2020

Exploring 4th Year Medical Students' Learning and Understanding in Mental Health and Psychiatry

Kimberly Smith
The University of Notre Dame Australia

Exploring 4th Year medical students' learning and understanding in mental health and psychiatry

Kimberly Smith

Thesis submitted in fulfilment of the requirements for the Master of Philosophy by Research

School of Arts and Sciences

Fremantle

June, 2020

Declaration

To the best of the candidate's knowledge, this thesis contains no material previously published by another person, except where due acknowledgement has been made. This thesis is the candidate's own work and contains no material which has been accepted for the award of any other degree or diploma in any institution.

The research presented and reported in this thesis was conducted in accordance with the National Health and Medical Research Council National Statement on Ethical Conduct in Human Research (2007) – updated March 2014. The proposed research study received human research ethics approval from the University of Notre Dame Australia Human Research Ethics Committee (July 2017), Approval Number #017070F.

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

Signature:

Kimberly Smith

Date: 7 June, 2020

Abstract

The stigmatisation and disempowerment of mental health consumers led to the consumer recovery movement, which now underpins the reform of Western Australia's (WA's) mental health system. As medical professionals are one of the first lines of care for consumers, it is necessary to understand whether future doctors' training aligns with the direction of the reform. This research explored a group of WA-based fourth-year medical students' learning in mental health and psychiatry to understand how their knowledge and training prepared them for working with people experiencing mental or emotional distress. Conducted under a qualitative research paradigm using critical theory and underpinned by constructionist assumptions, two key themes were developed: *Preparedness*; and *"Just" treatment and care*. *Preparedness* consists of two sub-themes, *Connections* and *Impacts upon learning,* which were the overarching issues that impacted the students' preparedness for both their final year rotations, and future practice with consumers. The students' preparedness for practice was dependent upon the connections made with the course content that constructed their understandings, as well as the human connections made to consumers' experiences. Time restrictions in multiple areas had consequences for learning as well as the extent to which participants were able to put theory into practice and develop their skills while on rotation. Therefore, the students' level of preparedness, as well as the perceived preparedness of other professionals they encountered during their rotations was found to potentially have an impact upon the *'Just treatment and care'* that consumers may receive. This means that many consumers may not, according to students' observations, be receiving the recovery-oriented services mandated by mental health policy and many are also still experiencing discrimination from health care professionals. Overall, the findings provide evidence for further developments for the current reform of the WA mental health system, such as underpinning mental health curricula in medical schools with the consumer recovery paradigm to ensure consistency in recovery-oriented service delivery across all mental health services. In addition, the research identified that utilising critical pedagogy in health professionals' education may further promote a more reflexive workforce that is

critical of power differentials that currently disadvantage consumers, while working to reduce discrimination and stigma. Therefore, the findings of this research may be used for the continuous quality improvement of medical students' learning and training, while working towards advancing the reform of WA's mental health system through transforming the underpinning assumptions and knowledges of the professionals working within the system. This research, the findings and any potential resulting reforms and continuous quality improvement of systems and curricula all have the ultimate goal of improving care and recovery for mental health service users.

Acknowledgements

I acknowledge the Whadjuk people of the Noongar Nation on whose land I live, work and study. I pay respects to the Whadjuk Elders past, present and emerging, acknowledging that their sovereignty over this land was never ceded, and honour and respect their continuing connections with the land, culture and spirit.

I would like to thank the staff of the School of Medicine, The University of Notre Dame Fremantle, for supporting my research and assisting me with information and connections wherever possible. I am also very grateful to the participants, who are now Junior Doctors, for sharing their experiences and insights. Without your willingness to share your time and perspectives this research would not have been possible.

My deepest thanks and respect to Dr Sharon McCarthy for her support, the sharing of her knowledge and expertise, and for constantly pushing me further to achieve the best possible outcomes for the research. Without your patience, passion and guidance, Sharon, I would not be where I am today. I am so grateful for every minute you spent with me on this project. Thanks also to Dr Ryan Anderton for your guidance and support. I am very grateful for your help, feedback, and enthusiasm for a project that was different to your usual ways of working and am grateful for having your clear perspective to enhance the rigour and critical analysis of my research.

I also want to acknowledge and thank my friend and Behavioural Science colleague Sarah Koelsch for proof reading, sharing your experience and prompting my critical reflexivity. You always make things so clear for me, Sarah, I am so grateful. A special thanks to my friend and colleague, Lana Hill, for also reviewing my work and providing a unique perspective. Lana, your comments helped me more than you may know. I am very grateful and humbled by your input. Thanks also to Angela Johns for your constant encouragement and proof reading.

Thanks also to The University of Notre Dame, Fremantle for providing the Bachelor of Behavioural Science degree. This degree allowed me to ‘see’ people and the issues affecting them in a completely different way and showed me how to be a conduit for transformational change. Thanks

to Associate-Professor Dawn Darlaston-Jones, Dr Sharon McCarthy and Dr Robbie Busch for their dedication to providing the carefully-structured content of the Behavioural Science program, for supporting my learning and development of my critical lens, reflexivity and professionalism. Further thanks go to the unknown peer reviewers who took the time to review and provide feedback on this research. I understand and acknowledge how much time and effort goes into the review process, so I greatly appreciate your careful considerations and experience.

The biggest thanks of course though, go to my family – Zac, Zac jnr and Shelby. Without their support, help with daily chores, and putting up with me constantly talking about it, I probably would not have finished it! Zac, thank you for understanding my need to do this project and for supporting me. Thank you for the shoulder massages, funny YouTube videos, for bringing me coffee and for your patience. You are an amazing man and the wind beneath my wings.

I would also like to acknowledge and give thanks to the Australian Government for their support of both my degree and my research through providing student scholarships; this project was made possible by the Australian Government through the Research Training Program (RTP) fee offset scheme. Without such generous support I would not have been able to undertake this research or my Masters degree. Therefore, the outcomes that this research may promote would also not be possible without such Government support.

Table of Contents

List of Tables

1. Background

A mental health consumer/service user is a "person who identifies as having a current or past lived experience of psychological or emotional issues, distress or problems, irrespective of whether they have a diagnosed mental illness or have received treatment" (Consumers of Mental Health Western Australia, 2016). This definition can also include family members and carers of individuals with mental health issues who may utilise certain services and have contact with the mental health system. Consumers have, and continue to experience stigma, which is the negative sentiment attached to a person whose experiences are deemed by the dominant majority as not being 'normal' (Goffman, 1968; Sane Australia, 2013). Stigma results from the process of labelling a person and applying stereotyped assumptions to them, which promotes the loss of social status and power (Link & Phelan, 2001). Consumers may experience a loss of status and power through being denied fair processes (procedural justice), and equitable access to resources (distributive justice) (Deutsch, 2006; van Dijk, 1992). Therefore, stigma and discrimination can negatively impact a person's life through receiving unjust treatment that may manifest as barriers to employment; not receiving appropriate services or government support; or exclusion from the broader community (Anthony, 1993; Piat & Polvere, 2014). The social exclusion and loss of power over their own lives is evidenced in the historical practice of long-term institutionalisation of consumers in asylums, or detainment in hospitals or prisons (Foucault, Khalfa, & Murphy, 2006; Foucault & Rabinow, 2010; Shorter, 1997).

The institutionalisation of distressed individuals throughout Westernised countries such as Australia, the United States and United Kingdom (Shorter, 1997) coincided with the assumptions of the medical field that symptoms of extreme distress were lifelong, and that a person could not and would not live a meaningful life if they developed such symptoms (Rickwood, 2004; Szasz, 1963, 1974). However, peak numbers of institutionalised consumers in the 1950's, along with the rising costs of asylums, and the advent and increased use of sedative pharmaceuticals is argued to have promoted an emphasis on using in-community treatment and support systems (Anthony, 1993;

Aviram, Syme, & Cohen, 1976; Moncrieff, 1999; Shepherd, Goodman, & Watt, 1961). The community model began to address individuals' social, physical and economic needs, and was found to be more cost-effective, and more importantly more effective for consumers' recovery (Anthony, 1993; Bateman & Smith, 2011). For example, a longitudinal study of individuals in community care from the 1950's to 1980's found the majority of participants' functioning improved and symptoms were reduced (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987a, 1987b). This early study demonstrated that people who experience mental distress can, and do, recover.

Recovery, however, can be complex and challenging, as it involves recovering from symptoms and resolving issues that contributed to the development of distress, while also overcoming the negative impacts that are often associated with having a psychiatric diagnosis (Anthony, 1993). Such negative impacts may include being subject to involuntary or coercive treatments, involuntary detainment, or being subjected to the system-focussed processes of the mental health system, which can function to further isolate consumers and potentially exacerbate their distress (Anthony, 1993; G. Smith, Williams, & Lefay, 2010; Weiland, Mackinlay, Hill, Gerdtz, & Jelinek, 2011). These factors highlight the disempowerment of consumers through their lack of influence in the mental health system, as policies and practices have historically been created *for* service users rather than led *by* them (Piat & Polvere, 2014). However, as a result of the consumer recovery movement, consumers now have greater influence over both their care and input into the system (Australian Health Ministers' Advisory, 2013; Piat & Polvere, 2014).

The consumer recovery movement aims to address power imbalances through advocacy, consumer leadership, and by reconceptualising mental health or distress in consumers terms rather than medical terms (Piat & Polvere, 2014). Through education, the movement further aims to address the stigma and discrimination that many consumers have experienced from some professionals, as well as the broader society (New South Wales Consumer Advisory Group Mental Health Inc, 2009; Piat & Polvere, 2014). Recovery is regarded by the consumer movement as an ongoing, nonlinear and individual process that the person is an active agent in achieving, rather than

being viewed as an objective state (Anthony, 1993; Piat & Polvere, 2014). Emphasising an individual's right to be active in their recovery process highlights that both the movement and recovery itself is underpinned by human rights, through addressing the individuals' personal, social, emotional, physical and economic needs (Piat & Polvere, 2014).

In addressing a person's holistic needs, the consumer recovery model is understood to be based upon a social model of health. The social model views a person's health and mental health as intrinsically linked to life events and social circumstances such as access to social resources, quality housing, nutrition, education, the ability to generate an income, and respectful relationships (World Health Organisation, 2018). These social determinants of health and mental health are argued to be politically influenced through social and economic policies, and the subsequent distribution of resources (Bambra, Fox, & Scott-Samuel, 2005; Brassolotto, Raphael, & Baldeo, 2014; Germov, 2014). Therefore, recovery is both concerned with, and impacted by, fairness in policies, procedures and resource distributions (Deutsch, 2006; Prilleltensky & Gonick, 1996).

In accordance with evidence that recovery-focussed, community-based care is beneficial for consumers (Harding et al., 1987a, 1987b), along with the increasing organisation of consumer-survivor advocacy groups since the 1960's, the recovery perspective began to be formally acknowledged as best practice in mental health from the early 1990's (Cromby, Harper, & Reavey, 2013; Piat & Polvere, 2014). Australia and New Zealand began reforming mental health policies and strategies towards recovery in the 1990's (Adams, Daniels, & Compagni, 2009; Commonwealth of Australia, 2009; Department of Health, 2003; Mental Health Commission of New Zealand, 2007), while England, Canada and the United States formally adopted the recovery approach in the early 2000's (Department of Health, 2001; Mental Health Commission of Canada, 2009; Piat & Polvere, 2014; SAMHSA, 2005). The World Health Organisation has also recently moved away from a wholly medical approach to mental health, towards recovery-based principles in its *Mental Health Action Plan 2013-2020* (World Health Organisation, 2013).

Following policy changes, from 2003 the Australian Government continued reforming the mental health sector by implementing structural changes to service delivery (Australian Health Ministers' Advisory, 2013). The reform has been underpinned by policies and frameworks including: the *National Mental Health Plan 2003-2008* (Department of Health, 2003); the *National Mental Health Policy 2008* (Commonwealth of Australia, 2009); the *Fourth National Mental Health Plan* (Department of Health, 2009); the *National framework for recovery-oriented mental health services* (the National Framework) (Commonwealth of Australia, 2013b); and most recently, the *Fifth National Mental Health Plan* (Australian Government Department of Health, 2017). To support the implementation of the National Policy and system reform, the *National Standards for Mental Health Services 2010* (Australian Government, 2010) provides direction for services to comply with the National Policy (Commonwealth of Australia, 2009), and meet the necessary standards of service delivery, reporting and evaluation. In addition to the National Standards, the *National Mental Health Workforce Strategy* (Australian Government Department of Health, 2011b) and associated Plan (Australian Government Department of Health, 2011a) together outline key areas for workforce development to ensure quality service delivery that is recovery-focussed, while growing and adequately supporting the workforces of the clinical and community-based mental health sectors.

Western Australia (WA) formally adopted recovery principles in 2004 with the policy *A Recovery Vision For Rehabilitation: Psychiatric Rehabilitation Policy And Strategic Framework* (Office of Mental Health, 2004). As of 2017, the WA Government is reforming the delivery of the states' mental health services through the Mental Health Commission's *Mental Health 2020* strategic plan (Government of Western Australia Mental Health Commission, nd), and the *WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025* (the Plan) (Government of Western Australia Mental Health Commission, 2015). The principles of the National Framework are embedded in the State Plan, informing the implementation of system-wide reform in WA towards recovery-oriented practice across the entire mental health service continuum (Government of Western Australia Mental Health Commission, n.d.).

The plans also emphasise the need for greater education and training programs to reduce stigma and promote the principles of recovery throughout the system, in line with the direction of the current reform. The Mental Health 2020 strategic plan draws upon the National Mental Health Workforce Strategy to guide workforce development in WA, emphasising the need to develop the current and future workforce to work within recovery principles, and build the workforce's capacity for innovation and reform. The reform includes rebalancing the mix of services to provide more access to community mental health services and supports for recovery, prevention and early intervention (Government of Western Australia Mental Health Commission, n.d.). These are important developments, as the majority of resources were previously directed towards acute-care hospital and institutional wards, and community clinics (Government of Western Australia Mental Health Commission, n.d.). This concentrated allocation of resources was argued to promote inequitable access to services, an uneven distribution of the mental health workforce, and an over-reliance on diagnosis-based rather than needs-based funding (Griffiths, Mendoza, & Carron-Arthur, 2015).

However, recent claims that the current system remains unbalanced (Western Australian Association for Mental Health, 2017a, 2017b), along with reports of individuals 'falling through the cracks' between mental health services (Griffiths et al., 2015; Hickie et al., 2014), and consumers reporting that they have not received recovery-driven services (Byrne, Happell, & Reid-Searl, 2016; K. Davies & Gray, 2015), suggest that reform may not be advancing as fast as necessary (Australasian College for Emergency Medicine, 2018; Byrne, Happell, & Reid-Searl, 2015; Griffiths et al., 2015; National Mental Health Commission, 2014a, 2014b; New South Wales Consumer Advisory Group Mental Health Inc, 2009; A. Taylor, 2017; Western Australian Association for Mental Health, 2017a, 2017b). Hence, former Commissioner of the Australian Mental Health Commission and psychiatrist, Professor Ian Hickie et al. (2014) highlighted that it is necessary "to identify those factors that are likely to be transformative and overcome many of the organisational, financial and professional barriers that have interfered with previous attempts to deliver better outcomes" (p. 446).

Reported barriers to system reform and enacting recovery practices at the workforce level include that some staff may not respect consumers rights and choices, maintaining paternalistic and coercive practices through the exertion of 'expert' status (New South Wales Consumer Advisory Group Mental Health Inc, 2009). Staff not receiving appropriate recovery training, and a lack of clearly articulated recovery-oriented outcomes have also been identified as potential issues impacting reform (Anthony, Rogers, & Farkas, 2003; New South Wales Consumer Advisory Group Mental Health Inc, 2009). Consequently, research evidence suggests many staff may have deficiencies in knowledge about consumer recovery, and/or may have a different perspective of what recovery means, or may assume they already work within the recovery paradigm (Anthony, 1993; New South Wales Consumer Advisory Group Mental Health Inc, 2009).

System-level barriers to reform have also been argued to be due to differences in the definition, values and concept of recovery between disciplines; meaning that recovery may be delivered from an 'expert' point of view that is grounded in the clinical model, or from the consumer point of view, or from a varied mix of both perspectives (Anthony et al., 2003; Brassolotto et al., 2014; Byrne et al., 2015, 2016; K. Davies & Gray, 2015; New South Wales Consumer Advisory Group Mental Health Inc, 2009). The characteristics of the clinical model of recovery have also been identified as a barrier to reform as the underpinning assumptions, values, practices and deficit-focussed discourses can act in tensions with the strengths-focussed consumer recovery model (Anthony et al., 2003; Byrne et al., 2016; K. Davies & Gray, 2015; New South Wales Consumer Advisory Group Mental Health Inc, 2009). Lastly, Brassolotto et al. (2014) and Piat and Polvere (2014) argue that transformational systems change requires leadership from consumers as well as professionals who underpin their practices with consumer recovery principles, which Byrne et al. (2015), Byrne et al. (2016) and Davies and Gray (2015) argue is not currently occurring in Australia.

1.1 Purpose of the research

Consistent with Hickie et al's (2014) assertion that "the challenge now is to identify those factors that are likely to be transformative and overcome many of the organisational, financial and

professional barriers that have interfered with previous attempts to deliver better outcomes" (p 446), this research aimed to identify potential transformational change factors for promoting the shift to the recovery paradigm in mental health in WA. As medical practitioners including General Practitioners and Emergency Department doctors are among the first lines of care encountered by many service users, it was deemed important to understand how undergraduate medical training in mental health aligns with current policy directions towards recovery, as well as to understand students' conceptualisations of mental distress and their application of their learnings. The research further aimed to explore students' perceptions about the discipline of psychiatry, to identify whether there are other factors that may be influencing students' interactions with consumers, and the recruitment of medical students into psychiatry in the WA context.

1.2 Structure of the thesis

In this thesis, I begin with a review of the literature that discusses the context of the consumer recovery paradigm that currently underpins mental health policies and strategies to provide the background for why the study was necessary. I then examine how the history of psychiatry and the recovery movement have established the current methods of care in mental health, and examine the conflict between the biomedical and consumer recovery paradigm knowledges operating within the sector. Here, I discuss how the conflict between these two paradigms can potentially create problems for consumers and pose challenges for health professionals, as well as challenges for the transformation of the system itself. In light of these knowledge conflicts and the challenges they pose, an overview of the impacts on consumers' recovery and care is provided, as discussed recently by WA consumers. Furthermore, I establish the arguments for changes in mental health curricula through outlining how mental health education is developing in multiple contexts, while discussing the current issues influencing medical students' learning experiences in psychiatry, and desires to specialise in the field. Given the arguments made throughout the literature review, I conclude the section by articulating the research questions and the specific aims of the project.

The second chapter provides a rationale and guide for the research methodology and the qualitative paradigm chosen to undertake the study, as well as a rationale for conducting the research with medical students. I also discuss why I collected data using focus groups and interviews, examine my personal researcher positioning, and how I ensured scientific rigour in the findings and interpretations. An introduction to the School of Medicine, Fremantle along with an overview of its mental health curriculum finally provides the background for the participants, leading into the findings.

Within the Findings and Interpretations chapter, I discuss in depth the two overarching themes, named *Preparedness* and '*Just' Treatment and Care*. These themes were developed as multiple factors were identified that affected the students' preparedness for both rotations and future practice, having the potential to impact the care and treatment given to consumers. *Preparedness* consisted of two sub-themes; *Connections*; and *Impacts upon Learning*; both of which were developed due to both connections and pressure having an impact upon the participant's learning, and therefore, their levels of preparedness. Issues such as connecting to the biomedical model primarily, the concentration on pharmacological treatments, and not having an understanding of the history and theory of either psychiatry or the consumer recovery paradigm, were examined in relation to how these issues were found to affect connections with the humanity in consumers, or the humanness of the issues that can promote a person's distress.

Further, the impacts of pressure on the students' learning and wellbeing, as well as the impacts of being time poor are discussed alongside the potential effects on students' understanding, and the issues that may arise for future consumers as a result of the participant's potential limitations. This includes a discussion of the students' calls for both more learning content and time to learn in psychiatry in order to be able to have a greater understanding of distress, and provide fair and appropriate care and treatment to consumers. The second theme, *'Just' treatment and care* further unpacks the students' experiences of, and at times unconscious or unintentional repetition of, stigmatising discourses and practices towards consumers, as well as the stigmatising attitudes

towards psychiatry and psychiatrists. The theme also outlines some systemic and institutional practices that may influence the care and treatment that consumers often experience, consequently indicating additional challenges for medical students' education as well as systemic barriers to reform.

Exemplar quotes are provided throughout the findings and interpretations section, demonstrating the themes and issues linking to the literature, while helping to address the research aims and answer the research questions. I conclude the thesis in the discussion section by summarising the main findings and answering the research questions. Here, I discuss the transformational change factors identified for both the education of medical students in mental health; outline limitations of the research; and provide recommendations for potential future research and development.

2. Literature Review

Introduction

The Western Australian mental health system is structured in accordance with national approaches, consisting of hospital and community bed-based services, community treatment and support services, and prevention efforts (Government of Western Australia Mental Health Commission, 2015). As such, the system comprises clinical services provided by mental health professionals including doctors, psychiatrists, psychologists, nurses and other allied health professionals, as well as community-based services provided by mental health and peer and community support workers. The Western Australian Mental Health Commission's *Mental Health 2020* strategic plan (the WA Plan) (Government of Western Australia Mental Health Commission, n.d.) aimed to incorporate the principles of recovery into the design of services, practices and procedures by the end of 2017 (Government of Western Australia Mental Health Commission, 2015).

The *National Mental Health Policy 2008* (Commonwealth of Australia, 2009), *Fifth National Mental Health and Suicide Prevention Plan* (Australian Government Department of Health, 2017) and the WA Plan require that professionals and services are person-centred, ensuring service users have freedom and choice in the services they receive, and to be able to self-determine their recovery plans and goals (Australian Government Department of Health, 2017; Commonwealth of Australia, 2013a, 2013b; Government of Western Australia Mental Health Commission, 2015). The policies emphasise person-centeredness due to being underpinned by the National Framework for Recovery-oriented Mental Health Services (the National Framework) (Commonwealth of Australia, 2013a, 2013b), which view recovery in consumers' terms rather than in clinical terms (Commonwealth of Australia, 2013b). This is an important point, as the different perspectives of recovery reflect the manner in which recovery is practiced by professionals, ultimately affecting an individual's recovery outcomes.

2.1 Definitions and perspectives of recovery

Recovery is acknowledged to be a highly personal concept and process that is different for every person depending upon their circumstances and goals, often involving learning and striving for a meaningful life with or without symptoms (Anthony, 1993; Consumers of Mental Health Western Australia, 2016). As such, each country, culture and stakeholder define recovery according to certain knowledge bases, values and goals. For example, as demonstrated in Table 1, the consumer definition views recovery as a personal process, emphasising personal empowerment and the consumer's perspective in achieving new meaning and purpose, while valuing diagnosis and reduction of symptoms less. In comparison, the psychiatric (clinical) perspective acknowledges consumer empowerment and self-determination in documents (Royal Australian New Zealand College of Psychiatrists, 2016b), but avoids such an acknowledgment in the definition, which instead emphasises treatments, interventions and the measurement of an individual's outcomes. Overall, the different definitions across nations including Australia, New Zealand, Canada, England and the United States value and promote the personal process of creating a meaningful life through self-determination and participation in the presence or absence of symptoms (Piat & Polvere, 2014). Table 1 provides an overview of the definitions of recovery from key stakeholders in Australia[1].

Table 1

Varying definitions of recovery from different stakeholders in mental health in Australia and Western Australia.

Stakeholder	Recovery definition
Academia	"..a personal process of rediscovering a new sense of identity, self-determination, and empowerment to live, participate, and contribute to the community" (Nelson, Kloos, & Ornelas, 2014, p. 6)
	"deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a

[1] A definition for recovery in mental health could not be located on the Australian Medical Association or Australian Medical Council's websites; the AMA's position statement on mental health in 2018 (available at https://ama.com.au/position-statement/mental-health-2018) only mentions recovery-focus in relation to workforce development.

	way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (Anthony, 1993, p. 13).
National framework for recovery-oriented mental health services (Commonwealth of Australia, 2013a, p. 40); *Western Australian Mental Health, Alcohol and Other Drugs Services Plan 2015-2025* (Government of Western Australia Mental Health Commission, 2015); *Fifth National Mental Health Plan* (Australian Government Department of Health, 2017)	"being able to create and live a meaningful and contributing life in a community of choice with or without the presence of a mental health issue" "a unique and personal journey; a normal human process; an ongoing experience and not the same as an end point or cure; a journey rarely taken alone; and nonlinear, with it being frequently interspersed with both achievement and setbacks"
Consumers of Mental Health Western Australia (2016, paragraph 1)	"A personal process of attaining a life that is meaningful, empowered and fulfilling from the person's own perspective, irrespective of diagnosis and/or symptoms"
Psychiatry (Royal Australian New Zealand College of Psychiatrists, 2016b)	'looking beyond clinical recovery, and measuring the effectiveness of treatments and interventions in terms of the impact of these on the things that matter to individuals as they try to find new meaning and purpose in their lives' (p. 2)

Note. These definitions were selected due to being the most relevant to the research, current policy, as well as the underpinning lenses that guide my research and practice; Anthony (1993) is a preeminent source in academic literature and Government documents; Nelson, Kloos and Ornelas (2014) is based in Community Psychology which underpins Behavioural Science, and is the perspective that this research is based within.

While there is slight differentiation between nations, the largest differences in concepts of recovery occur between the consumer and clinical perspectives. The differences between these perspectives are that the consumer recovery concept (also known as personal recovery or consumer/survivor recovery) harnesses the individuals' strengths, values self-determination and encourages empowerment and self-efficacy rather than focussing on personal problems and the need for diagnosis (New South Wales Consumer Advisory Group Mental Health Inc, 2009; Piat & Polvere, 2014). Further, the consumer recovery approach does not seek to 'cure' individuals, because if an individual is not and may never be, symptom-free, this can be seen as a failure on the individual's part, which they may be blamed for (victim-blaming) (Germov, 2014; Salmon & Hall,

2003). Instead, the consumer recovery perspective views the alleviation of symptoms as important, but as just one aspect of recovery, not the sole aim or focus (Davidson & Roe, 2007).

Conversely, the clinical concept of recovery that has historically underpinned medical and psychiatric approaches focuses on the alleviation and prevention of symptoms, and restoring an individual's functioning to the 'pre-illness state' (Farkas, Gagne, Anthony, & Chamberlin, 2005; Piat & Polvere, 2014). Therefore, it has been argued that the clinical perspective conceptualises recovery as a return to the pre-illness state, rather than an ongoing personal process consisting of varying levels of functioning at different times (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005; New South Wales Consumer Advisory Group Mental Health Inc, 2009; Piat & Polvere, 2014). A major issue with recovery being conceptualised as an objective return to the pre-illness state is that a relapse in symptoms may be positioned as the individual's 'poor adherence' to treatments (Barley, Pope, Chilvers, Sipos, & Harrison, 2008; Germov, 2014; Seale, Chaplin, Lelliott, & Quirk, 2006). This places the blame for the relapse on the individual, rather than exploring other contextual circumstances that may have promoted a setback in recovery or the person's decision to cease certain treatments such as medications (Germov, 2014; Kazadi, Moosa, & Jeenah, 2008; New South Wales Consumer Advisory Group Mental Health Inc, 2009).

Such victim-blaming often underscores a focus on an individual's deficits in the clinical/biomedical model, which may therefore be incompatible with the strengths-focussed consumer recovery perspective (New South Wales Consumer Advisory Group Mental Health Inc, 2009). Additionally, medical professionals within the system may believe they operate within the bounds of the recovery perspective because of the focus on recovering from symptoms, yet research has highlighted that this is not always the consumers' understanding, expectation or experience of what the recovery approach is or should be delivering (K. Davies & Gray, 2015; Hungerford & Fox, 2014; New South Wales Consumer Advisory Group Mental Health Inc, 2009). Research conducted by Byrne et al. (2015, 2016) highlighted that lived experience practitioners perceived some medical professionals' level of understanding about the consumer perspective as inadequate, which

negatively impacted the delivery of recovery-oriented services. Additionally, Byrne et al. (2015, 2016) argued that some professionals' resistance to operating within the consumer paradigm was a barrier to providing appropriate services, and that more opportunities for education and training in recovery as well as professionals' acceptance of the consumer paradigm is necessary to promote system reform.

Anthony, Rogers and Farkas (2003) further argued that the clinical recovery model was not developed in consultation with the consumer recovery perspective and its evidence; therefore, the clinical model may operate in isolation or opposition to consumers' perspectives and needs, a point which has been supported by consumer statements (Byrne et al., 2015, 2016; K. Davies & Gray, 2015; New South Wales Consumer Advisory Group Mental Health Inc, 2009). Due to such evidence that the consumer and clinical models can operate antagonistically, as well as arguments that some professionals' adherence to the medical model can inhibit the delivery of recovery-focussed services, there appears a need to question and more fully understand the elements for genuine transformational change in the mental health system.

2.2 Transformational change and the paradigm shift towards the consumer recovery perspective

Piat and Polvere (2014) highlight that a paradigm shift in the mental health system towards the consumer recovery perspective requires transformational approaches, rather than only constructing ameliorative programs and policies that do not fundamentally alter the way the system operates. Ameliorative ('first-order') change encompasses programs or measures that occur within an existing system, however the values and structures underpinning the system remain unchanged (Piat & Polvere, 2014). Conversely, transformational change ('second-order' change) occurs when issues of power imbalances, consumer leadership, and structural and systemic obstructions are addressed, and the inherent values and philosophies of the system are transformed (Piat & Polvere, 2014). However, a consumer in Davies and Gray's (2015) recent study from New South Wales claimed "they're trying to fit the philosophy of recovery into current practice… and I think it's that whole… medical model dominance that's sort of making that a bit more challenging." (p 55). This

means the current state of the Australian system may still be largely directed towards medical knowledge and practices rather than consumers perspectives. Therefore, if the mental health system is still operating predominantly under clinical conceptions of recovery and with the medical model's philosophy and assumptions about mental distress, this may promote a barrier to transformational change, leaving the status quo of power largely unchanged.

The transformational change approach can shift power imbalances between consumers and other stakeholders, such as practitioners, government departments and policy makers, by harnessing consumers as key drivers of reform (Piat & Polvere, 2014). As such, consumers actively *lead* policy construction and the process of changing systems and procedures, rather than being merely consulted about changes (Piat & Polvere, 2014). Additionally, involving consumers within the system as educators, lived experience workers, advocates and supporters further promotes transformational change (Byrne, Happell, Welch, & Moxham, 2013; Gordon, Ellis, Gallagher, & Purdie, 2014; Piat & Polvere, 2014). In this way, the philosophy of the system is reoriented towards the perspective of the very people who the system is directed towards, rather than being oriented towards a certain way of operating, or in favour of the professionals working within it. Such transformational change may require a form of 'decolonising' of the language, knowledges and approaches to mental health and distress from traditional medical perspectives to consumer perspectives (Mills, 2014).

Decolonisation is a term used in cultural studies, meaning to deconstruct the ideologies, values and motives that underpin a system that has harmful impacts on Indigenous groups (L. Smith, 2012; Walker, Schultz, & Sonn, 2014). Analysing a certain issue through a decolonised lens can reveal how minority groups are represented by the dominant group and then blamed for their unjust circumstances, as well as expose the knowledges that underpin the systems and processes that the group may be subjected to (L. Smith, 2012). For example, mental health consumers have historically been positioned as being incapable of making decisions about their own future, yet at the same time may be blamed for unjust living conditions through the assumption that the individual may 'choose'

to live that way. The assumption that individuals who have a mental health issue may be incapable stems from historical practices of institutionalisation, which was argued to actually promote madness and learned helplessness in consumers rather than rehabilitate them (Beers, 1934; Stanton & Schwartz, 1954). However, decolonisation also has an action agenda through highlighting and addressing unjust social circumstances and transforming power relations by privileging the knowledges and processes of the disadvantaged group rather than that of the dominant majority or authority (L. Smith, 2012; Walker et al., 2014). The consumer recovery paradigm therefore may be understood as a decolonising paradigm in mental health, as recovery also seeks to expose and address unjust practices that impact consumers lives and relocate power with the consumer through harnessing their knowledge, perspectives, and empowering both their voices and choices.

Mills (2014), Fay (2018) and Summerfield (2008) have proposed that western psychiatric approaches to mental health have 'colonised' concepts of distress in many non-western countries, imposing terms, diagnoses and classification that do not reflect the local people's understandings, experiences or the meaning people ascribe to their experiences. Therefore, it may be argued that psychiatric terms, diagnoses and classifications are having a similar impact in western countries by not privileging the knowledges of those with lived cultural experience of a mental health issue. In relation to mental health, decolonisation would refer to privileging the knowledges and perspectives of people with lived experience of distress, as well as reconceptualising forms of distress in consumers' terms rather than in psychiatric language that may not make sense to the consumer or explain their experiences (Kinderman, 2017; Kinderman, Read, Moncrieff, & Bentall, 2013; Summerfield, 2008). Privileging consumers' terms and perspectives over and above psychiatric perspectives may also enable individuals to regain control over the social representations of their capability and identity (Fay, 2018).

The next sections aim to provide a historical and contextual background, to explain how the psychiatric approach has become dominant in mental health, along with how the consumer recovery

movement developed, why it is important, and why it is currently considered best practice in mental health.

2.3 The history of psychiatry and development of the consumer recovery movement

Psychiatry's modern history spans at least the previous two hundred and fifty years (Shorter, 1997). Although multiple methods have been used for helping some individuals, such as foster care (Hochmann, 2017), or integration back into the community (Fauvel, 2015), asylums became the dominant method for 'treating' people with mental health issues. Throughout the 1800's, the asylum method brought 'colonial psychiatry' to colonies of the British Empire and the United States, growing the mental health industry along with its assets and rapidly increasing workforce (Farquharson, 2017; Shorter, 1997; Swartz, 2010). In Australia, distressed individuals were placed into prisons until asylums were established in the early 1800's in Sydney, Melbourne, Brisbane, Adelaide, Fremantle and various locations across Tasmania (Kirkby, 1999; Skerritt et al., 2001). However, the institutions were also used to preserve public order by becoming places to accommodate disadvantaged or homeless people, or those charged with criminal offences (Foucault et al., 2006; Kirkby, 1999). Foucault et al. (2006) argued that this evolution of the purpose of the asylum enabled the individuals placed within them to all be viewed by the dominant majority as 'insane' or 'abnormal' and needing segregation from the community.

As medically-trained doctors had generally operated asylums, they largely managed the growing numbers of facilities, providing the space and opportunity for specialising their skills (Lieberman, 2016; Shorter, 1997). Psychiatry, meaning 'medical treatment of the soul' (Lieberman, 2016, p. 26), was subsequently established by practitioners as a genuine medical discipline during the 1800's, as they provided care and treatments aimed towards the recovery of people's general daily functioning – a practice known as 'moral treatment' (Davidson, Rakfeldt, & Strauss, 2010; Mauger, 2012). Hence, the asylums were dubbed 'therapeutic asylums' and psychiatrists who managed them were referred to as 'alienists', from the French, aliéné, meaning insane (Lieberman, 2016; Shorter, 1997). Psychiatry had been dominated by different perspectives at various times in

different countries, often shifting between psychological-environmental explanations, to moral and spiritual explanations, and biological assumptions (Decker, 2016; Shorter, 1997). Consequently, some psychiatrists began to turn to biological science and theories to explore the brains of deceased asylum occupants, in an attempt to explain psychological phenomena (Decker, 2016). While biological evidence was found for some conditions that are now known as Parkinson's disease and Alzheimer's disease, identifiable differences in the brains of people who had symptoms of severe sadness, distress or psychosis were not found during that early time (Shorter, 1997).

Also around the late 1800's, Freud's psychodynamic theory was said to interrupt the dominance of biological psychiatry at the time (Shorter, 1997), gaining increasing interest in Europe (Lieberman, 2016) and later into the United States from the early 1900's (Hoffman, 2010). Freud devised a psychological therapy known as psychoanalysis, which provided psychiatrists with a means of operating outside of asylums through establishing lucrative private practices in providing therapy to wealthy individuals (Shorter, 1997). However, psychodynamic theory was critiqued regarding the more controversial aspects such as childhood sexuality (Hoffman, 2010; Shorter, 1997), and its scientific validity has also been critiqued given that it is difficult, if not impossible, to test its assumptions empirically (Grünbaum, 1984).

By the pre-World War II period, psychiatry was again attracting critique being that biological evidence for distress symptoms remained elusive and Freud's theory remained scientifically unsupported (Lieberman, 2016). Psychiatry was also widely critiqued by other medical professionals and disciplines due to not having clear, universally defined systems for classifying and diagnosing distress, unlike other medical specialties (Lieberman, 2016). Prior to the 1950's, different practitioners and asylums used their own diagnostic classification systems, meaning there was no universal, definitive method for classifying or diagnosing forms of distress as there was for physical ailments in other medical disciplines (Shorter, 1997). European psychiatrist, Emil Kraeplin had published a classification system in the late 1800's, underpinned by the assumption that mental 'disorders' resulted from of an inherited brain disease (Pilgrim, 2007). Kraeplin's foundational work

spread through Europe and the UK, and is evident within the current *International Statistical Classification of Diseases* (ICD). To address the lack of uniformity of classification and diagnosis across the USA, the American Psychiatric Association commissioned the development of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), similar to the ICD, first published in 1952 (Lieberman, 2016; Shorter, 1997).

The first DSM contained around 106 'disorders', relying heavily upon psychoanalytic descriptions of behaviours or emotions due to the absence of biological evidence (Lieberman, 2016; Sanders, 2011; Shorter, 1997). The DSM has since been revised multiple times, with the DSM-III (1980) and DSM-IV (1994)(American Psychiatric Association, 2018) argued to respond to the growing critiques regarding the epistemic crisis in psychiatry, by aligning diagnoses and approaches with a more positivist scientific methodological approach utilised in medicine (Kinderman, Allsopp, & Cooke, 2017; Sanders, 2011; Whitaker, 2017). The use of the DSM has grown significantly and is now used widely across psychiatric and medical disciplines globally, as has the growth in the number of classified disorders, to approximately 297 in the DSM-IV (American Psychiatric Association, 2018). Cooper (2018) argued that the number of disorders in the latest DSM-5 has remained largely unchanged (American Psychiatric Association, 2015). However, Black and Grant (2014) claim there are only 157 diagnoses in DSM-5 (p xxiii), while Davies (2017) had calculated 374 diagnosable disorders. Furthermore, the increased numbers of diagnoses as well as the decrease in diagnostic thresholds in DSM-5 have widely attracted criticisms even from within the profession itself, with some professionals claiming that psychiatry was over-medicalising people's understandable human reactions to distressing circumstances (J. Davies, 2017; Frances, 2013; Summerfield, 2008).

Diagnostic systems used in psychiatry, from psychoanalysis to the DSM have also been scrutinised due to the legitimacy of the knowledge bases and diagnostic classifications being widely challenged (Bracken et al., 2012; Critical Psychiatry Network, 2013; Johnstone, 2013; Lieberman, 2016), as well as for having questionable reliability and validity as some practitioners may diagnose differently even if using the same manual (Insel, 2013; Kirk & Kutchins, 1994; Moncrieff &

Middleton, 2015; Rosenhan, 1973; Timimi, 2014), and also for lacking connections to the many and varied human experiences that can promote distress (Kinderman et al., 2013). Additionally, rather than being developed purely in response to scientific evidence, psychiatric diagnoses have been routinely reviewed in response to changing political, social, and economic contexts (Foucault et al., 2006; Kinderman et al., 2017; Lieberman, 2016; Szaz, 2006). This means that disorders can, and have, been classified at one point in history, then later declassified. For example, homosexuality was removed from the *DSM-III* in 1973 following the civil rights movements and the subsequent decriminalisation of homosexuality in the United States and England in the late 1960's (Kinderman et al., 2017). In this example, homosexuality did not change, yet the social acceptance of it did and consequently, the following version of the DSM was altered to reflect this social shift in what was then considered 'normal' and 'acceptable' behaviour. Such changes mean that psychiatric diagnostic manuals also have both social and political functions and likewise are revised in response to changing social norms (Pilgrim, 2007; Sanders, 2011; Timimi, 2014).

Around the same time as the publication of the first DSM, decisions were made to close asylums across the US, UK and Europe in the 1950's as a result of the many growing criticisms about asylums and psychiatric practices (Davidson et al., 2010; Lieberman, 2016). Australia and New Zealand began to close asylums from the 1960's (MacKinnon & Coleborne, 2003) and Australia accelerated the closure of most asylums in the 1990's in favour of community mental health models in response to the first *National Mental Health Plan* in 1992 (Government of Western Australia Mental Health Commission, 2015). Within Australia, deinstitutionalisation has taken some time, and one institution still remains open in Western Australia in 2019; although its staged closure has been planned for some time, it is proposed to be concluded by 2025 (Government of Western Australia Mental Health Commission, 2015).

Deinstitutionalisation was assisted by the use of psychiatric medications during the 1950's, particularly of sedatives that were developed into 'antipsychotics' (Davidson et al., 2010; Lieberman, 2016). The long-lasting sedative effects of the substances made it possible for consumers to live in

the community (Davidson et al., 2010), due to the drug's reported ability to reduce distress (Moncrieff, 2017). Yet just a few years after the drugs began to be more widely used, physical side effects including shaking (Parkinsonism) and jerking (tardive dyskinesia) were reported (Ayd, 1961), leading to increasing and continued critique regarding psychiatry's use of the drugs as treatments (Breggin, 2017; J. Davies, 2017; Gotzsche, 2017; Moncrieff, 2017; Whitaker, 2017).

In addition, Moncrieff (2017) claims that the development and increased use of psychiatric drugs during the mid-1900's further promoted the enduring assumptions of the biological perspective, that underlying biological anomalies – chemical imbalances in the brain - were responsible for people's distress (Moncrieff, 2017). Moncrieff (2017) further argued that such assumptions have led to the promotion of psychiatric drugs as 'chemical cures' for mental distress, as the drugs alter the neurobiological processes that are assumed to be the cause of some major distress symptoms. However, psychiatric medications are also reported to have significant side effects that can promote other potentially disabling conditions such as Type II Diabetes or severe cognitive impairment (Breggin, 2017; Gotzsche, 2017; Moncrieff, 2006, 2017; Moncrieff, Cohen, & Mason, 2009; K. Smith, 2016). As such, it has been found that some consumers feel the medications help with reducing some symptoms, but often at the cost of side effects (Moncrieff et al., 2009; Morrison, Meehan, & Stomski, 2015; Salomon & Hamilton, 2013; Vilhelmsson et al., 2012). Whereas, others have reported feeling no difference with medication use (Morrison et al., 2015), or feeling disconnected from reality because of the drugs (Morrison et al., 2015; Vilhelmsson et al., 2012).

Psychiatry has been further critiqued even from within the profession, as psychiatrists such as Szasz (1970, 1974) have condemned the practices of involuntary or coercive treatments with medications that underscore psychiatry's role in social control through detaining people in asylums and restraining individuals whose behaviour could not be controlled. Such arguments led to many changes to mental health laws in the United States that greater enabled consumers' rights and freedoms (Williams & Caplan, 2012), however, Szasz was criticised for denying that 'mental illness' existed at all (Buchanan-Barker, 2009; Richards, 2014). Denying a person's lived experience of

distress has been argued as unhelpful as it has the potential for, and at times the effect of, some people not seeking or obtaining the treatments and help that would help them to recover (Buchanan-Barker, 2009; Richards, 2014; Williams & Caplan, 2012). However, other writers (such as Buchanan-Barker, 2009) argue Szasz's positions were misinterpreted and misrepresented, as Szasz had acknowledged that psychological distress was real, yet contended that the psychiatric categories which labelled such experiences as 'illnesses' were flawed, and therefore, a myth.

Szasz (1970, 1974) also debated that psychiatric diagnoses were subjective and dependent upon social norms that changed over time, meaning that diagnoses often reflected what was seen to be 'abnormal' or 'deviant' behaviour, rather than on scientifically valid methods of disease classification; arguments that have been reinforced by multiple practitioners, professional organisations, and authors (Cooke & Kinderman, 2018; Critical Psychiatry Network, 2013; Dowrick & Frances, 2013; Frances, 2013; Insel, 2013; Kinderman, 2005; Kinderman et al., 2013; Moncrieff & Middleton, 2015; Rapley, Moncrieff, & Dillon, 2011; Rosenhan, 1975; The British Psychological Society, 2011; Timimi, 2014). Moreover, Jablensky (2012) recently outlined that psychiatric diagnoses are not true 'diseases', but rather concepts created based upon people's behaviours and outcomes in order to guide clinical practice. Jablensky (2012) further argued that once a psychiatric concept becomes widely accepted and utilised, the term's validity is no longer questioned, particularly when official classification manuals provide operational definitions of the constructs. Hence, psychiatric diagnostic categories can become reified 'things' that are assumed to be actual disease entities.

The many and enduring critiques of psychiatry throughout the 1900's, including Goffman's (1961) book *Asylums*, Szasz's (1974) *The Myth of Mental Illness*, as well as Foucault's (1967) *Madness and Civilisation* promoted the development of an 'antipsychiatry' movement, which gained momentum and popularity during the civil rights movements in the 1970's (Shorter, 1997). Szasz (2008) argued that rather than denying people's legitimate experiences of distress, antipsychiatry critiqued psychiatry's *constructions* of 'mental illness', as well as psychiatrists' roles in the asylum,

and the use of unjust and inhumane treatments. Adding to Szasz's contentions with the profession, current psychiatrists who position themselves as 'critical' psychiatrists challenge the power, practices, epistemology and assumptions of the profession from within. Critical psychiatry currently aims to develop the integrity and scientific rigour of the profession, thereby facilitating better outcomes for service users (Bracken & Thomas, 2010; Middleton, 2007; P. Thomas & Bracken, 2004). Additionally, critical psychiatry as a movement challenges abuses of power, and the hegemony of a purely biomedical approach to distress, acknowledging that no singular perspective can provide, on its own, a comprehensive understanding and approach to mental distress (Middleton, 2007). Critical psychiatrists have called for consumer-led practices and services that holistically encompass neurobiological, psychological, social, political and spiritual aspects which do not violate human rights or promote further disability and disempowerment (Bracken et al., 2012; Middleton, 2007). As such, critical psychiatry scholars and practitioners claim that the perspective will expediate the incorporation of the recovery paradigm into psychiatry due to having similar values and critiques of traditional psychiatric practices and assumptions (Quadrio, Middleton, Banerjee, & Jureidini, 2014).

Drawing on the antipsychiatry movement and the 1970's civil rights movements for people of colour, women, and the LGBTQI+ community, the consumer recovery movement in mental health was led by service users who challenged the mental health system in response to the unfair practices also critiqued by anti-psychiatry and later by critical psychiatry (Davidson et al., 2010). The modern recovery movement and deinstitutionalisation signalled the re-empowerment of individuals towards reclaiming the direction of their lives and treatments (Davidson et al., 2010). The movement also draws on Adolf Myer's earlier model of care that demonstrated people can and do recover regardless of the existence of symptoms, as Myer recognised that social circumstances could promote distress, and he therefore addressed those issues to promote people's recovery (Davidson et al., 2010).

In addition, Basaglia's transformational model of community care in Italy promoted individual's freedom, autonomy, social inclusion and participation, and demonstrated that severely

distressed individuals can and do recover and live meaningful lives when appropriately supported (Davidson et al., 2010). In the modern context, community mental health (CMH) organisations provide recovery supports akin to Basaglia's model to consumers with moderate to severe functional challenges, and may also provide information and education to support families (Bateman & Smith, 2011). Services provided by CMH consist of, but may not be limited to: peer support, psychological therapies, advocacy and outreach services, family and/or carer support and respite, health care, leisure and recreational engagement, accommodation, as well as employment, education and training, and advocacy (Bateman & Smith, 2011; K. Davies & Gray, 2015). As such, the services provided by CMH address consumers' social determinants of health (SDOH) and wellbeing, which effectively involve individuals having access to essential community resources such as healthcare, employment and financial support, education and accommodation, as well as social justice in order to live a healthy, meaningful, and contributing life (World Health Organisation, 2018).

CMH services operate from the consumer perspective of recovery, working to harness the individual's strengths and promote self-determination (Bateman & Smith, 2011; Hungerford, Hungerford, Fox, & Cleary, 2016; J. Taylor, Jones, O'Reilly, Oldfield, & Blackburn, 2010). CMH organisations have therefore been recognised as being very beneficial for individual's recovery (J. Taylor et al., 2010). Yet despite having a history in Australia of over 100 years, Bateman and Smith (2011) argue the role of CMH is poorly understood by those outside the sector, as many health professionals, consumers and family or caregivers do not fully understand what CMH services can provide. This assertion is supported by research conducted by Byrne et al. (2016) and Hungerford et al. (2016) which highlighted that some clinicians lacked an understanding of the roles and services that CMH organisations and community/lived experience workers provided for consumers.

As well as being effective in promoting recovery, the CMH sector is argued to be a more cost-effective manner of service delivery compared with institutional care, and reduces the reliance upon, and need for institutional care (Bateman & Smith, 2011; J. Taylor et al., 2010). However, funding for services is still largely provided based upon diagnosis rather than the consumers' needs,

highlighting the continued dominance of the clinical model within CMH spaces (K. Davies & Gray, 2015). Additionally, consumers interviewed in a study by Hungerford and Fox (2014) outlined that following the redesign and restructure of services in the Australian Capital Territory, services that once provided holistic care were now split between clinical services and CMH services. Participants in the study felt that due to the changes, the dominance of the biomedical model had been strengthened as health professionals no longer needed to address psychological and social aspects (Hungerford & Fox, 2014). Therefore, although CMH services mostly operate within the consumer model, there is still evidence that suggests the mental health system and broader social support systems may retain clinical terms and practices that can be at odds with the consumer recovery paradigm, due to having to operate within the broader social and health services systems. This highlights that there are currently some problems with implementing the recovery-oriented services mandated by Government policies.

2.4 Issues within the current state of recovery-oriented service delivery: Deficits in consumer power

The Western Australian Statewide Suicide Prevention Network conducted a consumer workshop in February 2018, whereby participants reported issues of gatekeeping that prevented access to services due to individuals not being classified as 'sick enough'. Griffiths et al. (2015) argued that denying care due to an individual not being perceived as in crisis was the result of the concentration of mental health funding to acute care facilities such as hospital wards. Consumers in the workshop also highlighted not receiving referrals from clinicians for appropriate services that the individual identified they needed, or not receiving referrals for psychological or other services at all after being discharged from hospital (WA Statewide Suicide Prevention Network, 2018). Emphasising that, the participants discussed recovery-oriented service delivery problems such as the lack of recovery planning and/or planning for supports after being discharged from a facility (discharge planning), as well as not having input into decision making about their recovery (WA Statewide Suicide Prevention Network, 2018).

Similarly, the Chief Psychiatrist of Western Australia (2016) reported that many formulations completed by ED doctors lacked an assessment of an individual's protective factors that may prevent their re-presentation to the ED. This means that many ED doctors in WA may not be looking into a person's circumstances to identify factors that may help them to recover and prevent further distress (Chief Psychiatrist of Western Australia, 2016). Based on these findings, there appears to be a lack of recovery planning from WA ED's for a person's discharge. This means that doctors in the ED may not be aware of the need for recovery planning or how to do it, and therefore may not have knowledge of the recovery model. Some clinicians' self-reported lack of knowledge and education in mental health has been identified as a barrier to providing appropriate recovery-oriented care within medical spaces such as emergency departments and hospital wards (Jelinek, Weiland, Mackinlay, Gerdtz, & Hill, 2013; Marynowski-Traczyk, Moxham, & Broadbent, 2013; Weiland et al., 2011). Therefore, these points reinforce the argument that many clinical staff may still need greater education in the consumer recovery model (Byrne et al., 2015; Hungerford & Fox, 2014).

The experiences highlighted by consumers in the WA workshop are consistent with the WA-based *Bring Your Voice* forum conducted earlier by Consumers of Mental Health Western Australia (2017). Participants in both the forum and workshop reported stigmatising attitudes within services, which were described as some health professionals having dismissive and prejudicial attitudes towards consumers as well as staff using inappropriate language that promoted isolation and stigma (Consumers of Mental Health Western Australia, 2017; WA Statewide Suicide Prevention Network, 2018). Isolating language may include using terms such as 'commit suicide' when an individual attempts to take their own life, which has been considered inappropriate given suicide is no longer a crime (Beaton, Forster, & Maple, 2013), or terms such as 'crazy' or 'strange' which are stigmatising (Rose, Thornicroft, Pinfold, & Kassam, 2007).

Furthermore, the workshop and forum findings outlined that current key issues regarding stigma included that consumers had experienced being ignored by health professionals in hospital settings due to having a mental health, rather than physical health issue (Consumers of Mental

Health Western Australia, 2017; WA Statewide Suicide Prevention Network, 2018). In addition, the WA forum reported that some consumers felt the professionals they had contact with were focussed on only addressing medical aspects instead of viewing a person as a holistic individual, as required by recovery principles (Consumers of Mental Health Western Australia, 2017); a finding supported earlier by Weiland and colleagues (2011).

Liao, Thomas, and Bell (2014) argue that consumers' safety is at risk when a culture of practices, traditions and certain discourses override ethical and professional behaviours. Experiencing stigmatising attitudes and discrimination from health professionals has been found to impact the quality of care and treatment that mental health consumers receive (Morgan, Reavley, Jorm, & Beatson, 2016), negatively affecting some individual's ability to recover (Dinos, Stevens, Serfaty, Weich, & King, 2004; Henderson et al., 2014; Morgan et al., 2016). Discriminatory attitudes have been argued to potentially foster premature death due to the individual not receiving appropriate or timely treatment; or may promote consumers' refusal to 'adhere' to recommended treatments because of being treated unfairly and/or not having their concerns addressed (Henderson et al., 2014). In keeping with these research findings, Dinos et al (2004) reported on a number of individuals who avoided seeking help due to the fear of being stigmatised, which the authors argued can prevent recovery and/or lead to premature death.

Consumers from the WA forum and workshop therefore recommended that service delivery and outcomes would improve if access to peer supports were increased rather than adding further resources and emphasis on clinical approaches (i.e. concentrating on medications and psychological treatments). Participants further recommended the education of all mental health professionals and support workers in the consumer recovery model being delivered by lived experience workers as a priority, which may better promote empathic attitudes and holistic understandings of recovery in principle and practice (Consumers of Mental Health Western Australia, 2017; WA Statewide Suicide Prevention Network, 2018). The recommendation for lived experience workers to be involved in the

design and delivery of education for health professionals has also been made in previous studies, for example Byrne et al. (2015, 2016), Hungerford and Fox (2014) and Davies and Gray (2015).

Fifteen community mental health service providers interviewed by Hungerford et al. (2016) in their ACT-based study highlighted that they experienced some clinical professionals struggling with understanding the consumer concept of recovery, which has meant that those professionals and some clinical services have had difficulty enacting recovery in practice. For example, participants highlighted issues of paternalism, whereby some clinicians had determined recovery plans *for* consumers, or that recovery was viewed in terms of measurable clinical improvements gained through using medications (Hungerford et al., 2016). Hungerford and Fox (2014) argued that such examples highlight "a substantial disconnect between the principles and practice of recovery" (p 212) as the consumer recovery concept may be co-opted by prevailing clinical understandings, preventing true recovery-oriented service delivery. In other studies, consumers and service providers from across Australia have also suggested that the concept and language of recovery has been co-opted by the clinical model (Byrne et al., 2015; K. Davies & Gray, 2015). Some of those who participated in these studies perceived that such co-opting has resulted in the philosophy of consumer recovery being moulded into existing clinical terms, resulting in the renaming of existing services and processes, which has reportedly prevented transformational change (Byrne et al., 2015; K. Davies & Gray, 2015).

Not providing appropriate consumer-focussed care and excluding service users from decision making was perceived by participants in Hungerford and Fox (2014) study as a violation of their human right to self-determination. Potential human rights violations have also been raised through reports of consumers being involuntarily detained in locked wards and not informed of their rights (Griffiths et al., 2015), along with individuals being involuntarily treated, being placed in seclusion, or using physical or chemical (sedative) restraints in emergency departments or acute settings (Gregory, 2017; Griffiths et al., 2015; Hickie et al., 2014; McSherry, 2012, 2015; Mendoza et al., 2013). Chemical restraint practices are the use of sedatives or strong antipsychotic medications

to subdue an individual in order to control their behaviour instead of using physical restraints, which some former inpatients have described as being extremely distressing (Gregory, 2017).

Under the power provided by the Mental Health Act (2014), as well as institutional policy, acute-care doctors and psychiatrists are permitted to use these involuntary chemical restraints to reduce the risk of a consumer harming themselves, or another person. Although clinicians may feel professional liability pressures for the safety of others and themselves (K. Smith, 2016), the use of chemical restraints in risk-management practices are said to, and expected to, reduce liability for both the institution as well as the clinician (Barley et al., 2008; Davidson, O'Connell, Tondora, Styron, & Kangas, 2006; Gooding, 2015). However, while some consumers may recognise the need for risk-management practices, McGrath, Bouwman, and Kalyanasundaram (2007) reported consumers' concerns that psychiatric medications may pose a major barrier to recovery, due to the emotional 'numbing' caused by the drugs preventing them from appropriately working through their personal issues. In addition, medications are seen as a barrier to recovery particularly if consumers' needs and requests for psychological therapy go unmet due to a doctor's reliance on medications as the primary treatment. Meehan, King, Beavis, and Robinson (2008) suggest that such barriers to recovery created by coercively using and privileging medications are perceived by consumers as a denial of their right to recovery.

The denial of consumers' rights by both practitioners and systemic processes highlights that power imbalances remain an issue in the mental health system and more broadly throughout government departments. Deutsch (2006), van Dijk (1992) and Prilleltensky and Gonick (1996) assert that denial is a mechanism that maintains power and oppression through discourses, the denial of fair processes, and the denial of equitable access to social and financial resources. Within the mental health context, this could mean the denial of appropriate psychological, social or community supports, or the denial of self-determining one's own recovery plan. Furthermore, van Dijk (1992) highlighted that denial is often used as a strategy to defend one's own position; therefore, if a doctor denies a consumer's knowledge and rights to make decisions about their own treatment and

recovery, then the individual has been denied fair process. The results of such denial maintains the doctor's position as the 'expert' who holds the knowledge and retains power through claiming expert status, while maintaining the disempowered position of the individual as a person dependent upon expert medical help (Lupton, 2003; Nimmon & Stenfors-Hayes, 2016; Strickler, 2009). Deutsch (2006) outlines that fair procedures are important as they are seen to promote fair outcomes, yet if the decisional process is perceived as unfair, an individual is less likely to be committed to the resulting decision. This means that if a decisional process is seen to be unfair, a consumer may be less likely to go along with treatment or recovery plans that they have not had input into, and therefore, the procedural injustice may have detrimental impacts upon an individual's recovery, potentially promoting re-presentation to services for help.

Prilleltensky and Gonick (1996) described the creation of barriers to an individual receiving equitable access to social, economic and political resources, as well as decreased ability to self-determine, such as in determining one's own recovery plan, as political oppression. Political oppression and the circumstances it creates for individuals may result in psychological oppression, which is an individuals' oppression of themselves through internalising the dominant belief that they deserve such injustice (Prilleltensky & Gonick, 1996). Power is central to this issue, as oppressed individuals may experience greater levels of powerlessness, which the consumer recovery movement aimed to challenge and address for consumers on both individual and broader levels. However, it seems evident from the research outlined within this review that the balance of power still favours clinical knowledge, terms and practices rather than the recovery perspective currently emphasised in mental health policies and strategies. Byrne et al. (2015, 2016) and Davies and Gray (2015) argue that the power and dominance of the medical model over the consumer recovery perspective is a major barrier to transforming the mental health system. Hence, a review of the literature examining the medical model warrants further exploration for this reason, as well as due to being the dominant model that currently underpins medical students' education.

2.5 The medical/disease model in mental health: epistemology, discourse, power and marginalisation

Disease entities are theoretical concepts, underpinned by the theory of medical nosology – the system of classifying diseases according to their origin and cause, process, pathology, and outcome (Hucklenbroich, 2014). Modern medicine is underpinned by positivist (empirical) scientific methods, which constructed the understanding that dis-ease in the human body can be caused by a disruption in biological processes that can be identified and rectified (Germov, 2014). As such, the biomedical model of health assumes that all ailments have a biological origin, causing dis-ease in the human body in a consistent way that can be predicted. Therefore, this 'disease model' also assumes that a uniform manner of treatment for every person is also possible, and has developed clear, uniform procedures for both diagnosis and treatment (Germov, 2014).

However, the disease model used in medicine has been argued to be problematic in mental health as it conceptualises and treats an individual's personal difficulties in the same way as physical ailments (Bracken et al., 2012; Germov, 2014; Jablensky, 2012; Kinderman, 2017). As the disease model assumes a person may experience distress due to their biology, treatments are designed to target biological processes using pharmaceuticals, yet not pay as much attention to the social and psychological contributors of a person's distress (Cooke & Kinderman, 2018; Kinderman et al., 2013). Therefore, medicine and psychiatry have been critiqued for reducing an individual's experience of distress down to their biology (Germov, 2014). Although not all medical professionals may view mental health in purely biological terms, the disease model and its assumptions have been argued as remaining dominant within medical spaces (Germov, 2014), including in medical education (Donetto, 2012).

To counter the criticisms of biomedical reductionism and psychiatry's use of the biomedical model, Engel introduced the concept of the biopsychosocial (BPS) model during the epistemic crisis in psychiatry around the 1970's (Benning, 2015; Engel, 2012). The BPS model was employed by medicine and psychiatry, as it provided what was considered as a more holistic understanding by

conceptualising distress as having biological, psychological and social foundations (Benning, 2015; Engel, 2012). However, McLaren (1998) claimed that the BPS approach should not be used in psychiatry because it does not meet the criteria for a model; being one that is grounded in a rigorous, evidence-based scientific theory that can be used to predict the causes or the course of distress.

The BPS model assumes a person may have a biological predisposition to a certain psychological phenomenon, which may manifest due to the person's lack of psychological resources to cope with an environmental stressor (Craddock, 2014; Ventriglio, Gupta, & Bhugra, 2016). However, conflicting evidence suggests that adverse events and social stressors can, in and of themselves, promote changes in neurobiology (Chaijale et al., 2013; Mizrahi, 2016; Ventriglio et al., 2016), such as altered gene expression and synaptic connectivity (Turecki & Meaney, 2016), and short and long-term changes in stress hormone levels such as cortisol (Kudielka, Buske-Kirschbaum, Hellhammer, & Kirschbaum, 2004; Turecki & Meaney, 2016). Rather than being an existing trait or disposition, the research cited here suggests genetic alteration can occur as a *result* of stress or trauma through epigenetic modification, particularly during childhood development (Lewis & Olive, 2014; McGowan et al., 2009; Murgatroyd & Spengler, 2012; P. Thomas, Bracken, & Yasmeen, 2007; Tzanoulinou et al., 2014). Furthermore, despite the exhaustive studies undertaken regarding genetic predispositions for mental health issues, no single biological theory has provided conclusive evidence that genetic changes cause all types of distress, or that a particular genetic anomaly is always responsible for a particular psychiatric diagnosis (P. Thomas et al., 2007; Uher, 2009).

Despite these critiques, the BPS model is still widely used by psychiatry in Australia, to formulate an understanding of the potential causes, and approaches to treating, a person's distress (Royal Australian and New Zealand College of Psychiatrists, 2004; Selzer & Ellen, 2014), as the formulation provides a foundation for treatment approaches within the person's current context (Alyami, Sundram, Hill, Alyami, & Cheung, 2015; Selzer & Ellen, 2014). Essentially, formulation enables a more holistic understanding of the person's context and background, helping to identify

potential causes and treatment methods (Sim, Gwee, & Bateman, 2005). Case formulation in psychiatry has multiple approaches including psychodynamic, biopsychosocial (BPS) and cognitive-behavioural (Royal Australian and New Zealand College of Psychiatrists, 2004). While there are multiple methods to conducting a formulation, Selzer and Ellen (2014) provide a framework that identifies predisposing, precipitating, perpetuating and protective factors for the individual using a BPS approach. For example, the model identifies biological factors such as substance use or brain injury; psychological factors such as coping strategies or self-esteem; and social elements such as experiences of trauma, abuse and neglect, and social and economic circumstances (Selzer & Ellen, 2014).

Sim et al. (2005) additionally called for formulations to be culturally sensitive and account for cultural and spiritual aspects impacting the individual and their conceptualisation of their experiences, to better understand the person and their context. Yet despite the seeming comprehensiveness of the BPS approach, Álvarez, Pagani, and Meucci (2012) claim that many practitioners struggle to apply the BPS method into treatment plans and therefore, the clinical application of the BPS approach weakens as clinicians may default to providing mostly medical explanations and treatments. Therefore, as doctors who use the BPS method may still disregard the social and psychological aspects of a person's distress, Pilgrim (2002) argued that the BPS approach does not go far enough to prevent biological reductionism. Ghaemi (2009, 2010) supported this assertion, stating that the BPS method is inadequate as it does not guarantee that a physician will balance all three aspects in their assessment and treatment of an individual, and that the approach also fails to recognise the importance of subjective meaning, culture, and spirituality of both the individual and the physician.

These critiques of the BPS approach are important, given the wide acceptance of the method from the medical community as a valid model for conceptualising and treating distress, despite the model having the tendency in practice to reduce distress down to a person's biology. To emphasise the issues with the reductionist tendencies of the biomedical model, Johann Hari, an

author with lived experience, and leading Australian child psychiatrist and 2010 Australian of the Year recipient Professor Patrick McGorry, recently claimed that a biologically-focussed approach to mental health is inadequate (Pryor, 2018). This is because it fails to afford equal attention to the social underpinnings of distress, as well as the psychological consequences of social stressors and traumatic events (as cited in Pryor, 2018). Likewise, Kinderman et al. (2013) claimed that the problem with positioning mental health within the disease model and treating it the same way as a physical condition is that it attributes distress to an underlying biological predisposition or malfunction primarily, whereas it is now well understood and accepted that extreme distress and symptoms of it are promoted by social circumstances and traumatic events (Ventriglio et al., 2016). McGorry (cited in Pryor, 2018) reiterated Kinderman's argument during a national radio segment, stating that biological psychiatry had promoted a reductionistic perspective of distress by viewing people's distress as merely a result of a brain disease, however:

> "if you talk to any modern researcher in neuroscience or psychiatry no one would say that is the explanation, but when you go to see a GP or even some psychiatrists, they will still trot out that very simplistic explanation to people" (McGorry, in Pryor, 2018 from 8:20)

McGorry's comment highlights that some doctors may still use simplistic biological reductionistic models to conceptualise, explain and treat distress, despite the growing evidence that social and psychological aspects have a large role in the development of mental health issues. Additionally, the biological disease model largely ignores the meaning people attribute to their experiences and responses to situations, which Kinderman et al. (2013) suggests is very problematic, as it is the meaning of the experience that conveys the human element of psychological distress. The meaning and human element are particularly important due to potentially enabling others to relate to the person's experiences, rather than to view the person as completely different from oneself; meaning, to see them as 'unwell' and needing treatment (Kinderman, 2017). Being able to relate to, and therefore understand a distressed person's experiences is important as seeing another as very different from oneself can and has resulted in the stigmatisation and exclusion of individuals or

whole groups of people (Clayton & Opotow, 2003; Deutsch, 2006; Opotow, 1990a, 1990b, 1995, 2011).

Fay (2018), Mills (2014) and Summerfield (2008) further debate that the use of psychiatric terms may not only be reductionistic, but may also be unhelpful due to pathologising understandable human reactions to distressing events and circumstances. For example, the use of substances has been reported to be a behavioural reaction to feeling disconnected from others and is used as means of escaping feelings of isolation or psychological pain (Thornton et al., 2012), particularly in young people (Dow & Kelly, 2013). Therefore, rather than addiction being conceptualised as a neurologically-based psychiatric disorder, Hari (2015) argued that addiction stems from a person using substances due to needing meaningful human connections or having problematic relationships. Consequently, the psychiatric label a person may be given may not be representative of the experiences that contributed to their distress in the beginning (Kinderman, 2005, 2017).

Another important aspect of using psychiatric diagnoses is how a diagnosis is required to gain funding from government health systems and/or insurance companies for treatment and social supports (Johnstone, 2013). Pilecki, Clegg, and McKay (2011) argued that as government-supported health systems and insurance companies pay for treatments, the DSM has been developed in accordance with providing health systems with easily classifiable diagnoses, and treatments that are also as easy and cost-effective to provide as antibiotics. However, the creation of psychiatric categories or labels while also developing and providing medications to treat such constructs has been termed the 'medicalisation' of distress (J. Davies, 2017; Rapley et al., 2011). Davies (2017) argued that the medicalisation of distress and the increasing use of psychopharmaceuticals has been supported by neoliberal political and economic interests of creating market demand of psychiatric services, and supplying the product – meaning a diagnosis and medications.

Furthermore, researchers such as Harrow, Grossman, Jobe, and Herbener (2005); Harrow and Jobe (2013); Harrow, Jobe, and Faull (2012, 2014) suggest that psychiatric medications may

actually prolong symptoms, such as neuroleptics having the potential to prevent long-term recovery by promoting episodes of psychosis. Referred to as neuroleptic-induced supersensitivity psychosis, the medications have the potential to increase both the numbers and sensitivity of dopamine receptors, meaning once a person reduces or stops taking the medications, the change in brain chemistry may result in an experience of psychosis (Chouinard & Jones, 1980; Chouinard, Jones, & Annable, 1978; Fallon, Dursun, & Deakin, 2012; K. Smith, 2016). Psychopharmaceuticals may also promote damage to brain tissues, such as reductions in brain volume and reductions in the size of cortical structures such as the hippocampus (Haynes, Barber, & Mitchell, 2004; Huhtaniska et al., 2017; Moncrieff & Leo, 2010; Navari & Dazzan, 2009); as well as having the potential to promote suicide and suicidal ideation (Gotzsche, 2017). Considering such evidence, critical psychiatrists and psychologists therefore argue that the use of pharmacological treatments that alter biological processes to treat what they suggest are socially-born issues is flawed, inefficient and may actually cause more problems for a consumer in the short and long-term due to the side effects (Lally & MacCabe, 2015; Moncrieff, 2006, 2015; The British Psychological Society, 2011; Whitaker, 2004).

Despite the challenges from both within and external to psychiatry regarding the legitimacy of using, or over-using, psychiatric medications, current psychiatric guidelines recommend psychopharmaceuticals as primary treatments for diagnoses such as psychosis or schizophrenia, bipolar disorder and major depressive disorder (Gotzsche, 2017; K. Smith, 2016). However, recent reports from consumers reveal that social and psychological supports may be more beneficial for some people's recovery than medications (Consumers of Mental Health Western Australia, 2017; Petersen, Friis, Haxholm, Nielsen, & Wind, 2015; WA Statewide Suicide Prevention Network, 2018). In addition, critical psychiatrist Moncrieff (2017) highlighted that the mental health burden has actually been increasing despite the dramatic increases in research, knowledge, funding, policies and awareness-raising efforts. In line with Davies' (2017) argument about creating demand and supply, Moncrieff (2017) suggests that the increasing diagnoses of 'mental illness' in western countries is due to the growing pathologisation and medicating of a range of common human experiences.

This over-pathologising of common human experiences resulting in distress has been argued as problematic because of the stigmatisation a person may suffer as a result of being given a psychiatric label (Horn, Johnstone, & Brooke, 2007; Kinderman et al., 2013; Rose & Thornicroft, 2010). While a diagnosis can facilitate recovery through access to treatments and supports for some, many consumers in western countries have highlighted that psychiatric labels have promoted social isolation and negatively impacted their relationships, identity, employment, financial security and living standards as a result of the stigma and discrimination they have experienced (Horn et al., 2007; Rose & Thornicroft, 2010).

2.6 Stigma and discrimination towards consumers and psychiatric diagnoses

Stigma may be reproduced through the media, in social settings, politics and policy, as well as through social systems and institutions such as government departments or facilities (Hall, 2001; Potter, Edwards, & Wetherell, 1993; van Dijk, 1992). Common discourses (language practices), which Hall (2001) defines as "passages of connected writing or speech" (p. 72) both create and perpetuate stigma. Foucault described discourses as groups of statements that provide a certain representation about a topic, person, or phenomena at a particular point in time; meaning that discourses are dependent upon social and historical context (Hall, 2001). For example, the assumption that individuals may never recover from extreme distress may have been formed through the conditions of some asylums actually perpetuating and exacerbating, rather than ameliorating people's distress. Given an understanding of the historical context of asylums perpetuating distress and preventing recovery for some individuals, it becomes evident that negative assumptions regarding distress or people experiencing distress are based upon incomplete knowledge, which can promote stigmatising attitudes.

Blood, Putnis, and Pirkis (2002) emphasised that media's discursive framing of consumers as violent, deviant, or a risk to others, encourages audiences to draw inferences about the risk and threat that consumers are portrayed as posing, which can lead to fearing consumers and discriminating against them. McDonald (2005, 2011) and Friedman (2011) suggest that feelings of

threat and insecurity can promote the exclusion of the 'other' from an individual's personal moral boundaries, which may also extend to exclusion from the broader community through the creation of policies and laws designed to control the 'threat' that the 'other' is perceived to pose (Opotow, 1990b, 1995, 2011). For example, the Mental Health Act ("Mental Health Act," 2014) in Western Australia provides for the detainment and involuntary treatment of an individual in a mental health facility if they are perceived to pose a threat to themselves or another person. Opotow (1995) outlines that excluding others can occur when individuals or groups are perceived as different and/or psychologically distant from the 'self', meaning that if a psychological connection (such as understanding their experiences) to the 'other' is missing, that individual or group may be socially excluded and subject to unfair treatment from the group that holds more power – in this case, mental health professionals. Once an individual or a group has been excluded from this moral boundary of fairness, harmful treatment such as discrimination and withholding of resources can ensue, legitimised by positioning the 'other' as either different, inferior, or a threat (B. Davies & Harre, 1990; Opotow, 1995; van Dijk, 1992).

However, it is the psychiatric diagnostic categories that are used to label a person and create the meaning that is attached to the group or person, which often promote such stigma, discrimination and exclusion (Clayton & Opotow, 2003; Hall, 2001; van Dijk, 1992). For example, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2015) states that individuals with persecutory, erotomanic or jealous delusions (of which delusions are listed as a 'first-rank' criterion for a diagnosis of schizophrenia) can show anger and violent behaviour, and that hostility and aggression can be associated with 'schizophrenia'. As such, there seems to be a correlation between aspects of the diagnosis within the psychiatric manual and the media's representations of individuals diagnosed with 'schizophrenia', which are generally depicted as violent, aggressive and unpredictable (Francis et al., 2005; Francis et al., 2004; Parrott & Parrott, 2015). Such representations and assumptions persist despite the evidence that the vast majority of individuals who have been given the diagnosis are not aggressive or violent, and are more likely to

experience harm than become a perpetrator (American Psychiatric Association, 2015; Short, Thomas, Luebbers, Mullen, & Ogloff, 2013). Anderson (2003) therefore claims that individuals may base their views about consumers upon media depictions as well as information from mental health professionals conveyed through the media, and if the consistent messages received are that of violence and threat, such messages work to reinforce stigmatising attitudes. Therefore, discourses produce knowledge about a topic that has meaning, which may influence people's conduct towards others (Hall, 2001). More broadly, discourses can influence the social practices surrounding the phenomenon and the people it concerns, such as detaining people with mental health issues in locked wards or asylums and denying them fair treatment, compassion and resources; hence, discourse incorporates both language *and* practice (Hall, 2001).

Denying a person's entitlement to fair treatment and compassion is made easier by discursively dehumanising them (Deutsch, 2006; Opotow, 1990b). Dehumanisation involves denying or disregarding a person's human qualities, which can be achieved within mental health care settings by referring to individuals as 'the patient', as a 'case', or by labelling a person as their diagnosis (i.e. 'schizophrenic'). In these examples, dehumanisation can lead to viewing an individual as an object, such as a body with defective biological processes or as a disease (Haque & Waytz, 2012) and may promote disregard for the inherent humanness of the individual's experiences (Lammers & Stapel, 2011). Dehumanising someone can lead to disempowerment, by discursively positioning them as 'lesser', or non-human with a lower social value. Therefore, through discourses and their accompanying actions and ramifications, power differentials have been created between mental health consumers and mental health professionals, as well as policy makers and those in positions of authority that have historically resulted in many consumers' poor living conditions and barriers to recovery (Deutsch, 2006; Foucault & Rabinow, 2010; Hall, 2001; Knaak, Mantler, & Szeto, 2017; Link & Phelan, 2001; Opotow, 1990b, 1995; Prilleltensky & Gonick, 1996).

Both in Australia and internationally, there is a significant amount of literature detailing mental health consumers' experiences of stigma and discrimination by health care professionals that

has at times created barriers to some consumers' recovery (Dinos et al., 2004; González-Torres, Oraa, Arístegui, Fernández-Rivas, & Guimon, 2007; Henderson et al., 2014; Knaak et al., 2017; Mental Health Council of Australia, 2011; Morgan et al., 2016; Omori et al., 2012; Reavley & Jorm, 2015; Reavley, Mackinnon, Morgan, & Jorm, 2014; Reavley, Morgan, & Jorm, 2017). These issues mean that the literature regarding potential influences on medical students' attitudes towards consumers and distress also need examining. In WA, Lyons, Laugharne, Laugharne, and Appiah-Poku (2015) surveyed 81 medical students' attitudes towards mental health consumers and compared the results with 94 medical students in Ghana. Although the study found that WA students exhibited lower levels of stigmatising attitudes than Ghanaian students, there was still evidence that many of the WA students held negative perceptions towards mental health consumers. The WA students negatively viewed consumers' appearance and behaviour, and rated low on their ability to trust or have a meaningful relationship with a person who has been given a psychiatric diagnosis (Lyons et al., 2015), which may indicate the stigmatisation of psychiatric labels. However, as it was a quantitative assessment, the study did not demonstrate *how* students' perceptions may be constructed and/or potentially influenced by their learning experiences, nor did it explore what the students were learning, or the students' subsequent interactions with mental health consumers. As Lyons, Laugharne, et al.'s (2015) survey was the only study found for this literature review that looked at the WA context, more qualitative research is required to explore these issues with Western Australian medical students.

The examples and arguments in this section have provided an outline of how incomplete knowledge can lead to assumptions about a person, which can promote stigma and discrimination through the perpetuation of negative discourses. The stigma and discrimination can lead to unjust treatment and care of individuals through the health system on an individual basis, as well as on broader systemic levels through the creation of policies and procedures that can result in consumers being treated differently to people with physical ailments. As outlined previously, critical psychiatrists have argued that neither biological, psychodynamic or social approaches on their own

can provide an adequate method and that a holistic approach to recovery needs to encompass social, cultural, psychological, spiritual, political, economic and biological aspects. Such an approach is however afforded by the consumer recovery perspective, which when practiced appropriately, acknowledges and addresses each of these factors as well as discrimination, in working towards an individual's recovery (Anthony, 1993; Piat & Polvere, 2014). Therefore, an exploration of how the psychiatric field and medical education spaces may be incorporating the principles of recovery into psychiatric practice is necessary.

2.7 The paradigm shifts in psychiatry and medical learning spaces

Although psychiatry is traditionally underpinned by the clinical/biomedical model, the field is currently integrating the principles of consumer recovery into psychiatric approaches in Australia and New Zealand (Royal Australian New Zealand College of Psychiatrists, 2016b). The Royal Australian New Zealand College of Psychiatrists (RANZCP) (2016b) recommends that psychiatrists be aware of recovery concepts, understand the competencies required by national competency and standards documents, and ensure their practices are recovery-oriented. Additionally, RANZCP has made a commitment to work to improve the education and training of psychiatrists and the mental health workforce in the recovery perspective through providing professional development resources regarding recovery-oriented care; and encouraging the integration of the concept of recovery and recovery-oriented practice into the psychiatric Fellowship syllabus (Royal Australian New Zealand College of Psychiatrists, 2016b).

Currently, the Fellowship syllabus requires psychiatry trainees to develop a working knowledge of recovery principles (Royal Australian New Zealand College of Psychiatrists, 2012a, 2012b). However, the syllabus does not list an understanding of, or application of the principles of recovery as a learning outcome for the Fellowship program overall, and the learning outcomes discuss the development of *treatment* plans rather than *recovery* plans (Royal Australian New Zealand College of Psychiatrists, 2016a). In addition, the learning outcomes emphasise the use of the biopsychosocial approach, revealing that the current psychiatry training program is still largely

underpinned by the clinical recovery perspective rather than the consumer recovery paradigm. So although much effort has gone into shifting policy and implementing practice changes, Mabe, Ahmed, Duncan, Fenley, and Buckley (2014) contended that little transformative change has occurred in the training curriculums of the key professions that will be delivering recovery-oriented services.

Transforming training curricula is important as knowing how to practice the principles of consumer recovery is required by current policies, due to the evidence demonstrating that these transformational practices lead to better outcomes for service users (Nelson et al., 2014; Wyder, Bland, Blythe, Matarasso, & Crompton, 2015). Due to such evidence, the National and WA mental health strategies emphasise the need for educating and training the mental health workforce in the recovery paradigm and its practices so that professionals may implement the practices for improved recovery outcomes (Australian Government Department of Health, 2011a, 2011b, 2017; Government of Western Australia Mental Health Commission, 2015, n.d.). However in implementing recovery education, Morrow and Weisser (2012) argue that a major challenge to health professional educators is the need to resist further biomedical approaches due to having a long history of treating mental health consumers disrespectfully (Farkas et al., 2005; Germov, 2014). Recognising the need to shift away from the medical/clinical model aligns with Morrow and Weisser's (2012) social justice framework for recovery, which outlines that broad systemic change may not be possible until the dominant ways of understanding and 'doing' mental health are acknowledged and transformed.

To address the education and training of the workforce in line with the recovery approach, the WA Mental Health Plan emphasises the use of the National Mental Health Workforce Strategy (Australian Government Department of Health, 2011b) and the National Practice Standards (the Practice Standards) (Victorian Government Department of Health, 2013). The Practice Standards detail fifteen competencies (in *Standard 2*) for working within recovery-oriented practices for emerging mental health professionals and existing practitioners (Victorian Government Department of Health, 2013). These competencies include working with people as partners; supporting

consumers' and carers' decision making and self-determination; valuing consumers' perspectives and knowledge; and using appropriate strengths-based recovery language (Victorian Government Department of Health, 2013).

However, the professions emphasised within the document, and therefore the intended audience is directed at psychologists, psychiatrists, social workers, nurses and occupational therapists. In this way, the Practice Standards potentially leave out other medical professionals who will also have contact with consumers, such as ED physicians or GP's. This may be problematic due to ED physicians or GP's being among the first points of contact for many highly distressed consumers seeking help, and because all medical professionals require competencies in mental health in order to provide individuals with comprehensive care (Australian Government Department of Health, 2011b). Nevertheless, the practice standards provide an educational framework for undergraduate and postgraduate curriculum development for professions including psychiatry (Victorian Government Department of Health, 2013), meaning that medical schools could utilise the practice standards to help develop medical school curricula in mental health towards the consumer recovery paradigm in order to promote better outcomes for people's recovery.

The Practice Standards have been underpinned by the National Framework for Recovery-Oriented Mental Health Services (the Recovery Framework) (Commonwealth of Australia, 2013a), which highlights that "All Australian jurisdictions and all mental health services have a responsibility to promote and implement the framework." (Commonwealth of Australia, 2013a, p. 44) and emphasises that practitioners need to know the philosophy of the recovery paradigm and its history as a consumer movement. More specifically, the Framework emphasises, under Domain 2 of 'knowledge for key competencies', that practitioners need to

> "understand a range of personal recovery approaches including those developed by people with lived experience of mental health issues…. know major types of treatments and therapies and their possible contributions to a person's recovery including biological and pharmacological treatments, psychological and psychotherapeutic approaches, psychosocial rehabilitation and support, physical health care, physical activity and exercise interventions, alcohol and drug treatment and counselling, traditional healing in different cultures and alternative and complementary treatments" (Commonwealth of Australia, 2013a, p. 47)

Demonstrating that, all professionals working in mental health now need to implement recovery in their practices, and that practicing the principles of recovery means to understand and provide access to a broad range of therapies as well as to both understand and address holistically, all of a person's life and needs. In line with the Practice Standards, the National Mental Health Workforce Strategy (the Workforce Strategy) (Australian Government Department of Health, 2011b) requires all mental health staff have a clear understanding of what the recovery approach is and how to practice the principles of recovery (Australian Government Department of Health, 2011b). The Workforce Strategy also supports the position proposed by Byrne et al. (2015) and Hungerford and Fox (2014), that people with lived experience can and should deliver training programs as their perspectives and experiences can be powerful learning tools for mental health professionals.

However, a qualitative study by Dalum, Pedersen, Cunningham, and Eplov (2015) with 16 health care providers from the USA and Denmark found that despite undergoing recovery training, some professionals retained the problem-focussed language of the medical model. The professionals included social workers, case managers, nurses, a psychiatrist and an occupational therapist, who had undergone an Illness Management and Recovery (IMR) training program consisting of one or two sessions per week for six to twelve months (Dalum et al., 2015). While the majority of the participants used strengths-focussed recovery language and held more positive views towards consumers and their prospects in life, some outlined that even after the extended learning program it was difficult not to revert back to ingrained habits of the medical model, such as making decisions on an individual's behalf (Dalum et al., 2015).

In addition, Gordon, Huthwaite, Short, and Ellis (2014) further identified that a limited program of recovery teaching consisting of two one-hour tutorials in the medical school at the University of Otago in New Zealand did not positively impact students' attitudes towards recovery or consumers. The authors attributed the lack of impact of the tutorials to the opposing characteristics and dominant method of the traditional biomedical/psychiatric program and acknowledged that for a consumer tutor program to work effectively, the curriculum would need to align more with the

recovery paradigm (Gordon, Huthwaite, et al., 2014). Gordon, Huthwaite, et al. (2014) indicate that a transformational education strategy would underpin the psychiatry curriculum with the consumer recovery model as this approach may produce more empathic professionals who are skilled in recovery methods, which is a position supported by prior research by Feeney, Jordan and McCarron (2013) in Ireland. Feeney et al. (2013) delivered a recovery-focussed training program to 23 medical students and found that in comparison to their 96 peers who had undergone traditional psychiatry education, the students held statistically significant positive attitudes towards mental health, consumers, and psychiatry, as well as greater knowledge about recovery principles following the program.

As Gordon, Huthwaite, et al. (2014) found that the biomedical paradigm presented a major barrier to the recovery perspective being learnt and accepted by students, the authors transformed the psychiatry curriculum of the University of Otago Medical School towards the recovery paradigm. The University felt this approach was necessary as the trial tutorials with lived experience tutors demonstrated the need to shift the entire curriculum towards recovery (Gordon, Huthwaite, et al., 2014; Newton-Howes, Beverley, Ellis, Gordon, & Levack, 2018). Developed with leadership from consumer representatives, the transformed curriculum encompasses recovery-focussed tutorials delivered by consumer tutors; workshops and literature; as well as rotations within recovery centres alongside traditional psychiatry placements in inpatient or outpatient clinics (Newton-Howes et al., 2018). Newton-Howes et al. (2018) reported that after the redevelopment of the mental health curriculum, students who participated in the program expressed more positive attitudes towards consumers and had greater knowledge of recovery principles. Students consequently understood that psychiatric labels had negative impacts on consumers through creating stigma and recognised that alternatives to disease labels promoted consumers' recovery (Newton-Howes et al., 2018).

Improved attitudes towards working with and learning from mental health consumers was also demonstrated in a cohort of 104 medical students in Sydney, who undertook a program of six one-hour tutorials focussing on effective interviewing skills, delivered by consumer tutors (Owen &

Reay, 2004). Yet, while Owen and Reay's (2004) program demonstrates that an extended period of engagement with consumer tutors helps to improve students' attitudes, there was also some resistance to being taught by consumers due to an assumption that the tutors were not capable of instructing. Likewise, medical students in Gordon, Huthwaite, et al.'s (2014) New Zealand study struggled to accept the service-user tutor as a legitimate consumer, which the authors attributed to students having only interacted with acutely distressed individuals in an inpatient facility and not having witnessed, or had contact with people who were recovering, or were in recovery. Gordon, Ellis, et al. (2014) subsequently argued that the acute nature of inpatient facilities may not facilitate students' learning that individuals do recover as the rotation is generally too short to witness someone's recovery process. Therefore, the authors suggested that learning predominantly in an acute inpatient facility may be counter-productive to reducing some medical students' stigmatising assumptions that people do not recover from extreme distress (Gordon, Ellis, et al., 2014).

Totic et al. (2012) further suggested that students' stigmatising attitudes may be due to the dominant biomedical underpinning of the psychiatry curriculum, which the authors claim prevented students in their Serbian medical program from gaining a broader humanistic understanding and connection to consumers. In addition, Eksteen, Becker, and Lippi (2017) proposed that stigma maybe learned, legitimised, or reinforced through the discourses and behaviours of other medical practitioners. Learning implicit attitudes from other medical professionals has been referred to as the 'hidden curriculum' of medicine, as attitudes are not formally taught within the curriculum but may be learnt from observing or listening to other professionals while on rotation, or from teachers in the formal learning environment (Gaufberg, Batalden, Sands, & Bell, 2010). Hence, the hidden curriculum refers to aspects of medicine and medical culture that are not within formal defined curricula (Gaufberg et al., 2010). Having a rotation within a recovery-based setting such as that provided in the University of Otago's program, therefore has the potential to promote more positive attitudes towards consumers due to both learning positive attitudes and practices from other staff through the 'hidden curriculum', and through having additional contact with consumers in a non-

acute setting and witnessing their recovery (Eksteen et al., 2017; Gordon, Ellis, et al., 2014; Gordon, Huthwaite, et al., 2014; Owen & Reay, 2004).

Additional contact with consumers has also been successfully improved through having lived experience trainers sharing their experiences, which may invoke emotional responses and promote self-reflexivity from professionals regarding their practices, attitudes and biases that may negatively impact consumers (Wilrycx, Croon, van den Broek, & van Nieuwenhuizen, 2012). Members of the advantaged group (in this case, mental health professionals) can become sensitive to injustices suffered by consumers when they are made critically conscious of the unjust circumstances, and consequently may become motivated to change such unjust practices (Deutsch, 2006; Freire, 1974a, 1974b). Moreover, having close interactions with, and being taught by consumers, carers and advocates encourages person-centred care due to students taking on board consumers' experiences and perspectives, having the potential to promote greater empathy, rapport, and understanding (Bravery, 2018; Knaack, Modgill, & Patten, 2014; Mak, Maticevic, & Power, 2018).

In addition to utilising lived experience educators and transforming the psychiatry curriculum towards recovery, there are increasing arguments for also transforming the manner in which medicine and mental health are taught, towards using critical pedagogy (Bleakley, 2017; Dao et al., 2017; Halman, Baker, & Ng, 2017; J. Harden, 1996; Kumagai & Lypson, 2009; McKenna, 2012; Mikol, 2005; Ross, 2015). Critical pedagogy is a manner of teaching which promotes both teachers' and students' critical awareness of power, enhances critical self-awareness, and promotes empathy, respect and acceptance of others and their differing perspectives (Freire, 1974b; Freire & Faundez, 1989; Nouri & Sajjadi, 2014). Delivering health professional education using critical pedagogy has been found to promote students' critical awareness of the political, social and economic factors impacting patients and mental health consumers, as well as the potential negative impacts that health disciplines themselves may have on consumers (Bleakley, 2017; Dao et al., 2017; Donetto, 2012; Kumagai, 2014; Kumagai & Lypson, 2009; Mikol, 2005). Critical theory provides the pedagogy's underpinning framework, which aims to liberate individuals and groups from control and oppression

through exposing the often hidden power relations between individuals, groups, and social structures and institutions that can result in disadvantage and harm (Crotty, 1998; Halman et al., 2017; Sandars, 2017). Freire (1974a), who was key to the development of critical pedagogy, referred to this process of raising critical consciousness as *conscientisation*, which is the point where a person becomes motivated to act on an injustice due to being educated about the phenomenon.

Increasing numbers of authors also advocate that medical and health professional education needs to be underpinned by critical pedagogical methods in order to produce more critically aware, politically engaged, empathic and responsive practitioners (Bleakley, 2017; Dao et al., 2017; Donetto, 2012; Halman et al., 2017; J. Harden, 1996; Kumagai, 2014; Kumagai, Jackson, & Razack, 2017; Kumagai & Lypson, 2009; Mikol, 2005; Pereira & Almeida, 2009; Ross, 2015; Sharma, Pinto, & Kumagai, 2018). For example, Halman et al. (2017) reviewed thirty international studies that had used the principles of critical pedagogy to inform health professionals' education. The authors found congruent themes throughout the studies, including the significant value of incorporating the personal experiences of the learners, which promoted the humanisation of issues affecting the study participants, enabling them to be more reflexive of their own and others' personal contexts. Halman et al. (2017) further suggested that the studies reviewed proposed that critical consciousness shifts students from merely 'acting empathic' - which was argued by Donetto (2012) as being a consequence of students' empathy being scored during the Objective Structured Clinical Examination (OSCE) - to developing authentic concern for patients, as well as genuine cultural competence (Kumagai, 2014; Kumagai & Lypson, 2009).

In line with Freire's argument that critical pedagogy needs to be coupled with self-reflexivity, the studies reviewed by Halman et al. (2017) highlighted the need for health professionals to engage in both action and critical self-reflection, rather than merely demonstrating an ability to reflect upon practices for professional development, or reflecting upon a problem in order to solve it (Schon, 1983). The need for critical reflexivity rather than only reflection or reflective practice was also stressed by Naidu and Kumagai (2016) as being highly needed in medical education globally. Critical

reflexivity extends upon reflective practice and self-reflection by personally interrogating one's own identity, social context, and exploring personal taken-for granted assumptions, biases and language use, and how these factors can impact or disadvantage those who the professional is working to help (Kessl, 2009; McCorquodale & Kinsella, 2015; C. Taylor & White, 2001). Taylor (2006) and Taylor and White (2001) earlier argued that practitioner's reflexivity of their knowledge base is important, as in gathering information about an individuals' symptoms and clinical history, professionals actively construct a version of knowledge about a person which may not always reflect the individual's perspective or story. Therefore, Taylor (2006) proposes that practitioners need to engage in critical reflexivity rather than just reflection due to this need to interrogate how their knowledge is both construct*ed* and is construct*ive*.

In light of these issues, Bleakley (2017) clearly acknowledges that whilst having the benefits of producing caring, politically engaged and sensitive practitioners, a transformed curriculum towards critical reflexive practice in medicine comes with its own unique challenges. Most importantly, this includes having highly skilled faculty who are not only trained in the content, but who are also trained in pedagogy, critical theory, and are themselves critically self-aware, transparent about their knowledge biases and limitations, and being very open to critique of their knowledge from students (Bleakley, 2017). Such faculty also require well-developed facilitation skills, as well as skills in psychology, in order to appropriately facilitate classroom discussions, and negotiate sensitive topics that both challenge and enlighten students with a new found critical awareness (Bleakley, 2017). Bleakley (2017) further suggests that such a transformative shift also requires very careful attention to the use of language in medicine and education settings in order to expose the common stigmatising or marginalising discourses and assumptions surrounding a topic (Crotty, 1998), as it is the language people use that helps shape assumptions and represents people a certain way, creating power differentials that critical pedagogy aims to deconstruct and challenge (Giroux & McLaren, 1992; Pearlman, 2014).

While conscientisation is a necessary beginning step to addressing injustice, Prilleltensky and Gonick (1996) earlier suggested that liberation of the self from negative attitudes or limited knowledge, and liberation of others from the consequences of those attitudes or knowledges, can only occur when advantaged people begin to accept the reality of the injustices, then also accept new ideas and possibilities, and reject the myths that kept the injustice in place (Deutsch, 2006). Such myths may be the assumptions that consumers may never recover, or that medical professionals are the experts who know better than the individual due to their education and positioning. As an example, raising medical students' critical consciousness at the University of Otago resulted in some students detecting tensions between the biomedical/biopsychosocial and recovery models after undergoing education in the recovery paradigm. The students subsequently noted that the coercive and paternalistic ways of the medical model opposed the principles of respect for an individual's autonomy and wishes (Newton-Howes et al., 2018). This led to one student questioning the effectiveness and legitimacy of traditional psychiatric approaches when a consumer was repeatedly denied discharge from an inpatient facility that the student was placed in (Newton-Howes et al., 2018), demonstrating the students' growing willingness to challenge and therefore act towards changing unjust practices for the benefit of the individual who had less power.

In summary, delivering a transformed curriculum underpinned by the recovery perspective, utilising lived experience workers to deliver classes and supported by faculty and a pedagogy that are critically-orientated has the potential to transform medical education in mental health and psychiatry that aligns with current mental health policy. Yet, transforming curricula towards the recovery paradigm, as well as implementing new teaching methods will inevitably raise challenges that will need careful consideration, planning, and negotiation. However, evidence provided within this section suggests that such an educational program has the potential not only to produce empathic, responsive, and critical medical professionals, but also to produce practitioners who are capable and motivated to identify, challenge, and change unjust systems that can create or sustain unwell-ness and distress. In this way, a transformed medical/psychiatry curriculum and pedagogy

supported with lived experience educators may positively impact the recruitment of medical students into psychiatry due to potentially having more humanistic understandings of distress that can benefit future doctors' therapeutic relationships with consumers. To this end, the following section outlines the current issues regarding recruitment into psychiatry, as well as how students' learning experiences, what they learn and how, has the potential to impact recruitment.

2.8 The relationship between learning and recruitment in psychiatry

Psychiatry has seen declining recruitment numbers globally since the 1970's, coinciding with the field's epistemological crisis around the same time (Brockington & Mumford, 2002). Medical professionals' earlier questioning of psychiatry's epistemological basis during the early 1900's (Lieberman, 2016), as well as enduring critiques of the profession's approaches from both outside and within the discipline itself (outlined in section 1.3 of this review) may have resulted in psychiatry not attracting respect from some professionals in other medical disciplines. For example, a common persisting discourse is that psychiatry is not a 'real medical specialty', thereby demonstrating the profession's perceived low status within the medical profession (Lyons, 2013; Stampfer, 2011).

An Australian study of a cohort of medical students who had undertaken a ten-week psychiatry rotation conducted by Wigney and Parker (2007) revealed reasons why students may not choose psychiatry as their specialty. Twenty out of 55 medical students in the study viewed psychiatry as not 'real' medicine, commenting that it was 'ambiguous', 'imprecise' and 'unscientific' (Wigney & Parker, 2007, p. 728). The students in this study perceived psychiatry negatively due to treatments being based upon symptoms rather than an underlying aetiology, and because they did not perceive diagnostic procedures as having specific and clear methods (Wigney & Parker, 2007). Additionally, Archdall, Atapattu, and Anderson (2013) found in their qualitative study of 15 medical students in the UK, that some students believed that they were unable to 'fix' mental health consumers as they might with a broken bone, and therefore, were unlikely to consider psychiatry due to feeling it would be dissatisfying. Furthermore, junior doctors interviewed in a UK phenomenological study of their training experiences by Beattie, Crampton, Schwarzlose, Kumar,

and Cornwall (2017), reported low job satisfaction due to feeling helpless, frustrated and sad if they were unable to help a person recover. However, observing as well as contributing to a person's recovery was reported to give participants great satisfaction, which reinforced positive attitudes towards psychiatry (Beattie et al., 2017). Thirteen out of 55 medical students in Wigney and Parker's (2007) study also perceived psychiatry as having no ability to 'cure' consumers, and therefore, felt it would be a dissatisfying career option.

Within WA, a survey study of 30 psychiatric consultants and registrars working in a local psychiatric facility explored the consultant's experiences of stigma (Bassiri, Lyons, & Hood, 2011). The study reported that these professionals experienced significantly more negative views of their profession (self-reported measure finding 54 per cent negative views weekly compared to 27 per cent positive views weekly), coming mostly from other medical professions, as well as the media (Bassiri et al., 2011). However, the study did not explore the origin of the stigma through analysing the discourses these psychiatrists commonly heard about their profession. As such, a broader exploration of the sources of stigma towards psychiatrists in WA is needed, as well as the contributions of other medical disciplines towards the perpetuation of the stigma (Bassiri et al., 2011). In addition, an exploration of the influences of other medical professionals on WA medical student's perceptions of psychiatry is also warranted, as students may adopt such negative views and/or be deterred from a career in psychiatry due to not wanting to be subject to stigmatisation. These may be additional reasons for the reported low rates of recruitment into psychiatry in WA, and more broadly in Australia and globally (Lyons, 2013; Lyons & Hood, 2011; Royal Australian and New Zealand College of Psychiatrists, 2018a, 2018b); hence the need for learning and recruitment influences to be explored in the WA context.

Junior doctors from Beattie et al.'s (2017) UK study further reported that being involved in challenging situations with acutely distressed individuals were positive learning experiences, as acute situations resulted in learning more and having more experience. The participants felt these experiences translated to a more calm approach to extremely distressed individuals in other medical

environments (Beattie et al., 2017). Conversely, some participants felt that as they had a little responsibilities or opportunities to be actively involved, their desire to progress with psychiatry training was negatively impacted (Beattie et al., 2017). Having genuine opportunities to be involved in the care team highlights the potential importance of the clinical supervisor in mentoring upcoming professionals, as having positive role models has been associated with increased interest in psychiatry (Harper & Roman, 2017).

Stampfer (2011) and Lingeswaran (2010) argue that psychiatry can be an unattractive specialty if students have poor quality teaching and uninspiring role models. In contrast, positive role models and quality mentoring during rotations can result in increased interest in psychiatry and reduced stigma towards consumers (Harper & Roman, 2017). Clinical mentors in particular have been highlighted as one of the greatest factors frequently mentioned by medical students, as mentors are reported to have the ability to either positively or negatively impact students' career decisions (Appleton, Singh, Eady, & Buszewicz, 2017; Farooq et al., 2014; Karageorge et al., 2016; Pai, Vella, & Dawes, 2012). For example, Pai et al. (2012) conducted a study at a NSW medical school to understand students' psychiatric rotation experiences. The authors reported that some students noted the benefits of being less ignorant about mental health and consumers, and confronting their stigmatising attitudes following rotation, which helped shift their perspective towards mental health, consumers and psychiatry.

Although Pai et al.'s (2012) study emphasised the important role of clinical staff in the quality of the student's learning experiences, the research was conducted as a semi-structured questionnaire with qualitative response sections. Such a method disallows a greater exploration of the specific interactions on rotation that helped to shift their perspective, which may have been possible using an interview method. Indicating that, further qualitative research to explore student's learning experiences in Australia is needed. Pai et al (2012) also did not elaborate on why some students had positive perceptions of psychiatry, or the factors that might promote psychiatry as a career choice.

Also, an international cross-sectional quantitative survey of over two thousand final-year medical students across 20 countries by Farooq et al. (2014) explored students' reasons for choosing psychiatry. The study found that the more psychiatry placements the students undertook and the quality of those placements (i.e. level of supervision and teaching from clinicians and opportunities to practice skills) significantly correlated with considering psychiatry as a specialty, as well as students being given more responsibility while on placement. However, Farooq et al.'s (2014) study was limited in that it did not gather qualitative responses regarding students' views on stigma towards consumers, mental health or psychiatry, and whether such stigma was a factor impacting recruitment. Although, the study did highlight that students with a prior personal experience or exposure to individuals with mental health issues before beginning medical training, such as through family members, were more likely to consider psychiatry (Farooq et al., 2014). This could indicate that these individuals' prior experience with mental health may result in reduced levels of stigma towards consumers, as well as the potential desire to make a difference in the lives of those experiencing distress.

Psychiatry trainees interviewed in Appleton et al. (2017), who explored trainees' reasons for choosing psychiatry, highlighted that more time on rotations is needed so that students have more time to observe a consumer's recovery process and see 'results' of the treatments. Having more time on rotation may be important, as studies previously outlined had found that not witnessing improvements in consumers' symptoms and functioning was detrimental to students' and junior doctors' perceptions of the field (Archdall et al., 2013; Beattie et al., 2017; Wigney & Parker, 2007). In addition, Nash et al. (2016) conducted a survey with junior doctors (one and two years post-graduation from medical school) undertaking further training in psychiatry in New South Wales to understand their training experiences and how their training influenced their career decisions. The study highlighted that witnessing psychotherapy had a positive impact on the junior doctors' satisfaction with psychiatry training, and improved the trainees' career interest in psychiatry by 30 per cent. This result may be due to witnessing the positive outcomes of therapy on the consumer,

which 90 per cent of the respondents in Nash et al.'s (2016) study highlighted as a positive influence on their perceptions of psychiatry.

Stampfer (2011) argued that because psychiatry is viewed as an unattractive field, teaching "more of the same" (p. 3) in psychiatry is unlikely to attract more recruits. This argument is supported by Lyons (2013) and Lyons, Hans, and Janca (2015), who propose that developing the psychiatry curriculum and using innovative teaching strategies is integral to improving perceptions of psychiatry and increasing recruitment numbers. Additionally, targeted education, immersion in mental health settings and contact with consumers in recovery has been shown to improve students' attitudes towards consumers, reducing stigma and discrimination (Lyons, Hans, et al., 2015; Mortlock et al., 2017; S. Thomas, Pai, Dawes, Wilson, & Williams, 2013).

Recovery training has also been found to improve health professionals' attitudes towards consumers' potential for recovering (Tsai, Salyers, & Lobb, 2010). For example, the study by Nash et al. (2016) highlighted student's perceptions were positively influenced after witnessing a variety of improvements in consumers' functioning, as well as having exposure to a variety of mental health conditions and service users while on rotation (Nash et al., 2016; Pai et al., 2012). Therefore, incorporating the recovery model into medical training and increasing the number of immersion experiences may improve future professionals' attitudes towards, and abilities to care for consumers (Archdall et al., 2013; Mortlock et al., 2017; Newton-Howes et al., 2018; A. Wood & Wahl, 2006). Having such broad training and increased contact with consumers may potentially reduce the fear that students have reported about going into psychiatric placements (Archdall et al., 2013) due to enhancing the student's confidence and skills in appropriately caring for consumers (Jelinek et al., 2013).

Being intimidated by the psychiatric placement is suggested to be due to students' feeling they do not know enough and therefore, feel less confident and competent (Archdall et al., 2013); however, enabling more opportunities for real-setting practice may address such feelings. A systemic review of studies regarding student's competence for clinical practice found that students

did not feel ready for their rotations if there was a disconnection between their learning from pre-clinical to clinical years, and felt less confident for future practice if they lacked opportunities to apply their learning in a real clinical setting (Surmon, Bialocerkowski, & Hu, 2016). Further, medical students in the UK who had more opportunities to practice with real consumers in real settings during their degrees predicted greater readiness for the first year internship than students who had only one or two opportunities, or only simulated or observational experience (Burford, Whittle, & Vance, 2014). Therefore, having limited opportunities to practice skills has the potential to translate to students struggling to transition to clinical practice and apply their learning (Surmon et al., 2016), which may also mean that such students may struggle to provide appropriate care for consumers in future. Surmon et al. (2016) proposed that changes to curricula to enable more opportunities for practice in authentic environments, as well as to address the disconnection that students may feel between the pre-clinical and clinical years would improve students' readiness. In this way, they may gain greater confidence and feel reduced uncertainty going into the psychiatry rotation as well as for postgraduate internships (Surmon et al., 2016).

However, only increasing the number of clinical immersions may only be ameliorative as such measures will not, by themselves, transform the underpinning philosophy and values of psychiatry/mental health education. Educating future doctors in the recovery paradigm, however, requires a transformational shift in the culture of medical education in psychiatry and mental health. Medical education is a cultural process, as there are certain customs, practices, discourses, symbols, common understandings and meaning, and taken-for-granted assumptions that are inherent in medical culture (Gaufberg et al., 2010; Lupton, 2003). Students learn medical culture through observation, socialisation, and through role models such as supervising physicians (Bandura, 1971; Hafferty, 1998; Gaufberg et al., 2010; Lupton, 2003).

Gaufberg et al.'s (2010) narrative study from the United States of America reported on medical student's daily negotiation of medical culture, which brought ethical challenges such as not challenging questionable judgements made by higher-ranking doctors. Gaufberg et al. (2010) argued

that students may avoid challenging clinical supervisors as a students' professionalism may be judged upon how subservient, conforming and agreeable they are. Gaufberg et al. (2010) also argued that such negative learning experiences may prompt maladaptive coping mechanisms and emotional suppression in students, which can become the coping mechanisms they use as professionals to overcome difficult events. The suppression of, or disengagement with personal emotions may lead to disconnection or emotional distancing from others, including consumers (Gaufberg et al., 2010), potentially promoting unintentional moral exclusion and harmful treatment of consumers due to doctors not being able to identify with an individual's experiences (Opotow, 1990a, 1990b). Therefore, students' learning during clinical placements can potentially have long-term impacts on their future professional behaviour and interactions with mental health consumers that may not produce positive outcomes for either party.

The disengagement with emotions may also result from the high levels of emotional exhaustion that many medical students experience which can result in burnout (beyondblue, 2013). Burnout develops over long periods of chronic stress and is said to be characterised by emotional exhaustion, depersonalisation, and a decreased sense of accomplishment (Guthrie et al., 1998; Maslach, Jackson, & Leiter, 1997). Medical students may experience burnout due to the high workloads and demanding training, which highlights the time pressures that students experience (beyondblue, 2013; McGorry, 2015). A study by Qamar, Khan, and Bashir Kiani (2015) with medical students within the Pakistan Military found that students experienced stress due to there being so much to learn, and the limited amount of time for practice and longer-term learning, which could all be attributed to the condensed nature of the medical program. Such time pressure was also found by Rotstein and Jenkins (2017), who explored the career satisfaction of psychiatrists and trainees registered in the Royal Australian New Zealand College of Psychiatrists. The most common stressor reported was psychiatrists and trainees not having enough time to do their work, which extended to consultants not having enough time for their trainees (Rotstein & Jenkins, 2017). Time pressures for both students and doctors has been found to lead to extreme self-sacrifice such as forgoing sleep

and meals, which can promote exhaustion and have detrimental impacts upon the student, or the doctor and their patients/consumers (Kuhn & Flanagan, 2017). Students have also highlighted that the fear of not performing or making mistakes can promote burnout through emotional exhaustion (beyondblue, 2013; McGorry, 2015).

The beyondblue National Mental Health Survey of Doctors and Medical Students (2013) in Australia reported that burnout effects up to 53.6 per cent of students, with emotional exhaustion being the most prevalent issue averaging 52.3 per cent, while levels of cynicism were up to 27.2 per cent among those aged 22-25 and 26.6 per cent in clinical-stage students (beyondblue, 2013). The ramifications of burnout negatively impact students' and professionals' wellbeing, but also the individuals within their care as a doctor's ability to provide empathic, appropriate care can suffer if they are experiencing burnout (Hassed, De Lisle, Sullivan, & Pier, 2009). The beyondblue survey also revealed that up to 17.1 per cent male students and 20.5 per cent female students reported suicidal ideation, and nine to ten per cent of medical students overall have very high levels of psychological distress (beyondblue, 2013).

Students' distress has been reported as being highest prior to exams by multiple authors across multiple countries, which has been linked to performance anxiety (Dyrbye et al., 2008; Dyrbye, Thomas, & Shanafelt, 2005; Hassed et al., 2009; IsHak et al., 2013). In particular, students across various health and psychological disciplines in multiple countries including Australia have reported feeling significant stress prior to, and during the Observed Structured Clinical Examination (OSCE), which is a clinical skills examination (Labaf et al., 2014; Yap, Bearman, Thomas, & Hay, 2012; Zhang & Walton, 2018). The OSCE consists of multiple stations that students rotate around, each station having a time limit and particular objectives that students need to achieve, such as taking history or making an assessment (R. Harden, Stevenson, Downie, & Wilson, 1975; Yap et al., 2012). Feelings of stress have been attributed to the restriction of time which increased pressure to perform, which students feared they would be judged negatively for (Yap et al., 2012; Zhang & Walton, 2018). Additionally, OSCE uses standardised patients (SP's), who are generally actors

portraying a certain symptom of condition for students to assess. While some psychiatric trainees found SP's to be realistic and convincing (Hodges, Hanson, McNaughton, & Regehr, 1999; Sadeghi, Taghva, Mirsepassi, & Hassanzadeh, 2007), other students have felt the SP's were unrealistic which constrained their ability to make appropriate assessments, making the exam more stressful (Labaf et al., 2014; Melluish, Crossley, & Tweed, 2007).

Despite these reports of the OSCE being stressful, the method was developed by Harden and colleagues in Scotland in an attempt to reduce the stress created by students being unsure of what was in practical assessments, as well as to address both assessment and examiner subjectivity (R. Harden, 2016; R. Harden et al., 1975). The OSCE has now been adopted by the majority of medical schools globally due to its validity, reliability and adaptability to different disciplines (R. Harden, 2016; Yap et al., 2012). However, Harden (2016) argued that a potential disadvantage to OSCE is that students risk constraining their skills due to only learning the OSCE checklist: "Students organise their learning around a test" (p 4). Donetto (2012) also found in her study of medical education in one School in the UK, that students and educators both raised concerns that the OSCE encouraged a 'box-ticking' approach to communicating with patients, which was reported to promote inauthentic empathy rather than authentic, 'patient-centred' care which the School strived for. Donetto (2012) further highlighted that students noted that as they were being marked on certain responses that indicated patient-centredness, that certain rote-learnt 'empathic' responses such as 'oh that sounds really bad for you' were all that were needed to pass the OSCE. Hence, as a result of only studying what is in the OSCE, some students may be constraining the development of valuable skills in communication, developing authentic empathy, interviewing, assessing, formulation and case management, and also, authentic rapport building and connecting with patients on a meaningful level (Donetto, 2012; Marwaha, 2011).

In order to enhance students' rapport and communication skills with patients or consumers, video-taped interviewing with feedback has been used by multiple different disciplines, such as in psychology, the psychiatry clerkship (Mumford, Schlesinger, Cuerdon, & Scully, 1987), General

Practice (McAvoy, 1988; Nilsen & Baerheim, 2005), neurology (Fuller & Smith, 2001), oncology (Bonnaud-Antignac, Campion, Pottier, & Supiot, 2010), and internal medicine (Beckman & Frankel, 1994). Having students review their video-taped simulated interviews while receiving feedback from their supervisors has been found to result in students reflecting upon their performance and self-identifying areas for improvement, leading to a greater development in communications skills (Beckman & Frankel, 1994; Fuller & Smith, 2001; Nilsen & Baerheim, 2005), but also improved attitudes, behaviours, and knowledge (Beckman & Frankel, 1994). Video-taped interviews are potentially a more beneficial evaluation of students' interviewing and communication skills (Mumford et al., 1987) than the OSCE method, as the feedback and subsequent development of their skills was reported to enhance the student's confidence in their abilities (Bonnaud-Antignac et al., 2010; Nilsen & Baerheim, 2005), subsequently improving their feelings of competence (Nilsen & Baerheim, 2005).

Such an enhancement in competence may be of added benefit to students embarking on their clinical rotations, as IsHak et al. (2013) proposed that students can generally experience feelings of decreased competence going into clinical training that can promote greater feelings of stress or distress. However, research has explored the positive coping strategies that medical students have reported using to reduce such stress or distress (beyondblue, 2013), including talking to others, exercising, doing something enjoyable, or practicing mindfulness or meditation (beyondblue, 2013). Practicing mindfulness and meditation may be particularly beneficial, as recent research indicates that these practices can help reduce stress through enhancing positive coping skills and building resilience, which was shown to have positive impacts upon empathy, better decision making, and greater care shown towards patients/consumers (Rosenzweig, Reibel, Greeson, Brainard, & Hojat, 2003; Shapiro, Shapiro, & Schwartz, 2000; Warnecke, Quinn, Ogden, Towle, & Nelson, 2011).

Due to the ethical and moral importance of caring for oneself in order to be able to provide the best care for those in need, the World Medical Association (2017) amended the Declaration of

Geneva (akin to the 'Hippocratic oath') to include the requirement for physicians to "attend to my own health, well-being, and abilities in order to provide care of the highest standard". Hence, Kuhn and Flanagan (2017) argue that self-care is a professional imperative that individuals as well as medical institutions and systems need to value and address so that self-care becomes part of regular medical practice. Although, since the early 2000's many medical schools across the globe had already begun incorporating self-care programs into core skills training to address this professional imperative (Hassed et al., 2009; Rosenzweig et al., 2003; Shapiro, Schwartz, & Bonner, 1998; Shapiro et al., 2000; Wild et al., 2014).

For example, Monash University's Health Enhancement Program (HEP) which began in 2006 has become a model now used in many other medical schools, including Harvard Medical School (Hassed et al., 2009) and introduced to The University of Notre Dame Australia's School of Medicine (Fremantle) in 2014 (Chaney, 2018). The HEP is conducted in the first year of the medical program at Notre Dame, aiming to promote positive health and wellbeing behaviours in students while linking self-care content to biomedical and clinical learning and skills so that students can understand the relevance of the program (Hassed et al., 2009). The HEP consists of eight lectures providing the theoretical basis for the program and six tutorials to deliver a stress release program underpinned by the ESSENCE lifestyle model (Hassed et al., 2009).

ESSENCE is an acronym for *Education*; *Stress management*; *Spirituality*; *Exercise*; *Nutrition*; *Connectedness*; and *Environment*. The aspect *Education* emphasises knowledge and reflection; *Stress management* incorporates methods to enhance wellbeing and stress reduction, such as mindfulness practice; and *Spirituality* refers to the role and meaning of spirituality on wellbeing and resilience (Hassed, 2008; Hassed et al., 2009). The elements of *Exercise* and *Nutrition* are also emphasised to promote physical wellness (Hassed et al., 2009). *Connectedness* emphasises the role that social supports have in promoting wellbeing, and *Environment* includes the physical, emotional and social aspects of a person's life that may impact or promote wellbeing (Hassed, 2008; Hassed et al., 2009).

The two elements of connectedness and environment in particular highlight the psychological and social factors that are essential to mental health and wellbeing. This means these elements are particularly important, as it is now well known and accepted that the social environment has a significant role in distress through promoting prolonged periods of high stress, or traumatic life events for example. Throughout the HEP, students explore each of these elements in relation to how their own behaviours and attitudes may inhibit or foster healthy behaviours and behaviour-change strategies that may help (Hassed et al., 2009). The HEP further incorporates a stress release program (SRP), which is a stress management and cognitive therapy program that incorporates mindfulness practice and cognitive techniques to help students become more aware and critical of personal elements that may create unnecessary stress, such as perception and emotion (Hassed et al., 2009). Mindfulness is an awareness-raising technique that has been shown to foster self-awareness and self-compassion (Solhaug et al., 2016), which strongly correlates with an increased ability to be empathic (show compassion and care) and importantly, connect with others (Kingsbury, 2009). This is important as empathy and connection are important aspects of providing just treatment and care to distressed individuals. In addition, mindfulness may support clinical skill development and interviewing skills, as Solhaug et al. (2016) found that mindfulness helped some students to listen more to health care consumers, accept what they are saying and better attune to how the consumer was feeling.

Therefore, learning mindfulness and other wellbeing-promoting techniques may be beneficial for students' future practice as doctors, particularly as many GP's now incorporate non-biomedical therapies in their medical practice, which is a growing field referred to as Integrative Medicine (IM) (Australasian Integrative Medicine Association, 2014; Phelps & Hassed, 2011). IM integrates conventional biomedicine with complementary evidence-based therapies or techniques to provide a holistic approach that addresses all aspects of a person's life and promote wellbeing (Australasian Integrative Medicine Association, 2014). In relation to mental health, integrative medicine approaches to mind-body interventions can include mindfulness and meditation practices,

yoga, support groups, and also psychological therapies such as psychotherapy and cognitive-behaviour therapy (CBT), while incorporating other biomedical treatments such as medications where necessary (Australasian Integrative Medicine Association, 2014; Phelps & Hassed, 2011). GP's may engage in some of these therapies themselves if they have been trained or refer individuals to other professionals (Australasian Integrative Medicine Association, 2014; Phelps & Hassed, 2011), which highlights how GP's may be the first line of care and treatment for a distressed individual. The integrative medicine paradigm has also extended to Integrative Mental Health practice, particularly in psychiatry whereby pharmacological approaches are considered alongside psychological, social and physical interventions such as yoga and meditation (Lake, Helgason, & Sarris, 2012).

Given that learning in personal wellbeing may be transferred to future patients and consumers, and that potentially such learning may not be linked to the mental health and psychiatry curriculum, research is needed to explore WA medical students' learning in personal wellbeing to see if they relate it to content in mental health and psychiatry, and/or the recovery paradigm. Furthermore, research is also needed to explore students' learning in clinical skills training to understand whether mindfulness training assists students to better connect to consumers during clinical interviewing, which may be explored through their interactions with consumers on rotation. Research may also investigate how WA students put into practice their learning in clinical interviewing in psychiatry during their rotation, and how they perceive the OSCE assessment technique and whether it impacts the way the students learn and prepare for exams. Essentially, such research would encompass the exploration of the perspectives the students learnt from, as well as how they were able to apply their learning in practice, and how their relations with consumers and clinical supervisors during rotations impacted their learning.

While there is an abundance of literature exploring students' attitudes towards psychiatry and mental health in various contexts in Australia and globally, there is a paucity of qualitative literature in the Australian and Western Australian contexts that explores medical students' *learning experiences* in psychiatry and mental health. For example, Pai et al. (2012) highlight that the global

and Australian literature predominantly focuses on student attitudes towards psychiatry rather than their learning experiences or what they are learning in psychiatry. Additionally, Karageorge et al. (2016) conducted a narrative synthesis of international literature relating to students' training experiences in psychiatry, as the authors found that there was not enough Australian literature to complete the review in a purely Australian context. Karageorge et al. (2016) gathered recent international papers that met inclusion criteria and noted "There was no Australian paper describing prevocational psychiatry training experiences of junior doctors" (p. 310).

Only three relevant qualitative studies were found for this current literature review that looked into students' learning experiences in psychiatry in Australia, which have been previously outlined in this review (Pai et al., 2012; Wigney & Parker, 2007, 2008). Pai et al. (2012) provided a qualitative analysis of NSW medical students' learning in psychiatry, finding that rotations had shifted some students' perspectives towards psychiatry and consumers, and emphasised the need for quality teachers in psychiatry. However, Pai et al.'s (2012) research did not discuss or explore the potential origins of stigma, the hidden curriculum, or any learning students may have had in the recovery paradigm, yet the authors recommended that further research be undertaken with Australian undergraduate medical students to further understand their learning experiences in psychiatry and the hidden curriculum.

Additionally, one Western Australian study was found that quantitatively assessed WA medical students' attitudes towards mental health consumers through a survey (Lyons, Laugharne, et al., 2015). Although Lyons, Laugharne, et al. (2015) provided an analysis on the levels of stigmatising attitudes that WA medical students may have, the study did not explore *how* students' attitudes and understanding may be influenced or constructed as a result of their learning and training. This also means the study did not focus on aspects of the hidden curriculum that may influence the students' perspectives of mental health, psychiatry and consumers of services. Furthermore, while one study was found regarding the implementation of a recovery-oriented undergraduate psychiatry training program in Ireland (Feeney et al. 2013), there was no study found

in the Australian literature regarding the implementation of recovery-oriented undergraduate psychiatry programs in Australian medical schools, although one program delivered in New Zealand was found (Newton-Howes et al., 2018), which has been discussed in earlier sections.

There are also numerous studies evaluating the outcomes of recovery-oriented training for nursing students and mental health services workers more broadly (for example, Patterson et al., 2016); however the only research literature available regarding Australian medical programs that incorporated recovery aspects were regarding the outcomes of using consumer tutors to deliver tutorials. Hence, this literature review did not find research regarding the implementation of recovery-based psychiatry programs for undergraduate medical school courses in Australia or Western Australia. Therefore, there is a necessity to explore medical students' learning in psychiatry in the Australian and Western Australian contexts, particularly in relation to whether current learning aligns with the current direction in mental health policy towards recovery-oriented care.

More broadly, the available literature focusses on students' experiences in relation to how their education and learning could be enhanced to increase the desire to specialise in psychiatry, as well as how the image of, and recruitment into psychiatry may be improved. None of the Australian literature that was found and reviewed explored power relations in the students' experiences, or the impact that students' learning may have on their attitudes towards, or ability to appropriately care for mental health consumers. As such, this proposed research aims to address these gaps in knowledge and understanding, while acknowledging the challenges that students and medical institutions may face in shifting paradigms towards recovery. Understanding what medical students are learning in mental health and psychiatry training spaces may provide further information about the potential current issues regarding the transformation of WA's mental health system towards the recovery paradigm, which may also provide insights into possible barriers to individual's recovery from a mental health issue. As such, these highlighted issues will be explored and examined in this current research.

2.9 Purpose, significance and scope of the research

This research was significant because it explored medical students' understandings, preparedness, perceptions and ways of working with mental health consumers as a result of their training. Researching future medical professionals' understandings was essential given that the first line of care for consumers are frequently GPs, ED physicians and psychiatrists. Understanding whether upcoming professionals are operating purely within the clinical/biomedical recovery model, or whether they are learning to operate within the consumer recovery approach as well is also important due to the paradigm shift the Western Australian mental health system has been working towards (Government of Western Australia Mental Health Commission, n.d.). The findings of this research may therefore lead to changes that could enhance future students' understanding of mental health, distress, and recovery, and potentially positively influence perceptions of consumers and psychiatry.

In addition, this research was significant because there is a paucity of research that has explored these issues in the Australian and Western Australian contexts. While Lyons, Laugharne, et al. (2015) quantified the level of stigmatising attitudes from a cohort of WA medical students, the current research aimed to identify where the sources of stigma may arise, what stigma may look like, and how stigma may be a barrier to consumers receiving fair and appropriate care. The language students use was also important to explore as students, academics and medical practitioners actively contribute to medical culture, discourses and norms of practice through what they reproduce, repeat, challenge, resist, or overlook (Gaufberg et al., 2010; Liao, Thomas & Bell, 2014).

Gaufberg and colleagues (2010) further argued that medical educators need to listen to students, as what students report they learn may reveal the dominant messages that are actually taught. Therefore, this research project also aimed to harness the students' perspectives of what they were taught, in order to expose any gaps in teaching or learning that may have impacts on the students' future practice. The findings may therefore indicate potential issues that could have implications for students and the broader reform of the WA mental health system, as well as

highlight any issues that may be creating barriers to individuals receiving appropriate care and treatment.

2.9.1 Research question and aims

The overarching research question developed was *How have 4th year medical students understood and experienced their education in mental health and psychiatry, and how has this understanding influenced their engagement with mental health consumers and perceptions of psychiatry?*

The key questions developed to explore the overarching question included:

- What have medical students learnt and what do they understand about mental health and distress, as well as consumers and psychiatry?
- How has their learning prepared them for their psychiatric rotations and for future practice as doctors?
- What additional learning did the participants gain during placements?
- What are the participant's perceptions of psychiatry, and would they choose to specialise in psychiatry or do further training in mental health?

The research also examined how students' learning aligned with current mental health policy directions and reform towards the consumer recovery paradigm, in order to ascertain students' preparedness for working within mental health spaces and with consumers. This was important to identify factors that may be impacting the transformational change of the mental health system towards recovery.

3. Research Methodology

The research was guided by the theories and approaches of the Bachelor of Behavioural Science at The University of Notre Dame, Fremantle. The Behavioural Science discipline considers the social, political, cultural and historical elements acting upon an individual's experience, and works towards the emancipation of groups who are experiencing marginalisation and disadvantage. This research used a qualitative paradigm to provide an insight into how meaning and

understandings are constructed, and subsequently enacted and experienced by medical students in the mental health sector.

A qualitative paradigm was chosen as quantitative research methods can be limited in their ability to provide a deeper level of understanding of the meanings that people ascribe to their experiences, (Crotty, 1998; Edley, 2001; Hall, 2001). Further, Anthony et al. (2003) argue that qualitative research has provided more knowledge regarding evidence-based practice in mental health and recovery than the traditional positivist scientific method. Qualitative research utilises words as units of data to explore people's experiences and understandings of the phenomenon being researched, through an analysis of the language used to describe or construct knowledge or events (Braun & Clarke, 2013).

3.1 Social Constructionism

Knowledge is constructed through how people understand and interpret information which may depend upon how such information is delivered and received (Braun & Clarke, 2013), while understanding is achieved through the language used to give meaning to people, concepts, events or objects (Crotty, 1998; Edley, 2001). Therefore, within a social constructionist understanding, knowledge is socially constructed through language and dependent upon historical factors such as prior understandings, which themselves were socially constructed (Gergen, 2003). For example, Foucault (1972; 2006) argued that mental 'illness' was not a stable construct that endured throughout time, but rather 'knowledge' about mental illness has changed over time, constructed by the words that describe and explain it, and give it a name (Hall, 2001).

The current research was based within Constructionist epistemology, which acknowledges that there are multiple, diverse realities that individuals actively construct using language to convey meaning (Edley, 2001). Rather than view reality as being only one way that can be 'discovered' using empirical research, constructionism argues that reality is how a person comes to understand it, and also that reality becomes how a person 'constructs' it through the words they use (Gergen, 2009). Hence to the constructionist, reality is epistemic and reality and epistemology cannot be separated

(Edley, 2001); for example, a psychiatric diagnosis may be constructed as a mental 'illness', meaning that it is 'abnormal' and the person needs 'healing', or it may be constructed as an experience that may be a human reaction to stress and trauma which the person recovers from. The construction of each reality will therefore prescribe what can be known about the phenomenon and therefore, how it may be responded to by individuals, health professionals and the broader community (Crotty, 1998).

Constructionism further assumes that individuals are the experts of their own experience and thus contribute to knowledge formation via the narratives of their experiences (Edley, 2001). The use of social constructionism was important for the research as individuals are embedded in the social institutions, which construct, reproduce, and resist or maintain certain knowledges (Crotty, 1998). The medical students involved in this research are largely embedded within the epistemology of scientific positivism that underpins biomedical research, and the institutions of medicine and psychiatry. Students therefore reproduce the discourses and knowledges inherent within these structures to make meaning of their profession, the professions' aims and practices, and the professions' relationships with the people it serves.

3.2 Theoretical perspective: Critical Theory

This research was grounded in a Critical theoretical perspective as Critical theory interprets meaning in terms of conflict (or contradiction), provides the basis for exposing issues relating to power, and challenges normative discourses and practices that maintain the status quo (Crotty, 1998). Critical theory enables the deconstruction and exposing of political, philosophical, social, psychological and economic structures operating in a person's experience, thereby rendering invisible factors, visible. The theory highlights that as certain meanings are created through social interactions, these meanings may support certain power structures through maintaining inequality, fostering oppression and manipulating other sources of injustice (Crotty, 1998). In this way, critical theory aligns with the recovery paradigm as the movement is also concerned with fair treatments, practices and social conditions for people who have lived experience of a mental health condition.

Using Critical theory underpinned by social constructionism enabled the detection of language and meaning that can stigmatise and socially isolate consumers, which may promote inequities of power between them and medical practitioners. Critical theory had the further benefit of enabling the detection of unjust, unethical or absent practices that may otherwise be 'hidden' (Hafferty, 1998), rendering the invisible, visible. Identifying hidden issues and practices, or absent practices, is achieved through analysing the language that produces knowledge, legitimises practices, and positions people a certain way; such as, 'expert', which implies having power and status, or 'patient' which implies a lack of power and need for help (Crotty, 1998; B. Davies & Harre, 1990; Willig, 2001). Furthermore, the use of critical theory enables the exposure of systemic discourses and issues that are related to power which impact the recovery of mental health consumers.

3.3 Methodology: Constructionist Thematic Analysis

Thematic analysis is a flexible method of qualitative data analysis that is easily adapted to a particular theoretical framework to guide the analysis (Braun & Clarke, 2006). Adding the epistemological assumptions of constructionism means that the thematic analysis enabled the detection of issues that related to the construction of the students' knowledge and reality. Constructionist thematic analysis (CTA) was beneficial for this research as it is more focussed on the constructive features of language than other forms of thematic analysis and can function as both a methodology and method within qualitative research (Braun & Clarke, 2013). For the purposes of this research it was utilised as both the methodology to guide the research practice, and the approach to data analysis.

Using CTA means that the research was designed to examine how participants construct their understanding of topics such as mental health, and events such as learning experiences while on rotations (Braun & Clarke, 2013). This included looking at how different groups of people may be positioned using language, and therefore, a students' constructed reality may have impacts upon those who experience psychological distress. When underpinned by Critical theory, constructionist

thematic analysis also has the ability to reveal power issues through analysing the language used to speak about phenomena, and the language that socially positions the students, mental health professionals and educators, as well as consumers (Coyle, 2012; Crotty, 1998; Hall, 2001).

3.3.1 Informants

The participant group for the current study included all 4th year medical students in 2017 from The University of Notre Dame, Fremantle who had completed psychiatric clinical placements. The total number of students in the 4th year cohort was 95 (Appendix E). Eight psychiatry rotations ran from 31st January to 29th September, each with 11 to 13 students (Appendix E). Three focus groups were initially proposed to collect sufficient data, assuming six to twelve participants in each focus group to be conducted effectively (Braun & Clarke, 2013). Therefore, the minimum number of participants required was 18 to 36 people. However, if recruitment did not yield 18 – 36 participants then a minimum of ten individual interviews was proposed to potentially meet data saturation (Braun & Clarke, 2013).

The number of participants initially required for this study was based upon the optimum number of individuals needed for a small to moderate-sized project to meet data saturation (Braun & Clarke, 2013). Initially planning three focus groups was proposed to lead to data saturation due to the larger amount of data proposed to be collected (Braun & Clarke, 2013; Millward, 2012). Conversely, having too few participants may not have generated enough data to lead to saturation (Braun & Clarke, 2013), or could have resulted in response bias which may also impact the quality of the data (Stoop, 2012). The final participant group consisted of ten students in total (slightly more than ten per cent of the cohort), seven females and three males. All participants were over 18 years and had a high level of English proficiency. Four participants had completed rural clinical school in their third year of study, which was important to note as these participants had additional learning in psychiatry and mental health through completing a regional psychiatry rotation as well as having some community mental health service exposure during the third year.

Six students took part in the initial focus group, two participated in a joint interview and two participated in individual interviews. The minimum ten participants proposed as potentially being able to meet data saturation was sufficient for the study, as an appropriate amount of data was collected from the ten participants to reach data saturation and complete the analysis. Data saturation is "the degree to which new data repeat what was expressed in previous data" (Saunders et al., 2018, Table 1), and is considered met when data collected from participants become redundant, as the additional information does not add any new insights (Saunders et al., 2018). Therefore, further coding of the data is no longer feasible (Fusch & Ness, 2015). In line with Fusch and Ness (2015) and Saunders et al. (2018), data saturation was considered to be met within this current research after interviewing participant 10, as no new information was presented. This was unsurprising given the homogeneity of the cohort in relation to medical school, course content, and learning materials. In addition, it is not unusual in qualitative research for data saturation to be reached as there is no set minimum number of participants required (Braun & Clarke, 2013).

The School of Medicine assisted participant recruitment through posting an announcement about the study on the students' Blackboard page; posting a flyer on the student notice board; allowing myself and my secondary supervisor, Dr Ryan Anderton to speak to students about the study prior to a lecture; and through providing me the contact details of the student liaisons for the fourth-year cohort. Participants were recruited through the student liaisons and through my secondary supervisor providing further information about participation in the study to the medical students. The School was mindful that medical students are an over-researched group, therefore requiring that their time be respected, meaning all interviews or focus groups needed to be conducted outside of the students' exam preparation period from September to November 2017.

Informants were purposefully recruited as this research intended to harness medical students' valuable insights into the current training in mental health that future medical professionals undergo. Gaufberg et al. (2010) argue that medical students are uniquely positioned to comment on what they learn as they occupy both insider and outsider positions, meaning they are

situated within medical institutions but are not yet doctors. Hence, medical students can "observe and name cultural phenomena" (Gaufberg et al., 2010, p. 1709) that may eventually become invisible to, or taken for granted by, experienced medical professionals. Therefore, medical students are therefore well positioned to provide insight into practices that may impact the provision of care.

3.3.2 Setting of Informants: UNDA School of Medicine, Fremantle and an overview of the psychiatry curriculum

The University of Notre Dame's School of Medicine (SoM) was established to respond to growing and changing workforce demands in Medicine in Perth. The School places particular emphasis on Catholic values of compassion, respect and service (Lawson, Chew & Van Der Weyden, 2004). Service learning is considered particularly important as it enhances the students' understanding of their practice and interactions with others and themselves. Additionally, students are taught Catholic ethics, philosophy and theology in order to better understand the relevance of these areas in people's lives, which aims to enable students to be able to talk with individuals about all matters of health in a respectful and non-judgemental way (Lawson et al., 2004). To further encourage respectful interactions with patients, the School encourages students to reflect on their experiences in clinical debriefing tutorials, which aims to encourage reflective practice and practitioner self-care (Lawson et al., 2004). In addition, the School partners with 'expert' patients, patient advocates, carers and community members in teaching students; an approach that enables students to incorporate patient perspectives into their future practice, while also meeting the required standards of the Australian Medical Council's Standards for Assessment and Accreditation of Primary Medical Programs (2012) for promoting patient-centred care, collaboration, and relating teaching activities to the community's needs (Mak et al., 2018).

As students may not always remember everything covered throughout the four-year program during the interviews and focus groups, the School provided access to the curriculum mapping system throughout the study, along with the MED400/MED16400 Psychiatry Study Guide (School of Medicine Fremantle, 2017). This access enabled me to further explore whether students

may have been taught a particular knowledge, but not remembered it when questioned. In 2016, the SoM transitioned from a Bachelor of Medicine, Bachelor of Surgery (MBBS) program to a Doctor of Medicine (MD), resulting in some curriculum changes for some aspects of the course from the 2014 cohort to the present students. However, the final year psychiatry curriculum remained the same.

The curriculum is delivered through a focus on problem-based learning (PBL) (School of Medicine Fremantle, 2018), which is a small group teaching method that uses problems to increase knowledge and understanding, as well as develop self-directed learning skills and attitudes to inquiry (D. Wood, 2003). For example, students may research a clinical case that will prompt investigation of multiple facets such as anatomy, pathology and aetiology. The PBL method of learning is supported by lectures as well as 'expert' tutorials in which clinical professionals and advocates discuss certain topics and issues (School of Medicine Fremantle, 2018; D. Wood, 2003). Clinical debriefing (CD) tutorials also support PBL as students are given cases and topics to research and discuss professional and ethical implications (School of Medicine Fremantle, 2018). Additionally, clinical skills development sessions help students develop clinical interviewing and assessment skills (School of Medicine Fremantle, 2018). Reading resources such as peer-reviewed journal articles and online sources are also provided to students and the School recommends a number of introductory-level psychiatry text books to further support learning in this area (School of Medicine Fremantle, 2017). Although content may be covered in lectures or tutorials from other aspects of mental health that are not psychiatric (such as the recovery perspective or community mental health), only psychiatric-based content and resources are available in the curriculum.

First Year - MED100

In relation to mental health, the first year focuses on teaching students the philosophy and methodology of science, understanding the concepts of health or mental health and the factors determining mental health. Students are required to understand the role of family relationships in mental health, as well as the role of a GP to help address issues in the family that may be impacting

a person's mental health. The principles of 'patient-centred' care are emphasised, and through the CD tutorials, students are provided the space to learn to become reflective practitioners. The Physician Wellness Program (ESSENCE+ program) is also undertaken in the first semester to teach students methods for maintaining their own wellbeing and preventing burnout, due to the high levels of stress and burnout that medical students often experience (beyondblue, 2013).

Second year - MED200

The bulk of theoretical learning in psychiatry is mostly covered within the few weeks of the mental health block of the second year of the medical program. Here, students are taught biological approaches to distress, followed by the psychological and social aspects including the factors contributing to the development of a mental health issue and/or substance overuse. Students are also taught about psychiatric disorders and the use of psychiatric language, as well as psychiatric treatments in the form of medications. Substance overuse and appropriate treatments are also covered, along with learning how to conduct mental state examinations and performing a clinical interview, including clinical history taking. Physician burnout, maintaining personal wellbeing and the impacts of personal wellbeing on patient care are also discussed, which includes doctors' wellbeing and seeking help if they become distressed. Stigma and the ethics of involuntary treatment under the Mental Health Act are covered, as well as the personal, ethical and legal issues in mental health care. Students also undertake personal reflections on their perceptions of working with mental health consumers and are required to demonstrate an understanding of the mental health system.

Third year - MED300

Third year of the curriculum has no specific psychiatry or mental health rotation or learning focus unless students undertake Rural Clinical School, although learning in mental health may be gained from other rotations such as GP, paediatrics, or neonatal health. For example, during GP placements students may learn about the social and economic factors impacting mental health, including factors that may promote depression and factors influencing help-seeking behaviours. Self-

directed learning includes researching the common psychiatric and psychological issues associated with chronic medical conditions such as depression and anxiety, as well as understanding the types and side effects of antipsychotics, antidepressants and mood stabilising medications.

A portion of students undertake their third year with the Commonwealth funded Rural Clinical School (RCS) of Western Australia. The RCS coordinates student placements in regional areas of WA and sets out the psychiatry curriculum to consolidate the knowledge and skills learnt during second year (The Rural Clinical School of Western Australia, 2018). Four-week psychiatry rotations during RCS provide students the opportunity to practice clinical interviewing, taking psychiatric history, as well as perform mental state examinations and risk assessments (The Rural Clinical School of Western Australia, 2018). Within the rotation, students need to perform and present a diagnostic formulation as well as formulate management plans using a biopsychosocial approach, and be able to communicate those plans appropriately (The Rural Clinical School of Western Australia, 2018). Additionally, students are required to be able to explain the uses, indications, pharmacology and side effects of common psychiatric medications, along with the uses and roles of psychotherapies and psychoeducation in treating distress (The Rural Clinical School of Western Australia, 2018). RCS Students also need to develop an understanding of a patient's values, perspectives and preferences in formulating a management plan, as well as the importance of family and carer's perspectives, and include in the rehabilitation plan the person's goals, ways to enhance social functioning, addressing stigma and monitoring their progress (The Rural Clinical School of Western Australia, 2018). It is important to acknowledge here that only RCS students undergo this learning in third year, meaning a significant number of students do not have this exposure and learning experience prior to their final year psychiatry rotation.

Final year - MED400

Students undertake four-week psychiatry rotations in the final year and there is a specific formal learning program in psychiatry. The learning program focuses on eating and personality disorders, co-morbid physical and psychiatric conditions, physical health problems for consumers

and the medical complications associated with psychiatric disorders and treatments. Risk assessment and managing individuals who may pose a risk to themselves or others is also covered. The student learning outcomes for the psychiatric rotation are classified as either 'essential', 'desirable', or 'optional'; hence, students are required to learn the 'essential' aspects but not necessarily demonstrate understanding in the desirable or optional elements in order to pass.

Essential:

By the end of the psychiatry rotation, students are required to demonstrate their ability to undertake and record a mental state examination (MSE) and apply and interpret cognitive screening tools. Students also need to understand and be able to explain psychiatric symptoms (behaviours), undertake risk assessment and risk management in the emergency department and GP settings. Also essential is an understanding of the clinical features of major psychiatric diagnoses, and the ability to undertake assessment and make a differential diagnosis. Students are also required to demonstrate an understanding of how to manage a person's symptoms using medications and electroconvulsive therapy, as well as understand the role of psychological and social interventions for diagnoses such as 'schizophrenia', depression and anxiety. For example, students need to be able to discuss the role of cognitive-behavioural therapy (CBT) in managing depression. Students are required to be able to construct a management plan using the BPS model for the acute, intermediate, and maintenance stages of distress as well as know the indications for admission to hospital. Essential learning further includes explaining the indications for, and process of utilising the Mental Health Act, as well as the ethical issues involved in using the Act.

Desirable:

Understanding the classifications, subtypes, epidemiology, aetiology, pathogenesis and co-morbidities of each psychiatric disorder are considered desirable for students to know. Having an awareness of the risks that consumers may pose to others is also desirable, as well as an understanding of the role of psychiatric classifications and principles of classifications in the DSM-5 and ICD-10. Students may also learn the basic principles of CBT, and to describe and apply stress

management techniques for the management of an individual's distress or diagnosis. Additionally, the indications for community or in-home treatment are listed as desirable knowledge, meaning that students may not need to demonstrate an understanding of when community mental health services or in-home care may be more appropriate than hospitalisation.

Optional:

Non-essential learning includes having an awareness of the role and use of accommodation services, occupational assistance, self-help and community support groups, and financial supports to assist consumers – all of which have been listed as required understandings for competency in working within the consumer recovery model that underpins current mental health policy (Anthony, 1993; Commonwealth of Australia, 2013a, 2013b; Victorian Government Department of Health, 2013).

3.3.3 Materials

The informants received a participant information sheet (PIS) (Appendix A) written in plain English, detailing the purpose and procedures of the research and what was required of them. Participants also received a consent form (Appendix B) written in plain English to sign and return to the student researcher. A digital audio-recording device owned by the research student was used to record the focus groups and interviews. An interview schedule (Appendix C) was used for conducting the focus groups and interviews, consisting of open-ended, semi-structured questions to guide the discussions. In keeping with the aims of the qualitative research paradigm, the questions were exploratory by asking 'how', 'why', 'what' and 'can you tell me more about…' for example. The questions were designed to explore students' learning in mental health and psychiatry, how they applied their learning in practice and their understandings of psychiatry, mental health and consumers. For example, to explore theoretical learning, the question was worded: "What did you learn theoretically about mental health and psychiatry?" and "Were there any particular focusses or emphasis on any particular area?". To explore how students felt prepared for rotations and their application of their learning, questions were asked such as: "How were you able to utilise your

theoretical knowledge in practice?" and "Was anything particularly useful or relevant or not useful?".

3.3.4 Procedure

One focus group was conducted by myself and supervised by my primary supervisor prior to the students' exam preparation period. Questions were asked according to the interview schedule and where necessary, further probing questions were asked to gain further information or clarification from the participants. The focus group was recorded on a voice-recording device to enable later transcription. The focus group provided, as Millward (2012) suggested, a broader range of issues as well as new information and a depth of discussion between participants that is not always possible in a single-participant interview. Focus groups can also generate more data than single-participants interviews (Braun & Clarke, 2013; Millward, 2012), which was beneficial for the smaller number of participants that were recruited. An initial analysis of the focus group data identified areas to further explore with the interview participants. Conducting in-depth interviews following a focus group is a common method in qualitative research due to generating rich and more specific detail – referred to as 'thick' descriptions of phenomena (Braun & Clarke, 2013).

Using a semi-structured interviewing style meant there was freedom to explore areas in more depth where a student highlighted something that was of particular importance to the research aims, or to probe for further information if the answer required more detail (Breakwell, 2012). Therefore, some questions were asked that were not contained in the original interview schedule. For example, to probe students further about their additional learning while on rotation, students were asked "when you were observing the clinicians, what were some of the things you took away from those experiences?". To understand more about how their learning prepared them for rotations, "How do you think the clinical skills training helped you in preparation?". Feedback was taken on board about the interview schedule during the ethics approval process, whereby the questions were refined further. The questions were piloted on another person to ensure they would

elicite the appropriate information to answer the research questions, while being open-ended enough to provide space for participants to provide unanticipated information.

As the recruitment of the final four participants occurred with the School's permission after the exam period, interviews were logistically the most appropriate way for the students to participate. The interviews were an appropriate way to reach data saturation, as participants provided more rich detail and explanation of their experiences and understandings due to greater probing of the issues that were identified in the focus group. Interviews were conducted by myself, lasted between 50 to 60 minutes and were audio-recorded. All participants had the opportunity to nominate themselves for a follow-up interview in the consent form. Nine participants nominated for follow-up interviews; however the students who were approached for follow-up were later unavailable.

3.3.5 Data Analysis

Within 24 hours of the focus group and each interview, I manually transcribed the data verbatim into a Word document from the audio recordings. Each line of data was numbered to provide points of reference for the analysis and each participant was numbered to remove identifying information. In line with qualitative analysis methods described by Braun and Clarke (2013), during transcription and the initial analysis of the focus group data, a journal of my personal thoughts and assumptions was kept to keep them separate from the potential themes and issues. Within the comment column of the transcription documents, I began coding the data by making notes regarding the potential issues and themes within the data. After multiple readings of the transcript, an overview of the initial codes from the focus group data was written in a separate document, including the quotes that exemplified each issue so that these could be explored further.

The transcripts were read multiple times and during the readings I continued to journal my thoughts and assumptions and code the data in relation to potential issues and/or interesting statements. Reading the transcripts multiple times enabled a deep and sound understanding of the data, which provided me with an understanding of the participants' accounts of their learning

experiences as opposed to seeing the data as testable representations of one, true reality that characterises quantitative research. Subsequently, a question-ordered matrix was constructed using Microsoft Excel where each participants' responses were placed into the relevant interview question. This was necessary for the analysis as participants would often answer multiple questions in the one response as the conversation unfolded. Following all the data being placed into the matrix, the data was analysed to produce latent codes. The implicit meaning of the data was interpreted using the lens of social constructionism and critical theory.

A Constructionist thematic analysis (Braun & Clarke, 2013) approach was used to manually code the data, develop the themes and identify the issues. Codes that had the same underlying message, phenomenon or experience were grouped and sorted. From the coding matrix, the overarching themes were developed utilising Connelly and Peltzer's (2016) guidance on developing rigorous themes in qualitative research. After triangulating the data with my supervisor, I constructed a thematic 'map' of the initial codes using large brown paper and post-it notes to explore how the issues may be related and where they could potentially be grouped into themes. Using the brown paper and post-it notes allowed me to physically move the issues around and group them into themes which helped to refine the topics that needed exploring further during the interviews.

The themes were challenged and tested by myself, and later by my primary supervisor by continuously questioning them for potential deviant cases that could be in opposition to what I initially found. My principal supervisor also ensured that I was not projecting personal bias into the analysis by checking the draft documents and highlighting where assumptions may have been coming into the analysis. Each theme was placed into its own matrix in Excel, whereby the issues provided the heading for each column and each participants' responses were placed underneath. An audit trail was also kept to track the progress and details of how the CTA was conducted, including notes on the themes, codes and common issues (Braun & Clarke, 2013).

A triangulation process (Braun & Clarke, 2013) was used to iteratively analyse the data, whereby each focus group and interviews' data was compared, while referring back to existing literature and consulting with the principal supervisor to ensure the interpretations were rigorous, transparent and authentic. Triangulation also involved member-checking (Braun & Clarke, 2013) with interview participants who received an interview summary to ensure an authentic representation of what was said. This provided the participants with an opportunity to clarify any statements or issues prior to the finalisation of the thesis. However, feedback or further comments were not received from the summaries provided.

The CTA was conducted inductively so as not to subject the interpretation to an existing model/theory, although it was guided by the tenants of Critical theory as previously outlined. With this approach, I utilised works that aligned with critical theory, such as Opotow's Scope of Justice theory and Freire's writings on Critical Pedagogy. The participant's use of language was analysed to understand how their knowledge was constructed in relation to the history of biomedical approaches, psychiatry and the recovery perspective. This approach helped to understand how students position and utilise that knowledge in practice, as well as how the students positioned key stakeholders, such as consumers or psychiatrists, for example. Conducting the analysis this way enabled an understanding of what students learnt and how their learning was applied, providing the opportunity to discuss the potential consequences of the students' learning upon consumers of mental health services. The method of analysis also enabled the detection of any stigmatising attitudes and discourses that may have been evident, along with the factors that impacted upon the students' wellbeing.

3.3.6 Reimbursement

Focus group participants were provided with a light lunch due to the time and duration of the focus group, while interview participants were offered reimbursement for parking and transport costs associated with getting to the interview venue, and light beverages during the interview.

3.4 Ethical Considerations

The research was given ethical approval by the University of Notre Dame's Human Research Ethics Committee (approval number 017070F) (Appendix D). It was possible that participants could have become emotionally upset or distressed due to some of the issues surrounding experiences with consumers or mental health issues that could have been raised during the focus group or interviews. Some questions involved the participants recalling experiences that may have brought up personal issues or invoked memories of distressing experiences during psychiatric rotations. However, while this was a possibility, the risks were considered minimal given that all medical students are provided with debriefing mechanisms throughout their degree, including after their clinical placements. Students were also given the opportunity to stop their participation if they were feeling distressed and had the right to withdraw from the study, including any data collected (excluding from focus groups due to the difficulty of identifying all of the participants' contributions in the audio recordings), without prejudice or judgement.

The principal supervisor ensured that all students/responses were monitored during the focus group and was prepared to debrief any distressed individuals with respect to the risk management plan outlined within the ethics application. All participants were informed of the free debriefing services available on the participant information sheet (Appendix A), although there were no cases whereby a student became distressed during the focus group or interviews. The School of Medicine also agreed to provide the services of the School's Clinical Psychologist if participants felt distressed or were in need of support. This was the same debriefing mechanism available to all Medicine students throughout their degree and was of no cost to the student/participant. Participants were further informed that The University of Notre Dame's free Student Counselling Service was available to them should they need it.

Confidentiality may also have been an issue during the focus group, and therefore, at the commencement of the focus group, group rules/norms were discussed particularly in relation to confidentiality, levels of disclosure, internal (cohort) relationship, and professionalism. Specifically,

students were informed about the inability to ensure confidentiality during the focus groups and were reminded of how much they choose to disclose and given another opportunity to withdraw. No students withdrew their participation. Lastly, the School of Medicine supported the research provided that the School received a copy of the full ethics application and the approval before the commencement of the study and that the School received a copy of the findings. A copy of the full ethics application was provided to the School of Medicine, along with a copy of the written confirmation of approval by the University's Human Research Ethics Committee (Appendix J) prior to the collection of data.

3.5 Researcher positioning

My experience with distress and the mental health system are both personal and professional. I have experienced suicide in family, as well as periods of distress and post-partum distress. In turning to medical professionals for help, as is encouraged by mental health campaigns, I noticed from both my and my family member's experiences that medically-trained doctors explained that our distress was due to chemical imbalances in our brains, and would therefore need medications to correct these 'flaws'. However, I knew that my distress was brought about by my circumstances rather than my biology. As a result of my experiences and listening to other people's stories, I could see there were issues with how the mental health system and professionals within it were responding to consumers' distress. Consequently, I enrolled to study Science (Human Biology) and Behavioural Science at the University of Notre Dame Australia, so that I could learn more and equip myself with tools to understand more and help others.

The Behavioural Science degree at Notre Dame, Fremantle, is underpinned by social constructionist assumptions (Crotty, 1998; Edley, 2001), and the values and practices of Critical Community Psychology (Fox, Prilleltensky, & Austin, 2009; Nelson & Prilleltensky, 2002, 2010). These include the values of human rights and social justice, as well as harnessing the leadership of the individual and the community in transforming power relations and unjust social conditions that impact people's wellbeing. With the degree taking a Foucauldian approach to discourse, I learnt the

nexus between language, knowledge and power that constructs people's understanding of their world, and therefore, how they interact with others. As such, I have drawn on these assumptions and values, as well as the transformational change framework outlined in Nelson and Prilleltensky (2010) to guide my research.

Within the Behavioural Science program is the Community Mental Health course, which unpacked how mental health consumers can be labelled, stigmatised and dehumanised. The course provided a contextualising history of the mental health professions including psychology and psychiatry, that have led to current understandings, treatments, and the consumer recovery paradigm. I learnt that distress was a continuum rather than an either-or binary, which I intrinsically understood as I had experienced it. I resonated with the consumer recovery perspective as I had personal experience of going through the process. As a result, my personal experience as well as the consumer recovery paradigm and the social constructionist lens has underpinned my approach to this research.

Through my training in Community Mental Health, as well as what I had learnt in my Human Biology degree, I also came to understand the theoretical differences between the biomedical and consumer/social/psychological approaches to both conceptualising and treating distress. During my Science degree I studied neuroscience and researched the neurobiological evidence for the psychiatric diagnosis of schizophrenia (Smith, 2016). What I learnt prompted further research, which I undertook with a trans-disciplinary (Neuro-Behavioural Science approach) independent research project that explored the evidence for neuroleptic-mediated supersensitivity psychosis, and psychiatrists' reasoning for using antipsychotic medications (K. Smith, 2016). My research as well as my research supervisors helped me to understand that the education of future medical professionals, along with the legal and political parameters in which they work, is paramount to how they may approach mental health and service users in the future.

During my final undergraduate year, I completed a Behavioural Science Internship with the Western Australian Association for Mental Health (WAAMH), the peak body for mental health in

WA. My time at WAAMH as well as my education and research taught me that there are still many barriers to implementing the transformed mental health system. For example, I learnt that the medical system remains the dominant system that provides care for highly distressed individuals, despite efforts to reform the system towards more community-based treatment and services rather than hospital-based.

3.5.1 Development of the research project

Having learnt the biomedical and consumer recovery perspectives along with my experiences at WAAMH, I began to understand the many opportunities for transformative change in the mental health system. Despite having the same overall goal to help people and prevent them from having distress in the future, it became evident to me that the conflicting knowledges and approaches between the consumer and biomedical models may be promoting barriers to transforming the system. I sought to understand whether medical students were learning the recovery perspective that had been underpinning mental health policies for over a decade, and also wanted to know how they both applied their education, and what the potential effects may be for consumers as a result of what the students' learnt.

Within this research project, I hold an 'insider' perspective as I have had personal experience with distress. I am also an 'insider' as my education in Science was positioned within positivist epistemology, and hence I learnt empirical methods and assumptions that underpin medical and neuropsychiatric research. Yet, I also occupy an 'outsider' position as I have not trained as a medical professional and am not a medical doctor; therefore I cannot claim to understand all the experiences or perspectives of medical students or medical professionals. Breen (2007) discussed occupying both insider and outsider positions as a researcher, whereby being an 'insider' means having personal experience with the issue being researched. While, being an 'outsider' means not having an understanding of the realities of the group that the research is concerned with. As such, this current research is within the parameters of my experience and interest, but outside my domain of

understanding. Breen (2007) conceptualised this insider/outsider position as being 'in the middle'; however I prefer to conceptualise my position as a third space.

Bhabha (2004) proposes the 'third space' is a space for the negotiation of ideas and positions between two different social groups and their cultures. This negotiation opens up an opportunity for the cultures of the groups to be shared and understood, potentially leading both groups towards a new, common identity that is not one or the other, but a hybrid of both. Hence, I conceptualised this research as opening up a third space for such a negotiation between the consumer and biomedical perspectives in mental health. I see it as the coming together of both approaches to solve common issues, creating a new way of 'doing' that benefits not only the most vulnerable individuals, but both medical and consumer groups. In understanding both the consumer and biomedical perspectives as an insider, a third space is opened up that enables me to 'see' the arguments of both the consumer and biomedical approaches, finding ways of harnessing the strengths of both to fill gaps in understanding and practice.

Nevertheless, my personal experience as an insider has potential implications and impacts upon this current research. For example, my preference for not taking medications has the potential for me to become biased against the use of psychiatric drugs. However, both my education as well as personal relationships with other consumers has helped me to understand that many consumers feel the need for medication, and feel relief from their symptoms using them. Drawing on my personal and professional value of human rights, I believe that a person should never be denied medical intervention if it is appropriate and they agree with the treatment.

Although, being both insider and outsider means that I may be able to mitigate some of the issues that may come with being purely an 'insider' researcher. Such as, having less familiarity with medical students and medical practices means the participants may be less likely to assume I know the answers to the questions I asked, and therefore provide more detailed answers. Being an outsider to the group I am researching also provides an opportunity to learn more about medical

culture and practices, while potentially value-adding to future development, by using a multi-disciplinary approach in harnessing both my Behavioural Science 'lens' and biological knowledge. I also acknowledge that while my insider position has the potential to bias my analysis, by engaging in critical reflexivity while interpreting the data, along with using the triangulation method and subjecting my research to multiple reviewers, has ensured that the finalised research outcomes are authentic, thorough, and rigorous in providing an evidence-based argument.

4. Findings and Interpretations

The findings and interpretations provide a narrative explaining the key findings of this study, and interpret meaning of the students' quotes in relation to the literature and the research aims. Two main themes developed from the arising issues in the data – *Preparedness* and '*Just*' *treatment and care*, which describe the overarching phenomena throughout the findings.

4.1 Theme 1: *Preparedness*

This first theme outlines the factors and issues that can influence how prepared a medical student may feel going into their psychiatric rotation, and/or how prepared they may feel to care for consumers in future practice. These factors and issues range from systemic-level processes and practices, to the connections that students make to the learning content, as well as connections with clinical supervisors or tutors. The students' individual characteristics may also influence preparedness, such as, their personal perceptions of consumers or distress, their interpretation and use of the knowledges they have learnt, or their self-care regimen.

Throughout the data analysis, I found that the students' preparedness was a significant factor or issue running through their narratives, as well as an important factor within the literature in regards to how consumers receive care and treatment according to the levels of preparedness and knowledge that health professionals hold, particularly within the recovery space. These factors led to my viewing preparedness as a major theme, that has two further significant factors affecting it – *Connections* and *Impacts upon learning*, which I have identified as sub-themes.

The connections students make between the theoretical content and the practical application of it, the connections they make with clinical supervisors and lecturers/tutors, and the human connections to consumers' distress and circumstances were found to be influential in how prepared students felt they were for rotations and practice. In addition, specific issues and circumstances that impacted students' ability to make those connections made some of the students' learning experiences increasingly stressful, potentially hampering learning and therefore, their preparedness.

Following the development of the themes and sub-themes, a further literature search returned a systematic review of studies regarding medical students' feelings of preparedness by Surmon et al. (2016). Surmon et al.'s (2016) recent review was consistent with, and therefore supported the development of *Preparedness* and the sub-theme *Connection*. Similar to some findings within this current research, Surmon et al. (2016) labelled one theme 'disconnection', due to finding that disconnections between aspects such as the pre-clinical to clinical stages impacted students' preparedness for internship, along with feelings of preparedness being negatively impacted by limited opportunities to authentically practice skills. I chose to label this subtheme using more positive, strengths-based language, in line with Behavioural Science and the consumer recovery paradigm's values. In addition, as many of the comments were regarding connections rather than disconnections, I felt it was more constructive to label the theme in terms of connection, rather than disconnection. Table 2 provides an overview of the themes and issues.

Table 2

Outline of themes, subthemes, issues and exemplars

Theme	Subtheme	Issue	Exemplar
Preparedness	Connections	*Distress conceptualised primarily as a biomedical phenomenon*	*for psychosis, looking at pruning of axons and crossover between mesolimbic, mesocortical pathways that confuse emotional regulation with ideas of importance and drive some of those underlying elements (7)*
		Biopsychosocial approach – connecting to social and psychological elements	*everything I look at I always think of the biopsychosocial model (10)*
		Pharmacological treatment focus	*I know that for two years in a row I learnt about classes of antidepressants (7)*
		Observation connecting theory to practical situations	*just the way psychiatrists can pick on something and do it all in a way that like they're just having a conversation (8)*
		Psychiatric language disconnected from human experiences	*listening to his reflections on seeing patients… just using all the terms that we've heard but we didn't know exactly what it meant to have a flight of ideas or a certain type of speech (9)*
		Connections with the recovery paradigm lacking	*No not about the recovery model but I am aware that those structures* [community mental health] *exist* (7)
		Rural Clinical School enhanced students' understanding of mental health and recovery services	*we did outpatient days and I guess you kind of get a feel for community treatment orders and how they kind of have a role in keeping people out of hospital (8)*
		Connections between learning in mental health to students' own mental health lacking	*they're trying to find those quick tid bits to just be like 'here, this is a one action tool you can use and here's a nice acronym you can try and implement in your daily life which just doesn't work*

	Impacts upon learning	*Time pressure impacting learning, therefore preparedness*	*in final year there was only four weeks where you had definite defined blocks but there were lectures throughout the final year… four weeks is really not enough in my opinion to feel like, comfortable dealing with mental health issues*
			overall the time we spend doing psychiatry is very small
		Disconnections between formal learning and rotation impacting preparedness	*there were some lecture series which were useful, but I think that without the clinical context and seeing patients in a clinical context, maybe it's harder to focus on the lectures and see why they're relevant*
		Pressure and anxiety felt going into rotations due to feeling underprepared	*I was quite nervous about it as well just 'cause it seemed like such a different thing to any of the other rotations*
		Tutors, teachers and clinicians influence connections, and therefore, learning	*I had one experience last year with this particular tutor… he did a great job and people now reflect on our experience with him - the others that I was with they would just go "god I hated going to those sessions but how amazing was that?*
			sitting in with psychiatrists and chatting to them afterwards about why they were adjusting drugs or doses or dosing intervals stuff like that in the pharmacological treatment so yeah, they were always really receptive to teaching and offering teaching
		Systemic time pressures on clinicians potentially impacting students' learning opportunities	*the consultants didn't have a lot of time but did their best I suppose - it was mainly learning from observation with them*
		Time pressure and environment of the OSCE and clinical skills training may impede connections and skill development	*in our training as medical students we're given the standard 8 minute time frame to make that assessment which is what makes it even more unrealistic and what makes us as students so much more diagnostically focussed, rather than rapport building*

Just treatment and care	*Disease model language and psychiatric labels can promote dehumanisation, marginalisation, and unjust care*	*well I only saw like a specific group of mental illnesses and mainly psychosis and a melancholic depression*
	Lived experience workers may enhance understanding, reflexivity, leading to more just care	*we had a couple of patients with Parkinson's come in and talk about their diagnoses and their experiences and how it impacted on their life and I found that very powerful*
	Focus on pharmaceuticals as main methods of treatment may result in unjust care and prevention of full recovery	*if you're a med trained or psych* [psychiatry] *trained person the tendency is always to react to that, so to up the medications, to put them in locked wards, to be very reactive and very punitive*
	Systemic and institutional pressures - professional liability, funding models impacting recovery-oriented care	*we went to a particular institute and people are denied of* [sic] *their freedom… that was really upsetting… of course there are individuals who can come and go but I just felt like as a society we could be doing so much more. If someone is gonna be in an institution and some of their human rights taken away under the mental health act, that is an area that we need to put a lot of money into because you need to make sure… giving them the maximum chance of having like a good life*
	Negative perceptions of psychiatry reducing desire to specialise	*psychiatry... I d'know… lots of people don't like it because there's a stigma around it*
	Negative perceptions of psychiatrists as people adding to stigma, deterring recruitment	*maybe just the psychiatrists that I've seen… they interact quite strangely as well… I dunno if you pick that up as you go along…*

4.1.1 Sub-theme: Connections

This first sub-theme developed through understanding the main aspects the participants connected with while discussing their learning experiences. In this way, multiple factors were identified that influenced the students' learning and how they were consequently able to put their learning into practice. Overall, the influencing factors on students' understandings were found to relate to the connections that students made to the kinds of knowledges learnt, such as the biological perspectives, as well as links between theory and practice. Additionally, the connections made with personal mental health, tutors, and clinical mentors, as well as with consumers as people rather than as 'patients', also influenced students' understandings and their motivation to learn more.

The factors identified were found to impact how prepared students felt for working with mental health consumers in terms of knowledge, skill development, and communication. This sub theme further outlines the connections the participants made to the different perspectives of mental health, through looking at the language students used to talk about their learning, and how they constructed their knowledge about distress. The dominant perspective that the students reported having learnt were of the biomedical approach, and to a lesser extent, social and psychological approaches. The students' understandings are therefore discussed in relation to current mental health policies and strategies, as well as any perspectives they connected to which may have contributed to their perceptions of distress or consumers.

Connections largely biomedical

Half of the participants discussed in depth their understanding of distress and how it manifests, indicating that they constructed their knowledge predominantly within the biomedical model. These understandings were evident through the participants connecting mostly with biomedical concepts and assumptions; for example:

> *pretty much all I remember from the first two years is all these diagrams of receptors and hormones and the different drugs... what hormones they've got… (9)*

> *the things that stick out most are the models for how mental health illness and like theories of depression, theories of psychosis or schizophrenia, theories of anxiety and whether it's like neuroanatomical, neurophysiological or neurodevelopmental… (7)*

These two participants specifically emphasised that their learning focussed on biological elements, and in particular the neurobiological aspects associated with extreme distress which have become a research focus of neuroscience and psychiatry (or, neuropsychiatry) since the 1970's (Sanders, 2011). Mental distress was therefore positioned by these students as having biological underpinnings. The issues that have been raised about positioning distress as solely a biological phenomenon include that focusing principally on neural mechanisms ignores the social circumstances that are now well recognised as promoting extreme distress, such as trauma (McGorry, as cited in Pryor, 2018; Ventriglio et al., 2016); and that treating socially-underpinned distress with biological treatments alone is insufficient and ineffective due to not acknowledging and addressing a person's social needs (Lally & MacCabe, 2015; Moncrieff, 2006, 2015; The British Psychological Society, 2011; Whitaker, 2004).

Aligning with the biological perspective, the disease model language was particularly evident throughout all of the participants' narratives, as without exception, every student referred to distress as either a 'mental illness' or 'psychiatric illness' at multiple points throughout the interviews:

> *you might talk to some people and they've had some family member affected by mental illness and they're very understanding, and they realise that it's not an individual's fault, it's like cardiovascular disease or multiple sclerosis or something - it's its own pathological state (10)*

> *I think the main thrust of the certainly first year and maybe second year a little bit as well was like the biological underpinnings of it. So we had a few lectures… that was much more about the neurology and neuroscience of psychiatric illnesses without knowing terribly much about manifestations of psychiatric illnesses... (8)*

These comments outline how consumers' experiences of distress were conceptualised by these participants as disease 'entities', whereby a disease entity is a "theoretical entity of medicine" (Hucklenbroich, 2014, p 612), and therefore are assumed to be real disease objects. However, for many psychiatric diagnoses, assuming different forms of distress are 'diseases' or 'ilnesses' is

problematic, as currently there remains insufficient scientific evidence to conclusively support the idea that experiences of extreme distress such as psychosis are actual 'diseases' (Gotzsche, 2017; Jablensky, 2012). Additionally, psychiatric disorders have not been officially defined as 'diseases' in diagnostic manuals as they do not adhere to the scientific rules for classifying 'disease' (Jablensky, 2012).

Conceptualising distress as a pathological disease supports the more traditional position of there being something 'wrong' with the individual that needs 'fixing', rather than comprehending the person's behaviour as what continues to be argued as understandable human reactions to often very stressful and/or traumatic events (Cooke & Kinderman, 2018; Fay, 2018; Kinderman, 2017; Kinderman et al., 2013; Mills, 2014; Summerfield, 2008). Consumers have also called for a shift away from conceptualising service users as having an 'illness'. For example, a consumer's comment from the WA Mental Health Commission's report, *Mental Health 2020: Reforming Western Australia's Mental Health System* calls for a shift away from the concept of 'mental illness', towards the concept of "a diverse community which is just as 'normal' and part of everyday life as any other group of citizens." (Government of Western Australia Mental Health Commission, n.d., p 9).

However, despite the dominance of the disease perspective among the students interviewed, one participant demonstrated conflict with the concept of the disease model, which did not seem to fit the individuals presenting at the placement as the student did not perceive these consumers as being 'sick':

> *they have private inpatients but they're obviously not as sick as you would see in the public system… I didn't see a single psychosis - I saw a few personality disorders but everyone on the whole was very well and it was probably much more a situational crisis… (8)*

While participant 8's language use of 'sick' demonstrated the dominance of the disease model in the students' understanding, in positioning the consumer's distress as a 'situational crisis' rather than a 'mental illness', the student appeared to acknowledge the social underpinnings of distress. Here, the term 'situation' suggests a social circumstance as being responsible for the consumer's distress, differentiating these individuals from those who are perceived as being 'sick' due to an assumed

underlying neurobiological pathology. This means that for participant 8, what is understood as mental 'illness' is positioned as biologically-based, and any other forms of distress not perceived as severe enough are positioned as social issues. Such findings suggest that there may be epistemological contradictions between biomedical understandings and social concepts of distress that present during rotations, which may challenge some formal theoretical learning.

A major systemic issue regarding this epistemic contradiction was recently highlighted by a group of individuals with lived experience attending the WA Statewide Suicide Prevention Network (2018) workshop. Some participants of the workshop claimed that the current mental health system is still largely geared towards people who are in crisis, leading to some consumers being denied services as they were not perceived as 'sick enough' to access help, which actually promoted the exacerbation of their distress in order to receive services (WA Statewide Suicide Prevention Network, 2018). Yet the workshop participants highlighted that what goes unseen and therefore unacknowledged by health practitioners, are the events leading up to the person becoming distressed, which were reported to be socially-based issues (WA Statewide Suicide Prevention Network, 2018). As such, if a person receives help at an earlier stage in their distress, it is more likely to be positioned as a social issue, meaning they may not be diagnosed as having an 'illness'. However, when a person becomes acutely distressed and possibly suicidal, or has experiences of psychosis for example, then it will more likely be perceived as an 'illness' that has biological underpinnings rather than understood as the possible consequence of the person's distressing social circumstances.

Despite the School of Medicine's Psychiatry curriculum (2017) including psychological and social aspects, when asked about what they knew about distress, most of the research participants gave little insight into what they knew about the social elements that can promote distress and extreme distress. Just four of the participants discussed some social aspects that can have a role in distress after shifting from explaining distress in biological terms. This shift to the social perspective is encouraging, as it underscores that these participants may in future look to the broader causes of

a person's distress. However, their primary focus being the biological approach may dominate this social understanding, having the potential to limit the connections they make to a consumer's issues, their authentic human experiences, as well as the more broader aspects to holistically addressing their recovery - which are based within the social realm (Kinderman, 2005, 2017; Kinderman et al., 2013; McGorry, as cited in Pryor, 2018).

Biopsychosocial approach – connecting to social and psychological elements of distress

In response to the shortcomings of a purely biological perspective, many medical schools worldwide have since adopted the biopsychosocial (BPS) approach to mental health (Benning, 2015; Engel, 2012). The BPS approach views distress as being a biological predisposition, with adverse social and psychological conditions promoting the chances that someone may become distressed (Engel, 2012). Hence, the biological aspect may be focussed on primarily, with social and psychological issues being more secondary considerations, which was evident in the following participant's explanation of the causes of distress using the BPS method:

> *one of our professors in psychiatry who went through a model that explained mental health illness as like a predisposition on some level like a genetic predisposition, and then subsequent developmental insults or emotional insults that cause someone to display mental illness. So I think that was like the main one for depression but then we also spoke about like neurochemical models, we spoke about receptor statuses and like deficiencies and serotonin, dopamine… (7)*

The biopsychosocial approach seemed to begin to connect the student with broader causes and issues in the development of distress; however, biological aspects remained privileged given the biological emphasis and primary positioning of neurobiology within both the curriculum and the students' dialogues. Hence, despite the inclusion of the BPS approach in the curriculum, extreme distress continued to be seen by the participants as biologically predetermined, while the social experiences that impact on a person's development or emotions were viewed as only having a role in promoting the symptoms of distress, rather than being an actual cause for distress.

Likewise, another participant highlighted learning the BPS model's approach to treatment in that it emphasises the use of biologically-targeting pharmaceuticals primarily:

> *I think we got a lot of teaching about I mean we talk about it all the time but from teaching on biopsychosocial approach to treatment as well as literally like what drugs do you use for what conditions, which ones might be better within classes and then which psychological you use appropriately for different conditions as well and then what social interventions are relevant too (8)*

Emphasising the use of medications first, followed by psychological and social approaches to treatments, indicates that psychological and social measures may not be considered as important, or at best, secondary to medications. However, accepting both the social causes as well as the importance and effectiveness of social and psychological therapies is both important and necessary, as consumers have emphasised the need for clinicians and mental health workers to focus more on social supports and services to promote recovery, rather than purely focussing on clinical approaches (Consumers of Mental Health Western Australia, 2017). This illustrates to some degree, a divide or contradiction between what many consumers may find most beneficial and what medical students, professions, and institutions may perceive as important in promoting recovery.

More in line with consumers' perspectives, participant 10 did specifically emphasise the social causes of distress more than others, as well as the need to address social circumstances in balance with medical and psychological aspects:

> *so of course an individual might have a genetic predisposition to something and psychologically they haven't built up the resilience skills that maybe would help overcome certain anxiety episodes, or you know is the social- like social circumstances so poor and that they're currently being abused they're living in poverty... they have six kids to feed and no support... their social circumstances you know can be really huge and I think that it's important to remember that… you can't fix everything with a pill. You can't give someone who has awful social circumstances an antidepressant and think its going to make things better cause it won't, you know? It's all getting the balance right between all those different elements… (10)*

Participant 10's argument for a more balanced perspective may be the result of having undertaken a rotation where the clinical supervisor was reported to emphasise the social aspects of distress more, and was critical of using only medications in treatment. Such a critical perspective aligns with the approaches of both critical psychiatry and the consumer recovery paradigm; both of which suggests an overemphasis on medications can be detrimental to some consumers' recovery and that a more balanced focus on a person's social, spiritual, and psychological wellbeing better promotes recovery

(Anthony, 1993; Meehan et al., 2008; Middleton, 2007). Moreover, participant 10's learning here aligns with Domain 2 of 'knowledge for key competencies' of the *Framework for Recovery-oriented Service Delivery – Guide for Practitioners* (Commonwealth of Australia, 2013a) (refer page 34 in literature review) which essentially requires practitioners to understand and provide a broad range of therapies, as well as address a person's holistic needs, rather than only their treatment. In learning the importance of balancing the physical, social and psychological elements necessary for recovery, participant 10's experiences on rotation leant to understanding the psychosocial supports and psychological treatments are as important as medications may be.

Connections to treatments largely pharmacological

However, the following participant's narratives suggest that student doctors may be more prepared and therefore more confident in providing pharmacological treatments due to the significant amount of learning and emphasis on medications across their psychiatry training:

> *I think what happens is because as a medical student, you can talk about the lifestyle stuff, that makes sense, you can talk about weight loss, you can talk about exercise, you can talk about smoking cessation, stuff like that, and social supports and stuff like that… you can't really do counselling like you're not equipped with the skills, so… it exists in my mind as something that can be done but that I would say 'ah you probably need to go for CBT' and then someone would say.. 'well what is CBT?' and I would say "I don't know but you can go for it".. and I couldn't tell you all the different types of CBT that exists or even just different other types of therapy that exist as well.. so I know that that exists but the definite focus is-was on lifestyle and then pharmacological because.. pharmacological's easy to assess, its fair for students to know and it's the thing that we could do the most easily (7)*

Consequently, these participants may also understand less about the benefits and types of non-drug therapies, as most appeared to lack confidence in their knowledge of psychological and/or social interventions. Multiple participants stressed that medications were the focus of their learning regarding treatments; such as: "*we just learn some drugs" (5); "we learn the drugs" (3);* and *"Yeah the different drugs…" (9)*. Therefore, medications remain the primary learning focus about treatments for distress in these participant's experiences. This is despite the growing concern of practitioners and academics, as well as increasing research evidence suggesting many psychiatric medications may actually promote further harm to individuals through side effects or damage to

brain tissues (Haynes et al., 2004; Huhtaniska et al., 2017; Lally & MacCabe, 2015; Moncrieff, 2006, 2015, 2017; Moncrieff & Leo, 2010); promote suicidal ideation (Beard, 2018; Gotzsche, 2017); and/or prevent long-term recovery (Chouinard & Jones, 1980; Fallon et al., 2012; Harrow & Jobe, 2007, 2013; Harrow et al., 2014).

In addition to a focus on medications, another participant highlighted a lack of learning in non-drug therapies as well as feeling that they 'needed' to provide a prescription for medication:

> *not once has a therapeutic intervention been discussed, not once… CBT's mentioned but yeah… and the other thing I wonder I dunno if you guys got this but to recognise that conversation in and of itself is the is part of the treatment whereis* [sic] *I think we're so oriented towards "oh gosh well I've done nothing you know in this entire conversation now I need to prescribe something" (4)*

The formal education focussing on pharmaceuticals may have limited these participant's scope for potential treatments, as such a narrow focus may further work to disconnect future doctors from evidence-based non-drug treatments that could be a more appropriate treatment option for a particular individual. Hence, many new doctors may have a limited understanding of other therapies, and if so, may feel unable to advise a person on what they may be able to utilise. While some of the participants knew the names of some other therapies, many demonstrated a lack of detailed knowledge about what the therapies are, what benefits they have or how to apply them, and for which consumers the therapies may be beneficial. Participant 1 felt particularly unsure, saying "*is that CBT's? That's all I heard about, but I don't actually know anything about CBT"*. Participant 9 took this point further by stating:

> *I had to ask one consultant "can you please just nut it down - what is this CBT?" and they're like "ok, so you have to go the behaviours of the person and then you have to discuss why then have to unravel a little bit more to find the core belief, and then how that's related to a behaviour, and then you have to address the core belief first to change the behaviour properly" Ha! How?? I was like how? But that's so that's beyond me (5)*

The statement "that's so beyond me" suggests that perhaps the concept of CBT was beyond the students' comprehension, or beyond their scope of capability at this given time. Being beyond the students' practical capability would be understandable, as the medical program does not seek to teach students how to apply such therapies. However, if the concept of the therapy is beyond the

students' epistemological comprehension, teaching more about the types and usefulness of therapeutic interventions during formal learning could be warranted in order to address this gap in knowledge, and confidence in practice. Participant 8, however, discussed learning about some non-drug therapies from clinical supervisors during rotations, as the clinicians were either using or undertaking professional development in such therapies themselves:

> *[during rural clinical school] we had a tutorial with a psychiatrist who took us through the different options and I spent um a lot of time with a registrar who was also doing.. psychoanalytical training or something at the same time as doing his psychiatric training.. so I felt like I got a good handle on that but I don't think- there's no way I would've felt like I had the time to go and do it if I hadn't had it sort of offered to me on a plate so to speak.. and probably to be honest wouldn't have had a great deal of interest in it either because its not something that you see doctors doing and there's so much other stuff you feel like you have to learn that you would've felt a bit peripheral I think (8)*

Participant 8's claim that 'it's not something that you see doctors doing' may have led the student to assume that doctors do not provide such options, and believe that non-drug therapies are unnecessary to understand. However, non-biomedical therapies such as CBT or counselling are being increasingly incorporated into GP's practices in Integrative Medicine (IM) in General Practice (Australasian Integrative Medicine Association, 2014; Phelps & Hassed, 2011). IM recognises that many people may prefer non-medical approaches to their treatment, thereby utilising methods such as psychological or cognitive-behavioural therapy (Australasian Integrative Medicine Association, 2014; Phelps & Hassed, 2011). Therefore, learning such techniques may be of benefit to students who may eventually specialise in General Practice as well through being more prepared with the knowledge of multiple methods for treatments. However, if students do not have opportunities to witness clinicians engaging in psychological therapies, they may not perceive it as legitimate, worthwhile, or something they could provide or endorse in future practice.

Conversely, participant 9 highlighted a powerful learning experience during a lecture, where students witnessed a clinician using motivational interviewing, which left participant 9 more positive about the usefulness of the technique and its beneficial outcomes:

> *I just remember two specific other lectures that we had, one was motivational interviewing and that was by a psychiatrist.. that was actually quite amazing, yeah he brought somebody*

> *in.. one of his patients who was looking to quit smoking and actually did it with her and she was in tears and it was really.. had a lot of impact on us cause we could see that it could work and that was actually how he did it cause he actually had done it… (9)*

This quote demonstrates the connectedness students felt in being able to witness evidence-based non-drug therapies, better linking theoretical aspects with practical application. Observing the therapy in practice can help students better prepare, as they explicitly learn, and come to appreciate that such therapies can and do work. Perhaps more importantly, students come to learn such therapies are part of what doctors 'do', and therefore may seek to learn how to perform them.

To summarise, the participants reported learning little about non-drug therapies and approaches to recovery during their formal learning. However, some may have had some learning experiences while on rotation if their supervisors provided opportunities for students to make those connections.

Observation: Connecting theory to practical situations

Similar to the connections made through observing the application of a therapy, observing both consumers (or simulated consumers/actors) and psychiatrists engaged in consultation helped students connect the language and theory of psychiatry to the human experience of certain diagnoses, which seemed to enhance their learning:

> *something that I found useful – we didn't get a lot of exposure to it but.. um.. was going onto YouTube and watching videos of interviews with acutely unwell patients and just seeing that is really useful because otherwise if you sort of have a definition of a symptom, its hard to apply unless you actually see it. I think once or twice videos were shown in lectures and that is really useful… to have people talking to you about their own experience as opposed to it being written down on a piece of paper or lecture notes is* [helpful] *(10)*

This participant highlights that observing a consumer's behaviour was helpful, as the psychiatric language can function to disconnect their understanding from the consumer's experiences (Kinderman et al., 2013; Summerfield, 2008). Participant 10 further outlined that having a conversation with a consumer would be a more beneficial learning experience than simply reading theoretical material, which may be due to the personal interactions helping to promote human connection, thereby improving the connections for the students. Therefore, increased opportunities for an interactive and observational learning approach may be more beneficial for students' formal

learning in psychiatry, as a number of students also mentioned that observing real clinical interviews enhanced their understanding of theoretical content and psychiatric terms, helping them to learn or improve their clinical interviewing skills:

> *we feel like we need to clutter the interview process with rapid-fire questions but seeing consultants sometimes they will just like have an answer and pause… and just take it all in (6)*

> *just listening to his reflections on seeing patients like 'Oh that person's very unwell they've got this and this and this is how they're speaking' like.. just using all the terms that we've heard but we.. didn't know exactly what it meant to have a flight of ideas or a certain type of speech- that was probably the most useful thing… (9)*

Participant 9's comment that students did not know what psychiatric terms meant or look like in practice underscores the disconnection of psychiatric language to people's actual behaviours or experiences as argued by Kinderman (2005, 2017).

Psychiatric language disconnected from human experiences

Multiple participants reported that the language of psychiatry and what the behaviours may look like were not well connected during their formal learning. The students explained that those connections remained lacking unless a link was made by observing behaviours in a practical situation, for example:

> *I felt like it was really just.. like very little idea of how that actually would be presented in reality… you know what I mean? Obviously it was theoretical but there wasn't a lot of… I didn't find there was a lot of linking (2)*

> *… the lecturer might talk about like tangential thoughts or pressured speech and until you watch a YouTube video or see it in real life it's quite hard to grasp (10)*

The psychiatric language used to conceptualise and label forms of distress may therefore be resulting in a lack of connection to the actual human experiences. Such disconnection may leave students underprepared for rotation and/or future practice, as they may still be unsure of what a psychiatric label means in terms of consumers' symptoms or behaviours. Kinderman (2005, 2017), Cooke and Kinderman (2018) and Kinderman et al. (2013) assert that psychiatric labels often fail to adequately explain what an individual experiences, or their behaviours, and therefore, psychiatric labels need to shift towards more descriptive terms so that people may better understand a person's symptoms and behaviours, potentially reducing the stigma that currently accompanies

many diagnostic labels (Kinderman, 2005, 2017; Kinderman et al., 2013). For example, the psychiatric term 'schizophrenia' does not convey what a person may actually be experiencing, neither does it convey to others what kinds of behaviours the person may exhibit, such as seeing or hearing things that others cannot. Participant 5 outlined how observing service users' behaviours in acute situations was particularly beneficial in learning what diagnoses actually 'look' like in practice:

> *I think I've learned more from the acute like the end of the spectrum settings because those patients stick in your mind as to what that condition is related to like how they're acting what they're doing their thoughts when you delve in to the actual case so then the next time you see a patient* [expressing similar behaviours] *you're like OK that's a personality disorder or which particular type and this person is psychotic this person is depressed etcetera (5)*

In this way, formal learning in psychiatry may lack aspects of clinical context unless a practical situation can be observed, thereby meaning that connections between theory and practice may need enhancing in order to better prepare students for rotations and future practice.

Clinicians also have the power to facilitate students' learning about different approaches to both understanding and treating distress that may challenge their prior psychiatric-based learning and assumptions. Such challenges could be difficult for the student initially, but potentially result in a deeper understanding of the links between psychiatric diagnoses, labelling, and stereotyping consumers, which can lead to unjust interactions and care; for example:

> *well I was with a consultant this year who… my clinical partner and I kept on trying to decide what diagnosis a patient would have based on their symptoms and he was getting really frustrated at us that we were trying to put a label on what these patients had... he was saying that psychiatry is so broad and there's so much overlap that depression, anxiety and psychosis don't exist on their own - there's little, like - you can't label someone's brain and someone's identity. You can't put labels to certain things and we try because it makes it easier for us to do that.. it makes it easier to treat a person and understand something if we put a label to it. He wanted us to see patients holistically and see everyone as an individual and realise that the DSM is there - it makes everyone- it makes it easier to tick boxes and get funding and apply a drug and see if it works but realistically it's just going to be trial and error and it might be a good place to start but.. for him it was.. it was quite a difficult time with that particular consultant… I remember that time he was quite inspirational and he really wanted us to care for patients and see that what we were doing actually-... that particular individual spent a lot of time with us, that was incredible, so there was a lot of consultant time with that particular person... when they were with us with the allocated time they'd been given to us they did spend a lot of time… talking to us but it was mostly on the philosophy behind psychiatry and the history behind psychiatry, not so much-… they didn't like the DSM therefore they didn't teach us so much about.. those questions (10)*

Also outlined here by participant 10, the students' learning in clinical skills largely emphasises the need to diagnose a condition. Whereas participant 10 learnt from the supervising clinician that 'diagnosing' a specific condition is not necessarily helpful in mental health, as psychiatric diagnoses may negatively impact consumers through being given a psychiatric label that can promote stigma and impact people's identity, subsequently having impacts upon self-esteem, self-efficacy as well as negative impacts upon their life prospects (Horn et al., 2007; Rose & Thornicroft, 2010). As highlighted previously, participant 10's supervising clinician's approach may have been more critical in their perspective, due to the clinician holding more critical views of the DSM and psychiatric labelling.

While this participant may have been challenged by the different perspective taught by the supervising clinician, the student was 'inspired' and eventually seemed to find what was learnt beneficial. Participant 10 may not have come to the conclusion that the use of the DSM and diagnostic labels of the psychiatric perspective and medical model can be problematic for consumers without such supervision and critical perspectives. This illustrates that supervising clinicians have an important role in enhancing the students' understanding; hence learning more broad perspectives about mental health, including the recovery perspective may mean that future students may be more prepared for such challenges, consequently developing a deeper, more holistic understanding of the multiple approaches available after having more diverse clinical experiences.

Connections with the recovery paradigm lacking

Even though psychiatry is shifting towards more recovery practices, and the recovery paradigm underpinning current mental health policies and strategies, the majority of the participants reported that the consumer recovery paradigm was not explicitly covered in either their formal learning or rotations. For example, when asked about learning the recovery model, participants responded: "*my experience has been split with psych both between the city and the country, so like there was nothing in the country in terms of recovery model and stuff – nothing – ever" (3)*; and '*what is that?*' (6); as well as:

Facilitator: Have you heard of the recovery model? Did you learn anything in that space?
8: I don't think so
9: no I don't think so

As it is now a national requirement that practitioners involved in delivering mental health care are knowledgeable and competent in recovery (Australian Government Department of Health, 2011b; Commonwealth of Australia, 2013a, 2013b), and as psychiatry itself is implementing recovery-oriented practice (Royal Australian New Zealand College of Psychiatrists, 2016b), underpinning the psychiatry and mental health curriculum in medical education with the recovery paradigm could now be considered essential learning for future medical practitioners, who are often the first line of care encountered by consumers. Although, the participants in the focus group outlined that while recovery was not taught explicitly, some of the practices that the recovery paradigm includes were learnt through the biopsychosocial formulation method:

2: not by the name, but in practice, yes
1: formulation
3: as in like a discharge plan
1: yeah
6: yeah
1: as in like we learn about formulation which is the protective, precipitating, perpetuating
4: perpetuating
3: protection
1: predisposing factors
5: the biopsychosocial
1: they've got a son and a daughter so they're protective but then their housing situation's terrible and they're somewhere they don't want to be and that's causing distress… and then they've got family history of something - so you are thinking about this holistic sort of.. thing and then… where issues might stem from that, and why they might not be at less risk cause they've got good protective factors… yeah we do - we definitely think about that stuff but I've never heard o' the recovery model

The formulation method the students outlined identifies that factors that may have predisposed and led to the individual experiencing distress, such as trauma, abuse, or financial stress, along with addressing the factors that may perpetuate distress, such as living circumstances. Formulation also looks at the personal characteristics and relational aspects that could protect consumers from future distress and/or assist them to recover from their current situation; such as resilience, a strong identity, and supportive family and friends (Selzer & Ellen, 2014). Such formulations can be useful in creating recovery plans or discharge plans from a tertiary health

facility. However, some health professionals may struggle to apply the BPS formulation to treatment plans due to being focussed on, or only having skills to provide biological/pharmaceutical treatments (Álvarez et al., 2012). As such, the BPS approach does not ensure that practitioners will actually address and plan for the social and psychological aspects of a person's recovery (Álvarez et al., 2012; Pilgrim, 2002). The BPS approach therefore cannot always deliver the holistic and comprehensive approach that the recovery paradigm stipulates and affords to consumers.

Rural Clinical School rotations promoted connections to the recovery paradigm

Although the recovery model was not explicitly learnt by the participants, four participants who undertook rural clinical school (RCS) during third year learnt more about some aspects of recovery-oriented services, through spending time in community health or community mental health (CMH) organisations. CMH organisations are largely organised around the recovery perspective due to the current directions of mental health policy in WA, underpinning recovery approaches with recovery-oriented service delivery. This indicates that students who undertake placements in CMH may learn more about different approaches to care, as well as what the recovery perspective is, and looks like in practice (Bateman & Smith, 2011; K. Davies & Gray, 2015). Rural clinical school (RCS) provided the four participants with additional experiences and more learning in mental health, enabling greater opportunities to make connections between theory and practice:

> *I yeah spent some time with community mental health services that would do home visits and that was really incredible - it was great to see teams that would drive out you know hour, hour and a half to see patients, to check up on them and you know spend an hour just seeing how they're going, building rapport, talking about symptoms and whether they're going down or going up… if there was something like a stressor in the individual's life just making sure that things weren't getting worse around that time, and just being really tapped in… yeah that was really good to see that those services were there in particular for those individuals... (10)*

> *8: I did actually do a placement at [community mental health service] last year as well which was probably one of the most useful things I did last year I think.. you saw people one-on-one and you weren't doing a psychiatric history as much as sort of a head screen…*
> *Facilitator: so what's a head screen in that space?*
> *8: I guess it's like a proforma that people use when they're talking to young people and adolescents - so it's home, education, activity, drugs and alcohol, sex.. yeah they use that a lot in CAMS I think.. it was great- it was a really good opportunity*

Participant 10 described the work of one CMH agency as 'incredible', and participant 8's comment that the placement was 'a really good opportunity' demonstrates that a placement in community mental health was a highly beneficial learning experience. These participants learnt more about mental health outside the parameters of traditional psychiatry and hospital settings, learning different ways of both supporting and assessing consumers. More specifically, participant 8's experience of learning to undertake a 'head screen' may have been beneficial as the head screen focussed more on the social aspects of the service user's life that may have been impacting their mental health. This social focus was different to what the participant described learning formally during classes in psychiatry, which was more biomedically underpinned while considering social contributors as more secondary to biological elements. Hence, those who undertook a CMH placement during RCS appeared to learn more about recovery-oriented services, as well as the role of community mental health within the system, as opposed to students who did not complete RCS, for example:

> *I know that you can go there for therapy and I'm assuming some level of social support in order to deal with some of the social elements of mental illness… I know that it would be a good in-between as well if you have someone who can't get quite into hospital with what's going on and they can't afford a private psychiatrist then community mental health is probably the right spot for them* (7)

Participant 7's limited understanding of the role and services provided by CMH, supports Bateman and Smith's (2011) argument and research by Byrne et al. (2016), and Hungerford et al. (2016), that CMH services are poorly understood by health professionals outside the CMH sector. As outlined by participants 8 and 10 previously, experience and learning within CMH during RCS was highly regarded and valued, and therefore the additional experience was argued by participants 3 and 10 to better prepare them for the fourth-year psychiatry rotations:

> *I saw a lot of mental health stuff, plus we did ED as well on rural clinical school - probably us CS* [clinical school] *students going into it* [4th year psychiatry rotation] *with a bit more of an understanding potentially... maybe understanding is too political a word but exposure (3)*
>
> *I did the majority of my learning about psychiatry in those first two weeks of rural clinical school... I was lucky in that I had two [weeks] at the rural site, were very good at giving me a boost in confidence before I walked into the four weeks that I had in my fourth year at the*

> *city site… and I think that if I was a third year in the city that I would have liked to have had those extra two weeks - I think they were really important at putting down some ground work before I went into fourth year - I think that was really very important* (10)

Participant 3's claim that students who undertake rural clinical school may be more prepared for the fourthfourth-year psychiatry rotation may be justified. RCS students undertake a four-week psychiatric rotation as well as an immersion in community health/mental health, providing opportunities to practice interviewing, take history, complete mental state examinations, and conducting risk assessments (The Rural Clinical School of Western Australia, 2018). RCS students also perform and present a diagnostic formulation and create management plans using the BPS approach (The Rural Clinical School of Western Australia, 2018). Therefore, as argued by participants 3 and 10, as well as Eley (2010), RCS students may be greater prepared, more confident, and potentially less intimidated by the fourth-year psychiatry rotation than students who do not undertake RCS due to having made those earlier connections. This is an important point, as having greater exposure and experience has been found to enhance practitioner's confidence in appropriately caring for mental health consumers (Jelinek et al., 2013).

Disconnections between learning in mental health to the students' own mental health

The students' connections and therefore their confidence in providing care and treatment to consumers may also be enhanced through making stronger, more explicit links between theoretical content in MH/psychiatry and the students' own mental health and wellbeing. This is because connecting personal human experiences to those of others can enhance a person's empathic responses and desire to change their behaviours towards others (Freire, 1970, 1974a, 1974b). However, participant 4 reported that the links between learning about personal mental health during the Physician Wellness Program (ESSENCE+) and the theoretical material in psychiatry were not made explicit:

> *the problem is there's such a disconnect between that statistic and how in the hell we get to that point from where we're at… and I don't think anybody has a real sense of that process (4)*

Participant 4 was speaking about how there was a clear disconnect in learning between how a person can, by virtue of their social circumstances and life stressors, go from being stressed to suicidal, potentially being given a diagnosis of depression. This disconnection in learning may be due to the largely biological focus of psychiatry, in that it separates the social factors that promote distress from what is conceptualised as a biologically underpinned mental 'illness'. As previously discussed, conceptualising 'mental illness' as a biological phenomenon and anything that is not seen as severe enough to be an 'illness' as a social issue separates the two. However, in reality, distress encompasses social events that may trigger biological adaptations (Lewis & Olive, 2014; McGowan et al., 2009; McGowan & Szyf, 2010; Murgatroyd & Spengler, 2012; P. Thomas et al., 2007), and can be conceptualised as more of a continuum than an either-or binary of 'ill' or 'not ill'. If the students' learning regarding their personal mental health and wellbeing was disconnected from learning about the process of becoming distressed, the students may not have connected their own human experiences to that of consumers, potentially making it difficult to relate. Participant 4 went on to suggest ways to enhance learning through connecting the mental health curriculum to the ESSENCE+ program and clinical debriefing (CD) tutorials:

> *but that 5 weeks could be incorporated into the psych training so that.. you watch your therapeutic intervention unfold, you have your reflective window and then the ESSENCE stuff actually comes from what you learn about observing that interaction and what you learn about yourself in relationship to that observation… that is what ESSENCE is meant to be all about, is developing a greater sense of yourself, understanding yourself in the context of those relationships… so I could see it actually melding together and working really well (4)*

Participant 1 supported participant 4's suggestion, indicating that bringing together ESSENCE+ content with learning in mental health and psychiatry may help students to enhance their resilience due to being more personally aware of their own mental health and wellbeing:

> *but you know the stuff where they're trying to kind of equip you to be more resilient, it really doesn't help at all whereas something like that...*[participant 4's proposal] *might.. (1)*

In this way, participant 4 proposed that students may be able to better reflect on mental health cases while also looking more within themselves, to understand personal reactions or potentially also, biases that could impact the students' interactions with a consumer. Looking inward

at oneself is more than being reflective, it is being reflexive, which means to understand how personal experiences, perceptions and biases may impact a person's reactions to others and understandings about certain issues (Freire, 1970, 1974a, 1974b). Hence, encouraging reflexivity rather than mere reflection can further promote students' connections both with themselves as well as consumers, which has been found to promote empathic responsiveness (Freire, 1970, 1974a), particularly in health profession students (J. Harden, 1996; Naidu & Kumagai, 2016).

Despite the importance of encouraging students' reflexivity or the School's efforts to promote practitioner reflection, there may still have been a disconnect, or even a discouragement of reflecting upon emotional content that links with mental health and resilience, within some of the participant's CD tutorials:

> *I remember the clinical debriefing.. first and second year was a really set program - they'd be like "have you done your reading this week on our prescribed topic for clinical debrief?" and sometimes the conversation would descend into something really difficult that I saw on GP* [rotation]*, or someone else would say "I'm getting really down about exams" or "I'm really stressed".. and then.. tutors would be like "…yeah anyway.. we need to talk about the reading now" or they give maybe five ten minutes to that but the real crux was on something different.. which I thought was very counter-intuitive for the actual clinical debriefing – you want to talk about how you feel and then they're* [tutors] *like "but we need to cover this"... it has no relevance… my senior tutor he's like "look, I don't mind what you guy talk about but I'm just gonna say now I don't like touchy-feely things" … so it all has like a medical focus (1)*

Therefore, participant 1 felt that the CD tutorials could at times be disconnected from the students' needs if the students perceive the topics as not being applicable to their current rotation or experiences. In addition, participant 1's comment regarding CD being more medically-focussed, as well as the tutor avoiding, and therefore potentially preventing more emotional discussions, seems to disconnect students from the human experiences of medicine, meaning both the person in the case as well as the doctors' (or training doctor's) emotional responses to the case.

Participant 1's comments demonstrate the 'hidden curriculum' learning that students may undergo during formal learning. In avoiding the emotional content, the tutor may have inadvertently taught the students about an enduring medical culture, being that doctors are hardened to human emotion and talking about the emotional aspects of a case or issue is to be avoided. However,

implicitly teaching students to avoid difficult emotional discussions may promote the students' suppression of, and disengagement from those emotions (Gaufberg et al., 2010). If students learn to disengage their emotions, they may become emotionally distant from consumers (Gaufberg et al., 2010), which could lead to unintended moral exclusion of consumers resulting in unjust treatment and care (Opotow, 1990a, 1990b).

A tutor's understanding of psychology as well as being a skilled facilitator may therefore have a greater influence over the connections that students make with emotional elements, as well as enhance the reflexivity and debriefing that occurs, as outlined by participant 4:

> *I had one experience… this is last year* [3rd year] *with this particular tutor… he's very interested in psych and so he's done a lot of reading.. around* [psychology]*… he held the awkward silence and he challenged people.. each of us would have to present a clinical case so it was a very medically-oriented case with a professional development issue attached to it but he really facilitated those conversations such that.. in my presentation I'll be honest with you I was in tears.. I think he handled it so well… and allowed the whole group to be responsive and supportive and to personally gain – I didn't find it was a therapy session for me it was an emotional experience with this particular patient.. and he held to the scenario in such a fashion that I did become emotional… and everybody else was very responsive to that and then we were able to reflect on their own experiences in similar interactions… I think he did a really good job… anyway, my point is that it can be done brilliantly but this year's been a different experience sadly enough… he did a great job and people now reflect on our experience with him - the others that I was with they would just go "god I hated going to those sessions but how amazing was that?" (4)*

Holding the 'awkward silence' as well as challenging students further, promoting a responsive and supportive class are teaching methods akin to critical pedagogy, whereby facilitators and students alike challenge each others understandings of issues that results in class members having more in-depth discussions, being more open in front of peers, and therefore becoming more critically self-aware (Dao et al., 2017; Freire, 1974b, 1996). The tutor in participant 4's experience may have been very effective in this way, as Halman et al. (2017) found that medical programs utilising critical consciousness-raising approaches, were better able to connect students to the humanity of cases and social issues by incorporating the perspectives of the students, resulting in learners being more reflexive, as well as more empathic.

4.1.2. Sub-theme: Impacts upon learning

Impacts upon learning is the second sub-theme developed for *Preparedness*, as being able to practice what was learnt facilitated the participant's greater understanding of theoretical content, and therefore, their preparedness for both rotation and future practice. Experiences of pressure also impacted the connections that students were able to make, mostly through time constraints on the course or rotation duration, and systemically on clinical supervisors. The amount and type of formal learning content also led to many of the participants feeling theoretically and/or practically underprepared going into rotations. Pressures further arose from feelings of professional failure and futility towards caring for mental health consumers. This arose for some students who pointed out that many consumers may re-present to ED's or psychiatric wards due to not receiving appropriate care and assistance outside of the tertiary health setting, further indicating potential systemic issues impacting treatment and care. All of these factors have the potential to influence the just (fair) care that consumers may receive, as well as the just interpersonal treatment of psychiatrists and psychiatry as a profession.

The previous subtheme, *Connections*, outlined that the connections students made influenced their understandings and application of their knowledge. When their learning was negatively impacted, the resulting limited understanding was found to put added pressure on the students' preparedness for practice, as highlighted by their narratives. Overall, the students felt pressure across many aspects of their learning experiences, as well as in putting their learning into practice. Pressure weaves a narrative throughout the students' experiences and learning, beginning from their first semester of medical school in learning about their personal mental health and wellbeing, through to pressure they felt or witnessed while on rotations in their final year. As such, pressure was identified as a key factor that impacted students' learning.

Most of the participants highlighted feeling they had not had enough time to learn, or enough appropriate content necessary to feel adequately prepared for either rotations or future clinical practice. This was particularly emphasised in the areas of clinical skills training (interviewing,

assessment, and history taking) for psychiatry, or formal classroom theoretical learning in the area of mental health. Other elements of pressure were also identified, such as, systemic issues that seemed to put pressure on doctors, or time issues impeding some students' opportunities for practicing skills and interacting with consumers. Being time-poor was additionally reported to impact students' ability to appropriately self-care, potentially impacting learning if a student becomes very stressed or burnt out. Hence, despite the School making efforts to support the students' wellbeing through providing the Physician Wellness program, the demanding nature of the medicine course may still mean that some students could struggle to cope with study and take care of themselves, due to the dearth of spare time they may have for wellbeing or social activities.

Time pressure impacting learning, therefore preparedness

Having much to learn and little spare time means that students may often have to weigh competing interests and self-care against the importance of their studies, outlined by participant 2:

> *we got a lot of great offers of education and things in first and second year but you're weighing it up against, y'know like do I want go to bed before ten tonight and I've got lots to do and.. there's all of these completely competing things (2)*

These 'competing' priorities means that students are pressed for time to meet every priority, as well as feeling pressure and/or conflict due to having to discern the most important priority. As participant 2 points out, weighing those priorities can be difficult, and due to the time constraints, students may sacrifice either gaining additional knowledge/tutoring for much-needed self-care time, or sacrifice their self-care to have more time for study. Participant 2's experience has been supported with research by Kuhn and Flanagan (2017), who reported that medical students and doctors often sacrificed self-care, meals, and sleep for their work and studies, which can lead to burnout. The high workloads and demanding training of medical courses are reported to lead to burnout due to further increasing pressure on students in terms of emotional, mental, and temporal pressure, leading to physical exhaustion (beyondblue, 2013; Guthrie et al., 1998; McGorry, 2015).

Pressures which resulted in less time for study, preparation, and practice, as well as having a broad curriculum were found to increase pressure on medical students within the Pakistan Military

(Qamar et al., 2015). As such, some students may, in an effort to reduce pressure on themselves, dismiss some course content they perceive as less important or irrelevant. Participant 2 in the current study went on to highlight this issue:

> *to be honest as students if we hear about something that is now obsolete our minds just turn off - there's too much to learn that's actually relevant now… but that's across all topics though because I guess cause it's a condensed course*

Whether it be from the students spending less time learning what they perceive as less relevant content, or the School not providing certain content due the condensed nature of the course, the greater time pressure and having such a broad curriculum could potentially lead to lesser understandings of some aspects of the overall medicine program, such as psychiatry and mental health. For example, almost all the participants reported that the history and theoretical development of psychiatry is not provided in formal learning:

> *Facilitator: do you learn much about the theory and the history of psychiatry?*
> *3: no*
> *1: absolutely not*
> *3: unless you're interested*
> *4: unless you read your own books*
> *1: if you have an interest in it yeah but*
> *5: or unless you talk to an advanced trainee who'd just done their exam then they'll tell you all about the history*
>
> *no I couldn't really tell you much about psychiatric history... (7)*

Yet participants 8 and 9 felt the context and development of psychiatry is both important and relevant to learn:

> *I don't specifically remember any formal teaching about like an approach to psychiatry as much I think we kind of did that on our own a bit and it's probably one of the few bits of medicine where I'd be happy to sit through like the history of, because we do get that in various bits which sometimes your like 'oh gosh' but yeah you would because it's still way more relevant today than probably for many of the other disciplines (8)*
>
> *It's still so developing as well like the history and how it's evolved is... it's still doing that so it is very relevant (9)*

Examining the history and knowledge base of psychiatry may enable students to have a more critical understanding of how psychiatric diagnoses have developed, as well as a more critical view of the need for, and use of, psychiatric diagnoses. The history of psychiatry also helps to explain

the current state of the mental health system in terms of which disciplines and knowledges hold power and why; and therefore, why it can be difficult to motivate and sustain systematic change. As discussed by participant 9 above, psychiatry is still a developing practice, evident in the field's current shift towards incorporating consumer recovery principles and approaches into psychiatric practice (Royal Australian New Zealand College of Psychiatrists, 2016b). As such, learning the history would seem both necessary and relevant, and potentially a learning area that many students may appreciate, as noted above by participants 8 and 9. In having little understanding of the history and theoretical development of psychiatry, many students may as a result be underprepared for practice.

The time pressures within the intensive medicine program may also be leading to the pharmacological treatment focus that was discussed in *Connections,* previously highlighted by participant 7: "*pharmacological's easy to assess, it's fair for students to know and it's the thing that we could do the most easily".* For example, participant 8 stressed that if learning about non-drug therapies was not provided conveniently during rotation the students may not have had the time to learn more about such options: *"there's no way I would've felt like I had the time to go and do it if I hadn't had it offered to me on a plate so to speak"* (8).

Hence, many students may be underprepared to either provide or recommend therapies other than medications if time pressures within the curriculum and the degree impede learning and teaching in these areas. As such, more learning opportunities about broader ranges of treatments may need to be included by the School, supervising clinicians, and placement locations; otherwise, students may only be feel comfortable and competent enough to endorse, utilise or recommend medications to consumers in future practice, where non-drug therapies may be of additional or greater benefit.

Overall within this issue of preparedness, seven of the ten participants further commented that they felt they had insufficient learning time and content in psychiatry during the medical

degree, impacting their level of understanding and preparedness for rotation and/or future practice; for example:

> *I went in to it* [rotation] *based on what we had done in second year and having absolutely no idea (1)*
>
> *even though everyone knows that in any medical field psychiatry and mental health plays a big part even if you become a physician on say cardiology ward, or a GP, definitely you know, that's critical care like mental health is such a big aspect there and apart from the four weeks in fourth year, that's all you get… yeah it's kind of intimidating to think that.. that may be all the psych you get (3)*
>
> *I kinda think to myself if this is my experience of exposure to mental health issues and patients and mental health training I don't know how in the hell I would be a reasonable* [GP] *and then that's it - there's nothing more than that - how would I ever a) as an ED physician make a proper assessment, b) as a GP like go through a mental health care plan or recognise when someone's presenting with a somatic complaint that actually there's psychological and emotional issues behind that - you wouldn't… you wouldn't... what we get exposed to, I just now think oh my god it is woeful... in terms of ongoing training we get to choose whether we do another psych term or not …. Like that's it so this could be the entirety of our psych training from this moment (4)*
>
> *definitely a potential I think to expand... what's interesting though is that I don't think that any time within the general practice sphere which actually contains a lot of mental health.. none of our content was actually geared towards that, where if you think that in the primary care setting the GP is going to be handling a lot of mental health… so I think that was particularly interesting that there wasn't so much of a focus on learning about mental health in that arena (7)*

In addition, four of the participants noted that GP's in particular provide a lot of mental health care to consumers, and therefore would need to have greater skills and understanding:

> *if 50 per cent are more likely to be GP's and 50 per cent of GP's work is psychiatry, you'd want everyone to be quite good (8)*
>
> *you can easily neglect psych I think.. and it can be present in so many ways that it's better if we have doctors who are competent enough (9)*
>
> Interestingly, these participants strongly felt that their learning was not sufficient for them to feel prepared for both rotations as well as future practice, relating their own preparedness to that of existing professionals. The students believed that both they and other doctors should be much more knowledgeable and equipped for providing mental health care to consumers due to its ubiquitous nature, and the interplay between physical health and psychological wellbeing. Participant 4 for example, stressed that such learning needs to occur during the undergraduate years

due to additional psychiatry training only being optional after graduation. This means that many doctors who may have to address mental health issues may not have the necessary skills to do so if they have not had postgraduate mental health training, and may as a consequence, avoid addressing consumers' mental health concerns, or avoid consumers altogether (Bost, Crilly, & Wallen, 2014; Jelinek et al., 2013; Nicholls, Gaynor, Shafiei, Bosanac, & Farrell, 2011; Weiland et al., 2011).

Participant 9 suggested that "different, better teaching" may help to enhance their preparedness, potentially reducing the pressure students may feel in both going into rotations and for exams:

> *the four weeks in fourth year is probably enough cause that's the longest we spend in any rotation but maybe a bit more exposure in earlier years or… different, better teaching perhaps but I do feel like it came to fourth year and it was one of my later rotations, and so I thought I'm sitting an exam on this soon and I don't really.. I don't even know the basics yet' (9)*

While participant 9 did not elaborate on what 'different, better teaching' may entail, an innovative and transformational way of delivering course content could be provided by lived experience workers/consumer tutors, similar to other medical schools (Gordon, Ellis, et al., 2014; Gordon, Huthwaite, et al., 2014; Owen & Reay, 2004; Wilrycx et al., 2012) (refer pp. 36-37 in literature review). In this way, the teaching approach may also work to meet the Workforce and Practice Standards' stipulations of working with people as partners; valuing service users' perspectives and knowledge; and using appropriate strengths-based recovery language (Victorian Government Department of Health, 2013).

Participant 9 also points out here that an additional immersion earlier than fourth year may be beneficial to reduce feelings of pressure going into the final year rotation, and increase competence, experience, and therefore confidence. However, participant 10 had completed an additional rotation due to having undertaken Rural Clinical School, yet even after having the additional learning did not believe that six weeks practical experience was enough time to properly understand consumers' experiences and provide appropriate care:

> *I think that having six weeks of experience and even in that time only a smaller segment of that time with very acutely unwell people you can't begin to understand, especially if you don't have someone close to you that is affected by it.. it's a really- yeah it's not enough time - it certainly doesn't allow you I think to understand and treat appropriately I think you need further training to do that (10)*

Furthermore, the suggestion implies that an earlier, additional rotation or immersion may reduce feelings of unpreparedness potentially more so than formal lectures may, with participant 1 highlighting that:

> *if I had all the lectures that we've had from psychiatry going in I don't think that would've equipped me any better… because like you have to experience it - the first few interviews that you do are like woah! what do I say? what do I do? how do I act? and you realise that nothing could've prepared me for that anyway (1)*

Similarly, Participant 10 felt that the six weeks of practical immersion between RCS and final year rotation was not enough time to feel competent in being able to understand consumers' experiences or provide the appropriate treatments. It is understandable that six weeks is insufficient time to be competent enough to provide treatments, as both psychologists and psychiatrists have additional training to be able to appropriately treat consumers' symptoms. However, as highlighted in the subtheme *Connections*, other RCS students suggested that the additional experience gave them increased confidence and understanding: "*probably us CS* [clinical school] *students going into it* [4th year psychiatry rotation] *with a bit more of an understanding potentially…"* (3) ; and "*I was lucky in that I had two [weeks] at the rural site, were very good at giving me a boost in confidence before I walked into the four weeks that I had in my fourth year"* (10).

Having more immersion experiences increases the contact that students have with consumers, which has been suggested to reduce the students' anxieties about working with consumers, and therefore may reduce the pressure they may feel and increase their feelings of preparedness in going into their final rotation, or working with consumers in the future (Archdall et al., 2013; Burford et al., 2014; Surmon et al., 2016). In addition, Burford et al. (2014) found that those who had more opportunities to practice in real settings with real consumers predicted greater preparedness for postgraduate internships. Therefore, having more time in practical situations has

the potential to impact learning positively, and conversely, less time spent on rotation may negatively impact learning and understanding.

Disconnections between formal learning and rotation impacting learning and preparedness

The connections between formal learning and rotation were reported by multiple participants as lacking in clinical context, while the connection between theory and practice was frequently described as disjointed due to the time lapse between theoretical learning and rotation. For example:

> *I feel like we were busy learning those lists in second year only to have to re-learn them this year when we're actually seeing stuff - makes more sense now whereas in second year we were not doing it for a real purpose so perhaps some of that academic time where we're not quite ready for it we don't actually need to know it yet.. some things you learnt way back then, we spent such a little amount of time on it that you're doing it fresh anyway this year (2)*

> *there was a bit of a gap! there was a lot of reading we had to do really, to even be sensible-sounding on rotation I think… I found myself even in fourth year going back to first year lectures and revisiting them so by virtue of it being given in first year you wouldn't necessarily - it doesn't mean very much because you haven't seen any patients, you don't do any psych cases… I was definitely putting it together actively at the time - I wasn't like putting anything into practice it was like scrabbling bits together (8)*

These disconnections between theory and practice seemed to impact the participant's preparedness for rotation, as highlighted by participant 8 finding it difficult to put into practice what was learnt two years earlier. A systematic review of studies looking into medical students' preparedness for internships supported these findings, reporting that the disconnection between preclinical and clinical years affected students' ability to utilise their learning and apply their learned skills (Surmon et al., 2016). In addition, the same review found that having limited opportunities to apply learning in practical situations led to students having difficulty applying their knowledge during postgraduate clerkships (Surmon et al., 2016). Such under-preparedness was reported by participants in the current study to increase their feelings of apprehension about going into rotations.

Pressure and anxiety felt going into rotations due to feeling underprepared

Following the discussions regarding participant's feelings of preparedness for their psychiatry rotation, the students were asked if their feelings of having limited learning time and practice made them consequently more anxious (stressed, nervous, or apprehensive) about the impending rotation:

> *Facilitator: does it make you feel a bit more anxious going in?* [to rotations]
> *4: Of course*
> *1: a hundred percent more*
>
> *I probably felt a bit more nervous about entering the space because I probably didn't know as much and it wasn't like it was a passion area for me, so I knew that I would both have to work pretty hard and have to muster up some motivation for it as well... and it wasn't something that I had a good background knowledge in because so much time had passed (7)*

Although these participants felt nervous and underprepared about going into the rotation, the connections they made while on rotation were largely influenced by their supervising clinicians and registrars. Most of the participants reported having positive experiences and great learning opportunities; however those experiences were dependent upon both the supervisors as well as how many opportunities the students had to engage with practical experience.

Tutors, teachers and supervisors influence connections, and therefore, learning

The participants further discussed how their learning experiences with their supervising clinicians and clinical teams on rotation impacted the depth of connections they made to theoretical content in practice. Such as:

> *the team I was on was pretty good, they changed I think half way through - the registrars changed and the IMO but they were actually really involved in the team... the consultants didn't have a lot of time but did their best - it was mainly learning from observation with them, but I've definitely felt way less involved in teams than I did there... sometimes you don't even manage to introduce yourself so it was pretty good… it's so variable (9)*
>
> *2: doctors can be very variable a) in their … dealing with patients, and b) in their dealing with students and you know like there's just so many variables. Often sometimes I found that consultant level can be quite haphazard whether they spend time with you or not - I didn't spend much time with consultant–level doctors but the time I had was good and like it was positive time which was good, it's not always the case but I also got a lot of good stuff from my reg* [registrar] *as well so different levels can be helpful as well…*
> *Facilitator: So those clinicians can make a big difference?*

> *2: a huge-* [difference] *which seems ridiculous that some people get exposed to great people and others are misfortunate and don't*

Participants 2 and 9 outline here that their rotation clinicians were beneficial in facilitating their learning despite being very busy and not having much time to spend with the students. Being involved in the care team was particularly emphasised by participant 9 as being important for an overall positive learning experience on rotation. Such findings have been supported by research from Beattie et al. (2017) in the UK, finding that junior doctors who felt better connected to, and supported by the care team, as well as having responsibilities as a member of the team, was integral to learning and promoting a positive outlook on psychiatry as a speciality.

Both participants 2 and 9 also emphasised the variable nature of placement clinicians, whereby some were perceived as not helpful for learning. Participant 8 supported those views in the following statement, whereby the supervising clinician was reported to restrict the student's learning opportunities significantly:

> *this year the consultant I was with had no idea who I was at all, never invited me into rooms - I felt like I had to really like push to be involved at all stages. It was exhausting and by the end of it was like 'this is a waste of my time' so yeah it wasn't super enjoyable. I don't know if this particular consultant was not interested in medical students or had a bad time, I don't really know but she was thoroughly uninterested in me and I got no teaching from her whatsoever (8)*

Being excluded from involvement in consultations and having to work harder to be involved in practical opportunities to learn reduced the student's motivation in the rotation and enthusiasm for learning, meaning the student's disconnection from both the team and the rotation as a whole, may have negatively impacted learning outcomes. Participant 8's experience was supported by Beattie et al.'s (2017) research, whereby junior doctors felt disconnected from the care team if they had lack of responsibility or opportunities to be involved, resulting in the training doctor's decreased motivation to continue psychiatry training. As a result of participant 8's experience during this rotation, this student's motivation for further learning and training in mental health has also been negatively impacted. Participant 9 also indicated that providing a potentially incorrect suggestion to a clinician may impact both their learning, and other students negatively:

> *it didn't feel like I should say 'maybe beta blockers can't do that' or 'are you sure?' 'You don't want to.. refer him somewhere or?' I don't know… you don't often feel like you can suggest things just generally as a medical student, but then people do and then they make it worse for others when they're not the right things to suggest (9)*

Here, participant 9 alludes to the power interactions between medical students and clinical supervisors, as students may feel it is not their role and may be inappropriate to challenge a clinicians' decision or make suggestions based upon what they have learnt. Commenting that *"Making it worse for others when they're not the right things to suggest"* may indicate that a clinician's unfavourable reaction to a student's suggestion could result in other students being reluctant to speak out when they believe the clinician may be making a decision they feel is inappropriate or inadequate. This comment therefore also demonstrates a cultural element of the 'hidden curriculum' that students learn about, both in terms of their identity and role as a medical student while on rotations in WA medical settings (Gaufberg et al., 2010).

Akin to participant 9's experience, Gaufberg et al. (2010) outlined that medical students in their study from the USA experienced humiliation from supervising clinicians if they questioned the doctor's treatment or diagnosis, bringing about potential ethical problems regarding the adequate care of a consumer due to not feeling they could challenge questionable judgements made by their higher-ranking supervisors. As such, some medical students in Australia, including those within this research, could further experience the pressure to perform *correctly* in both cultural and technical terms while on rotation to avoid being humiliated or scrutinised in front of others. Potentially, not feeling able to question clinicians' judgements may place a student in an ethically problematic and stressful position if they believe a doctor's decision could impact a service users' recovery (Gaufberg et al., 2010). Furthermore, students' learning may be hampered if they feel unable to ask questions due to fearing a negative reaction from a supervising clinician.

These arguments again reinforce the importance of the relationship between clinical supervisors and students, as the greater connections that clinicians can facilitate for students, as well as their passion and quality teaching may both enhance understanding as well as influence

future career decisions (Appleton et al., 2017; Farooq et al., 2014; Harper & Roman, 2017; Lingeswaran, 2010; Pai et al., 2012; Stampfer, 2011). Such was the case in participant 5's experience in neurology:

> *that makes actually a really big difference is when you have a mentor or a teacher who's actually passionate – clear example, last week we had one neuro examination class where we just got grilled… and teaching from that was minimal.. we just didn't learn - we just felt belittled in a certain way and then the next day we actually went a saw the exact same two patients with a different tutor, and we come away from that actually understanding and I never considered neurology as a career but then after seeing a passionate consultant be like "this is why I love it this is why it's important".... I was like.. maybe, this is quite interesting" (5)*

Participants interviewed in a study by Archdall et al. (2013) also reported the positive influence of inspiring teachers in promoting a positive rotation experience. Extrapolating from participant 5's experience and Archdall et al.'s (2013) study, having inspiring supervisors could impact students' desire to specialise in psychiatry, as the profession may be seen as an unattractive medical specialty if students experience poorer quality of teaching, lack of opportunities to practice skills, and uninspiring role models (Lingeswaran, 2010; Stampfer, 2011), as highlighted by participants 1 and 5:

> *I think the influence has been our experience… from like if we've had a positive experience in psych and with that same part if we're interested in it like if we've taken away something and can see ourself then yeah we'll probably pursue it, but if it's been a negative experience, no deal* (5)

> *I had a good psych experience... most of it, yeah, I had a good experience and that's probably why I would consider it (1)*

Therefore, in order for students to make positive connection to psychiatry as well as consumers, inspiring clinicians seem to be necessary to potentially promote students' desire to pursue the profession or further training.

Systemic time pressures on clinicians potentially impacting student's learning opportunities

A potential consideration for the variability in clinicians' teaching may be the time pressures that some psychiatrists are currently experiencing systemically (Royal Australian and New Zealand College of Psychiatrists, 2018a, 2018b). Participants 2, 9, and 10 discussed how supervising

psychiatrists seemed 'time poor', resulting in the students not having much learning time with them. However, junior doctors and psychiatric registrars may have less time pressure and therefore be able to provide additional learning opportunities:

> *I think sometimes it was an area that was a bit time poor however with the time I spent with consultants on maybe in other areas of medicine I would say I spent less time with consultants in psychiatry (10)*
>
> *I didn't spend much time with like consultant – level doctors but the time I had was good and like it was positive time which was good – it's not always the case, but I also got a lot of good stuff from my reg* [registrar] *as well (2)*

Rotstein and Jenkins (2017) reported that consultants across Australia often did not have time to teach medical students or psychiatry trainees, which may be attributed to the time pressures on consultants created by the general shortage of psychiatrists across Australia (Royal Australian and New Zealand College of Psychiatrists, 2018a, 2018b). As such, the shortage of psychiatrists in general may have had flow-down effects on these participants, potentially impacting their learning opportunities, level of understandings, and positive connections with the profession.

Time pressure, environment of OSCE may impede some connections and skill development

Further to consultant's time pressures impacting the participant's learning, three participants suggested that the time restrictions placed on simulated interviews during the OSCE both impeded their ability to build rapport and undertake an appropriate psychiatric assessment with simulated consumers. For example, participant 8 commented "*to do a proper one which is obviously what they want to see us do, you need time"*, while participants 6 and 4 went further to talk about the time pressure preventing their ability to develop or demonstrate rapport-building skills:

> *you only have x amount of time to get it all out whereas in reality you really ease into it and you build rapport, and you might chat with the patient for thirty/forty minutes (6)*
>
> *this pressure to get ta the crux of it to not forget the suicidal ideation, to not forget to ask the really personal questions about sexual abuse and to not forget to ask about unsafe practices, drug use etcetera - really in 8 minutes those three things is all you're going to get out.... it doesn't matter what the presentation is, that's the examination time that we have but in reality that should actually be changed because you know every standard medical consultation is based on a 15 minute consultation, but psych is never like that, not in reality –*

> *it's always given more time… and for good reason you know… I think everyone gets a very false sense what it really is like (4)*

Participant 4 stressed here that the reality of conducting a clinical interview in practice while in a clinical setting was different to the way interviews were learnt and conducted during the OSCE, which was supported by participant 7:

> *it's obviously a fake environment because if a psychiatrist interviews a patient that will be over an hour and a half for just the first interview and then they'll see them subsequent times… so it is a very synthetic environment (7)*

The difference between practicing clinical skills in the classroom and the OSCE, and a clinical setting highlights a disconnection that may influence the way students conduct interviews later on. Surmon et al. (2016) suggest that while simulated environments are valuable starting points, skill development activities enhance learning more when they are authentic rather than simulated. The 8-minute time restriction of the psychiatric OSCE also seemed to create a stressful environment for these participants. Harden (2016) discussed the potential for the OSCE to potentially encourage a 'box ticking' approach to clinical interviewing due to such time restrictions, as students may consequently concentrate on only learning and assessing risk factors.

These participants emphasised that the 8-minute restriction also disallowed time to demonstrate the clinical skills they had been developing, such as taking the time to listen, allow for silences, and formulate the case. For example:

> *we can't- we can't employ it- with all the pressures on us we can't employ it anyway… you're like "oh yeah silences are sometimes good" yeah, well hang on, seven minutes and 56 seconds left- I got no time for silence!.... now I gotta figure out what's wrong with you (6)*

Hence, the standardised clinical interviewing and OSCE may impede the formation of, or desire to form, human connections with consumers and understand the presenting individual holistically (Donetto, 2012; Marwaha, 2011). Participant 4's claim that learning in clinical interviewing skills promotes a more risk-focussed assessment was supported by almost all of the participants. Such as:

> *I think the focus was on just knowing like life-threatening stuff as well so they said 'ok, you need to rule out suicide straight awa- not straight away but within your discussions or determine a risk stratification for suicide, within your history taking and also I think depression, anxiety was quite heavily focussed on as well… (5)*

While, participant 1 emphasised the point that the time restriction of the OSCE meant the students needed to prioritise the assessment questions over making genuine human connections; both of which would be a focus in practice:

> *when I have to do this in the OSCE because obviously the way I've got to do it is so devoid from everything I've actually learnt on rotation.. What do I do? do I just y'know "oh don't tell me about your life and your kids and your husband that comes later I need to ask you these things"? (1)*

The OSCE may have been particularly problematic for these participants if that is not the way they had been learning to conduct a psychiatric interview during their rotations, demonstrating a potential disconnect between theory and practice. Therefore, the OSCE was not seen as an effective and valid manner of assessing students' actual abilities and understandings: "*the OSCE was.. I don't think a good measure of what we knew, apart from can we list the proforma" (9).* Potentially, the disconnect between theory and practice, as well as the potential for the students' connection skills to be impeded by the issues discussed within the theme *Preparedness*, may lead to unjust or inappropriate care and interpersonal treatment of mental health consumers. The relationship between preparedness and the delivery of 'just' treatment and care is deconstructed in the next theme.

4.2 Theme 2: 'Just' treatment and care

In this theme, the term 'Just' refers to justice, or how 'just' a situation may be, while 'treatment' refers to how consumers may be treated on an interpersonal level, as well as how they may be psychologically, socially, or medically 'treated' in terms of their symptoms and needs. 'Care' therefore relates to the concern for another's welfare, or the care provided to consumers by the participants or other health professionals that the participants witnessed, or the care that participants may provide to consumers in their future practice. This theme, *'Just' treatment and care,* describes the implications for consumers that arise from both the medical model of care, as well as the way that doctors and medical students understand distress, how they may position consumers, and learn how to interact with, and provide care for consumers. The theme also

discusses the issues that impact the students' wellbeing; such as the 'just' care and concern shown for medical students by the School, as well as the care that students provide for themselves. Finishing with a discussion of the way psychiatrists and the psychiatric profession are perceived by the participants, the theme further unpacks the potentially unjust or stigmatising perceptions of psychiatric professionals, and how such perceptions may impact students' decisions to specialise in the profession.

The theme *Preparedness* has potentially significant implications for *'just' treatment and care*. This is because the pressures within the medical degree, as well as those experienced with in the medical system that may impact on future doctors' understandings, knowledge bases and skills, have the potential to lead to the inappropriate treatment of consumers as people, and also inappropriate treatment of their symptoms. Unjust treatment may therefore ultimately be a barrier to some people's recovery from distress. As such, there may be some overlap between the two themes; however they have been separated in order to tease apart the experiences of preparedness from the impacts of preparedness upon consumers, medical professionals, and the students.

Disease model language, psychiatric labels promoting dehumanisation, marginalisation, unjust care

Donetto (2012) argued that the dominance of positivist science in medical education may promote a disconnect between medical professionals and the humanity in people's experiences. Donetto (2012) reasoned that the disconnect can occur as the science and its assumptions, as well as the power of the politics of science may be uninterrogated or critically analysed by the staff, students, or not required to be critiqued within the curriculum. More recent findings support such reasoning. For example, Halman et al. (2017) identified that medical or other health professional programs that were utilising a critical pedagogical framework to deliver education actually promoted the humanisation of issues that affected both the students as well as potential future consumers. The authors found that the critical teaching approach promoted the future professionals to show more authentic empathy and be more responsive to service users (Halman et al., 2017).

In this way, Halman et al. (2017) and Donetto's (2012) findings suggest that being disengaged from the psychological, social and political elements and power issues operating in a person's experience may have functioned to inhibit some of the students in this current study from seeing or relating firstly to the behaviours and experiences of the consumers, and therefore ultimately to the humanity in these individuals. Some of this disconnection was evident in the way some students spoke about psychiatric diagnoses rather than about the person and their behaviours:

> *we got more into like classes or clusters of mental illness sort of groups into psychosis and mood and whatever else.. (8)*
>
> *I feel like the academic experience of psych.. has been very much like "oh yeah this is what a personality disorder looks like" (3)*

Speaking about 'clusters', 'groups' and 'mental illness' and what a *disorder* 'looks like' as opposed to how a person with a certain diagnosis may behave, or what they may experience, has been argued as dehumanising, as such language removes the human person who has the experiences from the conversation (Kinderman et al., 2013; Lammers & Stapel, 2011). Therefore, such language can function to separate students from the inherent humanity of people's distress, as they are not talking about people and what they are experiencing (Kinderman et al., 2013; Lammers & Stapel, 2011), but rather speaking about diagnosis, disorders and 'mental illness'.

This language of disease and using disease labels such as psychiatric diagnoses can also cause harm through dehumanisation, due to a person being referred to as their diagnosis rather than their identity (Haque & Waytz, 2012). Dehumanisation leads to viewing a person as an object or the disease, which functions to further promote disregard for the individual's humanness (Haque & Waytz, 2012; Lammers & Stapel, 2011) that may result in the individual being relegated to the margins of others moral concern (Opotow, 1990b, 1995). Participant 3, for example, unintentionally demonstrated this form of dehumanisation and labelling by referring to a person as a 'schizophrenic':

> *the schizophrenic actors were pretty out there, though I guess that was just a way to learn what a typical schizophrenic is like (3)*

The term ‘schizophrenic’ comes with a set of assumptions, both social and psychiatric, that people often attribute to an individual diagnosed with the disorder that can promote social exclusion and stigma (Eksteen et al., 2017; Opotow, 1990b). Such language becomes problematic as once an individual is dehumanised and removed from another’s personal moral boundaries, such as a medical professional, the practitioner may find it easier to deny the individual fair treatment, equitable resources, empathy and compassion (Deutsch, 2006; Haque & Waytz, 2012; Lammers & Stapel, 2011; Opotow, 1990b). This denial of fairness was highlighted by participant 8, who came to understand during rotations that people with certain diagnoses experience difficulties in receiving appropriate care due to having a certain label, which indicated discrimination among some professionals within the health system:

> *I guess because you see so much.. judgement against people with mental health issues in general and.. in medicine but particularly personality disorders I think they get a much worse time through the health system than if they didn’t have that diagnosis attached to their file (8)*

This student’s statement highlights the propensity of psychiatric labels to carry assumptions about people’s behaviour, potentially promoting discrimination and unjust treatment towards consumers, which may extend to practitioners avoiding consumers who have sought help (Weiland et al., 2011). Practitioner’s avoidance of consumers has also been attributed to inadequate knowledge and understanding regarding distress or the social contributors to its development (Bost et al., 2014; Jelinek et al., 2013; Weiland et al., 2011). The participants themselves recognised that practitioner’s avoidance of consumers or marginalisation of mental health issues is likely due to a lack of understanding and experience in mental health, as well as a bias towards physical conditions that may be more easily understood and ‘treated’:

> *8: I think all those medical specialists are very good at being like ‘this presenting complaint is or isn’t medical’ and then once it’s not, the interest level has gone.. and like I’ve seen a lot where you’ve got patients who’ll come in with functional something- like I saw a conversion disorder last year… and as soon as like- you know they’d had two MRI’s and a lumbar puncture and all this stuff, and you know she was like a young woman and then they’re like ‘oh there’s nothing wrong with you’ - complete lack.. disengagement from patient- she still couldn’t walk, couldn’t swallow, like, you know she was obviously still unwell.. but as soon as it became a non-organic.. like medical condition.. there was no-"*

9: mm… just drop it
8: yeah yep
9: probably because of the lack of knowledge….
8: and time maybe
9: yeah.. and a lack of concern because it's.. but that's probably where it should just get linked up with.. the next person- a psychiatrist or
8: 'could you see this patient?'
9: yeah! Or treat it like it should be… physio's and-
8: yeah
9: it still needs treatment
8: yeah… she got better on her own eventually and she did see physio's and stuff but I mean this is a good example of when you see stigma towards mental health patients cause you'd hear the physio's talking about her like 'oh what a waste of time', like 'there's nothing wrong with her'
9: 'why doesn't she just walk'
8: yeah, and I guess people misconstrue it often as like malingering rather than an expression of.. you know of psychiatric illness or in that same right I guess a psychiatric illness… it wasn't a very inspiring clinical encounter. I saw her for like a week or two weeks I can't remember how long she was an inpatient for but in the end the round wouldn't even see her.. so… which is common enough I guess like you have a few long stay patients that you don't see-
9: every single day
8: yeah, but I wouldn't have- certainly I wouldn't have liked to be her… wouldn't like any of my family members to be treated that way…
9: mm….
8: In the end the round wouldn't even see her

It is evident here that participant 8 witnessed the unjust treatment of a consumer within the hospital setting, and acknowledged that it was wrong. Yet this case highlights the propensity for the dissemination of negative attitudes towards consumers within medical spaces, which, as Gaufberg et al. (2010) suggested, may be learnt through the "hidden curriculum" and therefore may be repeated by medical students, potentially influencing their future practice. The practitioner's focus only on biomedical (physical) aspects of the symptoms as well as having little empathy for, and understanding about distress, seemed to lead to their avoidance of the consumer. Such behaviour has been recently highlighted as a major problem within the system by WA consumers, who noted being dismissed or ignored by medical staff if they did not have a biomedical issue, or not having their physical issues treated appropriately due to being labelled a psychiatric patient (Consumers of Mental Health Western Australia, 2017; WA Statewide Suicide Prevention Network, 2018). Not only may students implicitly learn to avoid consumers through observing the behaviour of more senior

staff, but some professionals may also actively discourage medical students from interacting with some consumers:

> *there was quite a bit of Munchausen actually which was interesting... yeah, definitely we weren't encouraged to go and speak to these people (9)*

Munchausen syndrome is a psychiatric term used for people who present to emergency departments and/or psychiatric wards whose symptoms cannot be explained or a physical issue cannot be determined (Abeln & Love, 2018; Yates & Feldman, 2016); therefore, it may be assumed by medical staff that the individual is seeking attention and may be subsequently referred to the psychiatric team for a mental health assessment (Abeln & Love, 2018; Yates & Feldman, 2016). Participant 8 and 9's previously outlined statements that underscored the potential for some health professionals to not believe consumers, were reiterated by participant 6 who also outlined that the supervising clinicians did not believe a consumer's story about her experiences:

> *on day two I was sent to interview this lady who had bipolar… quite far extreme end changing before my eyes.. so yeah just chucked in a room with my little my little beeper in case something went wrong and she just loved to have a chat… she went through all her experience of the mental health industry and her childhood… I found these really good signs and story you know like these tales that she told me and I presented it [to supervisors who said] "oh yeah we've heard it all before she's a pathological liar" - none of that happened (6)*

The supervisors' assumptions that the consumer was lying led to the student also not believing anything the consumer had said. Research by Owen and Reay (2004) also highlighted that students may disbelieve that consumers give reliable histories of their experiences, which Eksteen et al. (2017) argued may be learnt from listening to other medical professionals, who have more power and legitimacy due to their position of authority and experience. Hence, participant 6 may now be more likely to question or dismiss a consumer's story/history due to such comments by the supervisors. However, Owen and Reay (2004) found that after being taught by consumer tutors, students' beliefs that consumers do actually give reliable histories improved significantly. This improvement in belief could be due to the increased level of understanding students may develop from learning from a person with lived experience (Bravery, 2018; Mak et al., 2018), through

listening to the consumer tutors speak about their experiences of both their mental health as well as their experiences within the medical industry.

Lived experience workers may enhance understanding, reflexivity, leading to more just care

The School of Medicine, Fremantle engages former patients, carers, advocates and community members to share their experiences with students during the medicine program, to enable students' understanding, empathy and person-centred care (Mak et al., 2018), as required by the Australian Medical Council's Standards for Assessment and Accreditation of Primary Medical Programs (Australian Medical Council, 2012). Some of the students highlighted that learning from people with lived experience of neurological conditions or stigmatised issues such as teen pregnancy were beneficial learning experiences, particularly in reducing the stigma that can accompany some conditions or social issues:

> *8: no- we had like symposiums on sort of psychiatry-related stuff like drug use and domestic violence*
> *9: yeah*
> *8: teen pregnancy- was that one too? So I guess there's tenterhooks and that was quite- that was all about stigma and understanding more about y'know people who-*
> *9: sex workers as well*
> *8: yeah that's right… but there was never like a group of people affected by mental illness specifically... up there*

Listening to an individual with lived experience's story may have helped the students connect and relate to their stories and circumstances, thereby humanising the issues as well as the people, subsequently promoting greater understanding, and therefore, empathy. Learning from people with lived experience has been found to have a greater impact on students due to the individuals sharing their emotional experiences (Bravery, 2018; Mak et al., 2018), which can promote self-reflection within professionals regarding their own practices, attitudes and biases (Wilrycx et al., 2012), and consequently, having a positive influence on their ability to empathise, and use person-centred care practices (Bravery, 2018; Mak et al., 2018).

However, these participants did not have the benefit of learning from a mental health consumer, as the School may not have been able source a representative at the time (D. Mak,

personal communication, October 11, 2018). Participant's 8 and 9's above statements also suggest that this student cohort may not have experienced specific and explicit destigmatising education in mental health and psychiatry, such as a lecturer or tutor overtly challenging the language and assumptions commonly used that can stereotype and stigmatise people. Three participants reported that issues of stigma were raised, yet explicit learning about destigmatising mental distress was not evident in their narratives:

> *attempts to destigmatise I don't really think… maybe just in that they spoke to the cohort about our own mental health and like it was made very clear to us that there's so many of us with, obviously as there are in the general public, there's a lot of depression, a lot of anxiety and it was just like… very open to… the school psychologist and I think that was brought up a lot and it was very normalised and very ok to seek help for ourselves but I don't think in the teaching of psychiatry specifically was* [destigmatised] *(9)*

> *I would have to say that every… every person in psychiatry somehow stigma does get raised… we're definitely aware of the stigma around it (10)*

> *although the school tries to destigmatise and they provide counselling and all that stuff, I don't think that… providing therapy or counselling services is not actually the answer - I think it's important but it's not the answer. It's about actually building personal awareness is actually what will allow somebody to know how to understand themselves better (4)*

Participant 10 highlighted that stigma is raised within psychiatry, while participants 9 and 4 outline that destigmatising education only encompassed encouraging students to be open to seeking and accepting help when they need it. Hence, there may be a lost opportunity for learning and teaching about the root causes of stigma, or the links that teachers may be trying to make may not be as overt or explicit as may be assumed. This is because it appears that the language and the taken for granted assumptions that can promote unjust behaviour were uninterrogated in both the curriculum and the classroom. These results support Donetto's (2012) observation that currently in the UK, such critical analysis is largely missing from medical education and potentially more broadly through western medical schools using similar education techniques.

Importantly, participant 4's statement that '*providing therapy or counselling services is not actually the answer*' and that '*building personal awareness is actually what will allow somebody to know how to understand themselves better*' really emphasises that even some students understand

that encouraging the use of counselling is not the answer to addressing stigma or addressing students' distress. These comments also highlight that students themselves recognise that more attention to building students' personal awareness about their mental health is increasingly necessary. Having such critical awareness may enable students to better understand both themselves, as well as build the skills to challenge and potentially reduce stigma (Kumagai & Lypson, 2009), as well as through learning to be critical and reflexive of the knowledges they are positioned within that may promote negative attitudes (Donetto, 2012). Being cognisant of one's own mental health as well as having the skills to challenge and address stigma are highly necessary for the provision of 'just' treatment and care, particularly as the Framework for Recovery Oriented Practice, under Domain 5 (Knowledge) requires practitioners to "actively challenge stigmatising attitudes within service settings and community settings" (Commonwealth of Australia, 2013a, p. 75) in order to provide best practice and avoid further distress to consumers.

Donetto (2012) also advocated for raising students' critical consciousness about the impacts that the biomedical perspective itself has on mental health service users, through connecting the assumptions of the biomedical model to people's experiences of stigma and discrimination from within the health system. This point relates to participant 9's experience of being discouraged from interacting with the individual diagnosed with Munchausen syndrome. Medical professionals had assumed the individual was 'seeking attention', as a biomedical explanation for the person's symptoms could not be ascertained. Donetto (2012) argued that students may be aware of discrimination and stigma, yet not make the explicit connection between stigma and biomedical knowledge, as the knowledge, language and assumptions are left uninterrogated in medical education.

Recovery model and critical psychiatry approaches destigmatise, encourage greater empathy and understanding

Following the participant's claims that they did not know about the recovery model, they asked for an explanation about what it was. Participant 4 subsequently suggested the consumer recovery model would be beneficial learning in the medical program:

> *I think like with the mental health consumer model it might be similarly helpful to incorporate that in to training to just.. I supposed to help destigmatise it* (4)

As participant 4 observed, the recovery perspective may help to promote the destigmatising of both mental health and consumers, which was an outcome that Newton-Howes et al. (2018) found after transforming the University of Otago's School of Medicine's psychiatry curriculum towards the recovery paradigm. Newton-Howes et al. (2018) reported that students who undertook the recovery-based curriculum had more positive attitudes towards consumers and a greater understanding of the language and assumptions that promote stigma, as well as considerably enhanced knowledge and skills in recovery compared to students who had been educated within the traditional psychiatric curriculum. The authors also noted that the students had a greater ability to recognise and be critical of the tensions between the biomedical/biopsychosocial and recovery perspectives after learning the recovery model (Newton-Howes et al., 2018).

In order to facilitate transitioning the curriculum towards recovery, incorporating critical psychiatry perspectives into existing curricula may be both appropriate and beneficial (Quadrio et al., 2014). Due to having similar values and critiques of current psychiatric approaches as the recovery paradigm, critical psychiatrists argue that utilising critical psychiatry's perspectives would assist the incorporation of the recovery paradigm into medical teaching, while highlighting the issues of traditional approaches such as using the DSM (Quadrio et al., 2014). Such an approach may be beneficial, as the more critical perspective of the DSM and diagnosis that participant 10 learnt from the clinical supervisor was found to encourage a more holistic understanding of distress, rather than seeing a person as only a diagnosis:

> *like the DSM is there but you can't see patients like that he said.. this is someone's mind and you can't unpack that, you just have to try and do the best that you can for this individual*

> *because any of us… any person can… suffer in the way that these individuals are suffering (10)*

This consultant was able to help participant 10 understand that anyone may experience distress, not just "them" (ie consumers), thereby managing to both humanise and be able to relate to the individual as a person. Participant 10 consequently realised that distress can be experienced by anyone, therefore considered what it would be like to be treated on an interpersonal level as a consumer. Here, the consultant identified themes and issues consistent with critical psychiatry, which challenges the legitimacy and effectiveness of the DSM and traditional psychiatric/biomedical approaches, advocating for holistic and consumer-led practices (Bracken & Thomas, 2010; Bracken et al., 2012; Middleton, 2007). Participant 10's experience with this consultant highlights the important role clinicians can have in providing more broad perspectives for the students to learn from, while working to destigmatising distress and the experience of being a mental health consumer. As previously outlined in *Connections,* Participant 10 consequently emphasised that a balanced approach to addressing all aspects of a person's life was necessary for recovery:

> *everything I look at I always think of the biopsychosocial model… I think that it's important to remember that it doesn't matter if you're giving someone- you can't fix everything with a pill. You can't give someone who has awful social circumstances an antidepressant and think its gonna make things better cause it won't, you know? It's all… it's all getting the balance right between all those different elements… (10)*

As such, participant 10 recognised that focussing on medications alone is insufficient; however as discussed in *Connections*, medications are the predominant method of treatment that students are taught.

> *Focusing on pharmaceutical treatments may result in unjust care and prevention of full recovery*

To reiterate, the participants claimed: *we just learn some drugs (5); we learn the drugs (3); I know that for two years in a row I learnt about classes of antidepressants (7);* and *Yeah the different drugs… (9)*, as well as:

> *I think we're so oriented towards "oh gosh well I've done nothing you know in this entire conversation now I need to prescribe something" (4)*

Current Mental Health policies mandate that the consumer has the right to choose from as many available and appropriate therapies as they need to recover (Australian Government Department of Health, 2017; Commonwealth of Australia, 2013b; Government of Western Australia Mental Health Commission, 2015, n.d.). As such, focusing primarily on pharmaceutical-based treatments may be unjust for consumers, as only providing one method of treatment is not conducive to the recovery method. Yet if a practitioner is unaware of the benefits and range of more broad therapies or is biased towards medications due to their training, they may not be able to inform the consumer of their choices or provide referrals; such practice could be considered unjust (Adams et al., 2009).

In addition, the widely reported side effects of many psychopharmaceuticals may mean that consumers may be subject to short and long term health conditions that they may not have otherwise experienced (Breggin, 2017; Moncrieff, 2006, 2017; Moncrieff et al., 2009; Morrison et al., 2015; Vilhelmsson et al., 2012), as well as not being able to work through personal issues due to the emotional numbing that the drugs may promote (McGrath et al., 2007). Furthermore, there are growing arguments that some psychiatric medications such as antidepressants may not be beneficial at all for treating some common experiences of distress (Breggin, 2017; Gotzsche, 2017; Timimi, 2014). It may therefore be argued here, that learning only to provide medications that have potential side effects is unjust to potential future service users' recovery, particularly if there are non-drug therapies and supports that may be as effective, or in some cases more effective (Consumers of Mental Health Western Australia, 2017; McGrath et al., 2007; Meehan et al., 2008; WA Statewide Suicide Prevention Network, 2018).

Learning primarily pharmaceuticals for treating distress also raises issues of power, as under the Mental Health Act, doctors, psychiatrists and institutions have used, and continue to use the drugs as chemical restraints to control behaviour if the consumer is perceived to pose a risk to themselves or another (Gregory, 2017; McSherry, 2012; "Mental Health Act," 2014). This use of coercive, or involuntary treatment has been argued as unjust, as it denies the consumer's right to

self-determination, and because the practice has been reported as extremely distressing for some consumers (Gregory, 2017). The use of involuntary chemical restraints due to the issue of professional liability for others safety, as well as the systemic pressures that doctors may negotiate, were discussed by some participants as being a conflict that they had to reconcile.

Systemic or institutional pressures: liability, funding models impacting recovery-oriented care

During the discussion of the use of medications to control behaviour and reduce risk, participant 3 emphasised doctors' professional liability for someone's death or injury: "*I guess the doctor in that situation at the end of the day if that patient did… suicide like on the ward.. is the one signing the death certificate"*. Regarding psychiatry, participant 4 recognised the professional liabilities to the Mental Health Act, as well as the institution the doctor is working in, in relation to policies and procedures for acting in emergency situations:

> *Because they're in an institution there's this.. overarching responsibility, and that's the other thing that actually prompts them to medicate and constrain… there's just the standards and expectations of the hospital itself (4)*

Participant 4's suggestion aligns with previous findings from Smith (2016), which found that psychiatrists may prefer to use antipsychotics to sedate a consumer in order to reduce the potential risk of harm, thereby easing the pressure of professional liability. Within acute care settings, students may therefore be learning to medicate mental health consumers in line with risk-management protocols rather than what is in the best interests of the individual. This was evident in students reporting to learn to sedate a distressed person in the first instance in the ED, then shift responsibility for their care to the psychiatric team:

> *so yeah how to stay personally safe and how to get rid of them as quickly as possible* (2)
>
> *how to call the psych* (5)
>
> *sedate patient, set up review for the psych* (6)

This demonstrates that negative attitudes towards consumers and practices such as sedating consumers to avoid 'dealing' with them in the ED may be resulting in the perpetuation of moral exclusion of consumers (Opotow, 1990b, 1995). This was evident in participant 2's comment "get rid

of them as soon as possible". Underscoring that, institutional acute care procedures may often not align with the principles of non-maleficence (as sedation can be considered harmful by some consumers) and recovery-oriented care, but may be rather directed towards reducing risks and liability. Participant 4 further discussed the additional systematic and institutional pressures that psychiatrists have that are associated with the medical model of care:

> *a psychologist tends to just have all the time in the world you know because your main aim is not about holding that kind of medical model that says I'm responsible for the you know the bed days and the funding that's available and all that sort of stuff, so there's a whole different level of pressure (4)*

Having to manage systemic pressures such as funding and having enough beds leads into participant 2's comment that funding priorities are not always based upon consumers' actual needs, but on the diagnosis they are given:

> *days in hospital… in terms of like medicating them to the point where schizophrenia, 21 days.. that's how we fund it - you know? Like it's a weird kind of priority (2)*

This systemic issue of funding priorities being based upon diagnosis rather than need indicates the continued dominance of the medical/psychiatric model in the MH and ED/hospital systems (K. Davies & Gray, 2015; Johnstone, 2013), rather than an emphasis on the consumer recovery model, which focuses on a person's needs and does not necessarily place importance on diagnosis (Anthony, 1993; Deegan, 1988; Piat & Polvere, 2014). Kinderman (2017) argued the medical/disease model's prioritisation of funding in terms of 'beds' means the amount of beds can determine how people are treated, and therefore the pressure for 'beds' means consumers can often be discharged before their symptoms or issues are resolved, or without appropriate care being organised prior to discharge. Hence, these participants were found to have learnt about such systemic funding priorities during their rotations, but not about the need for, or how to deliver recovery-based care within such facilities. This is problematic, as the National Framework itself states that "Recovery-oriented approaches focus on the needs of the people who use services rather than on organisational priorities." (Commonwealth of Australia, 2013a, p 2).

A major reported barrier to providing recovery-oriented care and planning within hospital wards and ED's is many clinician's limited knowledge in mental health and lack of awareness of the consumer recovery paradigm (Jelinek et al., 2013; Marynowski-Traczyk et al., 2013; Weiland et al., 2011), or a limited understanding and ability to formulate appropriately (Chief Psychiatrist of Western Australia, 2016). Having such limited understanding in mental health or distress has been found to result in unjust treatment and care in the Australian context, such as the avoidance previously discussed, or through not receiving appropriate referrals and recovery planning upon discharge (Morgan et al., 2016; Thornicroft, Rose, & Kassam, 2007). This reinforces the need for underpinning future clinician's approaches in the recovery paradigm during the medical degree (Byrne et al., 2015; Hungerford & Fox, 2014).

If consumers are discharged before their symptoms have subsided due to funding priorities being based upon diagnosis rather than need, or if they are released without appropriate follow-up services and a recovery plan, they may inevitably re-present to the ED or other crisis services (Chief Psychiatrist of Western Australia, 2016). Essentially, the lack of recovery planning puts additional undue pressure on the system, which may result in ED doctors feeling their efforts are futile; as outlined here by participant 8:

> *seeing psychiatric patients in the ED is not the time where you feel like 'yes I've done something good for someone else' you know… we're just putting a bandaid over a bleeding artery… and I think you see it a lot - I saw it a lot on psych as well where the juniors, who probably don't want to be there in general… you know they'd kind of make fun of them in subtle ways and I think it was probably they're not happy with what they're doing, their job is not very satisfying all the time probably as a junior particularly and you have to kind of distance yourself from your professional failure of not getting sick people… better… understanding enough that you know you're not fixing the problem, like it just feels overwhelming sometimes I think (8)*

This comment links to a systemic issue of funding budgets being largely directed towards acute care rather than CMH, prevention, and wrap around follow-up services post-discharge (Griffiths et al., 2015). The futility of the current system being largely directed towards acute services can therefore result in individuals re-entering the hospital system, meaning doctors may consequently feel they are powerless to help consumers recover. They may therefore blame a

person's re-presentation on the consumer, rather than understanding the systemic issues that may have promoted the consumer's need for additional help.

Participant 8's comment that *'you have to kind of distance yourself from your professional failure of not getting sick people better'* also supports findings from Beattie et al. (2017), emphasising that due to holding the medical model, some doctors may further feel frustrated and as if they have failed if they do not 'see' a person recover in the short time that they provide care for.

Negative perceptions of psychiatry reducing desire to specialise

Feeling largely unable to provide appropriate treatment and care that promotes recovery may therefore lead to unfavourable perceptions of psychiatry, deterring future doctors from seeking careers in the field, as found by Wigney and Parker (2007) and outlined by participants 8 and 9:

> *I think I have ruled it out, mostly because I think it's- and this is not for all psychiatric illnesses - but it can either be very satisfying and you get people right at the right moment and you fix them and you change the course of their lives... but on the whole, not* ['fix' them].. *but I think from what I've seen you lose the people in the illness in a medical sense… it wouldn't be for me (8)*

> *I also remember feeling quite a lot like there's not that much that you can do - there's drugs and then there's like non… pharmacological things and there's… what's it called - ECT? Yeah.. and with a lot of patients after a month you would come to a point of like 'oh none of that's really worked'… maybe this is like the new status quo for them or like we'll just hope that time will heal… and yeah it didn't feel particularly satisfying (9)*

Perceiving psychiatry as not being able to 'cure' people due to the treatments being 'unsuccessful' and having reduced control over service users' treatment outcomes has been frequently cited as reasons for reduced recruitment into psychiatry (Archdall et al., 2013; Beattie et al., 2017; Wigney & Parker, 2007, 2008). Feeling as if they were unable to 'fix' people led to these participants feeling that if they are unable to fulfil their professional mandate to 'heal people, then a career in psychiatry would not be rewarding.

However, not all participants viewed the mental health field negatively, as participant 4 claimed "*it's very rewarding"*. Participant 4 may have perceived psychiatry or working in mental health rewarding due to having experience in the sector prior to medical training, a finding supported by earlier research from Farooq et al. (2014) and Appleton et al. (2017). Additionally, a

literature review by Lyons and Hood (2011) also found that some medical students thought of psychiatry as an intellectually stimulating profession; however the field was conversely positioned as an inferior specialty through the assumption that those who pursue psychiatry are academically weak (Eksteen et al., 2017). This assumption was repeated by some of the participants in this research, for example:

> *I think it is the general perception certainly the long held perception has been you know if you can't do anything else you do psych…isn't that the med the perception in medicine? (4)*
>
> *I think some people see doing psychiatry as a bit of a cop-out, like 'oh you couldn't make it doing a specialty training' like in surgery or medicine… or that you're a bit kooky… those are probably the stigmas that exist, like... the psychiatrist needs the psychiatrist the most more than their patients… (7)*

Being that participant 4 claims such negative perceptions are held by those in medicine, and participant 7 outlines the stigmas 'that exist', these attitudes towards psychiatry may be both culturally constructed and perpetuated from within medicine, through some disciplines and other professionals (Gaufberg et al., 2010; Hafferty, 1998); for example, as one participant stated:

> *It's got negative connotations in some areas of medicine and from some people but… that's just something that I've gotten from different consultants (1)*

Such negative attitudes may be deterring students from careers in psychiatry and contributing to the unjust treatment of psychiatrists themselves as human beings, through both believing they are less able and positioning them as less intelligent than other medical professionals.

Negative perceptions of psychiatrists as people adding to stigma, deterring recruitment

Furthermore, positioning a person or group as different or inferior makes it easier to marginalise or discriminate against them (B. Davies & Harre, 1990; Opotow, 1990b, 1995; van Dijk, 1992), similar to the manner in which consumers are often delegitimised and made fun of. Such marginalisation was evident during participant's discussion of the common perceptions of psychiatrists being 'kooky' (as per #9 comment above) or 'odd'; such as:

> *I'm pretty sure that's the perception... you have to be madder than the patients to do psych (4)*

8: they do have a reputation for being an odd group of people.. generally.. I guess don't they?
F: do you think that's a valid reputation in your experience?
8: it's not not valid

However, while some students may wish to avoid being stigmatised and therefore may not consider psychiatry, two other participants discussed that their learning experiences may have a greater weight in their decisions to specialise:

I think the influence has been our experience… like if we've had a positive experience in psych and if we're interested in it like if we've taken away something and can see ourself then yeah we'll probably pursue it, but if it's been a negative experience, no deal (5)

I had a good experience and that's probably why I would consider it… yeah it's something that's top of my list just because I've always been sort of interested in it and it's becoming clearer and clearer that… work-life balance is gonna be an issue in the future in a lot of different things… so yeah it's definitely something that's appealing but then again like [participant 5] *said I don't know… if it's something that on an emotional level you can deal with day to day… but then you need more exposure to that and I think getting more exposure in turn will be good for me (1)*

Negative learning experiences have been described as those where students have had little opportunity to be involved in treatments and care (Beattie et al., 2017), and having disengaged and uninspiring teachers and mentors (Lingeswaran, 2010; Stampfer, 2011). Therefore, the decision to specialise in psychiatry is complex, consisting of personal factors such as previous experience and contact with consumers, personal career needs, and having an interest in mental health; and cultural factors in medicine, such as stigma or perceptions of the field (Archdall et al., 2013; Bassiri et al., 2011; Beattie et al., 2017; Wigney & Parker, 2007). In addition, having positive educational factors such as having a good rotation experience (Beattie et al., 2017), inspiring clinical mentors (Harper & Roman, 2017; Pai et al., 2012), and witnessing psychotherapy and recovery outcomes (Appleton et al., 2017; Nash et al., 2016) have all contributed to students' positive perceptions and considerations of psychiatry.

Other participants, who also happened to be those who had undertaken Rural Clinical School, felt positive about learning more about psychiatry and mental health, yet did not desire to specialise:

> *in terms of influencing my future practice though I feel like next year I want to identify a rotation which has a psych block on it because I feel like going in - I don't think I'm gonna be a psychiatrist but I would like to do a psych job in my junior doctor years because I feel like it's gonna be so* [beneficial] *long term (3)*
>
> *I agree with [participant name] in saying that going forward I will need to do more psych to actually feel more comfortable in - like whatever area I do there's gonna be a psych component and I'll need to know how to manage it. It'll make you more equipped… for whatever you're going into (5)*

These students had a better understanding and appreciation of the importance that mental health care has for their future practice, regardless of which specialty they chose. In addition, it may be possible that as these students had additional and more broad learning experiences in mental health during their Rural placements, they were potentially more motivated to pursue further learning due to seeing that greater importance of understanding more (Farooq et al., 2014). More learning experiences generally translates to learners having more positive attitudes and being less discriminatory (Lyons, Hans, et al., 2015; Mortlock et al., 2017). This means that as a result of their additional experience and more positive outlook towards psychiatry, these participants may consequently provide more "just" treatment and care to future consumers. Moreover, as outlined within the previous sub-theme *Impacts upon learning* (refer pages 5 – 6), these participants outlined how a greater understanding of mental health or distress would be necessary to have as a future practitioner, and therefore be beneficial to both themselves and future service users irrespective of which field of medicine they specialised in.

5. Discussion

In this final section, I begin with a reiteration of the research aims and questions and provide answers to these with a review of the key findings of the current study. I then provide a discussion of how the themes interact, as well as the implications of the findings. For example, I discuss how learning predominantly the biomedical perspective could lead to future practitioners being limited in their ability to provide 'just' treatment and care to consumers, due to having a limited understanding of the broader causes of distress, or little to no understanding of the recovery paradigm. I also suggest implications for both consumers and the reform of the WA mental health system and provide suggestions for developing medical curricula in mental health, based upon evidence of the experiences of other medical schools. The section concludes with a summary of the key messages, along with making formal recommendations for future directions for medical schools and the WA mental health system, and outlines the limitations of the current study in order to provide suggestions for future research.

Research aims and questions

This research aimed to explore medical students' learning and understanding in mental health and psychiatry, as well as how their learning aligned with current mental health policy directions and reform towards the consumer recovery paradigm. The research also aimed to explore the students' preparedness for working within mental health spaces and with consumers, and their motivation for pursuing a career in psychiatry or further training in mental health. In exploring the way the participants constructed their understandings and the discourses they drew upon to discuss their learning, the research was also designed to learn whether there were instances of stigma or discrimination towards consumers during the students' education and rotations. To understand all these factors and reiterate the key research questions, I:

- Examined 4th year medical students' learning and understanding regarding mental health and distress, consumers and psychiatry

- Explored how their learning prepared them for their psychiatric rotations and for future practice as doctors;
- Examined how their learning prepared them for rotations and any additional learning the students gained during placements;
- Explored how learning influenced their perceptions of mental health, mental health consumers, psychiatry; and
- Explored whether students would or would not choose to specialise in psychiatry or do further training in mental health

5.1 Addressing the research questions

Using constructionist thematic analysis underpinned by critical theory was a beneficial approach, as I was able to meet the research aims and answer the research questions, with the additional benefit of exploring the issues around power. The thematic analysis was constructionist in nature, as the paradigm under which the students constructed their knowledge of distress was identified, and found to be underpinned by the biomedical, positivist scientific paradigm. This research has contributed an insight into the current knowledges and understandings, as well as the preparedness of a cohort of WA medical students in working with mental health consumers in line with the recovery perspective. In addition, this research has provided additional understanding towards some WA medical students' perceptions of psychiatry, and reasons for why they may or may not they may consider specialising in psychiatry. In response to the research findings, I provide areas of opportunity for medical schools to consider in both the content and delivery of mental health education, as well as for the ongoing reform of WA's mental health system.

The findings highlighted a dominance of the medical model within the participant's understandings and conceptualisations of distress, as they largely provided primarily biological and/or genetic explanations, while considering social issues and psychological aspects secondary to the biological. However, having a predominantly biologically-focussed perspective may be disadvantageous to medical students' understandings, as there is strong evidence showing that most

people who experience extreme distress have suffered trauma or some form of social and/or psychological hardship (Kinderman, 2005; Kinderman et al., 2013; Ventriglio et al., 2016).

Some of the participants also discussed their understanding of some social aspects to distress in terms of the biopsychosocial approach, indicating that while they may assume a biological underpinning, some students may also consider some social and psychological factors. Yet as discussed by Álvarez et al. (2012), Pilgrim (2002), and Ghaemi (2009, 2010), the biopsychosocial approach has shown to be inadequate for use in mental health as it does not prevent biological reductionism, and therefore may not prevent practitioners from disregarding social factors in formulating the person's case, or in devising a treatment or recovery plan. As such, learning only the biopsychosocial approach my not ensure consumers receive the best and most comprehensive care and treatment.

In relation to treatments, the participants within this study largely indicated learning mostly pharmaceutical options. Overall, the participants had little understanding of non-drug therapies or their role in promoting recovery, or whether a doctor's role can include utilising such therapies. Some students reported having opportunities to learn more about CBT from clinical supervisors, or witnessed some other psychological techniques in practice, further underscoring the importance of, and heterogeneity among clinical supervisors. In line with research from Nash et al. (2016), the participants reported that learning about, or witnessing other such therapies in practice was very inspiring and beneficial for their learning. Learning more broad ranges of therapies can also introduce students to the additional services that they may provide to consumers as part of the Integrative Medicine approach that is increasingly used in General Practice (Phelps & Hassed, 2011).

However, the learning emphasis on using primarily medications can be considered further problematic as more broad and holistic approaches to treatments is a requirement of the National Framework for Recovery-oriented Mental Health Services (Commonwealth of Australia, 2013a) (see page 34 in literature review). In addition to the National Framework, focus of the participant's learning on the biomedical model is largely disconnected from the directions of the reform of the

WA mental health system. Specifically, the WA Mental Health, Alcohol and other Drug Services Plan 2015-2025 (Government of Western Australia Mental Health Commission, 2015) emphasises that practitioners need to shift away from the medical model in mental health, and utilise the principles of the recovery paradigm as it is currently deemed best practice. While these frameworks are directed towards mental health service professionals, medical practitioners such as GP's also provide mental health services, and access to them through referrals (Phelps & Hassed, 2011). As such, it would be considered appropriate for medical students to learn more about the broad ranges of therapies, and their applications and roles within recovery.

Going further, underpinning approaches to consumer care and treatment of distress with the recovery paradigm are particularly important as consumers have recently reported that the holistic recovery approach has been more beneficial than being treated with medications alone (Consumers of Mental Health Western Australia, 2017; WA Statewide Suicide Prevention Network, 2018). However, the students participating in this current research indicated they had not learnt about the recovery paradigm, suggesting that these future doctors may be underprepared due to not having the understandings that are required of other health, and mental health professionals. A few of the participants in particular indicated that learning the recovery paradigm would be beneficial for their future practice, indicating these students recognised the relevance and need for such learning. Moreover, some participants claimed they wanted more learning in terms of theoretical mental health content; while others desired supervised extended consultations for greater practice of rapport building and consultation skills; and some wanted more clinical immersion time to feel more competent and confident in either undertaking rotations, or for their future practice. Overall, the participants felt they had not had enough time to learn or develop skills during the mental health blocks, and not enough practical immersion time. This resulted in many feeling largely underprepared and struggling to draw upon earlier learning during their rotations.

A potential reason for students feeling underprepared due to the reported limited learning and time for development and practice may be due to the time-intensive nature of the four-year

curriculum. Having a shorter degree may also be the reason for not including the recovery paradigm or history of psychiatry within the curriculum - as reported by the students, and as was revealed through an analysis of the psychiatry curriculum and degree framework. A study by Tešija et al. (2013) supports this finding, suggesting that shorter medical programs may be detrimental to medical graduates' preparedness as they have less time for more in-depth learning and development of clinical skills. Tešija et al. (2013) found that extending the medical degree at the University of Split, Croatia, from 5 to 6 years resulted in students receiving an additional 800 hours of teaching, as well as more time for study, skill development, and preparation. The authors reported that all this additional learning and preparation time resulted in greater knowledge retention and feelings of competence, leading to significantly higher graduation rates, enhanced student wellbeing, and less attrition (Tešija et al., 2013).

As such, the participant's desires for more time, content and practice could be considered logical, as greater preparation promotes greater confidence (Surmon et al., 2016; Tešija et al., 2013), and therefore, may result in better outcomes for the students' knowledge and preparedness for practice in mental health. Conversely, if a student, emerging doctor or seasoned professional lacks confidence in either skills, knowledge, or even the emotional capacity needed to provide empathic care, they may consequently avoid a mental health consumer – a finding reported in this current research, and supported by other studies (Reavley et al., 2014; Weiland et al., 2011). Some of the current participants indicated witnessing instances of qualified practitioners avoiding consumers, and consequently suggested that GP's and other doctors or professionals need greater competencies in mental health. These suggestions may have been in acknowledgement that, potentially, a doctor having limited competencies in mental health may result in a service user not receiving appropriate care.

The potential limited competencies of some professionals in the recovery paradigm was recently highlighted in the WA Statewide Suicide Prevention Network (2018) consumer workshop, where some of these consumers reported not receiving the appropriate referrals needed post-

discharge, and also not being listened to by their doctors when attempting to self-determine their recovery plans. This means that the workshop participants did not receive all the services they felt they needed to promote their recovery and believed they were denied the right to self-determination by some clinicians (WA Statewide Suicide Prevention Network, 2018). Such findings suggest that some practitioners in WA may have both limited understanding and skills for operating within the consumer recovery paradigm, or that they may be choosing not to adhere to the principles of recovery practice.

As there have been such recent reports from WA consumers of the recovery paradigm being insufficiently delivered by some practitioners, and as there is evidence suggesting many current physicians, including the participants of the current study, may have limited knowledge of how to deliver recovery appropriately, educating future practitioners in the paradigm is now considered essential. The need for teaching recovery to medical professionals is further evident in that other medical schools such as the University of Otago (UO) have begun to transform their psychiatry curriculum in response to this growing need for competencies in recovery. Another important reason for including the recovery perspective into medical curricula is due to the psychiatry profession in Australia also beginning to incorporate recovery principles into education and practices (Royal Australian New Zealand College of Psychiatrists, 2012a, 2012b, 2016a, 2016b).

One way to transition curricula towards the recovery paradigm may be to take a more critical approach to teaching and learning in psychiatry (Quadrio et al., 2014) due to the recovery paradigm having critiques of, and developing as a result of, the shortcomings of traditional psychiatry. For example, an important finding from this current research was a participant indicating critique of the DSM and traditional biomedically-focussed approaches. This student's more critical perspective may have been due to being supervised by a clinician who utilised the same arguments as critical psychiatry. Indicating that, incorporating such critical perspectives may assist in shifting students from a more biomedical focus toward other approaches, such as emphasising people's social needs for recovery, and the recovery paradigm itself.

The benefits of teaching the recovery paradigm to medical students are becoming increasingly evident within the Australian, New Zealand, and more global western contexts (Knaack et al., 2014). For example, after being educated within the paradigm the medical students from UO were found to have a greater understanding of recovery principles, and held less stigmatising attitudes and assumptions about consumers and distress (Newton-Howes et al., 2018). Such results from OU provide evidence that learning the recovery paradigm has the potential to also address stigma and discrimination towards consumers, which may translate into more 'just' treatment and care. This is also important, as some of the current participants had also witnessed the impacts of a few practitioner's stigmatising attitudes affecting the care delivered to some services users during their rotations – such as the consumer who had been diagnosed with Munchausen syndrome (see sub theme *'Just' treatment and care*, pp. 134 - 135).

To address stigma towards services users, research has identified that more extended periods of learning from lived experience educators has been found to reduce negative attitudes, as well as the potential for injustices such as denying a consumer's concerns or desires for their recovery plan (Feeney et al., 2013; Knaack et al., 2014; Owen & Reay, 2004; A. Wood & Wahl, 2006). Suggesting that, consumer tutors/educators may need to be a permanent inclusion to medical faculty, as they may help to greater connect the theoretical and practical aspects of learning through relaying their lived experiences to students and facilitating valuable discussions. Delivering mental health education through consumer tutors has also been found successful within programs at UO in New Zealand for example (Gordon, Ellis, et al., 2014; Newton-Howes et al., 2018), as well as medical schools in Sydney (Owen & Reay, 2004) and Georgia Regents University in the United States (Mabe et al., 2014), and in educating mental health nursing students in Queensland (Byrne et al., 2013). Consumer educators within these programs have been effective in raising students' critical consciousness of stigma and discrimination, as students became more critically reflexive of their own behaviours and language use due to being confronted with the reality of people's experiences of unjust treatment (Byrne et al., 2013; Mabe et al., 2014).

Health and mental health practitioners also need to be encouraged and supported to extend their reflective practice, to engage in critical reflexivity rather than simply reflecting on a case. In order to be critically conscious of the potential consequences of their knowledges and assumptions, professionals also need to interrogate their own knowledge and assumptions (C. Taylor, 2006). For a professional to commit to changing their behaviour, conscientisation requires critical reflexivity (questioning the self) of personal assumptions, conduct, and role or position of power by considering the use of language, subsequent actions, and the basis of the knowledge they have and use (C. Taylor, 2006; C. Taylor & White, 2001). Freire (1974a, 1974b) posited that the myths or processes of a dominant structure may spill over into new ways of thinking and doing despite revolutionary efforts to transform systems; and therefore, people may continue to think and do as they always have if they have not become critically conscious (*conscientised*) by engaging in reflexivity. In the context of this research, this means that the knowledges and practices of the medical model may persist within the mental health system despite efforts made to transform the system towards recovery-oriented practice, if the professionals involved are not conscientised and become reflexive of the power those knowledges hold, and the subsequent consequences. One participant's experience of the clinical supervisor critiquing the DSM and psychiatric labels (refer pp. 144-145) for example, demonstrates the potential for medical students to become more critically aware of such issues, provided they have the opportunity to have their knowledges and assumptions challenged with such critical perspectives by trained practitioners in supportive environments.

Being critically reflexive, rather than just reflective, also enables practitioners to interrogate the power relations between themselves and service users, to understand whose knowledge is being privileged, and explore who may be marginalised as a consequence (Askeland & Fook, 2009; C. Taylor, 2006; White, Fook, & Gardner, 2006). Importantly, exposing power relations explicitly requires a critical examination of the language that people and medical professionals use to position consumers socially, economically and politically, as well as to (consciously or subconsciously) stigmatise and/or marginalise them (Crotty, 1998; Hall, 2001). Haque and Waytz (2012) argued that

language practices common in medicine, such as calling a person by their diagnosis, promotes dehumanisation and can lead to moral exclusion (Opotow, 1990a, 1990b). These authors proposed that the antidote to these practices were the humanisation and personification of service users, which could enable professionals to identify with consumers and therefore, better ensure they morally include them.

To both promote greater understanding of distressed individuals' experiences and prompt person-centred care, the School of Medicine, Fremantle has begun to incorporate consumer or service-user perspectives in some areas. For example, some participants in the current study discussed the great benefits they drew from listening to people with lived experience of Parkinson's disease or teen pregnancy for example (refer pp. 95; 135). In these cases, the consumer 'educators' were found to promote the humanisation of service users, through the increased contact students had with them as a consumer, as well as through humanising their story and experiences. The humanisation of people's experiences can be further achieved through critical pedagogy, as similar to consumers' lived experience stories, the pedagogy also has the capability to expose the human consequences of power relations between consumers, doctors, and the health/mental health system that may otherwise be invisible to current and future medical professionals (Halman et al., 2017).

Critical pedagogy has the potential to achieve these outcomes as it promotes critical self-awareness, empathy, respect, and the acceptance of others and their perspectives (see literature review pp. 47 - 49)(Bleakley, 2017; Freire, 1970, 1974b; Freire & Faundez, 1989; Halman et al., 2017; Nouri & Sajjadi, 2014). Furthermore, in encouraging students to become conscious of the experiences of others and accept their perspectives, critical pedagogy has the potential to destigmatise social issues such as mental health by privileging the perspectives of those with lived experience, and highlighting the consequences of aspects such as power and language that may negatively impact mental health service user (Bleakley, 2017; Freire, 1970, 1974b; Freire & Faundez, 1989; Giroux, 2010). That said, delivering critical pedagogy presents challenges for both academics

and students. These can include students and educators being inevitably discomforted by confrontation with issues such as their own privilege, biases, and challenges to their preconceptions, similar to one participant's experience with their clinical supervisor (see p. 107) (Kumagai et al., 2017). However, exposure to discomforting issues is already very common in medical education, and seen as crucial to developing both personal and professional moral development (Kumagai et al., 2017).

Another challenge may include the need for academics and tutors to promote a relatively power-neutral dynamic between themselves and students. Having the tutor be open to learning from students' perspectives rather than positioning themselves as the 'expert' teacher who holds the balance of power, may encourage a more open dialogue between class participants, as students learn to direct the discussions themselves (Darlaston-Jones & Owen, 2011). To be able to deliver critical pedagogy, Sandars (2016, 2017) maintains the growing need for medical educators to underpin their scholarship with critical theory, as this enables scholars to question medical education in ways that help expose the aims, knowledges, potential biases, and therefore also the unintended consequences of their teaching practices and curriculum design.

Utilising critical theory to underpin medical scholarship and education, as well as in delivering critical pedagogy, also means the history and development of psychiatry needs to be more fully included in medical curricula. The participants in this research reported not receiving formal instruction in the history of psychiatry, with a few suggesting that it would have helped them to better understand how and why psychiatric categories had been developed. Not having undergone formal learning in the history of psychiatry therefore means that the context in which psychiatric diagnoses, and psychiatry as a discipline, have evolved remains unexamined. This is important as Foucault highlighted that knowledge and power are historically situated and dependent (Hall, 2001), meaning that the current knowledge and power of the psychiatric discipline is dependent upon psychiatry's history. Learning the history of psychiatry can therefore additionally promote a critical awareness of the history of factors that have led to the current policy priorities of the WA MH

system. In this way, curricula may not only teach students how the recovery paradigm developed as a response to the critiques of traditional psychiatric approaches (Davidson et al., 2010), but also begin to provide critical perspectives, such as how to address the disconnection between diagnostic labels and people's behaviours that some current participants reported (refer pp. 105 - 106).

Most of the participants discussed such disconnections as creating difficulty in understanding what diagnoses may 'look like' in terms of behaviours unless they had opportunities to observe consumer's behaviours, such as in watching video-taped interviews or observing behaviours during their rotation (refer pp. 104 - 105). This was said to impact some participant's preparedness for rotations as they had little idea of what to expect (refer pp. 120 - 123), having the effect of increasing some of the participant's anxiousness about undertaking the psychiatry rotation. In addition, the temporal disconnection between theory undertaken in second year and rotation in fourth year also added to feelings of being unprepared and anxious about the rotation, as many participants struggled to draw upon learning from two years prior during their immersion. However, the participants who had undertaken Rural Clinical School (RCS) overall felt more prepared for the fourth-year placement as well as future practice, due to having more exposure through community health or mental health organisations, as well as through having an additional psychiatry placement during the RCS year. These participants claimed the additional immersions during RCS consequently provided very beneficial learning experiences.

Having more practical immersion and learning experiences may therefore help to address the potential lack of preparedness some students may feel, as well as provide additional practice and time to develop skills or learn from clinicians. This may be an additionally beneficial experience for students, as the participants reported some of their greatest learning came from their supervising clinicians. As previously outlined by researchers as well as participants within this current study (refer pp. 146 - 147), clinical supervisors have great power to inspire students and encourage them to take up specialty training. Additional psychiatric rotations have therefore been found beneficial for reducing negative attitudes towards mental health and the psychiatry profession

(Mortlock et al., 2017). Mortlock et al. (2017) suggested that additional practical immersions between the pre-clinical and clinical years in the mental health space may help to enhance skills, and address any stigmatising attitudes, as well as potentially promote psychiatry as an appealing specialty (Lyons, Hans, et al., 2015).

Many students may not otherwise view psychiatry as an attractive field due to the negative assumptions about psychiatrists, as well as psychiatry as a profession (refer pp. 144 - 146). The students' reports of hearing stigma towards psychiatrists and psychiatry from other professionals, as well as Bassiri et al.'s (2011) WA study regarding psychiatrists and registrars' experiences of negativity, highlight a potential medical culture of stigmatising psychiatrists and psychiatry in WA. Such negative attitudes from other medical professionals may be adopted by medical students and could result in students reproducing the stigma, but also potentially not pursuing a career in psychiatry to avoid being stigmatised by other medical professionals. Therefore, having more exposure to psychiatry as well as consumers through more practical immersions, may work to address some of the potential stigma.

Another potential way to enhance skills and reduce negative attitudes towards psychiatry and/or consumers may be to utilise the taped-interview method of skill development and assessment. Some participants emphasised that taped interviews enable observation, interaction, and reflection upon the case as well as how the student interacts with the consumer, prompting critical reflection and further skill development. These benefits have also been found in previous research of both undergraduate medical students as well as those training in specialties (Beckman & Frankel, 1994; Bonnaud-Antignac et al., 2010; Fuller & Smith, 2001; McAvoy, 1988; Mumford et al., 1987; Nilsen & Baerheim, 2005), and therefore is a frequently used training method in the psychology and counselling professions to its effectiveness. Being able to view and critically reflect on their own performance could therefore promote greater rapport-building skills due to promoting students' critical reflexivity of how they treated the consumer interpersonally, including their language use, body language, behaviours and attitudes, as well as reviewing their knowledge

(Beckman & Frankel, 1994). This approach could further enable students the space to make those authentic human connections to the consumer (or simulated consumer) (Beckman & Frankel, 1994; Fuller & Smith, 2001; Nilsen & Baerheim, 2005), which may further provide better opportunities to understand the person's circumstances, potentially leading to more positive outlooks towards consumers, and a more appropriate and comprehensive assessment and treatment plan (McAvoy, 1988).

Many of the participants also noticed after undertaking psychiatry rotations that their clinical skill development and the OSCE assessment method was "devoid from reality"; meaning not aligned with actual clinical interviewing practice in a psychiatric setting. In addition, participants claimed that the eight-minute assessment time allowed in the psychiatry OSCE promotes a focus on diagnosis and risk assessment, thereby limiting students' ability to build rapport with the person and elicit the appropriate information, which was said to take much more time in actual practice. Taking the time to listen to a consumer and ask questions has been found to help medical students relate to the consumer on a human level, rather than perceiving them merely as a patient, with a 'case' that needs to be 'fixed'; which the biomedical/disease model can promote (Farkas et al., 2005; Germov, 2014). In line with the current participant's claims, Donetto (2012) and Marwaha (2011) raised concern that the OSCE method may therefore constrain students' development of appropriate communication skills, authentic empathy, interviewing and assessment, as well as impede the proper formulation of the individual's issues and treatment plan. Akin to Donetto (2012) and Marwaha's (2011) concerns about the OSCE, some of the current participants suggested that undertaking supervised video-taped interviews could be helpful to develop their clinical interviewing and rapport-building skills. These participants suggested this approach would be a more beneficial assessment method than the OSCE as it may be less stressful, as well as more representative of practical situations, and enable students to better develop, and fully demonstrate their clinical skills.

5.2 Future considerations for undergraduate psychiatry curricula in Australian medical schools

Transforming the undergraduate medical curricula in psychiatry and mental health towards the consumer recovery paradigm is important for multiple reasons. To reiterate the arguments made within this thesis, these reasons include addressing stigma, discrimination and delivering better care and recovery outcomes to service users; to better prepare all medical students to work with people who may experience distress in any field of medicine; to align undergraduate curricula with postgraduate psychiatry fellowship curricula and for potentially greater recruitment into psychiatry fellowship programs; to greater promote the transformation of the WA mental health system if all practitioners are trained and practice within the very paradigm that the system is transforming towards; and lastly, to greater promote future medical practitioner's critical awareness of the current knowledges and practices within the mental health system, as well as the reasons why the consumer movement developed.

To ensure students become more critically aware of the bases of the knowledges they use and reasons for why diagnoses are labelled the way they are, it would now be considered necessary for medical schools to include (if not already delivered) the history, development and theory of psychiatry, and the DSM/ICD. This approach could support the delivery of recovery education through including the historical context for the development of the consumer recovery paradigm. Furthermore, schools would benefit, as a matter of priority, to consider ways to transform existing psychiatry curricula towards being underpinned by the consumer recovery paradigm, in order to more closely align learning outcomes with mental health policies and frameworks, as well as workforce priorities, and practice standards. In this way, medical schools can more fully contribute to advancing the reform of the mental health system, as well as promote a whole-of-system approach in which all practitioners have shared goals with consumers, and utilise recovery-oriented services delivery in line with the standards required of other mental health services.

Medical schools may also deliberate the benefits of training a faculty of consumer tutors to assist in the delivery of a recovery-based curriculum, as well as the incorporation of critical pedagogy

to deliver mental health education. In meeting students' needs for greater preparedness, schools may further wish to consider providing more opportunities for clinical immersion, particularly in community mental health settings that deliver recovery-oriented services rather than only rotations within acute-care facilities. In this way, students may further learn more about the benefits of recovery approaches and therapies other than pharmaceuticals, as well as having the opportunities to witness more consumers going through their personal recovery process. In addition to more immersions, utilising taped interviews for skill development and as standard assessment practice rather than, or in addition to, the OSCE, may better align with real-setting practices, and enhance students' clinical skills. Lastly, schools may wish to review the length of courses in relation to students' preparedness, learning outcomes, and wellbeing, as the findings of this project highlight that the time-intensity of the four-year program may have negatively impacted the current participants; which has the potential to impact the level of care and empathy they may provide to future consumers if they have a limited understanding.

5.3 Directions for advancing the reform of the WA Mental Health System

The following points have been identified as areas that the Government of Western Australia's Mental Health Commission, as well as the Minister for Mental Health and other key bodies such as the Office of the Chief Psychiatrist and the WA Association for Mental Health may consider, to further advance the current reform:

- Update the current workforce strategy or develop a WA-specific workforce strategy to require all future doctors, as well as current professionals who provide care such as ED physicians, GP's and allied health professionals are trained in recovery as a matter of priority
- Require that critical perspectives such as critical psychiatry and/or critical psychology are included in curricula in order to address knowledge biases, power issues, and potential stigma and discrimination, as well as promoting critical reflexivity of new and existing practitioners to extend them from reflective practice

- Ensure all medical schools and universities are currently, or are beginning to, train doctors and other professionals in recovery
    - Mental health commission could develop a University liaison to ensure recovery education is delivered in tertiary education and professional development spaces (ie TAFE), as well as to help reform curricula, provide technical support, and connect schools to lived experience educators and/or critical practitioners
- Conduct further investigation into transitioning funding models for services and hospital stays to needs-based rather than diagnosis-based funding

5.4 Limitations and future research

This research was limited in its scope to a single cohort of medical students at one WA University to ensure the project would be achievable within the time frame for a Masters project. It was also limited to a minimum of ten participants as ten was sufficient to collect enough data to reach saturation. The findings may also have been limited as some further aspects could not be explored, due to not being able to contact the necessary participants for further comment. The findings suggest that a broader exploration of mental health curricula across medical schools in WA is necessary to understand whether the future medical workforce of the state is receiving education in line with recovery as current best practice and policy in mental health. The potentials for future research stemming from the findings of this study are vast, including for example:

- Utilising the findings of this research to create a survey delivered to greater numbers of students across multiple medical schools to understand any differences or similarities to other medical students' experiences and learning;
- Research all medical schools in WA to understand if there is a University or cohort effect that alters the students' perceptions, learning opportunities, and preparedness for practice;
- Analysis of other WA medical school's curricula and learning materials to understand whether current curricula includes the recovery paradigm, or the development opportunities for incorporating, or underpinning the curriculum with the recovery paradigm;

- Exploring how a shortened (4 year) medical degree may impact students' level of understanding and skill development, hence their preparedness for practice in mental health and/or psychiatry compared to longer degrees

Additionally, further research questions may consider asking:

- Do some students' struggle to draw on learning regardless of whether they have more practical immersions between 2nd & 4th year? And is understanding and learning enhanced if students undertake rotations straight after, and alongside theoretical learning?
- Does explicitly linking students' personal wellbeing and mental health with MH and psychiatry content lead to greater empathy, ability to humanise service users' experiences, and therefore, potentially lead to better care for consumers?
- How does learning the recovery paradigm change the perceptions students have about consumers' prospects for recovery? And does learning the recovery paradigm lead to more medical students taking up further training in mental health and psychiatry after graduation?
- Do more students undertake the psychiatry fellowship program after learning the recovery paradigm? Could or does the recovery paradigm promote recruitment in psychiatry?
- How much professional development in learning recovery have WA GP's and ED physicians undergone?
- What aspects of the recovery paradigm do current WA psychiatrists understand, and what practices do they utilise?

Conclusion

The findings of this research indicate that the participant's understandings in mental health were predominantly based within the biomedical model, consistent with medical education and the biological perspective of psychiatry. However, the participants claimed they had not learnt about the consumer recovery paradigm in mental health. This is despite the paradigm underpinning current

National and State mental health policies and frameworks, as well being a requirement within the National mental health practice standards and workforce development strategy.

As a result of their training, the current participants did not feel well prepared, confident or competent enough for their psychiatry rotations or future practice with mental health consumers. Suggesting that, greater connections and integration of theory and practical immersions may be necessary to enhance confidence and competence of future practitioners. In addition, training all future medical professionals in the recovery paradigm is a requirement to both ensure practitioners are appropriately equipped for providing any form of mental health care to consumers, as well as to advance the reform of the WA Mental Health system towards the recovery paradigm, as current policy requires.

Mabe et al. (2014) have earlier claimed that although much effort has gone into shifting policy and implementing practice changes, there has been little change in the training curriculums of the very professions that will be delivering mental health services. This is evident in the findings of this current research. In addition, Brassolotto et al. (2014) highlighted that professionals involved in any system need to accept the new paradigm and enact it in practice for transformation to occur; indicating that, transformation of the WA mental health system may continue to progress slowly, or not at all unless and until all professionals accept and transition to using the recovery paradigm. Furthermore, Adams et al. (2009) earlier stated:

> "addressing the workforce issues will require profound if not radical changes in curriculum and training as well as a redefinition of mental health workforce roles. Success in addressing these aspects will likely be critical to each country's success in overall systems change and realisation of the policies that have been articulated." (p. 44)

Therefore, advancing the reform of the WA mental health system requires disrupting the current dominant knowledge practices undertaken by institutions involved in training workforces that provide care for consumers. Ensuring that mental health curricula are both underpinned by the

consumer recovery paradigm, and promote conscientisation and critical reflexivity within future medical professionals may now be considered essential.

References

Abeln, B., & Love, R. (2018). An Overview of Munchausen Syndrome and Munchausen Syndrome by Proxy. *Nursing Clinics of North America, 53*(3), 375-384. doi:10.1016/j.cnur.2018.04.005

Adams, N., Daniels, A., & Compagni, A. (2009). International Pathways to Mental Health Transformation. *International Journal of Mental Health, 38*(1), 30-45. doi:10.2753/IMH0020-7411380103

Álvarez, A. S., Pagani, M., & Meucci, P. (2012). The clinical application of the biopsychosocial model in mental health: a research critique. *American Journal of Physical Medicine & Rehabilitation, 91*(13 Suppl 1), S173-S180. doi:10.1097/PHM.0b013e31823d54be

Alyami, H., Sundram, F., Hill, A. G., Alyami, M., & Cheung, G. (2015). Visualizing psychiatric formulation. *Australasian Psychiatry, 23*(5), 575-580. doi:10.1177/1039856215593024

American Psychiatric Association. (2015). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*.

American Psychiatric Association. (2018). DSM History. Retrieved from https://www.psychiatry.org/psychiatrists/practice/dsm/history-of-the-dsm

Anderson, M. (2003). 'One flew over the psychiatric unit': mental illness and the media. *Journal of Psychiatric and Mental Health Nursing, 10*(3), 297-306. doi:10.1046/j.1365-2850.2003.00592.x

Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11.

Anthony, W., Rogers, S., & Farkas, M. (2003). Research on Evidence-Based Practices: Future Directions in an Era of Recovery. *Community Mental Health Journal, 39*(2), 101-114. doi:10.1023/A:1022601619482

Appleton, A., Singh, S., Eady, N., & Buszewicz, M. (2017). Why did you choose psychiatry? a qualitative study of psychiatry trainees investigating the impact of psychiatry teaching at

medical school on career choice. *BMC Psychiatry, 17*(1), 276. doi:10.1186/s12888-017-1445-5

Archdall, C., Atapattu, T., & Anderson, E. (2013). Qualitative study of medical students' experiences of a psychiatric attachment. *Psychiatrist, 37*(1), 21-24. doi:10.1192/pb.bp.112.039065

Askeland, G. A., & Fook, J. (2009). Critical reflection in social work. *European Journal of Social Work, 12*(3), 287-292. doi:10.1080/13691450903100851

Australasian College for Emergency Medicine. (2018). *Waiting times in emergency departments for people presenting with acute mental and behavioural conditions*. Retrieved from Melbourne, VIC: https://mhas.wa.gov.au/assets/documents/18.02.26-ACEM_Mental-Health-Access-Block.pdf

Australasian Integrative Medicine Association. (2014). Best practice for integrative medicine in Australian medical practice. *Advances in Integrative Medicine, 1*(2), 69-84. doi:10.1016/j.aimed.2013.12.001

Australian Government. (2010). *National Standards for Mental Health Services*. Retrieved from https://health.gov.au/internet/main/publishing.nsf/Content/CFA833CB8C1AA178CA257BF0001E7520/$File/servst10v2.pdf

Australian Government Department of Health. (2011a). *National Mental Health Workforce Plan*. Retrieved from https://www.aihw.gov.au/getmedia/402bfe45-5fd2-49e2-9d30-3f9561db6f44/National-mental-health-workforce-plan-2011.pdf.aspx

Australian Government Department of Health. (2011b). *National Mental Health Workforce Strategy*. Retrieved from https://www.aihw.gov.au/getmedia/f7a2eaf1-1e9e-43f8-8f03-b705ce38f272/National-mental-health-workforce-strategy-2011.pdf.aspx

Australian Government Department of Health. (2017). *The Fifth National Mental Health and Suicide Prevention Plan*. Retrieved from http://www.coaghealthcouncil.gov.au/Portals/0/Fifth%20National%20Mental%20Health%20and%20Suicide%20Prevention%20Plan.pdf

Australian Health Ministers' Advisory, C. (2013). *A national framework for recovery-oriented mental health services: a guide for practitioners and providers*. Retrieved from Canberra, ACT: http://www.health.gov.au/internet/main/publishing.nsf/content/67d17065514cf8e8ca257c1d00017a90/$file/recovgde.pdf

Australian Medical Council. (2012). *Standards for assessment and accreditation of primary medical programs by the Australian Medical Council 2012*. Retrieved from https://www.amc.org.au/files/d0ffcecda9608cf49c66c93a79a4ad549638bea0_original.pdf

Aviram, U., Syme, S. L., & Cohen, J. B. (1976). Effects of policies and programs on reduction of mental hospitalization *Social science & medicine, 10*(11-1), 571-577.

Ayd, J. F. J. (1961). A survey of drug-induced extrapyramidal reactions. *JAMA, 175*, 1054.

Bambra, C., Fox, D., & Scott-Samuel, A. (2005). Towards a politics of health. *Health Promotion International, 20*(2), 187-193. doi:10.1093/heapro/dah608

Barley, M., Pope, C., Chilvers, R., Sipos, A., & Harrison, G. (2008). Guidelines or mindlines? A qualitative study exploring what knowledge informs psychiatrists decisions about antipsychotic prescribing. *Journal of Mental Health, 17*(1), 9-17. doi:10.1080/09638230701498358

Bassiri, M., Lyons, Z., & Hood, S. (2011). Stigmatisation of psychiatrists: Experiences of psychiatrists and psychiatric registrars in Western Australia. *Education Research and Perspectives, 38*(2), 35.

Bateman, J., & Smith, T. (2011). Taking Our Place: Community Managed Mental Health Services in Australia. *International Journal of Mental Health, 40*(2), 55-71. doi:10.2753/IMH0020-7411400203

Beard, T. (Writer) & T. Beard (Director). (2018). The Doctor who took kids off drugs Series 1, Episode 2. In D. Walker (Producer), *The Doctor who took kids off drugs*. BBC UK: BBC.

Beaton, S., Forster, P., & Maple, M. (2013). Suicide and language: why we shouldn't use the 'C' word. *InPsych, 35*(1).

Beattie, S., Crampton, P. E., Schwarzlose, C., Kumar, N., & Cornwall, P. L. (2017). Junior doctor psychiatry placements in hospital and community settings: a phenomenological study. *BMJ Open, 7*(9), e017584.

Beckman, H. B., & Frankel, R. M. (1994). The use of videotape in internal medicine training. *Journal of General Internal Medicine, 9*(9), 517-521. doi:10.1007/BF02599224

Beers, C. W. (1934). *A mind that found itself: an autobiography*. Garden City; New York: Doubleday, Doran & Company, Inc.

Benning, T. (2015). Limitations of the biopsychosocial model in psychiatry. *Advances in Medical Education and Practice, 2015*, 347-352. doi:10.2147/AMEP.S82937

beyondblue. (2013). *National Mental Health Survey of Doctors and Medical Students*. Retrieved from https://www.beyondblue.org.au/docs/default-source/research-project-files/bl1132-report---nmhdmss-full-report_web

Bhabha, H. K. (2004). *The location of culture* (New ed.). London;New York: Routledge.

Black, D. W., & Grant, J. E. (2014). *DSM-5® guidebook: the essential companion to the diagnostic and statistical manual of mental disorders*: American Psychiatric Pub.

Bleakley, A. (2017). The Perils and Rewards of Critical Consciousness Raising in Medical Education. *Academic Medicine, 92*(3), 289-291. doi:10.1097/ACM.0000000000001426

Blood, R. W., Putnis, P., & Pirkis, J. (2002). Mental-illness news as violence: a news frame analysis of the reporting and portrayal of mental health and illness in Australian media. *Australian Journal of Communication, 29*(2), 59-82.

Bonnaud-Antignac, A., Campion, L., Pottier, P., & Supiot, S. (2010). Videotaped simulated interviews to improve medical students' skills in disclosing a diagnosis of cancer. *Psycho-Oncology, 19*(9), 975-981. doi:10.1002/pon.1649

Bost, N., Crilly, J., & Wallen, K. (2014). Characteristics and process outcomes of patients presenting to an Australian emergency department for mental health and non-mental health diagnoses. *International Emergency Nursing, 22*(3), 146-152. doi:10.1016/j.ienj.2013.12.002

Bracken, P., & Thomas, P. (2010). From Szasz to Foucault: On the Role of Critical Psychiatry. *Philosophy, Psychiatry, & Psychology, 17*(3), 219-228.

Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., . . . Yeomans, D. (2012). Psychiatry beyond the current paradigm. *The British Journal of Psychiatry: The Journal of Mental Science, 201*(6), 430-434. doi:10.1192/bjp.bp.112.109447

Brassolotto, J., Raphael, D., & Baldeo, N. (2014). Epistemological barriers to addressing the social determinants of health among public health professionals in Ontario, Canada: a qualitative inquiry. *Critical Public Health, 24*(3), 321-336. doi:10.1080/09581596.2013.820256

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: a practical guide for beginners*. London: SAGE.

Bravery, B. D. (2018). Why patients should be part of medical training from day one. *Medical Journal of Australia, 208*(11), 480-480. doi:10.5694/mja17.00931

Breakwell, G. (2012). Interviewing. In G. Breakwell, J. Smith, & D. Wright (Eds.), *Research methods in psychology* (4 ed., pp. 367-390). London, England: Sage.

Breen, L. (2007). The researcher'in the middle': Negotiating the insider/outsider dichotomy. *The Australian Community Psychologist, 19*(1), 163-174.

Breggin, P. (2017). Neuroleptic (antipsychotic) drugs: An epidemic of tardive dyskinesia and related brain injuries afflicting tens of millions. In J. Davies (Ed.), *The sedated society: The causes and harms of our psychiatric drug epidemic* (pp. 123-162). Cham, Switzerland: Palgrave Macmillan.

Brockington, I. F., & Mumford, D. B. (2002). Recruitment into psychiatry. *The British Journal of Psychiatry, 180*(4), 307-312. doi:10.1192/bjp.180.4.307

Buchanan-Barker, P. (2009). The convenient myth of Thomas Szasz. *Journal of psychiatric and Mental Health Nursing, 16*(1), 87-95. doi:10.1111/j.1365-2850.2008.01310.x

Burford, B., Whittle, V., & Vance, G. H. S. (2014). The relationship between medical student learning opportunities and preparedness for practice: a questionnaire study. *BMC Medical Education, 14*(1), 223. doi:10.1186/1472-6920-14-223

Byrne, L., Happell, B., & Reid-Searl, K. (2015). Recovery as a lived experience discipline: A grounded theory study. *Issues in mental health nursing, 36*(12), 935-943.

Byrne, L., Happell, B., & Reid-Searl, K. (2016). Lived experience practitioners and the medical model: world's colliding? *Journal of Mental Health (Abingdon, England), 25*(3), 217.

Byrne, L., Happell, B., Welch, T., & Moxham, L. J. (2013). 'Things you can't learn from books': Teaching recovery from a lived experience perspective. *International Journal of Mental Health Nursing, 22*(3), 195-204. doi:10.1111/j.1447-0349.2012.00875.x

Chaijale, N. N., Curtis, A. L., Wood, S., Zhang, X.-Y., Bhatnagar, S., Reyes, B. A., . . . Valentino, R. J. (2013). Social stress engages opioid regulation of locus coeruleus norepinephrine neurons and induces a state of cellular and physical opiate dependence. *Neuropsychopharmacology : Official Publication of the American College of Neuropsychopharmacology, 38*(10), 1833. doi:10.1038/npp.2013.117

Chaney, G. (2018). Med schools doing more. *Medical Forum*. Retrieved from https://www.medicalhub.com.au/med-schools-doing-more/

Chief Psychiatrist of Western Australia. (2016). *Targeted Review: Mental Health Presentations in the Emergency Department*. Retrieved from http://www.chiefpsychiatrist.wa.gov.au/wp-content/uploads/2016/07/ED-Targeted-Review-Statewide-2016.pdf

Chouinard, G., & Jones, B. D. (1980). Neuroleptic-induced supersensitivity psychosis: clinical and pharmacologic characteristics. *The American Journal of Psychiatry, 137*(1), 16.

Chouinard, G., Jones, B. D., & Annable, L. (1978). Neuroleptic-induced supersensitivity psychosis. *The American Journal of Psychiatry, 135*(11), 1409.

Clayton, S., & Opotow, S. (2003). Justice and Identity: Changing Perspectives on What Is Fair. *Personality and Social Psychology Review, 7*(4), 298-310. doi:10.1207/S15327957PSPR0704_03

Commonwealth of Australia. (2009). *National Mental Health Policy 2008*. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/B4A903FB48158BAECA257BF0001D3AEA/$File/finpol08.pdf

Commonwealth of Australia. (2013a). *A national framework for recovery-oriented mental health services: Guide for practitioners and providers*. Retrieved from Canberra, ACT: http://www.health.gov.au/internet/main/publishing.nsf/content/67d17065514cf8e8ca257c1d00017a90/$file/recovgde.pdf

Commonwealth of Australia. (2013b). *A national framework for recovery-oriented mental health services: Policy and theory*. Retrieved from Canberra, ACT: http://www.mhima.org.au/pdfs/Recovery%20Framework%202013_Policy_theory.pdf

Connelly, L. M., & Peltzer, J. N. (2016). Underdeveloped themes in qualitative research: Relationship with interviews and analysis. *Clinical Nurse Specialist, 30*(1), 52-57. doi:10.1097/NUR.0000000000000173

Consumers of Mental Health Western Australia. (2016). Definitions. Retrieved from http://www.comhwa.org.au/about-us/definitions/

Consumers of Mental Health Western Australia. (2017). *Bring your voice: Lived experience perspectives for better mental health and wellbeing 2017 report to our new state government*. Retrieved from http://www.comhwa.org.au/wp-content/uploads/2013/02/CoMHWA-Bring-Your-Voice-Report-2017.pdf

Cooke, A., & Kinderman, P. (2018). "But What About Real Mental Illnesses?" Alternatives to the Disease Model Approach to "Schizophrenia". *The Journal of Humanistic Psychology, 58*(1), 47. doi:10.1177/0022167817745621

Cooper, R. (2018). Understanding the DSM-5: stasis and change. *History of Psychiatry, 29*(1), 49-65. doi:10.1177/0957154X17741783

Coyle, A. (Ed.) (2012). *Discourse Analysis* (4 ed.). London, England: Sage.

Craddock, N. (2014). Social neuroscience: bringing an end to the destructive and misguided "social" versus "biological" in psychiatry. *World Psychiatry, 13*(2), 140-141. doi:10.1002/wps.20119

Critical Psychiatry Network. (2013). *DSM 5 Statment by the critical psychiatry network* [Press release]. Retrieved from http://www.criticalpsychiatry.co.uk/docs/CPN%20statement%20DSM-5.pdf

Cromby, J., Harper, D., & Reavey, P. (2013). *Psychology, mental health and distress*. New York: Palgrave Macmillan.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. St Leonards, NSW: Allen & Unwin.

Dalum, H. S., Pedersen, I. K., Cunningham, H., & Eplov, L. F. (2015). From Recovery Programs to Recovery-Oriented Practice? A Qualitative Study of Mental Health Professionals' Experiences When Facilitating a Recovery-Oriented Rehabilitation Program. *Archives of Psychiatric Nursing, 29*(6), 419-425. doi:10.1016/j.apnu.2015.06.013

Dao, D. K., Goss, A. L., Hoekzema, A. S., Kelly, L. A., Logan, A. A., Mehta, S. D., . . . DeLisser, H. M. (2017). Integrating Theory, Content, and Method to Foster Critical Consciousness in Medical Students: A Comprehensive Model for Cultural Competence Training. *Academic Medicine, 92*(3), 335-344. doi:10.1097/ACM.0000000000001390

Darlaston-Jones, D., & Owen, A. (2011). *A collaborative learning and critical reflexivity model of anti-racism education.* Paper presented at the 46th Annual APS Conference.

Davidson, L., O'Connell, M., Tondora, J., Styron, T., & Kangas, K. (2006). The Top Ten Concerns About Recovery Encountered in Mental Health System Transformation. *Psychiatric Services, 57*(5), 640-645. doi:10.1176/appi.ps.57.5.640

Davidson, L., O'Connell, M. J., Tondora, J., Lawless, M., & Evans, A. C. (2005). Recovery in Serious Mental Illness: A New Wine or Just a New Bottle? *Professional Psychology: Research and Practice, 36*(5), 480-487. doi:10.1037/0735-7028.36.5.480

Davidson, L., Rakfeldt, J., & Strauss, J. S. (2010). *The roots of the recovery movement in psychiatry: lessons learned* (1. Aufl.;2;1; ed.). Hoboken, NJ;Chicester, UK;: Wiley-Blackwell.

Davidson, L., & Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *Journal of Mental Health, 16*(4), 459-470. doi:10.1080/09638230701482394

Davies, B., & Harre, R. (1990). Positioning - the discursive production of selves. *Journal for the Theory of Social Behaviour, 20*(1), 43-63. doi:10.1111/j.1468-5914.1990.tb00174.x

Davies, J. (2017). Political pills: Psychopharmaceuticals and neoliberalism as mutually supporting In J. Davies (Ed.), *The Sedated Society: The causes and harms of our psychiatric drug epidemic* (pp. 189-225). Cham, Switzerland: Palgrave Macmillan.

Davies, K., & Gray, M. (2015). Mental Health Service Users' Aspirations for Recovery: Examining the Gaps between what Policy Promises and Practice Delivers. *British Journal of Social Work, 45*(suppl 1), i45-i61. doi:10.1093/bjsw/bcv089

Decker, H. S. (2016). Cyclical swings: The bête noire of psychiatry. *History of Psychology, 19*(1), 52-56. doi:10.1037/hop0000017

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11-19. doi:10.1037/h0099565

Department of Health. (2001). *The journey to recovery: the Government's vision for mental health care*. Retrieved from http://webarchive.nationalarchives.gov.uk/20120503145017/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002700

Department of Health. (2003). *National Mental Health Plan 2003-2008*. Retrieved from http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-infopri2-toc~mental-pubs-n-infopri2-pt1~mental-pubs-n-infopri2-pt1-4

Department of Health. (2009). *Fourth National Mental Health Plan*. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-f-plan09

Deutsch, M. (2006). A Framework for Thinking About Oppression and Its Change. *Social Justice Research, 19*(1), 7-41. doi:10.1007/s11211-006-9998-3

Dinos, S., Stevens, S., Serfaty, M., Weich, S., & King, M. (2004). Stigma: the feelings and experiences of 46 people with mental illness: Qualitative study. *The British Journal of Psychiatry, 184*(2), 176-181. doi:10.1192/bjp.184.2.176

Donetto, S. (2012). Medical students and patient-centred clinical practice: the case for more critical work in medical schools. *British Journal of Sociology of Education, 33*(3), 431-449. doi:10.1080/01425692.2012.662821

Dow, S. J., & Kelly, J. F. (2013). Listening to Youth: Adolescents' Reasons for Substance Use as a Unique Predictor of Treatment Response and Outcome. *Psychology of Addictive Behaviors, 27*(4), 1122-1131. doi:10.1037/a0031065

Dowrick, C., & Frances, A. (2013). Medicalising unhappiness: new classification of depression risks more patients being put on drug treatment from which they will not benefit. *BMJ : British Medical Journal, 347*(dec09 7), f7140-f7140. doi:10.1136/bmj.f7140

Dyrbye, L. N., Thomas, M., Massie, F. S., Power, D. V., Eacker, A., Harper, W., . . . Shanafelt, T. D. (2008). Burnout and suicidal ideation among U.S. medical students. *Annals of Internal Medicine, 149*(5), 334-341. doi:10.7326/0003-4819-149-5-200809020-00008

Dyrbye, L. N., Thomas, M., & Shanafelt, T. D. (2005). Medical student distress: causes, consequences, and proposed solutions. *Mayo Clinic Proceedings, 80*(12), 1613.

Edley, N. (2001). Unravelling Social Constructionism. *Theory & Psychology, 11*(3), 433-441. doi:10.1177/0959354301113008

Eksteen, H.-C., Becker, P. J., & Lippi, G. (2017). Stigmatization towards the mentally ill: Perceptions of psychiatrists, pre-clinical and post-clinical rotation medical students. *International Journal of Social Psychiatry, 63*(8), 782-791. doi:10.1177/0020764017735865

Eley, D. S. (2010). Junior doctors' perceptions of their preparedness for hospital work: support for the rural clinical school model as a key to better preparation. *Medical Journal of Australia, 192*(2), 109-110. doi:10.5694/j.1326-5377.2010.tb03436.x

Engel, G. L. (2012). The need for a new medical model: a challenge for biomedicine. *Psychodynamic psychiatry, 40*(3), 377.

Fallon, P., Dursun, S., & Deakin, B. (2012). Drug-induced supersensitivity psychosis revisited: characteristics of relapse in treatment-compliant patients. *Therapeutic Advances in Psychopharmacology, 2*(1), 13-22. doi:10.1177/2045125311431105

Farkas, M., Gagne, C., Anthony, W., & Chamberlin, J. (2005). Implementing Recovery Oriented Evidence Based Programs: Identifying the Critical Dimensions. *Community Mental Health Journal, 41*(2), 141-158. doi:10.1007/s10597-005-2649-6

Farooq, K., Lydall, G. J., Malik, A., Ndetei, D. M., Bhugra, D., & Group, I. (2014). Why medical students choose psychiatry - a 20 country cross-sectional survey. *BMC Medical Education, 14*(1), 12-12. doi:10.1186/1472-6920-14-12

Farquharson, L. (2017). A 'Scottish Poor Law of Lunacy'? Poor Law, Lunacy Law and Scotland's parochial asylums. *History of Psychiatry, 28*(1), 15.

Fauvel, A. (2015). Beyond the asylum -An other view on the history of psychiatry in the modern age. *Therapeutische Umschau. Revue therapeutique, 72*(7), 429.

Fay, J. (2018). Decolonising mental health services one prejudice at a time: psychological, sociological, ecological, and cultural considerations. *Settler Colonial Studies, 8*(1), 47-13. doi:10.1080/2201473X.2016.1199828

Feeney, L., Jordan, I., & McCarron, P. (2013). Teaching Recovery to Medical Students. *Psychiatric Rehabilitation Journal, 36*(1), 35-41. doi:10.1037/h0094745

Foucault, M. (1967). *Madness and civilization: a history of insanity in the age of reason*. London: Tavistock.

Foucault, M. (1972). *The archaeology of knowledge: Translated from the french by AM Sheridan Smith*: Pantheon Books.

Foucault, M., Khalfa, J., & Murphy, J. (2006). *History of madness* (Vol. 2). New York; London: Routledge.

Foucault, M., & Rabinow, P. (Eds.). (2010). *Michel Foucault: The Foucault Reader*. New York, NY, United States of America: Vintage Books.

Fox, D., Prilleltensky, I., & Austin, S. (2009). *Critical Psychology: An Introduction* (Vol. 2nd). London: Sage Publications.

Frances, A. (2013). Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, big pharma and the medicalization of ordinary life. *Psychotherapy in Australia, 19*(3), 14-18.

Francis, C., Pirkis, J., Blood, R. W., Dunt, D., Burgess, P., Morley, B., & Stewart, A. (2005). Portrayal of depression and other mental illnesses in Australian nonfiction media. *Journal of Community Psychology, 33*(3), 283-297. doi:10.1002/jcop.20050

Francis, C., Pirkis, J., Blood, R. W., Dunt, D., Burgess, P., Morley, B., . . . Putnis, P. (2004). The portrayal of mental health and illness in Australian non-fiction media. *Australian and New Zealand Journal of Psychiatry, 38*(7), 541-546. doi:10.1080/j.1440-1614.2004.01407.x

Freire, P. (1970). *Pedagogy of the oppressed*. New York: Herder and Herder.

Freire, P. (1974a). Conscientisation. *Cross Currents, 24*(1), 23.

Freire, P. (1974b). *Education for critical consciousness*. London: Shead and Ward.

Freire, P. (1996). *Pedagogy of the oppressed: New rev. ed*. London u.a: Penguin Books.

Freire, P., & Faundez, A. (1989). *Learning to question: a pedagogy of liberation*. New York: Continuum.

Friedman, B. H. (2011). Managing Fear: The Politics of Homeland Security. *Political Science Quarterly, 126*(1), 77-106. doi:10.1002/j.1538-165X.2011.tb00695.x

Fuller, G., & Smith, P. (2001). Rediscovering the wheel teaching communication skills using video taped clinical consultations in specialist training. *Clinical Medicine, Journal of the Royal College of Physicians, 1*(3), 203-204. doi:10.7861/clinmedicine.1-3-203

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? data saturation in qualitative research. The Qualitative Report, 20(9), 1408-1416. Retrieved from https://nsuworks.nova.edu/tqr/vol20/iss9/3/

Gaufberg, E. H., Batalden, M., Sands, R., & Bell, S. K. (2010). The hidden curriculum: What can we learn from third-year medical student narrative reflections? *Academic Medicine, 85*(11), 1709-1716. doi:10.1097/ACM.0b013e3181f57899

Gergen, K. (2003). Knowledge as socially constructed. In M. Gergen & K. Gergen (Eds.), *Social construction: a reader* (pp. 15-17). London, England: Sage.

Gergen, K. (2009). *An invitation to social construction* (2nd ed.). London, England: Sage.

Germov, J. (2014). *Second opinion: an introduction to health sociology* (5th;5;5th; ed.). South Melbourne, Vic: Oxford University Press.

Ghaemi, S. N. (2009). The rise and fall of the biopsychosocial model. *The British Journal of Psychiatry, 195*(1), 3-4. doi:10.1192/bjp.bp.109.063859

Ghaemi, S. N. (2010). *The rise and fall of the biopsychosocial model: reconciling art and science in psychiatry*. Baltimore: Johns Hopkins University Press.

Giroux, H. (2010). Rethinking Education as the Practice of Freedom: Paulo Freire and the Promise of Critical Pedagogy. *Policy Futures in Education, 8*(6), 715-721. doi:10.2304/pfie.2010.8.6.715

Giroux, H., & McLaren, P. J. o. (1992). Writing from the margins: Geographies of identity, pedagogy, and power. *Journal of Education, 174*(1), 7-30.

Goffman, E. (1961). *Asylums: essays on the social situation of mental patients and other inmates*. Garden City, NY: Anchor.

Goffman, E. (1968). *Stigma: notes on the management of spoiled identity*. Harmondsworth, England: Penguin.

González-Torres, M. A., Oraa, R., Arístegui, M., Fernández-Rivas, A., & Guimon, J. (2007). Stigma and discrimination towards people with schizophrenia and their family members: A qualitative study with focus groups. *Social psychiatry and psychiatric epidemiology, 42*(1), 14-23. doi:10.1007/s00127-006-0126-3

Gooding, P. (2015). Psychiatrists' Perceptions of Supported Decision-Making: A Victorian Empirical Study. *Psychiatry, Psychology and Law, 22*(5), 701-722. doi:10.1080/13218719.2014.983217

Gordon, S., Ellis, P., Gallagher, P., & Purdie, G. (2014). Service users teaching the recovery paradigm to final year medical students. A New Zealand approach. *Health Issues*(113), 15.

Gordon, S., Huthwaite, M., Short, J., & Ellis, P. (2014). Discovering stigma through recovery teaching. *Australasian Psychiatry, 22*(2), 186-189.

Gotzsche, P. (2017). Psychopharmacology is not evidence-based medicine. In J. Davies (Ed.), *The sedated society: The causes and harms of our psychiatric drug epidemic* (pp. 23-50). Cham, Switzerland: Palgrave Macmillan.

Government of Western Australia Mental Health Commission. (2015). *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025*. Retrieved from https://www.mhc.wa.gov.au/media/1834/0581-mental-health-planprintv16acc-updated20170316.pdf

Government of Western Australia Mental Health Commission. (n.d.). *Mental Health 2020: Making it personal and everybody's business. Reforming Western Australia's Mental Health System*. Retrieved from https://www.mhc.wa.gov.au/about-us/strategic-direction/mental-health-2020-strategic-policy/

Government of Western Australia Mental Health Commission. (nd). *Mental Health 2020: Making it personal and everybody's business. Reforming Western Australia's Mental Health System*. Retrieved from

http://www.mentalhealth.wa.gov.au/about_mentalhealthcommission/Mental_Health2020_strategic_policy.aspx

Gregory, K. (Producer). (2017). Chemical Restraints. *RN Audio current affairs summer special*. [Radio program] Retrieved from http://www.abc.net.au/radionational/programs/currentaffairsspecials/chemical-restraints/9264160

Griffiths, K. M., Mendoza, J., & Carron-Arthur, B. (2015). Whereto mental health reform in Australia: is anyone listening to our independent auditors. *Med J Aust, 202*(4), 172-174.

Grünbaum, A. (1984). *The foundations of psychoanalysis: a philosophical critique* (1 ed.). Berkeley: University of California Press.

Guthrie, E., Black, D., Bagalkote, H., Shaw, C., Campbell, M., & Creed, F. (1998). Psychological stress and burnout in medical students: a five-year prospective longitudinal study. *Journal of the Royal Society of Medicine, 91*(5), 237-243. doi:10.1177/014107689809100502

Hafferty, F. W. (1998). Beyond curriculum reform: confronting medicine's hidden curriculum. *Academic Medicine: Journal of the Association of American Medical Colleges, 73*(4), 403.

Hall, S. (2001). Foucault: Power, knowledge & discourse In M. Wetherell, S. Taylor, & S. Yates (Eds.), *Discourse Theory & Practice: A Reader* (pp. 72 - 81). London, England: Sage Publications.

Halman, M., Baker, L., & Ng, S. (2017). Using critical consciousness to inform health professions education: A literature review. *Perspectives on Medical Education, 6*(1), 12-20. doi:10.1007/s40037-016-0324-y

Haque, O. S., & Waytz, A. (2012). Dehumanization in Medicine: Causes, Solutions, and Functions. *Perspectives on Psychological Science, 7*(2), 176-186. doi:10.1177/1745691611429706

Harden, J. (1996). Enlightenment, empowerment and emancipation: the case for critical pedagogy in nurse education. *Nurse Education Today, 16*(1), 32-37. doi:10.1016/S0260-6917(96)80090-6

Harden, R. (2016). Revisiting 'Assessment of clinical competence using an objective structured clinical examination (OSCE)'. *Medical Education, 50*(4), 376-379. doi:10.1111/medu.12801

Harden, R., Stevenson, M., Downie, W. W., & Wilson, G. M. (1975). Assessment Of Clinical Competence Using Objective Structured Examination. *The British Medical Journal, 1*(5955), 447-451. doi:10.1136/bmj.1.5955.447

Harding, C. M., Brooks, G. W., Ashikaga, T., Strauss, J. S., & Breier, A. (1987a). The Vermont longitudinal study of persons with severe mental illness, I: Methodology, study sample, and overall status 32 years later. *The American Journal of Psychiatry, 144*(6), 718.

Harding, C. M., Brooks, G. W., Ashikaga, T., Strauss, J. S., & Breier, A. (1987b). The Vermont longitudinal study of persons with severe mental illness, II: Long-term outcome of subjects who retrospectively met DSM-III criteria for schizophrenia. *The American Journal of Psychiatry, 144*(6), 727.

Hari, J. (2015). Everything you think you know about addiction is wrong [Video file]. Retrieved from https://www.ted.com/talks/johann_hari_everything_You_think_you_know_about_addiction_is_wrong

Harper, B. L., & Roman, B. J. B. (2017). The Changing Landscape of Recruitment in Psychiatry. *Academic Psychiatry, 41*(2), 221-225. doi:10.1007/s40596-017-0671-y

Harrow, M., Grossman, L. S., Jobe, T. H., & Herbener, E. S. (2005). Do patients with schizophrenia ever show periods of recovery? A 15-year multi-follow-up study. *Schizophrenia Bulletin, 31*(3), 723-734. doi:10.1093/schbul/sbi026

Harrow, M., & Jobe, T. H. (2007). Factors involved in outcome and recovery in schizophrenia patients not on antipsychotic medications: a 15-year multifollow-up study. *The Journal of Nervous and Mental Disease, 195*(5), 406.

Harrow, M., & Jobe, T. H. (2013). Does long-term treatment of schizophrenia with antipsychotic medications facilitate recovery? *Schizophrenia Bulletin, 39*(5), 962-965. doi:10.1093/schbul/sbt034

Harrow, M., Jobe, T. H., & Faull, R. N. (2012). Do all schizophrenia patients need antipsychotic treatment continuously throughout their lifetime? A 20-year longitudinal study. *Psychological Medicine, 42*(10), 1-11. doi:10.1017/S0033291712000220

Harrow, M., Jobe, T. H., & Faull, R. N. (2014). Does treatment of schizophrenia with antipsychotic medications eliminate or reduce psychosis? A 20-year multi-follow-up study. *Psychological Medicine, 44*(14), 3007-3016. doi:10.1017/S0033291714000610

Hassed, C. (2008). *The essence of health: the seven pillars of wellbeing*. North Sydney, N.S.W: Ebury Press.

Hassed, C., De Lisle, S., Sullivan, G., & Pier, C. (2009). Enhancing the health of medical students: Outcomes of an integrated mindfulness and lifestyle program. *Advances in Health Sciences Education, 14*(3), 387-398. doi:10.1007/s10459-008-9125-3

Haynes, L. E., Barber, D., & Mitchell, I. J. (2004). Chronic antidepressant medication attenuates dexamethasone-induced neuronal death and sublethal neuronal damage in the hippocampus and striatum. *Brain research, 1026*(2), 157.

Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., . . . Thornicroft, G. (2014). Mental health-related stigma in health care and mental health-care settings. *The Lancet Psychiatry, 1*(6), 467-482. doi:10.1016/S2215-0366(14)00023-6

Hickie, I. B., McGorry, P. D., Davenport, T. A., Rosenberg, S. P., Mendoza, J. A., Burns, J. M., . . . Christensen, H. (2014). Getting mental health reform back on track: a leadership challenge for the new Australian Government. *Med J Aust, 200*(8), 445-448.

Hochmann, J. (2017). Reflexions on the relationships between history and psychiatry. *L'Évolution psychiatrique, 82*(4), e38-e49. doi:10.1016/j.evopsy.2017.08.001

Hodges, B., Hanson, M., McNaughton, N., & Regehr, G. (1999). What do Psychiatry Residents Think of an Objective Structured Clinical Examination? *Academic Psychiatry, 23*(4), 198-204. doi:10.1007/BF03340055

Hoffman, L. (2010). One hundred years after Sigmund Freud's lectures in America: towards an integration of psychoanalytic theories and techniques within psychiatry. *History of Psychiatry, 21*(84 Pt 4), 455.

Horn, N., Johnstone, L., & Brooke, S. (2007). Some service user perspectives on the diagnosis of Borderline Personality Disorder. *Journal of Mental Health, 16*(2), 255-269. doi:10.1080/09638230601056371

Hucklenbroich, P. (2014). "Disease entity" as the key theoretical concept of medicine. *The Journal of Medicine and Philosophy, 39*(6), 609-633. doi:10.1093/jmp/jhu040

Huhtaniska, S., Jääskeläinen, E., Hirvonen, N., Remes, J., Murray, G. K., Veijola, J., . . . Miettunen, J. (2017). Long-term antipsychotic use and brain changes in schizophrenia – a systematic review and meta-analysis. *Human Psychopharmacology: Clinical and Experimental, 32*(2), n/a-n/a. doi:10.1002/hup.2574

Hungerford, C., & Fox, C. (2014). Consumer's perceptions of Recovery-oriented mental health services: An Australian case-study analysis: Recovery and consumers. *Nursing & Health Sciences, 16*(2), 209-215. doi:10.1111/nhs.12088

Hungerford, C., Hungerford, A., Fox, C., & Cleary, M. (2016). Recovery, non-profit organisations and mental health services: 'Hit and miss' or 'dump and run'? *International Journal of Social Psychiatry, 62*(4), 350-360. doi:10.1177/0020764016634384

Insel, T. (2013). Transforming diagnosis. Retrieved from https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2013/transforming-diagnosis.shtml

IsHak, W., Nikravesh, R., Lederer, S., Perry, R., Ogunyemi, D., & Bernstein, C. (2013). Burnout in medical students: a systematic review. *The Clinical Teacher, 10*(4), 242-245. doi:10.1111/tct.12014

Jablensky, A. (2012). The disease entity in psychiatry: fact or fiction? *Epidemiology and Psychiatric Sciences, 21*(3), 255-264. doi:10.1017/S2045796012000339

Jelinek, G. A., Weiland, T. J., Mackinlay, C., Gerdtz, M., & Hill, N. (2013). Knowledge and confidence of Australian emergency department clinicians in managing patients with mental health-related presentations: findings from a national qualitative study. *International Journal of Emergency Medicine, 6*(1), 1-7. doi:10.1186/1865-1380-6-2

Johnstone, L. (2013). Diagnosis and formulation. In J. Cromby, D. Harper, & P. Reavey (Eds.), *Psychology, mental health and distress*. New York: Palgrave Macmillan.

Karageorge, A., Llewellyn, A., Nash, L., Maddocks, C., Kaldelis, D., Sandhu, H., . . . Kelly, B. (2016). Psychiatry training experiences: a narrative synthesis. *Australasian Psychiatry, 24*(3), 308-312. doi:10.1177/1039856216646233

Kazadi, N. J. B., Moosa, M. Y. H., & Jeenah, F. Y. (2008). Factors associated with relapse in schizophrenia. *South African Journal of Psychiatry, 14*(2), 52.

Kessl, F. (2009). Critical reflexivity, social work, and the emerging European post-welfare states. *European Journal of Social Work, 12*(3), 305-317. doi:10.1080/13691450902930746

Kinderman, P. (2005). A Psychological Model of Mental Disorder. *Harvard Review of Psychiatry, 13*(4), 206-217. doi:10.1080/10673220500243349

Kinderman, P. (2017). A manifesto for psychological health and wellbeing. In J. Davies (Ed.), *The sedated society: The causes and harms of our psychiatric drug epidemic*. Cham, Switzerland: Palgrave Macmillan.

Kinderman, P., Allsopp, K., & Cooke, A. (2017). Responses to the Publication of the American Psychiatric Association's DSM-5. *The Journal of Humanistic Psychology, 57*(6), 625. doi:10.1177/0022167817698262

Kinderman, P., Read, J., Moncrieff, J., & Bentall, R. (2013). Drop the language of disorder. *Evidence-based mental health, 16*(1), 2-3. doi:10.1136/eb-2012-100987

Kingsbury, E. (2009). *The relationship between empathy and mindfulness: Understanding the role of self-compassion*: ProQuest Information & Learning.

Kirk, S. A., & Kutchins, H. (1994). The myth of the reliability of DSM. *The Journal of Mind and Behavior*, 71-86.

Kirkby, K. C. (1999). History of psychiatry in Australia, pre-1960. *History of Psychiatry, 10*(38), 191-204. doi:10.1177/0957154X9901003802

Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. Healthcare Management Forum, 30(2), 111-116. doi:10.1177/0840470416679413

Knaak, S., Modgill, G., & Patten, S. B. (2014). Key ingredients of anti-stigma programs for health care providers: A data synthesis of evaluative studies. *The Canadian Journal of Psychiatry, 59*(1 suppl), 19-26. doi:10.1177/070674371405901S06

Kudielka, B. M., Buske-Kirschbaum, A., Hellhammer, D. H., & Kirschbaum, C. (2004). HPA axis responses to laboratory psychosocial stress in healthy elderly adults, younger adults, and children: impact of age and gender. *Psychoneuroendocrinology, 29*(1), 83-98. doi:10.1016/S0306-4530(02)00146-4

Kuhn, C. M., & Flanagan, E. M. (2017). Self-care as a professional imperative: physician burnout, depression, and suicide. *Canadian Journal of Anesthesia/Journal canadien d'anesthésie, 64*(2), 158-168. doi:10.1007/s12630-016-0781-0

Kumagai, A. K. (2014). From Competencies to Human Interests: Ways of Knowing and Understanding in Medical Education. *Academic Medicine, 89*(7), 978-983. doi:10.1097/ACM.0000000000000234

Kumagai, A. K., Jackson, B., & Razack, S. (2017). Cutting Close to the Bone: Student Trauma, Free Speech, and Institutional Responsibility in Medical Education. *Academic Medicine, 92*(3), 318-323. doi:10.1097/ACM.0000000000001425

Kumagai, A. K., & Lypson, M. L. (2009). Beyond cultural competence: Critical consciousness, social justice, and multicultural education. *Academic Medicine, 84*(6), 782-787. doi:10.1097/ACM.0b013e3181a42398

Labaf, A., Eftekhar, H., Majlesi, F., Anvari, P., Sheybaee-Moghaddam, F., Jan, D., & Jamali, A. (2014). Students' concerns about the pre-internship objective structured clinical examination in medical education. *Education for Health: Change in Learning and Practice, 27*(2), 188-192. doi:10.4103/1357-6283.143787

Lake, J., Helgason, C., & Sarris, J. (2012). Integrative Mental Health (IMH): Paradigm, Research, and Clinical Practice. *Explore: The Journal of Science and Healing, 8*(1), 50-57. doi:10.1016/j.explore.2011.10.001

Lally, J., & MacCabe, J. H. (2015). Antipsychotic medication in schizophrenia: a review. *British Medical Bulletin, 114*(1), 169-179. doi:10.1093/bmb/ldv017

Lammers, J., & Stapel, D. A. (2011). Power increases dehumanization. *Group Processes & Intergroup Relations: GPIR, 14*(1), 113-126. doi:10.1177/1368430210370042

Lewis, C. R., & Olive, M. F. (2014). Early-life stress interactions with the epigenome: potential mechanisms driving vulnerability toward psychiatric illness. *Behavioural Pharmacology U6 - Journal Article, 25*(5-6), 341.

Liao, J. M., Thomas, E., & Bell, S. K. (2014). Speaking Up About The Dangers Of The Hidden Curriculum. *Health Affairs, 33*(1), 168-171. doi:10.1377/HLTHAFF.2013.1073

Lieberman, J. (2016). *Shrinks: The untold story of psychiatry*. London, England: Weidenfeld & Nicholson.

Lingeswaran, A. (2010). Psychiatric curriculum and its impact on the attitude of Indian undergraduate medical students and interns. *Indian Journal of Psychological Medicine, 32*(2), 119. doi:10.4103/0253-7176.78509

Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology, 27*(1), 363-385. doi:10.1146/annurev.soc.27.1.363

Lupton, D. (2003). *Medicine as culture: illness, disease, and the body in western societies* (2nd ed.). Thousand Oaks, Calif;London;: Sage Publications.

Lyons, Z. (2013). Attitudes of Medical Students Toward Psychiatry and Psychiatry as a Career: A Systematic Review. *Academic Psychiatry, 37*(3), 150-157. doi:10.1176/appi.ap.11110204

Lyons, Z., Hans, D., & Janca, A. (2015). Future-proofing the psychiatry workforce in Australia: evaluation of an innovative enrichment programme for medical students. *Australasian Psychiatry, 23*(5), 584-588. doi:10.1177/1039856215597535

Lyons, Z., & Hood, S. (2011). Stigmatisation of Mental Illness and its impact on recruitment of medical students to a career in Psychiatry. *Education Research and Perspectives, 38*(2), 20-34.

Lyons, Z., Laugharne, J., Laugharne, R., & Appiah-Poku, J. (2015). Stigma Towards Mental Illness Among Medical Students in Australia and Ghana. *Academic Psychiatry, 39*(3), 305-308. doi:10.1007/s40596-014-0147-2

Mabe, P. A., Ahmed, A. O., Duncan, G. N., Fenley, G., & Buckley, P. F. (2014). Project GREAT: Immersing physicians and doctorally-trained psychologists in recovery-oriented care. *Professional Psychology: Research and Practice, 45*(5), 347-356. doi:10.1037/a0037705

MacKinnon, D., & Coleborne, C. (2003). Introduction: Deinstitutionalisation in Australia and New Zealand. *Health and History, 5*(2), 1-16.

Mak, D., Maticevic, J., & Power, B. (2018). Why patients should be part of medical training from day one. *Medical Journal of Australia, 209*(7), 324. doi:10.5694/mja18.00740

Marwaha, S. (2011). Objective Structured Clinical Examinations (OSCEs), psychiatry and the Clinical assessment of Skills and Competencies (CASC) same evidence, different judgement. *BMC Psychiatry, 11*(1), 85-85. doi:10.1186/1471-244X-11-85

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 : AENJ, 16*(3), 96.

Maslach, C., Jackson, S., & Leiter, M. (1997). *The Maslach Burnout Inventory Manual* (Vol. 3). Menlo Park, CA: Mind Garden.

Mauger, A. (2012). "Confinement of the Higher Orders": The Social Role of Private Lunatic Asylums in Ireland, c. 1820–60. *Journal of the History of Medicine and Allied Sciences, 67*(2), 281-317. doi:10.1093/jhmas/jrr009

McAvoy, B. R. (1988). Teaching clinical skills to medical students: The use of simulated patients and videotaping in general practice. *Medical Education, 22*(3), 193-199.

McCorquodale, L., & Kinsella, E. A. (2015). Critical reflexivity in client-centred therapeutic relationships. *Scandinavian Journal of Occupational Therapy, 22*(4), 311-317. doi:10.3109/11038128.2015.1018319

McDonald, M. (2005). Constructing Insecurity: Australian Security Discourse and Policy Post-2001. *International Relations, 19*(3), 297-320. doi:10.1177/0047117805055408

McDonald, M. (2011). Deliberation and Resecuritization: Australia, Asylum-Seekers and the Normative Limits of the Copenhagen School. *Australian Journal of Political Science, 46*(2), 281-295. doi:10.1080/10361146.2011.568471

McGorry, P. D. (2015). Minding the mental health. *Australian Medical Student Journal*. Retrieved from http://www.amsj.org/archives/3906

McGowan, P., Sasaki, A., D'alessio, A. C., Dymov, S., Labonté, B., Szyf, M., . . . Meaney, M. J. (2009). Epigenetic regulation of the glucocorticoid receptor in human brain associates with childhood abuse. *Nature neuroscience, 12*(3), 342.

McGowan, P., & Szyf, M. (2010). The epigenetics of social adversity in early life: Implications for mental health outcomes. *Neurobiology of Disease, 39*(1), 66-72. doi:10.1016/j.nbd.2009.12.026

McGrath, P., Bouwman, M., & Kalyanasundaram, V. (2007). 'A Very Individual Thing': Findings on Drug Therapy in Psychiatry from the Perspective of Australian Consumers. *Australian e-Journal for the Advancement of Mental Health, The, 6*(3), 221-231. doi:10.5172/jamh.6.3.221

McKenna, B. (2012). Medical education under siege: Critical pedagogy, primary care, and the making of "slave doctors". *International Journal of Critical Pedagogy, 4*(1), 95-117.

McLaren, N. (1998). A critical review of the biopsychosocial model. *The Australian and New Zealand Journal of Psychiatry, 32*(1), 86-92. doi:10.1046/j.1440-1614.1998.00343.x

McSherry, B. (2012, October 5). Time to rethink mental health laws for treatment without consent. *The Conversation*. Retrieved from http://theconversation.com/time-to-rethink-mental-health-laws-for-treatment-without-consent-9302

McSherry, B. (2015). Decision-Making, Legal Capacity and Neuroscience: Implications for Mental Health Laws. *Laws, 4*(2), 125-138. doi:10.3390/laws4020125

Meehan, T. J., King, R. J., Beavis, P. H., & Robinson, J. D. (2008). Recovery-based practice: do we know what we mean or mean what we know? *Australasian Psychiatry, 42*(3), 177-182. doi:10.1080/00048670701827234

Melluish, S., Crossley, J., & Tweed, A. (2007). An Evaluation of the Use of Simulated Patient Role-Plays in the Teaching and Assessment of Clinical Consultation Skills in Clinical Psychologists' Training. *Psychology Learning & Teaching, 6*(2), 104-113. doi:10.2304/plat.2007.6.2.104

Mendoza, J., Elson, A., Gilbert, Y., Bresnan, A., Rosenberg, S., Long, P., . . . Hopkins, J. (2013). *Obsessive Hope Disorder: Reflections on 30 years of mental health reform in Australia and visions for the future*: BJN Graphic Design.

Mental Health Act (WA), (2014). Retrieved from https://www.legislation.wa.gov.au/legislation/statutes.nsf/main_mrtitle_13534_homepage.html

Mental Health Commission of Canada. (2009). *Toward recovery and wellbeing: A framework for a mental health strategy in Canada*. Retrieved from https://www.mentalhealthcommission.ca/sites/default/files/FNIM_Toward_Recovery_and_Well_Being_ENG_0_1.pdf

Mental Health Commission of New Zealand. (2007). *Te Haererenga mo te Whakaoranga: The Journey of Recovery for the New Zealand Mental Health Sector 1996-2006*. Retrieved from

Wellington, NZ: https://www.mentalhealth.org.nz/assets/ResourceFinder/te-haererenga-1996-2006.pdf

Mental Health Council of Australia. (2011). *Consumer and carer experiences of stigma from mental health and other health professionals*. Retrieved from https://mhaustralia.org/sites/default/files/imported/component/rsfiles/publications/Consumer_and_Carer_Experiences_of_Stigma_from_Mental_Health_and_Other_Health_Professionals.pdf

Middleton, H. (2007). Critical Psychiatry. *Mental Health Review Journal, 12*(2), 40-44. doi:10.1108/13619322200700021

Mikol, C. (2005). Teaching nursing without lecturing: Critical pedagogy as communicative dialogue. *Nursing Education Perspectives, 26*(2), 86-89.

Mills, C. (2014). *Decolonizing Global Mental Health: The psychiatrization of the majority world*. London: Routledge Ltd.

Millward, L. (2012). Focus groups. In G. Breakwell, J. Smith, & D. Wright (Eds.), *Research methods in psychology* (4 ed., pp. 411-437). London, England: Sage.

Mizrahi, R. (2016). Social Stress and Psychosis Risk: Common Neurochemical Substrates? *Neuropsychopharmacology: Official Publication of the American College of Neuropsychopharmacology, 41*(3), 666-674. doi:10.1038/npp.2015.274

Moncrieff, J. (1999). An investigation into the precedents of modern drug treatment in psychiatry. *History of Psychiatry, 10*(40), 475-490. doi:10.1177/0957154X9901004004

Moncrieff, J. (2006). Why is it so difficult to stop psychiatric drug treatment? It may be nothing to do with the original problem. *Med Hypotheses, 67*(3), 517-523. doi:10.1016/j.mehy.2006.03.009

Moncrieff, J. (2015). Antipsychotic Maintenance Treatment: Time to Rethink? *PLoS Med, 12*(8), e1001861. doi:10.1371/journal.pmed.1001861

Moncrieff, J. (2017). Opium and the people: The prescription psychopharmaceutical epidemic in historical context. In J. Davies (Ed.), *The Sedated Society: The causes and harms of our psychiatric drug epidemic* (pp. 73-99). Cham, Switzerland: Palgrave Macmillan.

Moncrieff, J., Cohen, D., & Mason, J. P. (2009). The subjective experience of taking antipsychotic medication: a content analysis of Internet data. *Acta Psychiatr Scand, 120*(2), 102-111. doi:10.1111/j.1600-0447.2009.01356.x

Moncrieff, J., & Leo, J. (2010). A systematic review of the effects of antipsychotic drugs on brain volume. *Psychological Medicine, 40*(9), 1409-1422. doi:10.1017/S0033291709992297

Moncrieff, J., & Middleton, H. (2015). Schizophrenia: a critical psychiatry perspective. *Current Opinion in Psychiatry, 28*(3), 264-268. doi:10.1097/YCO.0000000000000151

Morgan, A. J., Reavley, N. J., Jorm, A. F., & Beatson, R. (2016). Experiences of discrimination and positive treatment from health professionals: A national survey of adults with mental health problems. *Australian & New Zealand Journal of Psychiatry, 50*(8), 754-762. doi:10.1177/0004867416655605

Morrison, P., Meehan, T., & Stomski, N. J. (2015). Living with antipsychotic medication side-effects: The experience of Australian mental health consumers. *International Journal of Mental Health Nursing, 24*(3), 253-261. doi:10.1111/inm.12110

Morrow, M., & Weisser, J. (2012). Towards a Social Justice Framework of Mental Health Recovery. *Studies in Social Justice, 6*(1), 27-43.

Mortlock, A.-M., Puzzo, I., Taylor, S., Kumari, V., Young, S., Sengupta, S., & Das, M. (2017). Enrichment activities in the medical school psychiatry programme – could this be a key to engaging medical students in psychiatry? A study from a high secure forensic psychiatric UK hospital. *BMC Psychiatry, 17*(1). doi:10.1186/s12888-017-1236-z

Mumford, E., Schlesinger, H., Cuerdon, T., & Scully, J. (1987). Ratings of videotaped simulated patient interviews and four other methods of evaluating a psychiatry clerkship. *The American Journal of Psychiatry, 144*(3), 316.

Murgatroyd, C., & Spengler, D. (2012). Genetic Variation in the Epigenetic Machinery and Mental Health. *Current Psychiatry Reports, 14*(2), 138-149. doi:10.1007/s11920-012-0255-1

Naidu, T., & Kumagai, A. K. (2016). Troubling Muddy Waters: Problematizing Reflective Practice in Global Medical Education. *Academic Medicine, 91*(3), 317-321. doi:10.1097/ACM.0000000000001019

Nash, L., Karageorge, A., Llewellyn, A., Sandhu, H., Edwards, J., Kelly, B., . . . Reynolds, K. (2016). Accentuate the positives, but don't necessarily eliminate the negatives: A cross-sectional survey of junior doctor psychiatry terms. *MedEdPublish,* 14(5), 445-464. doi: 10.1080/13698575.2012.697130

National Mental Health Commission. (2014a). *Report of the national review of mental health programmes and services*. Retrieved from Sydney: http://www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx

National Mental Health Commission. (2014b). *Report of the national review of mental health programmes and services*. Retrieved from Sydney: http://www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx

Navari, S., & Dazzan, P. (2009). Do antipsychotic drugs affect brain structure? A systematic and critical review of MRI findings. *Psychological Medicine, 39*(11), 1763-1777. doi:10.1017/S0033291709005315

Nelson, G., Kloos, B., & Ornelas, J. (2014). *Community Psychology and Community Mental Health* New York: Oxford University Press.

Nelson, G., & Prilleltensky, I. (2002). *Doing Psychology Critically*: Palgrave Macmillan.

Nelson, G., & Prilleltensky, I. (2010). *Community Psychology: In pursuit of liberation and well-being* (Vol. 2nd). Basingstoke; New York: Palgrave Macmillan.

New South Wales Consumer Advisory Group Mental Health Inc. (2009). *Literature review on recovery*. Retrieved from http://www.mhcc.org.au/media/2498/nsw-cag-mhcc-project-recovery-literature-review.pdf

Newton-Howes, G., Beverley, G., Ellis, P., Gordon, S., & Levack, W. (2018). What Do Final Year Medical Students Understand by the Concept of Recovery? A Descriptive Qualitative Study. *Academic Psychiatry, 42*(3), 382-385.

Nicholls, D., Gaynor, N., Shafiei, T., Bosanac, P., & Farrell, G. (2011). Mental health nursing in emergency departments: the case for a nurse practitioner role. *Journal of Clinical Nursing, 20*(3-4), 530-536. doi:10.1111/j.1365-2702.2010.03504.x

Nilsen, S., & Baerheim, A. (2005). Feedback on video recorded consultations in medical teaching: Why students loathe and love it - A focus-group based qualitative study. *BMC Medical Education, 5*(1), 28-28. doi:10.1186/1472-6920-5-28

Nimmon, L., & Stenfors-Hayes, T. (2016). The "Handling" of power in the physician-patient encounter: perceptions from experienced physicians. *BMC Medical Education, 16*(1). doi:10.1186/s12909-016-0634-0

Nouri, A., & Sajjadi, S. (2014). Emancipatory pedagogy in practice. *International Journal of Critical Pedagogy, 5*(2), 76-87.

Office of Mental Health. (2004). *A recovery vision for rehabilitation: psychiatric rehabilitation policy and strategic framework*. Retrieved from http://www.health.wa.gov.au/docreg/Education/Population/Health_Problems/Mental_Illness/A_recovery_vision_for_rehabilitation.pdf

Omori, A., Tateno, A., Ideno, T., Takahashi, H., Kawashima, Y., Takemura, K., & Okubo, Y. (2012). Influence of contact with schizophrenia on implicit attitudes towards schizophrenia patients held by clinical residents. *BMC Psychiatry, 12*(1), 205-205. doi:10.1186/1471-244X-12-205

Opotow, S. (1990a). Deterring Moral Exclusion. *Journal of Social Issues, 46*(1), 173-182. doi:10.1111/j.1540-4560.1990.tb00280.x

Opotow, S. (1990b). Moral Exclusion and Injustice: An Introduction. *Journal of Social Issues, 46*(1), 1-20. doi:10.1111/j.1540-4560.1990.tb00268.x

Opotow, S. (1995). Drawing the line: Social categorization, moral exclusion, and the scope of justice. In B. B. Bunker & J. Z. Rubin (Eds.), *Cooperation, conflict, and justice: Essays inspired by the work of Morton Deutsch* (pp. 347-369). San Francisco, USA: Jossey-Bass.

Opotow, S. (2011). How This Was Possible: Interpreting the Holocaust: How This Was Possible. *Journal of Social Issues, 67*(1), 205-224. doi:10.1111/j.1540-4560.2010.01694.x

Owen, C., & Reay, R. E. (2004). Consumers as tutors - legitimate teachers? *BMC Medical Education, 4*(1), 14-14. doi:10.1186/1472-6920-4-14

Pai, N. B., Vella, S.-L. C., & Dawes, K. (2012). A qualitative analysis of medical students views of their first psychiatry rotation. *Online Journal of Health and Allied Sciences, 11*(2).

Parrott, S., & Parrott, C. T. (2015). Law & Disorder: The Portrayal of Mental Illness in U.S. Crime Dramas. *Journal of Broadcasting & Electronic Media, 59*(4), 640-657. doi:10.1080/08838151.2015.1093486

Patterson, C., Moxham, L., Brighton, R., Taylor, E., Liersch, S., Perlman, D., . . . Hadfield, L. (2016). Nursing students' reflections on the learning experience of a unique mental health clinical placement. *Nurse Education Today, 46*, 94-98.

Pearlman, S. (2014). Meaning making and making meaning meaningful: The relationship between language and thought in critical pedagogy. *International Journal of Critical Pedagogy, 5*(2), 100-113.

Pereira, O., & Almeida, T. (2009). Medical education as a pedagogy of resistance. *University of New Mexico Digital Repository*. Retrieved from https://digitalrepository.unm.edu/cgi/viewcontent.cgi?referer=https://www.google.com.au/&httpsredir=1&article=1004&context=lasm_cucs_en

Petersen, K. S., Friis, V. S., Haxholm, B. L., Nielsen, C. V., & Wind, G. (2015). Recovery from Mental Illness: A Service User Perspective on Facilitators and Barriers. *Community Mental Health Journal, 51*(1), 1-13. doi:10.1007/s10597-014-9779-7

Phelps, K., & Hassed, C. (2011). *General practice: the integrative approach*. Chatswood, N.S.W: Elsevier Australia.

Piat, M., & Polvere, L. (2014). Recovery-oriented mental health policies: Implications for transformative change in five nations In G. Nelson, B. Kloos, & J. Ornelas (Eds.), *Community Psychology and Community Mental Health* (pp. 327-348). New York: Oxford University Press.

Pilecki, B. C., Clegg, J. W., & McKay, D. (2011). The influence of corporate and political interests on models of illness in the evolution of the DSM. *European Psychiatry, 26*(3), 194-200. doi:10.1016/j.eurpsy.2011.01.005

Pilgrim, D. (2002). The biopsychosocial model in Anglo-American psychiatry: Past, present and future? *Journal of Mental Health, 11*(6), 585-594. doi:10.1080/09638230020023930

Pilgrim, D. (2007). The survival of psychiatric diagnosis. *Social science & medicine, 65*(3), 536-547. doi:10.1016/j.socscimed.2007.03.054

Potter, J., Edwards, D., & Wetherell, M. (1993). A Model of Discourse in Action. *American Behavioral Scientist, 36*(3), 383-401. doi:10.1177/0002764293036003008

Prilleltensky, I., & Gonick, L. (1996). Polities Change, Oppression Remains: On the Psychology and Politics of Oppression. *Political Psychology, 17*(1), 127-148. doi:10.2307/3791946

Pryor, C. (Producer). (2018, 5 February). Depression, anxiety and the pros and cons of antidepressants. *Life Matters* [Radio program]. Retrieved from http://www.abc.net.au/radionational/programs/lifematters/depression,-anxiety-and-the-pros-and-cons-of-antidepressants/9391218

Qamar, K., Khan, N. S., & Bashir Kiani, M. R. (2015). Factors associated with stress among medical students. *JPMA. The Journal of the Pakistan Medical Association, 65*(7), 753.

Quadrio, C., Middleton, H., Banerjee, A., & Jureidini, J. (2014). *Critical psychiatry and the recovery paradigm.* London, England.

Rapley, M., Moncrieff, J., & Dillon, J. (Eds.). (2011). *Demedicalizing misery*. Basignstoke, England: Palgrave Macmillan.

Reavley, N. J., & Jorm, A. F. (2015). Experiences of discrimination and positive treatment in people with mental health problems: Findings from an Australian national survey. *Australian & New Zealand Journal of Psychiatry, 49*(10), 906-913. doi:10.1177/0004867415602068

Reavley, N. J., Mackinnon, A. J., Morgan, A. J., & Jorm, A. F. (2014). Stigmatising attitudes towards people with mental disorders: A comparison of Australian health professionals with the general community. *Australian & New Zealand Journal of Psychiatry, 48*(5), 433-441. doi:10.1177/0004867413500351

Reavley, N. J., Morgan, A. J., & Jorm, A. F. (2017). Predictors of experiences of discrimination and positive treatment in people with mental health problems: findings from an Australian national survey. *Social psychiatry and psychiatric epidemiology, 52*(3), 269. doi:10.1007/s00127-016-1301-9

Richards, C. (2014). Of cocaine and scaffold bars: a critique of The Myth of Mental Illness by Thomas S Szasz. *Existential Analysis, 25*(1), 66.

Rickwood, D. (2004). Recovery in Australia: Slowly but Surely. *Australian e-Journal for the Advancement of Mental Health, The, 3*(1), 8-10.

Rose, D., & Thornicroft, G. (2010). Service user perspectives on the impact of a mental illness diagnosis. *Epidemiology and Psychiatric Sciences, 19*(2), 140-147. doi:10.1017/S1121189X00000841

Rose, D., Thornicroft, G., Pinfold, V., & Kassam, A. (2007). 250 Labels used to stigmatise people with mental illness. *BMC Health Services Research, 7*(1), 97-97. doi:10.1186/1472-6963-7-97

Rosenhan, D. L. (1973). On Being Sane in Insane Places. *Science, 179*(4070), 250-258. doi:10.1126/science.179.4070.250

Rosenhan, D. L. (1975). The contextual nature of psychiatric diagnosis. *Journal of Abnormal Psychology, 84*(5), 462-474. doi:10.1037/h0077123

Rosenzweig, S., Reibel, D. K., Greeson, J. M., Brainard, G. C., & Hojat, M. (2003). Mindfulness-Based Stress Reduction Lowers Psychological Distress In Medical Students. *Teaching and Learning in Medicine, 15*(2), 88-92. doi:10.1207/S15328015TLM1502_03

Ross, B. (2015). Critical pedagogy as a means to achieving social accountability in medical education. *International Journal of Critical Pedagogy, 6*(2), 169-186.

Rotstein, S., & Jenkins, K. (2017). Career satisfaction and work stressors in psychiatrists and psychiatry trainees in Australia and New Zealand. *Australasian Psychiatry, 25*(2), 172-174. doi:10.1177/1039856216684715

Royal Australian and New Zealand College of Psychiatrists. (2004). *RANZCP Clinical Examinations Formulation Guidelines for Trainees*. Retrieved from https://psychiatry-training.wiki.otago.ac.nz/images/6/6c/RANZCP-Formulations-Guide.pdf

Royal Australian and New Zealand College of Psychiatrists. (2018a). *RANZCP says more needs to be done to support mental health in rural Australia.* Retrieved from https://www.ranzcp.org/news-policy/news/ranzcp-says-more-needs-to-be-done-to-support-menta

Royal Australian and New Zealand College of Psychiatrists. (2018b). *RANZCP welcomes $338 million investment in mental health.* Retrieved from https://www.ranzcp.org/news-policy/news/ranzcp-welcomes-$338-million-investment-in-mental

Royal Australian New Zealand College of Psychiatrists. (2012a). *Stage 1 syllubus*. Retrieved from https://www.ranzcp.org/Files/PreFellowship/2012-Fellowship-Program/Stage-1-Syllabus.aspx

Royal Australian New Zealand College of Psychiatrists. (2012b). *Stage 2 syllubus*. Retrieved from https://www.ranzcp.org/Files/PreFellowship/2012-Fellowship-Program/Stage-2-Syllabus.aspx

Royal Australian New Zealand College of Psychiatrists. (2016a). *Learning outcomes - stages 1, 2 & 3.* Retrieved from https://www.ranzcp.org/Files/PreFellowship/2012-Fellowship-Program/Administration/Learning-Outcomes.aspx

Royal Australian New Zealand College of Psychiatrists. (2016b). *Position statement 86: Recovery and the psychiatrist* [Press release]. Retrieved from https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/PS-86-Recovery-and-the-psychiatrist-March-2016.aspx

Sadeghi, M., Taghva, A., Mirsepassi, G., & Hassanzadeh, M. (2007). How Do Examiners and Examinees Think About Role-Playing of Standardized Patients in an OSCE Setting? *Academic Psychiatry, 31*(5), 358-362. doi:10.1176/appi.ap.31.5.358

Salmon, P., & Hall, G. M. (2003). Patient empowerment and control: a psychological discourse in the service of medicine. *Social Science & Medicine, 57*(10), 1969-1980. doi:10.1016/S0277-9536(03)00063-7

Salomon, C., & Hamilton, B. (2013). "All roads lead to medication" Qualitative responses from an Australian first-person survey of antipsychotic discontinuation. *Psychiatric Rehabilitation Journal, 36*(3), 160. doi:10.1037/prj0000001

SAMHSA. (2005). *Transforming mental health care in America. The federal action agenda: First steps*. Retrieved from https://store.samhsa.gov/product/Transforming-Mental-Health-Care-in-America/SMA05-4060

Sandars, J. (2016). Critical theory and the scholarship of medical education. *International Journal of Medical Education*(7), 246-247.

Sandars, J. (2017). When I say … critical pedagogy. *Medical Education, 51*(4), 351-352. doi:10.1111/medu.13150

Sanders, J. L. (2011). A Distinct Language and a Historic Pendulum: The Evolution of the Diagnostic and Statistical Manual of Mental Disorders. *Archives of Psychiatric Nursing, 25*(6), 394-403. doi:10.1016/j.apnu.2010.10.002

Sane Australia. (2013). *A life without stigma*. Retrieved from https://www.sane.org/images/PDFs/ALifeWithoutStigma_A_SANE_Report.pdf

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: Exploring its conceptualization and operationalization. Dordrecht: Springer Netherlands. doi:10.1007/s11135-017-0574-8

Schon, D. (1983). *The reflective practitioner: How professionals think in action*. New York, NY: Basic Books.

School of Medicine Fremantle. (2017). *MED400/MED16400 Psychiatry Study Guide*. The University of Notre Dame Australia: Fremantle.

School of Medicine Fremantle. (2018). *Course descriptions*. Retrieved from https://www.notredame.edu.au/about/schools/fremantle/medicine/course-descriptions

Seale, C., Chaplin, R., Lelliott, P., & Quirk, A. (2006). Sharing decisions in consultations involving anti-psychotic medication: A qualitative study of psychiatrists' experiences. *Social Science & Medicine, 62*(11), 2861-2873. doi:doi:10.1016/j.socscimed.2005.11.002

Selzer, R., & Ellen, S. (2014). Formulation for beginners. *Australasian Psychiatry, 22*(4), 397-401. doi:10.1177/1039856214536240

Shapiro, S. L., Schwartz, G. E., & Bonner, G. (1998). Effects of Mindfulness-Based Stress Reduction on Medical and Premedical Students. *Journal of Behavioral Medicine, 21*(6), 581-599. doi:10.1023/A:1018700829825

Shapiro, S. L., Shapiro, D. E., & Schwartz, G. E. R. (2000). Stress management in medical education: A review of the literature. *Academic Medicine, 75*(7), 748-759. doi:10.1097/00001888-200007000-00023

Sharma, M., Pinto, A. D., & Kumagai, A. K. (2018). Teaching the Social Determinants of Health: A Path to Equity or a Road to Nowhere? *Academic Medicine, 93*(1), 25-30. doi:10.1097/ACM.0000000000001689

Shepherd, M., Goodman, N., & Watt, D. C. (1961). The application of hospital statistics in the evaluation of pharmacotherapy in a psychiatric population. *Comprehensive Psychiatry, 2*(1), 11-19.

Short, T. B. R., Thomas, S., Luebbers, S., Mullen, P., & Ogloff, J. R. P. (2013). A case-linkage study of crime victimisation in schizophrenia-spectrum disorders over a period of deinstitutionalisation. *BMC Psychiatry, 13*(1), 66-66. doi:10.1186/1471-244X-13-66

Shorter, E. (1997). *A history of psychiatry: from the era of the asylum to the age of Prozac*. New York: John Wiley & Sons.

Sim, K., Gwee, K. P., & Bateman, A. (2005). Case Formulation in Psychotherapy: Revitalizing Its Usefulness as a Clinical Tool. *Academic Psychiatry, 29*(3), 289-292. doi:10.1176/appi.ap.29.3.289

Skerritt, P., Ellis, A., Prendergast, F., Harrold, C., Blackmore, H., & Derham, B. (2001). Psychiatry in Western Australia since Federation:an eloquent testimony. *Australasian Psychiatry, 9*(3), 226-228. doi:10.1046/j.1440-1665.2001.00342.x

Smith, G., Williams, T., & Lefay, L. (2010). *Review of emergency mental health services in north metropolitan Perth*. Retrieved from http://www.health.wa.gov.au/mhpr/docs/Review_Emergency_MH_Services_North_Metro_2010.pdf

Smith, K. (2016). *Investigating the Evidence for Neuroleptic-Mediated Supersensitivity Psychosis and Examining the Influences on Psychiatrists' Treatment Decisions.* (Unpublished thesis), The University of Notre Dame Australia, Fremantle. Retrieved from https://www.researchgate.net/publication/324509489_Investigating_the_Evidence_for_Neuroleptic-Mediated_Supersensitivity_Psychosis_and_Examining_the_Influences_on_Psychiatrist's_Treatment_Decisions

Smith, L. (2012). *Decolonizing Methodologies : Research and Indigenous Peoples* (Vol. 2). London: Zed Books.

Solhaug, I., Eriksen, T. E., de Vibe, M., Haavind, H., Friborg, O., Sorlie, T., & Rosenvinge, J. H. (2016). Medical and Psychology Student's Experiences in Learning Mindfulness: Benefits, Paradoxes, and Pitfalls. *Mindfulness, 7*(4), 838-850. doi:10.1007/s12671-016-0521-0

Stampfer, H. (2011). The recruitment problem in psychiatry: A critical commentary. *Education Research and Perspectives, 38*(2), 1-19.

Stanton, A. H., & Schwartz, M. S. (1954). *The mental hospital: a study of institutional participation in psychiatric illness and treatment* (1st ed.). New York U6 - ctx_ver=Z39.88-2004&ctx_enc=info%3Aofi%2Fenc%3AUTF-8&rfr_id=info%3Asid%2Fsummon.serialssolutions.com&rft_val_fmt=info%3Aofi%2Ffmt%3Akev%3Amtx%3Abook&rft.genre=book&rft.title=The+mental+hospital&rft.au=Stanton%2C+Alfred+H&rft.au=Schwartz%2C+Morris+S&rft.date=1954-01-01&rft.pub=Basic+Books&rft.externalDocID=28436&paramdict=en-US U7 - Book: Basic Books.

Stoop, I. (2012). Unit non-response due to refusal. In L. Gideon (Ed.), *Handbook of survey methodology for the social sciences* (2012th ed., pp. 121-147). New York, NY, USA: Springer.

Strickler, D. C. (2009). Addressing the imbalance of power in a traditional doctor-patient relationship. *Psychiatric Rehabilitation Journal, 32*(4), 316-318. doi:10.2975/32.4.2009.316.318

Summerfield, D. (2008). How scientifically valid is the knowledge base of global mental health? *BMJ, 336*(7651), 992-994. doi:10.1136/bmj.39513.441030.AD

Surmon, L., Bialocerkowski, A., & Hu, W. (2016). Perceptions of preparedness for the first medical clerkship: a systematic review and synthesis. *BMC Medical Education, 16*(1), 89. doi:10.1186/s12909-016-0615-3

Swartz, S. (2010). The regulations of British colonial lunatic asylums and the origins of colonial psychiatry, 1860-1864. *History of Psychology, 13*(2), 160-177. doi:10.1037/a0019223

Szasz, T. (1963). *Law, liberty, and psychiatry: an inquiry into the social uses of mental health practices*. New York U6 - ctx_ver=Z39.88-2004&ctx_enc=info%3Aofi%2Fenc%3AUTF-8&rfr_id=info:sid/summon.serialssolutions.com&rft_val_fmt=info:ofi/fmt:kev:mtx:book&rft.genre=book&rft.title=Law%2C+liberty%2C+and+psychiatry&rft.au=Szasz%2C+Thomas+Stephen&rft.date=1963-01-01&rft.pub=Macmillan&rft.externalDocID=25350¶mdict=en-US U7 - Book: Macmillan.

Szasz, T. (1970). *The manufacture of madness: a comparative study of the Inquisition and the mental health movement* (Vol. 1). New York: Harper & Row.

Szasz, T. (1974). *The myth of mental illness: foundations of a theory of personal conduct* (Vol. Rev.). New York: Harper & Row.

Szasz, T. (2008). Debunking Antipsychiatry: Laing, Law, and Largactil. *Current Psychology, 27*(2), 79-101. doi:10.1007/s12144-008-9024-z

Szaz, T. (2006). Defining disease: the gold standard of disease versus the fiat standard of diagnosis. *Independent Review, 10*(3), 325.

Taylor, A. (2017, April 28). Mental health in Australia needs reform, not just more money: Ian Hickie. *The Sydney Morning Herald*. Retrieved from http://www.smh.com.au/national/health/mental-health-in-australia-needs-reform-not-just-more-money-ian-hickie-20170428-gvugth.html

Taylor, C. (2006). Practising reflexivity: Narrative, reflection and the moral order. In S. White, J. Fook, & F. Gardner (Eds.), *Critical reflections in health and social care* (pp. 73-88). Maidenhead, Berkshire, England; New York, NY;: Open University Press.

Taylor, C., & White, S. (2001). Knowledge, Truth and Reflexivity: The Problem of Judgement in Social Work. *Journal of Social Work, 1*(1), 37-59. doi:10.1177/146801730100100104

Taylor, J., Jones, R. M., O'Reilly, P., Oldfield, W., & Blackburn, A. (2010). The Station Community Mental Health Centre Inc: nurturing and empowering. *Rural and Remote Health, 10*(3), 1411.

Tešija, R. A., Kružičević, S. M., Banožić, A., Esteban, C. D., Sapunar, D., & Puljak, L. (2013). Impact of extended course duration and stricter study organization on attrition and academic performance of medical students. *Croatian Medical Journal, 54*(2), 192-197. doi:10.3325/cmj.2013.54.192

The British Psychological Society. (2011). Response to the American Psychiatric Association: DSM-5 Development [Press release]. Retrieved from http://psychrights.org/2011/110630BritishPsychologicalAssnResponse2DSM-5.pdf

The Rural Clinical School of Western Australia. (2018). *RMED5311/5321 Integrated Rural Medical Practice 1 and 2; RMED5312/5322 Integrated Rural Medical Practice 1 and 2 - Notre Dame Psychiatry Guidebook 2018*.

Thomas, P., & Bracken, P. (2004). Critical psychiatry in practice. *Advances in Psychiatric Treatment, 10*(5), 361-370. doi:10.1192/apt.10.5.361

Thomas, P., Bracken, P., & Yasmeen, S. (2007). Explanatory models for mental illness: Limitations and dangers in a global context. *Pak. J. Neurol. Sci., 2*, 176, 177.

Thomas, S., Pai, N., Dawes, K., Wilson, C., & Williams, V. (2013). Updating medical school psychiatry curricula to meet projected mental health needs. *Australasian Psychiatry, 21*(6), 578-582. doi:10.1177/1039856213500092

Thornicroft, G., Rose, D., & Kassam, A. (2007). Discrimination in health care against people with mental illness. *International Review of Psychiatry, 19*(2), 113-122. doi:10.1080/09540260701278937

Thornton, L. K., Baker, A. L., Lewin, T. J., Kay-Lambkin, F. J., Kavanagh, D., Richmond, R., . . . Johnson, M. P. (2012). Reasons for substance use among people with mental disorders. *Addictive Behaviors, 37*(4), 427-434. doi:10.1016/j.addbeh.2011.11.039

Timimi, S. (2014). No more psychiatric labels: Why formal psychiatric diagnostic systems should be abolished. *International Journal of Clinical and Health Psychology, 14*(3), 208-215. doi:10.1016/j.ijchp.2014.03.004

Totic, S., Stojiljković, D., Pavlovic, Z., Zaric, N., Zarkovic, B., Malic, L., . . . Marić, N. P. (2012). Stigmatization of 'psychiatric label' by medical and non-medical students. *International Journal of Social Psychiatry, 58*(5), 455-462. doi:10.1177/0020764011408542

Tsai, J., Salyers, M. P., & Lobb, A. L. (2010). Recovery-oriented training and staff attitudes over time in two state hospitals. *The Psychiatric Quarterly, 81*(4), 335-347. doi:10.1007/s11126-010-9142-2

Turecki, G., & Meaney, M. J. (2016). Effects of the Social Environment and Stress on Glucocorticoid Receptor Gene Methylation: A Systematic Review. *Biological Psychiatry, 79*(2), 87-96. doi:10.1016/j.biopsych.2014.11.022

Tzanoulinou, S., García-Mompó, C., Castillo-Gómez, E., Veenit, V., Nacher, J., & Sandi, C. (2014). Long-term behavioral programming induced by peripuberty stress in rats is accompanied by GABAergic-related alterations in the Amygdala. *PLoS One, 9*(4), e94666. doi:10.1371/journal.pone.0094666

Uher, R. (2009). The role of genetic variation in the causation of mental illness: an evolution-informed framework. *Molecular Psychiatry, 14*(12), 1072-1082. doi:10.1038/mp.2009.85

van Dijk, T. (1992). Discourse and the denial of racism. *Discourse & Society, 3*(1), 87-118. doi:10.1177/0957926592003001005

Ventriglio, A., Gupta, S., & Bhugra, D. (2016). Why do we need a social psychiatry? *The British journal of Psychiatry: The Journal of Mental Science, 209*(1), 1-2. doi:10.1192/bjp.bp.115.175349

Victorian Government Department of Health. (2013). *National Practice Standards for the Mental Health Workforce 2013*. Melbourne, Victoria Retrieved from https://www.health.gov.au/internet/main/publishing.nsf/Content/5D7909E82304E6D2CA257C430004E877/$File/wkstd13.pdf.

Vilhelmsson, A., Svensson, T., Meeuwisse, A., Carlsten, A., Linköpings, u., Institutionen för beteendevetenskap och, l., . . . Pedagogik och, s. (2012). Experiences from consumer reports on psychiatric adverse drug reactions with antidepressant medication: a qualitative study of

reports to a consumer association. *BMC Pharmacology & Toxicology, 13*(1), 19. doi:10.1186/2050-6511-13-19

WA Statewide Suicide Prevention Network. (2018). *Lived Experience Workshop Report: Discharge from services after a suicide attempt*. Retrieved from https://www.loomio.org/d/Twi9pJnq/lived-experience-workshop-report-discharge-from-services-after-a-suicide-attempt?utm_campaign=new_discussion&utm_medium=email&utm_source=thread_mailer

Walker, R., Schultz, C., & Sonn, C. (2014). Cultural competence - transforming policy, services, programs and practice. In P. Dudgeon, H. Milroy, & R. Walker (Eds.), *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (Vol. 2, pp. 195-220). West Perth, Western Australia: Telethon Institute for Child Health Research/Kulunga Research Network in collaboration with The University of Western Australia.

Warnecke, E., Quinn, S., Ogden, K., Towle, N., & Nelson, M. R. (2011). A randomised controlled trial of the effects of mindfulness practice on medical student stress levels. *Medical Education, 45*(4), 381-388. doi:10.1111/j.1365-2923.2010.03877.x

Weiland, T. J., Mackinlay, C., Hill, N., Gerdtz, M. F., & Jelinek, G. A. (2011). Optimal management of mental health patients in Australian emergency departments: Barriers and solutions. *Emergency Medicine Australasia, 23*(6), 677-688. doi:10.1111/j.1742-6723.2011.01467.x

Western Australian Association for Mental Health. (2017a). *Mental health incoming government brief* [Press release]. Retrieved from https://waamh.org.au/assets/documents/systemic-advocacy/2017-03-23-incoming-government-brief-min-mh-final.pdf

Western Australian Association for Mental Health. (2017b). *WAAMH welcomes some aspects of Labor's mental health policy but crucial reforms still missing* [Press release]. Retrieved from https://waamh.org.au/assets/documents/media-releases/media-release-waamh-welcomes-some-parts-of-labor's-policy-but-crucial-reforms-still-missing-23.2.17.pdf

Whitaker, R. (2004). The case against antipsychotic drugs: a 50-year record of doing more harm than good. *Medical Hypotheses, 62*(1), 5-13. doi:10.1016/s0306-9877(03)00293-7

Whitaker, R. (2017). Psychiatry under the influence. In J. Davies (Ed.), *The sedated society: The causes and harms of our psychiatric drug epidemic* (pp. 163-188). Cham, Switzerland: Palgrave Macmillan.

White, S., Fook, J., & Gardner, F. (2006). *Critical reflection in health and social care*. Maidenhead, Berkshire, England;New York, NY;: Open University Press.

Wigney, T., & Parker, G. (2007). Medical student observations on a career in psychiatry. *Australasian Psychiatry, 41*(9), 726-731. doi:10.1080/00048670701518023

Wigney, T., & Parker, G. (2008). Factors encouraging medical students to a career in psychiatry: qualitative analysis. *Australasian Psychiatry, 42*(6), 520-525. doi:10.1080/00048670802050637

Wild, K., Scholz, M., Ropohl, A., Bräuer, L., Paulsen, F., & Burger, P. H. M. (2014). Strategies against burnout and anxiety in medical education - Implementation and evaluation of a new course on relaxation techniques (Relacs) for medical students. *PLoS One, 9*(12), e114967. doi:10.1371/journal.pone.0114967

Williams, A. R., & Caplan, A. L. (2012). Thomas Szasz: rebel with a questionable cause. *The Lancet, 380*(9851), 1378-1379. doi:10.1016/S0140-6736(12)61789-9

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Berkshire: McGraw-Hill

Wilrycx, G. K. M. L., Croon, M. A., van den Broek, A., & van Nieuwenhuizen, C. (2012). Mental health recovery: Evaluation of a recovery-oriented training program. *The Scientific World Journal, 2012*, 1-8. doi:10.1100/2012/820846

Wood, A., & Wahl, O. F. (2006). Evaluating the effectiveness of a consumer-provided mental health recovery education presentation. *Psychiatric Rehabilitation Journal, 30*(1), 46-53. doi:10.2975/30.2006.46.53

Wood, D. (2003). Abc Of Learning And Teaching In Medicine: Problem Based Learning. *BMJ: British Medical Journal, 326*(7384), 328-330. doi:10.1136/bmj.326.7384.328

World Health Organisation. (2013). *Mental Health Action Plan*. Retrieved from http://www.who.int/mental_health/publications/action_plan/en/

World Health Organisation. (2018). *About social determinants of health*. Retrieved from http://www.who.int/social_determinants/sdh_definition/en/

World Medical Association. (2017). *WMA Declaration of Geneva*. Retrieved from https://www.wma.net/policies-post/wma-declaration-of-geneva/

Wyder, M., Bland, R., Blythe, A., Matarasso, B., & Crompton, D. (2015). Therapeutic relationships and involuntary treatment orders: Service users' interactions with health-care professionals on the ward: Relationships and Involuntary Treatment. *International Journal of Mental Health Nursing, 24*(2), 181-189. doi:10.1111/inm.12121

Yap, K., Bearman, M., Thomas, N., & Hay, M. (2012). Clinical psychology students' experiences of a pilot objective structured clinical examination. *Australian Psychologist, 47*(3), 165.

Yates, G. P. M. A., & Feldman, M. D. M. D. (2016). Factitious Disorder: a systematic review of 455 cases in the professional literature. *General Hospital Psychiatry, 41*, 20-28. doi:10.1016/j.genhosppsych.2016.05.002

Zhang, N., & Walton, D. M. (2018). Why so stressed? A descriptive thematic analysis of physical therapy students' descriptions of causes of anxiety during objective structured clinical exams. *Physiotherapy Canada*, *70*(4), 1-7. doi:10.3138/ptc.2016-102.e

Appendix A - Participant Information Sheet

PARTICIPANT INFORMATION SHEET (Focus group and/or interview)

Exploring 4th Year medical student's understanding and learning experiences in mental health and psychiatry

Dear ,

You are invited to participate in the research project described below.

What is the project about?

The research project seeks to investigate how 4th year medical students have understood and experienced their education in mental health and psychiatry and how this understanding has influenced their engagement with mental health consumers.

The aim is to:

- understand students' experiences with the mental health and Psychiatry curriculum and how this prepared them for their psychiatric rotations;
- Explore their experiences while on their psychiatric rotations and how this further influenced their perceptions of mental health and psychiatry, as well as their engagement with consumers of mental health services

The research is important as it intends to provide a deeper understanding of students' knowledge in mental health and psychiatry and their experiences and learning during their psychiatry rotations, their preparedness for treating people with mental health concerns, as well as an understanding of the perceptions students have of individuals with mental health issues. This may help the School of Medicine to further develop the mental health curriculum, which may potentially benefit future students, the School, and mental health consumers through enhanced quality of care and patient-centred focus.

Who is undertaking the project?

This project is being conducted by Kimberly Smith and will form the basis for the degree of a Master of Philosophy, within the School of Arts & Sciences, at The University of Notre Dame Australia, under the supervision of Dr Sharon McCarthy and Dr Ryan Anderton.

What will I be asked to do?

If you consent to take part in this research study, it is important that you understand the purpose of the study and the tasks you will be asked to complete. Please make sure that you ask any questions you may have, and that all your questions have been answered to your satisfaction before you agree to participate. You will be asked to:

- You will be asked to participate in a focus group and potentially also a follow up face-to-face interview.
- You may opt to participate in an interview only if you would prefer not to take part in a focus group.
- The focus group is estimated to take around 1 ½ hours and will be audio-recorded.
- The face-to-face semi-structured interview is estimated to take 30 – 60 minutes and will be audio-recorded.

- The types of questions you will be asked will relate to your learning in mental health and psychiatry, about your experiences and learning while undertaking psychiatry rotations, and about your perceptions of mental health and your engagement with mental health consumers.
- Focus groups will be held at the University of Notre Dame, Fremantle Campus (UNDA).
- You may incur costs associated with travelling to the UNDA, which the researchers are willing to reimburse for the costs of public transport or parking.

Are there any risks associated with participating in this project?

It is possible that you may experience some level of emotional distress or anxiety during the session as a result of some of the questions you will be asked. You will be monitored during the focus group and interviews and will be free to withdraw at any time during the sessions. If these feelings persist after the completion of the sessions, arrangements can be made for you to access support from the Clinical Psychologist within the School of Medicine, Fremantle, or the University of Notre Dame Student Counselling Service, Fremantle campus, at no expense to you. Alternatively, you can be provided with a list of free public support services.

What are the benefits of the research project?

The research may not provide immediate benefits to participants, however you may find that participating provides a good opportunity to debrief from your psychiatric rotation experience. Other benefits may include: the enhancement of the psychiatry curriculum for future students of the University of Notre Dame's School of Medicine, Fremantle; future student's subsequent enhanced understanding of mental health and psychiatry resulting from amendments to the curriculum; potential future increased number of medical professionals in the mental health field; and potential improvements to the therapeutic relationship between medical professionals and mental health service consumers.

What if I change my mind?

Participation in this study is completely voluntary. Even if you agree to participate, you can withdraw from the focus group at any time without discrimination or prejudice. If you choose to withdraw, the information already collected in the focus groups cannot be removed as it will be too difficult to identify you among the other participants in the focus group data. Also note that participation and/ or withdrawal from the study will not affect your ongoing assessment and grades within the School of Medicine.

Will anyone else know the results of the project?

Information gathered about you will be held in strict confidence. This confidence will only be broken if required by law. Audio recordings will be transcribed and any identifying data will be removed. Once the thesis has been accepted, the audio recordings will be permanently erased and only transcripts will be stored. Participants will be given pseudonyms.

During the data analysis, only the researchers will have access to audio recordings and transcripts, which will be stored in a secure, password-protected file. The School of Medicine will have no access to any of the data during or after the completion of the study and will only be given access to the final summary and thesis where all data will be de-identified.

Once the study is completed, only the de-identified data will be stored securely in the School of Arts and Sciences at The University of Notre Dame Australia for at least a period of five years. The de-identified data may be used in future research but you will not be able to be identified.

Will I be able to find out the results of the project?

Once the data has been analysed, a summary of the findings will be sent to you. You can expect to receive this feedback in 12 months. Results from the research will be then used to formulate a Master's thesis for the University. Articles may also be published from the thesis and submitted to peer reviewed journals. The results will also be presented to the School of Medicine and may also be presented at peer reviewed conferences.

Who do I contact if I have questions about the project?

If you have any questions about this project please feel free to contact either myself, Kimberly Smith on mobile: 0410048073 or email kimberly.smith1@my.nd.edu.au, or my supervisors, Dr Sharon McCarthy at sharon.mccarthy@nd.edu.au or Dr Ryan Anderton at ryan.anderton@nd.edu.au. My supervisors and I are happy to discuss with you any concerns you may have about this study.

What if I have a concern or complaint?

The study has been approved by the Human Research Ethics Committee at The University of Notre Dame Australia (approval number 017070F). If you have a concern or complaint regarding the ethical conduct of this research project and would like to speak to an independent person, please contact Notre Dame's Ethics Officer at (+61 8) 9433 0943 or research@nd.edu.au. Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

What if I experience emotional distress as a result of the topics discussed during the session?

Participants may contact the School of Medicine's Clinical Psychologist, Susie Stewart to make an appointment to debrief about any issues that may arise. Alternatively, you may contact The University of Notre Dame's Student Counselling Service, which is of no cost to Notre Dame Students, or contact one of the below listed free services for support:

University of Notre Dame Student Counselling Service:

Phone 9433 0580

Web: http://www.nd.edu.au/fremantle/current-students/student-services/counsellingservice.shtml

Lifeline:

Phone 131114

Web https://www.lifeline.org.au/get-help/get-help-home

BeyondBlue:

Phone 1300 224 636

Web https://www.beyondblue.org.au/

How do I sign up to participate?

If you are happy to participate, please sign the focus group consent form, *or* if you would only like to participate in a one-on-one interview, you will be provided with the information sheet for interview participants and asked to sign the interview consent form and email it back to me at kimberly.smith1@my.nd.edu.au and keep the hard copy for your records.

Thank you for your time. This sheet is for you to keep.

Yours sincerely,

Kimberly Smith

Appendix B - Consent Form

CONSENT FORM (Focus Group)

Exploring 4th Year medical student's understanding and learning experiences in mental health and psychiatry

- I agree to take part in this research project.
- I have read the Information Sheet provided and been given a full explanation of the purpose of this study, the procedures involved and of what is expected of me.
- I understand that I will be asked to take part in a focus group discussion that may take around 1 ½ hours.
- I understand that I may also nominate to participate in a follow-up interview before the August 31st that may take 30 to 60 minutes.
- I agree to the focus group discussion and follow up interview being audio-recorded.
- The researcher has answered all my questions and has explained possible problems that may arise as a result of my participation in this study.
- I understand that I may withdraw from participating in the project at any time without prejudice.
- I understand that all information provided by me is treated as confidential and will not be released by the researcher to a third party unless required to do so by law.
- I agree that any research data gathered for the study may be published provided my name or other identifying information is not disclosed.
- I understand that research data gathered may be used for future research but my name and other identifying information will be removed.

Name of participant			
Signature of participant		Date	
Please tick this box if you are happy to participate in a follow-up interview			
Participant's email address (to provide a summary of findings)			

- I confirm that I have provided the Information Sheet concerning this research project to the above participant, explained what participating involves and have answered all questions asked of me.

Signature of Researcher		Date	

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

Appendix C - Interview Schedule

Exploring 4th Year medical student's understanding and learning experiences

in mental health and psychiatry

Final Interview Schedule for Focus Groups and Interviews

- What did you learn theoretically about mental health and psychiatry?
    - Were there any particular focusses or emphasis on any particular area?
- What do you understand recovery to mean in the mental health sector?
- What did you learn about the history and theory of psychiatry?
- How were you able to utilise your theoretical knowledge in practice?
    - Was anything particularly useful or relevant or not useful?
- What has been your experience of your psychiatric rotation?
    - What were the highlights/challenges/issues during rotations?
- What were your main learnings throughout your rotation in psychiatry?
- Are you considering post-graduate psychiatry?
    - If so, what has influenced this decision, or if not why?

NB: Questions for follow-up interviews will be drawn from issues arising from focus groups, and therefore an interview schedule for these cannot be provided at this stage.

Appendix D – Copy of HREC Approval letter

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

19 Mount Street (PO Box 1225) Fremantle WA 6959
+61 8 9433 0555 | enquiries@nd.edu.au

1 June 2017

Dr Sharon McCarthy & Mrs Kimberley Smith
School of Arts & Sciences
The University of Notre Dame, Australia
Fremantle Campus

Dear Sharon and Kimberley,

Reference Number: 017070F

Project title: "Exploring 4th year medical students' understanding and learning experiences in mental health and psychiatry."

Your response to the conditions imposed by the university's Human Research Ethics Committee, has been reviewed and assessed as meeting all the requirements as outlined in the *National Statement on Ethical Conduct in Human Research* (2007, updated May 2015). I am pleased to advise that ethical clearance has been granted for this proposed study.

Other researchers identified as working on this project are:

Name	School/Centre	Role
Dr Ryan Anderton	School of Health Sciences	Co-Supervisor

All research projects are approved subject to standard conditions of approval. Please read the attached document for details of these conditions.

On behalf of the Human Research Ethics Committee, I wish you well with your study.

Yours sincerely,

Dr Natalie Giles
Research Ethics Officer
Research Office

Cc: Dr Raoul Oehmen, Acting SRC Chair, School of Medicine

Appendix E - Cohort numbers and rotation information

APPENDIX B

From: Merredith Jaap
Sent: Friday, 28 April 2017 1:10 PM
To: Raoul Oehmen
Cc: Sharon McCarthy; Ryan Anderton; Kimberly Smith
Subject: RE: MPhil project - cohort and rotation information

Hi Kim,
Psychiatry rotations are 4 weeks duration:
30/1/17 – 24/2/17, 12 students
27/2/17 – 24/3/17, 11 students
27/3/17 – 21/4/17, 11 students
1/5/17 – 26/5/27, 13 students
29/5/17 – 23/6/17, 11 students
10/7/17 – 4/8/17, 13 students
7/8/17 – 1/9/17, 10 students
4/9/17 – 29/9/17, 14 students

Kind regards,
Merredith

From: Raoul Oehmen
Sent: Friday, 28 April 2017 11:10 AM
To: Merredith Jaap <merredith.jaap@nd.edu.au>
Cc: Sharon McCarthy <sharon.mccarthy@nd.edu.au>; Ryan Anderton <ryan.anderton@nd.edu.au>; Kimberly Smith <kimberly.smith1@my.nd.edu.au>
Subject: RE: MPhil project - cohort and rotation information

Hi Merredith,

Are you able to answer Kim's questions in the email below regarding the Psych rotations?

Kim – we have 26 students undertaking Med400 (old MBBS degree) and 69 undertaking MEDI6400 (new MD degree) – for the purposes of what you are interested in, both are the same, so 95 in total.

regards

Raoul

Dr. Raoul Oehmen
BSc (Hons) Ph.D. Grad.Cert.Uni.Teaching

Research Manager,
School of Medicine, Fremantle
University of Notre Dame Australia
47 Henry St (PO Box 1225)
Fremantle WA 6959