is defined as the person being overwhelmed by the disability. It is during this stage that the person tries to understand what is happening to them and experiences feelings of confusion, disconnection and powerlessness. The second phase is defined as the person struggling with the disability, and involves the development of an explanation of the illness and coping strategies. However the reality of the illness remains and there

is the subsequent fear of failure. The third phase is described as living with the disability, and in this phase mental illness is viewed as a smaller part of the person's life as they experience a sense of purpose and become able to maintain meaningful and contributing lives.

The literature reveals a multitude of definitions, principles, processes and characteristics of the recovery journey; however, commonalities are evident and the key themes that are identified as being integral to recovery and are prominent within recovery discussion and policy will be now be elucidated.

Elements of Personal Recovery

Hope

Hope is a prominent theme throughout the literature. It is argued that it is the most powerful element in the concept of recovery (Turner-Crowson & Wallcraft 2002). As articulated by Deegan (1988, p. 14) recovery starts as: 'a tiny fragile spark of hope'. A consumer's individual and unique recovery journey will encounter many challenges and believing in one's self and facing challenges, both internal and external, with hope and optimism is vital to the recovery process. Hope is described as the catalyst of the recovery process (Andresen, Oades & Caputi 2003; Substance Abuse and Mental Health Services Administration 2013), and 'when one lives without hope, (when one has given up) the willingness to "do" is paralysed as well' (Deegan 1988, p. 13). Attitudinal factors that are posited as being integral to actuating hope are described as the ability of the consumer to focus on their strengths rather than on their weaknesses,

and to focus on looking forward and celebrating the small steps that are made, rather than ruminating on the past (Jacobson & Greenley 2001).

Recovery does not occur in isolation and many people are involved in a consumer's recovery journey, therefore it is equally important for family and friends to have hope for the consumer. Furthermore, it is essential that services provided to the consumer are done in a collaborative environment of hope and optimism (Lester & Gask 2006). Integral to facilitating this is the use of language that promotes hope and optimism (Australian Health Ministers Advisory Council 2013a).

To facilitate maintaining the recovery process, hope and belief in one's self is essential (Andresen, Oades & Caputi 2003). Leete (1988, p. 52) suggests:

Having some hope is crucial to recovery; none of us would strive if we believed it a futile effort... I believe that if we confront our illnesses with courage and struggle with our symptoms persistently, we can overcome our handicaps to live independently, learn skills, and contribute to society, the society that has traditionally abandoned us.

Connectedness

Slade et al. (2012) maintain that within the recovery process connectedness incorporates not only an individual's connection to other people, but also their connections to the community and society. Recovery is a social process (Jacobson & Greenley 2001) and it involves social inclusion and the ability of the consumers to engage in roles in society that they find meaningful. Onken et al. (2007, p. 10) state that:

Recovery is multidimensional, fluid, nonsequential, complex, and permeates the life context of the individual with some elements linked primarily to the individual and others that are more deeply fused with the role of the community to provide resources and opportunities to individuals as they embark on a recovered journey.

A significant and powerful form of connection that has been identified by consumers is the engagement with, and support of, other consumers who are living with mental illness (Happell 2008; Jacobson & Greenley 2001). Peer support can provide a sense of belonging and connectedness (Substance Abuse and Mental Health Services Administration 2013), and sharing experiential knowledge is a valuable resource. Those with lived-experience are the ‘authentic voice of recovery knowledge’ (Glover 2005, p. 180).

People with lived-experience who are living well in the community can act as positive role models and provide hope for consumers who are accessing mental health services. Because of their experience of living with a mental illness, peer consumers are considered credible, and are in a unique position to provide support and develop empathetic relationships with others on their recovery journey (Glover 2005). An important aspect of the relationship with others with lived-experience is that the support given focuses on the person as an individual, rather than on capabilities and categories, and that it is free from hierarchical roles (Mead & Copeland 2000). Furthermore, immense hope can be fostered through contact with other people who may be at a point further along on their journey of recovery. Lawn, Smith and Hunter (2008) argue that peer workers “walking with the person” are the vehicles by which recovery focused services can be achieved.

Empowerment

Jacobson and Greenley (2001, p. 252) posit that ‘recovery is not about accepting and accommodating to the “objective reality” of disease; rather, it is a process of claiming the power to create one’s own reality’. In addition, empowerment helps to correct the learned helplessness that many consumers experience due to their long-term reliance on, and interaction with, the mental health care system.

Empowerment is described as having three integral components; autonomy, courage and responsibility. Firstly, autonomy can be achieved through the provision of meaningful choices to the consumer, and also through the consumer’s acquisition of knowledge and self-confidence. Secondly, courage requires the consumer to be able to speak for themselves and to be willing to take risks on their recovery journey. Finally, responsibility incorporates the consumer’s obligations, and taking responsibility is a fundamental aspect of engaging actively in one’s own recovery (Ellis & King 2003; Happell 2008).

Self-determination is an essential tenet in recovery, and people have the right to be involved in the provision of mental health care that supports their recovery journey. The World Health Organization (1978) maintains this position in the Declaration of Alma Ata (1978) which is the declaration from the International Conference on Primary Health Care expressing the need for urgent national and international action to promote the health of all. The declaration advocates the promotion of self-reliance and participation and collaboration in the planning and implementation of healthcare.

The recovery process involves active participation. Mead and Copeland (2000, p. 318)

maintain that:

It's up to each individual to take responsibility for his or her own wellness. There is no one else who can do this for us. When our perspective changes from reaching out to be saved to working to heal ourselves and our relationships, the pace of our recovery increases dramatically.

However, participation not only involves collaboration in the planning and implementation of services for consumers, it also requires that resources and information are available to the consumer to enable the development of the skills necessary to facilitate effective interactions with service providers (Queensland Health 2005).

Active sense of self

Identity is defined as 'those persistent characteristics which make us unique and by which we are connected to the rest of the world' (Slade 2009a, p. 82). Living with a mental illness often results in an individual's sense of self being altered and a consequence can be that a loss of identity is experienced. An important aspect of their recovery journey then, involves the quest for a stable sense of self (Young & Ensing 1999). The individual engages in a transformative process of reconstructing a sense of self, and Jacobson and Greenley (2001) argue that redefining one's self necessitates the individual viewing their mental illness as only one facet of their total multi-dimensional identity.

The reconstruction of an individual's identity enables them to redefine themselves as someone striving to achieve goals and to live a meaningful life, rather than being

defined as a person who is living with a mental illness (Kerr, Crowe & Oades 2013). Slade (2009b) identifies perspectives of identity that combine to make an individual unique and connect them to the world. First, he identifies personal identity which involves a person's preferences and aspirations; second, social identity is identified and is described as encompassing membership within groups; third is the existence of recognisable characteristics that are individual to the person. Furthermore, Slade (2009b, 368) proposes a personal recovery framework consisting of four tasks by which the individual experiences recovery. The tasks are outlined as: the development of a positive identity; developing a personally satisfactory meaning; taking personal responsibility; and the individual being involved in acquiring valued societal roles.

People with lived-experience of mental illness have spoken of the profound impact that hopelessness and the loss of sense of self can have on their lives, and have described it as being more painful than the symptoms of the mental illness (Bellack 2006). This profound sense of loss that people feel is illustrated in a poem by Sandy Jeffs, an award winning poet and consumer advocate, who has lived with schizophrenia for over thirty years. The following poem entitled the 'Razor's Edge', gives readers privileged insight into the experience of loss of self when living with a mental illness.

The Razor's Edge

*Living on the razor's edge is a desperate struggle
to balance the hopeless and the ecstatic;
to separate the real from the imaginary;
to vanquish the ghosts; to establish a clear mind where
stability resolves all the quandaries
of a double-edged life.*

*But acid thoughts reveal the turmoil of
my mind in a state of agony,
and the task to liberate myself
from the bewilderment before me is awesome.*

*A fragile entity; my mind moves
in waves of thought upon confused thought,
and is driven by the ghosts which crush the self.*

*My soul teeters before the dark door -
its barriers assailed
by a myriad hostile spectres.*

*This agony consumes the life forces
and the once calm waters become
squalls and tempests that devastate
all in their wake, leaving no one unscathed.*

*And sinking into the turbulent waters,
I am drowning in a sea of madness,
lashed to the mast of the Sinking Ship of Fools.*

Jeffs (2003, p. 59)

A four part qualitative study undertaken by Tooth et al. (2003) in Australia examined consumers' perspectives on recovery. The fifty-seven participants identified

themselves as in recovery. Thematic analysis revealed an active sense of self as the theme that was the most frequently reported as being important in their recovery journey. As asserted by Slade (2009a), the multiplicity of opinions and perspectives about recovery and what actually defines recovery are wide-ranging. This leads to the acknowledgement that there is no “right way to recover” and adds weight to the notion that recovery is as individual as the myriad of people on the journey. Recovery intrinsically belongs to the individual and is a unique and personal journey. As such there can be no definitive set of processes or elements that a person living with mental illness must achieve or experience to validate their recovery journey. Recovery involves having a sense of autonomy, living a fulfilling life, having dreams and aspirations, and being a citizen in a community of one’s choice.

‘Recovery’ is an idea whose time has come. At its heart is a set of values about a person’s right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms. Recovery is based on ideas of self-determination and self-management. It emphasises the importance of ‘hope’ in sustaining motivation and supporting expectations of an individually fulfilled life. (Shepherd, Boardman & Slade 2008, p. 1)

The literature identifies many common facets of recovery and prevailing processes instrumental in facilitating recovery. However, there are many barriers and challenges to recovery. These will now be discussed.

Barriers to Recovery

Australian recovery literature outlines that there are many barriers that impede a consumers recovery., This literature includes national and state and territory strategies, plans, policies and documents such as the Fourth National Mental Health Plan 2009-2014 (Australian Health Ministers 2009a); the Roadmap for Mental Health Reform 2012-2022 (Council of Australian Governments 2012) and the National Framework

for Recovery-Oriented Mental Health Services (Australian Health Ministers Advisory Council 2013b). The barriers are said to occur at an individual, clinical or systemic level. Spaniol et al. (2002) maintain there are three factors influencing the degree to which an individual experiences a challenge to their recovery. These challenges are - the environmental context, the age of the individual at the time of the onset of their mental illness, and the presence of comorbid substance abuse.

Furthermore, it is argued that barriers may be internal or external. Townsend and Glasser (2003) discussed the recovery process and offered suggestions on how healthcare professionals and the healthcare system can support recovery. They contend that internal barriers including the fear of failure, internalised discriminatory attitudes and a person's feelings of helplessness, together with external barriers such as the consumer's loss of family or friends, loss of a job and societal stigma, can combine to limit a person's recovery.

Stigma and discrimination are pervasive barriers to a consumer's recovery (Moxham, Robson & Pegg 2012). Shera and Ramon (2013) describe the comparative policy work that they have undertaken since 2002 on mental health reform. The three-stage comparative analysis included Australia, Canada, England, Israel and Ireland. It examined the development of mental health reform, the implementation of the recovery concept in the provision of mental health services, and the progress in recovery-oriented reform and the identification of challenges to implementing reform. Stigma was identified as a challenge to the implementation of recovery-oriented reform, with Shera and Ramon (2013) reminding us that stigma, both societal and professional, is one of the most powerful barriers to achieving recovery. Furthermore,

many people living with a mental illness are not only subjected to the experience of stigma, but they also, can experience the anticipation of stigma and discrimination (Slade 2009a). Gray (2002) maintains that stigma can be described as felt or enacted. Felt stigma refers to the consumer's expectation of stigma and discrimination; it is internalised self-stigmatisation and can result in consumers declining to seek help due to the perceived shame. Enacted stigma refers to the experience of discrimination by others and is characterised as external stigma. Stigma can lead to isolation and consumers may utilise information management in order to minimise social exclusion.

A fundamental component of the recovery process is social inclusion. As alluded to above, as a result of stigmatisation people can experience social rejection. Vanderplasschen et al. (2013) maintain that stigma associated with mental illness is typified by inaccurate attributions and lack of knowledge. Gray (2002) maintains that stereotypes are not intrinsically unacceptable as they are a way of people structuring knowledge, however they do become objectionable when negative stereotypes are acted upon in a discriminatory manner, such as excluding members of society.

It is not only stigmatisation from others that is a problem for people who live with mental illness. Disempowered consumers may feel that they have to accept and conform to the image of incapacity that is perpetuated in society (Warner 2009). Deegan (1993, p. 9) maintains that there is an inherent danger in labelling a person as an illness because: 'once a person comes to believe he or she is an illness, there is no one left inside to take a stand toward the illness'. To support recovery, diagnostic practice must be considered within the context of consumers' lives and viewed as a

way that consumers can understand their present experiences, but with the knowledge that things can change (Recovery Devon n.d.).

Stigma is not the only barrier. Coercive practices also contribute to compromised recovery. Mancini, Hardiman and Lawson (2005) argue that coercion, which they describe as treatment forced upon individuals in outpatient or inpatient environments, is a factor that hinders recovery. Gilburt et al. (2013) maintain there is a tension, in that mental health service providers face the challenge of facilitating choice and self-determination, but have to balance this against society's expectations of the mental health care system. Recovery principles outline that health professionals engage in open and transparent discussion regarding legal responsibilities, and that they recognise that involuntary interventions, which many consumers argue are coercive, but which are often argued as necessary by health professionals, conflict with the self-determined choice of the consumer (Australian Health Ministers Advisory Council 2013a).

Within mental health care provision a significant barrier to recovery is the existing philosophical tension between the clinical/medical model and the recovery-orientation (Buchanan-Barker & Barker 2008; Roberts & Wolfson 2004). Within the objectivist medical model there exists a paternalistic and hierarchical approach to the provision of care (Munetz & Frese 2001; Walker 2006). Contributing to this is the language and terminology that supports paternalistic roles; it is pathologising and focuses on deficits (Walker 2006). There remain continuing consequences of the legacy of chronicity in mental illness (Braslow 2013).

Within the clinical environment another powerful barrier to recovery is the attitudes of health care workers (Mancini, Hardiman & Lawson 2005). The continual belief in chronicity (Xie 2013) which is bound to the clinical/medical model, as well as the conceptual association between mental illness and a life-course of negative outcomes, conflicts with the concept of personal recovery. The corollary is the perpetuation of stigma (Rickwood 2004).

In the United States of America Mancini, Hardiman and Lawson (2005) conducted a qualitative study to explore the recovery experiences of consumer-providers involved in the provision of services to other consumers. The aim of the research was to identify what factors facilitate and hinder the recovery process. Barriers that were identified as a result of the research included paternalism, coercion, indifferent and judgemental professionals, medication side-effects and psychiatric symptoms. Furthermore, the researcher's findings reveal that all participants in the study experienced stigmatising messages from health care professionals, reinforcing the idea that they were chronically dysfunctional with no hope of living fulfilling and meaningful lives in society.

The language used by health care professionals is a powerful tool that can either nurture and promote recovery, or perpetuate distress and stigma (Ashcraft & Anthony 2006). The significance of optimistic language in supporting recovery is outlined in the domains and capabilities of recovery-oriented practice and service delivery in the National Framework for Recovery-oriented Mental Health Services. Specifically, Domain 1 is titled 'Promoting a culture and language of hope and optimism'. This domain endorses:

A service culture and language that makes a person feel valued, important, welcome and safe, communicates positive expectations and promotes hope and optimism—this is central to recovery-oriented practice and service delivery. (Australian Health Ministers Advisory Council 2013a, p. 28)

Despite ongoing challenges, there have been significant changes with the language used in the mental health field (Australian Health Ministers Advisory Council 2013a). Walker (2006) contends that being labelled ‘insane’ or a ‘lunatic’ historically indicated the need to be incarcerated in a mental institution, then called an asylum, most of which were located out of town and surrounded by large walls and locked doors. In itself the geographical location and imposing architecture perpetuated certain perceptions and myths. However, contemporary changes in the provision of mental health care heralded the introduction of more appropriate language. Nevertheless, the continued use of words such as “treatment plan”, “assessment” and “case management”, serves to reinforce the paternalistic health care professional /consumer relationship and perspectives that are deficit-based and pathologising (Ashcraft & Anthony 2006; Walker 2006).

Language is indeed an integral element in facilitating recovery (Ashcraft & Anthony 2006). Unfortunately within healthcare services language that hinders recovery remains widely used (Walker 2006). Ashcraft and Anthony (2006, p. 12) describe common words and phrases that are used within healthcare services, some of which have already been identified above and are detrimental to facilitating recovery. Instead, the authors provide a recovery-focused alternative. This comparison is offered in Table 8 and illustrates how language can portray an image that is negative or positive.

Table 8: Language that hinders recovery and recovery focused alternatives

Language that hinders recovery	Language that promotes recovery
You're just	You are more than
Decompensating	Not him/herself today; he/she is experiencing symptoms
Manipulative	Resourceful; really trying to get help
Crazy	Unique
Compliant	Might not be confident enough about personal choices or decisions; afraid
Noncompliant	Beginning to think for him/herself; taking responsibility
Entitled	Aware of rights
Resistant	Not open to; chooses not to; has own ideas
Frequent flyer	Gives us many opportunities to intervene and support
Baseline	What a person looks like when doing well
Unmotivated	Has other interests; bored; doesn't know how to begin
Helpless	Unaware of capabilities
Hopeless	Unaware of opportunities
Grandiose	Has high hope and expectations of self
User of the system	Resourceful; good self-advocate
Druggie; crackhead; junkie	Person with an addiction or diagnosis of substance abuse
High-functioning, low-functioning, dangerous to others/dangerous to self (DTO/DTS)	Person is showing these issues or characteristics

Recovery as an outcome versus recovery as a process

Throughout the literature, recovery has largely been positioned as a process – “recovery in”, or as an outcome – “recovery from”. This dichotomy has resulted from the two major influences on the development of the recovery vision that have been alluded to previously; longitudinal research studies and the consumer/survivor movement (Davidson & Roe 2007; Gordon 2013). Debate continues, and probably will for some time given its uniqueness and personalised nature, as to the appropriateness of viewing recovery as a process or as an outcome (Rodgers et al. 2007). Rather than dichotomise recovery, some authors position it as both a process and an outcome (Lieberman & Kopelowicz 2005).

Ralph (2005) contends that they are part of the same continuum. Davidson and Roe (2007), maintain that between these two conceptions of recovery there exists fluidity and it is possible that co-existence can occur within an individual. This argument is reinforced by Lieberman and Kopelowicz (2005) who contend that it is difficult and not advantageous to delineate between the objective and subjective components of recovery that are in dynamic interplay.

Recovery as an outcome

The findings from longitudinal studies such as the ten year follow-up of six thousand, eight hundred and sixty five consumers with schizophrenia in Israel 1978-1986 (Rabinowitz et al. 2007), and a fifteen year multi-follow-up study of two hundred and seventy-four consumers in Chicago, United States of America (Harrow et al. 2005),

explicated better outcomes for people experiencing mental illness than was previously thought possible. This view of recovery, which encompasses outcome criteria, is grounded in objective measures rooted in the clinical/medical understanding of what constitutes an individual's health or illness (Callard 2012). The clinical and scientific conceptualisation of recovery, which generally views recovery as an outcome, is characterised by an end point (Bellack 2006). As asserted by Corrigan and Ralph (2005), this end point equates with "normalacy". However, Deegan (1996, p. 92) states that 'The role of recovery is not to become normal. The goal is to embrace our human vocation of becoming more deeply, more fully human'.

The clinical understanding of recovery is peppered with entrenched assumptions regarding what constitutes normality, but such assumptions are challenged by consumers (Slade et al. 2012). Furthermore, this conceptualisation of recovery leaves unanswered many questions about the accepted criteria for establishing when a consumer is engaged in 'normal living' (Corrigan & Ralph 2005). When recovery is thought of as an outcome, questions are raised, and Corrigan and Ralph (2005, p. 5) posit 'How many goals must be achieved to be considered recovered? For that matter, how much life success is considered 'normal'?'

Within the literature the concept of recovery by consumers who are experiencing schizophrenia has been extensively researched and, as discussed above, many operational definitions of recovery have been put forward that attempt to quantify what constitutes achieving recovery. But, Liberman and Kopelowicz (2002, p. 245), argue that the:

Promotion of recovery must go beyond the hype, vague ‘vision’ and glittering generalities that have all too often accompanied this topic and move into the realm of empirically supported validation of an operationally defined concept of recovery.

A number of authors call for a redefining of what it means to “be well”. Harrow et al. (2005) posit a criterion that consists of the absence for a period of one year of major positive symptoms (eg: hallucinations, delusions, thought disorder) and negative symptoms (eg: amotivation, inability to experience pleasure, poverty of speech). Torgalsbøen and Rund (2002) describe an operational definition that includes a diagnosis of schizophrenia that is not currently present, and the consumer having had no admissions to hospital for at least a five-year period. Liberman et al. (2002) propose a definition that includes two years of continued remission of symptoms, full or part-time engagement in activities such as work, volunteering or study, living independently without requiring the supervision of family or caregivers and engaging in social activities and friendships. Furthermore, Liberman (2012) argues that to address the prevailing stigma associated with mental illness, recovery must be defined by symptomatic and functional improvements, and that in order to promote and sustain the ability to live independently, consumers need not only psychosocial supports but also maintenance medication.

Crawford et al. (2011) suggest that focusing on evidence that can be observed or measured as outcomes may overlook the fact that recovery is not the aggregate of specific experiences or skills demonstrated by the consumer. Furthermore, Bellack (2006) contends that operational criteria overlook the subjective views of people living with mental illness, and do not take into account their personal appraisal of functioning nor how satisfied they are with life. Clinical measures do not assess what consumers

define as aspects that are important to personal recovery; however, it is argued that objective clinical measures can be augmented by subjective consumer-defined recovery measures (Andresen, Caputi & Oades 2010).

Lieberman and Kopelowicz (2002) maintain that the elements considered by consumers as integral to recovery, such as hope, can be considered as a motivational way-station on the journey to reaching the outcomes that they are striving to achieve. An Australian qualitative exploratory study by Happell (2008) conducted focus groups with sixteen consumers to explore consumers' perspectives on mental health service delivery. Happell concluded that there are limitations to using simple objective instruments to measure the complex phenomena of recovery. As a result of the research, Happell argued that it is imperative that outcome measures be developed in collaboration with consumers.

Sklar et al. (2013) conducted a systematic review of instruments of mental health recovery, and declare that using recovery-oriented recovery measures is a necessary step towards the evaluation and improvement of recovery-focused systems of care. The results of the review, which analysed two hundred and seventy eight papers, identified thirteen quantitative instruments published within the scientific literature that were consistent with a consumer-defined philosophy of recovery. These instruments comprised assessments of recovery processes/stages, recovery outcomes and recovery dimensions. One of these instruments is offered as an example and can be located in Appendix 1.

Recovery as a process

In contrast to recovery as an outcome, recovery is also viewed as a process (Kelly & Gamble 2005). Recovery as a process denotes a person as “being in recovery” and is not associated with measurable changes or achievement of a specified completion point. Instead, it focuses on concepts that indicate that a person is in recovery (Corrigan & Ralph 2005). People with lived-experience of mental illness view recovery as a process (Deegan 1988), and consider it to be a concept that is not based on pathology, functional disability and the amelioration of symptoms. These, they say, are simply manifestations of the mental illness. Furthermore, recovery as defined by measurable outcomes such as the symptoms that a person experiences and the frequency of their hospitalisations, conflicts with consumers’ understanding of recovery (Andresen, Caputi & Oades 2006). Deegan (1988, p. 14) argues that as a process, ‘Recovery does not refer to an end product or result’, and Torrey et al. (2005) maintain that defining recovery as an outcome can be disempowering for some individuals because it has the connotation of recovery success or no success.

Consumer definitions of recovery focus on recovery as a process that occurs in a non-linear fashion (Anthony 1993; Bellack 2006; Davidson et al. 2010; Deegan 1988; Farkas 2007). During this process the consumer may experience setbacks or relapses, and periods in which rapid change or minimal change can occur. Deegan (1988, p. 15) articulates this when she says:

...recovery is a process, a way of life, an attitude, and a way of approaching the day’s challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup, and start again.

O'Connor and Delaney (2007) state that recovery is a process and not an intervention, and although medication can be seen as being part of the recovery process, it is not considered as being at the centre of treatment. Furthermore, in regard to medication, recovery is understood by consumers as taking prescribed medication in conjunction with supports and services, and being actively involved in their medication treatment. Recovery, though, can also be understood as living without medication (Piat, Sabetti & Bloom 2009). Roberts and Wolfson (2004) posit that medication can be a tool used by people on their recovery journey and Happell (2008) maintains that consumers can view medication as an important part of their treatment, especially when health care professionals take into consideration the views and concerns of the consumer. Liersch-Sumskis (2013) in her doctoral phenomenological study which investigated the meaning of resilience for people who live with schizophrenia, identified the fact that consumers describe 'choosing' to use medication as part of their recovery.

Corrigan and Ralph (2005) claim that an evaluative element is suggested in recovery that is defined as an outcome. As such, this notion of recovery is viewed as unsatisfactory to many consumers due to the perception of external criteria being imposed on them. Rather, people experiencing a mental illness who are managing in their day to day lives and striving to achieve their goals, are considered to be 'in recovery' despite where they may "fit" in terms of operational outcome criteria (Corrigan & Ralph 2005). For consumers who are living with mental illness, improvements that they make when taking control of their own lives may not necessarily fit with indicators of recovery that are clinically defined (Shera & Ramon 2013). Furthermore, recovery is different for every person and it is not about setting a

“gold standard” that will enable people to be assessed on extent that they are recovering (Bradstreet 2004).

Mental Health Care in Australia

Recovery has become the guiding vision for mental health policy and services throughout the world (Mancini 2008; Slade, Amering & Oades 2010). Most developed countries have undergone phases of mental health system reform that have resulted in a transformation of the philosophy of how mental health services are planned and implemented (Adams, Daniels, & Compagni 2009). Slade et al. (2012) suggest that in most English speaking countries a recovery orientation is present in policy, however it only exists somewhat in German-speaking Europe and is not present in Asia, Africa and central and northern Europe.

The World Health Organization (WHO) (2013) affirms the notion of recovery in the Comprehensive Mental Health Action Plan 2013–2020. WHO describes mental health as:

...conceptualized as a state of well-being in which the individual realizes 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 community. (p. 6)

Furthermore, this global Action Plan outlines a shift from an exclusive medical model in order to achieve the vision of mental well-being through timely high-quality health and social care which promotes and enhances recovery.

The national mental health policies of seven countries, Australia, New Zealand, Canada, Italy, England, Scotland, and the United States were analysed by Adams, Daniels and Compagni (2009). Although they were all at different stages of reform,

with different strategies identified to facilitate the reform process, there was congruence in the common vision of incorporating the recovery paradigm. Within Australia, a recovery approach has been formally adopted into policy within national, state and territory governments, and a national framework for recovery-oriented services has recently been agreed upon by all governments throughout Australia (Australian Health Ministers Advisory Council 2013b).

Adams, Daniels and Compagni (2009) argue that New Zealand was the first country to articulate the word ‘recovery’ within their national policy documents. ‘Recovery’ appeared in the New Zealand Mental Health Commissions (MHC) Blueprint for Mental Health Services in 1998 (Mental Health Commission 1998), which emphasised the need for a recovery approach in the delivery of mental health services. The document states ‘that recovery is happening when people can live well in the presence or absence of their mental illness and the many losses that may come in its wake’ (Mental Health Commission 1998, p. 1).

The notion of recovery is now firmly embedded in mental health services and policy in Australia, and national policy documents have provided the framework for the development of a recovery orientation (Oades & Anderson 2012). The National Mental Health Strategy was endorsed by the Australian Health Ministers in 1992 and was the overarching policy framework to facilitate the national coordination of mental health reform.

Four major documents were integral to the implementation of the National Mental Health Strategy and included:

- The National Mental Health Policy 1992
- The Mental Health Statement of Rights and Responsibilities 1991
- The National Mental Health Plan 1992 and
- The Medicare Agreements (1993–1998)

The National Mental Health Policy 1992 communicated the aims for the reform in mental health in Australia. It outlined that the historical approach to the provision of mental health services was at times not conducive to achieving optimal outcomes and high standards of care for people experiencing mental illness. Throughout the 1970s and 1980s there were increasing public and professional criticisms regarding the provision of care for people who were experiencing mental illness. This criticism resulted in formal inquiries into the quality of mental health service delivery. Subsequently there were demands for a national coordination of mental health reform (Whiteford & Buckingham 2005).

In 1983 the Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled, also known as the Richmond Report, named after the author, was published. This report recommended that services should be funded and provided to consumers in their community environments and also recommended that the size and number of existing psychiatric hospitals be progressively reduced (New South Wales Department of Health 1983). However, as argued by Doessel, Williams and Whiteford (2009), deinstitutionalisation was already occurring in Australia prior to it being implemented as official policy as recommended in the Richmond Report.

Deinstitutionalisation involved processes that altered the location and style of treatment and care for people with mental illness and also changed the accessibility of mental health care services (Doessel, Williams & Whiteford 2009). It encompassed more than just the downsizing or closure of psychiatric hospitals, but also involved three elements: the release of people with mental illness from hospitals back into the community, their diversion from being admitted to hospital and the development of community mental health services (Lamb & Bachrach 2001).

An objective of the National Mental Health Policy 1992 was that mental health services would become part of the mainstream health system rather than being physically and organisationally separate. As outlined by Sharrock et al. (2008), mainstreaming refers to the co-location of mental health services into the general health care system thereby facilitating the integration. This policy therefore, endorsed the provision of acute mental health inpatient care within general hospitals (Australian Health Ministers 1992).

In 1993, the Report of the National Inquiry into the Human Rights of People with Mental Illness (Human Rights and Equal Opportunity Commission 1993), which is also commonly referred to as the Burdekin Report, named after Brian Burdekin, the author of the report, concluded that people with a mental illness were among the most disadvantaged and vulnerable groups in society. This marginalised cohort was said to be suffering from widespread discrimination and members were denied their entitled rights and services. The Burdekin report stated that the level of discrimination prevalent in the 1990s was completely unacceptable. Furthermore, the report outlined that although the mainstreaming of mental health services could have a positive impact

in reducing the stigma associated with having a mental illness, the fiscal gains from deinstitutionalisation had not been directed into community mental health services and support.

The Mental Health Statement of Rights and Responsibilities (Australian Health Ministers 1991) was the first policy to articulate the change in the role of consumers from passive recipients to collaborators in service development and provision. It is argued that, although there was no explicit mention of recovery in this document, the acknowledgement of optimism was the foundation for future recovery-based statements (Ramon, Healy & Renouf 2007).

The First National Mental Health Plan 1992-1998 was described a five-year strategy for the implementation of the aims of the National Mental Health Policy, and focused on restructuring mental health services. The major structural reform aimed to decrease stand-alone psychiatric hospitals, and to mainstream mental health services and expand community services. The First National Mental Health Plan did not make explicit reference to recovery; however, Ramon, Healy and Renouf (2007) argue that there is the assumption of improved outcomes.

Since the introduction of the National Mental Health Strategy in 1993 there has been an extensive process of implementing mental health reform in Australia including three additional 5 year National Mental Health Plans implemented in 1998-2003, 2003-2008 and 2009-2014. Furthermore, The Roadmap for Mental Health Reform 2012-2022 and the National Framework for Recovery-Oriented Mental Health Services 2013 are significant documents currently guiding mental health reform and

the delivery of recovery-focused mental health services. These policies and planning documents will now be discussed.

The Second Mental Health Plan 1998-2003, outlined a commitment to the renewal of the National Mental Health Strategy and identified priority areas for reform:

- promotion/prevention;
- the development of partnerships in service reform; and
- the quality and effectiveness of service delivery

Australian Health Ministers (1998)

Although a commitment to ongoing mental health reform was outlined in the plan, it could be argued that it is somewhat easier to change structures and provide increased funding to support services than it is to change attitudes towards people with mental illness. This is particularly so when such attitudes are entrenched in the healthcare professionals who are the very people delivering the services (Whiteford, Buckingham & Manderscheid 2002). This difficulty associated with culture change was illustrated in the evaluation of the National Mental Health Strategy in 1997, which stated that, despite the many positive developments that had occurred under the strategy, consumers reported their dissatisfaction with many aspects of mental health services, including access to services and the stigmatising attitudes of staff (Commonwealth Department of Health and Family Services 1997). Rickwood (2004) argues that, although the concept of recovery was not explicitly stated in the Second Mental Health Plan, the intent is evident and is demonstrated within the context of promotion and prevention in which mental health promotion is described as ‘action to maximise

mental health and well-being among both populations and individuals' (Commonwealth Department of Health and Aged Care 2000, p. 29).

This brings us to the Third National Mental Health Plan 2003-2008, which confirmed the accomplishments of the previous two plans and promoted a population health framework. In the Third Plan there appears a more implicit commitment to the concept of recovery in national policy, and recognition of recovery as being at the core of mental health service provision. The plan states:

A recovery orientation emphasises the development of new meaning and purpose for consumers and the ability to pursue personal goals. Mental health service providers should operate within a framework that supports recovery. (Australian Health Ministers 2003, p. 11)

The Fourth National Mental Health 2009-2014 further guides reform in Australia and sets out a whole-of-government approach with an emphasis on five priority areas for national action:

- social inclusion and recovery
- prevention and early intervention
- service access, coordination and continuity of care
- quality improvement and innovation, and
- accountability

Australian Health Ministers (2009a)

Australia also has a set of National Health Priority Areas (NHPA) that Australian Governments have chosen for focused attention. The NHPAs are conditions and diseases contributing significantly to the burden of illness and injury in Australia, and

mental health has been a NHPA since 1996 (Australian Institute of Health and Welfare [AIHW] 2014c). The nine NHPAs are presented in Figure 1:

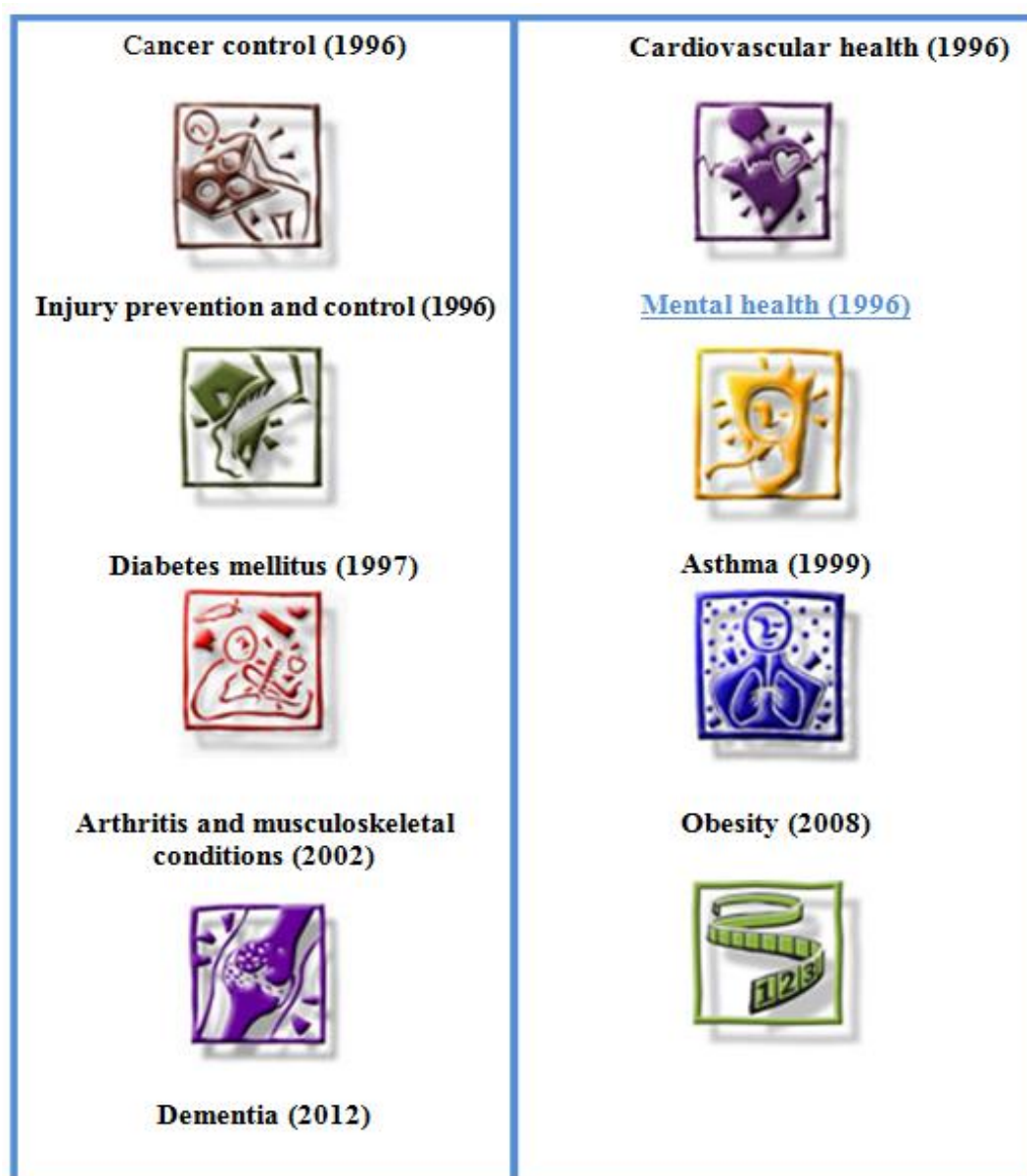


Figure 1: Australian National Health Priority Areas (AIHW 2014c)

Recovery is declared a guiding principle in the fourth plan. Espousing a recovery-oriented culture in services that deliver mental health care is identified in the plan as

being essential to facilitating coordinated service delivery. Also, it is perceived that greater collaboration can be achieved through improved understanding and respect across sectors that are able to adopt responsive models rather than operate as rigid silos. Within this area, the emergency department, which manages people who can be acutely unwell, is outlined as being an area of tension requiring increased collaboration between sectors (Australian Health Ministers 2009b). This is also highlighted by Broadbent and Moxham (2014) when they explore the notion of collegiate presence, and examine factors that affect this concept between emergency department triage nurses and mental health nurses who are providing care for people with a mental illness.

The Roadmap for National Mental Health Reform 2012-2022, is an initiative of the Council of Australian Governments (COAG), the peak intergovernmental forum in Australia, and outlines the direction for mental health reform for the next 10 years. Included in this document is the arrangement for the establishment of a COAG working group on mental health reform to develop a successor to the Fourth National Mental Health Plan. This will outline the implementation of the roadmap which identifies six priority areas:

Priority 1: Promote person-centred approaches

Priority 2: Improve the mental health and social and emotional wellbeing of all Australians

Priority 3: Prevent mental illness

Priority 4: Focus on early detection and intervention

Priority 5: Improve access to high quality services and supports and

Priority 6: Improve the social and economic participation of people with mental illness.

(COAG 2012)

Furthermore the Roadmap states that:

Recovery from mental health issue or mental illness is best described as a process, sometimes lifelong, defined and led by the person with a mental illness or disorder, through which they achieve independence, self-esteem and a meaningful life in the community. Each individual has different needs. These needs will also change over time. (COAG 2012, p. 45)

The National Framework for Recovery-Oriented Mental Health Services 2013 (Australian Health Ministers Advisory Council 2013b) is endorsed as a framework for supporting high quality recovery-oriented service delivery. Lived-experience is shown as being at the heart of the framework, and it affirms the diversity of people living with a mental illness and the need to provide recovery-oriented services responsive to this. The stated goal of the framework is improved outcomes and quality of life for people who are experiencing mental health issues, and within the framework personal recovery is defined as ‘being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues’ (Australian Health Ministers Advisory Council 2013b, p. 17).

The framework is linked to the National Standards for Mental Health Services 2010, and, from the start of the introduction of reforms, the standards were conceived as a vital component of the National Mental Health Strategy (Rosen 2006). The standards

emphasise recovery-oriented service delivery; Standard 10.1: Supporting Recovery, outlines that recovery principles are to be incorporated into practice, culture and service delivery (Department of Health and Ageing 2010b). The National Standards continue to support the implementation of current mental health policy in Australia, with the standards underpinning the National Mental Health Recovery Framework 2013.

The national policies and documents that have been discussed are pivotal to mental health reform within Australia. However, many other policies, often more at state, territory or local health district level, have been implemented to promote recovery-oriented mental healthcare. Together with key documents they serve to highlight the significant role of the ED in the provision of care to consumers experiencing mental illness. These key reform policies and documents which have been fundamental in facilitating recovery reform in Australia are presented in Table 9:

Table 9: Key Australian reform policies and documents

Key reform policies and documents	
<p>Richmond Report NSW Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled 1983</p> <p>(New South Wales Department of Health 1983)</p>	<p>This report recommended that the size and number of existing psychiatric hospitals be progressively reduced. The report also recommended that services should be funded and provided to consumers in their community environment.</p>
<p>The Burdekin Report 1993</p> <p>(Human Rights and Equal Opportunity Commission 1993)</p>	<p>This report concluded that people with mental illness were among the most disadvantaged group in society. Furthermore, the report outlined that although the mainstreaming of mental health services could have a positive impact in reducing stigma associated with having a mental illness, the fiscal gains from deinstitutionalisation had not been directed into community mental health services and support.</p>
<p>National Mental Health Policy 2008</p> <p>(Australian Health Ministers 2009b)</p>	<p>The original National Mental Health Policy 1992 marked the beginning of the National Mental Health Strategy in 1992. A revised National Mental Health Policy 2008 provides an overarching vision for a mental health system that supports recovery and ensures that all Australians experiencing mental illness can access appropriate and effective treatment and community support.</p>
<p>Mental Health Services in Australia 2014</p> <p>(Australian Institute of Health and Welfare 2014b)</p>	<p>This document provides an overview of mental health services that are provided in Australian emergency departments.</p>
<p>National Mental Health Report 2013</p> <p>(Commonwealth of Australia 2013)</p>	<p>The mental health report series monitors the progress of mental health reform in Australia. This current report provides a summary of the changes that have taken place during the period 1993 to 2011.</p>

<p>The Mental Health Statement of Rights and Responsibilities 2012</p> <p>(Commonwealth of Australia 2012)</p>	<p>This document is a revised version of the original Mental Health Statement of Rights and Responsibilities that was released in 1991. The document states that services must be recovery focused, integrated, high quality and accountable, to facilitate supporting the mental health consumers' recovery.</p>
<p>Mental Health Presentations to the Emergency Department</p> <p>(Victorian Government Department of Human Services 2005)</p>	<p>This document describes research that was commissioned by the Victorian Government Department of Human Services to identify why the ED is used as a point of care for people who are experiencing mental illness, and to promote an understanding of the nature of mental health presentations to EDs.</p>
<p>State and Territory Mental Health Plans</p>	<p>State and Territory plans and strategies are tailored to meet their own local requirements but demonstrate a move towards a collaborative Government approach to mental health care. They outline priorities for the reform and development of mental health care and the delivery of recovery-oriented services as outlined in the National Mental Health Strategy.</p> <p>These documents outline improved partnerships between mental health and other areas within healthcare such as EDs.</p>
<p>The Roadmap for National Mental Health Reform 2012-2022</p> <p>(Council of Australian Governments 2012)</p>	<p>The Roadmap is an initiative of the Council of Australian Governments (COAG) and outlines the direction for mental health reform for the next 10 years. This document also outlines the establishment of a COAG working group to develop a successor to the Fourth National Mental Health Plan.</p>

Shortcomings in mental health reform are evident (Hazelton et al. 2011) and there remains a disparity between the intent of Government reform policies and their actualisation. This has resulted in a lack of progress in the improvement of mental health services for consumers, including continuity of care and the reduction of

prejudice and stigmatization towards people with mental illness (Hazelton et al. 2011). To that end, the announcement by the Minister for Health, The Honourable Peter Dutton, on 4th February 2014 that there would be a mental health review, attests to the fact that mental health services need to be assessed for their efficiency and effectiveness. The media release identified that all existing mental health services and programmes across government, non-government and private sectors will be reviewed. The media release has been included as Appendix 2. The National Mental Health Commission will conduct the review, and will engage with state and territory governments and other stakeholders to ascertain ‘what really works and ensure that existing resources in the mental health sector are being targeted as effectively as possible’ (Dutton 2014).

Mental Health Care in Australian Emergency Departments

Previous discussion has identified the fact that in Australia the Emergency Department (ED) plays an integral role in the delivery of mental health services. It is well documented that mental health presentations to Australian EDs increased as a result of the mainstreaming of mental health care into general health services (Nicholls et al. 2011; Shafiei, Gaynor & Farrell 2011). Furthermore, Morphet et al. (2012), maintain that deinstitutionalisation has been a contributing factor in the increase in volume of mental health presentations, and the authors posit that people who present to Australian EDs with mental health issues make up 5 – 10 percent of the presentations to the ED. The latest data from the AIHW (2014b) illustrates the increase in mental health-related

emergency department occasions of service in public hospitals from 2008-09 to 2011-12. This is presented in Figure 2.

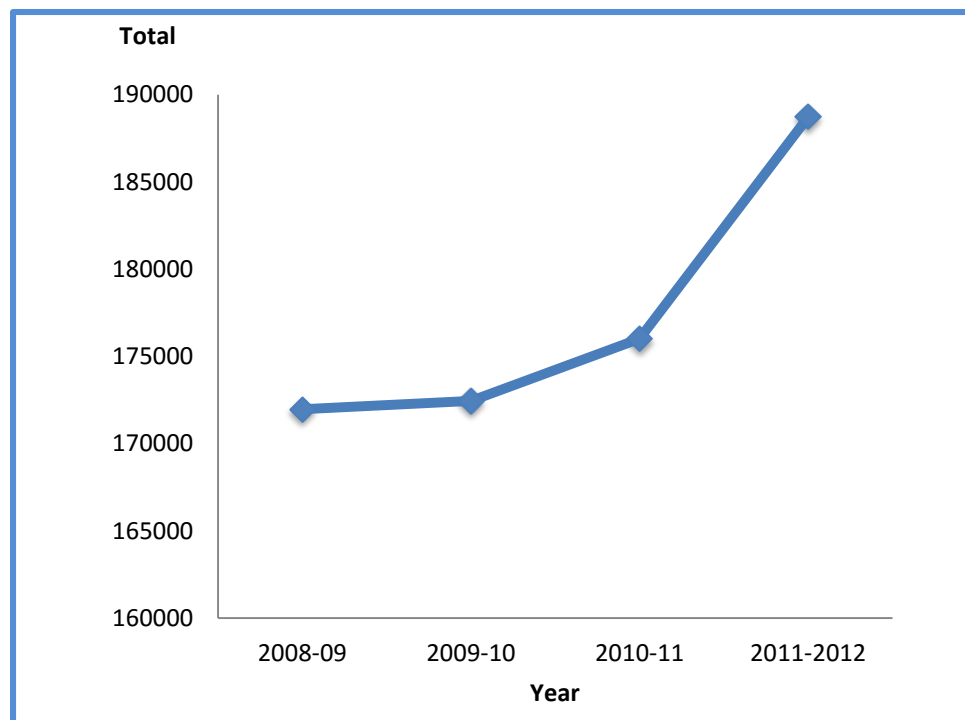


Figure 2: Mental health-related emergency department occasions of service in public hospitals, 2008-09 to 2011-12 (adapted from AIHW 2014b)

Furthermore, data from the AIHW (2014b) shows that in 2011-2012 it was estimated that there were 248,501 ED occasions of service with a mental health-related principal diagnosis, and that over 80 percent of mental health-related ED occasions of service were classified as either semi-urgent or urgent. Furthermore, mental health-related ED occasions of service were more likely to be classified as urgent, and more likely to result in an admission, compared to all ED occasions of service (AIHW 2014b). However, it should be noted that the AIHW maintains that the data, for various

reasons, does not capture all mental health-related presentations to Australian EDs. These reasons include the lack of a nationally agreed method of identifying mental health-related occasions of service in EDs, no standard diagnosis classification in use across states and territories for ED data, and the fact that the definition is based on the principal diagnosis only (AIHW 2014b).

The following Table 10 presents data on mental health-related occasions of service in public hospitals, by episode-end status, 2008-09 to 2011-12. As mentioned previously this data does not capture all mental health related ED presentations. As outlined by the AIHW (2014b) the number of occasions of service may not sum to the total, because data is missing or has not been reported. Furthermore, the 248, 501 ED occasions of service mentioned previously, is an estimate of the actual number of mental health-related emergency department occasions of service if coverage were 100 percent. The AIHW (2014b) estimates that the number of mental health-related occasions of service reported represents approximately 76 per cent of all mental health-related occasions of service in public hospital EDs. The actual number of such occasions of service could be more than 248,500 rather than the reported 188,739. The following table shows the increase in mental health occasions of service by episode-end status occurring from 2008 to 2012.

Table 10: Mental health-related emergency department occasions of service in public hospitals, by episode-end status, 2008-09 to 2011-12 (AIHW 2014b)

Mental health-related emergency department occasions of service in public hospitals, by episode end status, 2008-09 to 2011-12				
Episode end status	2008-09	2009-10	2010-11	2011-12
Admitted to this hospital	55,285	53,034	60,710	67,780
Non-admitted patient emergency department service episode completed	105,157	106,342	104,153	108,641
Referred to another hospital for admission	6,162	6,943	5,352	3,687
Did not wait to be attended by a health care professional	1,143	1,989	1,506	1,505
Left at own risk	4,047	4,047	4,234	4,519
Total	171,976	172,445	176,016	188,739

Data provided by state and territory health authorities defined mental health-related ED occasions of service in 2011-2012 as: occasions of service in public hospital EDs that have a principal diagnosis of mental and behavioural disorders. Some jurisdictions used the ICD-9 CM for coding, however most used the ICD-10 AM as presented in Table 11:

Table 11: ICD-10 codes for mental and behavioural disorders (World Health Organization 1993)

ICD-10 Codes for Mental and Behavioural Disorders	
F00-F09	Organic, including symptomatic, mental disorders
F10-F19	Mental and behavioural disorders due to psychoactive substance use
F20-F29	Schizophrenia, schizotypal and delusional disorders
F30-F39	Mood (affective) disorders
F40-F48	Neurotic, stress-related and somatoform disorders
F50-F59	Behavioural syndromes associated with physiological disturbances and physical factors
F60-F69	Disorders of adult personality and behaviour
F70-F79	Mental retardation
F80-F89	Disorders of psychological development
F90-F98	Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
F99	Unspecified mental disorder

Although, as discussed earlier, government policies promoted a move from institutionalised care in stand-alone psychiatric hospitals to care within the community, community mental health services did not benefit significantly from the

fiscal gains from deinstitutionalisation (Australian Health Ministers 1992). Kalucy, Thomas and King (2005) in their paper remind us that sufficient funding to support community based mental health services has not always accompanied government policies. This has often resulted in overstretched and under-resourced community services referring consumers to the ED.

There still remains a need for hospital-based care despite the introduction of community-based services (Kalucy et al. 2004), and the ED becomes the interface between community care and specialist inpatient services. Therefore, for consumers needing to access crisis assessment and intervention, the ED is the initial point of contact and the gateway into the mental health care system, and is increasingly being utilised in this capacity (Broadbent et al. 2010; Brown 2007; Hart 2008; Kalucy et al. 2004; Kerrison & Chapman 2007; Knott et al. 2007; Nicholls et al. 2011; Shafiei, Gaynor & Farrell 2011; Wynaden 2010).

In addition, although the introduction of mainstreaming aimed to increase consumers' access to comprehensive healthcare and reduce the stigma that was associated with the discrete delivery of mental health services, it has also contributed to a clash of cultures between the general healthcare setting and mental health care services (Broadbent & Moxham 2014; Happell & Platania-Phung 2005).

The unconditional availability of the ED and the commonly accepted expectation that the ED will deliver an immediate response (Heslop, Elsom & Parker 2000) makes it an obvious place for people experiencing a mental health crisis to go. Public hospital EDs are open on a 24 hour, seven days a week basis and do not charge a fee (Clarke,

Dusome & Hughes 2007). The Victorian Government Department of Human Services (2005) maintains that the EDs of all major hospitals play a significant role in providing a crisis service to consumers who require after-hours support. Clarke, Dusome and Hughes (2007) conducted a qualitative study in Canada which held focus groups, with twenty seven consumers, seven family members and five stakeholders. This study explored the satisfaction of consumers and their families with care received in the ED and the participants' evaluation of the Psychiatric Emergency Nurse. Consumer participants in the study stated that they accessed the ED because there was nowhere else to go. Furthermore, people who present to the ED with mental health issues range from those who have no prior contact with mental health services attending the ED, to those who regularly attend the ED and are well known to mental health services (Clarke, Dusome & Hughes 2007). Unfortunately the language used by health professionals to describe the latter group is generally negative. As discussed previously, language is powerful and serves to reinforce stigma and discrimination.

There is no concise definition within the literature to quantify the number of presentations made to be considered a frequent attender, and it is open to interpretation. Bolton (2009) maintains that five or more attendances a year can be considered frequent, however Wooden et al. (2009) maintain that an average of one attendance a month indicates over utilisation of ED resources. Frequent attenders are a small group of people who account for a disproportionately large number of visits to the ED and are often viewed as problematic by ED staff (Buus 2011). They are also felt to cause disproportionate workloads (Bolton 2009), to contribute to a significant burden on staff

working in the ED and on healthcare resources, (Marynowski-Traczyk & Broadbent 2011), and to present as a complex challenge (Wooden et al. 2009).

As the burden on EDs became increasingly obvious, concerns were raised regarding the appropriateness of the ED to provide care to people in mental health crisis. As a result, several responses were initiated and new models of care introduced. This included the placement of dedicated mental health clinicians in the ED to facilitate an immediate specialised response, and the establishment of Psychiatric Emergency Care Centres (PECC) (Australian Health Ministers 2009a; Brakoulis et al. 2010).

It is acknowledged that additional resources are required to relieve what are thought to be over burdened EDs of the assessment and management of people experiencing mental health issues. However, Slade et al. (2007) argue that PECCs are not an efficient use of mental health resources. Furthermore, Wand (2005), who at the time worked as a mental health nurse practitioner in a large metropolitan public hospital ED, suggests that PECCs contribute to the stigmatising views of people experiencing mental health issues, because PECCs may be seen as a segregated system operating parallel to general health care. This can be viewed as contradictory to the philosophy of holistic care, and the requirement ‘for a holistic response to mental health problems and mental illness’, as posited in the Fourth National Mental Health Plan (Australian Health Ministers 2009a, p. 10).

The placement of dedicated mental health clinicians in the ED, such as mental health clinical nurse specialists, mental health clinical nurse consultants (CNC) or indeed mental health nurse practitioners (MHNP), is an initiative that has been introduced by

State and Territory Health Departments throughout Australia to improve the support and services available for the increasing number of people presenting to EDs with mental health issues (Sharrock et al. 2008). Mental health clinicians also include mental health liaison nurses (MHLN). The MHLN is now an integral part of many ED settings throughout Australia. They provide direct clinical care and improve the quality of psychosocial care to consumers in collaboration with non-mental health colleagues within the ED (Wand & White 2007). Wand and Fisher (2006) maintain that the MHNP, who is an advanced practice nurse with expanded clinical autonomy, can provide expert mental health care as well as support and education for ED staff. The MHLN, sometimes known as Consultation Liason (CL) nurse, is seen as having specialist expertise, and is recognised by the Australian College of Mental Health Nurses (ACMHN) which has established a special interest group for MHLN.

In spite of the introduction of initiatives to alleviate the pressure on Australian EDs, consumers continue to be cared for by generalist Registered Nurses (RN). In the first instance, triage is usually conducted by a generalist nurse. The literature supports the view that general RNs are inadequately prepared to care for people experiencing mental health issues (Brinn 2000, Happell & Platania-Phung 2005; Sharrock et al. 2006), and that generalist RNs with no formal mental health training working in the ED often do not have the level of mental health knowledge and skills to provide optimal care to consumers presenting to the ED (Broadbent, Jarman & Berk 2004; Hart 2008; Kerrison & Chapman 2007; Plant & White 2013).

This loss of specialist expertise occurred in the context of a change in the model of nursing education in Australia which involved the transfer of nurse education from hospital training into the tertiary sector (Happell 2007). This transfer occurred at different times within Australian States and Territories with the first Australian diploma-level nursing course being introduced in 1975 in Melbourne, Victoria (Crisp et al. 2013); however, nursing education was ultimately transferred en masse into the higher education sector in Australia in 1985 (Grealish & Smale 2011). This move saw the introduction of comprehensive nursing that facilitated the transfer from general and specialist mental health registrations to a single comprehensive nurse registration. All hospital-based mental health nursing programs in Australia were then discontinued (Wynaden et al. 2000). The move was congruous with the philosophy of integration which gave prominence to the idea of preparing undergraduate nurses to work as beginning practitioners in a multitude of health care settings, including mental health (Happell 2006; Wynaden et al. 2000). Within Australia, university graduates with a Bachelor of Nursing degree emerge with a generic RN qualification (Morrison 2009) and are then thought to be able to work in any nursing discipline. There are many authors who contend that this is not so (Clinton & Hazelton 2000; Happell & Cutcliffe 2011; Happell & Platania-Phung 2005; Levett-Jones & FitzGerald 2005; Sharrock & Happell 2007; Stuhlmiller 2005; Usher 2006; Wynaden 2010).

Throughout Australia, different tertiary providers have different nursing curricula (Grealish & Smale 2011). Therefore different quantities and qualities of mental health content occurs. In the Australian literature the mental health content within pre-registration nursing programs is identified as being insufficient (McCann et al. 2009;

Mental Health Nurse Education Task Force 2008; Moxham et al. 2011). Darbyshire and Fleming (2008, p. 267) posit that nursing educational programs are ‘constituted by an amalgam of heterogeneous and conflicting practices’. It is argued that the mental health content within many undergraduate nursing programs is given a low priority (Wynaden 2010). However, the Fourth National Mental Health Plan 2009-2014 states that ‘the mental health content of relevant undergraduate and postgraduate courses should be of sufficient quantity and quality to enable competency at the level required’ (Australian Health Ministers 2009a, p. 50).

In 2008 the report on the Mental Health in Pre-Registration Nursing Courses was endorsed by the Australian Health Ministers’ Advisory Council and released by the Mental Health Nurse Education Task Force (MHNET). This report examined mental health content in undergraduate pre-registration nursing courses, and a framework for the inclusion of mental health in these courses was produced together with recommendations for its implementation (MHNET 2008). The results of the review of the progress regarding uptake of the framework and recommendations was released in 2010. The progress report states that, although improvements have been made in reviewing mental health content and improving its integration into subjects across the curriculum, an area of concern is the variation in the amount of clinical hours that are undertaken in mental health placements and the implications of this for the development of skills and knowledge such as mental health assessment (Mental Health Workforce Advisory Committee 2010).

Students who graduate from such courses go on to work in the ED and take their lack of mental health knowledge with them. Webster and Harrison (2004) argue that given

that EDs are significant gateways to mental health services, then ED staff must be provided with the necessary support to confidently manage people experiencing mental health issues. Staff also require the ability to adapt to the disparate nature of mental health care services. Kerrison and Chapman (2007) conducted a qualitative study at a West Australian teaching hospital involving focus groups with emergency nurses, and interviews with subject-matter experts including key clinical staff in the ED. Stakeholders in education were also included. This study investigated the mental health education and training needs of emergency nurses. The emergency nurse participants, who had no formal mental health training, identified three key learning areas. These were customer focus, workplace aggression and violence, and the management of mental health presentations.

ED staff play an integral role in the assessment of people presenting with mental health issues. However, Stuhlmiller et al. (2004), identified through their study assessing the clinical confidence of ED staff in working with people with mental illness ‘before and after’ mental health educational courses, that ED staff lack the confidence to respond to people who are experiencing mental health distress. Summers and Happell (2003) contend that ED nurses can find themselves overwhelmed by the expectation that they can deliver care to people experiencing mental health crisis. Experiencing challenging behaviours is inevitable for nurses who work in frontline care such as the ED (Farrell, Shafiei & Salmon 2010). However, although aggression is a problem faced by nurses in a variety of nursing areas, it is a particular concern for ED staff (Needham et al. 2005).

Ross and Goldner (2009) conducted a review of the literature related to nursing professionals' attitudes and discrimination towards mental illness. Within the body of literature originating from many countries including Australia, the consensus was that there is an identified need for improvement in the nursing care provided to people experiencing mental health issues. Furthermore, general nurses' lack of education and knowledge of mental illness is directly predictive of their negative attitudes to this marginalised and vulnerable group who then become stigmatised. (Ross & Goldner 2009). Perceived chronicity of mental illness, often thought to be demonstrated by frequent attendance, appears to impact on nurse's attitudes, and Rao et al. (2009) maintain that there is a greater degree of stigma imposed by health care professionals towards people with an enduring mental illness such as schizophrenia, than for people experiencing a short episodic mental illness such as a psychotic episode.

A tension exists between the clinical care required by people who present to the ED with mental health issues, and the very nature of emergency nursing. Many ED nurses maintain that psychosocial care is the role of mental health clinicians (Wright et al. 2003). Furthermore, many general nurses maintain that there is a conceptual separation of physical and mental health, and they believe that the care of consumers experiencing mental illness is not their role (Ross & Goldner 2009). Harrison (2001) posits that, in physical care settings such as the ED, the dualism perpetuated by the mind-body split contributes to staff overlooking the holistic needs of people and maintaining the proclivity to focus on the person's physical health issues. Indeed, Liggins and Hatcher (2005) suggest that within the medical model there is a continuing tension between the mind and the body, and a dichotomous way of thinking by healthcare professionals

relating to the mind-body split will only facilitate the potential for people experiencing mental illness to be stigmatised. Furthermore, Beresford (2005, p. 40) argues that the ‘modern understanding of madness and distress is still dominated by medicalised frameworks for analysis and ‘treatment’.

The language used by healthcare professionals is identified as a contributing factor in the perpetuation of the stigmatisation of people with mental illness, which was discussed earlier (Sartorius 2007). As mentioned previously a disparity exists between the language used in the medical/clinical model and in recovery oriented services. However, the use of language that hinders recovery is not confined to the frontline caregivers such as ED nurses; it is shown that it is also perseverated in the government policy that guides mental health reform in Australia. As maintained by Beresford (2005, p. 35):

The underlying construct that dominates ‘mental health policy, provision, practice and service users is that of ‘mental illness’. It is possible to be persuaded that this is not the case, because terms like ‘mental illness’, ‘mental disorder’ and ‘psychopathology ‘ are less often and less explicitly used nowadays. Instead a range of euphemistic terms like ‘mental health, ‘mental health problems’, and ‘issues’ are used. But their origins and meaning are the same ...Something is wrong with the person. They are ‘ill’....This is how we come to understand ourselves as mental health service users.

Summary

This chapter has provided a succinct review of the relevant recovery literature. The meaning of recovery as understood by people with lived-experience of mental illness has been elucidated and contrasted with that from the clinical/medical domain. In addition, the background contributing to the emergence of the two disparate meanings was outlined. Engagement with the recovery literature has identified that there is no

research pertaining to the understanding by ED Registered Nurses of what recovery means to people experiencing mental health issues. This research, which explored ED Registered Nurses conceptualisation of recovery adds to the body of knowledge on recovery and significantly contributes to addressing the gap in the literature.

The following chapter will discuss the study's research design. It will describe the qualitative research approach of phenomenography. This approach was used to facilitate exploration of the aim of this research, which was to understand how ED Registered Nurses conceptualise recovery for people with a mental illness. Additionally, the next chapter will also expound the methods utilised within this study.

CHAPTER THREE: THE RESEARCH APPROACH

We are seldom aware that our understanding of a phenomenon does not match someone else's understanding. We are not even aware that we see the world in an individual way. We believe tacitly that we see the world as it is; without further reflection, we take it for granted that others see it exactly as we do. (Marton 1992, p. 254)

Introduction

Research paradigms provide a distinct way of looking at the way in which the world is represented by research, and the interpretative framework that was chosen to guide this research is phenomenography. This research study, situated within the qualitative paradigm, aims to describe the different ways in which people conceptualise diverse phenomena. Therefore, phenomenography and its view of the nature of truth and reality, based on its epistemology and ontology, is the appropriate approach to effect this study's aim, that is, to understand how Registered Nurses (RNs) working in the Emergency Department (ED) conceptualise recovery for consumers who are experiencing a mental illness.

This chapter will explain the research approach of phenomenography, outlining its historical development and its epistemological and ontological assumptions. Conceptions are the central tenet within phenomenography; this unique position will be elucidated, and the fundamental definitions and structural elements that pertain to this approach will be expounded. In addition, the research design and the methods that were implemented will be discussed in detail, and recruitment and selection of participants, ethical considerations, data collection and data analysis will be explicated.

Qualitative Research

Qualitative research ‘is concerned with interpreting the subjective experiences, i.e. the perspectives, of the individuals being studied’ (Grix 2010, p. 32). The topic under investigation is explored and meanings are sought from the perspectives of the particular population involved with the topic (Mack et al. 2005). Further, a connection is acknowledged between the knower and what is known. The experiences and understandings of the knower are essential, and regarded as fundamental to the holistic understanding of people interacting with their world.

In contrast, within the quantitative approach ‘the knower and known are considered as relatively separate and independent’ (Gelo, Braakmann & Benetka 2008, p. 270) and the aim is to explore hypotheses regarding particular phenomenon, rather than exploring the phenomenon and seeking to describe variation, experiences and relationships. Quantitative research maintains a positivist world-view, and attempts to exclude subjectivity. Inherent within empirical knowledge is the view that there is only one objective reality (Van der Zalm & Bergum 2000). Given that this research is concerned with variation, experiences and relationships, a quantitative approach was considered too narrow and so a qualitative approach is appropriate.

Qualitative approaches embrace subjective experience, and ‘qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them’ (Denzin & Lincoln 2005, p. 3). The flexibility that exists within qualitative research enables spontaneity between the participant and the researcher (Mack et al. 2005) and facilitates interactions promoting research that is exploratory, rich in nature and meaningful to the participant.

The distinct characteristic of qualitative research is that the researcher is the means through which a facet of the world is explored (Rossman & Rallis 2012). Phenomenography is an interpretive research approach within the qualitative paradigm, and provides the means to explore a particular facet of the world; the conceptions of RNs as they relate to recovery of consumers with mental illness in the ED.

Phenomenography

At the root of phenomenography lies an interest in describing the phenomena in the world as others see them, and in revealing and describing the variation therein. (Marton & Booth 1997, p. 111)

Phenomenography is concerned with relations between people and the world around them. The focus is not solely on the phenomenon that is being experienced, or on the people who are experiencing the phenomenon, but rather with relations that exist between them (Marton 1986). Phenomenography aims to investigate the different ways in which people experience various phenomena in the world around them. Marton (1986, p. 31) states that:

Phenomenography is a research method adapted for mapping the qualitatively different ways in which people experience, conceptualise, perceive, and understand various aspects of, and phenomena in, the world around them.

Although people experience various phenomena in different ways, the basic premise of phenomenography is the notion that phenomena are experienced in a limited number of ways (Marton 1981) and the focus is describing the variation that exists. Phenomenography therefore, endeavours to capture the critical differences in the conceptions of a particular phenomenon. Marton (1992, p. 253) reminds us that

‘whatever phenomenon people encounter, there is a limited number of qualitatively different ways in which the phenomenon is experienced, conceptualized, or understood’. The description of the differing ways of experiencing a phenomenon is at the collective level, and phenomenography provides the means for a holistic exploration of collective human experience at a particular point in time (Akerlind 2005c). Given this fundamental tenet, phenomenography is a suitable approach for this research. Critical variation in the conceptions of recovery for consumers who have a mental illness, by ED Registered Nurses as a particular group, are both fully explored and described in detail.

It is posited that the empirical studies on learning, from which phenomenography emerged, were based on general assumptions rather than a defined theoretical position. The theoretical framework that inspired these early studies was Gestalt Psychology (Uljen 1996; Svederberg 2002). Despite some similarities in name, phenomenography was *not* derived from phenomenological philosophy, and it is argued that despite similarities to other established research traditions, phenomenography ‘cannot be “reduced” to phenomenology or any other established school of thought’ (Svensson 1997, p. 163). However, Svensson argues that, in order to provide the necessary philosophical foundation to support assumptions about the character of conceptions, there have been a large number of comparative references to the older research traditions, particularly phenomenology. Due to the extensive references made regarding the similarities between phenomenology and phenomenography, Gibbs, Morgan and Taylor (1982), Marton (1981, 1986), Marton

and Booth (1997) and Prosser (1993), the similarities and differences between the two approaches warrant exploration.

The etymological origin of phenomenography is from the Greek words *phainomenon* meaning appearance and *graphein* meaning description; therefore phenomenography involves the description of things as they appear (Pang 2003). Phenomenography and phenomenology both share human experience as the subject of study and the term *phenomenon* is common to both. However, phenomenography aims at description, whereas phenomenology, with the suffix *logos*, aims at the clarification of logic or structure (Giorgi 1999).

Marton (1986, p. 40) argues that both types of research are ‘relational, experiential, contextual and qualitative’. However, phenomenology, which was developed by the German philosopher Edmund Husserl, focuses on the ways of experiencing a phenomenon and aims to capture the richness of the experience. This focus on the essence of the person’s experience, as well as seeking the singular essence, contrasts with phenomenography’s prime focus of seeking to find variation, that is, the variation in the ways of experiencing a phenomenon. Phenomenography then, aims at describing collective meaning, and the commonalities and differences in a population’s experience of a particular phenomenon. Significant characteristics of this qualitative research approach are the focus on variation in experience, and the emphasis on description which is facilitated through the explication of categories of description describing the similarities and differences in conceptions. Marton (1986, p. 34) states that ‘we are looking for structurally significant differences that clarify how people define some specific portion of the world’. Furthermore, as claimed by

Svensson (1997, p. 168) 'The category is a description of what is the common meaning of the meanings of a phenomena grouped together' and the empirical presentation of the description is a characteristic of phenomenography.

Origins of Phenomenography

Phenomenography has a significant empirical background with its origin in educational research. The approach was developed in the 1970s by Ference Marton and his colleagues within the Department of Education at the University of Gothenburg in Sweden. This research group investigated students' experience of learning, and observations from this early work showed that:

...when people read a text or listen to a presentation or try to solve a problem or reflect upon a phenomenon, that which they encounter appears to them in a limited number of qualitatively different ways. (Marton & Booth 1997, p. 112)

The interest in investigating student learning produced seminal work from this period including Marton and Säljö (1976a, 1976b), Svensson (1976), Dahlgren and Marton (1978). Entwistle (1997) argues that although this early work cannot be described as strictly phenomenographic research, the discussion of the students' approaches to learning also drew attention to the relational nature of learning. Dahlgren and Marton (1978), posit that research that is based on an approach focused on the structural content of thinking

...should consist partly of finding out more about the various conceptions which different individuals have of certain phenomena, and partly of looking for relationships in terms of content - that is questioning how the conceptions of different phenomena are related to each other. (Dahlgren & Marton 1978, p. 32)

The term phenomenography first appeared in 1954 in work by Ulrich Sonnemann which discussed existential analysis and phenomenology; 'is itself restricted to what might better be called phenomenography, a descriptive recording of immediate subjective experience as reported' (Sonnemann 1954, p. 343). However, Marton (1986), states that that the word phenomenography first formally appeared in print in 1981 in an influential paper '*Phenomenography- Describing Conceptions of the World Around Us*' in which his arguments for this research approach were posited. Marton (1981) argued that this research, which is identified as phenomenography, is complementary to other kinds of research, and is a distinct field of inquiry with the aim of the description, analysis and understanding of experiences.

In the early stages of the research conducted at Gothenburg University there were three lines of research. The first was concerned with content related studies, while the focus of the second was learning and teaching of concepts, in particular domains. The focus of these first two lines of research was on conceptions, but it concentrated on the relation between conceptions and the processes that they came from. The third line of inquiry though, which Marton (1986) argued was 'pure' phenomenography, focused on the conceptions themselves and it is this specific approach that has been used to examine ED RNs conceptions of recovery as it applies to people with a mental illness; the focus of this study.

As phenomenography had its inception in research on student learning, the descriptions of conceptions were originally developed to elude descriptions of knowledge (Svensson 1997). This distinct research approach has evolved however, beyond the field of education and is now extensively utilised in diverse disciplines.

These are illustrated in the following phenomenographic papers;

- Differences in Japanese mothers' understanding of a tale (Samuelsson et al. 1998),
- Conceptions of physiotherapy knowledge among Swedish physiotherapists (Larsson & Gard 2006),
- Perceptions of the concept of health among nurses working in mental health services (Jormfeldt et al. 2007),
- How GPs [general practitioners] conceive consultation outcomes (Anden, Andersson & Rudebeck 2009),
- Small firm internationalisation (Lamb, Sandberg & Liesch 2011)
- Patients' perceptions of living with epilepsy (Räty & Wilde-Larsson 2011).
- Small firm internationalisation (Lamb, Sandberg & Liesch 2011)
- Surgical nurses' different understandings of their interactions with patients (Jangland, Larsson & Gunningberg 2011).

Epistemology and Ontology

Ontology relates to what people believe is real and exists in the world (Frost 2011). It is concerned with the nature of reality. As outlined by Blaikie (2000, p. 8) ontology involves:

...claims and assumptions that are made about the nature of social reality, claims about what exists, what it looks like, what units make it up and how these units interact with each other. In short, ontological assumptions are concerned with what we believe constitutes social reality.

The ontology of phenomenography is non-dualistic; Marton (2000) suggests that an objective world and a subjective world do not exist separately. Rather, he claims, there is one world that is objective and subjective simultaneously; one where people experience, and understand, in different ways. Phenomenography takes the view that object and subject are not separate, and sees the person's experience as the relation between the subject and object. 'The experience is as much an aspect of the object as it is of the subject' (Marton 2000, p. 105); therefore a person's reality exists through their conceptions of it.

Uljens (1996) provides commentary which advises that phenomenography's non-dualist position is in opposition to the metaphysical dualism of representational theories of cognition and the existence of two worlds that are interrelated but independent of each other. In contrast to this stance that asserts that there is a real world and a representational world, phenomenography maintains that the only reality that there is for a person, is the reality that they experience.

Epistemology is concerned with the acquisition of knowledge and also, importantly, with the value of being certain that the knowledge gained is true (Marton & Booth 1997). Fundamental epistemological assumptions in phenomenography that are linked to its ontology, are that the nature of knowledge is both holistic and relational, and that conceptions are considered the central form of knowledge. Knowledge is not only viewed as empirical but also created through thinking about the reality external to the person (Svensson 1997). Therefore phenomenography views knowledge as constructed in the internal relation between the person who is experiencing the world

and the phenomenon (Marton, Dall’Alba & Beaty 1993). Thus, they are inextricably linked.

In contrast to the traditional first-order perspective which deals with the world as it is understood and facts that are observed, phenomenography takes the second order perspective specific to this research approach, and sees how something is conceived to be (Marton & Booth 1997). Therefore the focus is not the subject (person) or the object (phenomenon); the focus is the relationship between the two. That is, the experience of the phenomenon. Furthermore, a second order perspective enables the researcher to observe and reveal things as they appear to a person, describing a person’s interpretation of an experience and not merely describing the experience (Pratt 1992).

It is through the implementation of a second order perspective that the underlying ways that a particular phenomenon is experienced, becomes the focus of study (Marton 1996). Knowledge is generated through elucidating the conceptions that people have of a phenomenon and not simply by studying the phenomenon. The second order perspective that is taken in phenomenography therefore enables the researcher to focus on the relationship between RNs (subject) and recovery (object), rather than on recovery itself.

The differences in the first and second-order perspective are diagrammatically represented in Figure 3.

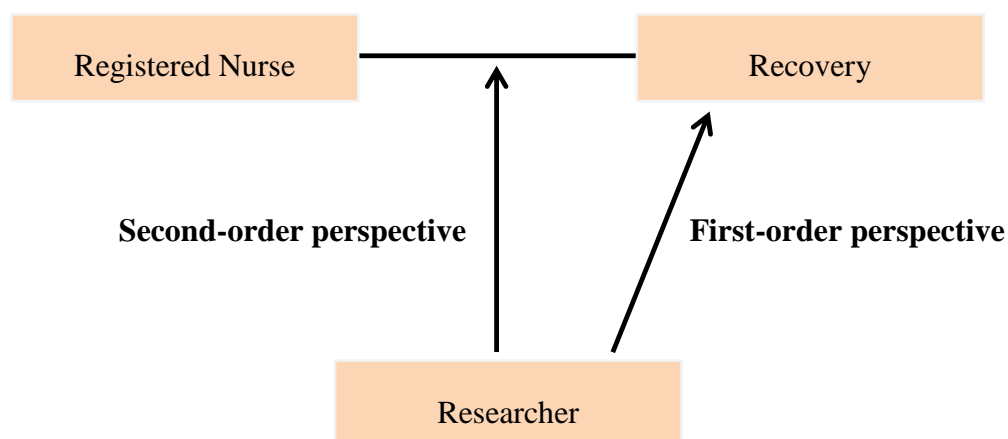


Figure 3: First and second order perspectives (adapted from Uljens 1991)

Conceptions

Conceptions are the central units of description in phenomenography (Marton & Pong 2005). The aim is to describe the variation of conceptions that people have of a phenomenon. A conception is not visible, but is a mental representation that is idiosyncratic to an individual (Fraser & Walberg 1995), and ‘remains tacit, implicit or assumed’ (Johansson, Marton & Svensson 1985, p. 236). It is a way that an individual sees something or understands it, or the meaning that it has for them (Johansson, Marton & Svensson 1985). Sandberg (1997, p. 203) explains it as follows – ‘in the phenomenographic approach the term conception is used to refer to people’s ways of experiencing a particular aspect of reality’.

A conception is an internal relation between the phenomenon and the person (Ekeblad & Bond 1994). Johansson, Marton and Svensson (1985, p. 249), describe how conceptions ‘refer to whole qualities of human-world relations’. Pratt (1992, p. 204) outlines that conceptions are ‘specific meanings attached to a phenomena’, and the

internal relation is further explained by Svensson and Theman (1983) who outline that conceptions are recognised as being constituted from dual aspects of a phenomenon. That is, the relationship of the phenomenon as experienced, and the phenomenon itself. These two unite to form an individual's understanding of the phenomenon. Therefore, people's conceptions of a phenomenon will be different with phenomenography seeking to illuminate these variations.

Conceptions are constructed from an extensive and diverse range of sources, and include images, experiences and knowledge, and people become committed to particular conceptions which assist them in ascribing meaning to experiences (West & Pines 1985). As people have different conceptions of a phenomenon, these variations have an effect on how they see their world and, as stated by Pratt (1992, p. 204), 'we view the world through the lenses of our conceptions interpreting and acting in accordance with our understanding of the world'.

Throughout the literature the term 'conceptions' is used interchangeably with various terms such as 'ways of experiencing', 'ways of conceptualising' and 'ways of understanding' (Marton & Pong 2005). However, all of these terms relate to phenomenography's concern with the relationship that people have with the world, their experience of phenomena and their construction of concepts about these phenomena (Austerlitz 2007). As outlined by Marton (1996) the term that is used should be appropriate to the context; however. However, Marton further asserts a preference for the term 'ways of experiencing'.

Conceptions are comprised of component parts, and Marton, Dall’Alba and Beaty (1993) differentiate these parts when they argue that there is a referential and structural aspect to a conception. Every experience therefore, has two intertwined aspects; one, a referential aspect that is the comprehensive meaning of the phenomenon and two, a structural aspect, which refers to how the different component parts of the conception relate to each other. These two aspects occur simultaneously.

Furthermore, within the structural aspect of the conception there exist two elements, the internal horizon and the external horizon. The external horizon reflects the external relationship of the phenomenon to its context, that is, how it is delimited from, and related to, a context. The internal horizon refers to the internal relationship that exists within the conception, that is the parts of the conception and their relationship with each other.

Marton illustrates this by describing how the structural aspect, which involves ‘Relating parts to parts, parts to whole and whole to context means having a simultaneous focal awareness of parts, whole and context’ (Marton 1996, p. 180). In their publication *Learning and Awareness*, Marton and Booth (1997, p. 87) suggest that awareness is both structured and layered, and use the example of a deer in the woods to illustrate the structural aspect of experiencing something. When we experience a deer standing in the woods it is not only discerned from its context (the woods), but we also see parts of the deer’s body, head and forequarters etc, and the relationship to the deer’s stance.

A person can be simultaneously aware of many different things, and this is called the thematic field; however, they are not aware of them in the same way. Within the thematic field, some things come to the fore, are figural, and this is referred to as ‘the theme of awareness’ (Marton & Booth 1997, p. 98), while others remain in the field or are relegated to the periphery which is the margin of a person’s awareness. Therefore, when a person experiences something at a particular time, the meaning that the experience has for them is constituted from aspects that are discerned and are simultaneously present in their awareness.

The constituent parts of a conception, that is the experience of a phenomenon, are diagrammatically represented in Figure 4.

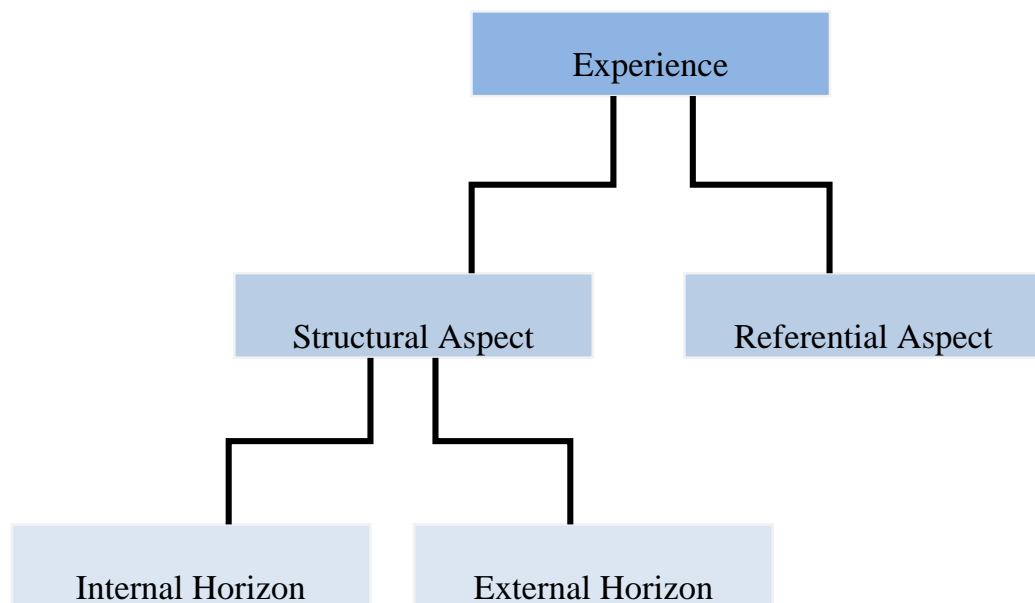


Figure 4: The component parts of an experience (Marton & Booth 1997, p. 88)

Categories of Description

The categories of description are not conceptions, but are the tools to describe conceptions, and as Marton (1996, p. 180) states, are ‘a way of describing a way of experiencing something is what we call a category of description’. However it has been suggested that, in phenomenographic research, the distinction between the boundaries of conceptions and categories of description can be blurred (Säljö 1994). The distinction is clarified by Johansson, Marton and Svensson (1985) who state that categories of description are not identical with conceptions, but they do, however, represent conceptions. Furthermore, the metaphor which was used by Marton (1981) to delineate the relationship of a conception and categories of description is that of Lewis Carroll’s’ grinning Cheshire cat, the cat being the conception, and the category of description being the grin that is left when the two are separated.

An assumption within phenomenography is that conceptions of a phenomenon are logically related to one another and the aim is to explore the relations. To facilitate describing the distinguishable and critical variation in a population’s experience of a particular phenomenon, the conceptions are organised into categories, and the categories of description that are derived must be complete for the population under investigation.

Phenomenography does not assert that the categories of description are exhaustive. The aim is to ensure that there is complete elucidation of the collective experience of the population experiencing the phenomenon. Marton and Booth (1997) report that:

All of the material that has been collected forms a pool of meaning. It contains all that the researcher can hope to find, and the researcher’s task is simply to find it. (Marton & Booth 1997, p. 133)

To facilitate achieving this aim and to ensure the quality of the categories, certain criteria must be implemented. The three criteria posited by Marton and Booth (1997, p. 125) to attain this are:

- The categories must stand in relation to the phenomenon, and a different component of the phenomenon should be described in each category, thereby telling something distinct about the way a phenomenon is experienced.
- All categories should be logically related to one another. As the various ways of experiencing a phenomenon can be more inclusive or complex than others and, as the categories of description are representative of the entirety of the variation in experiencing the phenomenon, the categories therefore are often a hierarchical representation of the relationships.
- The categories should be parsimonious, consisting of the minimum number of categories that describe the critical variation.

Outcome Space

Central to phenomenography is the identification of multiple conceptions. The limit on variation leads to the identification of distinctive categories representing the multifarious way in which phenomena can be experienced (Akerlind 2005c) and the entire categorisation forms the outcome space.

The phenomenographic outcome space is a composite of the logical relations between conceptions, but is also a representation by the researcher that expresses these

relations. The outcome space is usually hierarchical in nature and reveals hierarchical inclusiveness. Akerlind, Bowden and Green (2005) identify that a value is not attached to the categories because one particular category is better than another, but rather because, within the outcome space, some categories are more complex than others. Therefore, the structure reveals increasing complexity, and within the more complex ways of experiencing a particular phenomenon there are subsets of the constituent parts and relations (Marton & Booth 1997). The representation of the logical structure of the differing ways of experiencing a phenomenon is not always a linear hierarchy. Akerlind, Bowden and Green (2005) argue that branching structures can also be used; furthermore the elucidation of the categories and the relations between them can be presented graphically, but may also be represented in the written form, or indeed, both.

The outcome space enables the researcher to provide a representation of the relationships in the variation in ways of experiencing a particular phenomenon, and therefore facilitates the provision of insight into the critical differences in ED RNs conceptions of recovery. Akerlind reminds us that a central aim of phenomenography is to:

... describe variation in experience in a way that is useful and meaningful, providing insight into what would be required for individuals to move from less powerful to more powerful ways of understanding a phenomenon. (Akerlind 2005a, p. 72)

Rationale

The essential reason for paying an interest in people's conception of the world is a commitment to an epistemological position where the existence of a 'real' reality, common to all and available through 'unbiased' observation of the world is not recognised. There is always a filter through which the world is seen if it is to be meaningful. The interest in this filter - the conceptions of

reality that we have acquired as participants in human communication - is what characterises phenomenography as a scientific understanding. (Saljo 1988, p. 37)

The aim of this research was to explore Emergency Department Registered Nurses' conceptions of recovery for consumers with a mental illness in the ED. Therefore, the implementation of the phenomenographic method is justified as the focus is on the description of people's experiences of particular aspects of their world. Furthermore, this approach has the ability to achieve the purpose of the study as it provides the means to describe the collective variation in Emergency Department Registered Nurses' conceptions.

Research Rigour

Davis and Dodd (2002, p. 280) argue that 'rigor is the authoritative evaluation of good research and the unspoken standard by which all research is measured'. Within quantitative research the terms 'reliability' and 'validity' are used to establish confidence in research findings. However, Sandberg (2005) contends that applying criteria used within the positivistic tradition to justify knowledge is problematic in interpretive approaches, due to their ontological and epistemological viewpoints. Although there is diversity in the way in which the wide range of qualitative research can be justified, Denzin and Lincoln (2005) outline that all approaches have an ethical obligation to demonstrate to the research audience that the claims made are trustworthy accounts of a phenomenon.

In their seminal publication, *The Naturalistic Inquiry*, Lincoln and Guba (1985, p. 290) identify that the basic issue regarding trustworthiness is 'How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying

attention to, worth taking account of ? Furthermore, trustworthiness involves establishing confidence in the ‘truth’ of the findings, demonstrating the findings’ applicability in other contexts, and that the findings could be replicated with the same or similar respondents in the same or similar context’. In addition, trustworthiness is also determined by elucidating that the findings are constructed by the participants and not by the biases or interests of the researcher.

It is argued that within qualitative research rigour or trustworthiness is established through terms that provide a better fit for qualitative inquiry. Lincoln and Guba (1985) maintain that internal validity, external validity, reliability and objectivity, terms used in quantitative research, should be replaced with the terms credibility, transferability, dependability and confirmability respectively.

In the research investigating ED RNs’ conceptions of recovery the processes by which the researcher established rigour and trustworthiness are outlined as follows

Credibility

Golafshani (2003) describes how the credibility of qualitative studies is based on the researcher’s ability as well as the effort applied by the researcher. It relates to achieving the recognition of the experiences by others who share the same understanding, through the researcher’s accurate interpretation or description of the experiences, as articulated by the participants in the study.

Within phenomenographic research, credibility is concerned with the relationship between the data that the researcher obtains from the interviews, and the categories of description (Ornek 2008). Within qualitative research, member-checking is seen as

one auditable practice by which the researcher can be seen to enhance the rigour of their qualitative research (Sandelowski 1993). However, member-checking was not appropriate in this study as the emphasis in phenomenography is on collective meaning, and Akerlind, Bowden and Green (2005) outline that a single transcript is not understood in isolation from the other transcripts; but is analysed as part of a group. As such, returning transcripts to participants would be inappropriate as they would be unable to identify how their individual contribution informed development of the overall categories of description. To support the researcher's presentation of the categories of description revealing the critical differences and similarities in ED RNs' experience of recovery, the researcher included excerpts from the interviews.

Inter-rater reliability, also called interjudge reliability, has been used in many phenomenographic studies as a reliability check. In this regard, other researchers independently look for categories of description in the data. However, this reliability measure is questioned by Sandberg (1997, p. 207) who posits that this measure, which is implemented in 'positivistic research conducted from an objectivist epistemology', does not fit with and was not intended to measure research results from the phenomenographic perspective. This perspective views knowledge as relational, and considers the categories of description as the variations of individuals' experiences of a particular aspect of reality that exist at a collective level. In addition, Sandberg (1997) argues that interjudge reliability provides no information on the method implemented by the researcher, or its appropriateness.

Akerlind, Bowden and Green (2005), contend that obtaining feedback on a researcher's interpretations is commonly implemented to ensure rigour within

phenomenographic research. Cope (2004), outlines that interjudge communicability is a form of interjudge reliability. To facilitate interjudge communicability, the researcher presents the outcome space to independent researchers together with quotes or entire transcripts in order to classify the conceptions underlying them. During analysis of the data the researcher presented the outcome space to the research supervisors with appropriate quotes that were drawn from the transcripts. The researcher was cognisant that the quotes presented to the supervisors were only representative of aspects of the categories of description. Therefore the choice of quotes was based on the justification of selection outlined by Cope (2004, p. 15), that being quotes that illustrated the ‘discernment of a critical dimension of variation, relationship between dimensions of variation or difference in the boundary between internal and external horizons’.

The researcher was committed to being as faithful as possible to the participants’ experiences. Sandberg (1997, p. 209) though, maintains that in the research process the researcher cannot ‘escape from our interpretations in the research process’. Therefore, implementing interpretative awareness is a means whereby the researcher can acknowledge their subjectivity and be cognisant of their influence on the interpretations of the data. Interpretative awareness was applied in this study, and the processes that the researcher implemented to achieve this were horizontalisation and an orientation towards description. To facilitate faithful interpretation of the participant’s experience, horizontalisation required the researcher to treat all statements from the participants as equal and as significant as all others. Furthermore, the researcher avoided explaining the experience under investigation and maintained

a focus on description of the experience, thereby remaining oriented to how the phenomenon appeared.

Transferability

Marton (1986) maintains that:

The original finding of the categories of description is a form of discovery, and discoveries do not have to be replicable. On the other hand, once the categories have been found, it must be possible to reach a high degree of intersubjective agreement concerning their presence or absence if other researchers are to be able to use them. (p. 35)

Within qualitative research, reporting detail enables future researchers to repeat the study, but this is not necessarily in order to gain the same results (Shenton 2004). Sandelowski (1993) maintains that, when undertaking the same qualitative study, no two researchers will generate the same result, as there will invariably be differences in their theoretical approach to the research and their philosophical views. And, this is acceptable.

The researcher's responsibility lies in the provision of dense description, thus enabling judgements on transferability to be undertaken by other researchers (Lincoln & Guba 1985). In addition, to facilitate other researchers judging the applicability of the findings to be used in another context, the researcher provided sufficient detail of all stages of the research process. This included detail of the selection of participants for the study, as well as a dense description of the sample, including demographics. Further, comprehensive detail regarding obtaining and analysing the data, through to reporting the results of the study, is also provided.

Dependability

The researcher has provided a comprehensive and detailed methodological description which allows the integrity of the research findings to be scrutinised. Furthermore, the dependability of the study is established through an audit trail, explicating the research process and the researcher's decisions. Shenton (2004, p. 72) maintains that this 'allows any observer to trace the course of the research step-by-step via the decisions made and procedures described'.

Confirmability

Prior to exploring the phenomenon under investigation, the researcher identified personal ideas, values, and suppositions about the phenomenon. This self-reflection was undertaken in order to minimise the influence that these may have on the research (Gearing 2004). Although total detachment from the research may be desirable, it is in fact unobtainable. Inevitably, the researcher is an integral part of the research process, 'as opposed to being a disembodied bystander with the capacity to provide an 'uncontaminated' account' (Horsburgh 2003, p. 308).

Prior to commencing the research, the researcher started a reflexive journal and identified, from the outset of the research, preconceptions, values and personal beliefs that were held. She was committed to engaging in continuous reflection and self-evaluation throughout the research study, a process that occurred regularly and was constantly under surveillance from research supervisors. Reflexivity was implemented in this study, and Jootun, McGhee and Marland (2009) outline that reflexivity enables the researcher to be cognisant of how their belief system may influence the findings, and facilitates approaching the topic openly and honestly.

As discussed previously, phenomenography takes the second order perspective focusing on the ways that people experience a phenomenon. Marton and Booth (1997) state that it is essential that, throughout the research process, the researcher endeavours to make a conscious effort to put aside their experience of the phenomenon, and to see the phenomenon through the participants' eyes.

Marton (1994) argues that, when exploring others' experiences of a phenomenon,

Instead of judging to what extent the responses reflect an understanding of the phenomenon in question which is similar to their own, he or she is supposed to focus on similarities and differences between the ways in which the phenomenon appears to the participants. (p. 4428)

To facilitate transparency of the research process, and to layer credibility on the research, the researcher elucidated the choices made and the influence that these had on all stages of the research process. She also explicated the checks and balances that were made to neutralise the impact of her perspective on the interpretations and findings.

Sin (2010) provides an important prompt that the ethical conduct and integrity of the researcher is an essential feature to achieving quality in research. The ethical considerations pertaining to this research are outlined as follows.

Ethical Considerations

The Ethical approval for this research was granted by the CQUniversity Australia, Human Research Ethics Committee (HREC) on 22 November 2011, approval number H11/10-154 (See Appendix 3).

In 2012 the researcher transferred to the University of Wollongong to remain with her principal supervisor, and the amendment to the Human Research Ethics application was approved on 25 October by the University of Wollongong/Illawarra Shoalhaven Local Health District Health and Medical HREC, Ethics number HE12/111 (See Appendix 4).

The research was undertaken in accordance with the National Health and Medical Research Council (NHMRC) National Statement on Ethical Conduct in Human Research (NHMRC 2007b). The values outlined in the statement include respect for human beings, research merit and integrity, justice, and beneficence. The application of these within the research is described below.

Respect

All participants were treated as autonomous with the right to make an informed decision regarding their participation in the research. To ensure informed consent, each participant was given an information sheet (See Appendix 5). The information sheet outlined the purpose of the research and what would be required of them if they consented to participate. It also outlined the voluntary nature of the interview, the right of the participant to withdraw at any time, and reaffirmed that confidentiality would be maintained.

At the end of each interview the researcher reaffirmed the participant's contribution to the research. Additionally, participants were advised that they would receive a plain English summary of the results of the research if they had indicated this desire on their consent forms (See Appendix 6). The consent forms provided information regarding

dissemination of the results of the research, and the participants were informed that their de-identified contribution would inform a PhD thesis and may be presented at conferences and /or within journal articles. They were again reassured that they would remain anonymous throughout any dissemination activity.

Throughout all phases of participant recruitment, in both communication with the participants and implementation of the interviews, the researcher was courteous and professional, and at the end of the interviews the participants were thanked for their participation.

Research Merit and Integrity

There is a paucity of literature regarding ED Registered Nurses' knowledge of recovery as it applies to consumers with a mental illness. The researcher was committed to searching for knowledge and understanding of RNs' conceptions of recovery. Mental Health services continue to undergo reform and, as outlined by the Australian Health Ministers (2009a, p. 52), 'research and evaluation are critical to maintain momentum of reform and to question models of treatment and service delivery'. This research contributes to this agenda and to the body of knowledge by generating new understandings and insights pertaining to how RNs conceptualise recovery as it applies to consumers experiencing mental illness in the ED.

The research was undertaken under the supervision of persons with experience and expertise. The researcher had a primary supervisor and an associate supervisor who provided guidance to the researcher during all stages of the research process from inception to completion of the project. Adherence to appropriate methods, as outlined

previously in this chapter, ensured that the research would lead to the intended outcomes and achieve its aim, that being the elucidation of ED RNs' conceptions of recovery.

The Australian code for the responsible conduct of research, suggests that 'researchers have a responsibility to their colleagues and the wider community to disseminate a full account of their research as broadly as possible' (NHMRC 2007a p. 18). Throughout the undertaking of this thesis the researcher presented at conferences and published in academic journals, and while presenting the research, was aware of elucidating the status of the project and whether the findings were emerging or complete.

Justice

The National Statement on Ethical Conduct in Human Research (NHMRC 2007b) outlines that in research that is just, the selection, exclusion and inclusion of participants should be fair. This principle was applied in the equitable recruitment and selection process of this research. The inclusion and exclusion criteria and selection of participants were informed by the object of the study and the aim of answering the research question. Each potential participant was told of the inclusion criteria, that is, they needed to be a RN who is working in an ED and who had cared for a person or persons with a mental illness. To control potential discipline-based bias, RNs who were trained mental health nurses were excluded from the study. Participants were asked to identify if they were mental health nurses and, if they indicated that they were, then their participation was respectfully but politely declined. Furthermore, the participation was voluntary and therefore no unfair burden to be involved in the research was placed on participants. As alluded to previously, the participants could

receive feedback regarding the results of the research in an appropriate format if they had indicated this desire.

Beneficence

As outlined in the National Statement on Ethical Conduct in Human Research (NHMRC 2007b), the likely benefit of the research being conducted must justify any risks to the participants. The researcher was attentive to the welfare of the participants, with information imparted prior to the start of the interview that, should they experience any distress during the interview, the interview would be discontinued and they would be provided with information regarding counselling or support if needed. The researcher is a mental health nurse and trained in counselling, and therefore has had the experience and training to identify if a participant was becoming distressed, and as a result would intervene and stop the interview. Maintaining participant confidentiality was of paramount concern because the researcher was cognisant of the potential harm that could be experienced by the participants if their identities were revealed. Confidentiality was enhanced by the use of pseudonyms. In addition, participants were advised on the participant information sheets that any information that they provided would not be identifiable and, that if they happened to mention names of colleagues or their place of work during the course of the interview, these would be removed when the data from the audio recording was transcribed.

The protection of the participants' privacy and maintenance of their confidentiality was also reiterated on the consent forms and reaffirmed by the researcher at the commencement of the interviews. Furthermore, as the individual interviews were conducted by phone at a time and place that was convenient for the participants, this

facilitated the choice of an environment that they were comfortable with, and that would maintain their confidentiality.

In addition, secure data management was a priority to ensure the confidentiality of the participants. All data that was collected during the research was stored securely in an environment only accessible by the researcher. Following the interviews, the audiotapes were transcribed to individual word documents, stored on a password-protected computer and a pseudonym was assigned to each. After transcription was completed all of the interview tapes were then erased.

Research Sample

In phenomenography the emphasis is on collective meaning (Barnard, McCosker & Gerber 1999) and this research seeks to gain an understanding of ED RNs' conceptions of Recovery. Purposive sampling was therefore utilised with the participants being deliberately selected because of their relationship with the phenomena under investigation. Relevance and knowledge are essential elements in purposive sampling, that is, the selected sample needs to have relevance to the issue being examined. The ED RN participants in this study had privileged knowledge and experience of the topic under investigation (Denscombe 2010). As phenomenography seeks to achieve as much variation as possible in the experience of the phenomena (Akerlind, Bowden & Green 2005), the participants in the study were selected to facilitate this goal and to increase the chances of a maximum range of variation.

Participant Recruitment

Participants for this research were recruited through an email sent out to members of the College of Emergency Nursing Australasia (CENA) inviting them to participate

(See Appendix 7). In addition to this email, ongoing recruitment employed the snowballing technique where ‘the sample emerges through a process of reference from one person to the next’ (Denscombe 2010, p. 37). The snowballing effect, generated by participants contacting other potential participants, increases the size of the sample. The participants who were interviewed were asked at the conclusion of their interview if they knew of other ED RNs who may be interested in participating in the research. The interviewees contacted the potential participants on the researcher’s behalf and supplied them with the researcher’s contact details. Participants then made the choice to contact or not, which is also a demonstration of informed consent. In addition to providing a means of facilitating further recruitment, an additional advantage of implementing the snowballing technique is that, when the participants who have already contributed to the research refer the researcher on to others, they act as a reference for the researcher and their credibility (Denscombe 2010).

Participants

Silverman (2010) states that the participants should be selected after critical consideration of the parameters for the population under investigation. The selection criteria for this research included participants who were Registered Nurses currently working within an Emergency Department. As the focus of the study was to reveal generalist ED RNs’ conceptions of Recovery for people experiencing a mental illness in the ED, potential participants who have undergone formal mental health training were excluded from the study.

There were no specific criteria for age or gender; however, RNs with a minimum of two years experience were considered for selection as experience provides a

perspective for this research. Benner (1984) who is a nursing theorist and academic, outlines that in regard to nursing experience, typically a nurse with two – three years experience in the same area or in similar day-to-day situations is considered to be experienced.

Demographics are not provided because of any need/desire to compare, but as a way of providing the reader an overview of people who chose to participate. The age distribution for the participants is outlined in Figure 5. Four participants were aged between 22-28 years, five participants were aged 36-42 years, two participants were aged 43-49 years and three were aged over 50 years. There were no participants in the 29-35 years age category.

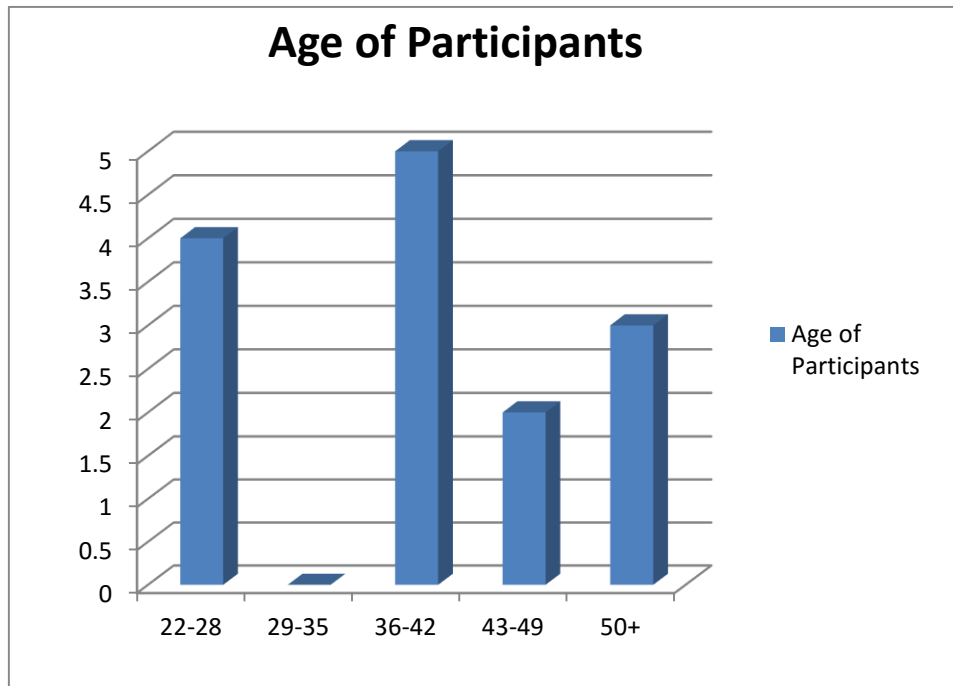


Figure 5: Participants' age

The selected participants were employed in a wide range of clinical positions within EDs located nationally throughout Australia, with varying levels of experience in both public and private hospitals and a broad range of clinical qualifications. However, all the participants were currently employed within public hospital EDs. The national geographical distribution of the participants is outlined in Figure 6.

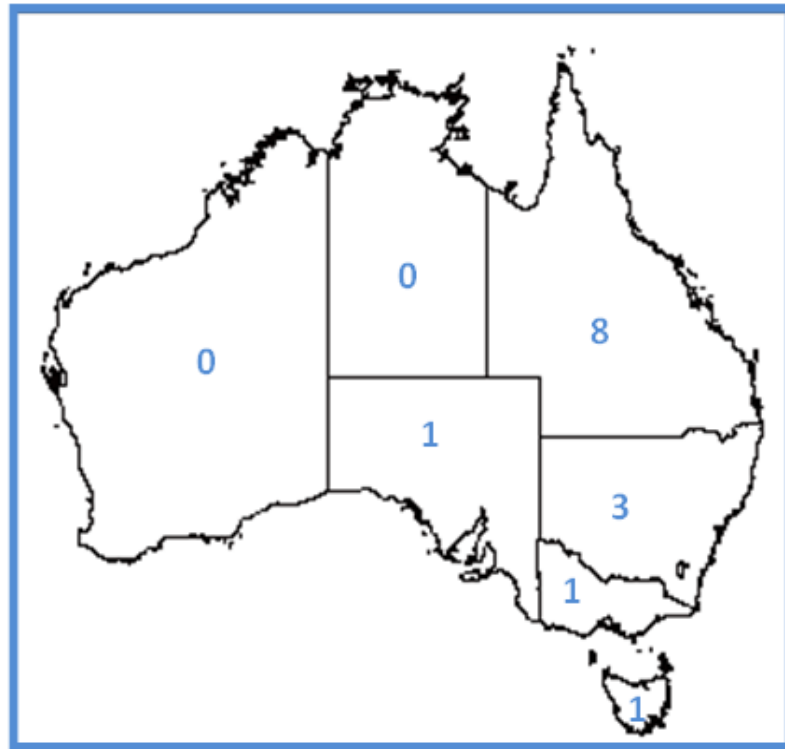


Figure 6: Geographic distribution of participants

The researcher recruited eight participants from Queensland, three from New South Wales, one from Tasmania, one from Victoria and one from South Australia. There were no ED RNs in the Australian Capital Territory, Northern Territory or Western Australia who volunteered to participate in this research. The recruitment of participants from throughout Australia aimed at achieving as much variation as possible in ED RNs' experience of recovery for people with mental illness in the ED. The geographic distribution of the participants in this study increased the chances of a maximum range of variation, and the geographic expanse of Australia is illustrated in Figure 7, which outlines a map of Australia superimposed over a map of the United States of America and Canada.



Figure 7: Map of Australia superimposed over the United States of America and Canada (Moulder 2014)

Out of the total of fourteen participants, there were ten female RNs and four male RNs. This was not unexpected given that nursing continues to be a female dominated profession with males comprising only 10.4% of employed nurses in Australia (AIHW 2014d). The researcher ensured that all RNs working in the ED had the opportunity to volunteer to participate in the research and the number of male participants was higher than expected. Figure 8 is a representation of the participants' gender.

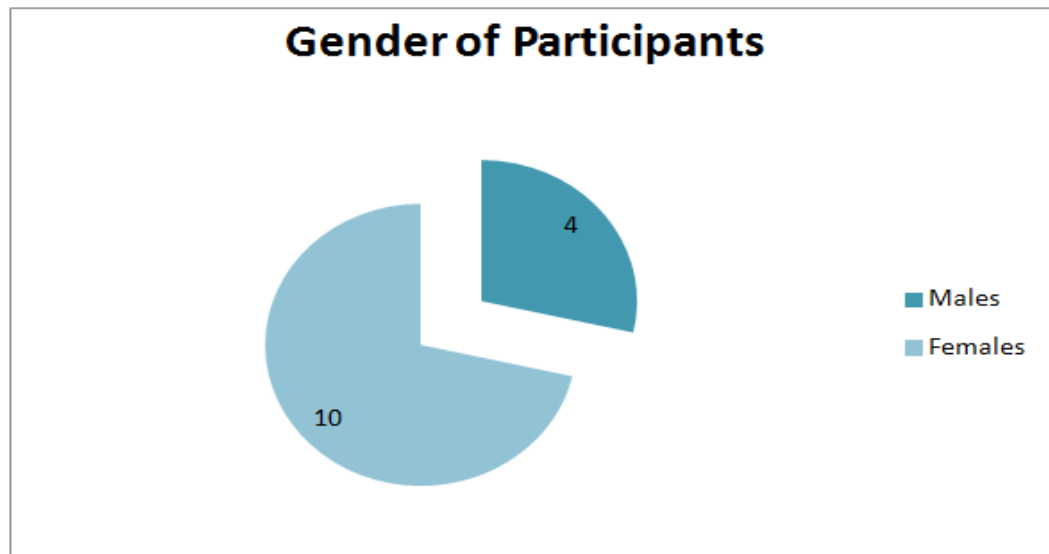


Figure 8: Participant gender

The participants had a wide range of years of experience as ED RNs. This is represented in Figure 9. One participant had between 2-5 years experience, four participants had 6-10 years experience, five participants had 11-15 years experience, two participants had 16-20 years experience and two participants had over 20 years experience.

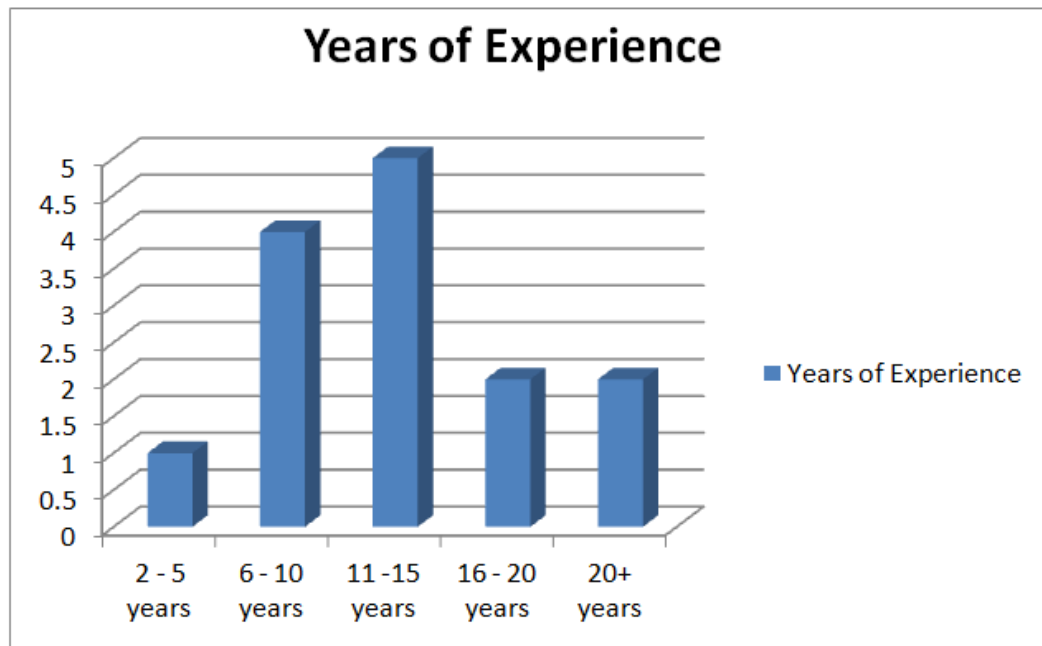


Figure 9: Years of experience as an Emergency Department Registered Nurse

Participant Numbers

Sandberg (2000) maintains that data saturation determines the sample size and is identified as being reached in a study when no new information is being added by continual sampling, and data is redundant (Bowen 2008). Furthermore, Mason (2010) contends that remaining faithful to the tenets of qualitative research generally requires the sample size to be determined by the idea of saturation. However, Trigwell (2000) argues that a minimum of ten to fifteen participants will ensure that an adequate variation of experience will be provided, and that a range of up to twenty participants will allow for the manageability of the large amount of data produced in phenomenographic research. Bowden (2005) agrees that these two factors influence the researcher's decision regarding sample size.

The literature reveals no single established size for the sample in phenomenographic research. In fact, a literature review regarding potential sample size revealed a wide range of participant numbers in previous phenomenographic studies, which is presented in Table 12. Examples include: research for PhD Theses by Qian (2009), Degen (2010) and Sendall (2009) used sample sizes of nine, six and sixteen respectively, research by Tang and Bain (1994) used a sample of ten, Bruce and Gerber (1995) used thirteen participants, Bruce et al. (2004) used thirteen participants, research by Larsson et al. (2010) used a sample size of fifteen, Ballantyne, Thompson and Taylor (1994) used a sample size of sixteen and Jangland, Larsson and Gunningberg (2011) used a sample of seventeen. The researcher was guided by previous phenomenographic research and, while 12 was deemed a suitable number of participants, interviews continued until saturation was reached after 14 interviews.

Table 12: Examples of sample sizes in phenomenographic studies

AUTHOR	STUDY TITLE	SAMPLE SIZE
Ballantyne, Thompson and Taylor (1994)	Principals' conceptions of competent beginning teachers	Sixteen
Bruce and Gerber (1995)	Towards university lecturers' conceptions of student learning	Thirteen
Bruce et al. (2004)	Ways of experiencing the act of learning to program: a phenomenographic study of introductory programming students at university	Thirteen
Degen (2010)	A phenomenographic study exploring nursing education and practice	Six
Jangland, Larsson and Gunningberg (2011)	Surgical nurses' different understandings of their interactions with patients: a phenomenographic study	Seventeen
Larsson et al. (2010)	Patients' perceptions of drug information given by a rheumatology nurse: a phenomenographic study	Fifteen
Qian (2009)	Host communication competence and mass media use among a sample of Chinese ESL students	Nine
Sendall (2009)	Conceptions of school based youth health nursing: a phenomenographic study	Sixteen
Tang and Bain (1994)	Repetitive learning, understanding and examination performance	Ten

Data Collection

Researchers using a phenomenographic approach describe the phenomenon ‘from the reports or inferences of their subjects’ (Marton & Booth 1997, p. 125). The most widely used method for data collection in phenomenographic research is the interview (Akerlind 2005c; Marton 1986; Marton & Booth 1997). Other approaches to gathering data can also be used including observations and drawings (Marton 1988), and written discourse (Bruce 1994b). Despite an individual’s conceptions being attainable in different forms, they are particularly accessible through language (Svensson 1997). Ashworth and Lucas (2000, p. 302) describe this and identify the fact that, although variations on the method for data collection exist, ‘the ideal situation is one in which the phenomenography is founded on as open a technique for eliciting experience as possible’. As the ‘qualitative research interview is a construction site for knowledge’ (Kvale 1996, p. 2) to facilitate discovering RNs conceptions of recovery, the interview was chosen as the appropriate strategy for data collection.

Pilot Interview

Pilot interviews enable the researcher to determine if the intended research question will elicit useful information on the phenomenon under investigation, and Akerlind, Bowden and Green (2005) argue that pilot interviews are an integral part of phenomenographic research. Prior to undertaking data collection the researcher conducted a small pilot study consisting of two interviews to enable the researcher to practise their phenomenographic interviewing skills and techniques. The pilot was an important phase of data collection as it allowed the researcher to practise avoiding the introduction of new information in the interview, other than that which the participant

has already articulated. This is an important aspect of the phenomenographic interview. Furthermore, it developed the researcher's confidence in initiating prompts which are required to facilitate full elaboration of the participant's experience of the phenomenon. The researcher had undertaken previous qualitative research and, as a qualified mental health nurse, was experienced in extrapolating information via an interview. However, the pilot interviews allowed the researcher the opportunity to refresh interviewing skills in a research context, an integral part of which is the ability to engage in active listening and being comfortable with, and valuing, the role of silence in the interview process. The data obtained from the pilot interviews was not included in the data for analysis. The researcher also had numerous practice sessions with her supervisors.

In-depth Interviews

The qualitative research interview is an interpersonal interaction. Kvale (1983, p. 174) describes it as a process 'whose purpose is to gather descriptions of the life-world of the interviewee with respect to interpretation of the meaning of the described phenomena'. This research relates not only to the participants experiencing the phenomenon, ED RNs, and the phenomenon under investigation, Recovery, but also to the relation between the two and the ways in which the phenomenon is experienced (Bowden 2000a).

The aim of this research was to elicit ED RNs' conceptions of Recovery. Therefore interviews were chosen as the appropriate method for data collection, because the implementation of in-depth individual interviews enabled RNs to give rich accounts of their experiences (Taylor, Kermode & Roberts 2006), and reveal their ways of

understanding recovery. The most common interview setting in phenomenographic research is the individual interview (Bruce 1994a). Individual interviews were chosen by the researcher as they enabled the researcher to probe the experience of the individual participant extensively. Furthermore individual interviews allowed the researcher to seek constant clarification of meaning and obtain extensive descriptions of the variation in meaning (Bruce 1994a).

The interviews were conducted with the participants via telephone. Mack et al. (2005) suggest that this method of conducting an interview qualifies as in-depth interviewing and enables the participants to reveal the way in which they understand the phenomenon. An advantage of this method is that it facilitated wide geographical access (Opdenakker 2006). This is instrumental in achieving a central aim of phenomenographic research, that is, to achieve as much variation as possible in the experience of the phenomena.

Although the interviews were not conducted face to face, the synchronous communication of time facilitated the spontaneity of responses by the RNs and allowed the interviews to be audiotape recorded. Although the researcher conducting the interviews could not see body language, the social cues of voice and intonation were still available. A disadvantage of the telephone interview is the asynchronous communication of place that results in the interviewer not being able to facilitate the environment in which the interview would take place and also not being able to view the situation in which the participant is being interviewed (Opdenakker 2006). However, this was mitigated by the fact that prior to the phone interview the researcher negotiated a time that was convenient for the participant, therefore ensuring that the

participant had the opportunity to chose an appropriate setting and environment in which they would be interviewed.

As posited by Bowden (2000b) throughout the interview, as with all other aspects of the phenomenographic study being undertaken, the focus must be maintained. To ensure this occurred a framework was implemented to guide the interview. The framework consisted of the following:

- An introductory statement
- A primary open-ended question
- A list of possible key prompts and follow up questions which were identified during the pilot interviews

The interview began with a standardised contextualising statement that introduced the phenomenon of recovery and enabled the participants to focus on the phenomenon under investigation. This also facilitated positioning the ED RN who was being interviewed as the expert in the interview (Aslop & Tompsett 2006). Furthermore, the introductory statement was used to reaffirm ethical issues (Trigwell 2000), such as the voluntary nature of their participation and their ability to withdraw from the interview at any time. The introductory statement read:

Registered Nurses working in the Emergency Department care for many people that have a mental illness. My interest is your experiences and conceptions of recovery as it applies to people experiencing a mental illness in the Emergency Department. I will begin the interview with a general question and will follow up on issues that you introduce, there may be pauses during the interview, this will allow me to take notes

and reflect on statements that have been made. Your participation in this interview is voluntary, you are free to withdraw from the interview at any time, and confidentiality and your anonymity will be maintained.

Bowden (2000b) advises researchers that in phenomenographic interviews the researcher should begin the interview by asking the participants a planned question or inviting them to respond to a particular situation. This advice was followed and after the introductory statement the researcher prompted the participant with the following primary question:

What is your understanding of recovery as it applies to consumers with a mental illness in the Emergency Department?

This question introduced the phenomenon under investigation and enabled the ED RNs to focus on the phenomenon that was being introduced and thus reflect on their experiences and understanding of recovery. Furthermore, the primary question maintained the focus of the interview and the subsequent conversation flowing from this research question.

Patton (2002, p. 353) asserts that:

Qualitative inquiry- strategically, philosophically, and therefore, methodologically- aims to minimise the imposition of predetermined responses when gathering data. It follows that questions should be asked in a truly open-ended fashion so people can respond in their own words.

Following the introduction of the primary question the researcher utilised subsequent open-ended questions on which there were no limitations on the length or range of

responses. Open-ended questions enable the participants to fully elucidate their experiences and understanding of Recovery for consumers (Mack et al. 2005). Furthermore, open-ended questions allowed the participants the opportunity to choose the dimensions of the answers that they provide. This is of particular importance in phenomenographic research as it enables aspects of the questions that are relevant to the participants to be revealed (Marton 1986).

Follow-up questions, probes and prompts were used to enable the researcher to seek clarification and explanation of meaning. Throughout the interview process the researcher was ‘working toward an articulation of the interviewee’s reflections on experience that is as complete as possible’ (Marton & Booth 1997, p. 130). The discourse gave the researcher the ability to continually check on the meaning that the participants attributed to particular words (Bruce 1994a). To ensure the quality of the data obtained, and that meaning was made explicit during the interview, it was important that the researcher immediately interpreted what the participant was saying, as this guided the decision as to whether further probing or additional questions were needed (Sjöström & Dahlgren 2002). However, the follow-up questions were only extracted from the discourse with the participant, and only from what the participant had already introduced to the interview (Bowden 2000b). Furthermore, the use of prompts enabled the researcher to focus the interview to facilitate achieving the aim of the research, that is, to discover RNs conceptions of recovery.

As prompts were integral to eliciting underlying meaning (Akerlind 2005a), the researcher used them to gather more detail from what the participant introduced. Given the context, prompts could not be planned in advance. However, the knowledge gained

from pilot interviews enabled the researcher to develop a list of possible prompts to assist when ideas or statements introduced by the participants required further exploration and/or clarification. The number and type of follow-up questions and prompts used by the researcher during the individual interviews depended on how specifically and comprehensively the participant answered the main question.

Examples of prompts that were used by the researcher during the interview process include:

- When you mentioned....can you tell me what you meant?
- Can you give me an example?
- I'm not quite sure I understood ... could you tell me more about that?
- Can you explain that further?
- Could you tell me more about your thinking on that?

The researcher stopped probing when the participants began to repeat themselves or when the researcher sought clarification on a phrase or statement that the participant had introduced and had difficulty elaborating further. As stated by Akerlind (2005b), these indicators are seen as signs that the full meaning has been expressed by the participant. In addition, the researcher asked the participants to give concrete examples of comments they made, as phenomenographic research seeks to elicit variation in meaning, and therefore goes beyond purely linguistic differences and seeks elucidation of the participant's intentional attitude towards the phenomenon (Akerlind, Bowden & Green 2005).

After the twelfth interview the researcher was becoming aware that repetition of information was occurring. The researcher continued interviewing the final two participants, at which point the researcher was confident that no new information was emerging. Tempone and Martin (2003) outline that although there is infinite variation in meaning; the variation that occurs in the significant features of the meaning is limited.

The interviews were audio recorded and had a duration of between twenty-four and fifty-eight minutes. As the interviews were the only source of data collection the transcripts were the focus of the analysis. As such the interviews were transcribed verbatim to ensure accuracy and comprehensiveness (Akerlind, Bowden & Green 2005).

The researcher undertook the transcription of the interviews as this enabled a greater and deeper familiarity with the data (Daymon & Holloway 2011; Merriam 2009). Furthermore, while transcribing the data, the researcher was afforded a greater knowledge of the content of the transcriptions, and as outlined by Hahn (2008, p. 78), 'transcribing is a pre-coding immersion into your data'.

It is argued that transcription occurs within a continuum that incorporates the two main approaches of naturalism and denaturalism (Oliver, Serovich & Mason 2005). Thus, the approach implemented in a study will relate to how the representation of language is considered. Within a naturalised approach, transcription is a verbatim representation of speech and contains comprehensive detail of all utterances including details such as pauses and stutters. In contrast, although denaturalised transcription also endeavours

to provide a verbatim representation of the participant's speech, the concern is with the content of the interview, that is, the meanings and perceptions, and therefore transcription of minor linguistic aspects and utterances such as involuntary vocalisations is not and was not undertaken. The researcher implemented denaturalised transcription of the interviews, as this approach was best suited to facilitate the purpose of this research and answer the research question of what are ED RNs conceptions of recovery.

The process of structuring oral discourse into written discourse provided the researcher with an overview of the participant interviews. Kvale (1996) argues that this is the beginning of the analysis. To ensure accuracy the researcher triple checked all 14 audio taped interviews against the transcripts. This verification was integral to maintaining trustworthiness in the research and remaining faithful to the participants' utterances.

Data Analysis

All of the data were collected by the researcher before analysis began as per phenomenographic methodology. Ashworth and Lucas (2000, p. 298) contend that 'assuming pre-given theoretical structures or particular interpretations' is a presupposition that must be bracketed. The researcher was aware of the risk of precategorying of the categories of description and the risk of altering later interviews and therefore the researcher bracketed the experience of the earlier interviews. Bowden (2005, p. 20) argues:

If the researcher has already begun to analyse the early interviews before the rest are complete, there is a real danger that the later interviews will be altered, either explicitly or perhaps unconsciously.

Throughout the research process the researcher was aware of a fundamental aspect of the phenomenographic approach, made up of intentionality and the existence of relationships; the relationship between the researcher and the participants, and the relationship between the researcher and the phenomenon. The notion of relationality is diagrammatically illustrated in Figure 10.

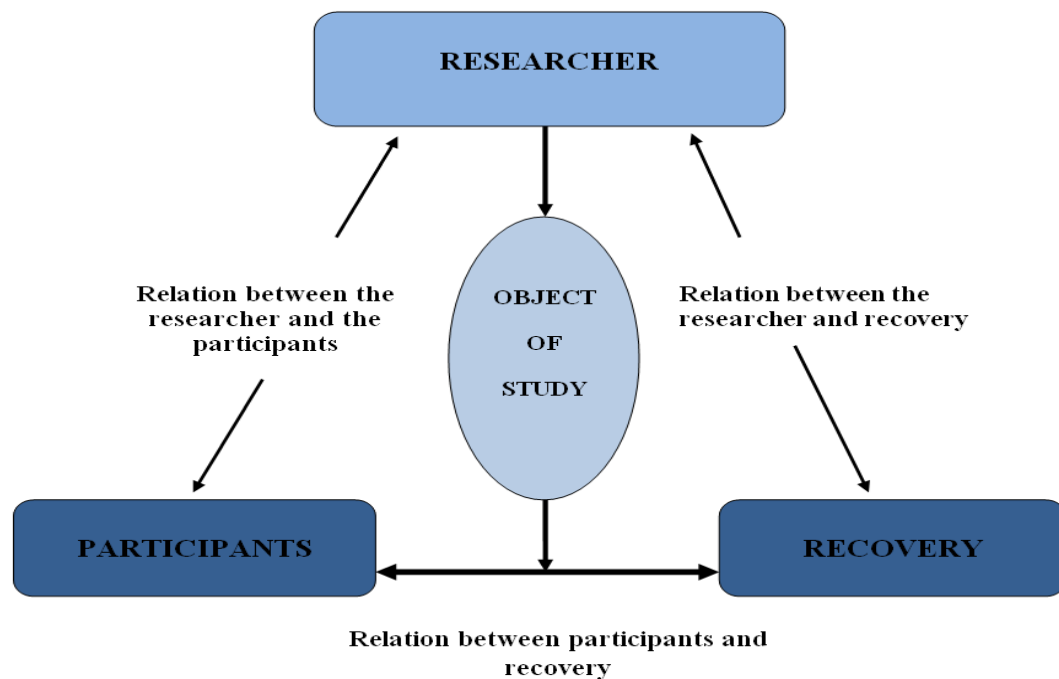


Figure 10: Phenomenographic view of relationality (adapted from Bowden 2005, p.13)

Bowden (2005) states that during interpretation of the data it is imperative that the researcher brackets their relation to the phenomenon under investigation and utilises only the transcripts as evidence. Throughout the study the researcher remained cognisant of maintaining the focus of the research, which was to explore the relationship between ED RNs and recovery.

A distinctive characteristic of phenomenography is the techniques utilised to facilitate rigorous qualitative analysis (Entwistle 1997). The analysis of the data is iterative and includes specific processes, the identification of relevant data (pools of meaning), repeatedly sorting, contrasting, grouping and developing categories of description. However, variations exist, and the phenomenographic approach is not limited to a particular method of analysis for obtaining the categories of description (Akerlind 2005c; Marton 1986; Yates, Partridge & Bruce 2012).

Commonalities though, do exist, and as Akerlind (2005c) outlines during phenomenographic analysis the researcher must be aware of keeping an open mind and avoiding an expeditious establishment of the categories of description. Ashworth and Lucas (2000, p. 300) purport that ‘Analysis should avoid premature closure for the sake of producing logically and hierarchically-related categories of description’. In addition, as the focus of phenomenography is on collective human experience, rather than focusing on individual transcripts and categories that are becoming known, the researcher maintained a focus on the entire set of transcripts and categories. It’s rather like keeping your eyes on the goal while being alert to objects in your peripheral vision.

In addition, variations exist in whether researchers undertake analysis alone or in collaboration with other researchers. The researcher chose to undertake the analytic process alone, but was monitored and reviewed by supervisors. Akerlind (2005c) suggests that high quality phenomenographic research can be achieved by individual researchers as shown by the large number of phenomenographic doctoral theses within the literature.

The literature reveals variations in the phenomenographic analytic stages. The algorithm that was implemented to analyse the data in this research consisted of a seven stage cycle as implemented by Dahlgren and Fallsberg (1991) and McCosker, Barnard and Gerber (2004). During the analysis process the researcher did not use computer software programs to assist with the coding of data but instead coded manually, as the researcher felt more comfortable coding using a hands-on method.

The seven stages alluded to above included the processes of familiarisation, condensation, comparison, grouping, articulating, labelling and contrasting. A visual representation of the stages of analysis is illustrated in Figure 11.

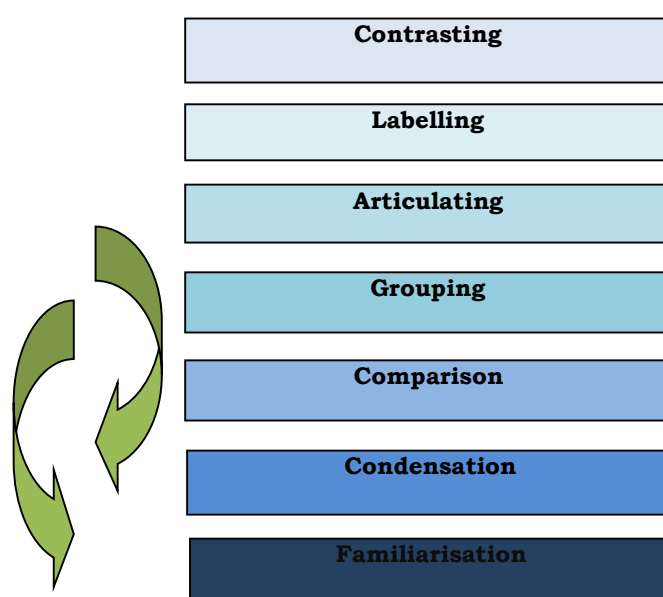


Figure 11: Seven stage cycle of data analysis

These stages and the researcher's application of each in the analysis of the data are now discussed in detail.

Stage 1: Familiarisation

This step of the analysis involved the reading and re-reading of the written transcripts in order for the researcher to become fully acquainted with the data. The researcher was afforded prolonged exposure to, and immersion in, the data while undertaking the interviews with the participants and the transcription of the interviews, which involved repeatedly listening to the audio recordings.

During this stage the researcher listened to the audiotapes while simultaneously reading the transcripts and compared what was written in the text to the recordings to ensure accuracy. She made any corrections where necessary and took the opportunity at this point to highlight any leading questions that may have been inadvertently introduced into the interview so that these portions of transcript could be removed during the next stage.

Following this stage of familiarisation the researcher started stage two of the analysis.

Stage 2: Condensation

The researcher read the fourteen transcripts as a set and reduced the interview dialogue into central parts. Then she selected and marked the most significant statements from the transcripts that were representative of the discourse regarding the phenomenon. These were considered by the researcher to be of relevance for the phenomenon under investigation (Marton 1986) and represented the range in variation of ED RNs experiences of recovery. The researcher highlighted the significant statements in coloured text in the word document.

The researcher was able to reduce the considerable amount of data that was produced from the interviews. This was achieved by the parts of the interview perceived to be extraneous and bearing no relation to the phenomenon in question being removed, as were any leading questions that the researcher had identified in the previous stage of analysis.

Stage 3: Comparison

The statements that were selected in stage two were compared, and the researcher looked for similarities and differences. Akerlind, Bowden and Green (2005, p. 87) inform researchers that ‘The emphasis when reading the transcripts is to discern the fundamental meaning of the phenomenon as expressed in the transcript’. In order to elucidate the underlying meaning expressed by the participants the researcher employed a strategy implemented by Bowden (2000a). This involved, when reading the transcripts, the researcher asking questions such as ‘what does this statement tell me about how the ED RN understands recovery’, and ‘why are the selected statements similar and why are they different?’ The selected utterances made up a data pool of meaning units and it was at this point that the researcher moved past the boundaries that separated the individual participants, and focused on the meaning within the selected statements (Marton 1986).

The researcher made notations in the margins of the word document next to the highlighted statements, as tentative attempts were made to search for meaning embedded in the quotes. When searching for meaning, the researcher maintained a focus on the interview as a whole and, with each selected quote, examined what was

being said in the rest of the interview. Therefore the highlighted statements were always focused on, but with regard to the whole transcript. As argued by Marton (1986), each of the selected utterances has two contexts in which the interpretation occurs, the interview from which it came and the data pool that the selected statement has been placed in.

As the researcher moved through the transcripts it became apparent that some transcripts contained more than one way of experiencing the phenomenon. Akerlind (2005b) maintains that in addition to the possibility that transcripts may hold several ways of experiencing a phenomenon, they may also only contain a fragment of a particular way of experiencing.

Stage 4: Grouping

In stage 4 the researcher grouped statements that appeared to be similar and placed them together into categories. The colour of the highlighted statements in the transcripts was changed so that a colour coding system was developed with similar hues correlating with similar experiences. The researcher did not engage in a 'cut and paste' approach to grouping the statements, wanting to maintain a focus on the interview as a whole and the transcripts as a set. Establishing categories of description that encapsulate meaning are central to phenomenographic research. Bowden (2000b, p. 12) posits that when seeking to produce categories of description 'de-contextualisation makes the task more difficult and is a methodological variant which is at odds with the underlying relational nature of phenomenography'.

During the analytic process the researcher sought to reveal the critical variation in experience. Akerlind, Bowden and Green (2005, p. 82) comment how the distinction between critical and non-critical variation can be challenging and as such they provide the following definition for distinguishing between the two:

‘Critical’ variation is that which distinguishes one meaning or way of experiencing a phenomenon as qualitatively different from another. ‘Non-critical’ variation in meaning is that which occurs within a particular way of experiencing, and does not distinguish between different ways.

The researcher continued with the iterative process; regrouping statements and constantly referring back to and re reading the transcripts as a holistic group, so that deeper interpretations of the data could be obtained.

Stage 5: Articulating

After the selected statements were grouped, the researcher engaged in a preliminary description of the core similarity intrinsic to each group. The researcher engaged in reflection and kept an open mind throughout the analysis in order to ensure that the extracted statements were representative of similar conceptions of recovery. Furthermore, the researcher did not move through each stage in a sequential process, but engaged in interplay between the various stages (Dahlgren & Fallsberg 1991). Further, there was repetition of the process until the researcher was confident that the description of the category reflected ED RNs understanding of recovery. The categories established were reflective of the collective understanding of ED RNs, with Johansson, Marton and Svensson (1985, p. 249) suggesting that ‘the categories are, however, not identical with conceptions – rather they are used to denote them’.

Stage 6: Labelling

Linguistic expressions were constructed by the researcher to serve as labels for the categories of description. Throughout the research process the researcher endeavoured to remain faithful to the participants' ways of experiencing recovery. When deciding on names for the categories of description the researcher focused on establishing labels that would appropriately reflect the distinctive content of each of the categories. The process of selecting names continued until the researcher was satisfied that the focus of each category was revealed with names that were fitting.

Stage 7: Contrasting

During the final stage of analysis the researcher searched for similarities and differences between the categories of description and the relationship that existed between them. The researcher engaged in establishing a logical structure that related the categories. Marton and Booth (1997) maintain that an epistemological assumption central to phenomenography is that different ways of experiencing a phenomenon will be logically related. Structural consistency between the categories was elucidated. Additionally a visual representation of the hierarchical relationships between the categories was developed, illustrating the logical relations and the complexity of dimensions of variation in ED RNs' experience of recovery.

Summary

This chapter provided a comprehensive discussion of the qualitative research approach of phenomenography. It described in detail the fundamental assumptions inherent

within this approach. Furthermore, the principal features that characterise phenomenography and facilitate its aim of describing variation in the experience of a phenomenon were expounded.

The process of data collection was explained, which included information on the number of participants, participant recruitment and ethical considerations. In addition, the method of data analysis was described and information on the algorithm utilised to facilitate analysis was discussed.

The following chapter will discuss the findings and elucidate the categories of description and the outcome space.

CHAPTER FOUR: FINDINGS

Introduction

This chapter presents the findings from this research that describes the qualitatively different ways in which the ED RN participants understand recovery for consumers with a mental illness. The first part of the findings explores the referential aspect of conceptualising recovery, with this being articulated as categories of description that represent the critical variation in ED RNs' conceptions. Verbatim quotes from the participant interviews are provided to support the researcher's formulation of the categories, with selected significant statements providing tangible examples for each of the identified categories of description.

The analysis of the fourteen interviews was reduced to a parsimonious set of six categories of description, which is in keeping with the criteria in phenomenographic research for ensuring the quality of the categories. Furthermore, each category reveals a distinct aspect of the phenomenon of recovery, and is a grouping of these different aspects. They are a description of the collective understanding of the research participants, as per the methodological approach within phenomenography, and therefore, the categories are not attributable to any one individual. The researcher does not assert that the identified categories of description represent all of the ways that recovery can be understood. However, the aim of the research was to fully elucidate the critical variation that exists in the ED RN participants understanding of recovery for consumers.

The second part of the findings explicates the structural aspect of conceptualising recovery, and is represented as an outcome space. Within phenomenographic research

the outcome space presents the organisation of the categories of description, and communicates the ways in which the participants understand a phenomenon. The structural relations between the six categories of description that represent how the ED RN participants understand recovery for people with mental illness are expounded. The outcome space is diagrammatically presented in Figure 12 as a staged hierarchical structure. This illustrates the researcher's representation of the logical relations that exist between the categories of description.

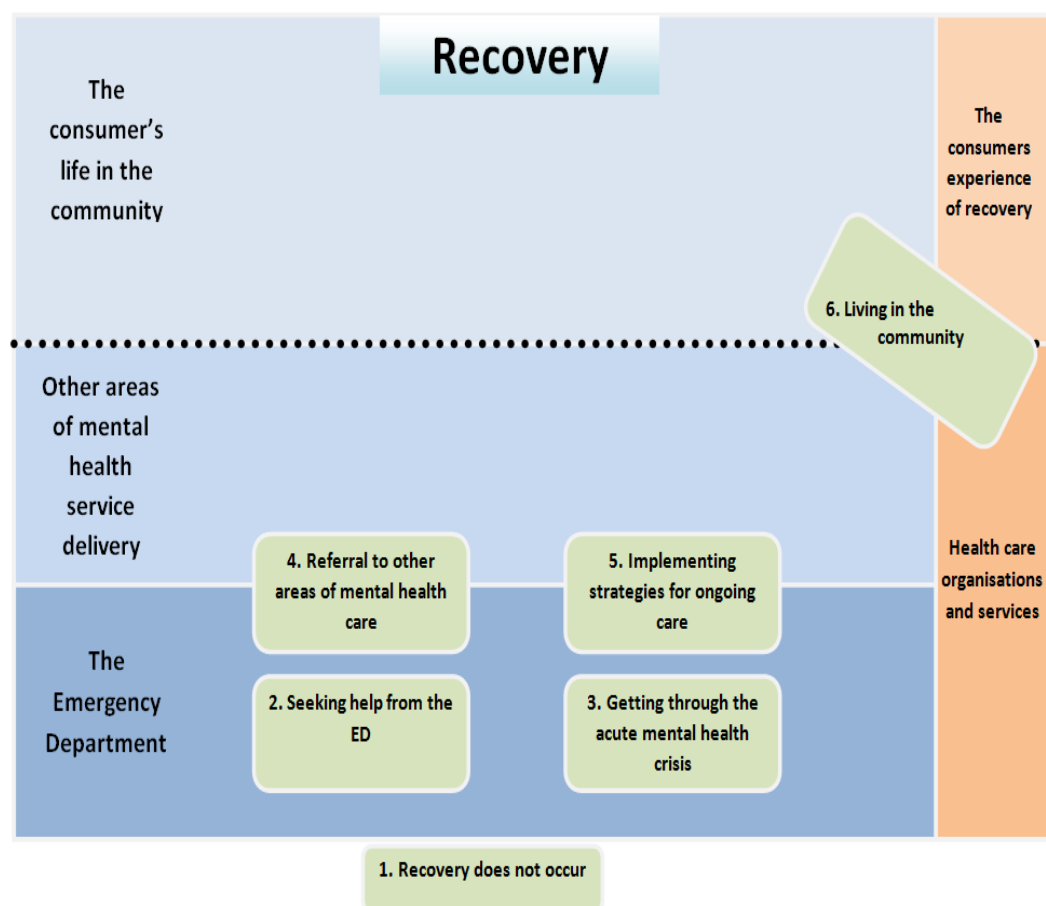


Figure 12: The outcome space for ED RNs' conceptions of recovery

The categories of description identified for ED RNs' conceptions of recovery

The categories of description represent the critical variation identified in the collective understanding of recovery by the ED RNs. The six categories of description identified for ED RNs' conceptions of recovery are:

- **Recovery does not occur**
- **Seeking help from the ED**
- **Getting through the acute mental health crisis**
- **Referral to other areas of mental health care**
- **Implementing strategies for ongoing care**
- **Living in the community**

Each of the six categories of description is now explained in detail and significant verbatim quotes taken from the participant interviews are included to support the researcher's identification of each category.

Category of Description One:

Recovery for consumers is: *Recovery does not occur*

Participant narrative drawn from the transcripts:

- *'I don't think that word 'recovery' occurs' (P6)*
- *'A lot of the time they don't actually get better do they, you know. I suppose you know even I don't sound particularly positive, in the sense of them having a full recovery. I mean what percentage of people do you see with a mental illness that actually recover?' (P10)*
- *'In emergency, I have never seen somebody recover in an emergency department, of a psychiatric patient, ever' (P4)*
- *'Generally in the ED we see someone with a mental illness in an acute disturbed circumstance so therefore usually we are just dealing with the acute episode and to me recovery conjures up that we have achieved something. So I would say personally that the thought of using the word recovery with mental health patients in the ED is limited to nonexistent' (P 1)*
- *'It's difficult for people with a chronic mental illness to be viewed as recovered in the ED' (P 12)*
- *'There is a lot of negativity and because we don't see many people with mental illness getting better at any level, there's a lot of negativity regarding the whole thing' (P 10)*
- *'I find sometimes, depending how people present, that they are labelled a bit too quickly. Or there is the mental health diagnosis that may not be appropriate, but that is tagged to that person before a full assessment is completed by a specialist rather than just a trainee. So for me, for someone that presents for the first time or newly diagnosed, I think that they have been labelled just a bit too early and once the mud sticks, its stuck' (P 9)*
- *'You can quite readily see medical recovery but in terms of psych, I don't know that you see too many you know' (P 10)*

- *'In terms of recovery for mental health patients that walk into an emergency department I think it probably has to be seen in the light of that individuals life, you know so a full recovery for someone with a brief drug induced, brief psychosis, you know that might be realistic. But it is related to the individual and what the outlook for that particular, their illness, would be' (P 10)*
- *'I don't think any mental illness has an end point. I mean depending on what it is, if medication works for them then there might be middle ground maybe. I don't think for Schizophrenics or Bi Polars there is ever an end point' (P 11)*
- *'...they have got a diagnosis and then they are able to move on' (P 7)*

In this first category of description, ***Recovery does not occur***, ED RNs understand recovery as something that does not happen for people who present to the ED when experiencing mental illness. Recovery is perceived as an improved clinical outcome for a person who presents to the ED, for example 'to get better'. Participants said that they do not consider recovery as possible for consumers. Consumers experiencing mental illness are not perceived by RNs as a population group that can actually can 'get better', so subsequently the associated pessimism related to the expectations for the consumer's future becomes the dominant discourse. RNs maintain the view that a mental illness and the associated symptoms cannot be alleviated for the consumer. Consequently they articulate an anticipated negative outcome.

Consumers who ‘**do** get well’ as defined within the RNs’ articulated clinical understanding of recovery, are perceived to be a small percentage of those who are living with a mental illness. This ultimately contributes further to the perpetuation of this understanding of recovery as being something that is fundamentally unachievable.

Category of Description Two:

Recovery for Consumers is: *Seeking help from the ED*

Participant narrative drawn from the transcripts:

- *'The recovery, I think it's just when they are trying to get help from the start, when they come in with psychosis or whatever episode they are having and just getting them the help to start with' (P11)*
- *'To begin with my understanding is the fact that the person has presented in the ED, it's like the first approach to wanting treatment and wanting some sort of help. Whether they have volunteered to come in or whether they have been brought in by health workers or police or other concerned family members, whoever has brought them in, it's the first point of commencing some sort of assistance for them' (P3)*
- *'Anyone who gets to emergency that's the start of their recovery phase, so if you walked into emergency saying you want help for your mental illness you've already started your recovery process because you've made the decision that you want help' (P 13)*
- *'The ED is a positive stepping stone to recovery' (P 6)*
- *'I guess medical and mental health patients like in the short term when they present to ED are very similar in a way, but we need to treat short term problems so they can move on, I guess the ED is in the initial part of that recovery' (P 7)*

In the second category of description, *Seeking help from the ED*, recovery is understood by ED RN participants as the consumer wanting to get help with their mental health issue, and therefore making the initial contact with health services by presenting to the ED. The ED is viewed as a place that consumers experiencing a mental illness can go to in order to begin their recovery by engaging with health services and seeking assistance with their mental health issue. This ‘connection’ is viewed as the start of a consumer’s recovery. Participants expressed their understanding that, given consumers present to the ED for help, the ED can therefore play an initial role in their recovery.

During the semi-structured individual interviews the ED nurses said that they thought the ED care environment provides initial treatment and specialises in acute care and that, although recovery for mental health consumers does not occur in the ED, by seeking assistance consumers are thereby making the first step towards their recovery. ED nurses expressed that they are involved in the recovery of consumers, even though the outcome, that is, the end result of intervention and care, is not seen in the ED. ED nurses further articulated that they contribute to and support a person in their recovery by providing care that is part of their daily practice. This care is identified as predominantly consisting of assessment, medical treatment and/or referral.

People presenting with emergent medical conditions (physical injury and illness) and people experiencing a mental health issue are seen as somewhat homogenous by participants in that they are both thought to require short term care from the ED staff

in order to facilitate the optimal outcome; ie an improved condition. People who present to the ED are seeking care for an emergent health issue, whether it is medical or mental health, and participants describe the role of ED nurses as the provision of assessment and immediate care. The statements from the participants suggest that they understand recovery for consumers as being the same as recovery for people presenting with physical illness and injury, in that the care provided in the ED is the initial step towards their recovery,' and thus "being recovered". Consumers presenting to the ED for care was perceived as a positive step, as a way of seeking health service support and as a constructive move towards getting well. As can be expected ED RNs' understanding of recovery for consumers experiencing mental illness remains grounded in the biomedical understanding of recovery, that being, getting better and ultimately having improved clinical outcomes.

Category of Description Three:

Recovery for consumers is: *Getting through the acute mental health crisis*

Participant narrative drawn from the transcripts:

- *'I think as part of ED the way I see it is, if I was going to apply the word recovery to it, which I have never thought about, but if I was going to use the word recovery it would be just about getting through that crisis like bringing it to a manageable place' (P5)*
- *'Now if you are coming to us under mental health paperwork via ambulance or police, that's part of recovery in the fact that we will provide you with a place of safety, we'll get you some medication that you need to help calm you down, we'll let you sleep off the alcohol or whatever you need to get better' (P13)*
- *'Recovery, I would interpret that as getting them to a level that you could either discharge or admit, which probably sounds a little bit weird I just find that the wording recovery an interesting concept in the ED in particular with mental health' (P1)*
- *'These poor people have a lot of these diagnoses for life and they will keep re-presenting, so it's up to us to keep recovering them' (P13)*
- *'A mental health patient you may well get some recovery from an acute crisis within the time they are in ED but it is not long term recovery, as compared to having a general health problem' (P1)*
- *'A lot of mental health issues are not really a short term fix; they are more of a long term sort of therapy... mostly because they keep coming back' (P 7)*
- *'The role of the ED is to get them seen and assessed quickly' (P 8)*

- *'When you say the word recovery, the word recovery sort of confuses me a little bit. So obviously in emergency I'll explain to you what we sort of do. We offer a service for patients in an acute stage of their illness. They present to emergency under a number of different forms, whether that be on their own accord, with the ambulance service or with police. Sometimes with multiple modes all at once and basically we provide a rapid assessment environment for these people' (P 13)*
- *'Patients come in, they are really unwell, this is the really agitated and the aggressive sort of patient and quite often they haven't slept for a very long time, for days or whatever and usually, often it's a drug induced psychosis. Quite often our role in the emergency department is to facilitate rest and then hopefully, by the time a bed has been allocated in the mental health system and they are not with us in the emergency department, they have had a bit of a rest' (P 2)*
- *'They don't actually have a wound or an illness, something that you can see' (P 3)*
- *'It's a more personal approach for a mental health consumer rather than a medical consumer because you have a disease process with a medical person and this is how you treat it A, B, C, whereas a mental health consumer you have got to actually listen, but you know you have to treat them more as an individual rather than a diagnosis' (P 12)*
- *'We see a lot of people that come in regularly...most of them have got a plan put in place so if they come into triage, there's a folder so you know what to do for a certain person' (P 8)*

- *'I mean some of them, the ones you can send home that shift, their recovery is obviously a fair bit quicker, but the ones that go to Ward X or Ward Y you don't kind of follow up on them from there. So you don't know how long they are in there for or how long they are going to be there' (P 11)*

In the third category of description, recovery for consumers as ***Getting through the acute mental health crisis*** is understood as getting through the mental health issue that has precipitated their presentation to the ED either voluntarily or involuntarily. Participants said that the timely assessment and implementation of appropriate nursing care is common to all presentations that they manage in the ED as part of their daily practice. RN participants state that recovery for people experiencing mental illness is understood as the immediate intervention to facilitate the management of the symptoms of mental illness that have intensified or have become unmanageable for the consumer. And as a consequence they have sought assistance from the ED during this crisis.

A person's signs and symptomology are central components of the clinical medical model in which ED nurses' practice is based, and the amelioration of a mental health consumer's symptoms is viewed by RNs as integral to facilitating recovery. Participants stated that being able to see a quantifiable change in the consumer's clinical presentation, such as an improvement of symptoms or alleviation of distress, contributes to their understanding of recovery as getting through the acute mental health crisis. Again, this demonstrates a reference to symptom reduction or getting better. Furthermore, in talking about recovery for consumers, reference was

continually made to the term ‘cure’ and a conceptual association between the terms ‘recovery’ and ‘cure’ is maintained. As stated previously, this is a conceptualisation grounded in the clinical medical model dominant within ED daily practice.

The clinical understanding of recovery embedded in ED RNs’ practice equates to, and is described by, participants in terms of the improvement or cessation of presenting symptoms. Such an outcome is viewed as necessary for recovery to be realised. Therefore, ED nurses focus on the treatment and management of presenting symptoms to facilitate the aim of recovery for consumers, as they understand it.

A pessimistic view of chronicity by RN participants emerged as a factor that negatively impacts the recovery of people experiencing mental illness. Participants expressed frustration that people experiencing mental illness re-present to the ED on numerous occasions. There were many terms used by participants for consumers who regularly appeared at the ED seeking health services which contributed to the notion of pessimism. Language included terms like “frequent flyers”, “revolving door”, and “non urgent”.

The conceptualisation of recovery as a return to a pre-illness state or cessation of symptoms reinforces and contributes to an understanding by ED nurses that it is their role to keep “recovering” people who re-present to the ED in a mental health crisis. The regularity of some consumer presentations contributes to the perpetuation by participants of the understanding that people with a mental illness “have a diagnosis for life” and will therefore continually need “recovering” throughout their lives. RN participants viewed recovery for people with mental illness through a specific acute

care clinical lens, and chronicity is viewed as a factor that can determine whether a person will or will not recover.

Category of Description Four:

Recovery for Consumers is: *Referral to other areas of mental health care*

Participant narrative drawn from the transcripts:

- *'I think that when people present in the emergency department they are assessed and redirected to areas appropriate to their need where recovery can take place there, in those areas' (P3)*
- *'I don't think they get what you call recovery from the ED, possibly management and then they are usually transferred to a another setting' (P6)*
- *'They come to us to be put on the right path for them to be recovered' (P12)*
- *'So about recovery, to sum it up if a patient presents to the Emergency Department and I guess if we are talking specifically about the mental health patient I don't see myself as an Emergency nurse has any role in the recovery phase of their mental health presentation' (P2)*
- *'Recovery for me would be addressing why the person has presented to the ED, and I don't think that is done well, so the person will come to the ED for whatever reason and they will be directed to the appropriate place' (P6)*
- *'I don't think recovery is part of the emergency department. I see the place of emergency in recovery is more about referral to speciality, you know to like mental health specialists that can manage and monitor crises far better than what I know generally EDs can' (P5)*
- *'ED is just like a doorway to further management' (P6)*
- *'...well I guess that's kind of what emergency nursing is, symptom relief, and then referring on to the appropriate area' (P 7)*
- *'They come into the ED, a short term fix for whatever is happening and then someone else takes over, the mental health system' (P 3)*

- *'You know like we will sort them, we will interview them, sort them and refer them and be part of the deal from there on but I don't think ED sees itself as a particularly therapeutic agent in this system, we just see things that come in on the day but they just happen to have a psychological component or be just purely psych you know. So I think that most ED staff wouldn't see themselves as part of the therapy, you know what I mean, as the getting better agents , I don't think so, not really' (P10)*
- *'It's like patients who are referred to a specialist, for you know specialist needs, I guess potentially that if they are presenting to an emergency department it could be to a mental health emergency department couldn't it' (P 7)*
- *'I think emergency does have a place, if it's an acute phase. It provides, I was going to say stress free environment, but it's not a stress free environment. It provides an environment separate to the situation that triggered their escalation at that point. I don't feel the ED is always the most appropriate, even though it's deemed by the Mental Health Act that way, the fact that we are busy and there is ambulances coming in, it's a loud noisy environment. Having someone who is in an acute phase of a mental health issue or even if it's just anxiety or something like that, coming into that environment is not going to help them settle' (P 9)*
- *'Our rooms that they use for mental health consulting are right in the middle of the department where there is ambulance access, so it is a very public area and it doesn't allow for the calming influence you need. You need environments that allow for that' (P 9)*
- *'In terms of recovery they definitely have to wait a bit longer, it can be very frustrating for them, because there is only a limited number of people who can assess them, often they will be waiting in the department for a few hours or so. I suppose the recovery process is a lot longer for them, there are people that come into the ED for medical problems and they also have to wait, but mental health waiting times are a bit longer' (P 8)*

- *'... it's a highly stimulating area and from my understanding of mental illness you don't stimulate people in an acute stage of illness' (P 13)*
- *'I think that here is probably nowhere else to take them at the moment but to me it's not really appropriate. Beginning from right when they are first brought in they are made to sit isolated, or they are made to sit there just like on display. I don't know if that's because I am a registered nurse that it stands out to me that they are mental health, does everyone else see it as well? They just usually have a police officer standing beside them, and that looks to me so harsh, and not a very friendly environment to bring someone into' (P 3)*
- *'I have seen a few patients that actually present, you know initially you are thinking bizarre behaviour, you are thinking it's a mental health issue but it ends up being a fairly separate cause. I do think these people do need some medical, like they have to have a medical review and then have a mental health review' (P 7)*
- *'I guess they have to be medically cleared to make sure there is no physical component to their presentation but it's just very different for mental health patients...it's not so streamlined for them, if that makes sense' (P 3)*
- *'We do have bed blocks so we do have patients here for a couple of days sometimes' (P 2)*
- *'In our situation we have to get a medical clearance for the patients before they can be seen by the mental health teams so facilitating the things that we need to do to do that so that might be one set of OBS, chest x-ray, breath alcohol, you know that sort of stuff to get a medical clearance' (P 2)*
- *'I don't think ED staff have enough of an understanding of some mental health conditions' (P 7)*
- *'I would like to understand, using the word recovery in mental health, what does it actually mean?' (P 1)*

- *'I just find sometimes it's very frustrating when somebody who is in an acute psychotic state has to have a medical clearance so they can go in and seek out mental health treatment. They are stuck in this horrid state and waiting for the medical system before they can get the help that they need in the mental health area. But also vice versa, people with mental health components that have a medical predisposition have to wait and are stuck suffering, not suffering badly, but suffering, while they wait for the two teams to decide who's going to look after them you know. One has to get clearance from the other before the next one accepts instead of working in together. I would like to see like the medical and the mental health people work together for the sake of the patient, to help the patient as quickly as possible' (P 3)*
- *'If people are made aware, taught, educated about triggers and the escalation process to start with, they may present a bit earlier or may seek a different form of help a bit earlier. So I think as an emergency nurse, with a bit more understanding, we can assist our clients in that way. We occasionally get one of the team leaders from mental health come down to do an in-service, they may come down three or four times a year and it hits our in-service time, but our in-service time may only catch an eight head count out of a hundred and fifty head count' (P 9)*
- *'I find that we have got a mental health CNC that works closely with staff where I work, and I find that very helpful, being able to ask questions and get help in managing people' (P 7)*

In the fourth category of description, ***Referral to other areas of mental health care***, the ED is characterised as being the referral point to other areas that are considered by ED RNs to be more appropriate to facilitate the management and care of consumers experiencing a mental illness. Participants expressed a lack of confidence in the ability of the ED environment to provide mental health consumers with optimal care. The

preferred option was referring consumers to other areas that deliver mental health services.

Participants articulate that they view the ED as a portal into the mental health care system and as a referral point to other specialist areas that will deliver appropriate mental health care. Consumers who seek care from the ED present with specific needs and often challenging behaviours, and participants said that, because ED RNs do not have a comprehensive understanding of mental health, this is a factor which impedes their ability to provide optimal care to consumers. Therefore referral from the ED is understood by RNs to facilitate consumers' recovery, as the ED is perceived to be inadequate in meeting the unique needs of consumers.

The RNs who participated in this study expressed the view that consumers present to the ED for assessment in an environment that focuses on episodic care and on the stabilisation of a person's presenting symptoms. As a participant's understanding of recovery for mental health consumers is seen through this lens, getting through the acute mental health crisis is understood within the parameters of the accepted meaning of recovery within the medical model. Clinicians' (participants') narratives consistently demonstrated that the model of care in the ED is that in which nurses are well versed. Utilising an acute care framework to manage this client group thus becomes problematic. In addition, participants conveyed that they do not consider that ED nurses play a role in the recovery of consumers. Again this was consistently demonstrated when discussing their understanding of recovery for consumers by the constant references made to '*getting better*' (P10). This was clearly articulated when

it comes to mental health consumers in the ED, *'ED nurses are not the getting better agents'* (P10).

Category of Description Five:

Recovery for Consumers is: *Implementing strategies for ongoing care*

Participant narrative drawn from the transcripts:

- *'Discharge planning is probably even more relevant to mental health patients than anyone else because I think there is with general emergency presentations it is quite obvious within the first hour the patients that are going to be admitted to hospital and the patients who are, that you will invariably send home to be followed up by GPs, and things like that' (P1)*
- *'Recovery, I guess I think of progression from an acute episode of a mental health illness, that from an ED perspective that probably what I think is putting in strategies and things in place so that they can take control of their situation and manage it in day to day life' (P5)*
- *'Because we see them in an acute crisis, the recovery is probably happening outside that acute crisis. The recovery would be after dealing with the acute event and making sure as part of the recovery that everything is in place for the ongoing care of that patient after that acute episode' (P1)*
- *'It's absolutely paramount that before we discharge them from emergency, that we have really good strong discharge planning in place, that is accepted by the patient and that is definitely well and truly set up, a clear appointment or plan for that patient, with their consent and with their understanding that they will follow through with their planned discharge and appointments and things' (P 1)*
- *'I think as with anyone with any chronic illness it's the tapping into the support they can get within the community and limiting the occasions that they need to come in to the ED' (P 12)*

- *'We need, as clinicians in emergency to make sure that they have got the right stuff in place, that in the community they will get the assistance and support and all the medications and stuff that they need so that they don't have to present back to ED again' (P 13)*

In the fifth category of description, ***Implementing strategies for ongoing care***, recovery is understood as occurring after the initial assessment and interventions for the mental health crisis have been implemented, and the symptoms that are associated with the crisis have been effectively managed within the ED. Participants understand recovery for consumers as planning for the provision of their ongoing care after they are discharged from the ED. Discharge planning and the implementation of the appropriate strategies and supports required by the consumer upon leaving the ED are considered by RNs as paramount to a consumer's recovery.

Discharge planning was considered to be even more relevant for consumers with a mental health issue than for patients experiencing a general health issue. Furthermore, it was articulated that the process for assessing whether a consumer is well enough to be sent home or requires further treatment by inpatient specialist mental health services is a long and complex process. In addition, participants placed particular emphasis on the assessment of whether the consumer would be well enough or adequately supported to be discharged back into the community. This is seen by RNs as a major contrast to general medical emergency presentations, where the process for deciding whether a person will require admission to hospital or can be sent home with organised follow up, involves a relatively shorter time-frame. Participants considered physical

health issues to be more straightforward. Thus, the participants were confronted with consumers who required an alternative approach to the acute medical model from initial presentation right through to discharge.

Adequate discharge planning is viewed as a necessary component of mental health service delivery to consumers in the ED, in order to prevent the consumer re-presenting to the ED in the future. Participants perceived a direct correlation between both good planning of ongoing support and follow up post-discharge from the ED, and a consumer's recovery and a reduction in the likelihood of re-presenting to the ED in the future.

Participants considered that recovery for consumers who presented to the ED with a mental health issue is about identifying the consumers' needs and coordinating the type of follow up care they will require on discharge from the ED. The ability of the consumer to access appropriate resources and follow-up with services in the community was articulated by participants as necessary to facilitate the continuity of consumer care. It was also considered necessary to enable the achievement of optimal outcomes for the consumer when discharged home.

Category of Description Six:

Recovery for Consumers is: *Living in the community*

Participant narrative drawn from the transcripts:

- *'I see recovery as going back to being able to manage, you know obviously they are not cured, but for them being able to manage, function at home as they would have prior to their presentation to emergency' (P6)*
- *'My concept of recovery is getting back to a baseline not necessarily a cure because I don't think that there is really a cure for many conditions' (P6)*
- *'I suppose when you think of recovery you think of people getting better but people with mental illness it's like are they getting on top of whatever is exacerbating them to come in to emergency whether it's a drug addiction, an alcohol addiction, are they not taking their medication? When I think of recovery I think of people getting on track to where they want to be' (P14)*
- *'I would understand it as being well and truly set up with hospital and community support. That they had a network in place where they had supportive people within their community or where they live, a combination of a really good GP, plus or minus a psychiatrist or psychologist and they had a supportive network of friends and family' (P 1)*

- *'I guess recovery for mental health is to try and get the person functioning back into their own environment' (P 7)*
- *'...they are fully functioning back in the community, being an upstanding citizen and contributing to their life in a way that they had previously' (P 2)*
- *'Recovery is your normal condition, being in a place where the person is cared for, where somebody takes care that they do take their medication and they are looked after, that is what recovery is, and not to come back three months later because of neglect' (P 4)*
- *'I don't know whether it's the fact that they are poorly managed in the community or they just have a lapse' (P 7)*
- *'...we get a lot of non-compliant clients' (P 7)*
- *'Recovery would see them functioning at a good level in society without the psychological component restricting that too much' (P 10)*

In the sixth category of description, ***Living in the community***, recovery is understood by participants as the ability of the consumer to live in the community with a level of functioning that was present prior to their presentation to the ED. Getting back to a baseline that enables the consumer to live well in the community is understood as a positive outcome for the consumer. Furthermore, the capacity of the consumer to address the issues perceived to have contributed to them becoming unwell and

consequently presenting to the ED for assessment and management, was viewed by participants as necessary for the consumer to be able to ‘recover’. Non-compliance with medication was articulated by participants as an issue that adversely affects a consumer’s mental health. Compliance with prescribed medications is understood by RNs as being integral to a consumer’s recovery.

Participants expressed an “intellectualised” notion that recovery is about the consumer living well in the community and getting “on top” of what has caused the consumers admission to the ED. Despite the rhetoric, there clearly existed a strong connection to the clinical understanding of recovery. Although participants expressed the idea that it is possible for consumers to be discharged home and to be able to manage and function well in the community, they also articulated that they are not “cured”. This suggests that recovery is not seen as a process and something that belongs to the consumer, as it is in the non-acute care and psychosocial medical model discussed in Chapter Two, but rather continues to be seen as an outcome that is understood within the limitations of acute care medicine.

The Outcome Space for ED RNs’ Conceptions of Recovery

The structural aspect of participants’ understanding of recovery is the outcome space, and can be demonstrated through a diagrammatic representation formulated to map the logical relations existing between conceptions. The focus of the phenomenographic research is variation and elucidating the critical differences in a population’s understanding of a phenomenon. The outcome space therefore enables the researcher

to facilitate revealing the relations between the referential aspects of the phenomenon, that is, the categories of description. The outcome space is presented in Figure 12.

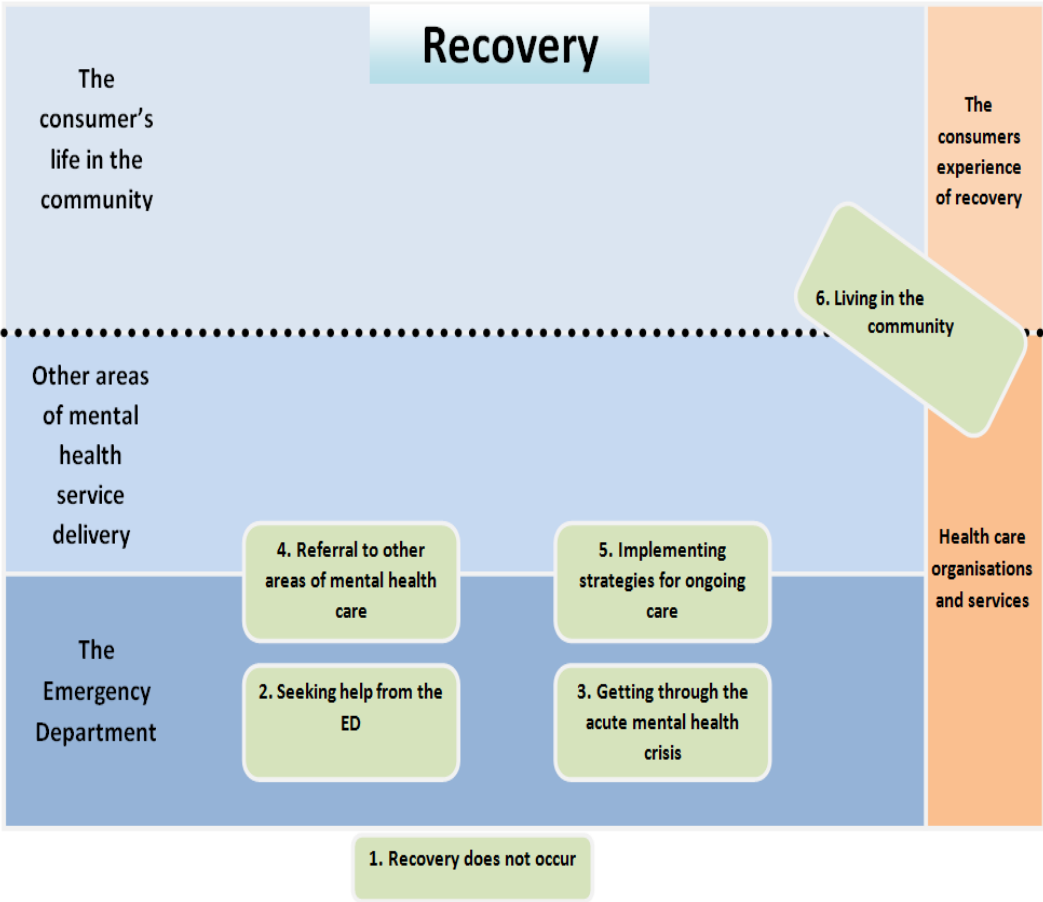


Figure 12: Outcome space for ED RNs’ conceptions of recovery

The outcome space provides the means for the researcher to map the interpretation of the qualitatively different ways that recovery is understood by ED RNs. It shows the six categories of description that ED RN participants understood as recovery for consumers. Within these six categories there exists an increasing level of understanding of recovery, and as such, the categories move from a position of less to more complex ways of understanding. It is the outcome space that enables the increasing complexity of the categories of description to be elucidated. The staged

hierarchical structure of the outcome space for this study shows participants understanding of recovery from less complex to more complex ways of understanding. This is now described in greater detail.

Internal and External Horizons

Within each of the six identified conceptions of recovery there exist two interconnected constituent parts; the internal and external horizons. The internal horizon reveals the relationship between the intertwined parts of the conception with each conception containing component parts integral to the conception. This has been articulated in the previous discussion of each of the six categories of description, as have the component parts that contribute and are integral to each category.

The external horizon illuminates the external relationship that the phenomenon of recovery has to its context. Within the outcome space for this study, there are two significant features. Firstly, the categories of description are positioned within three distinct domains identified by the ED RN participants. This reveals their contextualisation of the meaning of recovery for consumers. The three contextual domains are represented in the outcome space as three distinct horizontal areas. For ease of understanding these are offered in various shades of blue.

The three domains within the outcome space are:

- **The Emergency Department**
- **Other areas of mental health service delivery**
- **The consumer's life in the community**

For ease of readability the outcome space is presented again.

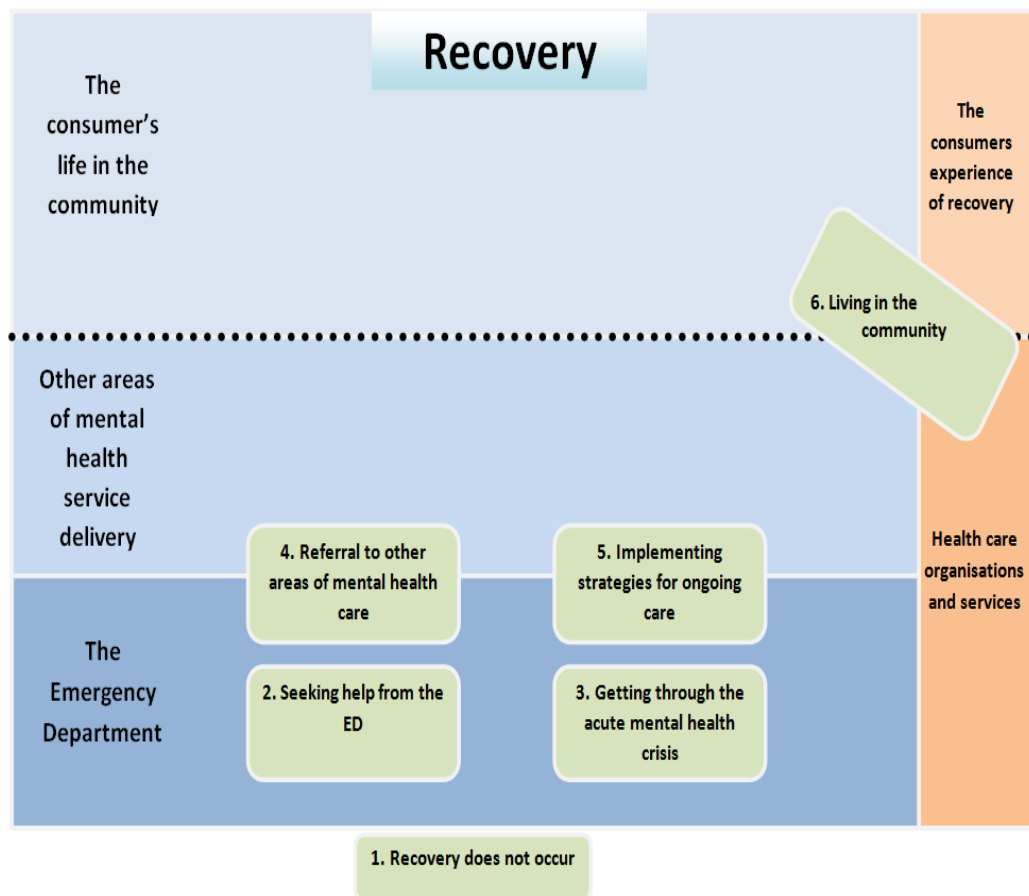


Figure 12: The outcome space for ED RNs' conceptions of recovery

The second important element within the outcome space are the two divisions that occur within the three contextual domains. These two areas are represented in the outcome space as a separated orange vertical column on the right hand side of the outcome space and are labelled as follows:

- **Healthcare organisations and services**
- **The consumer's experience of recovery**

Within the diagrammatic representation of the qualitatively different ways that Emergency Department RN participants understand recovery for consumers experiencing mental illness, the first category of description *recovery does not occur* is placed exterior to the outcome space. This category is located in this position, separated and unconnected to the other categories of description, because the ED RN participants' understanding of recovery for consumers is that recovery does not happen for those who are experiencing a mental illness. The position of the first category of description is illustrated in Figure 13.

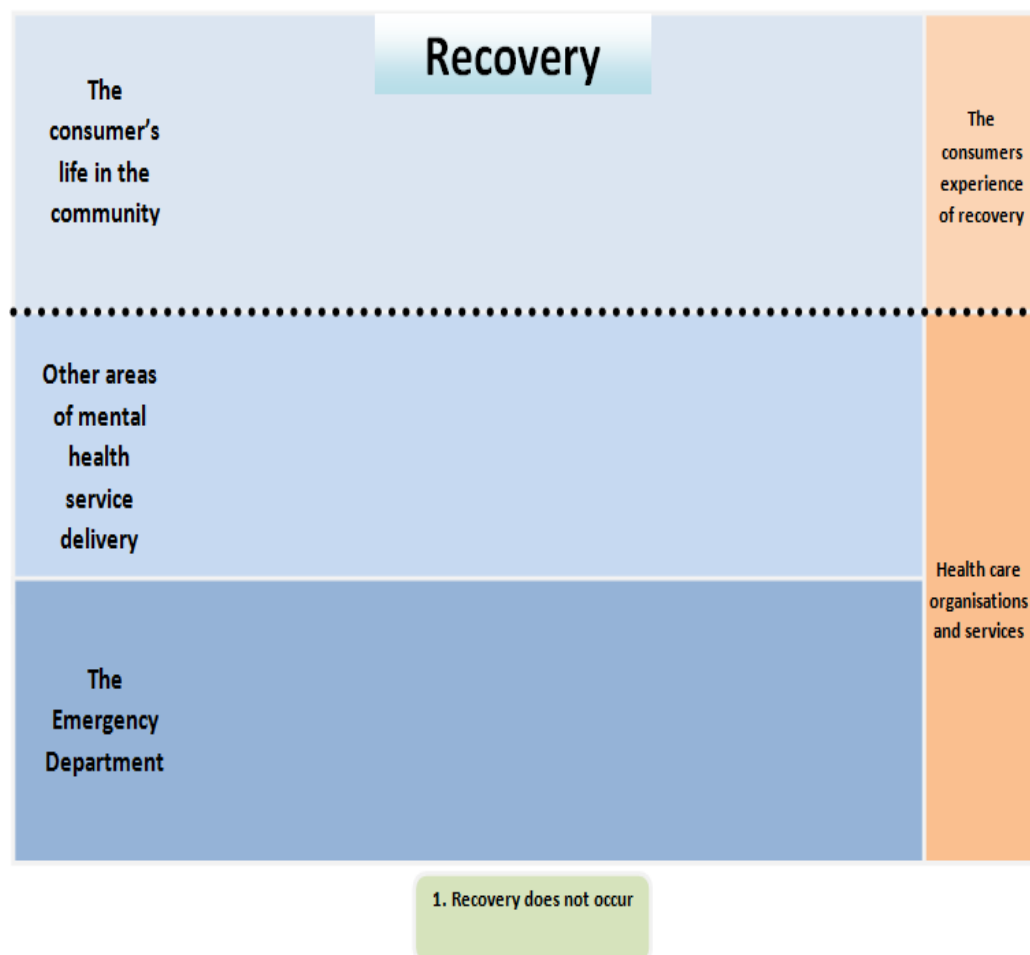


Figure 13: The position of category of description One within the outcome space

Diagrammatically the first contextual domain in the outcome space is represented by a dark blue horizontal area at the lowest level of the outcome space, and is identified as the Emergency Department. The second and third categories described as *seeking help from the ED* and *getting help through the acute mental health crisis* are positioned solely within this domain. The position of categories two and three within the outcome space is demonstrated in Figure 14. These two categories are placed exclusively within this Emergency Department domain, because the RN participants conceptions of recovery for consumers is expressed exclusively with reference to the presence of the consumer within the Emergency Department environment.

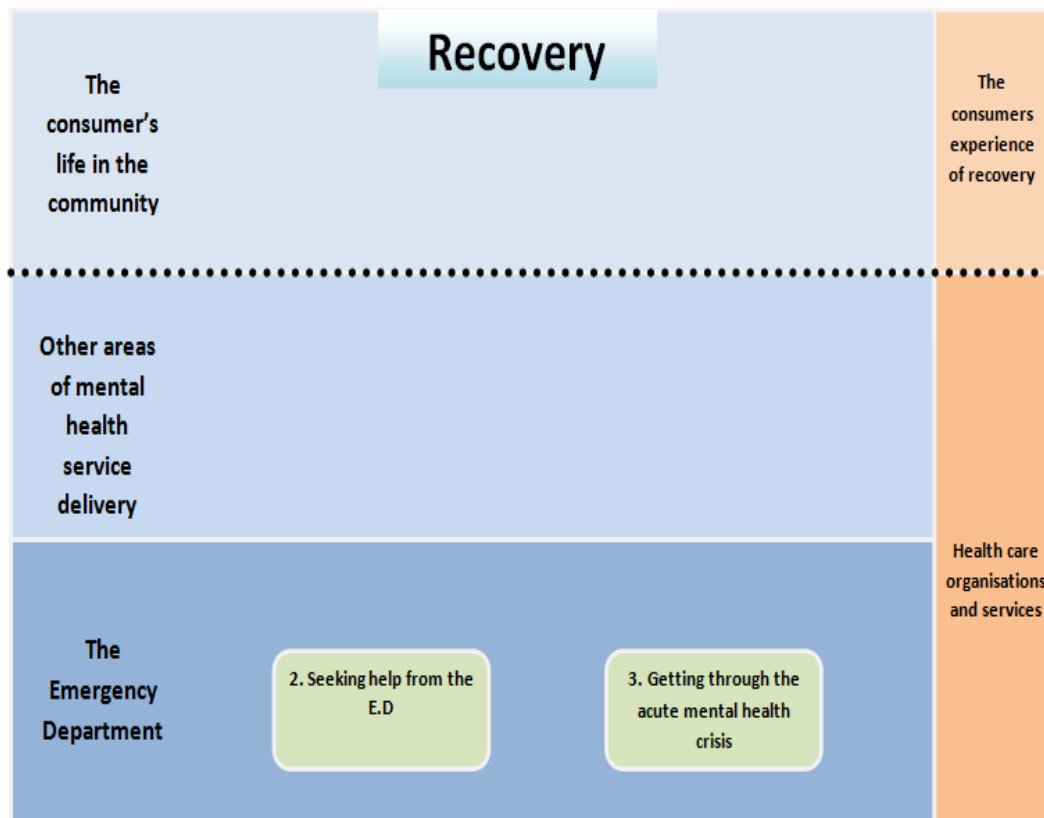


Figure 14: The position of categories of description Two and Three within the outcome space

Categories Two and Three are positioned within the division of healthcare organisations and services. This is because recovery for consumers is understood to occur with the intervention and support provided by the healthcare environment of the ED and the services provided by ED clinicians. The ED environment, the Emergency Department RNs who practice in this environment and the healthcare services that are provided to consumers while in the ED, are considered integral to the understanding recovery for consumers. This is shown as *seeking help from the ED* and *getting through the acute mental health crisis*.

The second contextual domain, which is labelled ‘other areas of mental health service delivery’, is represented as a medium blue horizontal area and is situated within the second level of the outcome space. This domain contains categories of description Four and Five, recovery as *referral to other areas of mental health care delivery* and *implementing strategies for ongoing care*. Figure 15 demonstrates how the position of categories Four and Five sit within the second contextual domain. However, as noted within the figure, these two categories also are located partly within the ED domain.

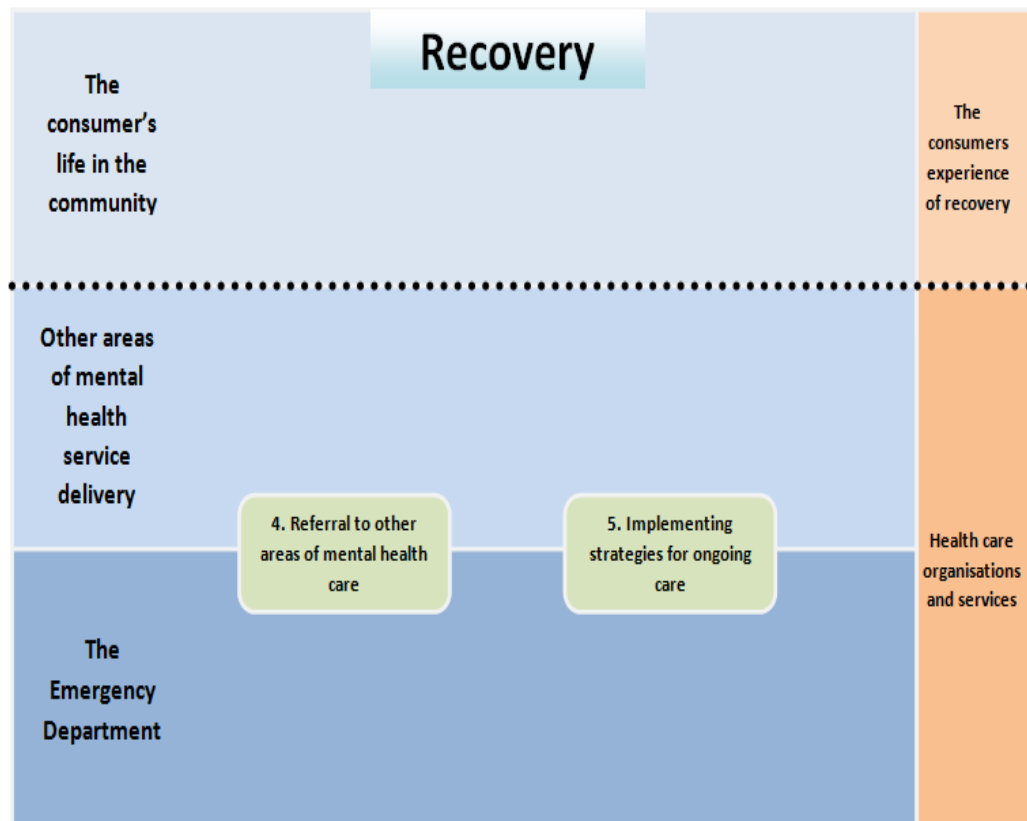


Figure 15: The position of categories Four and Five within the outcome space

These categories are situated in this position within the outcome space because they illustrate that recovery is understood by Emergency Department RNs as occurring outside of the ED. However, it is achieved through the ED's collaboration with other areas and other healthcare professionals delivering specialised mental health services. These categories are balanced between the two domains; the ED and other areas of mental health service delivery. This is because the ED is understood to be involved in a consumer's recovery through referral to other areas, or through planning ongoing care with coordinated supports when the consumer leaves the ED.

The second domain, other areas of mental health service delivery, is also positioned within the healthcare organisation and services division. The positioning of this domain results from the notion that recovery is understood to lie within the confines of the healthcare organisations and the healthcare services that can be provided to the consumer who is experiencing a mental illness.

The third domain, the consumer's life in the community is diagrammatically represented as a light blue horizontal area positioned at the top of the outcome space. Category six, *recovery as living in the community*, is located within this contextual domain, because participants understand recovery to mean that the consumer is able to manage in their day-to-day life, and to live in the community.

The location of category of description Six within the outcome space is illustrated in Figure 16.

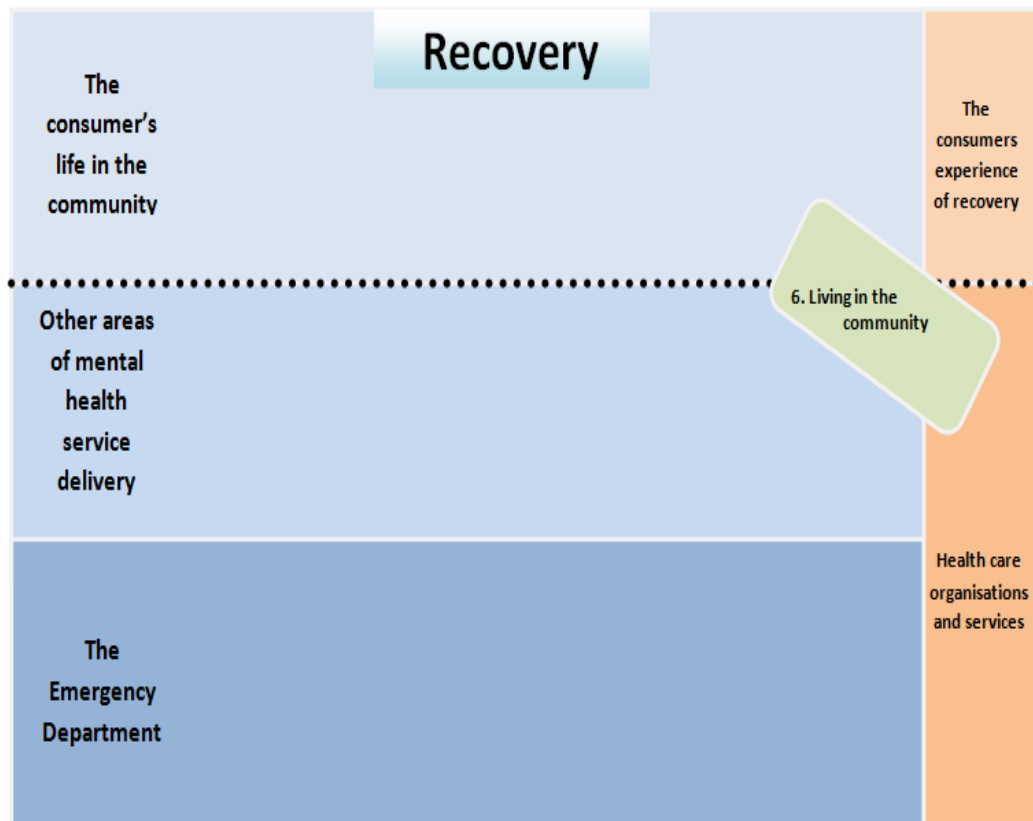


Figure 16: The position of category of description Six within the outcome space

The sixth category of description is placed highest within the hierarchical structure of the outcome space as it reveals a more complex understanding of recovery by Emergency Department RNs. However, this category of description does not lie exclusively within the domain of the consumer's life in the community as participants maintain a medically oriented connection to the consumer's recovery. Although recovery is not viewed as being dependent upon the ED or the clinicians who practise in this environment, within the notion of 'recovery' for consumers a connection to healthcare organisations and services still exists.

When discussing the consumer's ability to live at home in their own environment the word 'cure' was often used. Once again this implies that recovery for consumers as *living in the community* continues to remain linked to the clinical medical definition of recovery. Within this category Emergency Department RNs express a conception of recovery that reveals some understanding of what recovery means to the consumer. The notion of recovery as 'consumers being engaged in their own unique personal journey' is not fully understood. A tension of terms exists.

Summary

This chapter presented the findings that were elucidated through the data analysis as outlined in the previous chapter. The findings have fulfilled the aim of this research - to understand how Registered Nurses working in the Emergency Department conceptualise recovery for people who are experiencing mental illness. The description of the qualitatively different ways in which ED RNs conceptualise recovery for consumers who are experiencing a mental illness has answered the research question, 'What are RNs conceptualisations of recovery' as it applies to people who are experiencing mental illness within the ED?

The main outcome of phenomenographic research is to reveal categories of description and an outcome space. To achieve this, a parsimonious set of six distinct categories of description was explicated, and these revealed the critical variation that exists in Emergency Department RNs understanding of recovery. These six distinct categories of description, necessary within phenomenographic research, were presented as

- **Recovery does not occur**

- **Seeking help from the ED**
- **Getting through the acute mental health crisis**
- **Referral to other areas of mental healthcare,**
- **Implementing strategies for ongoing care and**
- **Living in the community.**

The outcome space reveals the logical relations that exist between the six categories of description, and was presented as a hierarchical structure. This structure reveals participant's conceptions of recovery which progress through levels of increasing complexity from less to more comprehensive ways of understanding. The system of categories presented as the outcome space reveals ED RNs' collective understanding of recovery for people experiencing mental illness.

The following chapter reviews and discusses the findings from this research and compares the findings with those within the published literature. The implications that the findings of the current study have for ED nursing practice, nursing education and service delivery to consumers in the ED, will also be discussed.

CHAPTER FIVE: DISCUSSION

Introduction

This chapter discusses the findings that were presented in the previous chapter. The relationship that these findings have with the current literature will be examined. Formal conclusions will not be drawn in this chapter but will be reserved for Chapter Six, the final and concluding chapter in this thesis.

The aim of this study was to identify and describe ED nurses conceptions of recovery for people experiencing mental illness in the ED. Implementing a phenomenographic approach enabled the researcher to undertake a holistic exploration of ED RNs' collective experience (Akerlind 2005c). As previously stated in Chapter Three, 'We are seldom aware that our understanding of a phenomenon does not match someone else's understanding' (Marton 1992, p. 254). This research facilitated the identification of the critical variation in the conception of recovery that exists within a diverse group of RNs working in Australian EDs.

The focus was not on recovery itself. Rather it centred upon the relationship between ED RNs and recovery. The researcher elucidated the relationship through the categories of description. These are again presented to re-acquaint the reader with the findings.

Recovery for consumers is conceptualised by ED RNs as:

- **Recovery does not occur**
- **Seeking help from the ED**

- **Getting through the acute mental health crisis**
- **Referral to other areas of mental health care**
- **Implementing strategies for ongoing care**
- **Living in the community**

The diagrammatic organisation of these categories into a hierarchical outcome space allowed for the emergence of a secondary finding and significant feature, the relationship of the conceptions to three contextual domains; the ED, other areas of mental health service delivery, and the consumer's life in the community. Furthermore, these contextual domains were encompassed within the spaces of healthcare organisations and services, or the consumer's lived-experience of recovery.

Most literature on recovery in mental health pertains to the mental healthcare arena. However, there was no literature on recovery that could be found within the specific context of the emergency department. In particular, the researcher was unable to identify any literature within the body of work on recovery that specifically discussed or examined ED RNs' understanding of what recovery means for people who present to the ED with mental illness.

For the purpose of facilitating ease of reading, each of the categories of description within the outcome space will be presented in diagrammatic form throughout this chapter. This approach also serves to re-acquaint the reader with each category of description and its hierarchal position within the outcome space.

Recovery does not occur

In the first category of description, the conceptualisation of recovery emerged as *recovery does not occur*. ED RN participants did not view recovery, as they understood it, as something that is possible for consumers with a mental illness. Key points which will be discussed within this category of description include ED RN's practice environment and stigma.

Recovery is a unique and personal journey for people experiencing mental illness. It is the central tenet in contemporary mental health service delivery and implicit within national mental health policy (Australian Health Ministers Advisory Council 2013b), and the Roadmap for National Mental Health Reform (Council of Australian Governments 2012). However, RNs working in the ED, practise their craft in the constructs of the traditional clinical/medical model, and within this model of care, the clinical concept of recovery is poles apart from the aforementioned understanding of personal recovery. This research has identified that RNs working in the ED conceptualise recovery for people experiencing mental illness as something that does not occur. However, it is important to note that ED RNs expressing this conceptualisation discuss recovery for consumers in the context of the term's established and traditional clinical meaning; ie recovery as a clinical outcome.

As outlined previously in Chapter Two, the outcome space is the means by which the researcher mapped the qualitatively different ways that recovery is conceptualised by ED RNs. The six identified categories of description are presented in a staged

hierarchical structure moving from positions of less to more complex ways of understanding recovery for consumers.

The diagrammatic representation of the hierarchical position of category of description

One within the outcome space is presented in Figure 13:

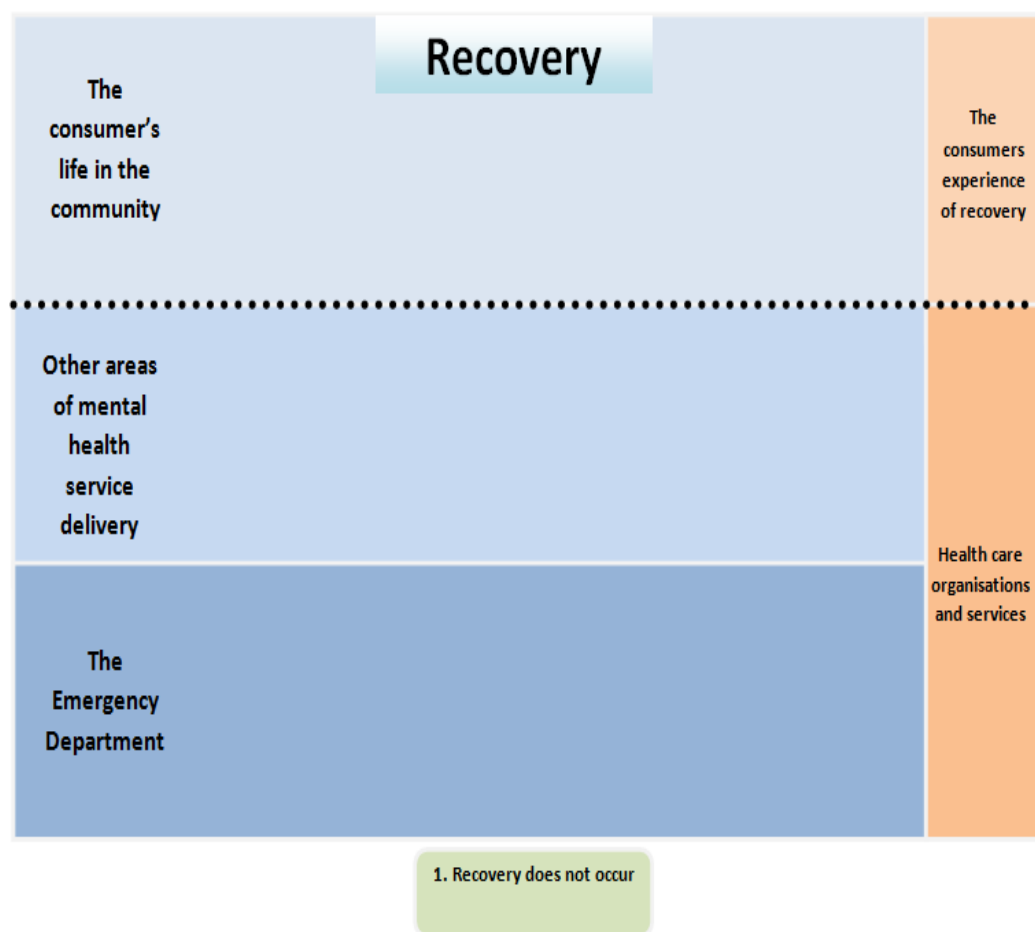


Figure 13: The position of category of description One within the outcome space

ED RN's practice environment

As discussed in Chapter Three, the word 'recovery' means different things to different people. Furthermore, linguistic confusion exists regarding the word 'recovery' itself.

Indeed, the lens through which recovery is viewed can influence how it is understood. The word ‘recovery’ was, though, already in use and fully entrenched in the clinical model of care that personal recovery was aiming to distance itself from. This has potentially added to the confusion and to the tension that surrounds the word and indeed to the very meaning that is ascribed to it.

The clinical/medical understanding of recovery, pervasive within the general healthcare setting, and personal recovery as understood by those with lived-experience, are polarised. Despite this dichotomy both meanings exist within the healthcare domain albeit in a tensional co-existence. As a result, it is not surprising that the medical understanding of recovery for people with mental illness who present to the ED is the one articulated by RNs who are working in this general healthcare environment. Their understanding is tightly bound to the medical meaning of recovery.

Within the Australian general healthcare system the dominant model of care is the medical model (Hally 2008). ED nurses’ practice is embedded within this model and objective clinical recovery is understood as the process of being recovered or recovering. The restoration of a patient to their former or better condition is the optimal outcome for ED nurses caring for people who present to the ED. This goal of ‘getting better’ is enacted through a process of treatment evaluation. The role of the ED nurse in this approach is outlined in the Practice Standards for the Emergency Nurse Specialist, 1.0 Domain: Clinical expertise, ‘Continues evaluations of patient responses to the effectiveness of interventions in accordance with evidence-based clinical pathways/guidelines’ (College of Emergency Nursing Australasia 2013, p. 7)

The participants, who expressed the idea that recovery does not occur, conceptualised ‘recovery’ as an outcome rooted in the understanding pervasive within the ED environment and their daily practice as emergency clinicians. Phenomenography facilitates describing how a person interprets an experience (Pratt 1992). Therefore as ED RNs’ experience of recovery is primarily based on their medical understanding and its application within their everyday work environment in the ED, difficulty viewing recovery in a different way, or having a limited cognisance of a separate and disparate understanding of the term ‘recovery’, should not be a surprise.

Emergency Department nursing practice functions within the general nursing domain where the provision of health care is task-oriented and outcome-focused (Westbrook et al. 2011), and the clinical understanding of recovery equates with a positive outcome. This is expressed in a statement by a participant who said that recovery is viewed as achieving something for their patients while they are in the ED. It is described in terms of a quantifiable outcome:

‘Generally in the ED we see someone with a mental illness in an acute disturbed circumstance so therefore usually we are just dealing with the acute episode and to me recovery conjures up that we have achieved something. So I would say personally that the thought of using the word recovery with mental health patients in the ED is limited to nonexistent’ (P 1)

Personal recovery, as understood by people with lived-experience of mental illness, acknowledges that recovery is an ongoing process that belongs to the individual. It is

not a fast process, and encompasses their individual unique journey (Aston & Coffey 2012). Personal recovery is not something that health professionals or services do “for” or “to” people (Davidson et al. 2006). However, proficiency in practical tasks and the skilled provision of appropriate interventions are inherent within ED nurses’ daily practice. Consequently, it is not unexpected that ED nurses might understand recovery as an outcome that could be achieved (or not) through the provision of this type of nursing care.

In addition, the existing dichotomy of “recovery in” versus “recovery from” that has emerged from the historical influences of longitudinal outcome studies and the consumer/survivor movement (Davidson & Roe 2007; Gordon 2013), has further contributed to the continuing confusion surrounding the word ‘recovery’ as it is placed within general healthcare and mental health care domains.

Phenomenography asserts that the reality experienced by an individual is the only reality that there is for that person (Uljens 1996). As such, RNs’ knowledge of recovery is constructed within the relation between the RNs and recovery. Therefore, RNs who understand recovery as “getting better” and have experience of recovery as a “return to a pre-illness state” may consequently construct a less than optimistic view of recovery in mental illness, as notions of chronicity continue within healthcare environments. The perceived pessimistic prognosis for people with mental illness is articulated by a participant who stated:

‘It’s difficult for people with a chronic mental illness to be viewed as recovered in the ED’ (P 12)

The scientific literature which significantly informs, or at least should significantly inform, the clinical domain in which ED nurses practise, maintains a conceptualisation of recovery that supports a direct correlation between recovery and decreased symptomology (Bellack 2006). Thus, the conceptualisation of recovery by ED RNs as articulated in this thesis is not surprising.

Stigma

The following statements by a participant reveal that there is an anticipated negative outcome for consumers. Given that recovery is understood by ED RNs within the dominant medical construct, recovery is not considered possible for consumers.

‘A lot of the time they don’t actually get better do they’ (P 10)

‘You can quite readily see medical recovery but in terms of psych, I don’t know that you see too many you know’ (P 10)

Furthermore, the following statements from participants resonate with the findings from a study undertaken by Rao et al. (2009) which aimed to assess health professionals’ stigmatised attitudes towards people with mental illness. One hundred and eight health professionals from acute and mental health settings in England completed the five-item self-completion Attitude to Mental Illness Questionnaire. The study revealed that health professionals were more likely to stigmatise people with a mental illness such as schizophrenia, than people with short psychotic episodes.

‘In terms of recovery for mental health patients that walk into an emergency department I think it probably has to be seen in the light of

that individuals life, you know so a full recovery for someone with a brief drug induced, brief psychosis, you know that might be realistic. But it is related to the individual and what the outlook for that particular, their illness, would be' (P 10)

'I don't think any mental illness has an end point. I mean depending on what it is, if medication works for them then there might be middle ground maybe. I don't think for Schizophrenics or Bi Polars there is ever an end point' (P 11)

Enduring perceptions of chronicity and pessimistic outcomes for people with mental illness results in the perpetuation of a barrier that significantly impacts their personal recovery. That barrier is stigma.

The impact of mental illness is a global concern (World Health Organization 2013). Whiteford et al. (2013) examined data from the Global Burden of Disease Study 2010 (GBD 2010) which was a collaborative effort involving researchers from three hundred and three institutions in fifty countries. The authors argue that mental and substance-use disorders were identified as the leading cause of years lived with disabilities (YLD) worldwide. Furthermore, in Australia the National Survey of Mental Health and Wellbeing 2007 (Australian Bureau of Statistics 2008) provided information on the prevalence of mental disorders in the Australian population. The survey shows that almost half (45% or 7.3 million) Australians aged 16-85 years had a lifetime mental disorder. A lifetime mental disorder is defined as having had a mental disorder at some point in their life. Furthermore, one in five (3.2 million) Australians

experienced a mental illness in the previous twelve months. This data is presented in Figure 17:

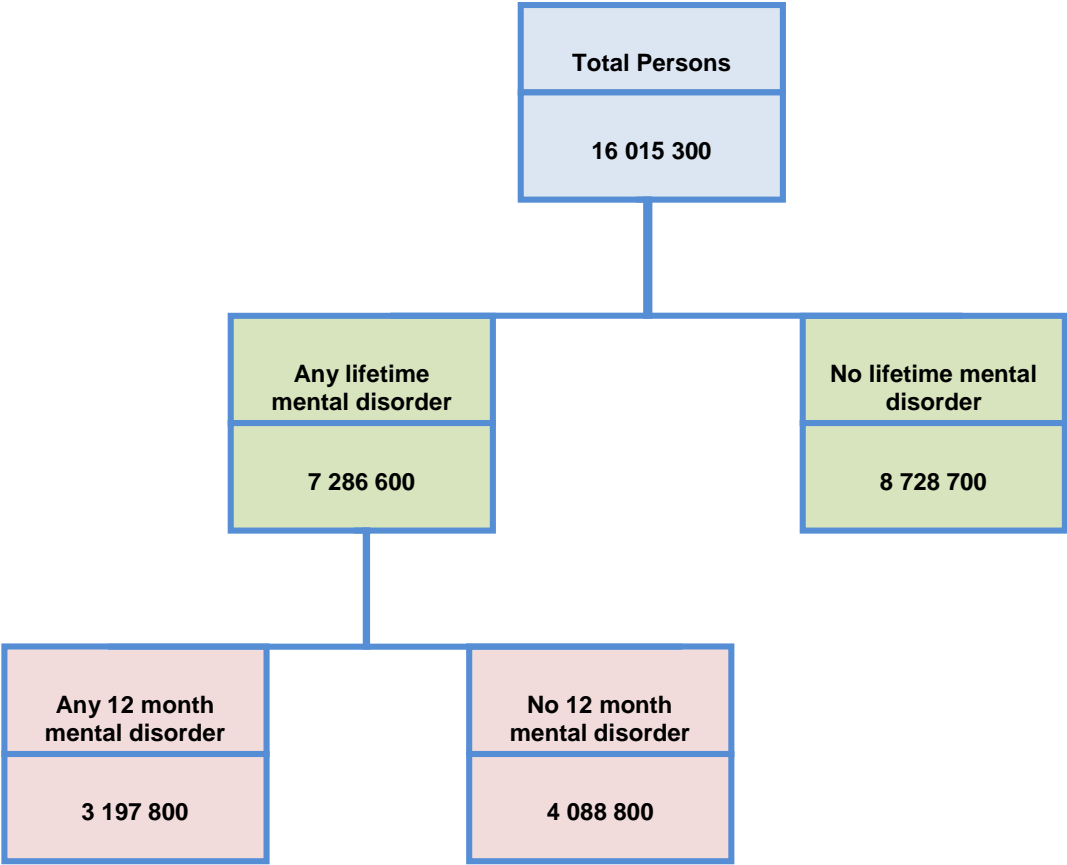


Figure 17: Prevalence of mental disorders in the Australian population.

Despite these alarming statistics confirming the significant prevalence of mental illness within Australian society, people who are experiencing mental health issues still continue to be subjected to stigma and discrimination (Council of Australian Governments 2012). A consumer’s personal recovery journey is idiosyncratic and dynamic. However, despite striving to live a full and meaningful life, a consumer’s

recovery can be impacted by many barriers, with stigma imposed on people with mental illness being one of the most powerful (Shera & Ramon 2013).

Pescosolido et al. (2008, p. 431), reminds us that ‘stigma is a mark separating individuals from one another based on a socially conferred judgment that some persons or groups are tainted and “less than”. The emergence of contemporary perspectives on stigma can be accredited to Erving Goffman, a Canadian-American sociologist (Major & O’Brien 2005). In his seminal work on the concept of stigma, *Stigma: Notes on the Management of Spoiled Identity*, Goffman (1963), defines stigma as ‘an attribute that is deeply discrediting’ (p. 3).

Stigma and discrimination towards people with mental illness are enduring phenomena (Lauber 2008). They are pervasive across countries, societies, cultures and professions (Arboleda-Flórez & Stuart 2012; Thornicroft 2008). Furthermore, Link and Phelan (2001, p. 367) maintain that a sequelae of stigma is that ‘labelled persons are placed in distinct categories so as to accomplish some degree of separation of “us” from “them”’.

When people are given a mental health label it can be viewed negatively and perceived as influencing an outcome which can have negative consequences for that person (Roberts & Wolfson 2004). This notion is expressed by the following participant:

‘I find sometimes, depending how people present, that they are labelled a bit too quickly. Or there is the mental health diagnosis that may not be appropriate, but that is tagged to that person before a full assessment is completed by a specialist rather than just a trainee. So

*for me, for someone that presents for the first time or newly diagnosed,
I think that they have been labelled just a bit too early and once the
mud sticks, its stuck'(P 9)*

This perception is consistent with the findings from Clarke, Dusome and Hughes (2007). Consumers in this study describe that a mental health label can result in diagnostic overshadowing in which a person's medical concerns are overlooked or dismissed. These people are thus triaged as "mental health" regardless of what their presenting complaint may be. Diagnostic overshadowing is not only detrimental to the provision of holistic care, but also perpetuates the stigmatisation of this vulnerable group (van Nieuwenhuizen et al. 2013).

'...they have got a diagnosis and then they are able to move on' (P 7)

This statement both recognises and illustrates that ED RNs typically view recovery through a clinical lens. Thus, receiving a 'diagnosis' is thought to facilitate the implementation of appropriate interventions and care in order to assist clinical recovery. However, a consequence of labelling, particularly when the label incurs stigma, can be the reinforcement of "differentness". Schiff (2004) maintains that a diagnostic label can challenge a persons' identity. Schiff positions herself as a 'prosumer', a consumer and a professional, and shows that the "us-them" mentality separates people with mental illness from the general population as 'our identity is challenged as we are placed in the 'them' category by virtue of our diagnosis' (p. 217).

Stigma is not only extrinsic but can also be intrinsic. Internalised stigma or self stigmatisation, in which an individual accepts a negative stereotype, is detrimental to

a consumer's recovery (Drapalski et al. 2013). Ritsher and Phelan (2004) describe how people who experience mental illness suffer harm from the unjust stigma that continue to exist within society, and the internalised stigma that is experienced epitomises 'its psychological point of impact' (p. 257).

Corrigan (2007, p. 36) maintains that stigma can be challenged by moving from the emphasis on the group, and 'highlighting people as individuals with complex lives that exceed the narrow descriptions of diagnosis'. A diagnosis can provide ED clinicians with information on the course and prognosis of an illness and interventions to ameliorate symptoms, perhaps an apt process for physical illnesses that often follow the same clinical pathway. However, it also assumes the homogeneity of a group and can impose stigma (Corrigan 2007). This is an important differentiation in mental health because assuming similar clinical pathways for the same diagnosis is not appropriate. Furthermore, Walker (2006) agrees that it is the clinician who holds the power of definition.

Gareth Edwards, a New Zealand consumer advisor with lived-experience of mental illness, maintains that diagnosis is limited only to facets of the person's internal experience:

The medical language of diagnosis and symptoms provides a framework for describing the mad experience, even if it isn't a framework I'd choose to use, but it only relates to some aspects of the internal experience - what it's like to be mad on the inside. There's also the external experience of madness - what it's like to be mad in a world that doesn't tolerate or accommodate madness very well. (Edwards n.d.)

Figure 18 presents the structures that comprise the experience of stigma, and outlines how a diagnostic label can augment the process of stigma.

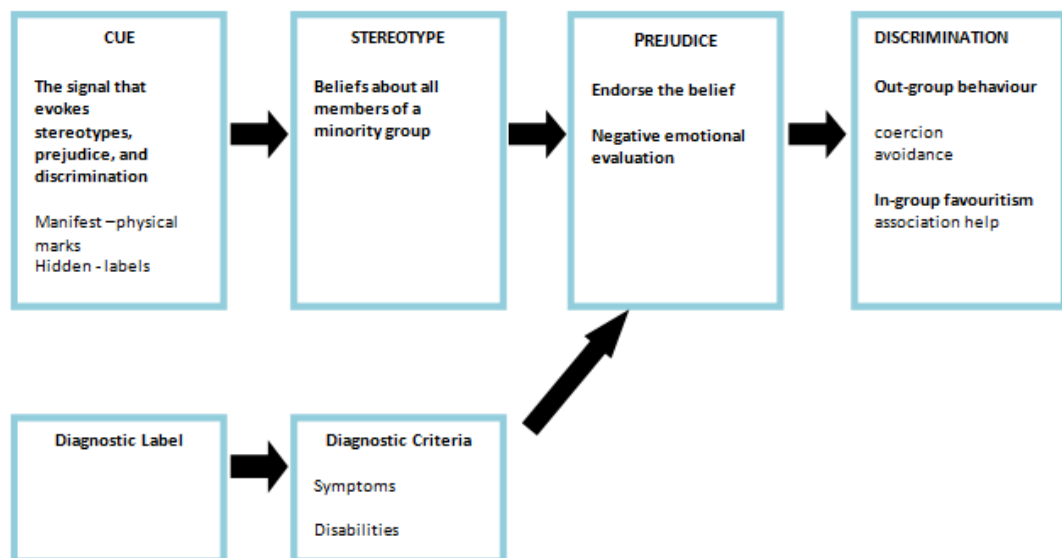


Figure 18: The structures of the experience of stigma (Corrigan 2007)

Stigmatised views of people with mental illness are pervasive within the general public (Rüsch, Angermeyer & Corrigan 2005). Of significant concern is that these views are also prevalent among healthcare professionals (Corrigan, Druss & Perlick 2014). Stigma can lead to discrimination. Bradley (2010) argues that discrimination is seen in all areas of health care provision including intensive care units (ICU) and EDs, and maintains that people experiencing mental illness express that it is in these settings that they can experience deeply felt prejudice. Thornicroft et al. (2008), suggest that acting with prejudice in rejecting a specific group of people involves not only negative thoughts, but also emotions such as anger, anxiety or distaste. Corrigan (2007) and Couture and Penn (2003) argue that contact with people who are experiencing mental

illness can change stereotypes, but Corrigan (2007) emphasises that the type of contact healthcare professionals have is an important factor, as they may only see people when they are acutely unwell.

The very nature of ED nursing is providing assessment and intervention to people seeking emergent care (College of Emergency Nursing Australasia 2013). Therefore, ED RNs' contact with people with mental illness is fundamentally limited to interactions of an acute nature. This may be a factor that influences ED nurses' attitudes and perceptions of people experiencing mental illness. A participant acknowledged that ED RNs do not have the opportunity to see people with mental illness getting better and stated that:

'There is a lot of negativity and because we don't see many people with mental illness getting better at any level, there's a lot of negativity regarding the whole thing' (P 10)

ED nurses' exposure to mental illness within the clinical working environment is primarily an experience that involves encounters with people presenting in mental health crisis. As such, ED nurses don't see consumers move from a phase of acute crisis to one of living well with or without the symptoms of mental illness. This could contribute to 'clinician's illusion' and negative clinician bias regarding the expected outcomes for consumers. 'Clinician's illusion' is a term coined by Cohen and Cohen (1984) to describe the pessimistic bias that can come from clinician's personal experience and outcome judgements based on the population that they are exposed to. For ED nurses this is generally people in mental health distress or crisis and this may

inevitably have a negative impact on their view of a consumer's personal recovery journey.

As the ED is a portal into the mental health care system (Kerrison & Chapman 2007; Broadbent, Moxham & Dwyer 2014), ED nurses are providing care on a regular basis to people seeking help for mental health issues (McAllister et al. 2009; Marynowski-Traczyk & Broadbent 2011). The importance of an accepting and non-judgemental attitude by clinical staff is paramount (Clarke, Dusome & Hughes 2007). People who present to the ED for mental health crisis assessment and intervention are members of the general public, and as such, it is reasonable to assume that they are well aware of the stigma attached to having a mental illness. Thornicroft (2008) describes how, as members of the general population, people with mental health issues also share a common pool of information regarding mental illness. And, as mentioned previously, this pool of information is pervasively negative. Therefore, the nature of the interaction that takes place between clinical staff and the person presenting to an ED with mental health issues can influence a person's decisions for future contact with health services, including mental health.

Stigma exists in contexts where there is unequal power (Link & Phelan 2001; Schulze 2009). Within the clinical/medical model, power inequality is strengthened by the inherent placement of the health care professional as the expert who interprets the subjective experiences of the consumer (Walker 2006). Healthcare environments embracing a recovery orientation emphasise empowerment, self determination, collaborative relationships and consumers as active participants in their care (Australian Health Ministers Advisory Council 2013b). This ultimately shifts the

power dynamic between the health care professional and the person seeking care, to one of equality. The realisation of this power shift within healthcare environments such as the ED would make a significant contribution to eliminating the perpetuation of stigma among clinicians working in that clinical domain. The ways in which a power shift can be promoted within the ED environment to support recovery will be discussed later in this chapter.

A finding from this research is that pessimism and negative attitudes regarding mental illness continue to be pervasive within the ED environment. This is consistent with the findings of Clarke et al. (2014) and Marynowski-Traczyk and Broadbent (2011). Furthermore, a diagnostic label of mental illness, which in itself continues to be associated with pessimistic outcomes, may influence ED nurses' negative perceptions of the anticipated life journey for people experiencing mental illness. It may also contribute to the conceptualisation that recovery does not occur, as was found in this research.

Recovery is ‘seeking help from the ED’

Within the second category of description, the conceptualisation of recovery as *seeking help from the ED*, participants expressed that they view the ED as playing an initial role in recovery for people experiencing mental illness who present to the ED. Key points which will be discussed within this category of description include the evolving role of the ED, ED RN’s mental health literacy and language supporting recovery.

The ED is an environment that provides emergent care, and many participants acknowledge that the crisis assessment and intervention for people with mental illness is a role of the ED. They also perceived that the initial contact with ED clinicians begins a person’s recovery. The diagrammatic representation of the hierarchical position of category of description Two within the outcome space is presented in Figure 19:

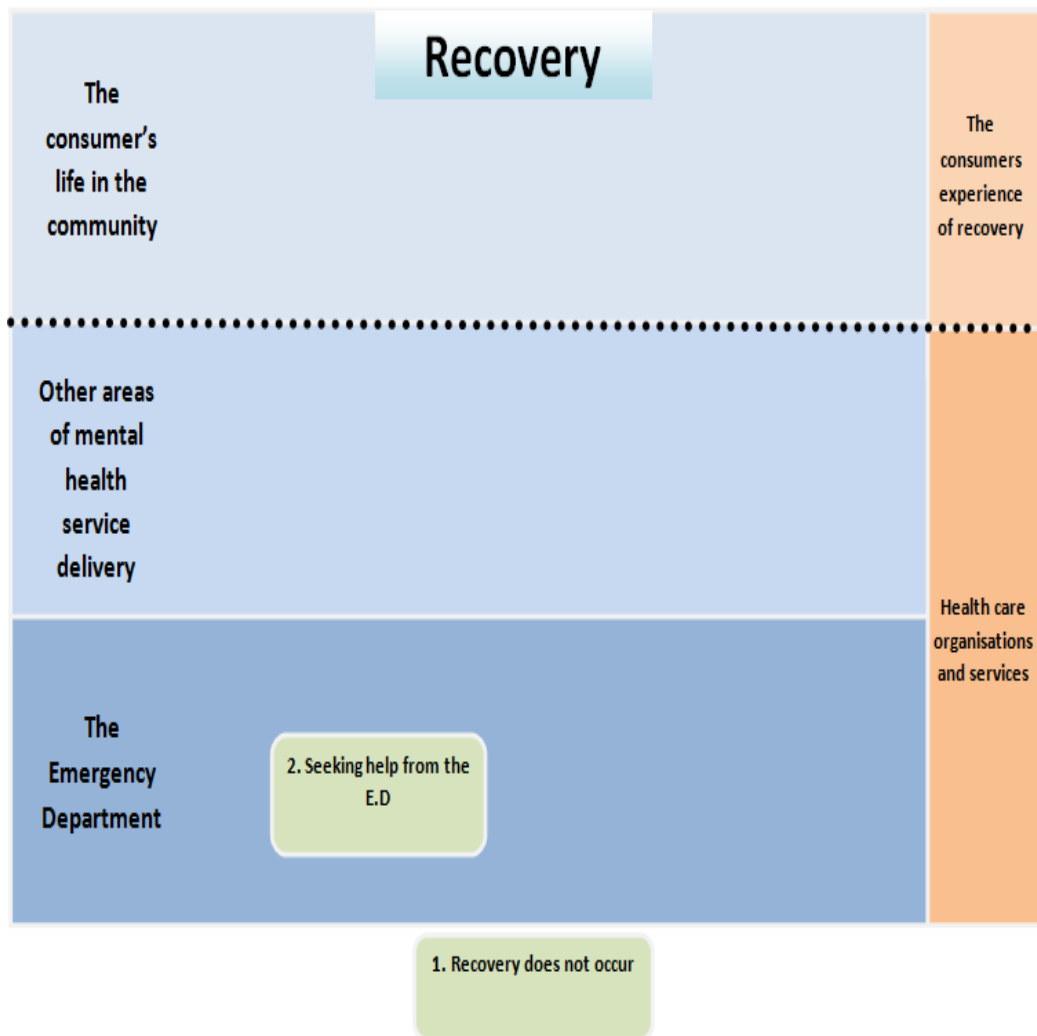


Figure 19: The position of category of description Two within the outcome space

The evolving role of the ED

The ED is an integral part of service provision to consumers, and the implementation of the first National Mental Health Strategy in Australia in the early 1990s changed the healthcare landscape in Australia. It was through this policy framework that the national coordination of reform in mental health began. However, the reforms had a

significant, unintended, impact on the ED and the health professionals who practice in the ED. The subsequent restructuring of mental health services not only altered the location for mental health services, but also impacted on the accessibility of these services (Doessel, Williams & Whiteford 2009). Concomitantly, the reforms placed increased demands on the general healthcare system and in particular the general hospital ED (Broadbent, Moxham & Dwyer 2014).

It is documented in the literature that mental health presentations to the ED have increased as a result of the changes in policy directives and mental health care reforms (Shafiei, Gaynor & Farrell 2011). Consequently, as the location for treatment and care of people with mental illness has changed, the ED has now become the interface between community and specialist inpatient mental health services and serves as the portal into these services.

Within Australia there are different models of emergency mental health services to EDs. These include the crisis and assessment team (CAT), consultation liaison service (CL Service), mental health nurses based within the ED, and Psychiatric Emergency Centres (PEC) (Broadbent, Moxham & Dwyer 2010). The models of emergency psychiatric services which have different nomenclature in different jurisdictions are presented in Table 13:

Table 13: Models of emergency psychiatric services to Australian emergency departments (Frank, Fawcett & Emmerson 2005)

Models of Emergency Psychiatric Services to Emergency Departments					
	Staffing Cost	Hospital size	Mental health takes early responsibility	Acceptance by ED staff	ED staff mental health skills
Consultation Model CAT or CL Service	+	<250 beds	NO	+	+++
Emergency Department -based mental health nurses	++	250-500 beds	NO	++	++
Psychiatric Emergency Centre	+++	> 500 beds	YES	+++	+
<p>KEY:</p> <p>Low +; Medium ++; High +++</p>					

The type of model implemented within the ED is influenced by hospital size, state and/or territory government policy and financial considerations (Frank, Fawcett & Emmerson 2005). ED staff accept each model differently due to the variations of when the ED relinquishes responsibility of the patients and when they become the responsibility of mental health services (Frank, Fawcett & Emmerson 2005). The Psychiatric Emergency Centre (PEC) provides time-limited acute mental health care

and facilitates the early and direct access to specialised mental health services (Brakoulis et al. 2013). Frank, Fawcett and Emmerson (2005) outline that, with regard to the PEC and dependent upon the role of the PEC within the ED, mental health assessment skills of ED staff can be reduced as a result of the decreased exposure to people experiencing mental illness. Promoting the mental health literacy of ED RNs is essential to enable them to provide optimal care and to facilitate optimal outcomes for consumers. However, Wand and White (2007) maintain that decreased exposure is a factor that consequently results in reducing the opportunities available for increasing mental health understanding and knowledge. Dr Tim Wand has firsthand knowledge of this given that he is a Mental Health Nurse Practitioner in a large metropolitan emergency department.

The placement of PECs and employment of permanent dedicated mental health professionals working in collaboration with ED staff is not consistent in all general hospital EDs throughout Australia, and is not always viable, as smaller country towns in Australia do not have trained mental health nurses. In light of this, and as many RNs working in the ED providing care for people with mental illness have no formal mental health training, there is all the more reason to increase the mental health literacy of generalist ED RNs.

Health care professionals such as those working in the ED interact with people experiencing mental illness at different stages of their recovery. However, as outlined by Le Boutillier et al. (2011), the consumer is the person who decides when and if their recovery begins. Some participants view recovery as beginning when help is sought during crisis, and stated that, because consumers present to the ED for initial crisis

assessment and intervention, they view the ED and the implementation of initial care as the start of their recovery.

‘Anyone who gets to emergency that’s the start of their recovery phase, so if you walked into emergency saying you want help for your mental illness you’ve already started your recovery process because you’ve made the decision that you want help’ (P 13)

Personal recovery has no defined place to begin; it is individualised and unique to the consumer. However, participants in this research conceptualise recovery as “seeking help”. Once again this illustrates how the conceptualisation of recovery remains grounded in the clinical understanding of recovery whereby intervention by health care services is seen to facilitate “cure”. Furthermore, when a person in need of emergent mental health care presents to the ED, interventions are initiated with the goal of helping them to “get better”.

When a person experiencing mental illness becomes unwell, the lack of available resources available in the community and an understanding that “there is nowhere else to go” can consequently result in presentation to general hospital EDs for crisis assessment and intervention. It is acknowledged within the Fourth National Mental Health Plan (Australian Health Ministers 2009a) that, as the ED may be the first point of contact for a person with mental health issues with the mental health care system, the ED must therefore be able to initiate care. Furthermore, The College of Emergency Nursing Australasia (2013, p. 5) states that ‘emergency care facilities accept and manage the full spectrum of physical, psychological and social health problems’,

therefore ED nurses as part of their daily practice care for people who are experiencing mental illness. However, Weiland et al. (2011) argue that despite the fact that the introduction of mainstreaming within the Australian health care system occurred in the 1990s, the dominant service model within EDs continues to focus on illness and injury of a physical nature. Therefore, in many general hospital EDs, people experiencing mental health crisis continue to be cared for in an environment with a predominantly physical focus, and ED nurses whose training, education and expertise is logically oriented to this domain.

An important finding from this research reveals where ED RNs place the ED in regard to recovery for this vulnerable and marginalised population. Participants acknowledge that the ED is an important initial support for people with mental health issues, however recovery for this group is conceptualised as “seeking help” with their mental illness. This reveals that the participants do not understand that recovery is more than something that is “done to a person by healthcare services”, and is indeed much more than an outcome that can be objectively measured. ED RNs daily practice involves a focus on episodic care, stabilisation and the alleviation of symptoms so that a person can begin to recover from whatever has precipitated their admission to the ED. However, Deegan (1997) maintains that a person’s ongoing personal recovery journey can be one with or without the presence of symptoms. McGruder (2002) posits that within the medical paradigm, symptoms that influence a clinician’s decision regarding the classification of a person’s mental illness and results in the assignment of a diagnosis, are actually the person’s experiences of living with the mental illness. These experiences have meaning to that person. Within a clinical/medical framework

recovery is viewed as the amelioration of symptoms and return to normal functioning. Therefore, it may be challenging for nurses working within the clinical ED environment to understand that, although these symptoms may cause distress, they may also have positive aspects. Personal recovery is ongoing, therefore when providing care to consumers, ED nurses are part of a consumer's recovery. As such, the interactions that ED RNs have with consumers, and the language that they use when providing care and support, can significantly impact on a consumer's personal recovery journey.

People presenting to the ED and seeking help while experiencing mental distress is perceived as taking positive action. This view is expressed by a participant who states that:

'The ED is a positive stepping stone to recovery' (P 6)

Rapid assessment, decision-making and intervention are the foundation of emergency nursing (Stanton 2007). Participants articulated that the similarity between medical and mental health presentations with regards to both types of presentation created a commensurate need for the implementation of short-term care within the ED. This is illustrated by the following participant:

'I guess medical and mental health patients like in the short term when they present to ED are very similar in a way, but we need to treat short term problems so they can move on, I guess the ED is in the initial part of that recovery' (P 7)

Within the context of the ED, recovery is conceptualised as initially seeking help, but not taking place in the ED. Indeed the participants revealed that they are not cognisant of an understanding of recovery outside the clinical/medical meaning. Supporting a person's personal recovery is fundamental within contemporary mental healthcare, and mental health clinicians incorporate recovery-oriented principles within their daily practice. ED RNs as part of their daily practice also care for people experiencing mental illness. Many of the principles consistent with recovery-focused care are also incorporated within nursing practice across diverse general practice domains including the ED, and include the provision of holistic care (Slade 2009a), listening non-judgementally and conveying an attitude of respect (Shepherd, Boardman & Slade 2008), and working with family members and carers to ensure that they are heard and supported (Council of Australian Governments 2012). However, an understanding of the meaning of personal recovery would also enable ED nurses to understand other important elements that are integral to nurturing recovery. These include the use of language that promotes hope and optimism (Australian Health Ministers Advisory Council 2013a), recognising that the attitudes of clinicians who are providing care are a powerful barrier to recovery (Mancini, Hardiman & Lawson 2005) and challenging stigma which remains prevalent among health care professionals (Corrigan, Druss & Perlick 2014). A descriptive exploratory study by Gertz et al. (2012) explored the perceptions of thirty-six Australian ED staff regarding factors influencing the accurate triage of people presenting with mental health issues. Social stigma associated with the diagnosis of a mental illness was identified as a barrier to accurate decision making. However, some participants were cautious about how their own attitudes towards mental illness may influence these decisions. As discussed previously, stigma is a

major barrier to recovery. Therefore, ED nurses who provide care to people experiencing mental illness contribute significantly in supporting consumers in their personal recovery by engaging in self-awareness, and challenging the perpetuation of stigmatisation within the health care profession.

ED RN's mental health literacy

Many ED RNs who are involved in the provision of care to consumers are generalist nurses, and the focus of their education, training and experience has been on the general medical needs of the patients in their care. The Practice Standards for the Emergency Nursing Specialist (College of Emergency Nursing Australasia 2013, p. 5) maintains that 'emergency nurses acquire a highly developed and uniquely comprehensive generalised knowledge and a diverse range of skills specific to delivering timely, competent emergency care'.

Generalised nursing knowledge and the development of generalist skills is the focus of undergraduate nursing education within Australia. The Australian Nursing and Midwifery Accreditation Council (ANMAC) outlines in the Registered Nurse accreditation standards, Standard Four: Program content; 'The central focus of the program is nursing practice, comprising core health professional knowledge and skills' (Australian Nursing & Midwifery Accreditation Council 2012, p.14). However, Happell and Platania-Phung (2005) argue that, within the undergraduate Bachelor of Nursing curricula, mental health knowledge and skills must not be secondary to other generic skills such as medical-surgical.

The report by the Mental Health Nurse Education Task Force (MHNET) in 2008 examined the mental health content in the Australian undergraduate pre-registration nursing course and outlined that the variation in the amount of clinical hours that are undertaken in mental health placements was an area of concern. However, the report identified that progress has been made in integrating mental health into subjects across the curriculum (MHNET 2008). Although there has been progress in addressing the amount of mental health content in the Bachelor of Nursing curriculum, concerns remain, and the nursing profession must be challenged to acknowledge that the inclusion of mental health as a core component of the curricula is essential to facilitate the preparedness of comprehensive nurses (Happell & McAllister 2014; Wynaden 2010).

As discussed previously, the prevalence of mental illness in the Australian population is a major concern, with one in five Australians experiencing mental illness (AIHW 2014b). Furthermore, the physical health of people with mental illness is equally alarming, and the results of the National Survey of Mental Health and Wellbeing 2007 (AIHW 2014b) outlines that the prevalence of co-morbidity within this population is significant. One in nine (11.7%) Australians aged 16-85 have a mental illness and a physical illness at the same time. It is therefore reasonable to suggest that nurses will care for people with mental health issues in all areas of health care. As such, it is essential that they are adequately prepared to confidently provide safe quality care to this population.

Although ED RNs practise in an environment that predominantly provides emergency care, medical care should not be considered more important than mental health care.

Equity in the provision of care to this vulnerable group must be supported (Broadbent 2011). Furthermore, cognisance of the meaning of personal recovery can facilitate care within all healthcare environments that acknowledge and involve consumers as active participants. This is integral to facilitating recovery- oriented services and supporting consumers in their personal recovery journey, and it also includes appropriate language.

Language supporting recovery

Throughout the recovery literature the significance of language is consistently stated (Ashcraft & Anthony 2006; Australian Health Ministers Advisory Council 2013b; Jensen et al. 2013; Mental Health Coordinating Council 2013). Notably, within the provision of healthcare, the use of language that is non-judgemental is outlined in the Practice Standards for the Emergency Nursing Specialist, 2.0 Domain Communication: ‘Uses a variety of communication strategies to establish rapport with patients, families and support people, such as active listening, paraphrasing and non-judgemental language’ (College of Emergency Nursing Australasia 2013, p. 9).

It would not be unexpected that RNs, who work within a health care system that is informed by the dominant medical model, would acculturate the vocabulary that is pervasive within this clinical framework as part of their daily practice.

Language is the means by which we ‘can alter thinking and attitudes’ (Jensen et al. 2013). Given that language influences thoughts, it can frame the way in which healthcare professionals experience people with mental illness (Ashcraft & Anthony 2006). Participants conceptualise recovery as seeking help from the ED, a

conceptualisation informed by the clinical environment in which ED nurses practise. Some participants used terms like “bi-polars” and “schizophrenics” when they were talking about people seeking help from the ED. It is important for clinicians to remember that the fact that a person presents to the ED with a mental illness is not a diagnosis. Although diagnostic labels do have a clinical and research function, illness, rather than person-focused language, is particularly powerful in perpetuating the stigma of people with mental illness (Ben-Zeev, Young & Corrigan 2010). The use of person-first language by health care professionals is a means whereby recovery can be supported, and the person is kept in the forefront (Ashcraft & Anthony 2006). Given that nurses purport to practice person-centred care, this is an important consideration.

Language transmits both intended and unintended meanings (Shattell 2009), and conveying unintended stigmatising meanings can become commonplace within health care services. Furthermore, commonly used language transmitting stigmatising meanings can become accepted and invisible (Shattell 2009). This is evident when participants use terms such as “psych” to describe the collective cohort seeking help from the ED. Language such as this, which labels consumers as an illness, perpetuates stigma. Furthermore, when healthcare professionals use this type of language the individual consumer and their unique personhood are lost to the collective understanding of what a “psych patient” means in the health care environment and culture in which the clinicians practise. It maintains the stigmatising difference of “them” and “us”. This practice is not conducive to facilitating recovery.

Recovery for people with mental illness who present to the ED is conceptualised by participants as ‘seeking help from the ED’, however, ED nurses’ practice is predicated

on the traditional medical model in which pathologising, paternalistic and deficit-based language remains dominant (Walker 2006). Vojak (2009) reminds us that language is a vehicle for change. As such, by challenging the continuing use of terms such as ‘bi-polars’ and ‘schizophrenics’ that were used by participants, ED RNs will continue to challenge stigma, facilitate change and actively support consumers’ recovery.

Recovery is ‘getting through the acute mental health crisis’

The first time I go mad I lie in my bed for days with my door shut and the curtains drawn. I struggle to put a thought or a sentence together. I can’t talk. I can barely move. My chest burns with a dark smouldering pain and I rasp with weak, shallow breathing. This is the completion of my crumbling into a profound nothingness. (O’Hagan n.d.)

The above quote from O’Hagan is a compelling illustration of a consumer’s experience of an “acute mental health crisis”. In the third category of description, a conceptualisation by ED RNs of recovery as it applies to people with a mental illness is *getting through the acute mental health crisis*. Key points which will be discussed within this category of description include the focus on emergent care and psychiatric advance directives.

The diagrammatic representation of the hierarchical position of category of description Three within the outcome space is presented in Figure 20:

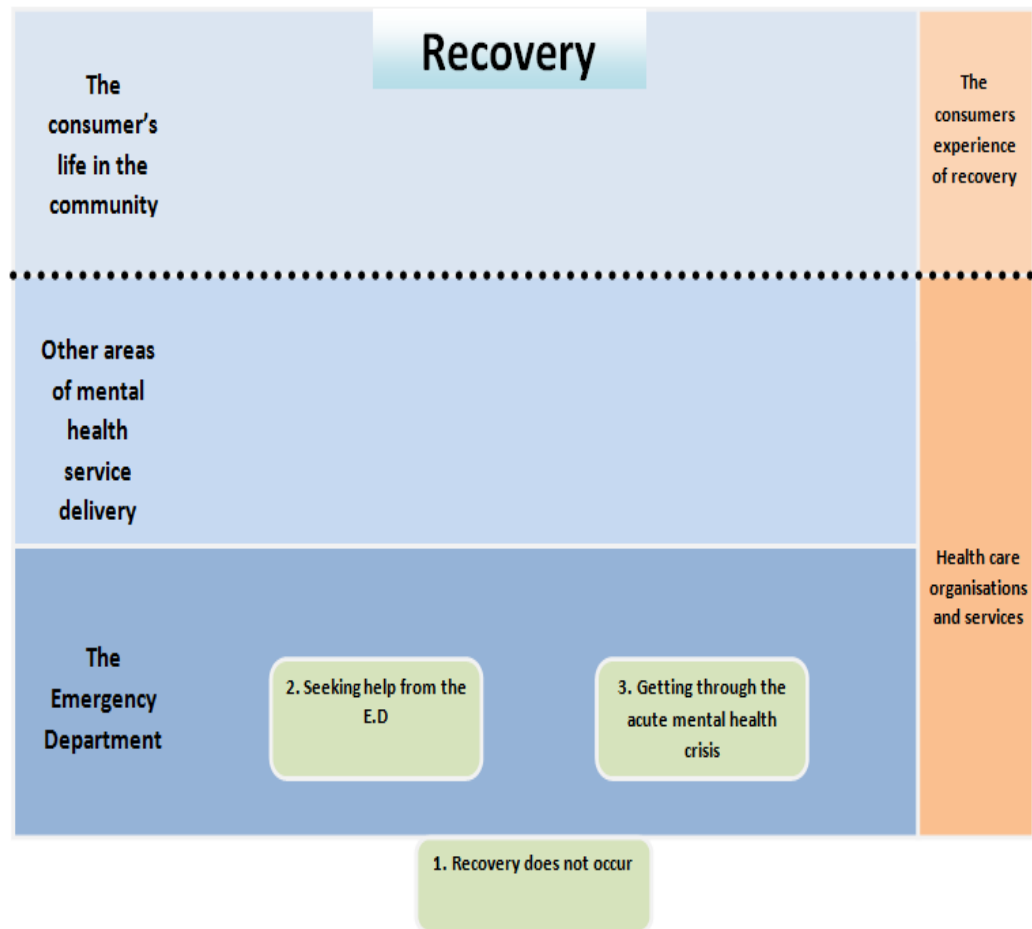


Figure 20: The position of category of description Three within the outcome space

The focus on emergent care

The role of the ED is essentially the provision of emergency care, as outlined by the

Australian College for Emergency Medicine (2014, p. 1):

Emergency medicine is a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all ages with a full spectrum of undifferentiated physical and behavioural disorders.

Participants stated that recovery for people who presented to the ED is ‘getting them through the acute mental health crisis’. RNs working in the ED are frontline caregivers in an environment that focuses on immediacy and short-term care. Attending to acute and urgent aspects of care is inherent in the role as an emergency nurse.

‘When you say the word recovery, the word recovery sort of confuses me a little bit. So obviously in emergency I’ll explain to you what we sort of do. We offer a service for patients in an acute stage of their illness. They present to emergency under a number of different forms, whether that be on their own accord, with the ambulance service or with police. Sometimes with multiple modes all at once and basically we provide a rapid assessment environment for these people’ (P 13)

It may be difficult for ED RNs to understand that personal recovery for people with mental illness is not contingent upon the amelioration of their symptoms. This is particularly challenging when this is the goal of clinical recovery entrenched in their daily practice as emergency clinicians. In contrast to clinical recovery, personal recovery acknowledges that people can go on to live fulfilling and meaningful lives with or without symptoms. This acknowledgement is at odds with the practice of ED nurses in which the alleviation or cessation of physical symptoms is synonymous with successful recovery.

The following statement by a participant reveals the understanding that medical recovery is an outcome that ED RNs strive to achieve for people who present with acute mental illness:

'Patients come in, they are really unwell, this is the really agitated and the aggressive sort of patient and quite often they haven't slept for a very long time, for days or whatever and usually, often it's a drug induced psychosis. Quite often our role in the emergency department is to facilitate rest and then hopefully, by the time a bed has been allocated in the mental health system and they are not with us in the emergency department, they have had a bit of a rest' (P 2)

Consumers present to the ED for assessment and management in an environment that focuses on stabilisation of presenting symptoms. ED nurses state that the very nature of their work results in the inability to provide more than acute intervention. Participants conceptualised 'recovery' as getting through the acute mental health crisis. This is illustrated by the following quote from participant eight;

'The role of the ED is to get them seen and assessed quickly' (P 8)

As the clinical/medical understanding of recovery is dominant with ED RNs practice, RNs may be unable to reconcile this traditional understanding of recovery with an illness that is considered chronic and enduring. In addition, the notion of chronicity for people experiencing mental illness appears intertwined with participants' understanding of consumers who frequent the ED for management of their mental health issues. This is reflected in the following statement by participant seven:

'A lot of mental health issues are not really a short term fix; they are more of a long term sort of therapy... mostly because they keep coming back' (P 7)

People who maintain a high level of ED utilisation are not a homogenous group. Individuals can frequent the ED to seek help for a variety of health concerns. Consumers who are frequent attenders were also referred to by participants as “frequent flyers” or “frequent users”. Some participants considered that this group placed additional demands on the ED. Some participants’ perceptions of the chronicity of mental illness and the subsequent need to repeatedly care for and ‘recover’ people experiencing mental health crisis is expressed in the following quote:

‘These poor people have a lot of these diagnoses for life and they will keep re-presenting, so it’s up to us to keep recovering them’ (P13)

This is consistent with the findings of Wooden et al. (2009). This retrospective descriptive study was conducted in a large metropolitan hospital in Australia with the aim of defining the clinical and demographic characteristics of people with mental illness who frequently attend the hospital’s Emergency Department. The study identified that this cohort placed an appreciable burden on ED resources; their use of the ED being nine times greater than the use by other people attending the ED.

However, re-presenting to the ED and engaging with mental health services can be a part of a consumer’s individual recovery. For many consumers the cyclic nature of mental illness means that they may require crisis intervention during their recovery. From a recovery orientation although it is necessary for consumers to take ownership of these setbacks, they are not viewed as failures in their journey to recovery. Furthermore, these interventions serve as opportunities for services designed to assist

people to see what has helped or hindered recovery from the consumer's perspective. In collaboration with the consumer, they also present an opportunity to work on strategies for better outcomes (Ashcraft & Anthony 2006). This approach may not be well understood nor appreciated by generalist RNs working in the ED.

Participants in this research often expressed the feeling that this group are presenting frequently to the ED for non-urgent reasons. This belief is consistent with findings from other research presented in the literature. Bolton (2009) states that a perception held by ED staff is that frequent attenders often have problems of a minor nature. Epping (2008) suggests that people requiring mental healthcare are not always viewed by healthcare professionals as needing emergency attention. In addition, Zeller (2010) maintains that some ED staff may not see this client group as having 'real emergencies'. Such a lens can negatively impact on the provision of care to this group.

Participants understood recovery for people with mental illness as getting through the acute crisis, a conceptualisation bound to the medical model that informs ED RNs' practice, being one in which recovery is understood as an objective outcome (Slade 2009a). Therefore, as consumers may "look healthy", this may influence nurses' perceptions that the needs of people with medical conditions are more deserving of immediate intervention. The sentiments of a participant suggest that the visible and tangible emergent needs of a physical nature can be clinically categorised as an illness or injury, and are perceived by some ED nurses as easier to respond to and provide interventions for:

'They don't actually have a wound or an illness, something that you can see' (P 3)

This is consistent with the findings of a qualitative study by Kerrison and Chapman (2007), which investigated the mental health training and other educational needs of emergency nurses who had no formal mental health training. Five ED nurses and twelve subject-matter experts from an Australian hospital participated in the study. The findings identified the fact that people presenting with mental health care needs may be actively avoided by ED staff due to the perception that their presentations are of a behavioural or social nature. This is consistent with the literature that ED nurses are not equipped to deal with presentations of this nature (Hart 2008; Kerrison & Chapman 2007; Plant & White 2013; Sharrock et al. 2006).

The perception of being a low priority within the ED is acknowledged by consumers. Clarke, Dusome and Hughes (2007) implemented focus groups with consumers and their families to determine their satisfaction with care in the ED, and found that that consumers were aware that they were not viewed as a priority in the ED. Furthermore some participants stated that the attitudes of ED staff towards them made them feel as if their concerns were not worthy of the ED staffs' attention.

ED nurses are specialists in the provision of emergency care. Their expertise predominantly focuses on peoples' physical health needs. Therefore it would be reasonable to suggest that these factors, having an objective orientation and being inherent within the traditional medical model, may influence how ED nurses in their daily practice position the provision of care to people with mental illness. However,

the subjective experiences of consumers is part of their recovery and although, from a purely clinical viewpoint people experiencing mental illness may appear to ED RNs to be in good physical health they may in fact be in extreme distress.

In contrast, one participant offered a different perspective and expressed that the provision of care for people experiencing mental illness has a different focus from that for people who present with medical illness or injury. It requires time to listen to the person:

'It's a more personal approach for a mental health consumer rather than a medical consumer because you have a disease process with a medical person and this is how you treat it A, B, C, whereas a mental health consumer you have got to actually listen, but you know you have to treat them more as an individual rather than a diagnosis' (P 12)

The comment by participant twelve also illustrates that “all” patients are considered as a diagnosis. This again reinforces the medicalisation of nursing care in the ED, but highlights that this participant was mindful of a humanistic, person-centred approach to people with a mental illness, suggesting that unknowingly they actually articulate the principles of recovery. In the provision of patient care the therapeutic relationship is an integral part of nursing practice (Ross & Goldner 2009) and is foremost within the mental health care domain. However, ED RNs practice in an environment where managing time and patient-flow is a priority.

A key ED performance indicator for Australian EDs is the National Emergency Access Target (NEAT). This is set out under the National Health Reform Agreement—

National Partnership Agreement on Improving Public Hospital Services (Council of Australian Governments 2011). The NEAT is measured as the percentage of patients who physically leave the ED within four hours of their arrival to the ED, and the measurement includes whether the patient is admitted to hospital, transferred to another hospital, or goes home. The objective of the NEAT is that by 31 December 2015 90 percent of patients will leave the ED within four hours (Council of Australian Governments 2011). Available data reveals that in 2012 65.5 percent of patients presenting to the ED within a public hospital completed their visit within four hours or less (AIHW 2012).

As the NEAT is an important performance indicator for Australian EDs there is ongoing pressure for staff working within the ED to meet these benchmarking standards. It can therefore be difficult for ED nurses to establish a rapport with consumers (Marynowski-Traczyk & Broadbent 2011). In addition, the acuity of the ED environment can dictate the amount of time that can be spent talking with consumers. This illustrates the challenges that ED RNs experience in their interactions with consumers when the ED becomes busy.

RNs working in the fast-paced emergency environment view recovery as getting their patients through the acute crisis. However, previous discussion has highlighted the fact that personal recovery for mental health consumers is an ongoing and non-linear journey during which the consumer may experience acute episodes, and that recovery does not start after the acute episode resolves (Davidson et al. 2006). ED nurses working within a model of care that focuses on moving patients from a state of being unwell to a restoration of their health, place the emphasis of recovery to an outcome

rather than the process. As such, they may find it difficult to understand that consumers can view the acute episode as a temporary disruption to their ongoing recovery journey, rather than being an episode that they need to be “recovered from”.

Healthcare professionals who are unaware of a separate and disparate meaning of recovery can have a, polar view of frequent attendance when compared to that held by people with lived-experience of mental illness, and by clinicians who do embrace and support personal recovery. Cognisance of personal recovery can have a positive impact on how healthcare professionals view frequent attendance by this vulnerable and disadvantaged group. In addition, viewing consumers’ attendance at the ED from a recovery orientation rather than through a clinical lens, will enable ED RNs to understand that re-presenting to the ED is a part of the process of a person’s ongoing and individual recovery journey. This awareness can facilitate a change in the understanding of frequent attendance as being something negative, to understanding it as being a positive step taken by people with mental illness who are actively engaging with health services. Furthermore, an accepting and non-judgemental attitude towards this group is integral to supporting their continued engagement with the mental health care system. Clarke, Dusome and Hughes (2007) maintain that how people are treated when they seek assistance from the health care system can influence their future engagement with services.

The mental health care reforms that have occurred within Australia have changed the delivery of mental health care services to a community focus. However, the Victorian Government Department of Human Services (2005) maintains that the ED is integral in providing support to people who are “missed” by community mental health services.

Currently people seeking help for mental health crisis intervention are required to access mental health services through general hospital EDs. Despite government policy that dictates this requirement, attending EDs is not consumers' preferred option for crisis intervention (O'Hagan 2008). This position is articulated by O'Hagan (2008) in the New Zealand publication entitled *'The Services We Need'*. This document reveals consumers' expectations; ease of entry into mental health services was identified as a change that was needed. Consumers stated 'we do not want to access services through accident and emergency departments' (O'Hagan 2008, p. 12).

However, until such time as there are policy changes regarding access to mental health crisis services in Australia, general hospital EDs will continue to serve as the interface between the community and specialist mental health inpatient services. ED RNs' cognisance of the reasons why consumers re-present to the ED and of consumers' personal understanding of relapse, and an understanding of how they can be supported during this period in their recovery journey, will ultimately be beneficial to consumers and to the ED nurses who provide care.

Consumers present to an ED environment focusing on the stabilisation of presenting symptoms, and ED nurses state that the very nature of their work results in the inability to provide more than acute intervention. ED nurses simply need to 'get people through the acute mental health crises'. That said, within ED RNs' clinical/medical understanding of recovery, this brief intervention is still viewed as facilitating recovery for people with mental health issues. Participant eleven stated:

'I mean some of them, the ones you can send home that shift, their recovery is obviously a fair bit quicker, but the ones that go to Ward X or Ward Y you don't kind of follow up on them from there. So you don't know how long they are in there for or how long they are going to be there' (P 11)

Recovery, as the above quote suggests, connotes going home/being discharged. Participants state that the interaction between ED nurses and consumers may be brief. However, cognisance of the meaning of 'personal recovery' can enable ED nurses to understand that maintaining a recovery oriented approach, within this short period of a consumer's journey, is in fact significant for the consumer who is the very person meant to be central to care. Davidson et al. (2006) maintain that the care consumer receives during an acute crisis can promote the recovery process; conversely it may also undermine the recovery journey.

Psychiatric advance directives

As alluded to previously, people who attend the ED regularly for mental health issues can be viewed by health care professionals as having a negative impact on the effective running of the ED. When working in an environment that provides care to people who are acutely unwell, participants said that managing the crisis situation is foremost. In order to facilitate an expeditious assessment and the implementation of appropriate interventions, a participant stated that individualised plans that are in place for consumers enable ED staff to have access to information regarding their care:

'We see a lot of people that come in regularly...most of them have got a plan put in place so if they come into triage, there's a folder so you know what to do for a certain person' (P 8)

During times when a consumer may be acutely unwell their personal recovery is still ongoing. It is therefore essential that the integral aspects of recovery which are valued by the consumer, such as autonomy and active participation, are respected. A means whereby ED RNs can actively support consumers' recovery in the ED environment is through psychiatric advance directives (PAD). A PAD, also known as a mental health advance directive, is:

a written document that describes what treatment a person does or does not want if at some time in the future they are judged to be incapacitated from mental illness in such a way that their judgement is impaired or they are unable to communicate effectively. (Australian Health Ministers Advisory Council 2013a, p. 80)

PADs are identified within the National Framework for Recovery-Oriented Mental Health Services (Australian Health Ministers Advisory Council 2013b). This is a strategic document that aims to improve mental health service delivery in Australia.

The respect for human dignity is considered central to nursing practice (Bennett Jacobs 2000). Walsh and Kowanko (2002) investigated patients' and nurses' perceptions of dignity in a phenomenological study that involved five patients and four nurses from a large Australian metropolitan hospital. Findings from the study identified elements that can influence an individual's sense of dignity; these include autonomy and choice, and the ability to have control of aspects of their care. In keeping with a recovery orientation that promotes autonomy, PADs are a key approach that can be

implemented for consumers during times of crisis, and are seen as a means for people with mental illness to maximise choice and self-determination. A PAD enables consumers, who anticipate that they may experience periods in their recovery journey where their capacity to make decisions may be affected, to be actively involved in decisions regarding their care (Slade 2009a).

Empowerment and personal choice are central tenets of personal recovery (Leamy et al. 2011). It is essential then, that consumers are involved in what happens to them when they are in crisis, and that their individual preferences are respected. In this thesis ‘recovery’ is conceptualised by ED nurse participants as getting through the acute mental health crisis. Psychiatric advance directives are a mechanism enabling consumers who present to the ED to retain control (Davidson et al. 2006). When ED nurses have access to information that identifies a consumer’s treatment preferences when they become unwell, the consumer is enabled to maintain autonomy during this difficult and often distressing time.

The Practice Standards for the Emergency Nurse Specialist 8.0 Domain Professional Ethics: states that ED the nurse ‘respects the individual’s right of choice and strives to ensure their choices are understood and promoted’ (College of Emergency Nursing Australasia 2013, p. 13). Psychiatric advance directives, which support recovery and their implementation within the ED, are a means by which ED RNs can promote consumers’ autonomy and choice and thereby support their personal recovery. Scheyett et al. (2007) outline the ways in which PADs support the components considered integral to recovery. These components are presented in Table 14:

As stated by participant 8, having a plan in place that can be accessed by ED staff enables nurses to know what to do for an individual presenting to the ED in a mental health crisis. Given that autonomy is integral to personal recovery, PADs are a means whereby consumer's autonomy and self-determination can be promoted. Therefore, it is vital that the purpose of the advance directive, from the consumer's perspective, is upheld and respected. The advance directive belongs to the consumer, as does their personal recovery. The PAD is a tool that they may choose to use to maintain participation in their recovery during times of mental health crisis.

Table 14: Components of recovery that are supported by psychiatric advance directives. Adapted from: Scheyett et al. (2007)

Recovery Component	Ways in which Psychiatric Advance Directives Support Recovery
Hope	An opportunity to take the pain and crises of the past and reframe them as learning experiences for a better future
Individualised and person - centred	Specific wants and needs of individuals, providing the opportunity to voice their lived experience and knowledge gained from prior life events
Holistic	Do more than focus on crisis pathology and treatment; they acknowledge and examine holistically the needs an individual may have during a crisis and can include a range of non-treatment requests such as contacting a loved one
Strengths - based	Grounded in the belief that individuals have the inherent wisdom and self-knowledge to be able to identify what they need during a crisis
Self -direction	Allow for self-direction of care during crisis when individuals may be unable to communicate their wishes

Within Australia, Senate Select Committees are established by the Australian Senate to examine a particular issue in depth. In the final report of the Senate Select Committee on Mental Health, *A National Approach to Mental Health – from Crisis to Community Final Report* (Commonwealth of Australia 2006), recommendation 18 states:

That the Human Rights and Equal Opportunity Commission (HREOC) be requested to complete its important work on advance directives and protocols

that would recognise the rights of consumers to, for instance, identify substitute decision-makers, appropriate treatments and other financial, medical and personal decisions, particularly for the care of children. (p. 14)

The legal complexities involved in the establishment and enforcement of psychiatric advance directives in Australia is not elaborated within this thesis. However, it is significant to note that there have recently been major advances within Australia which will eventually impact on the promotion of consumers' autonomy through advance directives. This includes the Advance Directives Act 2013, which was passed in the South Australian Parliament in April 2013 (Government of South Australia 2013). However, this is only one state of Australia's five states and two territories. This Act of Parliament has not yet become law, and within Australia advance directives are currently not legally binding (Australian Health Ministers Advisory Council 2013a).

Weller (2010) contends that, with regard to advance directives, Australian law has not kept up with international practice. Despite their current legal status they remain a means for consumers and their carers and/or family, if the consumer chooses to engage in discussions regarding plans for future care if it is needed. During a mental health crisis, PADs ensure that the consumer's choices are foremost and will facilitate informing healthcare providers, such as ED RNs, of individual care preferences. As a result of recovery for people experiencing mental illness being viewed as getting through the crisis, psychiatric advance directives are a means whereby ED nurses can facilitate that preferences are respected when the consumer presents to the ED for crisis assessment and intervention.

A psychiatric advance directive can include such things as:

- Who the consumer would like called when they become unwell

- What medications have worked in the past and what have not worked and which medications the consumer would like to be treated with
- Care of pets
- Child care arrangements
- Particular procedures that the consumer does not want to be treated with, such as electro-convulsive therapy (ECT).

However, when consumers present to the ED and are cared for within the clinical environment, the use of the PAD may be overshadowed by the overarching emphasis on treatment and risk management. This remains inherent within the clinical environment. Recovery is promoted through personal choice, and to support recovery-oriented services and a consumer's personal recovery, it is essential that PADs are viewed first and foremost from the consumer's perspective. Furthermore, it is empowering for consumers to know that they have actively participated in plans for any future engagement with health services, should the need arise (Sidley 2012).

Psychiatric advance directives can also provide guidance to ED RNs regarding the consumer's choice of interventions and management during times of crisis. In addition, they provide clinical staff with a tangible means of actively supporting consumers' recovery and respect for their voice/choice. However, barriers have been identified that can impede the implementation and utilisation of this recovery tool. Such barriers include health care professionals' education and familiarity with advance directives (Kim et al. 2007), clinicians' discomfort with shared decision-making (Henderson et al. 2008), operational barriers within the work environment such as lack of communication between clinical staff (Van Dorn et al. 2006) and access to the

documents (Srebnik & Russo 2008). Furthermore, the architectural environment of the ED (Broadbent, Moxham & Dwyer 2014) can also present a barrier.

This research has elucidated that one of the ways that ED RNs conceptualise recovery, is ‘getting through the acute mental health crisis’. Experiencing an acute crisis can be part of the ongoing process of recovery in a person’s personal recovery journey. This apparent tension/dichotomy of opinion illustrates the disparity between recovery as understood by ED RNs viewed through a medical lens, and the meaning of recovery as understood by people with lived-experience of mental illness.

Recovery is ‘referral to other areas of mental health care’

In the fourth category of description, *referral to other areas of mental health care*, recovery is conceptualised as occurring in other areas outside of the ED, and involves the referral of consumers to other areas that provide mental health care and services. Key points which will be discussed within this category of description include the Emergency Department environment, mental health assessment and management, mental health education and training and length of stay in the ED.

The diagrammatic representation of the hierarchical position of category of description Four within the outcome space is presented in Figure 21:

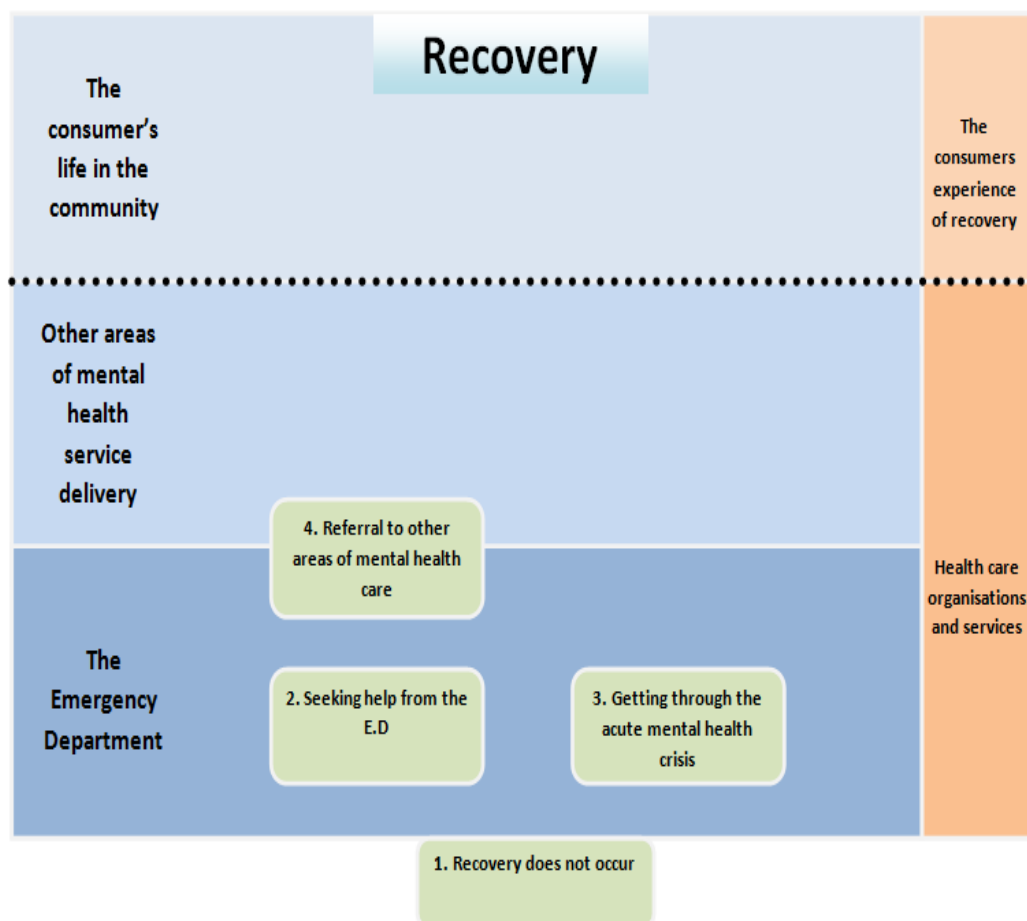


Figure 21: The position of category of description Four within the outcome space

ED RN participants said that they do not consider that the ED can effectively meet the needs of people presenting with mental health issues, and that recovery is best facilitated in other areas of health care delivery; namely, mental health services. Therefore appropriate referral is necessary to assist recovery for consumers, and is considered an integral part of an ED nurse's role. This sentiment is articulated by the following participants:

'well I guess that's kind of what emergency nursing is, symptom relief, and then referring on to the appropriate area' (P 7)

'They come into the ED, a short term fix for whatever is happening and then someone else takes over, the mental health system' (P 3)

The understanding of recovery as something that health services “do to a person” remains bound to the meaning of recovery embedded within general health care; an approach where healthcare professionals, with the goal of facilitating clinical recovery, establish interventions and treatment.

Participants singled out factors that they consider impact negatively on the EDs’ ability to provide optimal care to people with mental health issues, and which would subsequently impact on ED RNs’ ability to facilitate recovery. These factors include the ED environment as well as the lack of the necessary skills and knowledge to care for people experiencing mental illness. Recovery, in this instance, is viewed through a clinical lens. The factors that were identified by the participants as detrimental to their understanding of facilitating recovery within a clinical construct, are also factors that can have a negative impact on a consumer’s personal recovery.

The Emergency Department environment

The ED environment is the polar opposite of the environment that can facilitate the optimal care of people who present with mental health needs. The ED is a busy, loud environment and its frenetic nature is not conducive to providing optimal care for consumers and effectively supporting them in their personal recovery (Marynowski-Traczyk & Broadbent 2011). Participants stated that they consider this population group to have very different needs compared with people who present to the ED with

physical injury or illness. It was also suggested by a participant that a separate environment was an option that could meet the disparate needs of people experiencing mental illness:

‘It’s like patients who are referred to a specialist, for you know specialist needs, I guess potentially that if they are presenting to an emergency department it could be to a mental health emergency department couldn’t it’ (P 7)

Providing a separate ED for mental health presentations is not currently considered by some authors as conducive to supporting consumers’ recovery (Clarke, Dusome & Hughes 2007). Furthermore, people with mental illness are already a stigmatised group within society, and the segregation from the general population is thought by some to significantly contribute to the perpetuation of “differentness”. However, it is reasonable to suggest that striving to provide people with optimal care in an appropriate environment is a goal inherent in the practice of nurses across all health care domains. ED nurses conceptualise recovery as referral to other areas of mental health care in order to provide the appropriate care to people experiencing mental illness. Therefore, providing an environment which is considered conducive to meeting the unique needs of consumers could be seen by ED RNs as a possible alternative to the general hospital ED, an environment which they consider inappropriate. RNs who are cognisant of the meaning of personal recovery would be aware that people with mental illness, despite their illness, are striving to live full and meaningful lives, and that perpetuating a culture of “differentness” is a powerful barrier to achieving this goal. The findings from Clarke, Dusome and Hughes (2007)

support this. The authors maintain that the overwhelming consensus among consumers was that they did not want a segregated ED specifically designated for mental health, as they felt that this would further contribute to their stigmatisation. In contrast, it was identified that consumers wanted their medical and mental health issues addressed holistically.

It is acknowledged by the (Australasian College for Emergency Medicine 2012) that the ED does have an important role in the provision of the initial assessment and management of people in mental health crisis. This is articulated by a participant who felt that the ED does have a place in the provision of care for consumers, because it can provide a place of safety, away from triggers that may have precipitated the presentation. However, it was not always seen as the most appropriate environment.

'I think emergency does have a place, if it's an acute phase. It provides, I was going to say stress free environment, but it's not a stress free environment. It provides an environment separate to the situation that triggered their escalation at that point. I don't feel the ED is always the most appropriate, even though it's deemed by the Mental Health Act that way, the fact that we are busy and there is ambulances coming in, it's a loud noisy environment. Having someone who is in an acute phase of a mental health issue or even if it's just anxiety or something like that, coming into that environment is not going to help them settle'
(P 9)

Participants were aware that the environment within the ED is the antithesis of the environment required to provide optimal care to people who are experiencing mental distress and who are acutely unwell:

‘Our rooms that they use for mental health consulting are right in the middle of the department where there is ambulance access, so it is a very public area and it doesn’t allow for the calming influence you need. You need environments that allow for that’ (P 9)

‘... It’s a highly stimulating area and from my understanding of mental illness you don’t stimulate people in an acute stage of illness’ (P 13)

These statements outlining the perceived inappropriateness of the ED environment to facilitate supporting a consumer’s recovery, are consistent with a report by the Senate Select Committee on Mental Health (Commonwealth of Australia 2006). This report titled *‘A national approach to mental health – from crisis to community: final report’* maintains that the very nature of the ED environment, which is highly stimulating, may contribute to escalating behaviour.

The working paper entitled *‘What we know: The consumer perspective on mental health reform in NSW’* (Mental Health Commission of New South Wales 2013), outlines what consumers identify as areas in which change should occur, and which they consider are important areas of reform for the Mental Health Commission to focus on. This paper was the result of consultation with consumers, consumer organisations and the New South Wales Consumer Advisory Group. The ED was identified as an area in about which consumers had significant concerns. The triage process through

the ED was highlighted as sometimes being very traumatic, and staff avoidance of consumers was attributed to their lack of training in mental health (Brown & Clarke 2014). Furthermore, consumers articulated that the practice of having security guards supervise them while they were in the ED was intimidating, and of no therapeutic value. They also perceived this as a replacement for care that should have been afforded to them by the ED nurses (Mental Health Commission of New South Wales 2013).

The reality that the experiences of many people with mental illness who attend general hospital EDs are negative and less than optimal resonates with an ED RN participant. This participant said that although they are resigned to the fact that the ED may currently be the only option for people who are seeking help for mental health issues, as a RN, the appropriateness of the ED environment for this vulnerable and stigmatised population did not sit well.

'I think that here is probably nowhere else to take them at the moment but to me it's not really appropriate. Beginning from right when they are first brought in they are made to sit isolated, or they are made to sit there just like on display. I don't know if that's because I am a registered nurse that it stands out to me that they are mental health, does everyone else see it as well? They just usually have a police officer standing beside them, and that looks to me so harsh, and not a very friendly environment to bring someone into' (P 3)

Police referrals to the ED for people who are experiencing mental health issues are common (Lee et al. 2008). The comments from this participant are consistent with the findings of Bost, Crilley and Wallen (2014) whose descriptive, retrospective cross-sectional study compared and described the characteristics and process outcomes for mental health and non-mental health presentations to an Australasian general hospital ED. The study found that police were more involved in the transport of people with mental illness to the ED than with people with non-mental health conditions. One in ten mental health presentations to the ED were transported to the ED by police, compared to two in a thousand non-mental health presentations. Furthermore, the authors contend that police referrals impact the ED through the increased use of ED resources. However, it would be reasonable to suggest that the impact of police presence on the person requiring mental health crisis intervention is significant, and would have a negative impact on their recovery journey.

Recovery occurring in mental health crisis situations such as those that happen in the ED can be a difficult concept for ED RNs to understand. This is exacerbated as in these situations management may immediately focus on the safety of the person in mental health crisis, as well as on the safety of other people in the ED, including staff. Referring people with mental illness to other areas of mental health care may be viewed by participants as facilitating their recovery. Roberts et al. (2008) maintain that healthcare professionals can incorporate a recovery orientation into their daily practice in all health service environments. To this end, the Care Services Improvement Partnership, Royal College of Psychiatrists and Social Care Institute for Excellence (2007, p. 22) contend that there are no ‘recovery-free zones’. Even in crisis situations,

ED nurses practicing with a recovery orientation can support a person's recovery by ensuring that their rights are protected and that they are treated with respect (Australian Health Ministers Advisory Council 2013a). Furthermore, ED nurses can support recovery and promote a person's autonomy and self agency even in the most challenging situations, through the use of recovery language that is non-judgemental or stigmatising, and the implementation of psychiatric advance directives.

Mental health assessment and management

The ED is traditionally a critical care environment. It focuses on rapid assessments and the timely provision of necessary interventions. Within this context ED nurses are under pressure to maintain a constant flow of patients. Participants expressed that, with regard to the process of assessing whether a person will be admitted as an inpatient and the time that is associated with this process, there is a significant disparity between general medical and mental health presentations.

'In terms of recovery they definitely have to wait a bit longer, it can be very frustrating for them, because there is a only a limited number of people who can assess them, often they will be waiting in the department for a few hours or so. I suppose the recovery process is a lot longer for them, there are people that come into the ED for medical problems and they also have to wait, but mental health waiting times are a bit longer' (P 8)

Medical goals are distinct within the ED environment, and the medical review of consumers is a part of the process they undergo when attending the ED. In many EDs

this process must precede the consumer's mental health assessment by specialist mental health clinicians. Furthermore, co-morbidities, in particular drug and alcohol, can impact on a consumer's length of stay (LOS) in the ED; due to requirements for detoxification and medical clearance (Bastiampillai et al 2012; Bost, Crilley & Wallen 2014).

Zun (2005) outlines that medical clearance is the initial medical evaluation of an individual in order to ensure that the presentation is primarily a mental health issue. The medical clearance is undertaken to differentiate organic illnesses from functional disorders. Common underlying causes for mental health symptomology include central nervous system conditions, medications, infections and metabolic conditions (Zun 2005). Many participants stated that medical clearance was a necessary part of the review process for people who presented to the ED for mental health issues, as it facilitated differentiating the need for a medical or a mental health focus in the provision of care:

'I have seen a few patients that actually present, you know initially you are thinking bizarre behaviour, you are thinking its mental health issue but it ends up being a fairly separate cause. I do think these people do need some medical, like they have to have a medical review and then have a mental health review' (P 7)

'I guess they have to be medically cleared to make sure there is no physical component to their presentation but it's just very different for

mental health patients...it's not so streamlined for them, if that makes sense (P 3)

'In our situation we have to get a medical clearance for the patients before they can be seen by the mental health teams so facilitating the things that we need to do to do that so that might be one set of OBS, chest x-ray, breath alcohol, you know that sort of stuff to get a medical clearance' (P 2)

The ED is under constant pressure to maintain an efficient flow through the department. However people who are experiencing mental illness present ED staff with unique, and often challenging, assessment and management needs. The provision of mental health crisis assessment and intervention is very different to the provision of care for people with emergent medical needs. This disparity is perceived to impact on the demands placed on ED nurses, and to be a factor that impedes the flow within the ED which is crucial to its ongoing efficiency (Marynowski-Traczyk & Broadbent 2011).

In contrast, the need for a medical clearance prior to being seen by a mental health professional, and the subsequent time delay until this occurs, was viewed by a participant as a factor that was detrimental to the timely provision of appropriate care for people in mental health crisis. The following quote outlines the divide that continues to exist between medical and mental health care services:

'I just find sometimes it's very frustrating when somebody who is in an acute psychotic state has to have a medical clearance so they can go

in and seek out mental health treatment. They are stuck in this horrid state and waiting for the medical system before they can get the help that they need in the mental health area. But also vice versa, people with mental health components that have a medical predisposition have to wait and are stuck suffering, not suffering badly, but suffering, while they wait for the two teams to decide who's going to look after them you know. One has to get clearance from the other before the next one accepts instead of working in together. I would like to see like the medical and the mental health people work together for the sake of the patient, to help the patient as quickly as possible' (P 3)

Within general nursing the perpetuation of the dualism inherent within the mind-body split discussed previously, contributes to the continuation of nursing practice that delineates between caring for the mental health of individuals, and focusing on their physical/medical needs.

Mental health education and training

However, ED nurse participants have acknowledged that, when practising holistically, all facets of the individual must be considered in providing care, and they believe that the mental and physical health of the individual are intertwined. However, the participants also acknowledged that they lack the necessary skills and knowledge to be able to effectively care for people presenting to the ED with mental health issues. This finding is consistent with the literature (Jelinek et al. 2013; Sivakumar et al. 2011;

Stuhlmiller et al. 2004). But participants also stated that they are aware that ongoing mental health education would have a significant positive impact on their ability to provide optimal care to this group:

'If people are made aware, taught, educated about triggers and the escalation process to start with, they may present a bit earlier or may seek a different form of help a bit earlier. So I think as an emergency nurse, with a bit more understanding, we can assist our clients in that way' (P 9)

'I don't think ED staff have enough of an understanding of some mental health conditions' (P 7)

These statements from participants in this research are consistent with the findings of Kerrison and Chapman (2007) who identified that ED nurses viewed the mental health content within their undergraduate education as inadequate, and did not provide them with the necessary ability and confidence to care for consumers in the ED.

In order to achieve recovery for people with a mental illness who present to the ED for crisis assessment and intervention, participants conceptualise recovery as referring consumers to other areas of mental health care. The concept of personal recovery for consumers is not well understood by ED RNs. This is illustrated by the sentiments of participant one who would like to have an understanding of this disparate meaning of recovery:

'I would like to understand, using the word recovery in mental health, what does it actually mean?' (P 1)

Mental health training and education for ED RNs is essential to improve their mental health literacy, and to give them with the skills and knowledge that will enable them to confidently provide optimal and safe care for people experiencing mental health issues. However, the ED is a busy environment and is subject to rapid changes in patient acuity. Taking time off the clinical floor to attend educational in-services and professional development sessions is not always possible. Although many RNs would consider attending mental health professional development activities, the actual attendance may be small in relation to the number of RNs working in the ED. This was a factor that was acknowledged by a participant:

‘We occasionally get one of the team leaders from mental health come down to do an in-service, they may come down three or four times a year and it hits our in-service time, but our in-service time may only catch an eight head count out of a hundred and fifty head count’ (P 9)

The ED and mental health care environments are two diverse cultures each with their own cultural norms and practices (Broadbent & Moxham 2014). People who present to the ED in need of mental health care can transition between healthcare disciplines having two disparate focuses of care; ED care predominantly focusing on emergent physical injury and illness, and mental health focusing on the psychological and emotional health needs of consumers. Both groups have a mutual goal and strive to achieve optimal outcomes for people in their care.

Broadbent and Moxham (2014) contend that collegiate presence is required to develop collaborative relationships and a mutual connection between culturally diverse

professional groups so that they can facilitate optimal outcomes for people in their care. Therefore, collegiate presence based on respect, acceptance, insightfulness and effective communication can nurture a collaborative partnership and shared knowledge between ED staff and mental health professionals that will support the recovery of people with mental illness who attend general hospital EDs. Participants acknowledge the valuable support that they receive from clinicians with mental health expertise. This is illustrated in the following statement:

'I find that we have got a mental health CNC that works closely with staff where I work, and I find that very helpful, being able to ask questions and get help in managing people' (P 7)

Providing optimal care to people in mental health crisis can be challenging for ED nurses. Participants conceptualise 'recovery' for this group as referring them from the ED to other areas that provide specialist mental health care. Dedicated mental health clinicians working in collaboration with non-mental health colleagues in the ED aim to improve the quality of care provided to people with mental illness (Wand & White 2007). Therefore, sharing knowledge and engaging in collaborative partnerships can support ED RNs in providing optimal care to people experiencing mental illness and enable them to assist consumers in their recovery journey.

Length of stay in the ED

As outlined in the National Mental Health Report 2013 (Commonwealth of Australia 2013) the average length of time that consumers wait in the ED is an indicator for monitoring the progress and outcomes under the Fourth National Mental Health Plan.

This indicator relates to Priority area 3: Service access, coordination and continuity of care. However, there are currently no data sources available that include proxy measures providing information on the average times that people experiencing mental health issues have to wait when they present to the ED.

Shafiei, Gaynor and Farrell (2011) conducted a retrospective observational study of people discharged with a mental health diagnosis from a metropolitan ED in Melbourne Victoria, Australia. Over a two-month period the study examined the characteristics of, and outcomes for, two hundred and ninety adults aged between 18-65 years. The findings from the study identified that it was more likely for people to wait longer than eight hours in the ED if they arrived between 8 pm and 8 am, arrived intoxicated or were admitted to inpatient mental health units.

The Australasian College for Emergency Medicine (2012) maintains that, although the ED has a place in providing acute care to people with mental illness, it is not considered the appropriate environment for care past this initial stage. This is outlined in the Policy on Access to Care for Patients with Mental Health Conditions (Australasian College for Emergency Medicine (2012, p. 1) which states:

The emergency department is not an appropriate environment for the ongoing management of patients with mental health conditions. After initial management, patients with mental health problems must be transferred expediently to the appropriate site for ongoing care by the mental health service.

RN participants conceptualised ‘recovery’ for people with mental illness as referral to other areas of mental health care. However, general hospital EDs have a role in providing care to people with mental health needs, and as the capacity of mental health

inpatient services is insufficient to meet the demand for inpatient care, EDs are required to care for these people for extended periods (Victorian Government 2007). The Practice Standards for the Emergency Nurse Specialist 2013, 4.0 Domain: resources and environment, outlines that the ED nurse 'proactively manages patient flow to minimise the impact of access block and to optimise patient safety' (College of Emergency Nursing Australasia 2013, p. 10). Access block, colloquially known as bed block, is identified by Richardson and Mountain (2009, p. 369) as the 'inability of patients who need to be admitted to the hospital to be allocated appropriate beds in a timely fashion'. Participants identified access block as a factor that can have a significant impact on the time that consumers wait in the ED, and consequently affect the provision of optimal care to this group. A participant reflected on the considerable amount of time that some consumers had spent waiting for a bed while in the ED and stated that:

'We do have bed blocks so we do have patients here for a couple of days sometimes' (P 2)

This is consistent with the findings from Weiland et al. (2011), who identified that health care professionals working in the ED were concerned about the negative effects that access block can have on the quality of care provided to people who had presented with mental health needs.

Bost, Crilley and Wallen (2014) maintain that compliance with the target set out in the NEAT was significantly lower for people who presented with mental health issues (43%) than for non-mental health presentations (54%). Similar findings were reported

by Bastiampillai et al. (2012) who, over a one year period, conducted a retrospective analysis of patient flow for all mental health related presentations to an Australian ED before they were admitted to inpatient facilities. The findings from this study reveal that, irrespective of the availability of inpatients beds, the average wait-time in the ED was significantly longer than the four-hour target outlined in the NEAT. Furthermore, the authors suggest that the four-hour target may be unrealistic for mental health consumers, and they suggest that a factor significantly contributing to the increased LOS by consumers is the complexity of their presentations requiring extended time to work through psychosocial issues.

Recovery is ‘implementing strategies for ongoing care’

In the fifth category of description recovery is conceptualised as *implementing strategies for ongoing care*. Key points which will be discussed within this category of description include discharge planning, and community services and support.

The diagrammatic representation of the hierarchical position of category of description Five within the outcome space is presented in Figure 22:

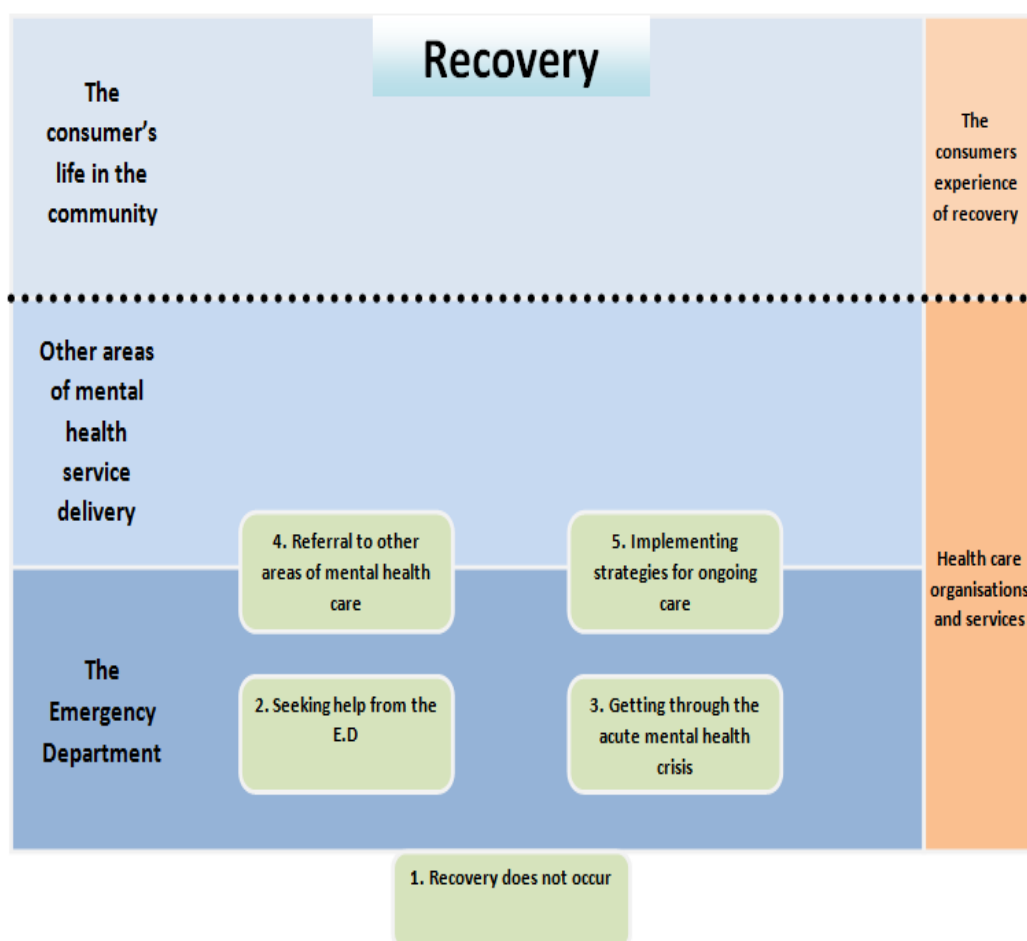


Figure 22: The position of category of description Five within the outcome space

Discharge planning

It is acknowledged by ED RNs that, for people who are experiencing mental illness and are not admitted to specialist inpatient units for ongoing care, the ED plays an important role in implementing strategies for ongoing care. Achieving stability and returning to normal function is tantamount to recovery as it is understood within the clinical environment in which ED nurses practise. Therefore, the view that recovery for people with mental illness encompasses effective discharge planning is not surprising.

A major function of effective discharge planning is to ensure continuity of care (Holland & Harris 2007). When people with mental health issues are not admitted to mental health inpatient units, the ED plays a vital role in facilitating their ongoing care through the implementation of optimal discharge planning. Nurses have an integral role in ensuring that people discharged from the ED return to the community with appropriate support (Han, Barnard & Chapman 2009a). Given that many mental health presentations to the ED are of a crisis nature, it is essential to ensure a safe and successful transition to the community with effective follow up (New South Wales Department of Health 2009).

‘Recovery’ is conceptualised as implementing strategies for ongoing care; the importance of constructing an effective discharge plan is expressed in the following statement:

‘It’s absolutely paramount that before we discharge them from emergency, that we have really good strong discharge planning in

place, that is accepted by the patient and that is definitely well and truly set up, a clear appointment or plan for that patient, with their consent and with their understanding that they will follow through with their planned discharge and appointments and things' (P 1)

As outlined in the Practice Standards for the Emergency Nursing Specialist 1.0 Domain: clinical expertise: 'ED nurses are required to demonstrate the ability to coordinate the admission and/or discharge of patients with a variety of clinical needs' (College of Emergency Nursing Australasia 2013, p. 8). It is acknowledged that the general hospital ED plays a role in the provision of care to people with mental illness (AIHW 2012). Furthermore, it is identified within Government plans and policies (Australian Health Ministers 2009a), that improved coordination of mental health care services between service sectors, achieved through increased collaboration and understanding, can support consumers transitioning between these service sectors. Therefore, as an initial point of care and an integral link to both mental health inpatient and community services, the ED has a significant role in supporting the optimal transition of consumers between services. Discharge planning from the ED is uniquely different from other health care environments. This is due to the very nature of the ED environment itself, and also the characteristics of the diverse patient population who present to the ED (Han, Barnard & Chapman 2009b). Furthermore, people who present to the ED with mental health issues have unique care needs that are very different from those for people attending the ED with physical injury or illness.

As discussed previously, within the ED environment negativity exists regarding people who frequently present to the ED with mental health issues. Effective discharge

planning is articulated by participants as an important factor that can prevent people re-presenting:

'I think as with anyone with any chronic illness it's the tapping into the support they can get within the community and limiting the occasions that they need to come in to the ED' (P 12)

'We need, as clinicians in emergency to make sure that they have got the right stuff in place, that in the community they will get the assistance and support and all the medications and stuff that they need so that they don't have to present back to ED again' (P 13)

Mental health clinicians who are working within the ED environment can provide ongoing support to generalist ED nurses. The Victorian Government Department of Human Services (2007) however, asserts that the assessment and provision of care to people who present to the ED with mental health issues is the responsibility of clinicians working in the ED. It is not the exclusive responsibility of mental health practitioners. This is identified in the Practice Standards for the Emergency Nurse Specialist 1.0 Domain clinical expertise: which states 'provides appropriate discharge education and treatment information and encourages appropriate follow up' (College of Emergency Nursing Australasia 2013, p. 8). Providing ED RNs with appropriate education and training will provide them with the knowledge to enable them to confidently provide consumers with information on the services and support that is available to them in the community. Ensuring that consumers are discharged from the

ED with information on ongoing follow-up and referrals is a way in which ED nurses can actively support consumers in their personal recovery journey.

Patient education is an integral part of the discharge process on leaving the ED. Han, Barnard and Chapman (2009a) maintain that most nurses accept the role as an educator for their patients, however ED nurses state that they lack confidence in the area of mental health (Kerrison & Chapman 2007; Happell & Platania-Phung 2005; Hart 2008; Plant & White 2013; Sharrock et al. 2006; Stuhlmiller et al. 2004). Furthermore, as the majority of care provided by ED RNs is of a physical nature, knowledge of the specific supports that are needed, and the availability of the appropriate mental health services and resources within the community, may be limited.

As discussed previously, people who present to the ED with mental health issues can spend considerable time in the ED due to a multitude of factors resulting from the complexity and unique care needs of mental health presentations. Bost, Crilley and Wallen (2014) contend that people attending the ED with a mental health presentation who were not admitted had a greater length of stay than those who required hospital admission. Siskind et al. (2012) suggests that a factor contributing to the length of stay within the ED for people with mental illness is that ED staff require more time to ensure that an appropriate discharge plan has been put in place to ensure follow up care.

Within contemporary emergency nursing, it is argued that discharge planning is neglected, and the ability of ED nurses to implement quality discharge planning can be impacted by time and workload constraints (Han, Barnard & Chapman 2009a). The

National Emergency Access Target may also be a factor that impacts on effective discharge planning, as this national benchmarking standard adds increased pressure on ED staff to transfer or discharge people from the ED. The unique care needs associated with mental health presentations can result in increased length of stay and this can have a negative impact on the ability to achieve the National Emergency Access Target. Therefore the negative sequelae of the pressure to achieve this ED performance indicator could potentially be less than optimal discharge planning for this vulnerable population.

Community services and support

The mental health community support sector is the leading provider of mental health services for people with mental illness (Siskind et al. 2012). The mental health reforms promoted within the National Mental Health Strategy and the Roadmap for National Mental Health Reform, advocated a change in the balance of services from institutionalised care. Increased investment occurred in community care including ambulatory care services, residential services and non-government organisations (NGO). As an integral part of service provision to people whose lives are affected by mental illness, NGOs provide a wide range of services in the community, including accommodation, self-help and mutual/peer support programs, respite care for carers of people with mental illness, and residential and rehabilitation units for consumers and their carers. These community services provide essential support to consumers in their

recovery journey, and complement mental health clinical services such as community treatment teams (Department of Health and Ageing 2010a).

Participants view 'recovery' for people experiencing mental illness as implementing strategies for ongoing care. However, knowledge of the community resources promoted in national strategies, plans and policies to support mental health reform, may not be considered by ED RNs as necessary, particularly within ED nursing practice where the focus is on emergent physical needs. ED nurses practice in an environment that is highly medicalised, and predominantly manages physical injury and illness. Therefore, it may not come as a surprise that research has revealed that ED staff lack confidence in the disposition of people with mental illness and the knowledge of the services that people can access in the community (Jelenik et al. 2013). However, because ED RNs care for people experiencing mental health issues as part of their daily practice, and can be involved in the discharge planning of this population, it is argued that being aware of these services is essential to facilitate the provision of optimal care and to assist people in their recovery journey. The importance of effective discharge planning in achieving optimal continuity of care is articulated by participant one.

'Discharge planning is probably even more relevant to mental health patients than anyone else because I think there is with general emergency presentations it is quite obvious within the first hour the patients that are going to be admitted to hospital and the patients who are, that you will invariably send home to be followed up by GPs, and things like that' (P1)

Personal recovery involves support and partnership; it is not a journey that a person undertakes alone. Knowledge of the resources available to support a person after they are discharged from the ED is a practical way in which ED RNs can actively support a persons' recovery process. However, the unique ED environment in which they practise presents many challenges. As argued by Han, Barnard and Chapman (2009a) the diverse characteristics of the population attending the ED contributes to the complexity of providing discharge planning. Furthermore, within EDs the focus is on the immediate needs of people who present for care, rather than on their long term needs and the provision of continuity of care (Han, Barnard & Chapman 2009b). In addition, as was previously outlined, the care of people with mental illness is not the exclusive responsibility of mental health practitioners (Victorian Government Department of Human Services 2007). However, many EDs within Australia have specialist mental health nurses to facilitate the provision of optimal care to this vulnerable group. Therefore, collaboration between ED and mental health services is essential, as an ED environment with a focus on a "recovery partnership" will facilitate the safe and optimal continuity of care for people experiencing mental illness.

As discussed previously, the morbidity and mortality of people with mental illness is a significant concern. So when discharge planning from the ED is implemented, it provides an opportunity for the appropriate referrals to ensure the follow-up of consumers' physical health needs. Although people may have initially presented to the ED with a mental health issue, in keeping with a holistic approach to nursing care, the physical health of the individual also needs to be considered. Personal recovery is

understood as striving to achieve a fulfilling and meaningful life, and optimal physical health is fundamental to supporting this.

Within the ED, nurses maintain close contact with people in their care, and they are in a position to assess their education needs as well as the community supports that they may require upon discharge. As posited by Han, Barnard and Chapman (2009a, p. 527), ‘emergency nurses are the key to effective discharge planning’ and education is integral to facilitating more effective discharge planning.

Recovery is ‘living in the community’

‘People live in society, not mental health services’ (Roberts & Boardman 2014, p. 41).

In the sixth category of description ‘recovery’ is conceptualised as *living in the community*. Key points which will be discussed in this category include functioning and normality and psychotropic medication and staying well in the community. The diagrammatic representation of the hierarchical position of category of description Six is presented within the complete outcome space presented in Figure 12:

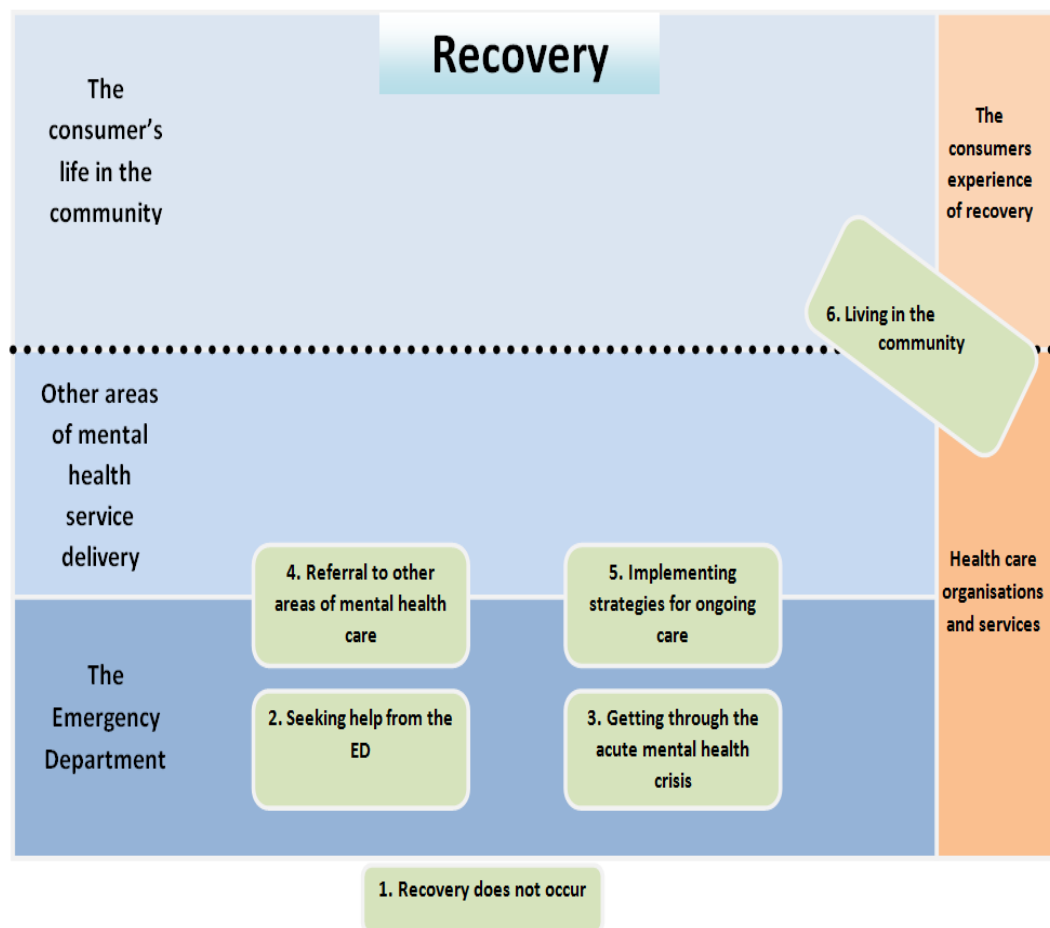


Figure 12: The outcome space for ED RNs' conceptions of recovery

Personal recovery is promoted in an environment of support and partnership, and as discussed earlier, the services and resources available in the community to support people who are living with mental illness make a significant contribution to assisting them in their recovery journey.

Recovery does not occur in isolation. It occurs within a network of relations between people with mental illness, family and friends as well as their community (Australian Health Ministers Advisory Council 2013a). Although people may seek the support of healthcare services throughout their recovery journey, most of a person's recovery happens at home. It is important to recognise that health care organisations and health care professionals do not 'recover' a person (Roberts & Boardman 2014).

'Recovery' is conceptualised by participants of this research as living in the community and is achieved through the support provided by a consumer's network of supportive family and friends. However, within this conceptualisation, participants discussed the support required from health care organisations, such as a hospital. Although participants acknowledge the significance of social connections, the consumer's ability to live a meaningful life in the community is also viewed as dependent upon the ability of the health care system to provide appropriate services and support:

'I would understand it as being well and truly set up with hospital and community support. That they had a network in place where they had supportive people within their community or where they live, a

combination of a really good GP, plus or minus a psychiatrist or psychologist and they had a supportive network of friends and family'(P 1)

Clinical recovery occurs because of the interventions provided by healthcare professionals and healthcare environments, such as the ED. Therefore, the importance placed by participants on the support from healthcare organisations to facilitate recovery and enable a consumer to live well in the community does not come as a surprise. ED nurses work in an environment where recovery, as they experience it in their daily practice, is facilitated by clinical interventions.

However, one of the characteristics of a person who has a mental illness is that their unique recovery journey can occur without professional intervention (Leamy et al. 2011). This is at odds with the understanding of recovery in the medical model dominant in the general health care domain. Furthermore, personal recovery can occur with or without the presence of symptoms. Anthony (1993, p. 15) posits, 'It is a way of living a satisfying, hopeful, and contributing life, even with limitations caused by illness'. This understanding was articulated by a participant who views recovery as living in the community and occurring despite having a mental illness and the limitations and challenges that occur due to that illness:

'Recovery would see them functioning at a good level in society without the psychological component restricting that too much' (P 10)

The statement from the participant suggests that there remains a connection to the traditional clinical understanding of recovery and an emphasis on recovery as an

outcome. There is also the recognition that this outcome does not exclude continuing presence of symptoms, and a fulfilling life can be achieved despite these. This suggests an understanding of recovery for people with mental illness which extends beyond the amelioration of symptoms and a return to premorbid functioning, which is the clinical view of recovery (Ahern & Fisher 2001). This understanding by participants is in contrast to the prevailing connection between symptomology and recovery that has been identified within the findings of this research.

Functioning and normality

Interestingly in the above statement by participant ten the term ‘functioning’ was used, and this term was also used by other participants:

‘I guess recovery for mental health is to try and get the person functioning back into their own environment’ (P 7)

‘...they are fully functioning back in the community, being an upstanding citizen and contributing to their life in a way that they had previously’ (P 2)

This again raises the issue of language. Consumers do not ‘function’, but rather they live their lives. Personal recovery is individual and unique, and there are no imposed goals or levels of achievement that need to be reached. It is the consumers who determine what is working well in their lives and gives their life meaning. This is clearly articulated by Deegan (1993), who states that:

‘High functioning’ and ‘low functioning’ are not attributes that exist inside a person. They are value judgements that are put on a person. There are no high-functioning or low-functioning people. There are people whose contribution we are able to see and value and there are those whose gifts we have failed to see and have failed to value. (p. 11)

Although recovery is conceptualised by ED nurses as ‘living in the community’, the phrase “functioning at a good level” used by participants, suggests that this conceptualisation of recovery continues to remain connected to the medical view in which recovery is viewed as an objective outcome and can be measured.

When discussing a person with mental illness living in the community, participant 4 used the term ‘normal’:

‘Recovery is your normal condition, being in a place where the person is cared for, where somebody takes care that they do take their medication and they are looked after, that is what recovery is, and not to come back three months later because of neglect’ (P 4)

This statement suggests that recovery is viewed by participant four as something that is “done to” the person. It is the provision of treatment or care that enables consumers to achieve a return to a state that is considered “normal”. Furthermore, the statement suggests that achieving normality is considered a successful outcome, and that adherence to treatment such as taking prescribed medications is considered an integral part of facilitating recovery and a subsequent return to “normal”. This is the position that is inherent within the dominant medical model. However, personal recovery is a unique journey and does not have the goal of achieving a desired outcome or

“normality”. Corrigan and Ralph (2005) attest that being able to actually define what is considered ‘normal living’ leaves many questions unanswered.

Personal recovery does not have normality as its goal. Rather, with hope and self-determination, consumers strive to live the best lives possible. Deegan (1993, p. 11) contends that:

They may tell you that your goal should be to become normal and achieve valued roles. But a role is empty and valueless unless you fill it with your meaning and your purpose.

Nevertheless, within society stigmatisation of individuals or groups who do not conform to what society considers acceptable or “normal” occurs, and people living with mental illness continue to be stigmatised due to the perpetuation of the idea of “differentness”. Erving Goffman (1963) maintains that people are considered normal when they do not display “differentness” and in his seminal work he argues that:

...an individual who might have been received easily in ordinary social intercourse possesses a trait that can obtrude itself upon attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on us. He possesses a stigma, an undesired differentness from what we had anticipated. We and those who do not depart negatively from the particular expectations at issue I shall call the *normals*. (p. 5)

The definition of ‘normal’ in the Merriam Webster Dictionary (2014) is a poignant testimony to the enduring legacy of the negative stereotype of mental illness. Within the definitions of normal, which include: not deviating from a norm, rule, or principle and conforming to a type, standard, or regular pattern, it is also defined as ‘free from mental disorder: *sane*’. Ward and Gorman (2010, p. 4), remind us that ‘Social justice

is about being treated equally, having the same rights, access and opportunities’. However, the stigmatisation of this marginalised group means that they are often not afforded the same level of citizenship as other members of society (Hamer, Finlayson & Warren 2014). This has a negative impact on the life chances of people with mental illness. The experiences of social rejection that people can encounter in their lives have a detrimental impact on their quality of life (Thoits 2011).

Social inclusion is an integral aspect of recovery, and recovery-oriented services aim to support people with mental illness so that they may experience a good quality of life, and live contributing, meaningful lives within the community of their choice. As set out in the Roadmap for National Mental Health Reform 2012-2022 (Council of Australian Governments 2012, p. 6-7), a society that supports people with mental illness must ensure that improved access to stable housing, education, employment and community resources that people can choose to assist their recovery, will all be available to enable inclusion and engagement to support living full and rewarding lives.

Psychotropic medication and staying well in the community

Participants conceptualise ‘recovery’ as living in the community, however they expressed that staying well in the community can be a challenge for many people with mental illness. Participants spoke of factors they consider can contribute to an individual becoming unwell, and these factors were medication non-compliance and inadequate management in the community.

This is illustrated in the following statement:

'I don't know whether it's the fact that they are poorly managed in the community or they just have a lapse' (P 7)

Within Australia, the notion of recovery and the focus on recovery-oriented care is now embedded within national policy and within services that are delivering mental health care. The Roadmap for Mental Health Reform 2012-2022, outlines the direction for mental health reform and identifies within the six priority areas, Priority 5: Improve access to high quality services and supports (Council of Australian Governments 2012). However, Kalucy, Thomas and King (2005) maintain that government reform policies have not always been accompanied by funding for the community sector. Therefore, under resourced community services often endeavour to deliver optimal assistance to people with mental illness despite inadequate funding (Kalucy, Thomas & King 2005).

Personal recovery involves empowerment, self-determination, personal responsibility and achieving self-management (Leamy et al. 2011). However, the dominance of the traditional medical model within health care, and the biological explanation for mental illness inherent within this model of care, is a significant factor contributing to the substantial use of psychotropic medication as treatment for mental illness (Freeth 2007). Furthermore, Braslow (2013) argues that the use of psychotropic medication as the main treatment for mental illness is pervasive within contemporary health care, so much so that its influence has become effectively imperceptible.

The following data from the Australian Institute for Health and Welfare (2014a) shows that medication is a significant part of the interventions used to treat mental illness in

the Australian health care system. In 2012-2013 there were over 31 million prescriptions for mental health related medications, which were non-subsidised or subsidised as part of the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS). This accounted for 11.4 percent of all the prescriptions that were dispensed in Australia during this period.

A participant reflected that non-compliance with prescribed medication is a factor that can contribute to people with mental illness becoming unwell while living in the community, and subsequently presenting to the ED for care. Participant seven stated:

‘...we get a lot of non-compliant clients’ (P 7)

Medication compliance is embedded in the paternalism inherent within the traditional medical model (Deegan & Drake 2006). The term non-compliant used by ED nurses highlights the existence of a power imbalance (Weiden & Rao 2005), and it is a term rooted in the model of care which remains dominant within the ED environment. ED nurses use this term when discussing people with a mental illness who become unwell while living in the community. It is likely to be acculturated into the vocabulary used in their daily practice. And, as previously discussed, language is very powerful.

Understanding personal recovery may help ED nurses to realise the complexity of the decision by consumers whether or not to take medication. It is influenced by many factors. A significant factor is that the adverse side-effects of medication can negatively impact on a person’s quality of life (Meehan, Stedman & Wallace 2011; Usher, Park & Foster 2013) and can be more distressing than the symptoms of mental illness. Therefore, a consumers’ choice can be influenced by weighing up whether the

benefits that they will get from the medication outweigh the negative side-effects. As posited by Liersch-Sumskis (2013), medication can be viewed as both highly supportive, but also very challenging.

Furthermore, people living with mental illness can have their own strategies and activities which they use to manage distress. Deegan (2005, p. 31) refers to these as “personal medicine”. They can support a person in who wants to engage in meaningful social roles and participate in the everyday activities in the community that are important to them. However, if psychotropic medication interferes with a person’s personal medicine it can be seen as detrimental to recovery, and will therefore affect their decision whether to include medication in their recovery process.

Empowerment and choice are integral to facilitating personal recovery. As posited by Stratford et al. (2013, p. 550) ‘recovery is not anti medication’, but it involves respecting the fact that consumers, as experts of their own experience, have the right to be heard and supported in making decisions about their wellbeing. Part of the role of health care professionals who interact with consumers at different stages of their recovery journey, is to support the consumer in how they can optimally use medication and other strategies as tools in their recovery, not just to ensure that they are compliant with taking their medications (Deegan & Drake 2006). Although the nature of the ED environment can impact on the interactions that ED RNs have with people who present to the ED with mental health issues, they can support consumers in their recovery journey. They can do this by approaching a consumer’s decision not to take medication with a non-judgemental attitude, and understanding that the consumer’s decisions to do so is complex and influenced by many factors.

An understanding of personal recovery can provide ED RNs with the knowledge that the term ‘medication non-compliance’ is not in keeping with a recovery orientation that emphasises personal choice. Furthermore, it can help them to realise that the role of medication in a person’s recovery journey is not the most important factor in achieving a meaningful and fulfilling life, but rather that medication is an individualised choice by the consumer. Lunt (2002, p. 34) suggests:

...the biochemical solution does not bring with it a dream, a goal, a journey, a direction, an inspiration, a faith, or a hope. These are what are sought in recovery.

ED RN participants have expressed the idea that a way of conceptualising recovery for people with mental illness is for them to be able to live in the community. This view elucidates the participants’ more complex understanding of the meaning of personal recovery. However, this conceptualisation continues to be bound to the medical understanding of recovery that is dominant within ED RNs practice. Furthermore, this conceptualisation of recovery continues to be connected to the notion of outcome, and the interaction of health care professionals, health care services and treatment interventions are viewed as integral to facilitating recovery for people with mental illness.

Summary

This chapter provided discussion of the findings of this research. It described the set of six discrete categories of description that reveal ED RNs’ collective understanding of ‘recovery’ as applied to people with mental illness in the ED. The categories of description are not conceptions, but the means whereby the researcher fully elucidated the critical variation in the ways that the ED RN participants conceptualise recovery.

It is acknowledged that other conceptions of recovery are possible. ‘Recovery for Consumers’ is conceptualised by ED RNs as:

- **Recovery does not occur**
- **Seeking help from the ED**
- **Getting through the acute mental health crisis**
- **Referral to other areas of mental health care**
- **Implementing strategies for ongoing care**
- **Living in the community**

The findings reveal that ED RN participants’ conceptions of recovery predominantly remain bound to the medical understanding of recovery, which is the amelioration of symptoms and a return to ‘normal’ function. This medical understanding of recovery, in which the role of the healthcare professional and services is viewed as integral to facilitating an optimal outcome, is rooted in the traditional medical model, the very approach that informs ED RNs’ practice. Recovery, as viewed through a clinical lens, is poles apart from the meaning of ‘recovery’, as understood by people with lived-experience of mental illness.

The final and concluding chapter of this thesis will provide a summary, and offer the recommendations generated from the findings. These will include recommendations for clinical practice, nursing education and areas for further research. The study’s limitations will also be discussed.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

To me, being recovered means feeling at peace, being happy, feeling comfortable in the world and with others, and feeling hope for the future. It involves drawing on all my negative experiences to make me a better person. It means not being afraid of who I am and what I feel. It is about being able to take positive risks in life. It means not being afraid to live in the present. It is about knowing and being able to be who I am. (Schiff 2004, p. 215)

The aim of this research was to understand how Registered Nurses working in the Emergency Department conceptualise recovery for people who are experiencing mental illness. This aim was fulfilled through the implementation of a phenomenographic investigation that identified and described the relationship between Emergency Department Registered Nurses and recovery. The research was guided by the research question, ‘what are Registered Nurses’ conceptualisations of recovery as it applies to people who are experiencing mental illness within the Emergency Department?’

The qualitatively different ways in which recovery is conceptualised by the ED RN participants have been described in the thesis. The critical variation in the multifarious way in which they understand recovery is revealed in six discrete categories of description that are a tool facilitating the description of their conceptions. The categories are diagrammatically presented in a hierarchical outcome space, enabling the researcher to express the logical relations that exist between the categories. The researcher maintains that there is no value placed upon the categories; however, the hierarchical structure reveals an increasing complexity in ED RNs’ understanding of recovery for people experiencing mental illness.

This study reveals that ED RN participants' conceptions of recovery move from an understanding that is deeply rooted in the traditional medical meaning, to one which extends beyond this to an understanding that encompasses other aspects of the consumer's life and ability to live within a community of their choice. However, of significance is the fact that, even within this more comprehensive understanding of consumers' personal recovery, the ties to the medical notion of recovery remain. Recovery for consumers is not conceptualised as independent of the participation by, and/or intervention of, healthcare professionals, services and organisations.

Participants in this research suggest that ED RNs have difficulty in contextualising their role in a consumer's unique recovery journey because recovery, when viewed through a clinical lens, means getting better and returning to normal function. Recovery is bound to the notion of outcome, and as something that health services 'do to a person' through the implementation of interventions and treatment. Furthermore, mental illness within the general healthcare setting of the ED continues to be associated with notions of chronicity and a pessimistic outcome. Therefore ED RNs have difficulty in reconciling the meaning of personal recovery as understood by people with lived-experience of mental illness, with the notion of medical recovery and improved outcomes.

Within the general healthcare environment of the ED, barriers exist that impede the ability of ED RNs to become aware of a disparate meaning of recovery, one which encompasses the individual's unique holistic experience of living with mental illness. The barriers include: the legacy of the chronicity of mental illness, negative attitudes

to mental illness that continue to be pervasive within the ED environment, and the need for improved mental health literacy, knowledge and skills.

This research has concluded that Emergency Department Registered Nurses' conceptualisation of recovery for people experiencing mental illness predominantly remains bound to the established medical meaning of recovery. This traditional understanding is embedded within general healthcare, and is intrinsic in ED RNs' everyday practice, deeply entrenched within the medically-focused ED environment. The polarity in meanings of 'recovery' existing within the ED setting is significant for people who attend the ED for mental health crisis assessment. It is significant also for the health care professionals who strive to provide the best possible care for this vulnerable and disadvantaged group within such a complex and demanding environment.

The purpose of this research was to contribute new knowledge. To the best of the researcher's knowledge there is no existing literature within the extensive body of recovery literature that elucidates how ED RNs conceptualise recovery for this particular population. As such, the purpose has been fulfilled. This research has significantly contributed to filling this void by achieving the aim of the research which was to understand how Registered Nurses working in the Emergency Department conceptualise recovery for people who are experiencing mental illness.

Limitations

A limitation of this study is that, within Emergency Departments throughout Australia, there are different models of service provision. Therefore, the interactions and

experiences of Registered Nurses working in this healthcare setting with people experiencing mental health crisis, will vary between Emergency Departments. However, a central tenet of phenomenography is that the phenomenon is only experienced in a limited number of ways. Furthermore, the elucidation of the critical variation in conceptions is of the collective experience of the participants, and the Emergency Registered Nurse participants were recruited for this study from throughout a large part of Australia. This was done to achieve maximum variation in the experience of recovery for people with mental illness.

A further limitation of this study is that the researcher only captured the participants' understanding of recovery at a specific point in time. However, consistent with phenomenographical methodology, the researcher fulfilled the aim of the research, and fully elucidated the critical variation that exists in the collective experience of the participants of this study. Revealing how the Emergency Department Registered Nurse participants' understand recovery was a form of discovery and was not intended to be generalisable.

Sample size may be considered a limitation of this study. However, the number of participants in this phenomenographic study facilitated obtaining sufficient variation in the phenomena under investigation to achieve the aim of the research. There is no intention to generalise this study.

Recommendations

The following recommendations are based on the findings of this research.

This research has examined ED RNs' conceptualisation of recovery for people experiencing mental illness, and has revealed that their conceptions remain bound to the clinical/medical understanding of recovery. Therefore it is recommended that:

- Education regarding the concept of personal recovery as understood by people with lived-experience of mental illness should be promoted within the ED. This will enable ED RNs to become aware of their role in a consumer's recovery journey. Furthermore, it will enable ED RNs to embrace the practical ways in which they can support consumers' recovery within the ED environment, and facilitate a move towards incorporating a recovery-oriented approach to ED culture and practice.
- ED RNs should be cognisant of what recovery means to people living with mental illness, as this would be invaluable in facilitating the continuity of recovery-oriented care while the consumer transitions between different service types.
- Further research to should be carried out to explore RNs' conceptualisation of recovery for consumers within other practice domains within healthcare.
- Quantitative research should be undertaken that can have a large sample size and be generalisable.
- Research should be undertaken to examine how a recovery-orientated partnership can be established with ED RNs and MH clinicians based in the ED.

This research has identified that ED RNs are cognisant of the fact that they lack the knowledge and skills to provide optimal safe care to people who are experiencing mental health issues. Furthermore, they acknowledge that mental health education would have a significant impact on their ability to facilitate effective care. It is therefore recommended that:

- Continuing mental health education should be promoted within the ED to improve ED RNs' mental health literacy and competency. This will help to provide them with the skills and confidence they need to care for people requiring mental health crisis assessment and intervention.
- An important area to be considered is the introduction of innovative training packages that will not be impacted by the time pressures that are inherent in the hectic nature of the ED environment.
- ED RNs should receive the necessary education which will enable them, as frontline caregivers and an initial point of contact for people seeking health services, to have a sound knowledge of the resources and supports available in the community to support people experiencing mental health issues.
- The mental health content of undergraduate nursing courses should be reviewed continually in order to ensure that generalist RNs have the knowledge and skills to provide optimal care for consumers in all practice domains. Importantly, they should be cognisant of the meaning of recovery as it is understood by people with lived-experience of mental illness, so that they can apply this knowledge in their daily practice and support consumers in their recovery.

- People with lived-experience of mental illness should be an integral part of mental health education strategies and their experience and expertise acknowledged as a valuable resource to increase general RNs cognisance of recovery.

This research has revealed that ED RNs acknowledge that their ability to access documented plans for consumers attending the ED are a valuable tool, giving them immediate access to information regarding their care. Furthermore, plans such as psychiatric advance directives (PAD) promote consumers' autonomy, and during times of mental health crisis enable them to maintain participation in their recovery. Therefore it is recommended that:

- Mental health service users should have documented PADs that are easily accessible to ED staff.
- In addition to the changes that would need to occur at an operational level to facilitate the introduction and implementation of PADs, ED clinicians' acceptance and support for advance directives for consumers must also occur. Mental health education for ED staff is therefore crucial to increase awareness of this valuable tool in supporting recovery for people experiencing mental illness in the ED.
- Research should be undertaken to determine if consumers would use advance directives, and to find out what consumers would like included.

This research has identified that that there is an anticipated negative outcome for consumers who present to the ED for care, and that the notion of chronicity and stigma

regarding mental illness continues within healthcare environments such as the ED. An element central to facilitating recovery-oriented practice and service delivery is the promotion of a culture and language of hope and optimism. It is therefore recommended that:

- As the ED plays a significant role in the provision of services to people with mental illness, general RNs working in the ED should embrace this guiding principle to support consumers' recovery.
- Documentation in EDs, including forms, policies and procedures, should be changed to use recovery oriented language
- ED RNs should promote a culture of change, and challenge the existing notions of chronicity in mental illness and the stigma and discrimination that is pervasively shown towards this vulnerable and disadvantaged group.
- Research be conducted to examine how these findings compare with studies conducted in other clinical areas in general healthcare.
- Research be conducted to measure the extent of stigma within particular clinical environments such as the ED, to identify the factors helping to maintain the stigmatising attitudes to mental illness and facilitate the implementation of strategies to address these factors.
- Research be conducted to explore what mental health consumers consider would be helpful for them to support the part of their recovery journey experienced in the ED, and also if accessing a separate ED would be a preferable option for them.

Final Statement

All health care professionals, including RNs working in the ED, would benefit significantly from mental health education strategies to challenge their existing assumptions and perspectives on mental illness. Knowledge of what personal recovery means to consumers and how they can be supported in their recovery journey is crucial for healthcare professionals across all healthcare domains. This will also have a positive corollary for ED RNs, and for consumers who present to the ED.

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APPENDICES

APPENDIX 1: STAGES OF RECOVERY INSTRUMENT

STORI

The following questionnaire asks about how you feel about your life and yourself since the illness. Some of the questions are about times when you don't feel so good. Others ask about times when you feel pretty good about life.

If you find some of the questions upsetting, and you need to talk to someone – please take a break and talk to a friend or support person.

The questions are in groups of five.

Read all five questions in a group, and then answer those five questions.

Circle the number from 0 to 5 to show how much each statement is true of you now.

Then move on to the next group.

When you choose your answer, think about how you feel now, not how you have felt some time in the past. For example:

Q.43 says "I am beginning to learn about mental illness and how I can help myself."

Q.44 says "I now feel reasonably confident about managing the illness."

If you are now fairly confident about managing the illness, you would give a higher score to Q.44 than you would to Q.43, which says you are just *beginning* to learn.

The questions are about how you feel about your life *on the whole* these days.

Try not to let things that might be affecting your mood just at the moment affect your answers.

STORI

Read all 5 questions in Group 1, then answer those five questions.

Circle the number from 0 to 5 that shows how much each statement is true of you *now*.

Then move on to Group 2, and so on.

When you choose your answer, think about *how you feel now*, not how you have felt in the past.

Group 1		Not at all true now			Completely true now		
1	I don't think people with a mental illness can get better.	0	1	2	3	4	5
2	I've <i>only recently</i> found out that people with a mental illness <i>can</i> get better.	0	1	2	3	4	5
3	I am <i>starting</i> to learn how I can help myself get better.	0	1	2	3	4	5
4	I am working hard at staying well, and it will be worth it in the long run.	0	1	2	3	4	5
5	I have a sense of "inner peace" about life with the illness now.	0	1	2	3	4	5

Group 2		Not at all true now			Completely true now		
6	I feel my life has been ruined by this illness.	0	1	2	3	4	5
7	I'm <i>just starting</i> to realise my life doesn't have to be awful forever.	0	1	2	3	4	5
8	I have <i>recently</i> started to learn from people who are living well in spite of serious illness.	0	1	2	3	4	5
9	I'm starting to feel <i>fairly</i> confident about getting my life back on track.	0	1	2	3	4	5
10	My life is really good now, and the future looks bright.	0	1	2	3	4	5

Group 3		Not at all true now			Completely true now		
11	I feel like I'm nothing but a sick person now.	0	1	2	3	4	5
12	Because others believe in me, I've <i>just started</i> to think maybe I can get better.	0	1	2	3	4	5
13	I am <i>just beginning</i> to realise that illness doesn't change who I am as a person.	0	1	2	3	4	5
14	I am <i>now beginning</i> to accept the illness as part of the <i>whole person</i> that is me.	0	1	2	3	4	5
15	I am happy with who I am as a person.	0	1	2	3	4	5

Group 4		Not at all true now			Completely true now		
16	I feel as though I don't know who I am any more.	0	1	2	3	4	5
17	I have <i>recently begun</i> to recognise a part of me that is not affected by the illness.	0	1	2	3	4	5
18	I am <i>just starting</i> to realise that I <i>can</i> still be a valuable person.	0	1	2	3	4	5
19	I am learning new things about myself as I work towards recovery.	0	1	2	3	4	5
20	I think that working to overcome the illness has made me a better person.	0	1	2	3	4	5
Group 5		Not at all true now			Completely true now		
21	I'll never be the person I thought I would be.	0	1	2	3	4	5
22	I've <i>just begun</i> to accept the illness as part of my life I'll have to learn to live with.	0	1	2	3	4	5
23	I am <i>starting</i> to figure out what I am good at and what my weaknesses are.	0	1	2	3	4	5
24	I'm <i>starting</i> to feel that I am making a valuable contribution to life.	0	1	2	3	4	5
25	I am accomplishing worthwhile and satisfying things in my life.	0	1	2	3	4	5
Group 6		Not at all true now			Completely true now		
26	I am angry that this had to happen to <i>me</i> .	0	1	2	3	4	5
27	I'm just <i>starting</i> to wonder if some good could come out of this.	0	1	2	3	4	5
28	I am <i>starting</i> to think about what my special qualities are.	0	1	2	3	4	5
29	In having to deal with illness, I am learning a lot about life.	0	1	2	3	4	5
30	In overcoming the illness I have gained new values in life.	0	1	2	3	4	5
Group 7		Not at all true now			Completely true now		
31	My life seems completely pointless now.	0	1	2	3	4	5
32	I am <i>just starting</i> to think maybe I <i>can</i> do something with my life.	0	1	2	3	4	5
33	I am <i>trying</i> to think of ways I might be able to contribute in life.	0	1	2	3	4	5
34	These days I am working on some things in life that are personally important to me.	0	1	2	3	4	5
35	I am working on important projects that give me a sense of purpose in life.	0	1	2	3	4	5

Group 8		Not at all true now			Completely true now		
36	I can't do anything about my situation.	0	1	2	3	4	5
37	I'm <i>starting</i> to think I could do something to help myself.	0	1	2	3	4	5
38	I am <i>starting</i> to feel more confident about learning to live with the illness.	0	1	2	3	4	5
39	Sometimes there are setbacks, but I come back and keep trying.	0	1	2	3	4	5
40	I look forward to facing new challenges in life.	0	1	2	3	4	5
Group 9		Not at all true now			Completely true now		
41	Others know better than I do what's good for me.	0	1	2	3	4	5
42	I want to <i>start</i> learning how to look after myself properly.	0	1	2	3	4	5
43	I am <i>beginning</i> to learn about mental illness and how I can help myself.	0	1	2	3	4	5
44	I now feel <i>reasonably</i> confident about managing the illness.	0	1	2	3	4	5
45	I can manage the illness well now.	0	1	2	3	4	5
Group 10		Not at all true now			Completely true now		
46	I don't seem to have any control over my life now.	0	1	2	3	4	5
47	I want to <i>start</i> learning how to cope with the illness.	0	1	2	3	4	5
48	I am <i>just starting</i> to work towards getting my life back on track	0	1	2	3	4	5
49	I am <i>beginning</i> to feel responsible for my own life.	0	1	2	3	4	5
50	I am in control of my own life.	0	1	2	3	4	5

Thank you for completing the "STORI"

For more information about the STORI, please visit our website <http://socialsciences.uow.edu.au/imh/stori/index.html>

Reference: Andresen R, Caputi P and Oades L (2006). The Stages of Recovery Instrument: Development of a measure of recovery from serious mental illness. *Australian and New Zealand Journal of Psychiatry* 2006; 40:972-980

APPENDIX 2: MEDIA RELEASE BY THE HON PETER DUTTON MP



THE HON PETER DUTTON MP MINISTER FOR HEALTH MINISTER FOR SPORT

MEDIA RELEASE

4 February 2014

Mental Health Review

The Minister for Health Peter Dutton today announced the Terms of Reference for the review of mental health services and programmes.

The wide-ranging review being undertaken by the National Mental Health Commission fulfils a Coalition election commitment and is aimed at delivering mental health services and programmes more efficiently and effectively.

All existing programmes across the government, non-government and private sectors will be reviewed.

Mr Dutton said the Government was committed to building a world-class mental health system that delivered appropriate services to support people experiencing mental ill health and their families.

"To do this, we need to know what really works and ensure that existing resources in the mental health sector are being targeted as effectively as possible.

"At the same time, we must work within the fiscal constraints that are facing all Australian governments, getting maximum value for taxpayers' dollars while ensuring people living with mental health issues get the support they need."

The review should identify gaps in service delivery, inefficiency, duplication and excessive red tape.

The National Mental Health Commission (NMHC) will engage with state and territory governments and other stakeholders in undertaking the review.

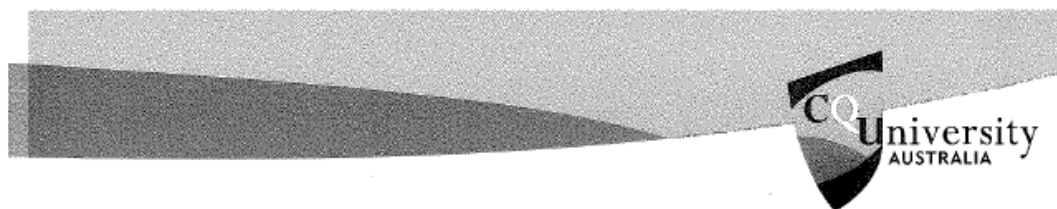
Chair of the NMHC Professor Allan Fels said: "The Commission welcomes the opportunity to conduct this important and timely review and looks forward to delivering its report to the Government in late November."

Detailed terms of reference are available at – <http://www.mentalhealthcommission.gov.au/our-work/Review-of-Existing-Mental-Health-Services-and-Programmes.aspx>

Contact officer with the NMHC is David Butt, Acting Chief Executive Officer.

Media Contact: Minister's Office on 02 6277 7220

APPENDIX 3: CQUNIVERSITY AUSTRALIA, HREC APPROVAL LETTER



Secretary, Human Research Ethics Committee
Ph: 07 4923 2603
Fax: 07 4923 2600
Email: ethics@cqu.edu.au

22 November 2011

Ms Donna Marynowski-Traczyk
16 Magenta Drive
Varsity Lakes QLD 4227

Dear Ms Marynowski-Traczyk

HUMAN RESEARCH ETHICS COMMITTEE APPROVAL: PROJECT H11/10-154, REGISTERED NURSES CONCEPTUALISATION OF RECOVERY AS IT APPLIES TO CONSUMERS WITH A MENTAL ILLNESS IN THE EMERGENCY DEPARTMENT

The Human Research Ethics Committee is an approved institutional ethics committee constituted in accord with guidelines formulated by the National Health and Medical Research Council (NHMRC) and governed by policies and procedures consistent with principles as contained in publications such as the joint Universities Australia and NHMRC *Australian Code for the Responsible Conduct of Research*. This is available at http://www.nhmrc.gov.au/publications/synopses/_files/r39.pdf.

On 25 October 2011, the committee met and considered your application. The project was assessed as being greater than low risk, as defined in the National Statement. On 22 November 2011, the committee acknowledged compliance with the conditions placed upon ethical approval for your research *Registered Nurses conceptualisation of recovery as it applies to consumers with a mental illness in the Emergency Department* (Project Number H11/10-154).

The period of ethics approval will be from 22 November 2011 to 31 December 2012. The approval number is H11/10-154; please quote this number in all dealings with the Committee. HREC wishes you well with the undertaking of the project and looks forward to receiving the final report and statement of findings.

The standard conditions of approval for this research project are that:

- (a) you conduct the research project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments required to be made to the proposal by the Human Research Ethics Committee;
- (b) you advise the Human Research Ethics Committee (email ethics@cqu.edu.au) immediately if any complaints are made, or expressions of concern are raised, or any other issue in relation to the project which may warrant review of ethics approval of the project. (A written report detailing the adverse occurrence or unforeseen event must be submitted to the Committee Chair within one working day after the event.)
- (c) you make submission to the Human Research Ethics Committee for approval of any proposed variations or modifications to the approved project before making any such changes;

Central Queensland University CRICOS Provider Codes: QLD - 00219C, NSW - 01315F, VIC - 01624D

- (d) you provide the Human Research Ethics Committee with a written "Annual Report" on each anniversary date of approval (for projects of greater than 12 months) and "Final Report" by no later than one (1) month after the approval expiry date, or upon submission of your thesis (Psychology honours students only); *(A copy of the reporting pro formas may be obtained from the Human Research Ethics Committee Secretary, Sue Evans please contact at the telephone or email given on the first page.)*
- (e) you accept that the Human Research Ethics Committee reserves the right to conduct scheduled or random inspections to confirm that the project is being conducted in accordance to its approval. Inspections may include asking questions of the research team, inspecting all consent documents and records and being guided through any physical experiments associated with the project
- (f) if the research project is discontinued, you advise the Committee in writing within five (5) working days of the discontinuation;
- (g) A copy of the Statement of Findings is provided to the Human Research Ethics Committee when it is forwarded to participants.

Please note that failure to comply with the conditions of approval and the *National Statement on Ethical Conduct in Human Research* may result in withdrawal of approval for the project.

In the event that you require an extension of ethics approval for this project, please make written application in advance of the end-date of this approval. The research cannot continue beyond the end date of approval unless the Committee has granted an extension of ethics approval. Extensions of approval cannot be granted retrospectively. Should you need an extension but not apply for this before the end-date of the approval then a full new application for approval must be submitted to the Secretary for the Committee to consider.

The Human Research Ethics Committee is committed to supporting researchers in achieving positive research outcomes through sound ethical research projects. If you have issues where the Human Research Ethics Committee may be of assistance or have any queries in relation to this approval please do not hesitate to contact the Ethics and Compliance Officer or myself.

Yours sincerely

Dr Tania Signal
Acting Chair, Human Research Ethics Committee

Cc: A/Prof Lorna Moxham, Mr Marc Broadbent (supervisors)
Project file

Application Category: A

APPENDIX 4: UNIVERSITY OF WOLLONGONG HREC APPROVAL LETTER



INITIAL APPLICATION APPROVAL -Transfer

In reply please quote: HE12/111

Further Enquiries Phone: 4221 3386

28 May 2012

Ms Donna Marynowski-Traczyk
16 Magenta Drive
VARSITY LAKES, QLD 4227

Dear Ms Marynowski-Traczyk,

I am pleased to advise that the application below has been approved.

Ethics Number: HE12/111
Project Title: Registered Nurses conceptualisation of recovery as it applies to consumers with a mental illness in the Emergency Department.
Researchers: Ms Donna Marynowski-Traczyk, Professor Lorna Moxham, Mr Marc Broadbent
Approval Date: 5 April 2012
Expiry Date: 4 April 2013

The University of Wollongong/ISLHD Health and Medical HREC has noted the previous Central Queensland University Human Research Ethics Committee approval (Project H11/10-154) and the transfer of the research to University of Wollongong.

The University of Wollongong/ISLHD Health and Medical HREC is constituted and functions in accordance with the NHMRC *National Statement on Ethical Conduct in Human Research*. The HREC has reviewed the research proposal for compliance with the *National Statement* and approval of this project is conditional upon your continuing compliance with this document.

A condition of approval by the HREC is the submission of a progress report annually and a final report on completion of your project. The progress report template is available at <http://www.uow.edu.au/research/rso/ethics/UOW009385.html>. This report must be completed, signed by the appropriate Head of School and returned to the Research Services Office prior to the expiry date.

As evidence of continuing compliance, the Human Research Ethics Committee also requires that researchers immediately report:

- proposed changes to the protocol including changes to investigators involved
- serious or unexpected adverse effects on participants
- unforeseen events that might affect continued ethical acceptability of the project.

Please note that approvals are granted for a twelve month period. Further extension will be considered on receipt of a progress report prior to expiry date.

Research Services Office University of Wollongong NSW 2522 Australia
Telephone: +61 2 4221 3386 Facsimile: +61 2 4221 4338
research-services@uow.edu.au www.uow.edu.au/research

If you have any queries regarding the HREC review process, please contact the Ethics Unit on phone 4221 3386 or email rso-ethics@uow.edu.au.

Yours sincerely,

Associate Professor Sarah Ferber
Chair, UOW & ISLHD Health and Medical
Human Research Ethics Committee

cc: Professor Lorna Moxham
School of Nursing, Midwifery and Indigenous Health

APPENDIX 5: PARTICIPANT INFORMATION SHEET

Participant Information Sheet

Principal Investigator: Donna Marynowski-Traczyk
Address: School of Nursing, Midwifery and Indigenous Health
University of Wollongong
Wollongong, NSW, 2500.

Research Project:

Thank you for taking the time to read this information sheet. The above research project is part of my Doctor of Philosophy program. Registered Nurses in the ED care for many people who have a mental illness. This research will specifically examine how Registered Nurses conceptualise recovery of persons with a mental illness within the ED.

What is required to participate?

Participation in this research is on a purely voluntary basis. You can withdraw from this study at any time and data can be withdrawn prior to de-identification.

To be involved in this research you will have a private one to one interview with me. The interview will be audio taped and take approximately 1 hour. This interview will be conducted at a time and place convenient to you.

During this interview I will not make any judgments about your responses, my interest is your experiences and perceptions of recovery as it applies to people who have a mental illness in the ED. Should you as a participant experience any distress during the interview, the interview will be discontinued and you will be provided with information regarding support or counseling if needed.

Any information you provide will not be identifiable. If you happen to mention names of colleagues or your place of work during the course of the interview, these will be removed when the data from the audio recording is transcribed onto paper. Taped interviews will be kept electronically on a CD and stored in a locked cabinet or alternatively kept on a password protected computer in my office. This is to ensure your confidentiality at all times.



How to participate in this research

Please complete the attached consent form and return it to me at your earliest convenience.

Ethical Approval

This study has been approved by Wollongong University Ethics Committee. If you have any concerns about this study please contact the Research Services Office 02-4221 3386. If you would like to receive the results of this research, a summary of the findings will be sent to you on completion of the study. Please indicate this on the consent form.

Thank you for taking the time to read this Participant Information Sheet. Please feel free to email me at dtm672@uowmail.edu.au, my Primary Supervisor Professor Lorna Moxham at lmoxham@uow.edu.au or my Associate Supervisor Dr Marc Broadbent at m.broadbent@cqu.edu.au, if you have any questions about this research.

Yours sincerely

Donna Marynowski-Traczyk. RN PhD (Cand)



APPENDIX 6: CONSENT FORM

CONSENT FORM

Registered Nurses conceptualisation of recovery as it applies to consumers
with a mental illness in the Emergency Department

I.....

of (address/email).....

agree to participate in a research project explained to me by the researcher about how
Registered Nurses working in the Emergency Department conceptualise recovery for
consumers who are experiencing a mental illness.

I understand that:

- I am to participate in an individual interview, which will be audio taped
- My privacy will be protected. Any personal information that I provide will not be
made public in any form that could reveal my identity to an outside party i.e. I remain
anonymous
- I am free to withdraw my consent at any time during the project and my data can be
withdrawn prior to de-identification
- I have had the opportunity to discuss this project and I am satisfied with the answers I
have been given
- I know who to contact if I have any questions about the research project
- I understand that my contribution will inform a PhD thesis and de-identified findings
may be presented at conferences and/or within journal articles


.....

Date Signature of participant

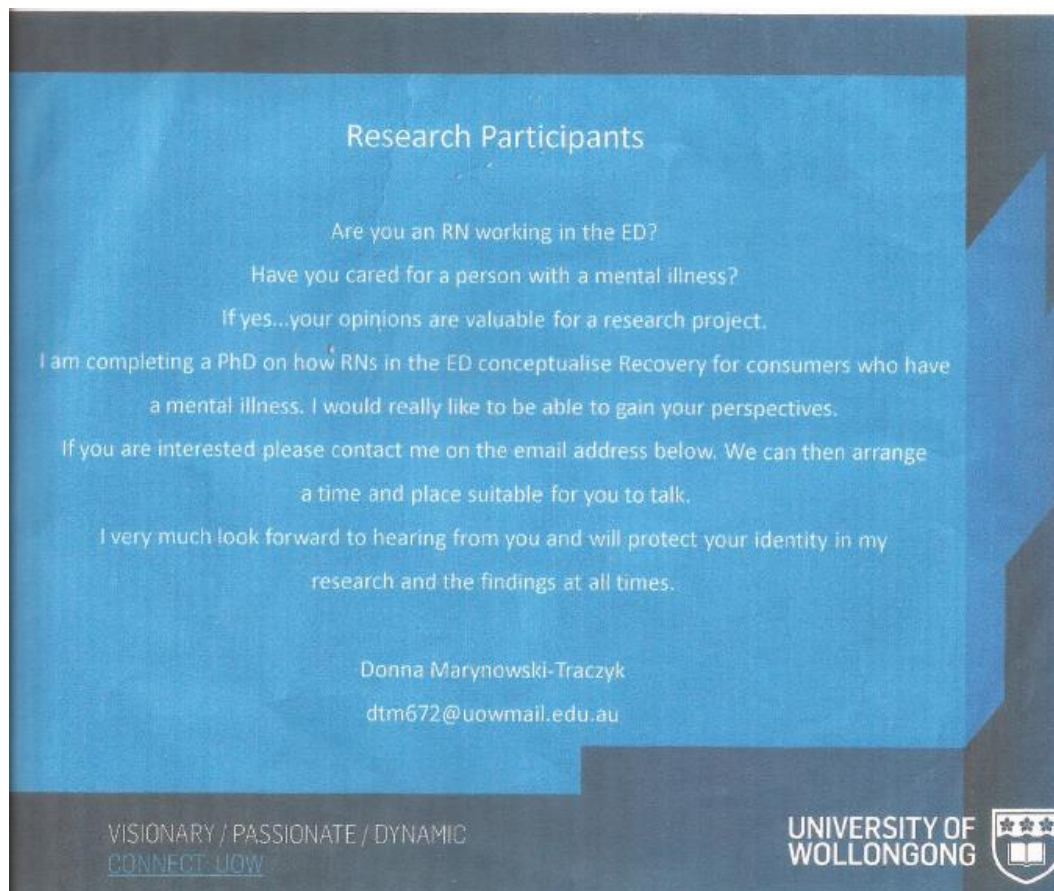
Please indicate if you would like to receive a plain English summary of results when
the study concludes. These will be sent to the above address.

Yes ☐

No ☐

**UNIVERSITY OF
WOLLONGONG**

APPENDIX 7: EMAIL TO MEMBERS OF THE COLLEGE OF EMERGENCY NURSING AUSTRALASIA



APPENDIX 8: DOMAINS WITHIN THE PRACTICE STANDARDS FOR THE EMERGENCY NURSING SPECIALIST

1.0 DOMAIN: CLINICAL EXPERTISE

1.1 *Performance Standard: Provides a concise and timely assessment of the undiagnosed patient.*

Performance Criteria

- a. Simultaneously collects and interprets clinical information and presenting problem
- b. Identifies clinically relevant presenting symptoms and clinical history to inform assessment and differential diagnosis
- c. Assesses and allocates the clinical urgency of all patients presenting to the emergency department, based on the interpretation of presenting symptoms, clinical findings and relevant medical history to inform the provision of emergency care
- d. Identifies deviation from the expected clinical course
- e. Identifies potential for deterioration
- f. Conducts ongoing timely and appropriate reassessment of patient.

1.2 *Performance Standard: Anticipates and instigates appropriate treatment and management strategies for multiple undifferentiated patients within a dynamic environment.*

Performance Criteria

- a. Prioritises the delivery of care for multiple patients in accordance with their clinical urgency
- b. Interprets assessment findings to inform treatment and management priorities
- c. Prioritises nursing interventions according to presenting patient symptoms and needs
- d. Initiates appropriate, timely nursing interventions and coordinates appropriate team response based on presenting history and clinical urgency
- e. Provides clinical support and expertise to interdisciplinary colleagues as necessary
- f. Facilitates patient management and flow through the emergency department to ensure undifferentiated patients are cared for in an appropriately equipped clinical area.

1.3 *Performance Standard: Evaluates patient progress against predicted outcomes.*

Performance Criteria

- a. Utilises theoretical and practical knowledge (e.g. pathophysiology, mechanism of injury, pharmacotherapeutics) to guide patient evaluation
- b. Assesses risk and responds accordingly to optimise patient safety
- c. Continues evaluation of patient responses to the effectiveness of interventions in accordance with evidence-based clinical pathways/guidelines
- d. Collaborates with other health professionals to identify appropriate evaluation criteria to measure patient progress.

1.4 Performance Standard: Demonstrates the ability to coordinate the admission and/or discharge of patients with a variety of clinical needs.

Performance Criteria

- a. Anticipates discharge/admission and works collaboratively to ensure efficient patient management while maintaining continuity of patient care
- b. Provides referrals to health and social services appropriate to the patient's needs
- c. Ensures safe transfer of patients to appropriate services
- d. Provides appropriate discharge education and treatment information and encourages appropriate follow up
- e. Provides a timely, comprehensive and appropriate handover of patients to continuing health care teams
- f. Transfers all patient data necessary for continuity of care.

1.5 Performance Standard: Demonstrates the ability to provide patient and family-centred care.

Performance Criteria

- a. Acts as a patient advocate
- b. Collaborates with the patient, where possible to establish an agreed treatment pathway
- c. Incorporates assessment of the social dynamics of family into care of the patient
- d. Supports family presence during the patient's journey in the emergency department, including in resuscitation
- e. Interactions with the patient are respectful of the individuals health choices
- f. Recognises the role of the family/support people in patient care and involves them throughout the patients' assessment, management and discharge planning
- g. Demonstrates sensitivity to the cultural and spiritual needs of patients and their families.

2.0 DOMAIN: COMMUNICATION

2.1 Performance Standard: Provides effective communication with all members of the health care teams and external agencies.

Performance Criteria

- a. Consults with colleagues to plan, deliver and evaluate care
- b. Communication is clear, concise, accurate, timely and delivered in a professional manner
- c. Communicates patient information to ensure the continuity of care
- d. Recognises and accounts for the challenges that impact on effective communication
- e. Selects appropriate modes of communication and uses feedback to ensure the effective transfer of information.

2.2 Performance Standard: Communicates effectively with patient, family and support people.

Performance Criteria

- a. Uses a variety of communication strategies to establish rapport with patients, families and support people, such as active listening, paraphrasing and non-judgemental language
- b. Ensures communication approaches with patients/family/support people are individualised, and considers factors such as cognitive development level, education level, culture and ethnicity
- c. Provides referrals and educational materials as appropriate
- d. Engages interpreter services and utilises available technologies to maximise communication and promote patient independence and autonomy
- e. Maintains patient privacy and confidentiality.

3.0 DOMAIN: TEAMWORK

3.1 Performance Standard: Performs effectively as a team member.

Performance Criteria

- a. Is aware of the expectations and is accountable for one's own role within the team
- b. Displays commitment to the common purpose and team goal/s
- c. Interacts with multidisciplinary team members in a manner that promotes positive attitude, trust and respect for team diversity and inclusivity
- d. Has knowledge of the individual team member's roles and how they contribute to the team based approach
- e. Contributes to team activities within own scope of practice
- f. Utilises knowledge of multidisciplinary / organisational hierarchy to deliver team outcome
- g. Develops and maintains specialist skills and knowledge to enable effectiveness in emergencies or crisis situations
- h. Recognises and responds effectively to emergency situations
- i. Establishes cohesive working relationships to positively influence patient outcomes
- j. Demonstrates and fosters an understanding of organisational processes that support care delivery
- k. Appropriately initiates referrals to multidisciplinary team members or service providers outside the emergency department.

3.2 Performance Standard: Effectively leads a team to provide safe, quality patient care.

Performance Criteria

- a. Defines team goals / priorities and communicates them to the team
- b. Delegates roles and responsibilities for care to team members according to their competence and scope of practice
- c. Recognises performance limitations within the team and provides timely support and direction as appropriate
- d. Interacts with multidisciplinary team members in a manner that promotes a positive attitude, trust and respect for team diversity
- e. Recognises when team or organisational function is impeded and implements appropriate solutions
- f. Provides feedback that acknowledges individual performance, encourages staff development and fosters team cohesion
- g. Recognises and values the contribution, opinion and ideas of each team member

- h. Initiates debriefing as determined by the event or as requested by team
- i. Identifies and promotes opportunities for the professional development of individuals within the team
- j. Maintains self-control and professionalism in stressful situations.

3.3 *Performance Standard: Appropriately manages critical incidents and stressful situations.*

Performance Criteria

- a. Initiates grief support and crisis intervention when appropriate
- b. Supports staff caring for patients with challenging family and/or personal needs
- c. Identifies and defuses potential conflict and facilitates conflict management
- d. Demonstrates effective negotiation skills
- e. Facilitates the initiation of debriefing as requested by peers or as determined by the event
- f. Recognises the potential for cumulative stress and its impact on staff health, well-being and work performance
- g. Works alongside colleagues to build emotional intelligence within the team, to develop colleagues' awareness of the importance of self-care and resilience in protecting self to care for others
- h. Uses positive coping strategies to manage critical incidents and workplace stress.

4.0 DOMAIN: RESOURCES and ENVIRONMENT

4.1 *Performance Standard: Practices to promote and maintain patient and staff safety.*

Performance Criteria

- a. Practices in accordance with organisational and national standards that are designed to guide and promote patient, visitor and staff safety
- b. Supports and enacts relevant hospital policies/protocols and identifies gaps in the promotion of patient and staff safety
- c. Identifies and reports all actual/potential risks to patient, staff and visitor safety
- d. Initiates, promotes and evaluates strategies to eliminate or minimise identified actual/potential risks to safety
- e. Prepares and transfers patients safely in intra-hospital and inter-facility settings
- f. Proactively manages patient flow to minimise the impact of access block and to optimise patient safety.

4.2 *Performance Standard: Effectively anticipates and provides appropriate human resources to promote optimal patient care.*

Performance Criteria

- a. Seeks assistance when patient needs surpass individual capacity or scope of practice
- b. Recognises imbalances in workload and skill mix
- c. Proactively allocates staff to provide optimal patient care in a dynamic environment
- d. Evaluates strategies to address imbalances in workloads and staff skill-mix.

4.3 Performance Standard: Utilises and manages material resources effectively and responsibly to promote optimal patient care.

Performance Criteria

- a. Demonstrates both a comprehensive working knowledge of all equipment and the ability to use the equipment appropriately
- b. Checks and maintains equipment according to hospital/manufacturers recommendation to ensure a state of readiness for use
- c. Manages faulty or malfunctioning equipment appropriately
- d. Prepares and maintains work environment to ensure adequate material resources are available to support safe and efficient patient care
- e. Manages space within the emergency setting to achieve efficiency and optimise patient flow
- f. Utilises materials cost-efficiently
- g. Contributes to the evaluation of the safety, efficiency and effectiveness of clinical products and equipment.

4.4 Performance Standard: Demonstrates preparedness and response for major incidents and disasters.

Performance Criteria

- a. Demonstrates working knowledge of the organisation's emergency/disaster management plans
- b. Demonstrates awareness of equipment used in major incidents and disasters and its location
- c. Maintains emergency-related skills in accordance with legislation, policy and procedures
- d. Anticipates, prepares and manages internal/external incidents and disasters, within the scope of practice and within the organisation's capacity.

5.0 DOMAIN: PROFESSIONAL DEVELOPMENT

5.1 Performance Standard: Maintains own professional development.

Performance Criteria

- a. Identifies professional strengths, weaknesses and knowledge/ skill deficits to support the development of learning objectives and professional goals
- b. Delivers emergency care within individual scope of practice and seeks support or guidance where appropriate
- c. Participates in professional development activities to meet identified learning and professional goals
- d. Actively seeks and critically reflects on feedback from colleagues about own nursing practice
- e. Maintains a Professional Portfolio including documented learning and performance goals
- f. Holds or is working towards a post graduate qualification in emergency nursing
- g. Engages in and contributes to the evidence-base of emergency care.

5.2 *Performance Standard: Contributes to the professional development of colleagues.*

Performance Criteria

- a. Role models the professional coordination and delivery of emergency care
- b. Provides constructive feedback and encouragement to support the professional development of colleagues
- c. Contributes to the orientation, preceptorship and mentoring of colleagues
- d. Provides and supports formal and informal learning opportunities for colleagues.

5.3 *Performance Standard: Promotes the specialty of emergency nursing.*

Performance Criteria

- a. Maintains membership of relevant professional organisations and industry groups
- b. Participates and contributes to activities or events that profile emergency nursing
- c. Participates in and supports research that will promote and enhance emergency nursing
- d. Promotes and practices according to CENA practice standards.

6.0 DOMAIN: LEADERSHIP

6.1 *Performance Standard: Demonstrates leadership that enables positive role modelling for nursing and other health professionals.*

Performance Criteria

- a. Demonstrates values that underpin caring nursing practice
- b. Possesses a level of clinical knowledge and skill that demonstrates expertise and credibility in emergency nursing practice
- c. Utilises effective interpersonal skills to engage, inspire, motivate and empower colleagues
- d. Demonstrates effective and inclusive decision making skills related to clinical and system issues
- e. Generates ideas and supports innovation within the domain of emergency nursing
- f. Guides change through effective communication, education and staff support mechanisms
- g. Sets direction as a patient advocate within the interdisciplinary healthcare team
- h. Develops personal qualities such as self-awareness, self-reflection, self-management, professionalism and self-development.

6.2 *Performance Standard: Advocates for and provides consultancy in emergency nursing.*

Performance Criteria

- a. Recognises and articulates contemporary issues influencing emergency health care
- b. Participates as an emergency care representative on hospital committees and in relevant professional forums
- c. Evaluates available evidence to identify opportunities for change
- d. Applies specialist knowledge and evidence to make decisions and evaluate impact of change / outcomes

6.3 *Performance Standard: Able to safely lead a team in caring for the at-risk patient.*

Performance Criteria

- a. Utilises experience and knowledge to ensure all appropriate care is given
- b. Advocates for patients through proactive consultation with multidisciplinary team members
- c. Seeks advice from senior colleagues when the need arises to protect the at-risk patient
- d. Able to role model behaviours that support safe practice
- e. Able to maintain collegial respect within the team through this interaction.

7.0 DOMAIN: LEGAL

7.1 *Performance Standard: Complies with prevailing legislation and standards of best practice.*

Performance Criteria

- a. Demonstrates a thorough working knowledge of relevant Commonwealth and State legislation
- b. Works at all times in accordance with the standards for Registered Nurses
- c. Demonstrates a thorough working knowledge of department and organisational policies and procedures
- d. Takes responsibility for own clinical decisions and undertakes clinical practice within scope of practice
- e. Practice reflects an understanding of duty of care
- f. Practice reflects an understanding of the requirements for delegation and supervision of practice
- g. Identifies breaches of legislation and standards of practice, and takes appropriate action.

8.0 DOMAIN: PROFESSIONAL ETHICS

8.1 *Performance Standard: Functions within an ethical framework.*

Performance Criteria

- a. Practices in accordance with the Code of Ethics for Nurses and other relevant professional standards that inform the fundamental rights and behaviour of nursing professionals toward all providers and recipients of nursing care
- b. Recognises and respects diversity and the influence of culture on emergency nursing and clinical decision-making
- c. Values the inherent worth and dignity of every individual
- d. Advocates for respectful treatment of all individuals
- e. Respects the individual's right of choice and strives to ensure their choices are understood and promoted
- f. Protects the confidentiality of patient information and practice within the laws governing privacy and confidentiality of personal health information
- g. Provides nursing care without prejudice or partiality
- h. Recognises and critically reflects on the evolving nature of ethical issues impacting emergency nursing practice within the profession's ethical framework.

9.0 DOMAIN: RESEARCH and QUALITY IMPROVEMENT

9.1 *Performance Standard: Demonstrates support for quality improvement within the emergency care environment.*

Performance Criteria

- a. Critiques practice to seek opportunities for continuous improvement
- b. Plans, initiates and/or participates in measures to improve the quality of care
- c. Appraises and incorporates evidence to inform quality activities
- d. Evaluates outcomes of quality improvement activities
- e. Determine the appropriateness of applying findings to practice
- f. Disseminates results of practice improvement outcomes at local forums, conference presentations and publications
- g. Promotes a culture of quality improvement within the emergency care environment.

9.2 *Performance Standard: Utilises and supports the development of research within the emergency care environment.*

Performance Criteria

- a. Practices in accordance with best practice guidelines
- b. Seeks out and critically evaluates research findings relevant to emergency practice
- c. Evaluates the impact of integrating evidence into practice
- d. Identifies and addresses factors that hinder the adoption of evidence based practice
- e. Supports and contributes to emergency research in order to inform theory and practice development
- f. Fosters teamwork and collaboratively engages professionals from within emergency and other disciplines to identify and address evidence gaps
- g. Encourages research confidence through research interest groups, journal clubs or support from clinical educators and proactive management teams
- h. Disseminates results of research findings at local forums, conference presentations and publications
- i. Promotes a culture of research and evidence based practice within the emergency care environment.