

Embedding a physical health nurse consultant within mental health services: consumers perspectives

Abstract

The life expectancy of people living with mental illness is significantly shorter than that of the rest of the population. Despite the profound impact of physical health issues on both quality of life and life expectancy, the perspectives of mental health consumers have yet to be thoroughly explored. Furthermore, research has focused far more on describing barriers than on identifying solutions. This paper reports on findings from a qualitative exploratory research study with the aim to examine the potential role of a specialist nurse with advanced physical health care skills. Focus groups were conducted with 31 consumers. Data were analysed thematically. The concept of a role like this was supported; however, participants stressed: i) the importance of integration between health professionals and various components of the health care system, and, ii) the need for culture change for nurses to work from a less medically-dominated approach. Previous research literature suggests a nursing position dedicated to physical health care and coordination may produce positive outcomes for mental health

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consumers. Findings from the current research project emphasise the need for consumers to be identified as key stakeholders in a solution-focused approach to improved physical health care for mental health consumers.

Keywords

Physical health

Mental illness

Specialist nurse role

Integration

Culture change

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Introduction

Preventable physical illnesses are of higher prevalence among mental health consumers. Illnesses, particularly cardiovascular disease and diabetes, account for the drastically reduced life expectancy for people with mental illness and contribute to poor general health and reduced life expectancy (Lawrence *et al.* 2013; National Mental Health Commission 2014). Risk-behaviours for cardiovascular disease and other chronic physical illnesses are higher among people with mental illness. These include high levels of smoking, low levels of physical activity, and poor diet (Mitchell *et al.* 2015; Stanley & Laugharne 2014). At the outset these lifestyle factors, coupled with the adverse impact of medications, and amplified by social and economic marginalisation, contribute to the elevated prevalence of physical illnesses among consumers (Robson & Gray 2007). To provide an equitable standard of care to this vulnerable population, formidable systemic issues must be resolved (Robson & Gray 2007).

Consumer-specific health care services designed to prevent, manage and treat physical illnesses were consistently found to be either less accessible or of lesser quality than mainstream alternatives (Lambert &

Newcomer 2009; Lawrence & Kisely 2010). Despite these findings, research examining attitudes to the quality and availability of physical health services for mental health consumers has been confined almost exclusively to seeking the opinions of health professionals (Robson *et al.* 2013; Hyland *et al.* 2003; Wheeler *et al.* 2010). Minimal attention has been paid to the consumers who have accessed or seek to access physical health services (Chadwick *et al.* 2012). A comprehensive examination of the views of consumers regarding access and experience of physical health care is needed to guide the translation of consumer participation from a policy rhetoric into quality service delivery (Commonwealth of Australia 2013).

More recently we have observed a growth in health care strategies of improving physical health, such as lifestyle and education programs, changing medication approaches, integrating wide-ranging services within a single locale, and enhanced physical screening and referral systems (McKenna *et al.* 2014; Millar *et al.* 2014; Lorig *et al.* 2014). Despite such growth, input has rarely been sought from consumers of mental health services about what physical health services are needed and how such services might operate (Commonwealth of Australia 2013). *Where consumers have been involved their role has tended to be relatively passive,*

for example responding to surveys developed by health professionals or academics to changes in behaviour and attitude, or consumer satisfaction (Brunero & Lamont 2010; Shuel *et al.* 2010; Bradford *et al.* 2008; Brunero *et al.* 2008). Consumer involvement in research which actively seeks their views and opinions about initiatives to improve physical health is therefore vital. It is also apparent that the policy platform for mental health consumer participation within the recovery paradigm has largely excluded any reference to physical well-being.

In the rare instances that the consumer perspective about physical health has been included, the findings have been insightful, outlining the challenges for all parties and corresponding practical solutions (Schmutte *et al.* 2009; Chadwick *et al.* 2012). For example, an integrative review of barriers to physical health services by Happell, Scott and Platania-Phung (2012b) noted numerous barriers in the process of health care interaction for mental health consumers including disconnection from required physical health care services, and a sense of interpersonal neglect upon arrival at a primary health care service. The voicing of physical health problems was not taken seriously during consultations, and the uptake of any referrals was low.

Discrimination and professional siloing were central to these perceptions of disconnection to physical health care.

The creation of a physical health nurse consultant (PHNC) position is proposed here as an effective strategy to mitigate these issues to improve the monitoring and management of cardiometabolic risks (Brunero & Lamont 2009). These positions, generally referred to as Cardiometabolic Health Nurses (CHN), are specialist nursing positions, specifically designed to improve physical health services in mental health settings (McKenna *et al.* 2014; Nankivell *et al.* 2013; Happell *et al.* 2014b). Embedding this position within public mental health service provision is congruent with holistic and recovery—orientated care. Formative studies have found that nurses in mental health care have been receptive to this type of role (Happell *et al.* 2012a; Happell *et al.* 2014a).

Services provided by the PHNC would include screening, facilitation of referrals, and facilitating continuity of comprehensive physical health care, thus adopting a collaborative approach to care (Happell *et al.* 2012a). Preliminary evaluations cautiously suggest the introduction of such a nursing role may contribute to improved physical health care outcomes among

consumers. (Happell *et al.* 2012a; Happell *et al.* 2014a). It is however crucial that further research incorporates consumer perspectives on the development of a PHNC role and this proposed method of physical health care service delivery.

In a recent survey undertaken by the Australian Capital Territory, Mental Health Consumers Network (ACTMHCN) to identify the major priorities for consumers in the Australian Capital Territory (ACT), physical health was ranked third in importance. In acknowledgement of the magnitude of physical health needs for consumers of mental health services, and the absence of consumers' voices in both identifying the problem and seeking solutions. The current study explores one component of this broader agenda to seek the views and opinions of consumers regarding the introduction and implementation of a physical health care nursing position within the mental health clinical team.

Methods

Design

A qualitative exploratory design was utilised based on the work of Stebbens (2001). Qualitative exploratory research enables the detailed exploration of a topic or issue from the perspective of a particular group of participants. It is an effective approach to examining areas of importance that have not been well researched to date, and broadening the understanding of the issue by including participants who are traditionally marginalised in formal decision making processes.

Setting and recruitment

The research was undertaken in the ACT with the full support of ACTMHCN, the ACT consumer peak body which represents the interests of consumer perspective policy development and other formal decision-making forums. ACTMHCN advertised the project in their weekly bulletin for members. Participant Information and consent forms were provided on request. Prospective participants were invited to select from four dates and times for focus groups. ACTMHCN kept registration data confidential. A total of 31 adult consumers participated in the focus groups, ranging from seven to nine per group. Consumers were paid for their time as per rate and policy of the ACTMHCN.

Procedure

The ACTMHCN was selected as an ideal venue for its central location, its familiarity to many of the participants, accessibility to public transport and to emphasise the organisation's support for this research. Focus groups were conducted by a mental health nursing researcher and a consumer researcher, both with significant expertise in the conduct of focus groups and working with mental health consumers. The researchers had extensive knowledge of the physical health needs and concerns of consumers of mental health services; garnered from academic, advocacy and lived experience perspectives. The researchers briefly described themselves and their professional or personal experience at the commencement of each interview. The inclusion of a consumer researcher is congruent with the spirit of co-produced research and also encouraged more frank disclosure than might have otherwise occurred.

An interview guide was prepared by the researchers. The questions were intentionally broad to allow scope for participants to describe their experiences and opinions without restrictions. Participants were provided a

brief description of the role of the proposed specialist physical health care nurse and asked to consider whether such a role might be valuable in improving physical health care, and if so in what way. The findings from this question and broader discussion about the role of nurses in addressing physical health issues are presented here. Duration of focus groups ranged between 90 and 150 minutes. The groups were audio recorded to provide an accurate record of the interviews.

Ethical issues

Ethical approval for the study was obtained from the University Ethics Committees representing the research team. Participants were required to submit a signed consent form prior to commencement of the interview. A brief outline of the study (as described in the plain language statement) was provided verbally at the beginning of the interview and participants were encouraged to ask questions or seek clarification. Participants were assured that their privacy and confidentiality would be maintained and no names of people or health services would be published. The researchers explained that recording was solely to ensure an accurate interview transcript and all participants indicated their approval for interviews to be taped. All

participants were also asked to respect confidentiality of others by not disclosing any information disclosed in the focus group.

Data analysis

Each interview was transcribed verbatim by an external transcribing service to provide an accurate account of the interviews. Data analysis was undertaken independently by two members of the research team. Thematic analysis was conducted based on the framework developed by Braun and Clarke (2006), frequently used as a qualitative data analysis tool. This approach involves reading transcripts numerous times to enhance appreciation of the data and the voice of participants. The next step involves identifying and manually coding specific areas of content. The codes were then reviewed and clustered according to similar features. Tentative themes were identified and provisionally labelled. A conceptual map was constructed of the tentative themes and they were rechecked for accuracy and to determine if all key information was extracted from the data. The team reviewed the thematic structure and modifications were made until a consensus was able to be achieved. The research focus and primary aim was to ascertain consumer perspectives on the value of a specialist physical health nursing role within mental health care provision. Two sub-themes were

identified: the importance of integration, and the need for a culture shift.

These sub-themes are explored below and supported with direct quotes from focus group participants.

FINDINGS

Importance of integration

The responses to the concept of a specialist nursing position in mental health were largely positive. It appears this potential strategy has merit as a means of addressing the consumer-identified complex physical health problems, issues and barriers to care. The extract below demonstrates some of the ways that participants described their current physical health care and treatment as inadequate. There is potential capacity for this new nursing role to facilitate the integration of physical health care into mental health services.

Often mental health nurses and doctors will overlook all or not be able to treat medical complaints, which can escalate and play on your

mind if you're not feeling well and the more unwell you become the more it hurts. And sometimes mental health people don't see the medical aspect side of it and they don't link them together. So it's often hard to be treated for medical health problems by mental health staff ... (1)

As in the following extract, a specialist nursing role was seen as particularly appealing in traversing professional silos and at least providing baseline cardiometabolic data for practitioners.

I'd like to see a service at the hospital that just specialises in medical health of mental health patients, so that you can identify things that are making their life hard or things that they could be complaining and what are they depressed about, because they're in actual physical pain most of the time (2).

Furthermore, participants saw benefits in facilitating the integration of services they already accessed and an increased emphasis on holistic care within mental health services, including health education:

There needs to be people trained in both mental health and physical that know about food and nutrition and vitamins and minerals and how they all play a part and can interact ... (1)

Integration was also very important in facilitating closer communication between health professionals. A fundamental lack of communication could otherwise pose a significant barrier to the effectiveness of this initiative:

... it would be a nice go-between for the person to make sure that everybody is talking together but there needs to be a massive shift first because doctors don't want to share. Nurses don't want to share, social workers don't want to share, psychiatrists don't want to share. (3).

Without first addressing the integration problem there was concern that an additional position might further exacerbate rather than overcome the problem:

... you don't want them to be just another rung in the ladder either ... you'd see your doctor, then your doctor goes, "Oh, you can see the

nurse, she'll do your physical health." So then you'd have to see the nurse and then depending on what the nurse says, you know ... having another person in that (3).

Participants raised the ongoing problem of having to repeat their history numerous times and were frequently answer similar questions asked by various health professionals. The specialist nursing position had potential to assist with addressing physical health issues but a coordinated approach was important to avoid repetition:

It would be a good portal, where you've ... had your chat with your doctor ... in terms of mental health, as you move across to the nurse that's looking into the physical health and wellbeing. But you don't need to go over your story again (1).

Need for a culture shift

Although the potential of the specialist nursing role was widely supported, some participants had a very clear view that these roles were more suited to the community rather than the inpatient setting to change the

focus from the more clinical aspects of care to those that would enhance health and wellbeing at a more psychosocial level:

... we need more nurses ... out in the community, on the ground where people are struggling to live independently in their homes or trying to get those links ... to the healthy activities ... the psychosocial stuff that with diet, nutrition, sleep ... I think it's great the more the mental health nurses get into that, but it's really a community psychosocial model rather than a clinical model (4)

The importance of this type of resource in the community was identified by many as a necessity given the relative lack of resources available and the capacity for specialist nurses to address physical health care needs in that environment:

... people were thrown into the community, and the resources didn't follow. There have been improvements since the Inquiries, seeing mental health consumers living in poverty in boarding houses and being exploited ... But there's still not enough - from this discussion - still a lot more needs to be done in the community ... (2)

Although there was a divergence of opinion on this point, the view was expressed that transitioning to this type of role may not come easily to many nurses, due to the way they have been educated and socialised into a biomedical approach.

... there's a real political and social and stigma resistance to allowing that sort of freedom within the clinical professions to have that mobility and flexibility and getting out of their clinics or in their hospitals - - - it's politically systemic in the way that nurses and doctors are trained to perform and the way they're funded, all reinforces a model that locks them into a certain way of relating to people (4).

The power embedded in health professionals as a result of their expertise was seen as a major barrier to nurses working outside what participants regarded as their usual scope of practice, with a reluctance to give up power to engage with consumers in a way that reflects recovery-oriented practice, psychosocial and health promotion principles:

... that's the shift that the clinicians don't want to really make, they're the top dogs, this is our authority, this is our turf, this is what we do (4).

The need for consumers to be actively engaged in the development of roles such as these was clearly stated. At the minimal level there was an expressed need for an advisory group that included consumer representation to provide formal input:

... if mental health nurses are going to have a committee to help how we develop these sorts of new approaches, then please get a consumer advocate rep on there that can bring that exactly those critical skills of lived experience (4).

Discussion

The findings in the current study suggest a specialist physical health nurse consultant may play an important role in addressing the physical health inequities faced by consumers of mental health services, albeit with some logistical concerns. To date the literature has been effective in identifying the physical health issues experienced (Happell *et al.* 2015; Kaufman *et al.*

2012; Millar *et al.* 2014). However, it is now time to move from the identification of the problem to finding solutions and address this long standing inequity in access to, and the provision of, physical health care. The findings of the current study are significant in facilitating dialogue between consumers and health professionals by seeking and articulating the views and opinions of consumers enabling them to be influential at the development and implementation stages of any such initiatives.

The introduction of a PHNC nurse position to address cardiometabolic health may be one possible strategy to redress inequity in access to, and provision of, physical health care. The capacity of such a role to address consumer physical health disparities has been well received by nurses (Happell *et al.* 2014a; Happell *et al.* 2014b), particularly following the implementation of a similar role (Happell *et al.* 2015). Consumer input in the early stages of the design, structure and development of this position is crucial.

Participants in the current study responded positively to the idea of a specialist nurse role, acknowledging the potential to enhance consumer access to physical health care. The lack of integration between physical and

mental health services has been identified from qualitative data collected from health professionals and mental health consumers (albeit limited) in other studies (Chadwick *et al.* 2012; Lester *et al.* 2005; Borba *et al.* 2012; Bradford *et al.* 2008; Brunero & Lamont 2010; Shuel *et al.* 2010; Brunero *et al.* 2008). An embedded PHNC primary health nurse could provide a crucial conduit and thus bridge the gap between physical health and clinical mental health care provision, resulting in improved consumer outcomes for both sectors (Happell *et al.* 2012a). The research in this field is currently limited; however, there is evidence that specialist roles of this kind can improve the integration of mental and physical health treatment and monitoring (Druss *et al.* 2010; McKenna *et al.* 2014; Happell *et al.* 2014b; Brunero & Lamont 2010) and ultimately enhance quality health care.

Importantly, the current research findings reinforce the importance of breaking down existing professional silos and increasing collaboration within multidisciplinary mental health teams. Consumers interpreted siloing as a reticence of the mental health disciplines to collaborate across professional boundaries to provide optimal care and treatment. The tendency towards “tribalism” (Braithwaite 2010) and “professional homophily” (West & Barron 2005), where each profession works in relative isolation from others,

unfortunately presents a major barrier to an integrated approach to care and treatment . This tendency for professional silos (see also Braithwaite 2006; Finn *et al.* 2010) would need to be acknowledged and addressed during implementation to avoid the new role becoming yet another health professional the consumer sees in isolation from the treating team as a whole.

Previous research highlights the benefits of multidisciplinary collaboration on nursing care. Happell and colleagues (2013) showed substantial variability in how regularly nurses discussed physical health issues of consumers with other professions. The frequency of collaborations correlated positively with the number of direct interventions with consumers (Bradford *et al.* 2008) demonstrating a relationship between collaboration and the provision of physical health care and reinforcing the importance of the multidisciplinary team approach.

The PHNC is proposed as an appropriate inclusion to the multidisciplinary team providing services for inpatient units and community health services (Happell *et al.* 2012a). Participants saw the notion of a dedicated nursing position as having particular relevance for community mental health services. Community settings were seen to provide the scope to change the culture from a biomedical and clinical focus to a greater

emphasis on psycho-social issues, health promotion, emotional well-being and social inclusion. These outlooks are consistent with calls in the literature for a broader and more holistic approach to health in the community (Ramon *et al.* 2007; Mezzina *et al.* 2006; Mann *et al.* 2004). The continuing dominance of biomedical perspectives on health care was seen as a potential barrier to the CHN performing non-clinical functions, such as co-ordination and effective communication. These concerns echo those from nurses about what is seen as the dominant influence of biomedical approaches to care on their practice (Richardson & MacGibbon 2010; Cutcliffe *et al.* 2013).

While integration and the need for a cultural shift were particularly apparent, concerns voiced by participants highlighted the interrelated nature of these themes. Specific workplace culture may be a factor in the extent to which a lack of integration and a need for culture shift are present. A professional setting where staff strongly adhere to their identities and their professional group (indicating rigid roles and a potential lack of cultural shift) is likely to be an obstacle to authentic collaboration and to result in lack of integration. The well documented collective stigmatised attitudes towards consumers reflect a major theme identified in the literature; the vast power

imbalance between consumers and health professionals (Bennetts *et al.* 2011; Brunero *et al.* 2008; National Mental Health Commission 2014). The disempowerment of consumers has adversely impacted on the physical health discussions, with the consumer voice not clearly articulated. The absence of a strong consumer voice to inform responses to the issues of integration and culture means these themes are likely to persist and pose a major barrier to improved physical health care for mental health consumers.

Consumer representation on committees to implement the PHCN roles was raised as an essential component of new initiatives. Enhanced consumer participation is urgently required to formulate consumer-centred solutions that improve access to physical health services. The available knowledge on consumers' experiences of issues of physical health service provision has been critical to furthering the understanding of barriers in the health care system. The consumer perspective is especially relevant when exploring the healthcare journey; from first contact with services to ongoing continuity of care (Chadwick *et al.* 2012; Happell *et al.* 2012b).

The inclusion of consumer perspective is growing in the mental health field, albeit much progress is still to be made (Bennetts *et al.* 2011). While

there are some studies of consumer perspectives on access to physical health care (Lester *et al.* 2005; O'Day *et al.* 2005), there is minimal research literature on consumer views on physical health care reform within mental health settings. This study has contributed to addressing this knowledge gap. Existing practices where mental health clinicians refer consumers to external services for physical health care has been largely ineffective.

The integration of physical and mental health care is therefore urgently needed to redress the current inequity (van Meijel *et al.* in press; Shuel *et al.* 2010; Mitchell *et al.* 2015). Consumers need to be the critical reference group, central to all activities and active at all levels throughout the research agenda to ensure the issues identified and the corresponding strategies are appropriate. This ideally would include consumer involvement in designing and directing the research, as recommended in the literature on consumer-led research (Horsfall *et al.* 2007; van Draanen *et al.* 2013; Rose 2011). Transferable frameworks to enhance consumer participation, with consumers as co-researchers, will provide a suitable starting point (Ochocka *et al.* 2002; Hancock *et al.* 2012). The benefits of consumer researchers include producing different findings to those implemented by non-consumers (Clark *et al.* 1999).

The inclusion of the consumer perspective in this study has resulted in an enhanced understanding of the issues of integration and professional culture. A dedicated physical health care role has the potential to holistically integrate physical health care into the existing clinical care of mental health consumers. A trial of a specialist physical health nurse role in a community mental health service demonstrated effectiveness in terms of linking mental health consumers to a variety of services such as allied health and primary care (Brunero & Lamont 2010). The nurse initiated referrals for 62 per cent of the mental health consumers to primary care, allied health or community-based services and for routine blood testing, mammography screening and nutrition counselling, with high follow up rates (Brunero & Lamont 2010). Previous studies have also shown such a role is well-supported by nurses in mental health (Happell *et al.* 2014a; Happell *et al.* 2012a). These research findings add the weight of consumer support. There is a sense from consumers that organisation and structure are important to the success of the PCNC role.

The unique demands on the PHNC will require the incumbent to have a strong interpersonal skill set and the capacity to advocate for consumers. It is likely that the role will need a person with a strong background in both

physical health nursing and mental health. This would facilitate clinical credibility by the health sector generally by mental health consumers, including equitable physical health care provision and access to services. It would be incumbent of the CHN to also play a role in community and clinical education to improve inter-professional collaboration and understanding to maximise utilisation of the role, and the subsequent benefits for consumers.

Limitations

Mental health consumers, including those who participate in research, are very diverse people. Others consumers may have views that differ from those of the participants in the current study. Further research with the active involvement of mental health consumers is needed and will be valuable to determine the efficacy of PHNC type roles and how their effectiveness can be maximised.

Conclusions

A PHNC position has the potential to improve access to physical health care in mental health settings and is likely to be considered favourably by

consumers. The development of this role must occur with ongoing consumer input and consideration of cultural and structural changes to the public health care system. The dearth of consumer perspective in the vast majority of physical health research is problematic and needs to be addressed as a human rights issue. High level involvement of mental health consumers to further enhance understanding of the existing barriers to equitable care and developing and evaluating strategies in this area are vital. Reducing inequities in physical health status of mental health consumers is slowly being considered in health care system reform. Consumer leadership and participation must be a central feature in the reform to physical health care services.

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**Embedding a physical health nurse consultant within mental health services:
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