UMEÅ UNIVERSITY

Promoting epistemic justice through kindness and reflective practice

Towards recovery-oriented practice in general emergency care for people with mental ill-health

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I suppose it's about all these centuries of ideas surrounding mental ill-health and madness, that it's a different type of person, a different type of patient.

/Participant with lived experiences of mental ill-health, Study III

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Abstract

Background: Negative experiences and inadequate treatment can impact the well-being and mental health recovery of people with mental ill-health seeking general emergency care. In addition to people with mental ill-health reporting that their physical and mental health needs are not being met in this context, nursing staff in general emergency departments (EDs) describe a lack of knowledge and training regarding mental ill-health. While person-centred, recovery-oriented practices are advocated for in mental health care, their practical application in general emergency care remains unexplored, highlighting the need for research in this area.

Aim: The overarching aim of this thesis is to generate knowledge on how nursing staff in general emergency care can support mental health recovery, with a focus on recovery-oriented practices.

Methods: Studies I and II employed a qualitative design aimed at describing the experiences of people with mental ill-health in general emergency care (I) and the nursing staff caring for them in general EDs (II). In both studies, individual semi-structured interviews were conducted and analysed using qualitative content analysis. The participants included 11 people with experiences of mental ill-health (I) and 14 nursing staff working in general EDs (II). Study III employed a modified Delphi technique to systematically gather explicit and implicit knowledge from a 24-member expert panel, with the goal of reaching group consensus on key aspects of recovery-oriented practices in general ED care. The expert panel included people with lived experience of mental ill-health, registered nurses (RNs) working in emergency care, RNs specialized in psychiatric and mental health nursing and mental health recovery researchers.

Findings: The findings from these studies (I, II, III) suggest three values as central to guiding nursing staff in supporting mental health recovery through recovery-oriented practices in general emergency care. First, the *recognition* of patients' experiences and self-knowledge is vital. For ED nursing staff, this recognition involves actively listening to and acknowledging patients with mental ill-health as capable persons with valuable insights and perspectives regarding

their own health issues and situations. It also requires ED nursing staff to reflect on their own biases, knowledge gaps, and attitudes towards mental ill-health, as these factors may affect their engagement with patients. Second, *kindness*, manifested through small caring actions, can influence the interactions between ED nursing staff and patients with mental ill-health, making a difference in both the short and long term. For ED nursing staff, such kindness involves recognising and reflecting on the importance of seemingly 'simple' personal interactions alongside technical care, where these interactions can often be perceived as challenging and are underestimated. Third, *knowledge-sharing* which emphasises the recognition and integration of the ED nursing staff's experience-based and practical knowledge, alongside the opportunities to learn from patient encounters. Such knowledge-sharing requires a culture of collaboration and support within the ED, with dedicated time and resources for sharing experiences and insights through reflection.

Conclusion: By prioritizing recognition, kindness, and knowledge-sharing, ED nursing staff can support the mental health recovery of people with mental ill-health through recovery-oriented practices. Such practices can not only promote epistemic justice but also highlight the importance of a deeper understanding of kindness, manifested through small caring actions, and underscore the need for reflective practice. In conclusion, this thesis demonstrates that discussing mental health recovery is meaningful within the context of general emergency care.

Keywords: Delphi technique, epistemic justice, general emergency care, general emergency department, kindness, mental health care, mental health recovery, mental ill-health, person-centred practice, qualitative content analysis, recovery-oriented practice, reflective practice

Svensk sammanfattning

Bakgrund: Negativa erfarenheter och bristfällig vård kan påverka välbefinnande och återhämtning hos personer med psykisk ohälsa som söker allmän akutsjukvård. Utöver att personer med psykisk ohälsa beskriver att deras fysiska och psykiska vårdbehov inte tillgodoses i denna kontext, beskriver vårdpersonal på allmänna akutmottagningar en brist på kunskap och utbildning gällande psykisk ohälsa. Även om ett personcentrerat, återhämtningsinriktat arbetssätt förespråkas inom psykiatrisk vård, är dess praktiska tillämpning inom allmän akutsjukvård fortfarande outforskad, vilket understryker behovet av forskning inom detta område.

Syfte: Det övergripande syftet med denna avhandling är att generera kunskap om hur vårdpersonal inom allmän akutsjukvård kan stödja återhämtning vid psykisk ohälsa, med fokus på återhämtningsinriktat arbetssätt.

Metod: Studie I och II använde en kvalitativ design med syfte att beskriva erfarenheter av allmän akutsjukvård bland personer med psykisk ohälsa (I) och erfarenheter av att vårda patienter med psykisk ohälsa bland vårdpersonal som arbetar på allmänna akutmottagningar (II). I båda studierna genomfördes individuella semistrukturerade intervjuer som analyserades med kvalitativ innehållsanalys. Deltagarna inkluderade 11 personer med erfarenhet av psykisk ohälsa (I) och 14 vårdpersonal med erfarenhet av att arbeta på allmän akutmottagning (II). I studie III användes modifierad Delphi-teknik för att systematiskt samla in explicit och implicit kunskap från en expertpanel bestående av 24 personer, med målet att nå konsensus på gruppnivå om nyckelaspekter i ett återhämtningsinriktat arbetssätt inom allmän akutsjukvård. Expertpanelen inkluderade personer med egen erfarenhet av psykisk ohälsa, sjuksköterskor med erfarenhet av allmän akutsjukvård, specialistsjuksköterskor inom psykiatrisk vård, samt forskare inom området psykisk hälsa och återhämtning.

Resultat: Resultaten från dessa studier (I, II, III) belyser tre värden som centrala för att vägleda vårdpersonal i att stödja återhämtning vid psykisk ohälsa genom återhämtningsinriktat arbetssätt inom allmän akutsjukvård. För det första, att *erkänna* och bekräfta patienters erfarenheter och kunskap om sig själv är av största

vikt. För vårdpersonal på akutmottagningar innebär det att aktivt lyssna på och bekräfta patienter med psykisk ohälsa som kapabla personer med värdefulla insikter och perspektiv på sitt eget hälsotillstånd och sin situation. Det är också viktigt att vårdpersonalen reflekterar över sin egen förförståelse, fördomar, kunskapsluckor och attityder gentemot psykisk ohälsa, eftersom dessa faktorer kan påverka deras engagemang med patienterna. För det andra, kan *välvilja*, manifesterad genom små vårdande handlingar, påverka samspelet mellan vårdpersonal och patienter med psykisk ohälsa, vilket kan göra skillnad både på kort och lång sikt. För vårdpersonal är det viktigt att bli medveten om och reflektera över vikten av till synes 'små' eller 'enkla' handlingar av välvilja vid sidan av teknisk vård, där personliga interaktioner kan underskattas och upplevas som utmanande. För det tredje, betonar *kunskapsdelning* beaktande och integration av vårdpersonalens erfarenhetsbaserade och praktiska kunskap, tillsammans med möjligheterna att lära av patientmöten. För att sträva mot detta krävs en kultur präglad av samarbete och stöd inom akutmottagningen, samt avsatt tid och resurser för att dela erfarenheter och insikter genom reflektion.

Konklusion: Genom att erkänna och värdera patienters erfarenheter och kunskap om sig själva, vara medveten om vikten av till synes 'små' handlingar baserade på välvilja och prioritera kunskapsdelning av erfarenhetsbaserad och praktisk kunskap kan vårdpersonal på allmänna akutmottagningar stödja återhämtning vid psykisk ohälsa genom återhämtningsinriktat arbetssätt. Ett sådant arbetssätt kan främja epistemisk rättvisa, lyfta fram betydelsen av en djupare förståelse för välvilja manifesterad genom små vårdande handlingar, och understryka behovet av en reflekterande praktik. Sammanfattningsvis visar denna avhandling att det är meningsfullt att diskutera återhämtning vid psykisk ohälsa inom ramen för allmän akutsjukvård.

Nyckelord: Allmän akutmottagning, allmän akutsjukvård, Delphi-teknik, epistemisk rättvisa, kvalitativ innehållsanalys, personcentrerat arbetssätt, psykisk ohälsa, reflekterande praktik, välvilja, återhämtning, återhämtningsinriktat arbetssätt.

Original papers

This thesis is based on the following papers, which are referred to by their Roman numerals in the text.

I. Derblom, K., Molin, J., Gabrielsson, S., & Lindgren, B-M. (2021). "Acknowledge me as a capable person": How people with mental ill health describe their experiences with general emergency care staff – A qualitative interview study. *International Journal of Mental Health Nursing, 30*(6), 1539–1549. https://doi.org/10.1111/inm.12903

II. Derblom, K., Molin, J., Gabrielsson, S., & Lindgren, B. (2022). Nursing staff's experiences of caring for people with mental ill-health in general emergency departments: A qualitative descriptive study. *Issues in Mental Health Nursing*, *43*(12), 1145–1154. https://doi.org/10.1080/01612840.2022.2138653

III. Derblom, K., Dahlberg, K., Gabrielsson, S., Lindgren, B-M., & Molin, J. (2024). Key aspects of recovery-oriented practice in caring for people with mental ill-health in general emergency departments: A modified Delphi study. *Journal of Clinical Nursing.* Accepted.

Definitions/Terms

In this thesis, several terms are used that require clarification and motivation.

General emergency care

General emergency care refers to both prehospital and hospital emergency care services (Sagan & Richardson, 2015). *Prehospital care* includes immediate medical actions outside hospitals, such as ambulance services, and *hospital care* includes general EDs that are available 24 hours a day, 7 days a week (National Board of Health and Welfare, 2023). Study I of this thesis explores patient experiences in general ambulance services and EDs, while Studies II and III focus specifically on general EDs, making these the primary focus of the thesis. Psychiatric ambulances and psychiatric EDs are not included.

People with mental ill-health

In this thesis, the term *people with mental ill-health* includes anyone affected by mental ill-health, whether currently or in the past. It does not imply that a person is currently experiencing mental ill-health at the time of seeking general emergency care, nor does it suggest a persistent condition. This broad definition allows for subjective interpretation and relevance to different individuals, enabling informants to assess how the term aligns with their own experiences or perceptions. This approach accommodates personal and contextual variations in understanding mental ill-health, providing a comprehensive view of how these experiences are perceived and managed in the ED setting.

Patient

The term 'patient' is a subject of debate and is often contrasted with alternatives such as 'client', 'consumer' and 'survivor', among others (Costa et al., 2019). In this thesis, *patient* is used to refer to people with mental ill-health who are temporarily seeking assistance in general emergency care for mental and/or physical care needs. The term is retained for pragmatic reasons: it is widely understood, aligns with existing research, and – importantly – is preferred by

many people seeking care, although preferences may vary (Costa et al., 2019). This choice is made to ensure clarity and consistency rather than to reflect an ideological stance.

Nursing staff

In this thesis, the term *nursing staff* refers to both registered and enrolled nurses. A *registered nurse* is defined as a nurse with education at the graduate level or higher, while an *enrolled nurse* is defined as a nurse with education at the secondary school level or below. In Study I, the term *general emergency care staff* is used, which includes both nursing staff and physicians. However, the focus of this thesis will be on nursing staff because they are often the first point of contact with patients and are closest to them in the caring process.

Introduction

Seeking general emergency care for mental and/or physical ill-health can be part of a person's recovery process, potentially influencing that person's overall well-being and mental health recovery. Research indicates that nursing staff in general EDs have a limited understanding of recovery from the perspective of those with lived experiences of mental ill-health and struggle to contextualise their role in a patient's recovery process (Marynowski-Traczyk et al., 2017). When people with mental and/or physical care needs arrive at the general ED, they encounter an environment operating within a biomedical model that may not fully address their needs (McIntyre et al., 2021; Roennfeldt et al., 2021). Nursing staff training emphasises medical and technical tasks focused on life-threatening physical conditions (Shin et al., 2020). This approach narrows nursing practice to measurable, task-driven and time-sensitive activities, often overlooking mental health needs, even though patients at risk of suicide also present with a clearly life-threatening condition (Betz et al., 2016). The James Lind Alliance (2022) has identified the optimisation of general emergency care for patients with mental ill-health – regardless of whether they present with physical or mental health needs – as a top research priority. This priority highlights the specific need for research focused on improving aspects of emergency care such as nursing staff training, prioritisation and overall patient experience. Despite global initiatives by the World Health Organization (WHO, 2019) advocating for person-centred, recovery-oriented practices in mental health care, their practical application in general EDs remains unexplored. This thesis aims to address this gap by exploring how nursing staff in general EDs can support the recovery of people with mental ill-health through the integration of recovery-oriented practices, as a step towards more inclusive and optimised care in these settings.

Background

Mental health recovery

This thesis is based on an understanding of mental health recovery as an active and dynamic process. Here, 'active' refers to the ability of both the person and others to influence the recovery, while 'dynamic' suggests that the various dimensions of recovery can affect each other. These dimensions can be described as *personal*, *social* and *clinical* recovery (Topor et al., 2018). *Personal* recovery involves achieving a fulfilling life despite the limitations imposed by mental ill-health (Anthony, 1993). *Social* recovery addresses overcoming stigma and promoting inclusion and active participation in society (Topor et al., 2011). *Clinical* recovery concentrates on symptom reduction and curing illness (Slade, 2009). While these different dimensions of recovery may be intertwined, they can also be experienced one without the other (Slade et al., 2014). General ED care predominately focuses on clinical recovery (Marynowski-Traczyk et al., 2017; Shin et al., 2020; McIntyre et al., 2021; Roennfeldt et al., 2021), leaving a gap in understanding how to adopt a more inclusive approach that incorporates the personal and social dimensions of recovery for people with mental ill-health. Mental health recovery is further elaborated in the theoretical framework of this thesis.

General emergency departments

According to the Swedish Agency for Health and Care Services Analysis (2018), general EDs – while lacking a specific definition in Swedish legislation – serve as hospital units that provide emergency care without the need for prescheduled appointments. Patients seeking ED care present a wide range of symptoms across various healthcare areas, often with a shared sense of urgent need for care. To address these diverse conditions and levels of severity, a broad range of knowledge and experience is required from staff working in ED settings. Triage systems in EDs vary, with RNs typically being responsible for initial assessments, while subsequent evaluations are conducted by physicians. In Sweden, team triage is occasionally employed, in which physicians and RNs collaborate to increase efficiency and reduce waiting times. The predominant triage system used in

Swedish EDs is the Rapid Emergency Triage and Treatment System (RETTS). RETTS involves an initial assessment based on vital signs, a standardised medical history, and emergency symptoms and signs. Together, these form guiding recommendations for priority levels and necessary tests and monitoring procedures (Swedish Agency for Health and Care Services Analysis, 2018). Fekonja et al. (2024) report that triage nurses perceive caring behaviours as inseparable from patient safety in the triage process, since providing care ensures safety. Triage nurses emphasise the importance of a respectful attitude, connection with patients, a conscious focus on their needs and maintaining a safe triage environment. However, they often find their ability to provide care compromised by overcrowding and staff shortages, which force them to prioritise patient safety over individual needs, creating a tension between care delivery and safety (Fekonja et al., 2024).

EDs are often organised into specialised sections, such as medicine, surgery and orthopaedics. Each section may be assigned a specific area within the ED and is staffed by teams of physicians and nurses. In Sweden, general EDs employ enrolled nurses (ENs), RNs, specialist nurses and physicians (Swedish Agency for Health and Care Services Analysis, 2018). General EDs hold a key position in the healthcare system, often serving as the first or only healthcare contact for patients in need of acute care and as a gateway to further hospitalisation or specialised care. While specialised psychiatric EDs or similar services are available in many regions of Sweden, access to these services varies, and people experiencing mental ill-health are often directed to general EDs. As a result, general EDs – despite being primarily designed for physical health emergencies – frequently serve as the first point of contact for mental health crises, thereby playing a crucial role in the continuity of mental health care (Duggan et al., 2020). Research is lacking on how mental health care can be integrated into the existing structure of general EDs to ensure that the needs of all patients in crisis are met.

Mental health

Mental health is defined by the WHO as an integral component of health and well-being and as a basic human right, which includes the right to available, accessible, acceptable and good-quality care and the right to liberty, independence

and inclusion in the community (WHO, 2023). According to Swedish authorities, mental health is an umbrella term encompassing both *mental well-being* and *mental ill-health* (National Board of Health and Welfare, 2024). From this perspective, mental health is not the opposite of mental ill-health but is rather an overarching concept that encompasses the entire field. Thus, mental well-being and mental ill-health represent distinct dimensions rather than opposites. These dimensions are interconnected; for example, people without mental ill-health may still experience low well-being. At the same time, it is important to note that people with psychiatric conditions can experience well-being in various forms. This means that well-being and mental ill-health can coexist and that a person can experience different levels of these dimensions independently of each other (National Board of Health and Welfare, 2024).

Mental ill-health

Mental ill-health is defined by Swedish authorities as a term that encompasses both mental health issues and psychiatric conditions that meet the criteria for a psychiatric diagnosis. *Mental health issues* can range from mild to severe and can last for shorter or longer periods; they can include moderate anxiety, a low mood or feeling down, insomnia and suicidal thoughts. Mental health issues can sometimes lead to the development of *psychiatric conditions*, which are symptoms that meet the criteria for a psychiatric diagnosis and include mental disorders and syndromes such as psychosis, depression, affective and anxiety disorders, neuropsychiatric disabilities/disorders and substance-use disorders. Psychiatric conditions are classified based on diagnostic criteria in international classification systems (ICD-10/DSM-5-TR) (National Board of Health and Welfare, 2024). This thesis adopts the definition of mental ill-health provided by Swedish authorities, as it is broadly recognised and used among both professionals and the Swedish public. By embracing this inclusive definition, we seek to explore how general EDs approach mental ill-health from a broad perspective.

Experiences of ED care among people with mental ill-health

Previous research has identified both similarities and differences among the experiences of ED care of people with mental ill-health and those without (Bull et al., 2024). A common issue across all patient groups is the presence of relational

power imbalances, which often compel patients to adopt passive or compliant behaviours to secure the attention of care providers. For people with mental ill-health, such power imbalances are particularly linked to their authority as 'knowers', based on their lived experiences, and often result in these individuals being ignored, dismissed or questioned due to societal prejudices (Bull et al., 2024). They frequently face difficulties in obtaining both adequate mental health care and proper physical health care in ED settings (Molloy et al., 2021). These difficulties are further compounded by the fact that people with mental ill-health often rely on general ED care for both their mental and physical health needs, viewing it as either an unavoidable or the only accessible option (Vandyk et al., 2018; Roennfeldt et al., 2021). Research indicates that the way people are treated by ED nursing staff when seeking care for mental health concerns is the most significant factor in determining whether their experience is positive or negative (Bull et al., 2024). Once categorised as having mental ill-health, patients often find that their needs are deprioritised in favour of those with physical concerns, which leads to insufficient mental and emotional care (Vandyk et al., 2018; Navas et al., 2022; Brosseau-Paradis et al., 2024). Furthermore, the attitudes of ED nursing staff, when characterised by a lack of understanding, compassion and flexibility, are critical factors that negatively impact the overall care experience (Quinlivan et al., 2021; Sacre et al., 2022). This situation is particularly concerning given that severe mental health conditions are established risk factors for suicide, with people experiencing these conditions being at a significantly higher risk of premature death compared with others (John et al., 2018; O'Connor et al., 2023). Those seeking ED care for suicidal ideation or actions often report feeling trapped, neglected, and mistreated, which result in distressing and unhelpful experiences (Brosseau-Paradis et al., 2024). Importantly, they primarily desire non-judgmental engagement from staff, characterised by understanding and acceptance (Vandewalle et al., 2020). However, research indicates that empathic approaches to suicide prevention are rarely applied in EDs, reflecting the prevailing biomedical focus (Shin et al., 2020) rather than a person-centred mental health response (McIntyre et al., 2024).

Unsatisfactory treatment in ED care is also linked to a lack of information and limited involvement in decision-making (Fleury et al., 2019). Frequent visitors to the ED (Thomas et al., 2018; White, 2021) and people diagnosed with borderline

personality disorder, trauma histories, substance-use disorders, or those who self-harm are especially prone to feeling unwelcome, as their reasons for attending the ED are often not seen as legitimate (Owens et al., 2016; Wise-Harris et al., 2017; Vandyk et al., 2019; Corscadden et al., 2021; O'Keeffe et al., 2021). Having the legitimacy of their ED visit questioned can make the people seeking care feel guilty and burdensome, as though they are wasting everyone's time (Byrne et al., 2021), which only deepens feelings of self-loathing, shame and worthlessness and further discourages them from seeking future help (Owens et al., 2016; Vandyk et al., 2019; Byrne et al., 2021).

People with a history of mental ill-health seeking ED care for physical health issues have reported frequently being dismissed, disbelieved and having their medical needs overlooked (Ewart et al., 2016). This is a serious issue, as those with psychiatric conditions have a shorter life expectancy – 10.2 years less for men and 7.3 years less for women – primarily due to treatable conditions such as respiratory and cardiovascular diseases, diabetes, dental issues and cancer (National Mental Health Commission, 2016; Erlangsen et al., 2017). These healthcare inequities heighten risks and worsen health outcomes, increasing the likelihood of physical deterioration by delaying timely assessment, treatment and holistic care (Molloy et al., 2021). One reason for this healthcare inequity is diagnostic overshadowing, or 'clinical blindness,' where healthcare staff misattribute physical symptoms to a person's mental health condition (Shefer et al., 2014; Molloy et al., 2021; O'Connor et al., 2023). Additionally, people with physical health conditions face misattribution of mental health issues (O'Connor et al., 2023). Diagnostic overshadowing has been directly linked to avoidable premature deaths (Shefer et al., 2014) and may contribute to undetected suicide risk in clinical settings (van Brakel et al., 2019).

People with mental ill-health have also reported experiences where they have felt listened to, supported and respected by ED nursing staff who acknowledge their needs (Vandyk et al., 2018). These experiences often involve being given time, taken seriously and shown compassion (Thomas et al., 2018; Fleury et al., 2019). Positive interactions with nursing staff can have a meaningful influence on patients, instilling hope (O'Keeffe et al., 2021), enhancing their overall experience in ED care and helping to mitigate any negative effects from treatment received

(Harrison et al., 2015; Thomas et al., 2018; Fleury et al., 2019; McIntyre et al., 2024). Although existing research sheds light on both positive and negative experiences of people with mental ill-health in general EDs, further exploration is necessary to understand how this knowledge can be utilised to improve care and support mental health recovery.

Experiences of ED nursing staff caring for people with mental ill-health

ED nursing staff find caring for patients with mental ill-health more challenging and complex than managing patients with common physical ailments (Østervang et al., 2022). They cite a lack of knowledge and training as major barriers to providing appropriate care (Marynowski-Traczyk & Broadbent, 2011; Weiland et al., 2011; Plant & White, 2013; Chapman & Martin, 2014; Holmberg et al., 2020; Perrone McIntosh, 2021; Østervang et al., 2022). This lack of knowledge is closely tied to negative attitudes, stigmas and difficulties in forming empathic relationships with these patients (Vedana et al., 2017). Biases – whether conscious or unconscious – may lead ED nursing staff to view patients with mental ill-health as dangerous or unpredictable, resulting in fear or avoidance (Roennfeldt et al., 2021; Navas et al., 2022; García-Carpintero Blas et al., 2023). Such stigmas and biases significantly impact the quality of care, particularly in assessment, treatment and communication (Roennfeldt et al., 2021; García-Carpintero Blas et al., 2023).

The entrenched clinical model of recovery in ED care predominantly emphasises biomedical aspects, often overlooking social factors and personal experiences (Marynowski-Traczyk et al., 2017; Shin et al., 2020). This focus shapes the practices of ED nursing staff (Holmberg & Fagerberg, 2010), whose understanding of recovery is often limited to symptom relief rather than a holistic approach (Marynowski-Traczyk & Broadbent, 2011). Consequently, nursing staff who feel unprepared or unsupported in caring for patients with mental ill-health may adopt a technical approach, finding it easier to meet patients' physical care needs and provide medical interventions than to address their emotional and relational needs (Vedana et al., 2017; Østervang et al., 2022). The hectic ED environment and time pressures lead to short interactions, further hindering nurses' ability to address patients' needs (Marynowski-Traczyk & Broadbent,

2011; Weiland et al., 2011; Broadbent et al., 2014), which includes making proper assessments that consider the person's subjective experiences (Holmberg et al., 2020). To optimise general ED care for people with mental ill-health and support their recovery, it is essential to identify the specific support that ED nursing staff require in order to appropriately address the needs of these patients.

Mental health recovery in general ED care

To the best of my knowledge, no previous research has focused on how nursing staff in general ED settings can support the mental health recovery of people with mental ill-health or how recovery-oriented practices can be applied in this context. Although much is known about the experiences of and challenges faced by patients and nursing staff in ED settings, there remains a gap in understanding how this knowledge can be applied to optimise care. Comprehensive research is also lacking on how recovery-oriented practices can be integrated into ED care, particularly regarding their potential to mitigate healthcare inequities and diagnostic overshadowing, ultimately optimising care. Additionally, there is limited understanding of how general ED settings might transition from predominantly biomedical models to models that incorporate personal and social dimensions, addressing the full spectrum of patients' needs in a high-pressure environment. To address this gap, it is vital to engage people with lived experience in discussions about their care, ensuring that their voices guide the process. Equally important is the need to engage ED nursing staff in discussions about their practices, thus fostering a more inclusive and optimised approach to care. Ultimately, in order to optimise general ED care for people with mental ill-health and support their recovery, it is essential to identify the specific support that ED nursing staff require to appropriately address the needs of these patients.

Theoretical framework

This thesis is guided by a theoretical framework that incorporates mental health recovery as an active and dynamic process. Here, 'active' is used in the sense that the individual and others can influence the individual's recovery, and 'dynamic' is used to imply that the various dimensions of recovery may affect each other. This theoretical framework was used as a lens to discuss the findings in Studies I and II and formed the basis for Study III.

Historical roots of recovery

The understanding of recovery as a process encompassing personal, social and contextual dimensions is rooted in the 1960s civil rights movement. It emerged as a response to stigma and suppression and is based on ideas of human rights and empowerment (Hummelvol et al., 2015; Davidson, 2016). During that time, marginalised groups of former patients came together to advocate for change, drawing inspiration from the Black, LGBTQ+ and women's liberation movements (Chamberlin, 1990). This early recovery movement functioned as a social justice initiative outside the conventional healthcare system, challenging the existing power dynamics between healthcare professionals and patients (Davidson, 2016). Additionally, it raised important epistemic questions regarding what constitutes valid knowledge and who should be recognized as 'knowers'.

Judy Chamberlin played a central role in the early recovery movement, advocating for the rights of people with mental health challenges. Her activism was deeply influenced by her own experiences of abuse and coercive practices during mental health hospitalisations. A fundamental aspect of her advocacy was the fight against the violation of basic human rights (Chamberlin, 1990). Similarly, Patricia Deegan, a prominent recovery activist with lived experience of mental ill-health, challenged stigma, marginalization, and oppression within mental health contexts, while emphasizing the importance of people having a voice and making meaningful contributions to their own lives and circumstances (Deegan, 1996).

In the 1980s and 1990s, the concept of recovery further evolved through the efforts of the mental health consumer/survivor movement and the emerging

substance-use recovery advocacy movement (Davidson & White, 2007). People with lived experiences began to challenge the dominant views of chronicity and limited hope associated with mental ill-health, sharing their stories and insights (Marynowski-Traczyk, 2015). It was recognised that, while full clinical recovery might be achievable for some following an acute episode of mental ill-health, a more personal sense of recovery was needed and suitable for others (Davidson, 2021). Such recovery involved learning to navigate daily life in the presence of – or within the constraints of – mental ill-health. Furthermore, it became apparent that mental health and substance-use services, which focused on acute symptom relief, often neglected the importance of supporting overall functioning and enabling people to lead fulfilling lives within their chosen communities. The recovery movement sought to transform professional practices and influence government policies regarding mental health care (Subandi et al., 2023). People with lived experiences of mental ill-health advocated for a transition from being passive recipients of care to becoming active, informed collaborators with mental health care providers (Chamberlin, 1990).

Recovery as an outcome

The concept of recovery as an outcome originates from the clinical research perspective and traditional psychiatry. Within this framework, recovery is often termed *clinical recovery*, emphasising the reduction of symptoms and improvement in functioning, typically achieved through therapy and medication (Slade & Longden, 2015). This view aligns with the biomedical model, which tends to focus on treating the illness rather than considering the person experiencing the illness within a social context (Davidson & Roe, 2007; Topor et al., 2016). Furthermore, it has been criticised for being overly individualistic and paternalistic. Critics note that this view overlooks the efforts people make in their own recovery (Davidson & Roe, 2007), the significance of everyday life contexts (Borg & Davidson, 2008), and the opportunities and obstacles related to human rights and social participation (Topor et al., 2011).

Recovery as a process

The perspective of recovery as a process encompasses both the personal and social dimensions and the interplay between them, with an emphasis on finding ways

to live well with or without symptoms of mental ill-health (Sommer et al., 2021). Although recovery is fundamentally a personal experience, it can be understood as deeply intertwined with the interdependence of human life, including our relationships with others and our social and environmental contexts (Price-Robertson et al., 2017; Dell et al., 2021). Price-Robertson et al. (2017) suggest that while many recovery models recognize relationships or connectedness as components of the recovery process, an overemphasis on the 'inner' subjective experiences of those with lived mental ill-health may obscure the interpersonal contexts of recovery. Sommer et al. (2021) further argue that social relationships play a central role in recovery processes, encompassing interactions with both professionals and 'ordinary' people.

One of the most frequently cited definitions of *personal recovery* is by Anthony (1993), who describes it as a unique process of living a fulfilling life despite the limitations imposed by mental ill-health. The CHIME framework, which was developed within a mental health context, synthesises people's experiences of personal recovery. It consists of five themes: connectedness, hope, identity, meaning and empowerment (Leamy et al., 2011; Bird et al., 2014). Here, *connectedness* involves feeling connected to society and being part of a community, with supportive relationships being crucial for recovery. *Hope* and belief in one's recovery are essential, and it is important to have hopeful relationships that foster trust in the possibility of recovery. *Identity* involves redefining self-worth beyond a diagnosis, overcoming stigma and being valued as a unique person. *Meaning* is about living a fulfilling life, rebuilding one's life and finding purpose in mental ill-health experiences, which helps reduce self-stigma. *Empowerment* involves having control of one's own life, focusing on strengths and participating in decisions about care and treatment.

The CHIME framework has been criticised for its overly optimistic approach. Researchers argue that a comprehensive understanding of recovery should also encompass an individual's struggles with life's inherent challenges within the recovery journey (Stuart et al., 2017; Jagfeld et al., 2021). Stuart et al. (2017) proposes extending the CHIME model to CHIME-D, to explicitly recognise the theme of *difficulties*. This modification could enhance our understanding of how the challenges encountered during recovery are influenced by contextual

factors. It could also aid in identifying how services can more effectively support people, representing a step towards addressing the social inequities often associated with mental ill-health.

Social recovery examines the impact of mental ill-health on a person's ability to participate in society and can be influenced by health-related issues, stigma and societal biases. It focuses on overcoming these barriers to encourage inclusion and active societal participation (Topor et al., 2011). Klevan et al. (2021a) emphasise that recovery is not a solitary process; rather, it necessitates looking beyond the individual to recognise the importance of supportive social contexts and environments, including accessible services. This perspective enhances social capability by aiding the shift from feelings of powerlessness and disconnection to empowerment and connection, while promoting recovery in environments free from stigma and discrimination (Klevan et al., 2021a).

Recovery-oriented practice

The WHO launched the Quality Rights initiative in 2019 (WHO, 2019) to transform mental health care across all healthcare services by promoting person-centred, human rights-based and recovery-oriented practices. This initiative advocates for the dignity, autonomy and empowerment of people with mental ill-health, emphasising the importance of treating everyone with respect and supporting their recovery process.

According to Klevan et al. (2021b), recovery-oriented practices are complex and encompass a wide range of approaches, yet they share several core characteristics: the significance of relationships and connectedness, the vital role of experience-based knowledge and the need for community participation. Gabrielsson and Looi (2019) suggest that a recovery-oriented practice has four central aspects. *Person-centred aspects* involve adopting a relational and holistic approach, engaging with patients as people and striving to understand their needs, experiences and strengths. *Strength-based aspects* require nursing staff to be mindful of how their actions may impact a person's recovery and to inspire hope by encouraging patients' capabilities and supporting their growth. *Collaborative aspects* emphasise the importance of the nurse-patient relationship: staff need to view patients as partners and respect their right to make informed decisions about

their own care and recovery. *Reflective aspects* involve recognising that mental health recovery is nonlinear and using insights from own and peer experiences of situations in care to continuously refine one's own practice. A caring, reflective, recovery-oriented, health-promoting and therapeutic practice is advocated as central in effective mental health nursing and nursing education (Gabrielsson et al., 2020).

Rationale

Despite global initiatives advocating for person-centred, recovery-oriented practices in health care for people with mental ill-health (WHO, 2019), their application in general ED settings remains underexplored, possibly contributing to inadequate care and hindering both immediate health outcomes and mental health recovery. General EDs serve as critical access points for people experiencing mental and/or physical health crises, often representing their first or only contact with the healthcare system. This dual role positions EDs as essential not only for immediate crisis response but also for ensuring continuity of care and facilitating access to specialised health services.

People with mental ill-health often face stigmas and biases in ED settings, which can result in discriminatory practices leading to negative experiences, inadequate assessments and treatments, exacerbating conditions and impeding mental health recovery. Integrating recovery-oriented practices could improve care and help address issues hindering appropriate care for people with mental ill-health in ED settings.

While care in general EDs predominantly focuses on clinical recovery (Marynowski-Traczyk et al., 2017; Shin et al., 2020; McIntyre et al., 2021; Roennfeldt et al., 2021), there is a critical gap in understanding how to integrate personal and social dimensions of recovery into these practices. This gap limits the ability of ED nursing staff to meet the diverse needs of patients with mental ill-health in this high-pressure environment.

Despite the critical importance of this area, understanding remains limited regarding how the experiences, challenges and opportunities encountered by people with mental ill-health and by nursing staff in general EDs can be leveraged to optimise care. Recognising that insights from both patients and staff are central to guiding this transformation, this thesis aims to address the existing gap by illuminating these experiences and translating them into actionable guidance for ED nursing staff. Ultimately, this thesis seeks to lay a foundation for future initiatives focused on optimizing ED care for people with mental ill-health, supporting their mental health recovery through recovery-oriented practices.

Aim

The overall aim of this thesis is to generate knowledge about how nursing staff in general emergency care can support the recovery of people with mental ill-health.

Specific aims

Study I To describe how people with mental ill-health experience encounters with staff in general emergency care.

Study II To describe nursing staff's experiences of caring for people with mental ill-health in general EDs.

Study III To identify key aspects of recovery-oriented practice in caring for people with mental ill-health in general EDs.

Methods

Research design

In Studies I and II, a qualitative design was employed, as a primary aim was to describe the participants' experiences of general emergency care, with a focus on general EDs in Study II (Marshall & Rossman, 2016). To address the research focuses of Studies I and II, individual semi-structured interviews (Brinkmann & Kvale, 2014) were conducted and subjected to qualitative content analysis (Graneheim & Lundman, 2004; Graneheim et al., 2017; Lindgren et al., 2020).

Study III employed a modified Delphi technique (Keeney et al., 2011) with multiple rounds, with the aim of reaching consensus on key aspects of recovery-oriented practices in caring for people with mental ill-health in general EDs. A diverse panel of 24 experts was recruited to provide multiple perspectives. In the first round, important aspects were identified through focus group interviews. A thematic analysis generated statements that were reformulated into a questionnaire for the two subsequent rounds. This process captured both explicit and implicit knowledge from the experts (Niederberger & Köberich, 2021). The experts rated each statement's importance on a 5-point Likert scale, with consensus set at ≥80%. Descriptive statistics were used to analyse the questionnaire data. Table 1 presents an overview of the studies.

Table 1. Aims, participants, type and year of data collection, analyses and status of the studies.

Study	Aim	Participants (*n*)	Data	Year of data collection	Analyses	Status
I	To describe how people with mental ill-health experience encounters with staff in general emergency care	11	Individual interviews	2019	Qualitative content analysis	Published
II	To describe nursing staff's experiences of caring for people with mental ill-health in general EDs	14	Individual interviews	2020–2021	Qualitative content analysis	Published
III	To identify key aspects of a recovery-oriented practice in caring for people with mental ill-health in general EDs	24	Focus group interviews, questionnaire	2022–2023	Delphi technique, thematic analysis, descriptive statistics	Accepted

First, I will describe the research process for Studies I and II in an intertwined manner, since they share the same methods; I will then provide a detailed account of Study III.

Studies I and II

Context

In Study I, people with experiences of mental ill-health and general emergency care were recruited from one region in Northern Sweden. In Study II, nursing staff working in three different general EDs across two regions in Northern Sweden were recruited. In the regions where the participants for Studies I and II were recruited, publicly funded general EDs operated 24 hours a day, 7 days a week, serving both rural and urban areas.

These EDs lacked on-site staff specialising in mental health, such as psychiatrists or psychiatric and mental health nurses; however, psychiatric consultations were accessible. One region had a dedicated psychiatric ED that operated 24 hours a day (II); in the other region, psychiatric emergency services were only available during specific hours (I, II).

Participants

In Study I, participants with experiences of mental ill-health and general emergency care were recruited through purposive sampling. The recruitment was facilitated by mental health professionals, and posters with information about the study were placed in waiting rooms at mental health services in the studied area (Brinkmann & Kvale, 2014). Individuals interested in participating in the study either contacted the author directly or provided their contact information through mental health professionals. A total of 12 potential participants received more information about the study, and 11 individuals (7 women and 4 men) aged between 23 and 86 years (median 49) chose to participate. One person declined for an unknown reason. The participants' number of visits to general emergency care varied, with two having 1–3 visits, four having 4–7 visits, and five having >8 visits. The participants' last visits ranged from 1 week before the study began to 16 years prior. Self-reported diagnoses among the participants included emotionally unstable personality disorder, posttraumatic stress disorder, phobic personality disorder, anxiety, depression, schizophrenia, bipolar syndrome, obsessive-compulsive disorder, burnout, attention-deficit hyperactivity disorder and (for one participant) 'unknown'. Self-reported reasons for seeking general emergency care included cardiovascular disease, allergic reactions, suicidal intentions, self-inflicted injuries, anxiety, back pain and issues related to bile, stomach and intestinal disorders.

In Study II, purposive sampling was used to recruit RNs and ENs with experience in caring for people with mental ill-health in general EDs. In one ED, the author provided information about the study during a workplace meeting; in the other two EDs, the unit manager assisted in recruiting potential participants. Further information about the study was given to 15 interested recruits. In total, 14 interviews were conducted with 10 women and four men (9 RNs and 5 ENs)

aged between 24 and 56 years (median 39.5). One recruit declined for an unknown reason. The duration of the participants' employment in ED care varied from 1 to 18 years (median 4) among the ENs and from 7 months to 27 years (median 3.25) among the RNs. Two ENs and two RNs had additional education in emergency care, while another two ENs and two RNs had experience working in mental health care.

Data collection

Individual interviews

Individual semi-structured interviews were conducted in both Studies I and II to explore the participants' experiences (Brinkmann & Kvale, 2014). In Study I, the interviews were conducted from April to October 2019, with each lasting between 29 and 104 minutes (average 60 minutes). The interviews took place either in the participant's home or at the university. An interview guide featuring open-ended questions, such as 'Can you tell me about your experiences of being cared for in general emergency care?' and 'Can you tell me about a meeting you experienced as positive/negative?', was utilised. In Study II, the interviews were conducted from March 2020 to February 2021, with each lasting between 53 and 101 minutes (average 75 minutes). One interview was conducted face-to-face at the participant's workplace, while the others were carried out via telephone or zoom due to the COVID-19 pandemic. An interview guide was employed with open-ended prompts such as 'What are your experiences caring for people with mental ill-health in emergency care?' and 'Please tell me about a situation you experienced as satisfying/challenging'. In both Studies I and II, follow-up questions such as 'Please tell me more about that…', 'What examples can you share?' and 'How did you experience that?' were posed to encourage the participants to elaborate on or clarify their responses. The interviews were audio-recorded and transcribed verbatim by the author and a person experienced in transcribing research interviews.

Data analysis

Qualitative content analysis

In Studies I and II, qualitative content analysis was used, involving a systematic interpretation of both the textual content and its underlying meaning. An inductive approach was adopted in both studies to identify patterns, similarities and differences (Graneheim & Lundman, 2004; Graneheim et al., 2017; Lindgren et al., 2020). First, the interviews were read multiple times to gain a comprehensive understanding of the content. Subsequently, the transcripts were imported into the analytical software MAXQDA (VERBI Software, Germany, 2020) and divided into meaning units aligned with the study's aim, which were then condensed and assigned codes. Similar codes were grouped together, leading to the abstraction and interpretation of subthemes, themes and a main theme in Study I, and subthemes and themes in Study II. For example, in Study I, codes such as *my perspectives were requested*, *my experiences were valuable* and *staff cared about my answers* were grouped, abstracted and interpreted to form the subtheme *Feeling listened to*; the latter was then subsumed with related subthemes under the theme *Recognise me*, which together with two other themes formed the main theme, *Acknowledge me as a capable person.* In Study II, codes such as *lacking time to listen*, *doing what is needed to keep the unit flowing* and *feeling insufficient* were grouped together and formed the subtheme *Struggling to prioritise within limited time* under the theme *Dealing with competing priorities*. All the authors of the studies (I, II) engaged in discussions and reflection on the abstractions and interpretations in relation to the original data before reaching consensus on the findings.

Study III

Participants

In Study III, a snowball technique was employed to recruit an expert panel comprising people with lived experience of mental ill-health, RNs in general emergency care, specialist nurses in psychiatric and mental health care and researchers in mental health recovery. The participants – all adults from various regions of Sweden – were recruited as experts based on their personal and/or

professional experiences, knowledge and interest in the subject under investigation. The authors of the study utilised their professional network to identify potential participants, who were then asked to suggest others who could be approached. In addition, emergency care nurses were identified through the preceding study (II). Except for one nurse who had experience in pre-hospital and acute psychiatric care, all the emergency care nurses had worked in general EDs. The experts who had lived experiences were forthright about their experiences of mental ill-health and recovery and were either actively involved in mental health interest organisations or employed/previously employed as user involvement coordinators. A user involvement coordinator is a professional that facilitates the active participation of service users (patients) in improving services. This role involves, for example, engaging users in feedback activities, organizing workshops or focus groups, and ensuring user insights are shared with decision-makers. Ultimately, a panel of 24 experts consented to participate in the study.

Data collection and analysis

In Study III, data were collected between December 2022 and June 2023. Figure 1 presents a Flow Chart illustrating the three Rounds in the modified Delphi study.

Round 1 – Focus group interviews

The first round comprised focus group interviews conducted digitally between December 2022 and February 2023. Experts with similar backgrounds or types of experience were interviewed in seven distinct focus groups, each consisting of 2–5 participants. The groups were organised based on each person's availability to participate. In the interviews, aspects of the CHIME framework (Leamy et al., 2011) were introduced as discussion areas, supplemented by examples from the findings of the preceding studies (I, II). This approach allowed the experts to reflect on these previous findings while also contributing their own thoughts and experiences. The initial question prompted experts to discuss how ED nursing staff can support mental health recovery in people with mental ill-health. Follow-up inquiries included: 'What aspects do you consider important?', 'Why do you believe these aspects are important?', 'What specific actions can nursing staff take?', and 'Could you provide an example?'. In each group session, there was a

moderator (the author) and one assistant present to engage with the experts and pose additional questions. Of the four co-authors, three served as assistants during these sessions, but only one was present in each focus group. The interviews ranged in duration from 88 to 110 minutes (median 103) and were audio recorded and transcribed verbatim by the author and a person experienced in transcribing research interviews.

Round 1 – Reflexive thematic analysis

The interview data were analyzed using reflexive thematic analysis, following the six-step method outlined by Braun and Clarke (2022). First, familiarity with the data was achieved by listening to and reading the interviews to gain a thorough understanding of the content. Subsequently, the analytical software MAXQDA (VERBI Software, Germany, 2020) was utilised to perform the initial coding, constructing statements and exploring themes. The interview data were systematically reviewed, and text units relevant to the study's aim were coded at a semantic level and formulated as statements. The author conducted the coding, striving to preserve the participants' original wording as closely as possible. Initial coding was inductive, allowing codes to emerge from the research question without preconceived themes. Subsequently, similar or redundant codes were merged. The codes were then compared for differences and similarities, leading to the identification of patterns and themes. To enhance coding consistency, all authors of the study independently reviewed the codes before coming together to discuss and refine definitions. Each code's wording was carefully considered until a consensus was reached, ensuring that the final codes accurately represented the data. A total of 78 statements were initially identified that suggested important aspects of nursing staff practices supporting mental health recovery in the context of ED care. Here, 'statements' refers to specific assertions or propositions that the expert panel was asked to evaluate in subsequent rounds. During this phase, the framework for recovery-oriented practice proposed by Gabrielsson and Looi (2019) was adopted. This framework served as a guide for organising the statements and as a lens highlighting the themes present in the material. Applying this framework to the data illuminated four prominent themes: *Person-centred aspects*, *Strength-based aspects*, *Collaborative aspects*, and *Reflective aspects*.

All stages of the analysis were discussed and reflected upon by all authors of the study.

Rounds 2 and 3 – Questionnaire

The 78 statements derived from Round 1 were utilised to develop a web-based questionnaire for the subsequent rounds. The questionnaire was created and distributed using an online survey platform (Artologik: Survey & Report, Artisan Global Media, Sweden). A pre-test of the questionnaire was conducted to identify potential issues related to clarity, relevance, wording, similarity or any other aspects of the statements (Hasson et al., 2000). The test group invited to provide feedback on the questionnaire consisted of six RNs who were not involved in the main study; of these, five were specialised in psychiatric and mental health nursing and one was specialised in intensive care. Based on their feedback, minor adjustments were made, including clarifying the wording and reducing similar statements. The final questionnaire comprised 73 statements and was introduced with the question 'How important do you consider the following to be in recovery-oriented practices for people with mental ill-health in the ED?'. The 24 members of the expert panel received an email with a link to the questionnaire. They were asked to rate the importance of each statement using a 5-point Likert scale ranging from 1 (*Not at all important*) to 5 (*Very important*). Open-ended sections were included to give the experts the opportunity to provide feedback on existing statements or to suggest additional ones, although no additional statements were suggested. Three reminders were sent over a period of 3 weeks in Round 2, resulting in a 100% response rate. The consensus level was predefined at ≥80% agreement on the rating of specific statements. While Keeney et al. (2011) has recommended a minimum of 75%, Varndell et al. (2021) reported varying thresholds with a median of 80%. Statements that reached consensus in Round 2 were excluded from Round 3, leaving 41 statements that did not reach consensus for further evaluation. Before distributing the questionnaire in the final round (3), the experts received personalised PDF feedback on the Round 2 findings, including the agreement percentages and individual responses, allowing them to compare their answers with the group's. Over a period of 3 weeks, three reminders were sent, achieving a 96% response rate, with all but one expert completing the questionnaire. The

data were analysed using descriptive statistics. Three rounds were considered appropriate to reach consensus and mitigate potential reductions in response rates (Keeney et al., 2011). A total of 39 out of 73 statements reached consensus after three rounds, with all 39 statements being considered 'very important' in recovery-oriented practice in general EDs.

Rounds 2 and 3 – Descriptive statistics

Data from the questionnaire were analysed using an online survey platform (Artologik: Survey & Report, Artisan Global Media, Sweden) to assess agreement levels using percentages, mean values and standard deviations.

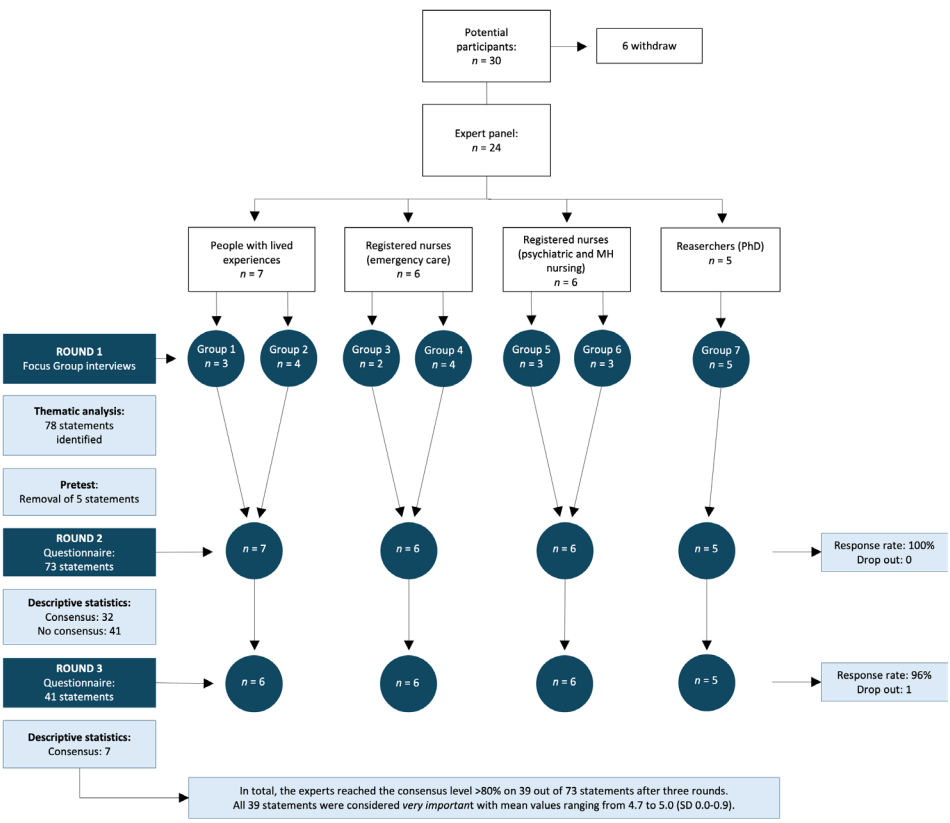

Figure 1. Flow Chart illustrating the three Rounds in the modified Delphi study.

Ethical considerations

The overall project received ethical approval from the Swedish Ethical Review Authority (No. 2017/284-31; 2019-00028). Additional ethical approval was applied for and received for Study III (No. 2022-04824-02). All the participants in Studies I, II and III were provided with both verbal and written information regarding the purpose of the research, the voluntary nature of their participation and their right to withdraw at any point. Prior to their involvement, informed consent was obtained from each participant. To safeguard their confidentiality, any data that could reveal the participants' identity was either altered or omitted in the reports.

In Study I, it was recognised that interviews concerning interactions with general emergency care staff might evoke unpleasant memories for participants with experiences of mental ill-health. Similarly, in Study II, it was acknowledged that interviews focusing on the challenges and circumstances of the daily duties of ED nursing staff could potentially cause distress. The participants were informed that the interviews could be paused if necessary to allow them to address any concerns or process emotional responses with the interviewer. It is also the case that undergoing an interview may yield positive outcomes for participants, as it can be be validating or even cathartic when someone shows a genuine interest in attentively listening to one's experiences (Biddle et al., 2013).

The modified Delphi technique used in Study III involved expert panel members who may well have been familiar with each other, making complete anonymity unlikely. It was necessary for the author to associate each member with their questionnaire response in order to provide feedback; however, the author had sole access to these responses. The feedback, which was sent as a PDF via email after Round 2, was delivered to the individual participants, allowing them to see only their own ratings and the group's ratings. This approach, which has been referred to as 'quasi-anonymity' by Keeney et al. (2011), ensures that confidentiality is maintained and the opinions expressed in questionnaire responses remain strictly anonymous to other panel members. All the participants across all the studies (I, II, and III) were informed of the option to contact the interviewer during and/or after the research process if the need arose.

Findings

This section presents a synthesis of the main findings, beginning with a description of the approach taken to summarise and synthesize the findings from the three studies included in the thesis. This is followed by a summary of these findings. Next, a more detailed presentation of the findings from each study is provided, focusing on the opportunities for and challenges of recovery-oriented practices in general ED settings. Links between the studies are highlighted to demonstrate their interconnectedness.

First, in the overall analysis of the findings of this thesis, the findings of Studies I and II were organised under the four key aspects of recovery-oriented practice in general EDs identified in Study III (*person-centred, strength-based, collaborative, and reflective aspects*), in order to interweave and summarise the findings from all three studies. This was done by reviewing the findings sections of the first two studies (I, II) and highlighting the content that aligned with the four key aspects from the third study (III). The highlighted text was then summarised under each of the four aspects. However, after completing this process, I dug deeper into the essence of the findings from all the studies and sought a more tangible answer on the question of how nursing staff in general EDs can support recovery among people with mental ill-health. Throughout this process, three main concepts became visible in the findings: *recognition*, *kindness* and *knowledge-sharing*. I propose that these concepts represent essential values that can guide ED nursing staff in supporting mental health recovery through recovery-oriented practices in this context.

Summary of the main findings

As described above, the findings from studies I, II and III suggest three values as central to guiding nursing staff in supporting mental health recovery through recovery-oriented practices in general ED settings. First, patients' experiences and self-knowledge should be *recognised* and validated. For ED nursing staff, such recognition involves actively listening to and acknowledging patients with mental ill-health as capable persons with valuable insights and perspectives into their own health issues and situations. Second, *kindness*, manifested through small caring

actions, can influence the interactions between ED nursing staff and patients with mental ill-health, making a difference in both the short and long term. For ED nursing staff, such kindness entails recognising and reflecting on the importance of seemingly 'simple' personal interactions alongside technical care, as these interactions can often be perceived as challenging and are underestimated. Third, *knowledge-sharing* which emphasises the recognition and integration of the ED nursing staff's experience-based and practical knowledge, alongside the opportunities to learn from patient encounters. Such knowledge-sharing requires a culture of collaboration and support within the ED, with dedicated time and resources for sharing experiences and insights through reflection. Overall, by prioritising the recognition of patients' expertise, valuing kindness and committing to knowledge-sharing, ED nursing staff can support the mental health recovery in people with mental ill-health through recovery-oriented practices.

Recognition

From the patients' perspective (I), the findings suggest that ED nursing staff can support mental health recovery by recognising patients as capable persons with valuable experiences and self-knowledge. The interviewed people with experience of mental ill-health expressed a strong desire to be seen, heard and respected as unique individuals by staff, rather than being defined solely by their psychiatric diagnosis. They emphasised the importance of being listened to and taken seriously by the staff who were present, being asked relevant questions, having genuine interest shown in their views, and having what was said during interactions documented in the medical records. Being treated as equals and being involved in decision-making, with staff seeking their input and collaborating on tailored solutions, further strengthened the patients' sense of safety, control and participation in care. These experiences were echoed by the interviewed ED nursing staff (II), who stressed the importance of listening attentively to these patients, dedicating time to them, adapting their nursing approach to the patients' needs and being prepared to address mental health concerns. The ED nursing staff believed that understanding and addressing patients' concerns – whether mental or physical – up front could prevent repeated emergency visits and improve long-term outcomes. The ED nursing staff, who described themselves

as confident in caring for patients with mental ill-health, noted that efforts to understand patients' needs and situations helped make the patients feel recognised and listened to, which gave the staff opportunities to provide appropriate guidance. The expert panel (III) reinforced these findings, reaching consensus on the importance of person-centred aspects of recovery-oriented practices when caring for people with mental ill-health and emphasising active, non-judgmental listening and transparent communication as central to recovery-oriented practices in general ED care. These practices were seen as essential for facilitating participation and aligning care with patients' preferences. The expert panel also underscored the importance of strength-based aspects, such as treating patients with mental ill-health with respect and seriousness. Other aspects of recovery-oriented practices that were identified included recognising the person behind the diagnosis, valuing the patient's self-knowledge and empowering patients to trust their own experiences.

While the advantages of these practices are clear, the findings also highlight challenges within ED settings that may negatively impact mental health recovery, related to the *lack* of recognition of patients' knowledge and experiences. People with mental ill-health (I) often struggle to be seen as knowledgeable about their own health, frequently facing scepticism or dismissal from ED nursing staff regarding their symptoms. In some cases, the interviewees reported experiences in which their physical symptoms were mistakenly attributed to mental health issues. Conversely, the described ED nursing staff sometimes focused solely on their physical symptoms, avoiding addressing their mental health concerns. This was perceived as a sign of the staff member's discomfort or an unwillingness to complicate situations that could otherwise be seen as straightforward. However, such avoidance could result in them receiving inadequate care or being sent home with unresolved issues. As a result, some of them brought friends or relatives with them to the ED for advocacy. People seeking help for self-harm injuries described encounters with judgmental ED nursing staff who blamed them, dismissing their actions as foolish. Others reported that the staff turned away from them and addressed their companions instead. The interviewees emphasised that the ED nursing staff's lack of training in and knowledge of mental health made it difficult to communicate with them and feel understood. From the perspective of the interviewed ED nursing staff (II), there was an acknowledgment that patients

with mental ill-health were often treated disrespectfully in the ED, with their concerns being dismissed or even ridiculed. This attitude was seen as a risk for misdiagnosis and inadequate care. Still, some ED nursing staff reported viewing patients with mental ill-health as unpredictable, unreliable or manipulative, while simultaneously recognising that their own knowledge gaps and biases may contribute to these perceptions. Others recognised that mental health care was often deprioritised compared with other medical concerns, reflecting the lower status of these patients in the ED. Moreover, some of the ED nursing staff expressed uncertainty or a lack of interest in mental health care, often opting to focus on physical health issues, which they perceived as less demanding and offering clearer guidelines and outcomes. There were instances in which the ED nursing staff did not inquire about mental health concerns, even if they suspected these to be the underlying cause of a patient's physical symptoms, especially in situations where no medical issue was found. The interviewed ED nursing staff suggested that it was not their responsibility or that they lacked the time for such inquiries, viewing their primary role as being to address acute physical health issues. Limited knowledge, time, resources and organisational constraints were further identified by the ED nursing staff as barriers to providing appropriate and tailored care for patients with mental ill-health. Although the staff expressed a commitment to being attentive, they often felt constrained by these limitations. In line with these findings, the expert panel (III) did not reach a consensus on whether ED nursing staff should be equally responsible for patients' mental and physical well-being, or whether care should be customised to address specific needs rather than relying on generalisations. However, the experts reiterated that avoiding diminishing actions, moralising and blame is essential in recovery-oriented practices within the ED.

Kindness

From the patients' perspective (I), the findings suggest how ED nursing staff can support mental health recovery through kindness manifested in small caring actions. The interviewed people with experience of mental ill-health emphasised the importance of genuine encounters with staff who were perceived as present and kind, treating them as a person rather than just a diagnosis. They also praised 'courageous' ED nursing staff who interacted with them on a personal, human

level. ED nursing staff who introduced themselves by name, made eye contact, engaged in casual conversation, shared a laugh or showed warmth and compassion were perceived as helpful. Subtle gestures, such as body language, tone of voice and word choice, were also described as making a significant difference in vulnerable situations, whether encouraging or discouraging. Furthermore, the interviewees appreciated when ED nursing staff recognised them from previous visits, knowing that important details from past interactions were remembered. Small caring actions were highly valued, such as ED nursing staff checking in regularly, ensuring comfort, conveying hope in difficult situations or accommodating personal preferences. The interviewees expressed their particular appreciation of staff who stayed in the room not just to perform tasks but to connect on a personal level. Similarly, the interviewed ED nursing staff (II) who felt confident in caring for patients with mental ill-health emphasised the importance of making even brief interactions meaningful, viewing moments when they could be present and attentive to the patient as valuable. Initially focused on the technical and medical aspects of care, the experienced staff came to recognise the value of what they referred to as the 'smaller things', such as giving time, listening and validating patients. Some ED nursing staff also reported being prepared to make exceptions to certain unit policies or routines if they assessed that it would benefit the patient, based on their own judgment. These confident ED nursing staff described having established relationships with patients who frequently visited the ED; they recognised that gestures such as sharing a cup of coffee or offering a hug could significantly affect these patients' experiences and contribute to their well-being. The ED nursing staff stressed the importance of connecting with patients as fellow human beings, rather than acting like impersonal 'care robots'. The expert panel (III) reached a consensus on the importance of collaborative aspects in recovery-oriented practice in ED settings, emphasising the need for honest communication from ED nursing staff, along with authenticity, genuine interest and empathy. They agreed that conveying hope and performing small caring actions were impactful in patient interactions. However, the expert panel did not reach a consensus on the importance of building relationships with patients and reflected differing views on this aspect of care.

Nevertheless, the findings also reveal instances of a lack of kindness and attentiveness within ED settings which may negatively impact mental health recovery. Specifically, the interviewed people with experience of mental ill-health (I) reported encounters with ED nursing staff who did not listen or seemed distracted. Instances of harsh or rude conduct by ED nursing staff were reported and perceived as especially harmful during episodes of mental ill-health; the patients emphasised the need for kindness and gentleness in these situations. When struggling with their mental health, the patients also described being more sensitive to stress and to the hurried actions of ED nursing staff. Stressed staff were perceived as absent-minded, more impersonal and often working on 'autopilot'. As a result, the patients worried about omitting important information because the staff seemed too rushed to listen. Some even reported feeling criticised for seeking care. The interviewed ED nursing staff (II) observed variability among their colleagues in prioritising care for patients with mental ill-health, with some avoiding interactions due to feelings of uncertainty and discomfort. ED nursing staff who felt uneasy or uncertain when interacting with patients experiencing mental ill-health often viewed these interactions as more complex and demanding than interactions with patients with physical health issues. These nursing staff expressed uncertainty about what to say or do, fearing that they might unintentionally upset the patient or worsen the situation. Some staff members also reported feeling anxious about potential risks, believing that certain patients with mental ill-health could be dangerous. They expressed a need to always be prepared for unforeseen situations, especially when interacting with patients they perceived as 'outspoken'. In these situations, the interviewed ED nursing staff reported sometimes feeling compelled to be firm, raise their voices and make it clear that the patient's behaviour was unacceptable. They also tended to keep a physical distance from patients they considered unpredictable. The ED nursing staff also reported differences in how these situations were handled by their colleagues. While some staff would 'flare up' and respond to patients in a hostile manner, others were more inclined to adapt to the patient and the circumstances, finding ways to manage the situation more calmly.

Knowledge-sharing

The findings suggest that ED nursing staff can support mental health recovery through knowledge-sharing and learning from patient encounters. The interviewed ED nursing staff (II) observed that their colleagues' attitudes towards patients with mental ill-health influenced their care, both positively and negatively. Some ED nursing staff described encounters with patients with mental ill-health as particularly meaningful and personally rewarding. They described the situation as an opportunity to learn from patients' different experiences and considered this to contribute to their personal and professional growth. This aligns with the accounts from the interviewed people with experience of mental ill-health (I), who noted that when ED nursing staff genuinely listened, it not only fostered a sense of safety but also facilitated an exchange of insights. They felt their knowledge about themselves was valued alongside the staff's expertise, which strengthened their confidence in the care. This attentiveness made them feel respected and empowered to participate in decisions, describing the experience as a collaborative process with skilled professionals who recognised and valued their perspectives. The ED nursing staff who prioritised patients experiencing mental ill-health often faced dissatisfaction and a lack of support from peers who did not share the same focus, although some colleagues expressed relief that someone with the 'aptitude and skills' to care for these patients took on the responsibility.

However, with experience, many of the ED nursing staff learned to disregard their colleagues' frustrations and focus on patient needs, growing more confident in managing their time and interactions in the ED. Less-experienced ED nursing staff emphasised the importance of support from seasoned colleagues, especially in difficult situations. They found informal reflections on patient situations – such as discussions in the staff room or at the nurses' station – valuable. Still, such reflections were often limited by heavy workloads, which sometimes resulted in staff privately reflecting on work situations at home, as formal reflection time was not prioritised due to the urgency of patient care demands. Some of the interviewed ED nursing staff believed that allocating dedicated time for reflection could enhance mutual support by enabling them to learn from each other's experiences and improve their practices. The expert panel (III) reached a

consensus on the importance of reflective aspects in recovery-oriented practice in ED settings, such as the need for ED nursing staff to actively address mental health stigmas and promote a positive approach through ongoing knowledge-sharing and learning from experiences.

The interviewed ED nursing staff (registered nurses) (II) pointed out gaps in their undergraduate education, noting limited training in psychiatric and mental health nursing and a lack of focus on acute mental health care. While clinical placements in psychiatric care were beneficial, many still felt unprepared, describing their early ED experiences caring for patients with mental ill-health as 'learning by doing'. Continuing education and training in acute mental health care were often deprioritised in the ED, where the primary focus remained on acute physical health and life-saving measures. Some ED nursing staff considered their responsibility for acute mental health care to be limited, feeling that it ended with arranging a room for the patient and calling psychiatric staff. Others, however, expressed a desire for more knowledge and understanding in order to better support patients with mental ill-health. The expert panel (III) reached a consensus on the importance of ED nursing staff building professional self-confidence, prioritising interpersonal skills training, and fostering collaboration with psychiatric units to enable the integration of a recovery-oriented practice.

Discussion

The overall aim of this thesis was to generate knowledge on how nursing staff in general emergency care can support the mental health recovery of people with mental ill-health. This thesis identifies three values as central to guiding nursing staff in supporting mental health recovery through recovery-oriented practices in general ED settings: *recognition* of patients' experiences and self-knowledge; *kindness*, manifested through small caring actions; and *knowledge-sharing*, which emphasises the recognition and integration of the ED nursing staff's experience-based and practical knowledge, alongside the opportunities to learn from patient encounters. The following sections address and discuss these values in relation to the concepts of epistemic justice, embodying kindness (which is not contrasted with another concept but rather deepened), and reflective practice. I have chosen to focus on these specific concepts not only because they can be understood to align with recovery-oriented practices but also because they reflect specific areas of challenges and opportunities for both patients and nursing staff in ED settings. While I do not believe that everything can be attributed to epistemic justice/injustice, kindness/lack of kindness, or reflective practice/the lack thereof, these concepts can assist in understanding and explaining the findings. By addressing issues related to epistemic justice, embodying kindness, and reflective practice, this thesis provides insights that can increase the ability of ED nursing staff to support patients' mental health recovery in a meaningful way.

Epistemic justice

The findings suggest that ED nursing staff can support mental health recovery through epistemic *recognition* of patients, which involves acknowledging and valuing patients' self-knowledge, experiences and contributions as essential to understanding and problem-solving. This approach can be understood as aligning with the foundations of mental health recovery, which highlight the importance of empowerment, hope and identity (Leamy et al., 2011; Bird et al., 2014). The findings further suggest that person-centred and strength-based aspects of care for people with mental ill-health, grounded in non-judgmental listening and treating people with respect and seriousness, are essential for recovery-oriented practice in general ED settings. Such practices may promote epistemic justice –

an area of growing interest in healthcare. However, this positive ideal of epistemic justice is still far less researched than its counterpart, epistemic *in*justice, which is often the primary focus in research (Kidd et al., 2022).

The concept of epistemic injustice was coined by the philosopher Miranda Fricker (2007) and is defined as harm done to an individual in their capacity as a knower – that is, as someone making contributions by offering their opinions, interpretations and knowledge. Fricker (2007) identifies two kinds of injustices: *testimonial* and *hermeneutical* injustice. In *testimonial* injustice, negative prejudices and biases cause a listener to unfairly diminish a speaker's credibility as a knower. This bias can make the listener view the speaker's account as less competent or sincere, leading to distrust. More specifically, patients' stories may be disbelieved, their requests ignored, or their perspectives excluded (Fricker, 2007; Carel, 2023). *Hermeneutical* injustice occurs when people are unable to make sense of their experiences because there is no common way to understand or explain them within the dominant framework. In this case, patients' experiences can be misunderstood or undervalued if they, for example, use words or explanations that do not fit the predominant medical language (Kidd & Carel, 2017). Crichton et al. (2017) state that people with severe mental ill-health are particularly vulnerable to testimonial and hermeneutic injustice as described by Fricker, due to entrenched negative stereotypes and poor public understanding of mental ill-health, reinforced by problematic media representations. These injustices may also be linked back to those addressed by the recovery movement, which has long sought to address power imbalances, stigmas and epistemic considerations in society and healthcare (Davidson, 2016).

The findings reveal several challenges faced by people with mental ill-health in ED care, which may relate to both types of epistemic injustices. Examples of testimonial injustices described by the interviewed people with experiences of mental ill-health included reporting scepticism and dismissal from staff, struggling to be recognised as knowledgeable about their own health issues and experiencing being labelled as a 'psychiatric' patient regardless of the reason for seeking ED care. When seeking care for physical health concerns, the interviewees described observing shifts in staff's attention or attitudes upon learning of their psychiatric diagnosis, which resulted in their concerns not being

taken seriously. The interviewed ED nursing staff echoed these experiences, expressing an awareness that patients with mental ill-health risk being treated disrespectfully, having their concerns dismissed or even being ridiculed in the ED. The ED nursing staff recognised the prejudices and stigma surrounding mental ill-health in the ED as a potential risk for misdiagnosis and inadequate care.

Examples of hermeneutical injustice described by the interviewed people with experiences of mental ill-health included perceiving a lack of mental health knowledge among staff, which created communication barriers and challenges in being understood. Similarly, the interviewed ED nursing staff acknowledged their limited knowledge in this area and expressed uncertainty – or even reluctance – to address mental health concerns in the ED, feeling unprepared and therefore avoiding conversations related to mental health. This pattern may exacerbate both testimonial and hermeneutical injustices by limiting opportunities for patients to share their experiences in ways that reflect their perspectives. When people experience negative interactions and injustices of this kind, it can lead to a loss of confidence in their ability to be seen as a credible source of knowledge (Fricker, 2007). This can happen in the form of losing confidence in their own beliefs or – even worse – in their intellectual ability to form beliefs. The findings provide examples of this, as the interviewed people with experiences of mental ill-health described becoming discouraged, doubting themselves and beginning to think that the problem might be 'all in their head'.

Fricker (2007) argues that, because epistemic injustices – especially testimonial injustices – stem from ingrained identity-based prejudices, we all have a responsibility to critically examine our own biases. Reflective awareness is essential to reduce such biases, as it helps us shift from unexamined reactions to more thoughtful assessments and interactions. Della Croce (2023) adds that, although raising awareness of epistemic injustice among staff is necessary, it is insufficient on its own; actively promoting epistemic *justice* is crucial to address these prejudices. Shared decision-making processes offer a potential path to overcoming epistemic barriers by ensuring that patients' voices are fully acknowledged and integrated into their own care (Grim et al., 2019; Galasinski et al., 2023). By inviting patients to become collaborative partners who share

views, preferences and priorities, the healthcare system can embody epistemic justice through mutual respect and balanced contributions (Grim et al., 2019; Galasinski et al., 2023). This perspective aligns with the findings of this thesis, as the interviewed people with experiences of mental ill-health emphasised the importance of being treated as equals and being involved in decisions by staff seeking their input. The findings further suggest that ED nursing staff who described themselves as confident in caring for patients with mental ill-health acknowledged the importance of attentive listening, dedicating time and addressing patient's needs – whether mental or physical. These nursing staff members observed that the effort to understand patients' unique situations helped the patients feel recognised and validated, fostering a supportive relationship that allowed the staff to provide more appropriate guidance. This finding aligns with Shah et al.'s (2023) assertion that relational care is fundamental in addressing epistemic injustice, highlighting that ethical practice in healthcare is rooted in the quality of interactions and mutual understanding.

Embodying kindness

Expanding on the importance of relational care, the findings suggest that ED nursing staff can support mental health recovery and promote epistemic justice by embodying kindness through small caring actions and by treating each patient as a unique individual with attentiveness and presence. This approach aligns closely with the foundations of mental health recovery, which emphasise inclusion, connection and meaningful interactions that foster hope (Leamy et al., 2011; Bird et al., 2014). Furthermore, the thesis findings emphasise qualities such as authenticity, honesty, genuineness and empathy as essential in recovery-oriented practices within general ED care, serving as means to strengthen trust and collaboration in care.

According to Ballat et al. (2020), kindness is more than a 'nice' side issue of care; it is the essence or 'glue' that fosters collaboration. Rooted in the concept of kinship, kindness draws upon our shared humanity and the inherent responsibilities we have towards one another (Campling, 2015). Kindness, which is closely linked to compassion and civility, encompasses attentive listening to patients' concerns and responding to their needs in a warm and respectful manner

(Gage, 2022). While 'kindness' is often used interchangeably with terms such as 'compassion' and 'empathy', there are differences between these concepts (Jesudason, 2022). *Empathy* can be referred to as the ability to understand and share another person's feelings, putting oneself in their shoes. *Compassion*, literally meaning 'to suffer with', involves not only shared distress and a sense of solidarity but also a call to action (Malenfant et al., 2022). In comparison, kindness has more of an emphasis on practical, everyday actions; in a healthcare setting, such actions serve to maintain a respectful and dignified atmosphere for patients. Thus, kindness has been suggested to have a practical, everyday quality that goes beyond the mere alleviation of suffering (Jesudasson, 2022). Adding to this, Campling (2015) suggests 'intelligent' kindness involves turning intention into action and fostering collaboration to integrate this awareness into daily routines. Furthermore, that intelligent kindness is neither a sentimental gesture nor a superficial response but a unifying, creative force in healthcare that encourages problem-solving and fosters goodwill. In everyday practice, expressions of kindness can range from 'small acts of kindness' to more complex, systematic initiatives (Ballat et al., 2020).

While the importance of kindness in ED care seems evident, it is essential to recognise that relational dynamics within these settings can complicate these interactions. According to Ballat et al. (2020) there is a tendency to define ourselves in opposition to others, which often causes us to narrow our sense of kinship to particular social groups. This sense of profound difference or 'otherness' can shape attitudes, particularly towards people with mental ill-health, who may be perceived as outside one's social boundaries and responsibilities.

The thesis findings identify several challenges associated with this dynamic, as the interviewed people with experience of mental ill-health frequently reported feeling dismissed, judged or treated differently in the ED. Fear of being judged or receiving different treatment sometimes led patients to withhold information about their mental health, even when they believed it could be relevant to their care. 'Small things', such as word choice, a questioning glance from staff, or lack of recognition, were perceived to influence how they felt treated and whether they would disclose their mental ill-health. Experiences of harsh, rude, or critical treatment from staff who seemed distracted or unwilling to listen were described

as particularly harmful during struggles with mental ill-health. The ED nursing staff conveyed a different perspective, citing uncertainty about how to approach patients with mental ill-health and noting that this discomfort sometimes led them to avoid interactions. The staff also mentioned constraints such as high workloads, limited resources and unit policies, which made it challenging to provide the attentive, person-centred care they knew was needed. For some nursing staff, the ED environment fostered an attitude of resignation towards mental health issues, further complicating interactions based on kindness and compassion.

Research shows that, despite constraints in time and resources, staff can still forge meaningful connections through their manner, tone, intention, and presence, even in brief interactions with patients (Malenfant et al., 2022). Grant and Brisco (2002) emphasise that *how* care is provided is more important than *how long*. This was further supported by the thesis findings, where some of the interviewed ED nursing staff highlighted the significance of making short interactions meaningful by being present and attentive. The interviewed people with experiences of mental ill-health also described how simple, attentive gestures from the ED nursing staff, such as introducing themselves, making eye contact, or sharing moments of warmth or laughter, fostered a sense of being seen and respected. Thus, created an environment where they felt safe to share their experiences openly and without judgment. Skorpen et al. (2015) suggest that what may seem ordinary to staff can feel extraordinary to patients, and that neglecting these small details can undermine patients' dignity. Similarly, Topor et al. (2018) note that such 'small things' play a crucial role in helping those with mental ill-health to rebuild a positive sense of self and to promote mental health recovery. Furthermore, that these gestures convey shared humanity and hope, offering meaningful reassurance to people in distress. According to Borg and Kristiansen (2004, p. 499), small acts can 'make the individual feel both more human and valuable, a person who means something to someone else.' However, if these actions lack kindness, they can conversely contribute to stigma (Topor et al., 2018), reinforcing negative perceptions and undermining the dignity of those they intend to help (Skorpen et al., 2015).

According to Shah et al. (2023), addressing epistemic injustice through relational care requires open dialogue among staff about shared values and their practical application, with a particular focus on staff-patient relationships. For ED nursing staff, cultivating an awareness of the impact of kindness and small caring actions in their everyday interactions, however brief, is essential. This awareness can enable staff to create a more trusting and dignified environment, empowering patients to express their needs and concerns openly.

Reflective practice

Building on the importance of epistemic justice and embodying kindness in ED settings to support mental health recovery for people with mental ill-health, there is a need for ED nursing staff to increase their awareness of these concepts. The findings of this thesis emphasise reflective aspects of care, such as knowledge-sharing and learning from experiences, as essential for addressing mental health stigmas and promoting a positive approach among ED nursing staff when caring for patients with mental ill-health. ED nursing staff need opportunities to reflect on their practices and examine how conscious or unconscious biases, prejudices, and other factors may influence their care. Engaging in reflective practice can empower staff to address these issues.

Reflective practice is considered to be at the core of nursing education and practice, serving as a means for the continuous improvement of knowledge (Patel and Metersky, 2021). Defined by Patel and Metersky (2021), reflective practice is a cognitive skill that requires conscious effort to examine situations with awareness of one's own beliefs, values, and practices. This approach enables nursing staff to learn from their experiences and apply that learning to enhance patient care. Reflective practice integrates theory and practice, forming a foundation for personal and professional development while supporting person-centred care (Gabrielsson et al., 2016; Goulet et al., 2016). The concept of reflective practice was first introduced by organisational theorist and researcher Donald Schön, who drew inspiration from educator John Dewey. According to Schön (1983), reflective practice involves adapting to situations, especially those that are uncertain, unique and conflicting. Schön's theory encompasses two types of reflection: 'reflection-in-action' and 'reflection-on-action.' *Reflection-in-action*

involves reflecting during a situation as it unfolds, questioning initial understandings, constructing new insights, and testing them, while *reflection-on-action* refers to the process of reviewing, analysing and evaluating a situation afterward. Schön argues that reflective practice can help healthcare staff to become aware of their tacit knowledge base and learn from their experiences. Ultimately, reflective practice seeks to validate the knowledge, skills, and experiences used in practice, recognizing these elements as valuable components of learning (Thompson & Pascal, 2012).

In alignment with this, the thesis findings suggest the need to recognise and acknowledge the practical knowledge that ED nursing staff possess, as well as to create opportunities for them to articulate their experiences and share insights with one another. This approach can not only empower ED nursing staff in their current practices but also assist colleagues who feel uncertain when interacting with patients experiencing mental ill-health, thereby building confidence and enhancing their ability to provide appropriate support to these patients. Sherwood et al. (2018) suggest that reflective practice fosters positive engagement, allowing nursing staff to value their work while identifying areas of concern. Similarly, Oelofsen (2012) emphasizes that reflection is marked not only by 'curiosity' but also by a 'questioning stance' towards established practices and assumptions. Reflective practice, therefore, can support ED nursing staff not only in enhancing their skills but also in aligning their actions with their personal convictions. This is consistent with the experiences of some ED nursing staff who, feeling confident in their approach to mental health care, chose to prioritise time for these patients, even when they faced dissatisfaction or a lack of support from peers who were less focused on this priority.

Additionally, the ED nursing staff described interactions with patients as opportunities to learn from their diverse experiences, contributing to both personal and professional growth. Thus, the findings suggest that knowledge-sharing should encompass not only exchanges among nursing staff but also learning from patients' experiences to enrich staff understanding of how to best support them. Research on stigma-reduction interventions clearly demonstrates that social contact between people with and without lived experiences of mental ill-health is the most effective way to reduce stigma (Thornicroft et al., 2022).

Some of the interviewed nursing staff expressed a desire for dedicated time for formal reflection as a means to support one another and enhance their professional development. However, they noted that this need was often deprioritised due to high workloads and the urgency of patient care demands. According to Thompson and Pascal (2012), staff frequently assert that time constraints and work pressures make reflection an unrealistic goal. They argue, however, that this perspective is shortsighted; in fact, the busier we become, the more essential it is to engage in reflective practice. The greater the pressure we are under, the more we need to understand what we are doing, why we are doing it, and what knowledge is available to help us do it in the best possible way.

In summary, this thesis identifies the importance of ED nursing staff's role in promoting epistemic justice through kindness and reflective practice to integrate recovery-oriented practice in general ED settings. Both nursing staff and managers share the responsibility of creating opportunities for such practices. Managers must foster an organisational environment that prioritises and supports reflective practice by implementing policies that provide dedicated time and resources. Meanwhile, ED nursing staff have a responsibility to actively engage with these opportunities when offered. This collaborative effort can lead to optimised care that supports the mental health recovery of people with mental ill-health.

Methodological considerations

The initial plan

Conducting research within clinical practice is a delicate matter. With an empirically extensive project, problems can arise, especially when the world is struck by a pandemic. Initially, this PhD project consisted of four studies. The plan for Studies III and IV was to evaluate the feasibility of an intervention with a focus on structured reflection as a support for recovery-oriented practices in general EDs. To prepare for this, I completed a course in complex interventions at Lund University in March 2020 and participated in recovery-oriented reflection groups for mental healthcare, with the aim of learning how to lead them. The intervention was scheduled to begin in the spring of 2020, which coincided with the onset of the COVID-19 pandemic. On the day of the first meeting with the ED nursing staff participating in the intervention, we received a message from the unit manager stating that the staff was unable to participate under the current circumstances, and everything was cancelled. Once the pandemic subsided, we planned to make another attempt to evaluate the intervention. After receiving approval from the Swedish Ethical Review Authority in December 2021, which addressed a change in the study site, the re-recruitment of ED nursing staff began. The recruitment process included informing nursingstaff about the study at a workplace meeting, distributing written material and putting up posters in the ED staffroom. Unfortunately, we were unable to recruit enough participants to carry out the intervention. According to the unit managers, the ED nursing staff members were worn out after dealing with the worst effects of the pandemic; moreover, several internal training courses were taking place at the ED at the same time. This necessitated a rethink and the development of a new plan for the PhD project. Our ambition was to transition from the *what* to the *how*, by specifically addressing how nursing staff in general EDs can support recovery in people with mental ill-health. Therefore, we decided to conduct a Delphi study involving experts in the field. This study addressed the same fundamental question as the originally planned studies but in a way that was practically feasible. Ultimately, this change may have led to an approach even more beneficial than initially planned, as the studies

included in this thesis can lay the groundwork for the future planning, development and implementation of interventions in general ED care aimed at optimising care for people with mental ill-health and supporting recovery through recovery-oriented practices.

The qualitative studies

Qualitative methods stem from the humanistic tradition, which is philosophically grounded in the belief that people construct their own subjective reality. Thus, such methods focus on understanding phenomena from the participants' perspective, emphasising that there is no absolute truth, nor is there anything incorrect in an experience or perception (Patel & Davidsson, 2019). In the qualitative studies included in this thesis, we aimed to describe the lived experiences of people with mental ill-health and of ED nursing staff, focusing on their personal perspectives within the specific contexts in which their experiences unfolded. "Qualitative inquiry cultivates the most useful of all human capacities – the capacity to learn from others" (Patton, 1990, p. 7).

Both Study I and Study II employed qualitative designs based on interviews analysed using qualitative content analysis. These studies are reported according to the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (Tong et al., 2007). The participant selection and data collection methods were deemed appropriate for the aims of both studies, which strengthens their credibility. The richness and depth of the interview data, which captured a variety of experiences, further enhances the credibility of these studies, although women were overrepresented in both studies.

Study I focused on patients' experiences and included participants of varying ages with self-reported mental ill-health. It is important to note that the participants were recruited through staff working in psychiatric outpatient care, who primarily meet people with severe mental health conditions or psychiatric diagnoses, as reflected in the self-reported data. This recruitment method may have influenced the findings, given our aim to explore how general EDs address mental health from a broad perspective encompassing both identified and unidentified mental health issues. However, the experiences reported by the participants did not always indicate whether they sought emergency care before or after receiving a

formal psychiatric diagnosis. Furthermore, recruiting people with unidentified mental health issues may have posed additional challenges – hence the practical decision to utilise psychiatric care staff for recruitment. In Study I, we also considered the possibility of recall bias in the participants' experiences reported 16 years later. However, these experiences were likely significant enough to be remembered clearly. The older experiences did not seem to stand out compared with the more recent ones and were equally included in the study.

Study II focused on the experiences of ED nursing staff and included a diverse range of participants in terms of age, gender and experience in acute care. Both RNs and ENs were included in the study, as they often work together in teams in the ED and are involved in direct patient care. However, there may be differences in their responsibilities and roles, which the reader should consider when applying these findings to other contexts.

To enhance the dependability of the studies, all authors actively participated in the analysis processes in Studies I and II, engaging in discussions and reflections that facilitated the co-creation of interpretations. Throughout the research process, we maintained a critical awareness of any preunderstandings that could influence the formulation of interview questions and the interpretation of participants' experiences. This collaborative approach was essential, as diverse perspectives among the authors allowed for alternative interpretations and consensus building. We recognise, following Krippendorff (2013), that texts can convey multiple meanings; thus, our presented interpretations reflect what we believe to be the most probable meanings derived from the data. While we refrained from specifying the occupational categories of the general emergency care staff discussed by the participants in Study I, an approach that might be viewed as a limitation, our primary goal was to illuminate the interpersonal encounters between individuals rather than to compare patient experiences across different professional roles. By equally including all general emergency care staff involved in patient care, we aimed to achieve a more holistic understanding of the participants' experiences. To prioritise the participants' voices and bolster the dependability of our findings, representative quotations were included under each subtheme in both studies. We have carefully described the study context and

participant selection, leaving it to the reader to determine the transferability of our findings to other contexts.

The Delphi study

The Delphi method, with its constructivist nature, functions as a heuristic tool that draws on expert opinions. The goal is not to uncover an objective truth but to negotiate a shared understanding and co-create knowledge through consensus. However, the outcomes of a Delphi study are only as reliable as the quality of the available evidence and the expertise of the participants (Jünger et al., 2017). The Delphi method is inherently pragmatic and recognises the importance of implicit or tacit knowledge (e.g. clinical experience), which may not be directly accessible through clinical trials (Greenhalgh et al., 2014; Jünger et al., 2017). As Kahlil Gibran noted, "It takes two of us to create a truth – one to utter it and one to understand it" (Gibran, 1926, p. 17).

Study III employed a modified Delphi survey that was conducted over three rounds. The modification involved focus group interviews in the initial round, followed by questionnaires in subsequent rounds. Data from the focus group interviews were analysed using reflexive thematic analysis, in line with Braun and Clarke (2022). The questionnaire data were analysed using descriptive statistics. To ensure methodological rigor, the study adhered to the Conducting and REporting of DElphi Studies (CREDES) guidelines (Jünger et al., 2017).

The selection of participants and data collection methods were considered appropriate for the study's aim, thereby enhancing its *credibility*. In the absence of clear guidelines, the sample size of 24 stakeholders – chosen for their varied experiences and professional backgrounds – was deemed suitable based on the study's aim and design. This approach ensured the capture of a diversity of relevant perspectives on the topic (Keeney et al., 2011). Treating the expert panel as a homogeneous group during the analysis fostered the development of solutions grounded in theoretical, practical and experiential knowledge, thereby increasing the relevance of the Delphi process (Niederberger & Köberich, 2021). A strength of this sample size was its ability to encourage strong participant engagement, particularly through

focus group discussions and follow-up communication via email. This engagement was vital in reducing participant dropout across all study rounds.

Reflexivity, including the consideration of personal preconceptions, is a crucial aspect of thematic analysis (Braun & Clarke, 2022). To enhance *dependability* and *confirmability*, all authors were actively involved in the analytical process, engaging in reflective discussions to ensure a thorough examination of the data. This collaborative approach facilitated the co-creation of interpretations and ensured that the findings accurately reflected the experts' views. As far as possible, we maintained the original wording and formulations used by the participants when constructing statements for the development of the questionnaire used in subsequent rounds. The expert panel was also given the opportunity to provide open-text feedback in the questionnaires to express opinions about the existing statements or suggest the addition of statements, although no additional statements were suggested. The feedback from the open-text sections is summarised in the findings section of the study and reflected on in the discussion section.

For the quantitative rounds, we considered face validity, internal validity and external validity (Holmberg & Svensson, 2023). *Face validity* was addressed by pre-testing the questionnaire to identify any issues related to clarity, relevance or ambiguity. The pre-test led to a few minor adjustments, including rewording for clarity and the removal of statements deemed too similar. *Internal validity* was reflected by the high response rate, with only one participant dropping out in the final round. Regarding *external validity*, it is important to note that achieving consensus in a Delphi study does not necessarily equate to identifying the 'correct' opinion (Hasson et al., 2000). Nevertheless, our findings highlight aspects of ED care that support mental health recovery deemed important by the expert panel, providing a solid foundation for further exploration. While our predetermined consensus threshold was set at ≥80% agreement on specific statements, potential limitations exist with this threshold, as no definitive guidelines are established in the literature (Hasson et al., 2000; Keeney et al., 2011). Adjusting the consensus level or converting the 5-point Likert scale into a 3-point scale in the analysis might have influenced the outcomes, as many statements received high ratings without achieving full consensus. However, our decision to maintain these criteria

allowed us to focus on the most significant aspects of recovery-oriented practices within the study's context. Additionally, we acknowledge the potential impact of statement phrasing on the positivity of responses (Hasson et al., 2000). To address this, we transparently presented all statements in the study, including those that did not reach consensus, allowing readers to assess both the wording and the levels of agreement achieved.

Conclusions

In conclusion, this thesis demonstrates that discussing mental health recovery is meaningful within the context of general emergency care. By prioritizing recognition, kindness, and knowledge-sharing, ED nursing staff can support mental health recovery in people with mental ill-health through recovery-oriented practices in this context. Such practices not only promote epistemic justice but also emphasise the importance of a deeper understanding of kindness and the need for reflective practice.

Epistemic justice can be pursued by recognizing patients' self-knowledge and experiences as credible and essential within general ED care settings. Kindness, manifested through small caring actions, is fundamental to fostering collaboration between ED nursing staff and patients, helping to counteract feelings of 'otherness' and creating an inclusive, respectful environment. Reflective practice can support and empower ED nursing staff by encouraging awareness of their practice and knowledge-sharing. Through reflection, ED nursing staff are given opportunities to question assumptions, learn from experiences, and build greater confidence in providing mental health care.

This continuous process of awareness and learning can contribute to cultivating an ED environment where epistemic justice, embodying kindness, and reflective practice are foundational to supporting mental health recovery in patients with mental ill-health. To optimize ED care, it is crucial to strive for a practice that ensures every person, regardless of their health condition, is treated with dignity and respect.

Clinical implications

The clinical implications of this thesis concern the role played by nursing staff in supporting mental health recovery in patients with mental ill-health in general ED settings. The findings from the studies included suggest the following clinical implications:

(1) *Structured reflection* can provide ED nursing staff with a systematic framework for examining patient interactions and recognizing their own beliefs, values, and practices. This process can not only promote learning from experiences and knowledge-sharing but also encourage staff to appreciate their contributions to patient care, creating a positive sense of engagement in their work. Additionally, it can help identify areas for improvement. Managers in ED settings play a critical role in facilitating and supporting structured reflection by ensuring that staff have access to the necessary resources and time, thereby fostering an environment where continuous learning and professional development can thrive. Suggestions for promoting reflection are listed below:

- **Co-facilitated reflection.** Organize reflection groups, workshops, or shared reflection sessions that include people with lived experience of mental ill-health and specialist nurses in psychiatric and mental health care as facilitators or co-facilitators alongside ED nursing staff. This approach promotes a collaborative environment where diverse perspectives can be valued and discussed.
- **Feedback opportunities.** Organise feedback opportunities in which patients can share their perspectives on care received in the ED, thus helping nursing staff reflect on their practices and improve their interactions with patients.
- **Peer-support programmes.** Implement peer-support initiatives in which people with lived experience, for example, can mentor ED nursing staff, providing guidance on how to approach patients with mental ill-health.

(2) *Educational initiatives* may play a crucial role in enhancing the knowledge and skills of ED nursing staff in mental health care. By providing targeted training programmes, workshops and seminars, these initiatives may equip staff with knowledge on mental ill-health, mental health recovery and recovery-oriented practice and foster a deeper awareness and understanding of the importance of epistemic justice, kindness and reflection in such practices. These initiatives can

also create opportunities for staff to share their experiences and insights, fostering a collaborative learning environment. Moreover, educational initiatives can help address biases, enabling staff to provide more appropriate care for patients with mental ill-health. Suggestions for promoting educational initiatives are listed below:

- **Educational contributions.** Invite people with lived experience and specialist nurses in psychiatric and mental health care to contribute to training modules focused on mental health in collaboration with ED nursing staff. They can serve as guest speakers, conduct workshops, or participate in the evaluation of educational initiatives, using their insights to refine and enhance future training programmes.
- **Mentorship programmes.** Establish mentorship programmes in which people with lived experience and specialist nurses in psychiatric and mental health care can mentor ED nursing staff, helping them navigate perceived challenges in mental health care.

(3) *Policy changes* can foster continuous improvement in ED settings regarding mental health care. By prioritising epistemic justice, kindness and reflective practice, frameworks can be created to guide and empower ED nursing staff to address both mental and physical health in care delivery. These policies must emphasise the importance of mental health education alongside physical health training, ensuring staff are equipped to address the unique needs of patients with mental health challenges. Suggestions for promoting policy changes are listed below:

- **Advisory committees.** Establish advisory committees that include people with lived experience and specialist nurses in psychiatric and mental health care. These committees could collaborate with ED nursing staff and managers to inform policy development, review existing policies, recommend necessary changes, and ensure that policies reflect the needs of patients with mental ill-health.

Future Research

Originally, this thesis aimed to evaluate the feasibility of recovery-oriented reflective practice groups in general ED care. However, the pandemic necessitated a shift in direction, which, in hindsight, may have been beneficial. This shift has led to valuable insights that can guide future strategies for integrating reflection into ED settings, promoting recovery-oriented practice through epistemic justice, kindness, and reflective practice. Questions have arisen about the practicalities of integrating structured reflection in a fast-paced ED environment. Future research should investigate tailored methods for integrating recovery-oriented practice into ED care, with a particular emphasis on structured reflection and educational initiatives. A collaborative approach with a diverse group of stakeholders would be essential for planning these interventions. Possible research directions are listed below:

- **Structured reflection.** To examine the possibilities of integrating structured reflection into the fast-paced ED environment. Specifically, research should focus on how this integration can be achieved while addressing the unique challenges of the ED setting, as well as how it might improve patient interactions and optimise ED care for people with mental ill-health.
- **Educational initiatives.** Targeted training programmes for ED nursing staff on mental ill-health, mental health recovery and recovery-oriented practice, can be developed and evaluated; these could include training on the importance of epistemic justice, kindness, and reflective practice.
- **Collaborative initiatives.** To investigate how collaborative initiatives can enrich educational content and provide practical insights. For example, research could explore the suggested co-facilitated reflection or educational initiatives, workshops, and mentorship programmes.
- **Development of evaluation tools:** Development of tools for evaluating emergency care environments, promoting alignment with recovery-oriented practices.

By focusing on these areas, future research can provide valuable insights into the integration of recovery-oriented practices within ED care, ultimately enhancing the support available for patients with mental ill-health.

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