Physical health nurse consultant role to improve physical health in mental health services: A carer’s perspective

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ABSTRACT: The physical health of people diagnosed with a mental illness is significantly poorer in comparison with the general population. Awareness of this health disparity is increasing; however, strategies to address the problem are limited. Carers play an important role in the physical health care of people with mental illness, particularly in facilitating navigation of and advocating in the health care system. A specialist physical health nurse consultant position has been suggested as a way to address the physical health care disparity and limited research available suggests that positive outcomes are possible. In the present study, a qualitative exploratory research project was undertaken, involving in-depth interviews with people identifying as mental health carers. Two focus groups and one individual interview were conducted involving a total of 13 carers. The resulting data were analyzed thematically. Views and opinions about the proposed physical health nurse consultant (PHNC) position were sought during these interviews and are reported in this paper. Two main sub-themes were evident relating to characteristics of this role: reliability and consistency; and communication and support. Essentially carers expressed a need for support for themselves and consumers in addressing physical health concerns. Successful implementation of this position would require a consistent and reliable approach. Carers are significant stakeholders in the physical health of consumers of mental health services and their active involvement in identifying and tailoring services, including development of the physical health nurse consultant must be seen as a priority.

KEY WORDS: carers, communication, mental health, mental illness, nursing, physical health.

INTRODUCTION

Individuals diagnosed with mental illnesses such as schizophrenia are more likely to present with comorbid physical health problems such as cardiovascular disease, a factor that contributes to early mortality (Laursen 2011; Laursen et al. 2014; Scott & Happell 2011). For instance, it has been estimated that people with bipolar disorder are 2.25 times more likely to have metabolic syndrome compared to the general population and metabolic syndrome was significantly more prevalent in those treated with antipsychotic medications (Vancampfort et al. 2013). Higher rates of a range of physical illnesses have been observed for both low and high prevalence mental illnesses (Lawrence et al. 2013). Furthermore, there are also lower prospects of survival after diagnosis of physical health problems in people with mental illness (Hawamdeh & Fakhry 2014; McAndrew et al. 2014). These physical health problems are a major contributor to premature death (Colton & Maderscheid 2006; Laursen et al. 2014; Lawrence et al. 2013).
Psychiatric conditions, coupled with physical health conditions have an adverse effect on health-related quality of life and improving resource allocation may address this public health concern.

Tackling inequalities in physical health and life expectancy demands improved access and quality of physical health care for people with mental illness. There is often inconsistent and low access to quality physical health services such as screening, effective referral processes, continuity of care and participation in health-behaviour programmes (Connolly et al. 2015; Hyland et al. 2003; Nasrallah et al. 2006). In recent years, the debate on how to address physical health service gaps has become more prominent (De Hert et al. 2011; Ehrlich et al. 2015; Lawrence & Kisely 2010; Richardson et al. 2005). In a policy environment emphasizing collaborative, recovery-focused and cross-sectoral care (British Medical Association 2014; National Mental Health Commission 2012), it is important that all stakeholders views are sought and considered to determine how to best reform health care to improve access to quality physical health care for people with mental illness.

In this regard, a number of studies have explored the perspectives of health care providers (Happell et al. 2012; Happell et al. 2013; McCabe & Leas 2008; Wheeler et al. 2010), and there is some exploratory research on consumer views (Chadwick et al. 2012). In contrast, no studies have comprehensively examined physical health care from the carer’s perspectives. For the purposes of this paper, the term ‘carers’ is used to describe people outside the health care systems such as friends and family members who support the person with mental illness.

For example, Dean et al. (2001) conducted focus groups in the United Kingdom with carers, consumers with mental illness, and health care providers to investigate views about physical health service access and adequacy. Dean et al. (2001) found that carers saw health care services as difficult to access for the consumer, marked by a predominant biomedical approach to care and an absence of holistic health, including dismissal of physical health issues raised by carers and consumers, as major problems. Carers also described health care services non-responsiveness was a source of burden for them. Despite efforts to adopt holistic, recovery-oriented treatment of mental illness, these issues with respect to navigating the health care systems remain problematic for carers or, and people with, mental illness.

When carer’s views are sought it is usually with respect to mental illness and associated symptoms of the consumer they care for (e.g. McCann et al. 2015). Physical health, which is important to overall well-being and to recovery processes, has not been considered. In recognizing chronic physical illness as one of a number of co-morbidities experienced by people with mental illness, Lee et al. (2013) interviewed a range of people including carer groups. They found that: “Both consumers and carers (with the consent of consumers) wanted to be involved in determining what collaboration occurred and what goals were being worked towards.” (p. 336). Based on these findings from the primary data and their accompanying review of the literature on collaborative care, Lee et al. (2013) recommended that “Collaboration should be led by the needs and goals of consumers and carers and be built on recognition that recovery is achievable.” (p. 343).

In Australia, the Not for Service Report (Mental Health Council of Australia 2005) documents how carers expressed concern over the dismissal physical health care and the adverse effects on the consumers overall mental and physical well-being. In response to these concerns the views of carers of people with mental illness have been given careful consideration by their contribution to the Australian Clinical Guidelines for the Physical Care of Mental Health Consumers (Stanley and Lague, 2011). This document provides a benchmark by which service providers can structure the delivery of evidence-based physical health care.

Research seeking the views of carers on the physical health of people with mental illness is limited. To address this imbalance, research providing the opportunity for carer’s voices to be given full appreciation is urgently required. As people with mental illness are frequently socially isolated (Elisha et al. 2006; Jaremka et al. 2014), the input of carers becomes even more salient as they may be the primary source of support. Knowledge of carer’s views would also inform development of integrated care approaches. One suggested integrated approach is a specialist nursing position dedicated to physical health care within mental health services (Brunero & Lamont 2009; McKenna et al. 2014). For instance, Happell et al. (2014d) suggested a care model whereby a specialist nurse would co-ordinate cardio-metabolic care for mental health consumers with emphasis on health care provider and consumer education and on collaborative care. Carer views will illuminate whether this key stakeholder group sees this role as progressive in integrating services. This paper reports on perhaps the first focus group research study of carer’s views on the physical health needs of the person they care for.

**Methods**

*Design*

The conduct of this research reflected the qualitative exploratory research design articulated by Stebbens (2001).
A significant advantage of qualitative exploratory approaches is facilitating detailed exploration of an issue of interest from the perspective of a group of participants with direct experience or involvement. This approach is particularly useful when exploring topics where there is little research as a guide for using other research designs.

Setting and recruitment
Data collection took place in the Australian Capital Territory (ACT) with the full support of Carers ACT. Carers ACT is recognized as the organization providing the expert voice, and working with and for carers in the ACT. Carers ACT sent information about the study to members of their mailing list, placed an advertisement in the weekly bulletin and spoke about the project on community radio. Participant information and consent forms were sent to those who expressed interest in the study. Where further contact was made participants were booked into a preset interview date and time. Carers ACT maintained the list of participants, and individual information was not shared with the research team to preserve confidentiality. A total of 13 carers participated in one of two focus groups plus one individual interview provided for a carer who was unable to attend either focus group but was very keen to participate in the research. Consumers were provided with a gift voucher to thank them for participation according to the policy of Carers ACT.

Procedure
Interviews were held at the premises of Carers ACT. This was a familiar environment to many. Furthermore, using this location reflected the partnership between the organization and the research team. All interviews were conducted by a mental health nursing researcher and a mental health carer, both with appropriate expertise. The researchers briefly introduced themselves and described their professional or personal experience in mental health research at the commencement of each interview. The inclusion of a carer in the research project reflects the principles of collaborative research. It was also felt that the presence of a carer may influence participants to speak more openly than may have been the case otherwise.

Prior to the interviews the researchers collaboratively prepared an interview guide. The questions were open and broad to encourage participants to describe their views and experiences from their own perspectives and in their own words. During the interview participants were introduced to the idea of a physical health nurse consultant with their opinions about whether such a role may have value, and if so how in what way. These specific findings form the basis of this paper.

Ethical issues
This research received ethics approval from the relevant committee representing the research team. Participation occurred only after written consent was provided and participants had been given a copy of the participant information sheet to retain. In addition to the written material, 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 mentioned in the interviews, would be included in publications. The researchers sought consent to tape the interviews to enable complete and accurate transcripts to be achieved.

Data analysis
Verbatim transcriptions were produced by an external service. Data analysis was undertaken independently by members of the research team. Thematic analysis was conducted based on the framework developed by Braun and Clarke (2006), a commonly used tool for qualitative data analysis. The initial stage of the process requires reading transcripts line by line several times to gain familiarity with the data and understand the main issues the participants are raising. In the following stage, specific areas of content were discovered and coded manually. The codes were subsequently reviewed for their accuracy and relevance and grouped according to similarity of content. These groupings formed the basis of provisional themes and were assigned titles as this point. A conceptual map was developed from the tentative themes and they were revised to ensure accuracy and to be confident all key information was obtained from the data. The conceptual map and thematic structure were reviewed by the team with changes made as required.

The aim of this paper is to present findings related to carer perspectives on the potential role a physical health nurse consultant embedded within mental health services, may play in improving the physical health of consumers of mental health services. Sub-themes to the theme, role for a physical health nurse consultant, were: consistency and reliability; and communication and support. These sub-themes are explored below and where relevant are illustrated with the words of participants.

FINDINGS
Role for a physical health nurse consultant?
Most participants saw some potential value in a nursing position dedicated to physical health care in improving the quality of, and access to, appropriate services for the people
they cared for. However, there were important characteristics the carers considered necessary for the role or for the individual nurse or both, these being: consistency and reliability; and communication and support.

**Consistency and reliability**

The carer participants in this study were active participants in coordinating services, both physical and mental, and advocating for appropriate care and treatment. Consistency and reliability of services was therefore considered essential. One participant described what was seen as a similar need within the service some 10 to 15 years back that had subsequently disappeared and resulted in disruption to the quality of care available:

... the whole process [of providing physical health care] is ... hugely complicated and it needs to be long term, it needs to be ongoing and you can’t have it stop and start and there needs to be a continuation of service, if there is one (2).

Consistency in the person providing the care was considered important, to enable the development of trust, and therefore maximise the benefits of the relationship:

There needs to be consistent people ... who they [consumers] can develop a relationship with ‘cause you’ve got to be able to trust what they’re saying (2).

The success of a position of this type would depend on it being readily available and reliable:

... there needs to be a system in place ... at the moment there isn’t anything. If there’s an automatic system in place and when someone visits a psychiatrist and then from there, you have someone there linked in with to do with the physical [health] ... medication, pathology, et cetera, et cetera. ... After my daughter’s first psychiatrist appointment, there wasn’t anything. We had to investigate everything ourselves. There wasn’t any advice; there wasn’t anything (2).

Regularity of contact was also seen as important, with brief, irregular meetings with different people not likely to be helpful:

... the nurse idea would be good ... if it was consistent person and ... a weekly thing: it couldn’t be a once off come and tell me all the things I should be doing ... (2)

Having the position on a full time basis was considered important; carers described many examples of being let down by positions that were not adequately resourced:

It would need to be a full-time position ... a carer nurse consultant that I met once when she was first appointed but other than that, I’ve never seen her or heard from her. I know she’s apparently at the hospital one morning a week or something but I don’t know what she does (1).

For other participants, regular face to face meetings could be supplemented from time to time with other forms of communication such as telephone calls and electronic means, for example:

Would technology help at all? ... if you made contact initially with a mental health nurse but the follow-up doesn’t always have to be face to face (1).

Having this kind of role embedded within mental health services was seen as a particular advantage, meaning that consumers didn’t need to go to a different location to receive physical health care:

That would be really good if you’re there, you’ve got him [consumer] there in the place and you only have to go next door to this other room (2).

This level of familiarity could assist with relationship building, through this relationship an initial reluctance to be seen by the PHNC could gradually be overcome, something much less likely to be achieved if the services weren’t physically co-located:

Sometimes they get to the appointment and they can’t deal with anything else and they say, “No, no, no, go away, I don’t want anything to do with him here.” And then the next time they go, they might – or the next time after that, they might say, “No, I can’t deal with it.” It [physical health services] has to be there (3).

**Communication and support**

A primary benefit of the nurse position in physical health was increased access to information and support for both the physical health aspects of care and treatment for the consumer. However, concerns were raised by several participants that the potential effectiveness of this kind of role would be limited by the need for consumer consent if carers are to be part of these discussions. It is also about acknowledging the role of the carer and the information they have to offer, if there is consent:

I think we need somebody who knows what it’s about [physical health and mental illness] that you can contact ... I’ve been doing it alone 50 years ... and then I was told about this mental health nurse ... but he said, “I can’t talk to you about your son.” So I thought well what else would I want to talk about? [Laughs]. I mean it is so futile (1).

In discussing the characteristics the nurse would need in a role like this, consumers expressed the importance of an understanding of the impact of mental illness. Many carers had prior experience with health professionals who made unrealistic suggestions about how consumers could improve their physical health without considering the impact...
of their mental illness. Suggestions like “go to a gym”, “stop smoking”, “lose weight” were not viewed as helpful. The following example relates to eating habits:

They’d [physical health care nurse] also have to have a really good understanding of different mental conditions ’cause my son has OCD [Obsessive Compulsive Disorder] … and he has particular obsessions about certain food … since probably the age of eight has only ever eaten Weet-bix and pasta with cheese and chicken nuggets and he’s 25 now and that’s still all he eats (2).

Throughout the interviews, carers described how difficult the broader health system was to navigate, and the consumers they cared for often found this particularly difficult. They believed physical nurse consultant position could potentially play an important role in this respect:

… there’s no connection between inside the hospital and the outside. I felt like I had to do all the coordinating because she went into the detox unit at one point … I had to make sure … the rehab was dove-tailed otherwise … I had to case manage everything without her knowing cause she didn’t want me involved (1).

DISCUSSION

The views of carers expressed in these findings lend support to the potential value of a physical health nurse consultant in improving physical health for consumers of mental health services. The nature and rate of physical health problems identified in this population is now widely understood, at least from the perspective of service providers (Happell et al. 2015; Kaufman et al. 2012; Millar et al. 2014). Two significant gaps are evident in the current literature. Firstly, the description and evaluation of strategies to address the identified problems; and secondly, a clear pathway for including views and experiences of consumers of mental health services and those who care for them. The voice of carers has been notably silent (Goodwin & Happell 2006; McCann et al. 2015; Mental Health Council of Australia 2005; Rowe 2013). This is antithetical to the underlying philosophy of contemporary mental health policy that the input of carers is integral to all aspects of mental health services (Council of Australian Governments 2012).

Nurses have been identified as ideally placed to play a major role in improving the physical health of people utilising mental health services (Hemingway et al. 2014; Robson & Haddad 2012; Rosenbaum et al. 2014). However, the neglect of physical health continues within mental health services (Gray 2012). The barriers to nurses incorporating physical health care as important components of their role are acknowledged including ambivalence about whether physical health care is a legitimate role for nurses working in mental health (Blythe & White 2012; Bradshaw & Pedley 2012; Happell et al. 2012), lack of perceived skill and confidence, and inadequate training (Blythe & White 2012; Bradshaw & Pedley 2012).

A specialist nursing position has been proposed as a potential approach to promoting improved physical health care within mental health services. Positions of this kind, while limited in number, have been evaluated positively (Druss et al. 2010; Happell et al. 2014c; McKenna et al. 2014), and the attitudes of nurses from mental health services have been favourable (Happell et al. 2014b; Happell et al. 2014a), becoming more so following the introduction of a position of this type (Happell et al. 2015). However, at this stage the views and opinions of those most closely affected by the inadequacy in physical health care including carers, have not been canvassed.

The research presented in this paper represents an important step toward listening to, and acknowledging the views of carers. More significantly, it ensures their views and experiences contribute to initiatives developed to address this significant physical health inequity. A partnership approach with carers as identified partners has been recommended (Wallcraft et al. 2011). The broader literature also calls on the need for more carer focused services and greater capacity for carers to be influential in service development (Johansson et al. 2014; Rowe 2013). Carer input into the development of a physical health nurse consultant or similar role is therefore crucial.

Although attitudes to a PHNC were generally positive, they were not without caution. Carers noted that it was crucial that the nurse play a supportive role and be a good communicator to both consumers and carers. The importance of communication and support for carers is consistently described in the mental health literature (McCann et al. 2015; Meehan et al. 2011; Rowe 2013). Carers frequently feel that their unique needs are not fully understood, left alone addressed by mental health services (Ewertzon et al. 2011; Weimand et al. 2013). This was strongly reinforced in the interviews with many carers describing instances of not being listened to.

Consistency and reliability were concepts that also emerged from the carers’ interviews. Interestingly these terms do not specifically appear in the literature, however, it is quite likely these are embodied aspects of communication and support and contribute to the successful therapeutic relationship between consumers and nurses and between carers and nurses. The therapeutic relationship is regarded as the cornerstone of the nurse – consumer connections and interactions (Becker 2015; Havamdeh & Fakhry 2014; McAndrew et al. 2014; Polacek et al. 2015).
It is through this relationship that nurses can provide safe and effective care for consumers within mental health services. These characteristics are equally important to the PHNC role as the more mental health focused aspects of nursing care.

The PHCN would therefore need to play a strong supportive role not only to consumers, but also to their carers. While this may seem self-evident and a reasonable expectation, the degree nurses involve family in the mental health services for the person they care for differs significantly (Blomqvist & Ziegert 2011). Furthermore, nurses commonly describe experiencing conflict between the needs of consumers and of carers (Blomqvist & Ziegert 2011; Goodwin & Happell 2006; Weimand et al. 2013). The needs of consumers often take priority as they are considered core business; leaving carers feeling unsupported and ill informed (Blomqvist & Ziegert 2011; Ewertzon et al. 2011; Weimand et al. 2013). If carers are to be engaged as genuine stakeholders as contemporary mental health policy dictates, the incumbents of PHNC roles would need to be aware of this tension and work to overcome this tension and ensure carers are actively involved in physical health care issues.

Limitations

Given the sample size from one specific geographical location, the opinions of carers in this research can only be seen as representative of these individuals themselves. The views of the carers in this study are likely shaped by their experiences of the mental health care systems to which they have been exposed. As a heterogeneous group of people, other carers may have quite different views. Further research with larger numbers of carers from a diverse range of settings is needed as a matter of priority.

Conclusions

The significant disparity in the physical health of people diagnosed with mental illness in comparison to the general population is unacceptable and solutions are urgently required. A specialist nursing position such as a PHNC has been identified as a potential solution focused strategy. Despite the important role they provide in supporting family and significant others through their mental health challenges, carers have rarely been consulted on the important matter of physical health. Carers saw some promise in a PHNC role, particularly in facilitating communication and information provision. To maximize the chances of success for this position, consistency and reliability were considered essential components of the role. Carers have considerable wisdom to bring to discussions about mental health care delivery and their opinions must be actively canvassed to promote the highest quality of physical health care within mental health services.

ACKNOWLEDGEMENTS

The research team extend our sincere thanks to Carers ACT for facilitating this research through access to participants, organizing the focus groups, providing the venue catering and for co-funding this important work in collaboration with the Mental Health Branch, ACT. Thanks so much to the participants for your generosity and openness in sharing your views and experiences.

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