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Health workers' views of a program to facilitate physical health care in mental health settings: implications for implementation and training

Abstract

Objective
Physical co morbidities shorten the lifespans of people with severe mental illness. Mental health clinicians need to support service users in risk factor-related behaviour change. We investigated mental health care workers' views of a physical health self-management support program to identify implementation requirements.

Method
Qualitative interviews were conducted with workers who had differing levels of experience with a self-management support program. Themes were identified using interpretive descriptive analysis and then matched against domains used in implementation models to draw implications for successful practice change.

Results
Three main themes related to (i) understandings of disease management within job roles (ii) requirements for putting self-management support into practice and (iii) challenges of coordination in disease management. Priority domains from implementation models were inner and outer health service settings.

Conclusion
While staff training is required, practice change for care which takes account of both mental and physical health also requires changes in organisational frameworks.

Keywords

Physical health, severe mental illness, self-management, implementation

Introduction

Physical co morbidities, particularly cardiovascular disease, significantly shorten the lifespan of people with severe mental illness (SMI) [1]. More active treatment and prevention is urgently required to reduce cardiovascular risk in this population [2]. Reducing cardiovascular risk requires changes in behaviours that are substantially under the control of the patient, such as tobacco smoking, diet and exercise, and day-to-day management of diabetes, hypertension and hyperlipidaemia. Health professionals therefore need ways to support self-managed behaviour change by people with SMI. Advice-giving is a commonly used but ineffective support strategy while effective approaches are currently under-used in mental illness care [3][4]. Any training and implementation efforts in more effective approaches should begin from current staff perspectives and current practice environments. However, there are few studies of mental health care workers' views of self-management support integrated into mental health care [5]. We therefore conducted a study of views of health care workers informed about a particular self-management support program, the Flinders Chronic Condition Management Program [6], to understand implications for training and implementation.

The Flinders Program has a strong self-management orientation. It provides the health worker with tools and structured motivational process to collaboratively agree and facilitate achievement of both clinical and psychosocial goals with the patient. The program has been associated with improved self-management in mental health and physical health conditions and comorbidities [7] [8].

Methods

Health workers with varying degrees of experience with the Flinders Program and mental health experience were identified from records of the training organisation and invited to participate in a qualitative interview. Their experience ranged from attendance at the first part of a 2-day training program (where information on the theoretical background and the Program tools was presented) through to accreditation and experience in training others to use the Program.

Open ended questions with follow up probes were asked [9]. Interviews were recorded, professionally transcribed and checked by the interviewer (WB). Coding for themes by WB and MH used interpretive descriptive analysis [10]. In interpretive description, inductive analysis focuses on understandings that can lead to applications in health practice. Here the interest was in any themes relating to training and implementation of physical health related self-management support in mental health care. Inductively derived themes were examined against a composite implementation model, the Consolidated Framework for Implementation Research (CFIR) [11] to assess priority areas for further implementation research.

Ethical approval was granted by the Human Research Ethics Committee, SA Department of Health (ref 448/05/2014).

Results

The sample
Three health worker categories were identified; (i) nurses delivering care in mental health clinics who had received initial training in the Flinders Program (ii) rural health workers delivering psychosocial rehabilitation in SMI using the Flinders Program (iii) clinician-trainers with experience in supporting mental health care workers to use the program. Six of the 9 health workers invited were available within the study timeline. All were female, experienced health care workers in rural and metropolitan South Australia, with nursing or psychosocial support backgrounds. Three of the 6 were from group (i), 2 from group (ii) and 1 from group (iii). The 3 not available were from group (i).

Findings
Participants' accounts could be encapsulated in 3 main themes: understandings of disease management in relation to job roles, the multiple requirements for putting a program such as the Flinders Program into practice, and the challenges of coordination in disease management.

Theme 1: Disease management in relation to job role

Participants' accounts of the disease management aspects of their jobs were of two distinct types. One type focused on the clinical care system with goals, plans and action decided and directed by clinicians only, and acknowledged lack of effective strategies for physical health care. The other type emphasised clinician partnering with the patient for goal setting and action in general, and showed knowledge of skills needed to work in this way.

The perspective prioritising the clinical system included accounts of work to fit mental and physical health care procedures into the system.

The consultant psychiatrist overseeing the care of each consumer should have …….. the information to make a complete review, you know when they see the client every six months. (P4)

Disease management goals were developed by clinicians.

I explain to the client the goal which may be that a blood test needs to be done. (P3)

The patient was recipient and not active in goal setting.

If they [staff] take a blood pressure that's more than 140/90 then they know that they've actually got to refer that up to the GP. (P5)

Physical health care was seen as clinicians taking and recording measurements.

Clients get sent off for those tests on an ad hoc basis if there's a clinical concern. (P3)

Referral to GPs was seen as the route to physical health care, often unsuccessful in real practice.

We really encourage people to link in with GPs but that's not necessarily always happening well because of waiting times in GP practices and competing for priority (P5)

Other physical health options were not clear or detailed.

Somehow you've got to inspire the right people to step up to deliver the care or to oversee the care or to coordinate it. (P4)

Health professional time was seen as the main barrier to better provision of physical health care.

I think perhaps it might be better if it was a care coordinator person rather than the actual clinics. (P5)

The alternative perspective within this theme centred on partnership with the patient, building patients' own goals and priorities into planning and action.

I think people always have a very clear idea of what it is that they want and so it's very important to get that out on the table (P1)

The importance of client goals was present in all accounts from participants using the Flinders Program.

Prior to using Flinders we used to talk to people about their goals so I guess the language is similar …………… but there was no process to go through with the client (P2)

Participants who used the Program spoke of facilitating role rather than managing everything for the patient.

I see Flinders as being a bit of a roadmap for people ………….. that helps them to move forward. (P2)

A participant who had recently had training saw advantages in developing self-management support skills.

They showed us how to facilitate the client discovering for themselves where they're stuck and where they can get an opportunity from (P3)

Participants using partnership orientations spoke of a lack client-centeredness in mental health care.

Once someone is diagnosed with a mental health condition that tends to become the focus. (P1)

Organisational barriers to self-management support were raised.

There's all these different systems ……… how can I engage in connecting with this person? (P2)

Theme 2: Requirements in using self–management support skills

Regardless of their theme 1 orientation, all participants described challenges in appraising, learning and applying a comprehensive self-management program such as the Flinders Program. It was seen as an approach which required organisational change so that it could be fully implemented after training.

Participants who were not users of the Flinders Program had all recently attended part of a training workshop. Many used this partial training to appraise the Program and its fit with job needs.

For clinicians primarily concerned with operation of existing clinical care systems, the Program could be seen as too time-consuming.

So the actual time that they [mental health clinic nurses] get to spend with the people is probably not intensive enough or frequent enough to actually do the Flinders model justice in those clinics. (P5)

Another did see a fit with self-identified needs and intended to complete the training.

I think it [training] is a very important thing if we're to do a client-centred recovery-focused service. (P3)

Some participants could see ways of integrating parts of the Program where job structures prevented standard use of the Program.

There's been very few people that we haven't been able to use the Flinders Program with, and even then we've still been able to use components. (P1)

Whole-team implementation was seen as ideal but not easily achieved.

You want to have a team that can actually support this Program, as opposed to one person that's holding and propping it up. (P2)

Theme 3: Managing among multiple programs and services

Coordination challenges were frequently raised across the participant group, with partial success discussed by users of the Flinders Program, and indications that a more uniform approach would overcome many current barriers.

The Flinders Program is designed to structure self-management support and broader disease management and coordination. Participants who used the Program spoke of partial success in using it for coordination, because of variable use by other groups.

When I do the Plans with people I say, "Well anyone who's mentioned on the plan we like to give them a copy too". ….. I'm not sure they [mental health team] use it but they get a copy of it. (P1)

Participants who did not use the Program also spoke of coordination challenges, but not of possible methods to overcome them or any involvement by the patient.

You've got your Coordinators, you've got your Mental Health Teams, you've got your hospital staff and then of course a whole another big door opens up if you're starting to transfer these people between Metro and Country or interstate. (P4)

Viewing findings against an implementation model
The CFIR model [11] proposes six major domains for successful implementation: the unadapted and adapted innovation, individuals involved, the inner and outer settings and implementation processes employed. Participants in this study did not challenge the need for innovation (involvement in improving physical health) or the potential effectiveness of the adapted innovation (Flinders Program), but obstacles were evident within other domains. In relation to individuals involved, orientation towards partnership with patients is consistent with changing clinical practice, but orientation towards clinically-organised care does not. Clinically-organised care delivery also appears to be supported by inner organisational and broader health service settings. Visible organisational re-orientation would be required for effective implementation of both self-management support and coordination.

Discussion

This study indicates that individual and organisational orientations towards physical health care can support or block self-managed behaviour change by patients. As well as training, changes in inner and outer organisational settings may be required so that self-management support can be provided in practice, and so that coordination can be improved.

This study had limitations and strengths. Numbers of potential participants were limited in line with numbers of mental health workers being introduced at the time to the Flinders Program. However, participants were from diverse backgrounds and included workers using the program and those assessing it for use.

Other recent studies support the findings of our study. Psychiatric patient involvement in planning and care appears low, with paternalism and professional control the dominant worker perspectives [12] [13]. Another Australian study on screening showed similar findings to those of our study on follow-up action for physical illness. While mental health nurses saw screening as important, existing roles and time problems were barriers to its implementing [14]. A related survey highlighted the importance of organisational enablers for implementation [15].

For clinicians trained in the Flinders Program, success in partnering with patients to facilitate self-management is consistent with other studies. Patients with SMI state that they do have concerns about physical health but do not currently receive help for these concerns [16]. Similarly, provision of a patient-held card, containing information on physical health risks and designed to improve consumer involvement in care, showed improved patient knowledge of physical health risks in SMI [17].

In conclusion, training of front line care workers is a requirement to provide self-management supporting mental health services which take account of physical health, but training may not be relevant, and skills cannot be implemented, unless underpinned by the inner and outer organisational framework.

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