Consumers at the centre: Interprofessional opportunities for meeting the physical health needs of mental health consumers

Abstract

Interprofessional care and consumer oriented services are embodied in modern health care policy and practice. The views, needs and values of consumers are essential to ensuring translation of policy to practice. This is particularly pertinent for people diagnosed with mental illness who experience higher risk of physical health problems and premature death. A qualitative, exploratory research project was conducted, involving focus groups with members of a mental health consumer group in the Australian Capital Territory. Participants were asked about their experiences and opinions in relation to physical health and care and treatment provided. Focus group transcripts were thematically analysed.

Three themes arose via analysis: (1) *Meeting diverse physical health care needs*, where mental health consumers connect with many types of health care providers, conventional and non-conventional, (2) centre of the interprofessional team for holistic care, where there is preference for a consumer-centred group effort in addressing health issues as the model of care; and, (3) more gateways, less gate keeping, where points of access were affected by cost, place and gatekeepers could be enabling. People with mental illness seek enhanced collaboration between a broader range of

health professionals, with potential to contribute to their overall health and well-being.

Keywords

Consumers

Interprofessional

Mental health

Mental illness

Physical health

Introduction

Population studies indicate a higher risk of cardiovascular disease and diabetes in people with mental illness (British Medical Association, 2014; Galletly et al., 2012). In addition, atypical anti-psychotic medications routinely prescribed for mental illnesses are associated with negative metabolic effects on physical health. Atypical antipsychotics are primarily prescribed for the treatment of psychosis, they differ from traditional drug therapy in having less extra pyramidal side effects (Foley & Morley, 2011; Teff et al., 2013).

Despite this knowledge, under-detection and poorer treatment of physical health characterises modern health care of people with mental illness (Littman et al., 2015; Mitchell & Lord, 2010; Mitchell, Vancampfort, De Hert, & Stubbs, 2015). For example, people with mental illness are significantly less likely to undergo routine screening for metabolic disorders and cancers, compared to the general population. Moreover, metabolic data such as waist circumference, hypertension or fasting glucose screening is often absent or poorly reported in consumer clinical records (Happell, Platania-Phung, Gaskin, & Stanton, 2016; Happell, Scott, & Platania-Phung, 2012; Millar, Sands, & Elsom, 2014; Rosenbaum et al., 2014). However, despite significant attention to poor physical health care of people with mental illness, there is little evidence of solution implementation in policy or practice (Ehrlich, Kendall, Frey, Denton, & Kisely, 2015).

For the purposes of this paper the term consumer is defined as:

> Any person who identifies as having a current or past lived experience of psychological or emotional issues, distress or problems, irrespective of whether they have a diagnosed mental illness and/or received treatment. It is most commonly used when referring to a person utilising, or who has utilised, a mental health service (Mental Health Commission, 2015, p. 61).

Background

People with mental illness have a right to access quality and comprehensive care from all health care services, ranging from primary care through to specialist mental health services. In addition, given inequalities in physical health between people with and without mental illness (Laursen, Musliner, Benros, Vestergaard, & Munk-Olsen, 2016; Laursen, Nordentoft, & Mortensen, 2014), health services should commit heavily to providing comprehensive physical and mental health care. Indeed, despite recent innovations in mental health care policy leading to an increased focus on provision of physical health care services, disparities in physical health between people diagnosed with mental illness and remainder of the populace are widely reported (Laursen et al., 2016; Sugawara et al., 2014).

Debates about how to address siloing of specialist services and responsibilities are unresolved (Breslau et al., 2017; Reddy & Rado, 2017). Proposed solutions include changing culture in mental health settings, or attitudes of health care professionals to improve focus on physical health care (Suetani, Rosenbaum, Scott, Curtis, & Ward, 2016), and to redesign professional roles to improve access to and delivery of service (Collins, Hewson, Munger, & Wade, 2010; Lawrence & Kisely, 2010). One example of this is collaborative care arrangements for people with mental and physical health diagnoses of specific illnesses (such as depression and diabetes) to provide physical and mental health care in one location (Johnson et al., 2012).

The strongest consensus on improving physical health services for people with mental illness lies with better collaborative and interprofessional care. For instance, Ehrlich et al. (2015) examined perspectives of attendees to a workshop of health service groups in Australia. Participants believed "an inclusive, networked approach to care delivery" (p.1), combined with increased funding, would best support physical health needs of mental health consumers. Thirty-seven per cent of participants from the private sector and 44% of public sector representatives endorsed 'collaboration and communication' as the most high-priority solution to improve physical health care (Ehrlich et al., 2015).

Collaborative, interprofessional, continuous, consumer-oriented care are themes emphasised in contemporary health policy (Commonwealth of Australia, 2009, 2013). In practice, however, health care environments are often fragmented and in conflict, resulting in services that do not achieve such ideals (Cranwell, Polacsek, & McCann, 2016; Ehrlich et al., 2015; Kaufman, McDonell, Cristofalo, & Ries, 2012). Views of mental health consumers reinforce the significance of these problems, and major differences that health provider collaboration would make to their experience. In their review of research on consumer perspectives, Chadwick, Street, McAndrew and Deacon (2012) noted: "The quality of this [physical health] care is compromised by practical problems and interpersonal difficulties between service users and health-care providers, and between providers of mental health services and those providing physical care." (p. 212). They reported later that: "The coordination between those who provide physical health care and those who provide mental health care is poor." (Chadwick et al., 2012, p. 216). Similarly, in an in-depth qualitative study, Blixen *et al*. (2016) concluded that: "Care approaches that provide social support, help in managing stress, optimise communication with providers, and reduce compartmentalisation of medical and psychiatric care are needed to help these vulnerable individuals avoid complications and premature mortality." (p.194) Furthermore, Naylor et al. (2016) reported that: "Many of those we interviewed believed that having someone to help with co-ordination – someone with a good overview of both mental and physical health needs – would be a significant step towards integrated care." (p. 16).

In light of the need for consumers to have co-ordinated health care solutions, some innovative practices have been trialled. It is encouraging to see practical solutions developed consistent with addressing attitudes and culture of physical health care in mental health settings, and reconfiguration of professional roles. One example of such a solution is a physical health nurse consultant role being piloted and implemented to facilitate decisive and comprehensive care (Happell, Stanton, & Scott, 2014).

The issue of interprofessional collaboration also raises the question of what health care professionals and carers consider important to the physical health care of people with mental illness. There is a lack of evidence referring to the physical health of people with mental illness (Happell, Platania-Phung, & Scott, 2013). There is a considerable body of literature from general medicine, epidemiology and psychiatry (De Hert et al., 2011; Morgan et al., 2013), as well as nursing (Happell et al., 2013; Hardy & Gray, 2010), social work (Aschbrenner, Bartels, Mueser, Carpenter-Song, & Kinney, 2012), and psychology (Bisconer & Harte, 2010; Pollard et al., 2014). In terms of collaboration, the literature mainly concerns medical practitioners communicating more effectively, with the importance of collaboration between psychiatry and general medicine commonly discussed. For instance, Lambert, Velakoulis, and Pantelis, (2003) asserted there should be "specific interprofessional teams with broad medical and psychiatric expertise and training should be created. These could serve as enhanced

models of shared care." (p. S69). There does appear to be movements in this direction. For example, research teams on the public health issue of joint mental and physical health problems have been becoming more interprofessional, with the inclusion of sociology and health psychology (Coventry, Dickens, & Todd, 2014).

Despite these endeavours, health service options, provision and policy have much work to resolve the question of how to meet the physical and overall health needs of people with mental health difficulties (British Medical Association, 2014; Happell et al., 2015; Horvitz-Lennon, Kilbourne, & Pincus, 2006) and the consumer voice is pivotal to directions forward as is asserted in health policy (Commonwealth of Australia, 2009, 2013; National Mental Health Commission, 2012) and internationally (Baum, 2016; Department of Health, 2010). In addition, developing services to meet the needs and values of mental health consumers is clearly important for informing the provision of public funding and subsidies of health services.

This paper contributes to centre the consumer voice on health care provision (e.g. nature and scope) by reporting mental health consumer views on services and other sources of support and partnership in relation to their physical health. The overall aim of the research was to explore consumers' views of how their physical health needs are addressed within mental health services; and strategies that have or could be used to improve the current situation.

Methods

Research Design

An exploratory qualitative design was considered the most suitable to examine the chosen topic. Qualitative exploratory research is particularly appropriate when the issue of interest has not previously been researched in any detail (Stebbins, 2001). A qualitative exploratory approach was also favoured because it allows the participants' own perceptions to be heard as informants about the topic. Mental health consumers have had little opportunity to contribute to this research agenda (Happell, Ewart, Bocking, et al., 2016; Happell, Ewart, Platania-Phung, & Stanton, 2016), and therefore a method which elicits their views, experiences and opinions is important.

Participants

The research was conducted in the Australian Capital Territory (ACT). The peak body for mental health consumers, ACT Mental Health Consumer Network (ACTMHCN), endorsed the research and provided invaluable assistance.

The ACTMHCN advertised the project in the weekly bulletin it sends to members and asked interested consumers to make contact with them. Consumers who made contact were sent a copy of the participant

information sheet and a consent form. They were then advised the time and date for the four scheduled focus groups and asked to select the most convenient. Participants were also provided with contact details for the research team should they have additional questions. Thirty two consumers contacted ACTMHCN indicating their willingness to participate and were enrolled in one of the focus groups. One participant was subsequently unable to participate on the day leaving a total of thirty-one participants in the research. The number of participants in each focus group ranged from 7 – 9. Consumer participants were paid $75, according to ACTMHCN policy and consistent with contemporary mental health practice that acknowledges the right of consumers to be reimbursed for their expertise (Australian Capital Territory Government, 2013; Commonwealth of Australia, 2010)

Procedure

Focus groups were conducted at the premises of ACTMHCN. This venue is centrally located and accessible by public transport. It is also familiar to many participants and therefore may have enhanced their sense of comfort in the environment. Focus groups were digitally recorded, and were of 90 - 150 minutes in duration.

The interview guide was developed by the research team. A list of questions was initially developed from a comprehensive review of the

literature, and reflected areas where more information was needed. These questions were further discussed by the two interviewers. The interview guide included the following questions:

1. Please describe your experience of physical health care within mental health services
2. Please provide examples of how physical health concerns been responded to:
    a. Within mental health services
    b. By general practitioners or other community based clinicians
3. How much emphasis has been placed on diet, physical activity, smoking status, sleep and other health promotion activities?
4. Please describe any actions or factors that have assisted you with physical health issues
5. Please describe any actions or factors that have been a barrier to addressing physical health issues?
6. Can you describe ways the current system could be improved?

Participants were, however, encouraged to raise opinions and issues beyond those encompassed in the questions from interviewers.

At the commencement of each focus group participants were provided a brief overview of the study, entitled: *Physical health of consumers*

of mental health services: articulating the consumer perspective. They were advised that our aim was to better understand their opinions and experiences regarding their physical health and physical health care, and how both might be influenced by their diagnosis of mental illness. The researchers indicated that they had some specific questions to ask but these were not intended to be restrictive and they were free to discuss any issues of interest within the broad framework of the topic. The opportunity to ask questions or seek clarification was clearly stated.

Two interviewers facilitated all four focus groups. Both were highly experienced and qualified researchers. They were deliberately selected because of their diverse backgrounds. One had a mental health nursing background. The other was a consumer researcher and advocate for physical health for mental health consumers. This approach reflects the genuine commitment of the research team to the embodiment of consumer participation through co-production. The term co-production describes collaboration and partnership between consumers and academics from health professional backgrounds (Meddings, Byrne, Barnicoat, Campbell, & Locks, 2014). Genuine co-production requires equitable relationships where knowledge based on lived experience of mental health challenge is regarded as equally valuable to professional knowledge (Durose, Beebeejaun, Rees, Richardson, & Richardson, 2011). This approach has been found to enhance the quality and relevance of research findings (Gillard, Simons, Turner, Lucock, & Edwards, 2012). In addition, it is likely the presence

of a consumer researcher facilitated more honest and open discussion than might have been the case with only health professional researchers.

Ethical considerations

The research was approved by the University of Canberra Human Research Ethics Committee. Participants were provided with a comprehensive overview of the purpose of this research and how the findings would be utilised. Assurance about privacy and confidentiality was provided given that no names of people or organisations would be made public in any form.

Participants were informed that participation in the research was their personal decision, and they were free to withdraw from the study at any time should they choose to do so. Participants signed the consent form before the focus group commenced and were given a copy of the participant information statement to retain.

Data analysis

Audio recordings were transcribed by an independent service to provide a complete and accurate record of focus groups. Data were then analysed thematically according to the systematic framework developed by Braun and Clarke (2006). Focus group transcripts were read several times

and coded independently by two members of the research team using the qualitative computer software program NVivo10. A thematic framework was developed based on common patterns observed through the coding process. The identified themes were discussed by the two researchers, with some further refining to ensure accuracy and achieve consensus. The thematic structure was then discussed by the research team as a whole, with minor revisions resulting.

Results

Three closely intertwined themes were identified through the analysis: (1) *seeking diverse services for physical health needs; (2) centre of the interprofessional team for holistic care; and (3) more gateways less gatekeeping. These themes will be presented and supported with verbatim illustrative quotes from participants.*

Seeking diverse services for physical health needs

Mental health consumers describe their need for a diverse range of health professionals and other support people, both within and outside the traditional health system, to support physical well-being. These included specific people and services they had accessed for physical health matters. 'GPs' were commonly the first line choice for physical health help seeking but there was great variability in the nature of primary care practices

available and their level of accessibility. For example some participants referred to the dominance of medical model approaches to care and treatment with other services that might contribute to physical health frequently being neglected:

> *How can we promote physical activity as a part of the holistic approach? There's a psychologist, psychiatrist, family, friends, supports available. Where does physical activity fit in there? How is that promoted and how is that actually going to be considered an appropriate means, in conjunction with everything else that's going on, ... (FG2).*

Participants also referred to a lack of some specialist services relative to the larger cities:

> *... Beyond Blue [Community organisation aimed at addressing issues associated with depression and anxiety] should be in every regional and capital city ... Why can't we have local depression, anxiety, mental health, addiction organisations that operate at a local level?- ... Where you can go and say, "Look, I need help with my addictions, my loneliness, my eating problems (FG2)."*

Many consumers described experiences of being compelled because of financial circumstances, to use large primary care practices to access

providers at no charge (Referred to as 'bulk billing' services, where there are no out of pocket expenses for consumers as the health service charges back to Medicare, Australia's public health insurance program): "*When you have a limited income, your option is to see a bulk billing doctor (FG1).*

Even this form of free access was not always easy to find and sometimes came at the expense of having an ongoing relationship with one provider: "*I go to somewhere you can get bulk billed, but that's not always easy, and it's hard to then get the continuity in some of these big GP clinics anyway (FG4).*"

With difficulties accessing GPs and receiving referrals for specialist services to address diverse physical health needs, some consumers had received referrals to physiotherapists, occupational therapists, exercise physiologists and dieticians. However, this was often after a period of being unaware of health provider options:

> *So only recently I've discovered I can see a physio ... after seven years, nothing has ever been suggested to me. I had to figure out what was available (FG1)*

Participants reported highly valuing access to practitioners such as chiropractors, naturopaths, acupuncturists and massage therapists. Though these practitioners did not require referrals, cost was a major barrier in the

absence of private health insurance, as these services do not attract a government rebate in Australia:

> *….they'd [doctors] give me medications that made me sick or they threw my mood out ... the only way I could manage it was ... it wasn't just lifestyle stuff, I actually needed naturopath support and different alternative therapies and they helped a lot, but then I just couldn't afford it anymore..(FG4)*

When discussing physical health, participants frequently talked about community-based activities that included mind-body practices such as yoga, pilates, tai chi, stretch therapy and meditation. The importance of accessing healing through body practices, and the limitation of talk therapies was raised, especially in the context of trauma:

> *…related to my alternative therapies is embodied practices… because and with [experiencing] trauma, a lot of that stuff is in your body… that's something I find really frustrating that I can't access… it affects my physical health as well and I know some physical things have changed because I've done some body work (FG4)*

The cost of services considered as 'alternative health practices' were prohibitive to the participants. However, many of these services were highly valued. While they might not lead to cures or eradicating chronic health

problems, they were greatly valued for symptom relief and general well-being:

> *I would absolutely love to [do] much more, like, alternative [therapy]…I prioritise once every six months….And I try and save for it…. I don't think they cure you, but they help with symptoms and that [alternative] helps with feeling more relaxed and… I think that is an important point about being able to access those sort of things…like naturopathy, and massage and acupuncture… (FG1)*

Some also engaged, or would like to engage, in community cooking groups, sports groups, dance classes and local gyms, which meant engaging with leaders of those activities:

> *So I joined the local gym… and I'm trying to do body balance twice a week and I've just signed up for a personal trainer, which is, really, you know, so difficult, difficult. But it does help, makes me feel a little bit better and I'm getting muscles (FG3)*

Centre of the interprofessional team for holistic care

The second theme reflected participants' desire to be at the *centre of the interprofessional team for holistic care*. The most common physical health challenges that consumers reported were the impacts of psychiatric medications, weight gain, diabetes, and pain management, although very few spoke of having access to specialised interprofessional clinics to support them. Nonetheless, one participant from personal experience talked about the importance for psychiatrists, psychologists, general practitioners, caseworkers and naturopaths to work together and its role in improving prospects for one's physical health:

> *If you have all these people working holistically, you have a chance … finally when it falls into place, things work out. I think it's very silly if just one arm of this does some work and they're not all talking to each other because you need all that together to have a good mental health care plan. If that doesn't happen, it's very, very difficult ... it's mind, body and spirit and they're all interconnected (FG3)*.

Participants provided many examples of care which focused on the mental health condition itself at the neglect of a more holistic approach to care, for example:

> I have, in my experience, with my particular diagnosis, from my psychiatrist all the way down, they say ... your condition fits the medical model very well. So they don't think in terms of the whole person. They don't think in

terms of those lifestyle factors and they don't think about the effect the medication will have on you ... weight gain, your loss of functioning, in terms of not having the energy to go out and do those sorts of things. There are some people in mental health who do take that more into consideration, but there's not really the support to do that outside of the room in which you see that person, where they tell you this is what you should be doing and then they don't really facilitate that in the real world. (FG1)

The importance of keeping the consumer at the centre of healthcare team was articulated particularly in relation to the importance of coordination of care and communication between various components of the health care system: *…[it is important] not to forget to talk to the client…The client is at the focus of it.*

Communication was negatively impacted by short GP consultations:

they've [GPs} got this 10-minute window where they can see you ... you've got to condense everything down into that period of time, and then they've got to write down whatever, and give you a script, and send you on your merry way. But having a doctor actually sit and listen to you and say, "Okay. Well, all right I'll check your blood pressure," or, "I'll check your stomach," and whatever parts of your body that are

causing problems, and actually be more interested in your actual health. (FG2)

Crucial to the effectiveness of coordination roles would be the understanding that people's health is dynamic, such as changing health between consultations, and recognising that despite the impressions of health professionals, the individual is ultimately the best judge of his or her own state of health:

No, she [clinical manager] ... goes, "I'm speaking to your doctor and she said you're okay. I've spoken to your outreach worker and she said you're okay, you know, so I'm really glad."… I said, "Actually I've been through a really bad depression." And she sort of said, "Oh well, they didn't tell me that." I haven't seen them for six weeks, what do you expect? (FG3)

Participants believed, in coming to a more collaborative arrangement, practitioners needed to have more comprehensive knowledge related to both physical and mental health:

….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 … (FG1).

Keeping the consumer at the centre of care can only be possible if the consumer is an active participant in shared decision-making. One consumer spoke about the desire to work with a team to explore medication choices but was confronted with a top-down response from the health practitioner:

> *…I'm doing vitamin therapy and I said, you know, hopefully with the goal of reducing or ceasing one of my medications, and she [psychiatrist] said, "That will be up to me to decide, nothing to do with you." And I said, "Well, obviously I'm not going to come off it without everybody working together." But she was just so dismissive of it, just absolutely (FG3).*

While consumers wanted practitioners to communicate and share, they talked of distress and fatigue of relaying complex histories over and over again. Effectively this practice amounted to story-telling fatigue:

> *…you get so tired of saying your story over and over and over again to umpteen dozen different – I don't know how many different psychiatrists I had to tell my story to when I was in that hospital, you know. …and not only them, but just everybody, just constantly, you know… (FG2)*

More gateways, less gate keeping

Primary care, especially seeing a GP, was seen as a potentially important gateway into the health care system. However, lack of continuity of care made interprofessional care much harder to achieve. For one participant, GPs were accessed solely to get a referral:

> *I pretty much use GP's only – I haven't had a regular GP for years because they've never helped me with anything, but I use them as gatekeepers… (FG4)*

There were cases where providers actually did not respect each other as evidenced by consumers' experiences of how one provider talked about another provider:

> *My ex-psychiatrist absolutely totally and utterly belittled everything I was doing with my GP, my naturopath, even my exercise, just completely…(*FG3)

For many consumers, getting through a gate was simply a matter of affordability. As one participant put it: *'Can't access the service if you can't pay for it' (FG3)*. But the presence of gates was also influenced by where services were accessed. For instance, in one focus group a health co-operative was discussed, where consumers were supported by nurses who were seen as opening gates for them:

Actually at the Co-op… you have an appointment with the nurse first, and she does all that…routine-type stuff, blood pressure… Just physical nurses. Nothing to do with mental health. They'll spend up to 45 minutes with you. So you get more care. And then the doctor literally signs the paper [laughs]. (FG1)

It is during a health consultation that some consumers became aware of what, at least on paper, was available as health service options but felt that they were constrained by both the person consulting them and what was covered under the national health insurance program:

…. most people – can't afford these astronomical tests and the costs involved of getting X-rays and ECGs and others (FG2)]

Furthermore, consumers were frequently not advised about what the out of pocket expenses would be once the insurance rebate had been paid (Australia's Medicare system, in many cases, requires the consumer to cover cost and claim a rebate later):

…It's often they'll [medical specialists] tell you how much it will be, but they won't tell you how much of that you'll get back until you're actually talking to them (FG2).

These represented multiple gates and potentially access would depend on how one went about asking the gatekeeper:

…. I got referred to a dietician and a physiotherapist…But I looked on the form, and there was a lot of other options, and I thought: I think you can only be referred two, isn't it? … They didn't ask me what I would like … when I saw the other options, I thought … now I know the service exists, and I know …what to ask for…. (FG1)

Many participants had not been made aware of the option of being referred to health practitioners by their general practitioner for physical health support and often shared their understandings of how the referral system worked to assist other participants. A participant described the impact of a GP liaison role that was based in public mental health hospital that opened up the gateways:

A lot of allied services that I've had, I've had a lot of difficulty trying to access to, particular like an occupational therapist; it's been the biggest problem - and an exercise physiologist. For about two years I had been trying to get my doctor to refer me, and it wasn't until - the public hospital have got a GP liaison, and once they were informed as to what was going on, they contacted my GP and said, "She needs to see an exercise physiologist. She needs to see an OT. You need to refer her straightaway." And as soon as that happened, I'd got an appointment straightaway (FG1).

Discussion

The participants in this research expressed strong interest in, and described efforts to access, a broad spectrum of health care providers, both mainstream and alternative. These preferences in relation to consumers' physical health care raise questions about current policy and practice, particularly in light of ongoing debates about how to reduce inequalities in physical health of people with mental illness. To date, discussions about physical health inequities have typically centred on a narrow set of roles such as medical practitioners, psychiatrists and nurses (Druss & von Esenwein, 2006; Lawrence & Kisely, 2010; Muir-Cochrane, 2006; The Royal Australian and New Zealand College of Psychiatrists, 2015). In contrast, participants interacted with a wide range of people in sourcing support for their physical health, including those in primary care, hospital walk-in centres and emergency departments, ambulance services, public and community mental health services, mental health professions, physical health professionals, medical testing staff, alternative therapists, sport and recreational activity leaders, gyms, community transport providers, and food bank providers.

Data pertaining to the first theme, suggest one reason for seeking a diversity of providers reflects the trouble accessing primary care and GPs as their first point of contact in seeking physical health care. While significant barriers to primary health care of this target group are well recognised (Happell, Scott, & Platania Phung, 2012), the current findings raise the question of whether such a breadth of providers would be preferred if

primary health care services were made affordable and consumer-centred. The fact that many GP services accessed were bulk-billed, and that some participants saved their money to be able to afford complementary medicine in particular, suggests there were deliberate choices to access alternative health providers. It is also notable that other qualitative studies of mental health consumers have raised 'non-conventional' health practices when taking care of their physical health, such as tai chi (Young, Praskova, Hayward, & Patterson, 2016). Consumer interest in these avenues in health should therefore be explored, especially as they are rarely discussed in relation to inequalities in physical health of people with mental illness.

While mental health consumers valued holistic health approaches such as acupuncture and other alternative approaches, these approaches are also popular amongst the general population (MacLennan, Myers, & Taylor, 2006; Zhang et al., 2015). In fact, demand for alternative health approaches by the Australian public suggest mainstream health services are not meeting peoples' health needs (Sointu, 2012). It could, therefore, be argued that current research and related policy has overemphasised disease management and treatment for people with mental illness. Although the medical approach is needed, a broader approach to prevention and health promotion would encompass what people value as important to their well-being.

Consumers expressed interest in greater collaboration between providers. This clearly demonstrates that access to a broader range of healthcare practitioners alone is not enough, unless communication is effective and inclusive. Indeed, views expressed by participants suggest mental health consumers should be at the centre of the interprofessional team for holistic care. However, current evidence about the extent to which this approach would lead to better health outcomes for people with mental illness is unclear. For example, Kelly, Perkins, Fuller and Parker (2011) reviewed shared care models for people with mental illness, involving integration of numerous service providers, focusing on meeting all health care needs for the consumers, with clear distribution of responsibilities between health professionals. Although the review identified some evidence of the benefits of shared care models in social function, self-management skills, service acceptability and reduced hospitalisations, the consumer-centeredness of the model was unclear, leading the authors to conclude greater attention is needed in the design and implementation of such models.

Further, Kelly et al. (2011) argued there is insufficient evidence for a definitive generic model and that evidence is needed for specific types of clinical settings. While models of integrated care are currently being explored (Collins et al., 2010; Lawrence & Kisely, 2010), the current study findings highlight that mental health consumers believe consumer-centered and affordable care services would improve their health outcomes. It is important to acknowledge that consumer-centred collaborative care is reflected in

health policy in Australia (Commonwealth of Australia, 2009, 2013) and the failure of health services to deliver high standards of collaborative care only serves to extend inequities faced by people from this vulnerable group.

Achieving a health care system that robustly supports consumers in both mental and physical health means a broad range of providers need to learn how to effectively provide support and consideration to often unmet, high level, or unique physical health needs. A key implication for this is that such a model of care be built into education and training of health care providers, particularly, primary care practitioners (Hardy, White, Deane, & Gray, 2011; Hemingway, Clifton, Stephenson, & Edward, 2014).

Perhaps most importantly, health professionals require training in how to collaborate with providers from other professions, the value of which was supported by a Cochrane review (Reeves, Perrier, Goldman, Freeth, & Zwarenstein, 2013) and reflected in Australian and international policy (Bywood, Brown, & Raven, 2015; Mental Health Foundation, 2013). Training initiatives need to be expanded to more conventional and non-conventional providers, and should be guided by national level policy rather than in an ad hoc manner.

A potential limitation of the current study is the small sample size that might not necessarily represent broader views of consumers in Australia or internationally. Given participants self-selected their involvement in the

research, it is likely they had particular interest in physical health that may not reflect broader interests of consumers. That acknowledged, it is important to note that when considering their views in depth, mental health consumers in other studies have stressed the importance of holistic health and being appreciated as a whole person (Chadwick et al., 2012).

Conclusions

People with mental illness not only seek greater collaboration between health professionals but envisage that a broader view be taken regarding health care. Health care providers recognised as important to their physical and overall well-being include: Occupational Therapists, Exercise Physiologists, Dieticians, Naturopaths, Chiropractors, Massage Therapists, and activities facilitators such as gyms or yoga, pilates, tai chi, and walking groups.

The findings of this study raise questions about the health care system and intersecting areas, such as community services, as to how collaboration should be organised and nurtured. They also highlight the importance of reviewing policy, with respect to how government funding might support collaborative models of healthcare. Implementation of policy recommendations to integrate physical and mental health care appears to have been unsuccessful in the views of the participants in the present study. If reflective of the broader mental health consumers' views, serious and

sustained dialogue with mental health consumers must be prioritised in developing solutions to reduce the inequalities in healthcare provision for this vulnerable group.

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