INTRODUCTION

Mental health presentations now encompass a large and rapidly growing proportion of patient presentations seen by paramedics (1). In their recent scoping review, Smith et al. (2) found that this increase in exposure to patients with mental illness has been 10-fold in the last 10 years. How paramedics perceive persons with mental illness is vital, as their experiences in providing treatment and care can significantly impact decision-making. This article investigates these experiences and how they may influence patient care.

Stigma is an issue impacting the treatment and care of people with mental illness and can be defined as a ‘mark separating individuals from one another based on socially conferred judgment’ (4). This definition can lead to negative beliefs and stereotypes that endorse prejudice at excluding people who have been stigmatised (5). Seminal work in health care has shown that a person with mental illness is likely to be subjected to stigma (5–7), and that issue extends to the families and health care providers of people with mental illness (8).

There is a lack of research regarding stigma and patients with mental illness in paramedicine. Only a few articles describe specific scenarios of self-harm or schizophrenia (9–11). In a 2020 study published on paramedic students’ attitudes, it was identified that students also stigmatise people with mental illness. Simpson et al. (12) offer insights into ‘initiatives and interventions’ to reduce stigma in the tertiary education of paramedics. It is therefore important to consider how stigma may be conceptualised. Using the lens of symbolic interactionism (SI), Erving Goffman argued that the label of ‘mental illness’ was a socially constructed phenomenon that rose to prominence through the institutionalised setting of mental health services (13). Indeed, the creation and use of the label ‘mental illness’, one may reason, increases the risk of stigmatisation.

Little is understood about the actual experiences that paramedics have with people with mental illness; this
study aims to address that gap by: 1) offering accounts of experiences that paramedics have had together with reasoning for their behaviour, and 2) proposing a reform model for improving the care that paramedics provide to people experiencing mental illness.

**METHODOLOGY**

**Research paradigm**

The methodology used in this research was a qualitative descriptive research design. Qualitative description is a practical approach for studies that are descriptive in nature, especially in the field of health care research (14,15). In this aspect, it is particularly relevant where the researcher is looking to report on those experiencing a phenomenon and where time and resources are limited (16). It is perhaps labelled as one of the most basic qualitative research methodologies because it is the least theoretical and encumbered. It aims to describe from naturalistic inquiry, which entails a commitment to studying something in its natural state (14).

Qualitative descriptive data collection focuses on discovering the nature of specific events under study. In this research, those events were paramedics’ experiences of working with people with mental illnesses. Data collection common with qualitative descriptive studies can utilise structured, open-ended, individual or focus group interviews (17). In this study, focus group interviews were conducted. This data from the focus groups allowed the participants to describe the ‘who what, and where of experiences’ from their perspective (18). A focus group encourages interaction between participants and allows the researcher to explore consensus (or lack of) about topics (19). A feedback effect can occur which encourages further conversation that may not have come up in an individual interview.

**Participants**

Paramedics within Australia, New Zealand, Canada, and the United Kingdom were invited to participate in the research. Participants could be working within any field of paramedicine to be included in the study.

**Recruitment**

A convenience sample of participants was recruited over four weeks via a social media announcement on the Facebook page of the Australian & New Zealand College of Paramedicine. The social media announcement included the participant information sheet where participants could contact the researcher to express interest. Once contact had been established, a consent form was completed and a date organised for the focus groups to be conducted.

**Data collection**

The focus groups used an online meeting platform to capture audio recordings. The theme guide used for the focus groups is attached in Supplementary Materials. A transcription service transcribed the audio recordings of the focus groups under a confidentiality agreement. Transcribed data were then coded using computer-assisted qualitative data analysis software (NVIVO). Two authoring team members completed the coding (authors one and three). Author two contributed to the data analysis and editing process.

Study participants are anonymised within the data management of the research study. Storage of de-identified data is held on secure organisational servers. Both electronic and hard copy data, including consent forms, will be destroyed after the completion of the retention period mandated by institutional ethics requirements (five years).

**Data analysis**

This research used Braun and Clarke’s (2006) six steps of thematic analysis method viewed through the lens of SI. This tool SI is regarded as appropriate for understanding how mental illness is viewed by a person or a group of similar people, and indeed, some of the most notable literature on the topics of ‘stigma’ and ‘mental illness’ has been conducted from the perspective of SI (13). Of pragmatist origins and rooted in the view that an ‘individual’s knowledge and understanding of the world is based on what is most beneficial to them’, themes were interpreted in keeping with Herbert Blumer’s principles: first, individuals act towards things based on meaning; second, meanings are derived from social interaction; and third, meanings are modified through social interaction (13).

The steps for theme generation were as follows. The first step was familiarisation of the data, during which the authors read each transcript several times. Second, initial codes were generated; NVIVO was used as a tool to assist with the process of identifying codes within the data set. These codes represented times that participants shared experiences, including comments, thoughts, feelings, and actions. Third, searching for themes was undertaken. As the codes began to develop, themes from the data emerged and these were placed in alignment with the research aims. Data were organised into different categories based on identified themes or concepts (20). Fourth, a review of themes was performed. Throughout the theme-generating sessions, the lens of SI was used to view the data. Fifth, themes were named, and lastly the findings were drafted.

**Trustworthiness and reflexivity**

This study was conducted by the primary author (a paramedic academic) to attain a higher degree by research qualification, and completed under the supervision of highly qualified and experienced career researchers. Reflexivity is commonly used to assess the validity or trustworthiness of qualitative research practices (21). The concept of reflexivity in qualitative research is directed at understanding how the social interaction between the interviewer/interviewee may affect the credibility of the research outcomes (22). Participants in this study had no prior relationship with any research team member. Prior to data collection for this study, direct interactions were kept to a minimum between the researcher and the participants. All pre-data collection interaction was conducted via email, with no verbal interaction until the day of the focus groups. This strategy was adopted to reduce any perception of power
that the researcher may impose, implied or actual, upon the research participants.

The authors (all registered paramedics) acknowledge their position within the industry as irremovably situated within the general context of the study. Rather than this being a limitation, this should be seen as granting the researchers the ability to utilise their prior knowledge, experiences, and foundational understanding of the problem being examined to interpret what they see in the data to construct the codes that are important to the project to best answer the research question (23).

Whilst NVIVO was utilised in the research process, the researcher performed the cognitive work of data analysis and coding, and the software offered a tool to assist with the process only. The scope and size of this project were well suited to using NVIVO, and the researcher recognised and acknowledged the tool’s strengths and weaknesses (24).

Ethics

This research study was approved by the Charles Sturt University Human Research Ethics Committee, Approval No: H17045. The study was conducted in line with the principles for ethical research as set out in the Australian Code for the Responsible Conduct of Research (25).

RESULTS

Six paramedics participated in the two focus groups (four male and two female) that lasted for 90 minutes and 85 minutes, respectively. The sex of the participants was 40% female and 60% male. Five themes were identified after the two focus groups were performed. These themes are listed below, along with focus group recorded data excerpts.

Theme 1 – Frequency of exposure to mental health patients alongside paramedic workload are perceived to attribute to stigmatising behaviour

The surrounding discussions of paramedic behaviour towards people with mental illness gradually developed during the focus groups. All participants agreed that they had seen and experienced first-hand behaviour that they would deem to be stigmatising of the mentally ill person. With what appeared to be a very open statement of the current situation, one participant said:

I don’t think we can deny that they are stigmatised. (Participant one)

Some participants indicated that they felt they had performed (or seen) this behaviour; however, they considered that the incidence was low across the profession. The behaviours ranged from the rolling of eyes when viewing the job on the mobile data terminal to not trying to build rapport with the patient:

It’s one of those things. Half the time, you get a job like that, and you’re with a crewmate, and people roll their eyes and go, ‘Oh, here we go again. Not another one’. A lot of the time, you judge that person before you’ve even gotten to the scene ... Like we’ve said before, it’s one of those things. Sometimes you’ll get a job come down and roll your eyes and go, ‘Oh ‘dear’, before you leave the station ... Some paramedics, again, this is a tiny percentage, don’t try and build that rapport. It’s not seen as their job, I think. Our job is to get them to the hospital. (Participant two)

Two circumstances which participants believed led to paramedics behaving this way were the frequency of times a paramedic had treated/responded to a particular patient (also known colloquially as ‘frequent flyers’), and secondly, burnout of the paramedic from recurrent exposure to similar cases of mental illness. Behaviours associated with frequent contact with the same patient have been identified in previous research as ‘seeing the illness ahead of the person’ and have been previously reported by emergency department and mental health inpatient unit staff (26).

In some cases, it really depends on, unfortunately, how many times we’ve seen the patient. I think a lot of paramedics – well, I probably shouldn’t say a lot of paramedics – still, some paramedics can essentially run out of patience with particular patients if we repeatedly go back to them for the same issue. (Participant two)

The participants added that this combination of burnout and recurrent exposure to the same patient was more likely to occur in the larger city areas, where the frequency of mental illness presentations and the overall workload was significantly higher:

I was working with one of our brand-new paramedics at the station, and I’m guessing her experience has informed her........ to sort of deal with mental health patients and issues. But yeah, she really gave me that vibe of the 10–12-year veteran suffering burnout and has seen this patient a million times before; I don’t want to deal with this, so I don’t see why we should do anything for this person. (Participant four)

Whilst this type of stigmatisation may be detrimental to patient care and paramedic practice, it is not altogether surprising:

Unfortunately, we absolutely do with some of the patients [stigmatise them], whether they’re a very sub-acute presentation of mental health or a highly acute mental health presentation. Those people at either end of the spectrum tend to get more stigma than someone who sort of classically presents. (Participant two)

The following comment shows that the paramedic’s behaviour can flow over into their personal lives, and is an excellent example of how deeply the participants reflected and how genuine participant responses were during the focus group sessions:

A woman on my soccer team who I have known for ages told me the other day that she is better medicated these days. Instantly I felt myself rise in my behaviour towards her, and then she disclosed being diagnosed with bipolar. I immediately moved into my paramedic’s brain and judged her for having a mental illness. (Participant five)

Theme 2 – Paramedic culture can negatively influence behaviours and care towards patients with mental illness
During the focus group meeting, the research participants explained how paramedic behaviour was primarily driven towards influencing newly recruited paramedics to ‘fall into line’ and conform to the views of current paramedics. This is evidence that the notion of ‘enculturation’ is a driving force behind stigma towards mental health patients within the profession. Enculturation is defined as ‘the process by which an individual learns the traditional content of a culture and assimilates its practices and values’ (27).

Van der Gaag and Donaghy’s work on enculturation in paramedic practice suggests that this process begins even at a student level, and that attitudes may change (28). The student can become entrenched, as they are influenced by perceived legitimate practitioners whose endemic traditions are portrayed as professional and are difficult to challenge. This means that new paramedics find it easier to assimilate in the workplace if they adopt the behaviours of the more senior members, even if they initially may not always agree with them.

How do you change the culture when it is embedded so deep in the system? Paramedics are passing on their beliefs and behaviours to all the new people. (Participant six)

Feelings and experiences about what constitutes ‘paramedic work’ from participants in this research reverberate with previous research outcomes (3). Work involving mental illness is not considered core business for paramedics. One participant shared such thoughts:

Paramedics feel like their work is about acute trauma and medical presentations, not chronic presentations. And mental illness is a chronic phase, and paramedics are disinterested in helping people in those situations. (Participant one)

Participants further expanded to identify what the issues were with how they perceive their work versus the actual reality of cases that they are attending:

Our training and education programmes need to be modified to align more with the chronic presentations that paramedics are now expected to deal with as patient presentations. This is a mind shift, and we need to work on a cultural change within paramedicine to incorporate chronic mental illness presentations. This may facilitate a shift in the paramedic experience and the person with mental illness. (Participant three)

This enculturation within paramedicine appears to be affecting new paramedics. Participants state that it is commonplace for paramedics to persuade or ridicule others who provide what they consider ‘too much care’ to a person with mental illness who frequently presents to paramedics. Alongside the label of ‘frequent flyers’, ‘time wasters’ is also used:

I remember going to a frequent caller patient with mental health issues. I’d never met him before; I was relatively new in the job. I went through the whole procedure of treating and assessing this person, was very kind and compassionate. We presented to a major hospital where there were lots of crews there. Everyone sort of just had a little chuckle when I turned up with him; they all laughed because they thought, oh well, the patient has got a new paramedic to look after them now, they all regarded this patient to be a timewaster. (Participant four)

Theme 3 – Empathy and inadequate education of mental health management are an unbalanced workplace frustration
Participants in this study discussed their empathy towards people with mental illness, highlighting that they do still empathise. However, they also felt that they did not have the answers to help them or provide the optimal care plan.

And they’re waiting for hours, and they don’t get the help they need. And you go back to hospital, and you see them, and they look worse and worse. You feel terrible because you want them to get help, and they need help, but they’re not in the right place for it … it’s a shame from my point of view … I just don’t think that’s really good enough. (Participant three)

During the discussions, participants shared experiences of situations with a positive outcome for the patient. These were often specific instances when health care workers provided ongoing treatment with qualifications in mental illness.

And you can definitely see a positive change in how the patients interact with the mental health nurses and how they’re looked after in a facility geared towards their kind of complaint. (Participant one)

However, in contrast, the participants felt frustration about the patient’s care on many occasions. As clinicians, they were unsatisfied when facilities had a decreased ability to offer specialist assistance, such as specifically trained staff.

… it’s about having the facilities available to take people to and not getting knocked back, because that’s just – it’s demoralising for the patient, I
think, when we have to do that. (Participant four)

Theme 4 – Education versus ability for knowledge translation

Recently, paramedic training in clinical judgment for patients with mental illness has improved (29). Additionally, there are tertiary and employer education programmes and specific clinical practice guidelines designed to assist mental health patients’ care. However, this research shows that this has so far been insufficient to meet their needs, and paramedics still feel ill-prepared to treat these people.

Unfortunately, the training isn’t there … Many people don’t really have that training to know how to approach a lot of those situations. (Participant one)

And:

Mental health management training is probably non-existent. We get a kind of a brief overview of what different mental illnesses are, but we don’t really get much in terms of mental health first aid or even scenario-based type of activities. (Participant six)

Interestingly, when discussing management, participants thought that patients who presented as aggressive or combative were easier to treat because they felt they were ‘doing something’. However, most cases were considered low acuity, and thus paramedics felt less able to help.

We can’t fix it, and we don’t have the training to resolve their emotional problems, their psychiatric issues. We can sedate, and we can support. We can’t do much more than that, to be honest. The training just isn’t there for us to be able to do that. (Participant one)

Clearly, the low acuity patient presents a unique challenge to paramedics.

And we could have a lot more training, especially in sort of crisis de-escalation, communication, and just generally verbal and non-verbal communication skills. Those kinds of techniques would probably be very invaluable to everybody. (Participant one)

From the experiences and insight provided, an education and knowledge translation gap needs to be filled in order for paramedics to feel better prepared.

Theme 5 – Patient behaviours are a pre-cursor to paramedic behaviour

Participants noted that people’s behaviour with mental illness could be unpredictable, making it difficult for paramedics to know how to react, respond, treat, and care. Patient behaviour is identified as a significant influencer upon the attitude or management approach taken by the paramedic. Patients can display physical and psychological aggression towards paramedics, placing paramedics in very unpredictable situations:

One or two patients are quite violent mental health patients, just due to their sort of general lifestyle habits. If they’ve been using methamphetamine quite hard for the last few days, they begin to have some dark and dangerous thoughts, and they tend to act on them. And unfortunately, paramedics have been injured in the past from that. (Participant two)

A female focus group participant discussed her concern regarding a male patient with mental illness who displayed intimidating behaviour. She struggled to know how to react when she felt threatened, which affected the treatment she provided for him:

... and in the back of the ambulance, he was staring at me and playing with himself, which is what he was arrested for, for masturbating in public. And he’s known for that with the police. And so that was quite uncomfortable for me and affected the way that I approached him. (Participant one)

Another difficulty that paramedics face is treating people with mental illness who fall into the category of being vulnerable, young, or elderly:

And I had to present to the Children’s Hospital. You’re walking on through this kid’s playground of a hospital with a kid who is still actively trying to seriously harm you, who stabbed me with a pen at that point. This child had already received sedation from us, and the entire situation is distressing for all involved. And you feel like the hospital staff are judging you. (Participant one)

These patient behaviours can be challenging to manage and need a considered approach often tailored specifically for each individual. Safety, efficiency, and empathy can be, at times, at odds with each other. In the following discussion, the authors consider these challenges with reference to a broader framework for consideration.

DISCUSSION

The five themes that emerged in this research contribute to a proposed model for improving paramedics’ care for people with mental illness. Based on the model’s elements (Figure 1), the following discussion relates to how some paramedics feel about patients with mental illness and should be considered an adjunct to Prener and Lincoln’s work (30). As diagrammed in the model, the centre represents paramedic practice and how it is affected by the themes presented in this paper.

Culture affecting paramedic practice

Stigma amongst health professionals towards people with mental illness is not new (31). This cultural behaviour has resulted in poor experiences for the
person with mental illness and affects ensuing patient care outcomes. As identified by the participants in this research, paramedics are exposed to, and are enacting, poor cultural behaviour regarding treating and assisting people with mental illness. More specifically, this is aimed towards patients who paramedics believe are wasting their time or who are recurrent attendees that the paramedics have decided do not warrant care. Paramedic behaviour can make recruits and long-term employees conform to the enculturated dominant thoughts and attitudes towards frequent callers whom paramedics have determined do not need any care or are ‘trying to get one over you’ (Participant two). This behaviour is not singular in that a new paramedic will experience this with multiple shift partners. This point of stigma is identified in the model of care – as a profession, there is a need to be aware of the implications of such behaviour on paramedics and their patients.

Goffman (1963), in an attempt to combat the stigma of mental illness, offered advice on ways in which this could be managed by society as a whole (32). Indeed, stigmatising behaviour towards mental illness goes back to at least the 1960s. From this research, one can conclude that society and paramedics, in particular, are no better at abstaining from this type of behaviour. Since Goffman’s work was published, very little has changed, with Thornicroft recording in his edition published in 2006 that ‘discrimination against people with mental illness is both common and severe, and that little real progress towards combatting this has been made’ (23).

Research supports the experiences of participants in this research. For example, Roberts and Henderson (3) found that paramedics identified their role as solely about transportation, not providing health care for people with mental illness. They also identify their priority as dealing with any life-threatening presentation, which aligns with the feelings expressed by participants in this research. Paramedics view their work as dealing with acute trauma and medical conditions, not with chronic mental illness. The paramedics in the Roberts and Henderson (3) research valued mental illness as a secondary consideration, not a primary consideration. Further to the findings of Roberts and Henderson (3), research by Prener and Lincoln (30) identified that paramedics involved in their study struggled to frame people with mental illness as appropriately using paramedic services, and they fundamentally questioned if ‘psych calls’ were ‘genuine emergencies’.

The outcomes of this research have identified that stigma towards people with mental illness is happening during care from paramedics. This was identified in the focus groups through the social interaction between participants and SI, which explained the behaviours of a small percentage of paramedics. Whilst the participants felt the occurrence of this was low, any occurrence of

Figure 1. Model for future practice – improving the care of people with mental illness in paramedicine
stigma should not be tolerated in the profession of paramedicine.

It could be expected that this potential form of discrimination by paramedics is just a part of society’s more comprehensive picture of discrimination and stigmatisation against people with mental illness; when people put on a paramedic uniform and go to work, their societal views do not necessarily change. The behaviour identified in this research showing a culture of stigmatisation towards people with mental illness may reflect broader societal stigmatisation of mental illness. Researchers, employers, paramedics, and people with mental illness must work together to shift the culture and prioritise the care of people with mental illness from paramedics into a space where it results in positive experiences for both the paramedic and the person with mental illness. By reflecting on the model of how cultural behaviour can shape potentially adverse outcomes for paramedics, we can begin to provide more positive experiences for paramedics and positively affect paramedic practice.

**Knowledge Translation**

Knowledge translation is ‘a dynamic and interactive process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge to improve health care’ (33). It is a movement from the simple dissemination of knowledge to health care workers into the actual use of knowledge in practice. In this research, participants felt that even though they had received training and education and had more knowledge, they could not apply this to benefit the patient.

The model of care identifies areas where knowledge translation may not be occurring through training, education, and exposure to people with mental illness in low-acuity care scenarios. The paramedic profession needs to identify the barriers to productive use of knowledge in paramedic practice. Why is knowledge translation not occurring for paramedics? Why do we seem to have a ‘Bermuda Triangle’ where training and education are somehow lost?

Previous research has identified the benefits of providing a positive experience for the person with mental illness when quality education and training is provided to the health care provider (3,6,9,30). Prener and Lincoln (30) investigated patients’ perspectives of the education and training of health care workers. The patients identified that health care workers who had received education and training provided them with a higher quality experience (30). Furthermore, intensive education programmes provided health care workers with the skills to assist in feeling comfortable in knowing ‘what to say’ and ‘what to do’ for the person with mental illness. This led to a more positive experience. The focus groups identified these principles, and participants acknowledged that they felt underprepared and ill-equipped to deal with what patients required.

**Burnout effects on empathy and compassion**

The participants’ reference to burnout may not be unexpected; other researchers have identified burnout as a potential reason that health care workers feel exhausted with specific patient presentations. The ‘emotional slippage’ (34) typical of burnout can affect the performance of health care workers (35). As noted in the model of care, perceived burnout, especially in those in metropolitan areas, influenced paramedic practice. Research participants in this study identified with the depersonalisation of the health care provider–patient relationship. This burnout is potentially due to the constant exposure to people with mental illness that paramedics are experiencing and the overall saturation in daily workload. High-level exposure to patients with severe mental illness has previously been identified as resulting in burnout for health care workers (36). For some paramedics, it appears that recurrent exposure to the same patient with a mental illness presentation can also result in burnout-like behaviour. Prolonged exposure to job stressors has been identified as a cause of burnout syndrome (36). These job stressors have also been related to long working hours, night shifts, extended times between holidays, and organisational complexities, all of which are found within paramedicine.

Until recently, burnout has not been an area that has received much research attention in paramedics, particularly how this may affect their ability to show empathy or compassion. Additionally, as part of this research, the literature search identified no information on burnout or health care worker fatigue that correlated to stigmatising behaviours within paramedicine. However, the present research demonstrates that paramedics feel that burnout plays a part in their behaviour and demeanour towards people with mental illness, highlighting the need for further research on its impact upon stigma.

During the focus groups, the participants shared experiences of attending to up to four or more people with mental illness each shift. There is value in understanding these feelings and experiences of the paramedics who frequently respond to people with mental illness and a need to validate that there is a rising sea of patients seen in the community. As noted in the proposed model, experience aids understanding and builds compassion towards the patient but can also lead to caregiver fatigue. Roberts and Henderson (3) stated in their research in 2009 that 50% of paramedics believed that cases related directly to mental illness made up 10–20% of their workload, while a further 24% believed that it made up greater than 20%.

Previous research by Roberts and Henderson (3) supports the experience of these participants, finding that ‘people with mental illness comprise a growing proportion of the workload of paramedics’. If this was the case in 2009, one might surmise that the prevalence of mental illness cases has risen again in 2022.

The participants reported that patient behaviour directly affected their own. This seems to contradict some.
previous research, such as Rees et al. (10) who state that the behaviour of the person with mental illness should not affect the clinical decisions and treatment offered by health care workers. The reasoning for this difference between the Rees et al. (10) findings and the experiences of the research participants may be that paramedics’ work environment is unique compared to other health care areas. The research from Oblak (37) verifies the findings in this study; paramedic behaviour and decision-making may change according to the presenting complaint of the patient.

Whilst Rees et al.’s (10) study identifies the desired professional conduct of paramedics, Oblak discussed at length in her PhD thesis that this may not always be the reality in terms of paramedic behaviour, conduct, and attitudes. Participants in Oblak’s study openly identified that their behaviours, attitudes, and even clinical decision-making all changed when caring for patients suffering mental illness. The overarching reason given for this was a ‘fear’ of patients with mental illness, borne predominantly from a lack of education about and understanding of these types of patient presentations. Oblak states that this lack of education leads to paramedics developing their own frames of reference for mental health patients which in turn results in the exaggeration of stigmas (37).

Other research has investigated the attitudes and perceptions of paramedics and people with specific types of mental illness, such as self-harming. A recent article by Prener and Lincoln (30) suggests that research has not yet identified how paramedics feel about specific types of patients or how a paramedic may respond when presented with a person who has a mental illness. This research has subsequently explored and described stigmatising behaviours that paramedics highlighted, such as:

- ignoring the person with mental illness,
- not giving due attention to their complaint,
- failing to build rapport,
- physical behaviours such as displaying inappropriate body language and rolling the eyes in front of a patient.

For paramedic registration agencies or boards, these behaviours would be described as unprofessional or inappropriate for a paramedic and provide a less than ideal experience for the person with mental illness (38).

**Application to practice – future recommendations**

The model for future practice provides symbolic meaning and presents a valuable visual aid for capturing the vital components of this research. The centre of the model represents paramedic practice and how that can be affected by the experience of caring for a person who has a mental illness. Three factors that impact paramedic practice are culture, knowledge translation, and empathy/compassion. These three factors were derived by reflecting upon the prominent themes that evolved from the interviews. These factors are used in the model to identify areas of improving the paramedic’s experiences when caring for people with mental illness.

The model provides a way to understand how paramedic experiences can positively or negatively alter holistic care and how stigma could be reduced by mitigating burnout and providing more tailored educational support. Fundamental education in mental illness, ongoing training, and exposure to alternative low/non-acute environmental settings are pivotal elements within the model. As discussed previously, the increasing incidence of mental illness presentations in paramedic practice highlights the need for appropriate mental health education to support paramedics in this area. Despite efforts to introduce mental health education and training initiatives, significant gaps exist, and extensive debate and discussion surround the quality and effectiveness of this education within the Australian paramedic landscape (2). These issues were previously identified in the work of McCann and Savic (39), who conducted a study on paramedics’ perceptions of their scope of practice in caring for non-medical emergency-related mental health and alcohol and other drug problems.

The research in this field strongly suggests that knowledge translation into practice is complex, and the amount and depth of education in mental health remain limited and inadequate. We propose that the presented model could inform educational reform in mental health care for paramedics and address the problem within Australia. It is reasonable to suggest that this would have a meaningful impact on reducing the stigma held by paramedic practitioners towards patients with mental health-related illnesses.

**Limitations**

The researchers would have valued the opportunity to speak with more paramedics and have further focus groups. This was not possible due to exhausting the participant pool. The recruitment was left open during the early stages of the focus group formation, but no further participants joined the research. A further restriction was the inability to recruit participants from other geographical locations. Unfortunately, although the advertisement was not limited to Australia, it only captured a small pool of participants. Finally, there was a lack of paramedic research relevant to the topic area that could be utilised to inform the literature review. This required the researchers to draw upon research from other disciplines to provide the basis of the literature review.

**CONCLUSION**

Paramedics are not immune from stigmatising people with mental illness, but they perceive that this behaviour is infrequent in their experiences. One underlying aspect of this is the high exposure to patients with mental illness, leading to burnout, especially for metropolitan paramedics. The model for future practice provides valuable insights into the issues surrounding the stigmatising of patients with mental illness and how these issues can be mitigated with an improved understanding of cultural paramedic practices, education of the condition, and knowledge translation into practice.
Contributions

LB completed the research, analysed the data, and conducted the thematic analysis. SM and RB reviewed the data and synthesised the themes. All authors assisted in the writing of the manuscript.

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COMPETING INTERESTS

The authors declare no competing interests. Each author of this paper has completed the ICMJE conflict of interest statement.

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SUPPLEMENTARY MATERIALS

Theme Guide

Paramedic experiences of working with people with mental illness: A qualitative inquiry.

The research questions will be general and specific when facilitating the focus groups. This allows the participants to voice their opinion and begin a conversation on mental illness in general, then move more specifically to stigma and mental illness. The semi-structured questions posed to the group will be:

1. Tell me about a time when you encountered a person with mental illness.

This opening question, being descriptive, is unlikely to be threatening or misinterpreted. The conversation will allow the researcher to understand the experiences, how the paramedics have worked, and how they identified people with mental illness. The question will help to know if the participants have experience with people with mental illness, both professionally and personally. This question is indirectly linked to the data generated on the exposure of paramedics to people with mental illness. The lead-on question will be only changing the word ‘people’ to ‘patient’. The emerging data will come from the paramedic’s actual experiences with mental illness patients. The research attempts to identify their personal experiences and elicit any bias issues towards these patients early in the conversation.

2. How were your experiences when treating or caring for these people?

It is important to gather an understanding of the paramedic’s experience when treating and caring for these people. They may share a variety of information here in relation to their experiences. This will assist in opening the conversation and allowing participants to understand each other’s experiences. The questions are:

3. What has been your experience when dealing with people who have mental illness?

4. What has been your experience when dealing with people who have mental illness and their relationship with paramedics or other health professionals?

5. In your experience do you think people with mental illness experience stigma in their lives?

Data acquisition will concentrate on the participants’ experience in their understanding or lack of knowledge of stigma in mental illness. Previous empirical research identifies that people with mental illness face various forms of stigma.

6. In your experience do you think people with mental illness experience stigma from health professionals? If so, can you provide an example?

7. In your experience do you think people with mental illness experience stigma from paramedics? If so, can you provide an example?

Participant responses to this question are intended to create an understanding about how the participants feel about occurrences of stigma from health professionals and/or paramedics regarding people with mental illness. Research would suggest that paramedics are potentially stigmatising these people.

8. If you feel that people with mental illness face stigma from paramedics, do you think this has a potential to affect patient care?

It is valuable to understand if paramedics think that stigma is happening. We will ask questions to contextualise this, ask probing questions, and seek examples. From this, we can then understand how the participants make meaning around the object of stigma and mental illness. As noted, SI attempts to identify how or why a group of people view an object a certain way.

This semi-structured approach has the above opening questions, with ongoing questions to create responses.