Active steps towards a healthier life for people with severe mental illness: a qualitative approach to understanding potential for implementing change

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ABSTRACT

Objective: Our health systems are failing to provide optimal physical care for people with severe mental illness. To address this gap, Queensland Health and General Practice Queensland in partnership, developed a comprehensive package of guidelines and health messages. However, guidelines alone are likely to be inadequate motivators of change. The objective of this research was to qualitatively explore key stakeholders expectations about the implementation of guidelines with the purpose of identifying potential interventions to support practice change.

Method: Participants were recruited from the partnership governance committee. A semi-structured interview guide was used to gather data. Using grounded theory techniques, the data was analysed to identify key themes.

Results: All stakeholders agreed that the purpose of developing comprehensive guidelines and health messages was to achieve change through innovation and the promotion of early intervention, reduction of avoidable admissions and sectoral integration. However, existing structures within the system were considered to be insurmountable barriers.

Conclusion: Key stakeholders sought broader change than just guidelines and health messages developed by the partnership focused specifically on awareness-raising about the physical care of people with severe mental illness. However, there was no clear consensus as to what that change should be. This mismatch between the goals and actions of such a large-scale initiative is problematic. Some suggestions are made about how to address change.

Introduction

Despite improvements in the early detection of psychosis, and the implementation of community-based services for those with severe mental illness (SMI), our health systems are failing to provide optimal physical care for this population (1). The poor physical health of this population is widely appreciated and features prominently in the Fourth National Mental Health Plan (2). Mortality risk is over 70% higher in people with SMI than the general population even after adjusting for demographic factors such as socio-economic status (3). Indeed, the risk of mortality from chronic physical disorders, including cardiovascular disease, cancer and chronic lung disease, is 10 times that of suicide (3) although the latter is most often the focus of attention (4). A recent systematic review identified 36 unique studies in 19 different countries that demonstrated the significance of this problem (5). The oral health of people with SMI is an even more neglected area; the resulting caries and periodontal disease leading to a threefold increase in the loss of all dentition (6). Although many factors are likely to contribute to the poor health of people with SMI (7-9), explanations usually point to lifestyle factors (e.g. obesity, lack of exercise, alcohol and tobacco use). Commonly prescribed antipsychotic agents, mood stabilisers and antidepressant medications can also predispose people to physical illness through mechanisms such as weight gain (10, 11). However, mortality remains high for this population even after adjusting for behavioural risk factors (12).

In 2008, the Queensland Health Mental Health Alcohol and Other Drugs Directorate funded General Practice Queensland to consult a broad range of stakeholders and comprehensively investigate ways of addressing the physical health needs of people with SMI. Key recommendations were identified and a partnership between Queensland Health and General Practice Queensland was formed. A core initiative of the partnership was a project, which

aimed to improve the physical and oral health of people with SMI by developing and then implementing supportive structures for clinicians and consumers. A state wide governance structure was established. Key activities included the following: (a) development, implementation and delivery of an awareness campaign, resources, state-wide clinical protocols, and an ongoing monitoring system; (b) liaison between the public mental health sector and general practice; (c) education and training; (d) targeted health promotion; (e) research; (f) ensuring that every consumer in a mental health service had a nominated general practitioner; (g) consumer and carer led information programs; and (h) clear communication strategies. Underpinning this activity was a comprehensive program of guidelines and health promotion messages for use by primary and tertiary care clinicians, the community sector and families, carers and consumers (see Table 1). This project was named *activate: mind & body*¹.

[INSERT TABLE 1 ABOUT HERE]

The most common strategy for modifying behaviour of health professionals is to develop and disseminate guidelines that encourage the standardisation of good practice (13). Unfortunately, the translation of health promotion and preventative knowledge into practice is usually hindered by the lack of time, resources, training, incentives, feedback, and supportive systems (14). Some researchers (15) have concluded that the adoption of guidelines is not a unitary activity and, instead, exists within a complex context that must be fully considered if change is to occur. In this regard, others (16) have proposed a circular process of change, showing how actions at the system, environment or organisational level

¹ A branding and marketing exercise involving mental health consumers, carers and clinicians was undertaken during the consultation stage of the partnership. The brand *activate: mind & body* with an associated logo was agreed as a result of the branding and marketing exercise. Once agreed upon, both the project and the program, which was the major output of the project, were named *activate: mind & body*. A specific requirement of the branding is that “activate” does not commence with a capital ‘A’, and the ampersand is not replaced with ‘and’. This protocol will be adhered to through this paper.

(e.g., policy, resources, culture and leadership) influence and strengthen the likelihood of changes at the group/team level (e.g., motivation, capacity, and climate). These changes then influence and strengthen the likelihood of changes in the delivery of care, which ultimately impacts on the consumer experiences, clinical outcomes and costs.

If standardized guidelines such as those contained within the *activate: mind & body* program are to be adopted and embedded as part of everyday practice, partnerships need to be developed, consensus needs to be reached and engagement in the process needs to be achieved (17). One theoretical framework that guides understanding of the process of embedding new practices is Normalisation Process Theory (18). Normalisation Process Theory focuses on the experience of those within the systems into which complex interventions are introduced. The General Theory of Implementation, which is a further iteration of Normalisation Process Theory, has recently been developed (19). This general theory articulates four main constructs that impact on implementation, namely (a) *capability* (i.e., complex interventions need to be workable and able to be integrated within contexts and relationships); (b) *capacity* (i.e., deliberate attempts to initiate complex interventions are affected by existing social roles and networks as well as the availability of resources); (c) *potential* (i.e., operationalization of a complex intervention is reliant on individual intention and collective commitment) and (d) *contribution* (i.e., continuous contributions of sense-making, participation, collective action and appraisal are required if a complex intervention is to become routine practice). According to this theory, *potential* provides the starting point from which the implementation process can be understood (19). In this research, which was conducted prior to the implementation of the *activate: mind & body* program, we sought to develop a qualitative understanding of the implementation potential of the *activate: mind & body* program according to key stakeholders.

Method

The research was approved by the human ethics committees of Queensland Health and Griffith University.

Participants

The sample comprised members of the *activate: mind & body* governance steering committee. Four members of the project governance team who had nominated a permanent proxy and therefore had not been actively involved were excluded from the sample. The remaining seventeen members were contacted by electronic mail and fourteen consented to be interviewed (female = 9 and male = 5). Most held senior or executive management positions in their organisations (see Table 2).

[INSERT TABLE 2 ABOUT HERE]

Data collection

The interview questions explored perceptions about the purpose and expected outcomes of the partnership. Consistent with General Theory of Implementation (19), we ascertained individual and collective intentions, values and commitment that were pertinent to the potential of the *activate: mind & body* program. A semi-structured interview guide was electronically mailed to each participant prior to the interview and included the following questions: (a) How did you come to be a part of the *activate: mind & body* governance committee? (b) What were you hoping to achieve by being involved in the project? (c) What were the key drivers that enabled the development of the project? (d) What will help the project to progress? (e) What are the barriers to progression of the project? and (f) What do you think are the most important things that will be achieved by the project? Each interview was digitally recorded and lasted between fourteen and thirty minutes. The interview time

was kept short in recognition of the busy executive and senior management roles of participants. The audio recordings were transcribed verbatim and checked for accuracy.

Data analysis

Data were thematically analysed using grounded theory. The following steps were conducted: (a) each interview was read; (b) data was open coded on a line by line basis using NVivo 9TM; (c) codes were organized into categories and explanatory themes were developed by asking the question “What is this an example of?” (i.e., second level coding) (20) until all data could be accounted for (21-23) and (d) emergent themes were discussed to determine the most salient, and their relationship to each other (23). The themes and examples of the data are provided in Table 3. A full data coding matrix is available from the first author on request.

[INSERT TABLE 3 ABOUT HERE]

Results

The results revealed strong levels of individual commitment to the *activate: mind & body* program. In terms of the General Theory of Implementation, potential for the implementation of the program was evidenced by key stakeholder enthusiasm for the purpose of the program, the principled approach they took to its design and the strength of their partnerships. There was a sense of pragmatism that tempered their enthusiasm, but rather than addressing their doubts, the participants tended to overlook those challenges leading to a flaw in the implementation potential of the *activate: mind & body* program.

Enthusiasm for the purpose

Overwhelmingly, participants identified their hope for long term change in the provision of physical and oral health care to people with SMI. This hope was based on a strong sense of equity, social justice and human rights. Participants believed that achieving this change required the formation of collaborative relationships and partnerships. In turn, collaborative

partnerships required leaders with vision and an enthusiasm for improving the physical and oral health care of people with SMI, which accounted for their decision to join the governing body. Change required innovation, sectoral and policy integration, time and funding. Participants anticipated that improvement was a long-term objective beginning with awareness-raising but eventually becoming embedded within everyday practice.

Principles – a commitment to achieving good health

Participants discussed their belief that consumers needed to be treated holistically. They believed that access to good health and good healthcare services was a fundamental right. Participants believed that good health went beyond the individual with SMI and included family relationships, social networks and access to opportunities to be productive members of society. However, other society members needed to advocate on behalf of people with SMI to ensure that the fundamental principles of good health and good healthcare were available and accessible. For many participants, their ability to advocate for change contributed to both their intention and commitment to deliver the *activate: mind & body* program.

Partnerships – an essential response

Participants believed that the physical and oral health outcomes for people with SMI depended upon collaborative relationships and partnerships across multiple levels. Trusting relationships needed to be developed with consumers and carers, based on respect for their knowledge and information. It was within long-term relationship with consumers and carers that clinicians were able to best monitor and manage chronic physical as well as mental health conditions. Participants believed that effective partnerships with other healthcare providers were required to provide optimal healthcare. When effective partnerships were established, healthcare providers were able to more efficiently coordinate care within a

fragmented healthcare system. Participants believed that effective partnerships were founded on trust and were mutually beneficial.

Pragmatism – the thread of concern

Overwhelmingly, participants believed that pre-emptive early intervention would lead to a reduction in avoidable hospital admissions however, long-term change across the entire healthcare sector was essential. Time was especially important to achieve improved outcomes. However, the short-term vision of funding cycles was likely to be problematic because achieving measurable improvements in the physical and oral healthcare of people with SMI might take years to become apparent. They believed that an existing focus on mental health needs at the expense of attending to physical and oral health, combined with contextual divisions created by increased professional specialisation, disciplinary boundaries, and sectoral boundaries within the healthcare system contributed to care fragmentation. Thus, care fragmentation needed to be overcome if improved health were to occur. Although partnerships were recognised as essential to delivering accessible healthcare, this contextual separateness created situations whereby different organisations did not know how to work with one another in meaningful ways with the result that finding synergies within and between organisations was difficult. Consequently, optimal care of people with SMI was jeopardized.

Importantly, some participants believed that already disadvantaged people were further disadvantaged by broader societal barriers to good health. These barriers included a failure to provide valued roles such as sustainable and meaningful employment, and the promotion of negative lifestyles through continued advertising of unhealthy behaviours in the broader media (e.g., junk food and alcohol advertising). Participants also acknowledged that providing care to this population was challenging, not only in terms of their physical and oral

health, but also in terms of complex issues such as homelessness and the complexity associated with mental healthcare needs.

In summary, participants were enthusiastic about improving the health of people with SMI. This enthusiasm was underpinned by notions of human rights, social determinants of health, equity and social justice, and holism. Improving the physical and oral health of people with SMI was dependant on collaborative relationships and partnerships, active leadership by enthusiastic people with a vision for the future, continual monitoring of progress, and adequate funding and resources. However, over-specialization within and between professional groups, contextual separateness, and territorialism were considered barriers to achieving change.

Discussion

The primary purpose of this research was to understand, from a qualitative perspective, the potential for implementing guidelines as a mechanism to improve the physical and oral health of people with SMI. We conducted this research prior to the state-wide implementation of guidelines for practice, and used the General Theory of Implementation as a theoretical framework for guiding data collection and interpretation. We found that although participants were enthusiastic about improving the health of people with SMI, they pragmatically identified multiple existing barriers to achieving that vision. They identified that the first step in achieving long term change was to begin with awareness raising and the development of consistent guidelines and health messages, (i.e., the *activate: mind & body* program). Thus, although the purpose of the *activate: mind & body* program was to reduce avoidable admissions, and achieve sectoral and policy integration, guidelines on their own were unlikely to achieve these goals. Further ways of developing collective commitment to overcoming barriers were required. Without processes for engendering shared values and

commitments, the potential of the program would be jeopardized (19). Thus, engaging individuals to explore their own attitudes and values, and ultimately share a commitment to implementing changes that facilitate improved health for people with SMI will be essential (19).

Participants believed that long term change was essential to achieve the objective of improved health for people with SMI. However, healthcare professionals are nested within complex professional and organisational relationships within specific service delivery agencies (24). Thus, successful implementation of new ways of working is dependent on establishing interpersonal relationships within systems and organisations (25). However, little is known about these relationships inside the organisational and professional cultures within the local context (26). Without understanding the interactions between the social roles and norms of organisations and professional groups in the local context, the capacity for successful implementation to occur is likely to be variable (19). Unless the structures and processes within individual organisations were understood, achieving long-term change from outside organisations was unlikely to be successful (27). Thus, prior to implementation, it will be essential that context specific relationships and affiliations are explored (19).

There are limitations to this study. Participants were limited to members of the *activate: mind & body* steering committee with governance responsibility for the *activate: mind & body* project. The small number of participants combined with the limited participant pool may affect transferability.

Conclusion and Next Steps

A major focus the *activate: mind & body* program has been the development of guidelines for dissemination amongst health professionals. We have reported the perceptions of members of the *activate: mind & body* governance steering committee who were involved in a partnership

which aimed to develop and disseminate supportive mechanisms to improve the capacity of health professionals to provide care that improves the physical and oral health of people with SMI. This study is the first of a series of studies, which aim to understand how healthcare professionals can be supported to implement guidelines in practice. We investigated the implementation potential of the *activate: mind & body* program by exploring the motivations and understandings of members of the *activate: mind & body* governance steering committee and found that, although the short-term focus of the *activate: mind & body* program was awareness raising about guidelines and professional practice that could improve the physical and oral health of people with SMI, the governance steering committee were aiming to achieve much longer term change by healthcare professionals and within service delivery organisations who were providing care to this population. However, there was no clear consensus on realising long term change, or the embedding of new practices in everyday clinical practice routines. Although there was a common desire to achieve long-term cultural change, the aspects of existing care processes that were problematic or required changing were not clear in the data. Thus, further research is required to understand the structures and processes within organisations and the impact that they have on the implementation of the *activate: mind & body* program in practice. It is particularly important that the way in which interventions interact with existing patterns of organisational service delivery, professional practice and consumer-provider relationships be explored (28). Furthermore, implementing effective models and systems of care must be linked with theoretically informed frameworks to succeed with achieving long-term change (27). Thus, we plan to prospectively apply a theoretical basis (i.e., General Theory of Implementation) to the implementation of guidelines and explore the clinical context in which the physical and oral healthcare of people with SMI is being provided.

Acknowledgements

This research could not have occurred without the support of the project team who were involved in the development and implementation of the *activate: mind & body* program. We respectfully acknowledge the ongoing commitment and dedication of the team members from Queensland Health and General Practice Queensland.

The partnership between General Practice Queensland and Queensland Health received joint funding from the Australian Government Department of Health and Ageing (DoHA) and Queensland Health.

The research reported in this paper forms part of a larger project, which has been supported by funding from an ARC linkage grant (Grant number LP110200261).

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