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What Determines Whether Nurses Provide Physical Health Care to Consumers With Serious Mental Illness?

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A B S T R A C T

People with serious mental illness (SMI) have heightened rates of chronic physical disease. This study aimed to identify what nurse and organisational factors predict physical health care provided by nurses in contact with consumers with SMI, through a survey in Australia ($N = 643$). Statistical analyses revealed that physical health care could be accounted for in terms of nurse views on consumer health, rights and nurse role ideal ('nurses should be involved in physical health care'), and organisational factors. However, organisational factors may be more important in determining physical health care than views and perceptions about consumers, roles and ideals.

People diagnosed with serious mental illness (SMI) have significantly shortened lives due to a higher incidence of physical illness such as cardiovascular disease, diabetes, and cancers (De Hert et al., 2011a). Increased risk of physical illness is due to: poor management of current co-morbidity; social–economic disadvantage; stigma of mental illness; use of second generation anti-psychotics; and lifestyle factors such as poor sleep and high calorie diets (Hardy & Thomas, 2012; Robson & Gray, 2007; Scott & Happell, 2011; Simonelli-Munoz et al., 2012). Despite clear evidence from clinical epidemiology of inequalities in health between people with and without SMI, there is continual demonstration of a neglect of the former group in terms of access to needed physical health care (De Hert et al., 2011b). Poorer access to physical health care for people with SMI is an international issue (Chaudhry, Jordan, Cousin, Cavallaro, & Mostaza, 2010; De Hert et al., 2011b). Health care gaps include screening and identification of chronic physical disease (Scott, Platania-Phung, & Happell, 2011), and reluctance of primary care staff to engage when aware that a consumer has been diagnosed with mental illness (Happell, Scott, Platania-Phung, & Nankivell, 2012; O'Day, Killeen, Sutton, & Lezzoni, 2005; Schmutte et al., 2009). One potential reason for these gaps is that physical health concerns voiced by consumers with SMI are not taken at face value by primary care service providers (O'Day et al., 2005; Van Den Tillaart, Kurtz, & Cash, 2009).

Improving physical health of people with SMI requires comprehensive approaches in physical health care systems (Lawrence & Kisely, 2010). Mental health care systems are integral as many people with SMI do not have linkage to primary care services (Ministerial Advisory Committee on Mental Health, 2011). Nurses situated in mental health care settings have an important role to play in boosting physical health care access and quality (Blythe & White, 2012; Bradshaw & Pedley, 2012; Happell, Platania-Phung, & Scott, 2011; Muir-Cochrane, 2006; Robson & Gray, 2007), although traditionally they do not play an active role in physical health care provision (Muir-Cochrane, 2006). However, physical health impacts on mental and other dimensions of consumer health (Prince et al., 2007), and nurses as a major group of health care professionals in mental health can respond more assertively to the lack of positive change in physical health of people with SMI (Happell et al., 2011; Robson & Gray, 2007).

The literature on the role of mental health nurses in physical health care of consumers include trials of intervention programs or care models aimed at improving physical health prevention and management (Griffiths, Kidd, Pike, & Chan, 2010; Porsdal et al., 2010; Shuel, White, Jones, & Gray, 2010; Smith et al., 2007), qualitative studies of nurse views on the physical health of consumers and health care arrangements (Happell et al., 2011), and inquiries into training needs (Howard & Gamble, 2011; Nash, 2005). As far as we are aware, only one study in the international literature has sought to identify predictors of physical health care (Robson, Haddad, Gray, & Gournay, 2013). In that study, nurses in a Mental Health Trust ($N = 585$) of the UK were asked about the physical health care they provide. Physical

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health care was significantly predicted by self-reported attitudes of participation in, and confidence in performing physical health care, training background in physical health learning (previous 5 years), nurse grade level, and inpatient employment (Robson et al., 2013). Organisational factors, such as the level of clarity in responsibility on physical health care among health care teams, were not investigated. This may be because in the UK there is policy on physical health care responsibilities (Department of Health, 2006) compared to places, such as Australia, where governance of physical health care in mental health services is less clear and more diverse. There has yet to be a direct investigation of nurse views and attitudes, and organisational factors as potential predictors of nurse physical health care. Given that an enhanced role of physical health care by nurses is a potential pathway of improving consumer well-being (Bradshaw & Pedley, 2012; Muir-Cochrane, 2006), predictive factors for current practices may represent foci for increasing physical health care.

This study aimed to determine what nurse and organisational factors predict a spectrum of physical health care practices by nurses in Australia. It was hypothesized that four groups of variables (nurse background, nurse views of consumer health, nurse attitudes on involvement and view of rights to care, and organisational factors) would predict physical health care. The specific variables in each group that may significantly predict types of physical health care were an open empirical question to be addressed in this study.

METHODS

Design

This was a cross-sectional study, employing an online survey of nurses employed in mental health settings in Australia. To gain the best possible representative sample of nurses across Australia, participants were accessed via the electronic membership list of the Australian College of Mental Health Nurses (ACMHN), the professional body representing nurses working in mental health. The study was approved by a university-based human research ethics committee. Participation was voluntary and consent was indicated by responding to the online survey. To ensure full survey responses, it was required that closed format questions be completed in order to proceed through the survey. Email reminders was sent by the ACMHN, to gain as high a sample size as possible.

Measures

The survey was largely composed of newly formulated questions as well as two selected scales from the Physical Health Attitude Scale (PHASe) (Robson & Haddad, 2012), developed in the UK, and utilised in the only other study available that looked at predictors of nurse physical health care of consumers with SMI in that region (Robson et al., 2013). This measure was adopted after gaining permission from the lead developer of that measure. Other items of the survey were developed to suit the context of Australia and to operationalize viewpoints of nurses that were identified in an earlier qualitative study by the researchers (Happell et al., 2012). The new items and PHASe scales adopted for the survey were pilot tested with a group of adults involved in public health. The survey was found to be highly comprehensible and easy to respond to, and minor revisions were made to questions as a result of feedback.

A set of questions of nurse background were included such as gender, years as nurse, type of mental health setting, and whether or not credentialed as a mental health nurse (which is governed and administered by the ACMHN). *Nurse perceptions of consumer physical health* (to be described herein as 'physical ill-health') were investigated by asking participants to 'rate' consumer health with the general community as a reference point, specifically: How would you rate the health of consumers of MH services, compared to members of the wider community? The specified health disorders were cardiovascular disease, diabetes, respiratory conditions and oral–dental conditions. The response options were: 'much worse', 'somewhat worse', 'about the same', 'somewhat better', and 'much better'. *Consumer lifestyle behaviours* were inquired about as follows: "In your opinion, in general what is the level of health problems among consumers of MH services, compared to members of the general community?" The behaviours were: poor diet, physical inactivity, excessive alcohol use, smoking, poor sleep behaviour, illicit drug use, and unsafe sex. The response options were the same as for the question on consumer physical health, just described.

To minimise the number of predictor variables, nurse perceptions of consumer physical health and behaviour were submitted to principal components analysis to explore whether the responses formed two composite variables. Communalities ranged from .47 to .67. The first two eigenvalues accounted for 56% of item variance. The pattern matrix showed clear differentiation between the items on physical health problems and the items on risk behaviours. Items for each set were summed to create scales. Higher scores represented perceived higher physical health of consumers with SMI. The internal consistency level of perceived consumer health was .84, and that of perceived consumer risk behaviours was .83.

The remaining independent variables were based on participant responses to statements in terms of (dis)agreement level. Nurse perceptions of consumer and nurse roles, and organisational factors were measured via nurse self-report, in terms of level of agreement with statements rated from 1 ('strongly disagree') to 5 ('strongly agree'). On consumer rights and nurse role the variables were: *nurse responsibility* ('Nurses in mental health settings should be involved in physical health care of mental health consumers'), consumer rights ('Consumers have a right to physical health care from mental health care services'). There was also a single statement drawn from the PHASe (Robson & Haddad, 2012, p. 77), to measure what will be called "consumer health worries"; the statement was "Consumers' health worries are mostly due to their mental illness". In terms of organisational factors, the variables were: *team meetings* ('The physical health of consumers is often discussed during mental health care team meetings'), *clarity of responsibility* ('There are clear lines of responsibility on physical health care of consumers, for each staff member in the team'), and presence of a *lifestyle program* ('We have a lifestyle program available for consumers').

The measure of physical health care was also drawn from the larger PHASe set of questions (Robson & Haddad, 2012). Health care actions [called "physical health-care practices" by Robson et al. (2013, p. 6)], were presented, such as "monitoring consumer's blood pressure". The rating response scale was: 1 ('never'), to 5 ('always'). This set of items addressed the following types of physical health care: *advice provision*, such as "giving consumers advice on dental health"; *assessment*, such as "testing consumers on glucose abnormalities (e.g. checking glucose in urine)"; *general practitioner (gp)/assessment on entry*, such as "checking if consumers have had their general physical health assessed when they first came into contact with our service", *drugs and alcohol*, such as "providing consumers with information and support to stop or reduce drug use"; and *lifestyle education*, such as "helping consumers manage their weight". Two changes were made to PHASe to suit the purposes of the current study. The prompt to the list of health care actions was changed to read as: "How often do you undertake each of the following practices with consumers?" In addition, four health care actions relevant to consumer physical health were added (ensuring regular eyesight assessment, advice on STD protection, and informational support in stopping or reducing drug use and alcohol intake).