Author/s:
Gray, R;Brown, E

Title:
What does mental health nursing contribute to improving the physical health of service users with severe mental illness? A thematic analysis

Date:
2017-02-01

Citation:
Gray, R. & Brown, E. (2017). What does mental health nursing contribute to improving the physical health of service users with severe mental illness? A thematic analysis. International Journal of Mental Health Nursing, 26 (1), pp.32-40. https://doi.org/10.1111/inm.12296.

Persistent Link:
https://hdl.handle.net/11343/292232

Corresponding author email id: RGray@hmc.org.qa r.j.gray@me.com

What does mental health nursing contribute to improving the physical health of service users with severe mental illness? A thematic analysis

Richard GRAY RN PhD[1, 2] and Eleanor Brown BSc (hons)[3]

1. Hamad Medical Corporation, Doha, Qatar
2. La Trobe University, Melbourne, Australia
3. The University of the West of England, Bristol, UK

This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.xxxx/inm.12296

Received Date : 22-Mar-2016
Revised Date : 18-Sep-2016
Accepted Date : 03-Oct-2016
Article type : Original Article

What does mental health nursing contribute to improving the physical health of service users with severe mental illness? A thematic analysis

File name: What_does_MHN_contribute_v8_9.6.16

Abstract

Authors have generally reported that mental health nurses (MHNs) have positive attitudes to providing physical health care to service users with severe mental illness. We aimed to explore if this positive attitude translates to enhanced clinical practice by interviewing mental health nurses and the service users they work with. Semi-structured interviews were completed with 15 service users and 18 MHNs from acute, rehabilitation and community services. These were then transcribed and analysed using thematic analysis. Six themes emerged: 1. Not the work of MHNs, 2. The physical effects of psychiatric drugs are ignored, 3. The need to up skill, 4. Keeping busy, 5. Horrible hospital food/living on takeaways, 6. Motivation to change. Our overarching meta-theme was of unmet physical health need among service users.

Key words: physical health, mental health nursing, severe mental illness, multimorbidity, qualitative research, thematic analysis

Background

Male and female service users with a severe mental illness (SMI, such as schizophrenia and bipolar disorder) diagnosis can expect to die—respectively—15 and 13 years younger than might be expected (Crump et al. 2013). Cardiovascular disease (CVD) is the major cause of excess mortality. Well-understood risk factors for CVD—such as obesity, smoking, lack of exercise and high blood cholesterol—have been shown to be prevalent in service users with SMI (DeHert et al 2011; Eldridge et al 2011; Robson and Gray 2007). For example, in a cohort of 782 service users in England, Eldridge et al. (2011) reported that two thirds were overweight or obese and half smoked cigarettes. DeHert et al. (2011) observed that obesity is at least 2-3 times higher in people with SMI compared to the general population. Robson & Gray, (2007) reported an increased prevalence of a number of other co-occurring conditions including infectious diseases, osteoporosis, as well as poorer dental health, constipation and sexual dysfunction.

The assessment and management of physical health problems in the SMI population is acknowledged to be poor (Happel et al. 2013). The World Health Organization comprehensive mental health action plan advocates that member states need to focus on enhancing access to physical healthcare for service users with SMI (WHO, 2015). In England the National Institute for Health and Care Excellence recommends that people with psychosis should be offered a combined program of healthy eating and physical activity (NICE, 2014).

There have been several studies and reviews that have examined MHNs reported practice and attitudes towards physical health (for example Blythe & White, 2012; Robson, et al. 2013; Howard & Gamble, 2011; Hyland, Judd, Davidson,

Jolley, & Hocking, 2003, Happel et al 2013). An integrative systematic review by Blythe & White (2012) identified nine studies that examined the role of mental health nurses in the physical health care of service users with SMI. They observed that mental health nurses were not routinely supported by physical health care education. Nurses—especially those working in inpatient settings—also expressed role ambiguity. The authors highlighted that poor communication between primary and secondary care was also a significant issue. Robson et al., (2013) surveyed 585 nurses in South London. Overall, nurses were positive about addressing the physical health challenges of people with SMI and there was a willingness to extend their role in this regard. Respondents reported involvement in promoting physical health with varying degrees of intensity; the most frequently provided intervention was diet and exercise advice. They were less likely to provide advice regarding cancer screening or smoking cessation. In a study of 27 (nurse) case managers in Australia Hyland et al (2003) reported a pessimistic attitude about their ability to effect the physical health of SMI service users. Finally, Happel et al (2013) reported that MHNs tended not take a systematic approach to managing the physical health of service users. None of these studies has explored or contrasted nurses and service users experiences of MHN provided physical health care in both inpatient and community settings.

Aim

The aim of this study was to examine and contrast—from both the service user and clinician perspectives—the practice of mental health nurses in promoting physical health in people with SMI.

Methods

The qualitative approach adopted was that of thematic analysis. We sought to interview adult service users with an SMI diagnosis (schizophrenia or bipolar disorder) currently in receipt of mental health services from NHS (National Health Service) Lothian in the East of Scotland. We have strictly followed COREQ (Consolidated Criteria for Reporting Qualitative Research; Tong et al., 2007) guidelines. The study was approved by the South East Scotland Research Ethics

Committee and the Research Ethics Committee of the Faculty of Health, Life and Social Science at Edinburgh Napier University.

Research team and reflexivity

The research team comprised a service user (male), a Nurse manager (female), three academic researchers (one female Registered Nurse (RN), two male RNs), a clinician (female, RN) and a researcher (male, not clinically qualified as a health professional). The service user was a member of the patient council and had no previous experience being involved in a research project. The project was funded by NHS Lothian Health Services Research Programme.

Participant selection

The fieldwork for the study was carried out in Lothian, Scotland a region of 666 square miles with a population of 858,090. The major city is Edinburgh. The city's population is predominantly white (92%) with a high proportion of young people (20% in their 20s). At the time of the study NHS Lothian provided mental health services to the region.

We aimed to recruit 20 service users with SMI and a similar number of MHNs who were using or working in mental health services. A convenience approach to sampling was used. We focused on recruiting (service user) participants that had known acute (e.g. constipation) and long-term physical health problems (e.g. type 2 diabetes) as well as those in generally good health. MHNs were recruited to both inpatient and community settings.

Procedures

All inpatient and community mental health services in the Trust were contacted. The researcher offered to visit the team to explain the objectives and methodology of the study. Nurses were asked to consider if they would consent to being interviewed about their clinical work promoting the physical health of service users with SMI. Nurses were also asked to help in identifying service users that might be interested in taking part in the study. They were requested at

their next meeting with appropriate clients to explain the study and ask the service user if they were interested in participating. Nurses were instructed to emphasize the voluntary nature of the study but also to explain how participating might positively impact on service user care within the service. They were also asked to confirm that service users had capacity to give informed consent. We acknowledge that this approach may introduce bias into our sampling as service users may have felt subtle pressure to participate. However, a member of the clinical team was required to make the initial approach to service users and we were careful to emphasize the voluntary nature of participation. All potential participants were provided with written information sheets. Service user who agreed to take part signed informed consent forms.

Setting

Nurses and service users were interviewed on a one-to-one basis. All interviews were undertaken by the fieldworker. Patient interviews were conducted on the ward or in the service users own home. In so far as was possible the interviews were conducted in a private room and every effort was made to minimize interruptions. We acknowledge that conducting interviews with service users on wards may have been distracting and not necessarily conducive to a free flowing conversation. Unfortunately, largely for safety reasons, it was not possible to take service users off the ward. Offices in the community team and on inpatient wards were frequently used to conduct nurse interviews. Again efforts were made to minimize interruptions during the interviews (e.g. putting up do not disturb signs).

The research team developed a short topic guide to help guide the researcher in his conversations with service users and nurses. The topic guide did not list prescribed questions rather set out areas that the researcher should discuss with participants. A decision was made by the research team not to record detailed participant demographic information as this was felt to potentially compromise patient anonymity. Participants were asked about the approaches they used/experienced to improve physical health. They were also asked about the

intended outcomes of these approaches and about barriers and facilitators to improving physical health. The interviewer also enquired about the educational needs of mental health nurses that related to promoting better physical wellbeing in service users. Interview transcription was undertaken by an independent service.

Analysis

The field worker and two academic researchers conducted data analysis. As qualitative researchers and mental health clinicians we are conscious of our own perspectives on the interplay between physical and mental health services. When analyzing our data we have been mindful of this, considering the effects that our own beliefs and values can have on the interpretations we derived from the data. Our view is that mental and physical health is interlinked and that all professionals have a duty to improve service users' physical well-being.

Thematic analysis is a predominantly 'essentialist' method that reports experiences, meanings and the reality described by participants but also allows the researchers to unpick or unravel the surface of 'reality' (Braun and Clarke 2006, p 81). It involves an integrative, interpretative process between the data and the researcher in order to 'code' the data. Thematic analysis involves the careful reading of all the transcripts, looking to identify meaningful units of text that are relevant to the area being researched and assigning these 'codes'. Analysis then moves to the broader level of 'themes' whereby codes are combined to form an overarching meta theme. Themes are considered so if they capture something that is important in relation to the research question. This thematic analysis was inductive and data-driven. All of the data were analysed together. Three members of the team analysed the data to minimize the risk of extreme or idiosyncratic interpretations.

Results

Service users

A total of 15 service users with SMI consented and were interviewed. The researcher did not record detailed demographic information about the service users interviewed but reported that most were male, in their early thirties and from community services. All of the participants had experienced at least one previous admission to an acute inpatient ward. Most had existing chronic or acute health problems although there was a minority of participants with no known physical health issues. As clinicians were involved in the recruitment of participants they did not keep a log of the number of people they approached. Nobody who consented to take part withdrew from the study.

Nurses

We recruited 18-registered mental health nurses, 6 from acute inpatient and 12 from community services. The researcher did not record detailed demographic information about the participants interviewed so there is no information on qualifications or years since qualification. However, he noted that the majority were staff nurses and female. In the acute setting nurses were relatively recently qualified, those working in rehabilitation and community settings had more clinical experience and had more autonomous roles; they also tended to have comparatively large caseloads and spent a substantial proportion of their time in a brokering role and supervising unqualified staff (those without professional registration) who were responsible for much of the direct care delivery. All participants worked in multidisciplinary teams that included psychiatrists and unqualified support staff (e.g. health care assistants). Nurses working in inpatient settings tended to work with a broader range of professionals that included occupational therapists, recreational activity workers, nursing assistants and support workers. Again, there is not a log of the number of nurses who were approached to take part in the study and refusal rates, however nobody who consented to take part withdrew from the study.

Conduct of interviews

The researcher recorded each of the interviews using an audio-recorder. Interviews were independently transcribed and checked to make sure no

personally identifiable information was logged. He noted that both service user and nurse participants seemed comfortable and relaxed talking about physical health. No repeat interviews were required. We did not invite participants to check their interviews. Interviews typically lasted between 40 and 60 minutes. Patient interviews tended to be shorter in duration that those with nurses.

Thematic analysis

Data were analyzed using thematic analysis following the phases set out by Braun and Clarke (2006). This involves generating an initial list of ideas of what is set out in the data. From this, codes are formed to identify a feature of the data. In this study, data were coded by the field worker and reviewed by the academic researchers. Initial codes were then sorted in to potential themes, (of which there were fourteen) and these were then refined through discussion with the wider research group, considering the relationships between each potential theme and sub-theme. We have supported the formulation of each of our themes with participant quotes and indicated if quotes were from service users [SU] or nurses [N] and if they were inpatient [I] or living in the community [C] at the time of the interview. We identified six themes and six sub-themes that are shown in table 1.

Theme 1: The work of mental health nurses?

Both service users and nurses talked about how they had noticed that there was an increasing emphasis on the physical health of patients. Generally this seemed to be perceived as positive. For example one nurse noted that *"compared to years gone by, we are much more conscious of physical health"* [N, C]. Nurses working in inpatient wards described that when service users were admitted to hospital there would be a medically led physical examination. The nurses working on acute wards described lacking confidence in providing physical health care. Despite this increased awareness there was evidence that physical health was not a high priority for some nurses.

"Some nurses are absolutely spot on with things like that [health checks] and other people don't seem to bother really" [N, I]

"I do not consider it [physical health] a priority" [N, I]

"I think our premise, you know, is just deal with the physical problems when they happen" [N, C]

"I think our main focus obviously is maintaining people's mental health" [N, C]

Service user comments seemed to confirm this observation. One service user said *"unless I bring it to their attention I don't really believe …that they would ever question how well you are feeling, as in physically well, not mentally"* [SU, I]. A number of service users that we talked to said that, from their perspective, nurses were too busy to help them address their health behaviors (e.g. being overweight, not exercising). For example:

"[The nurses] don't really have hands on involvement with the patients" [SU, I]

"It's really just a question of you having the courage to bring it to their attention…" [SU, I]

Sub-theme (1a): joint multidisciplinary care planning

There was some evidence of positive joint care planning that was focused on service users' physical and mental health. One service user told us how the team worked to develop *"my plan"* [SU, C]. Nurses in the community described how they would integrate a physical assessment into care planning to ensure careful monitoring. A nurse described that there was *"a general health check… that the medical staff will do when patients are first admitted and after four weeks, there's a large review of the individual"* [N, C]. Service user expectations that their physical health needs would be addressed were low. This was reflected in comments made by a number of participating nurses, for example *"sadly I think*

they are very tolerant and have very low expectation of us [regarding physical health]. They should have higher." [N, C]

Sub theme (1b): fractured responsibility

Both nurses and service users felt that there was a fracture between physical and mental health care. One service user told *us "you can't divide things up and say we're only dealing with that, the GP's dealing with this… It's impossible because I'm not split into bits, I'm a whole person"* [SU, C]. A number of service users complained that General Hospital clinicians and GPs (General Practitioners) did not deal well with people with mental health problems, in part this seemed to be because clinicians in (general settings) can be circumspect towards service users with SMI. One service user described this particularly well *"you go into a general ward and because you have mental health problems they're a bit wary"* [SU, C].

Nurses that we interviewed were critical of the GPs they worked with. Whilst they reported giving feedback about service users' mental health to GP's, they felt that the GPs rarely reciprocated and almost never contributed to service user reviews. Discrepant with this perspective, service users described how psychiatric services were slow to communicate with their GP. One participant said *"I'd go down [to the GP's] and ask for the medications and they'd be saying, well we haven't heard from your psychiatrists so we'll give you the dose of your medication that we have on record"* [SU, C].

Theme 2: The physical effects of psychiatric drugs are ignored

Service users that we interviewed stated that medication side effects were common, impacted on their sense of physical wellbeing and were frequently ignored by nurses. *"Putting on weight from medication"* [SU, I] was a major issue reported by service users who also complained about a number of other side effects including "blurry vision" [SU, C], "shaking" [SU, I], "tiredness" [P, C] and "incontinence" [SU, I]. A number of service users talked about side effects not being taken seriously:

"It took me years to get it actually recognized… to get this [side effect] recognized was like climbing Everest" [SU, C]

"It is so hard trying to get anyone to listen" [SU, C]

"In a way, they [Nurses/Doctors] are making the choice between our mental and physical health" [SU, C]

Theme 3: Need to up skill

Generally there was an acknowledgment among nurses that they needed to develop their physical health skills.

"It was that long ago since we done it [put up an IV]…, then maybe one member of staff does it and we'll all just gather around trying [laughs] to, you know, trying to reskill ourselves". [N, I]

"Physical health is not really one of our fortes as such because we've never been training in physical health" [N, C]

A nurse who had dual training talked in detail about how physical health problems would get missed by her mental health (only) nursing colleagues.

"It's a different emphasis, you know, a mental health nurse would primarily look at the mind, and so if anything went a bit awry, they would think oh it's something to do with their mood or their psychosis or whatever and as a secondary thought they would think maybe there's something physically wrong while I found myself excluding the physical first" [N, C]

There were some dissenting voices to the theme that nurses needed to up skill. For example one nurse reported *"the work that we do [around physical health]… I feel is adequate enough"* [N, C]

It was interesting that a number of service users talked about how they would like the nurses who worked with them to be more skilled around providing physical health care. For example:

" I think they should have more general training… they certainly need it…" [SU, I]

"I know mental health is a wide ranging subject in itself and throwing in physical health as well, is… it is quite challenging for the nurses but, you know, remember, it's even more bloody challenging for the person that's got mental health problems." [SU, C]

Sub-theme (3a): a specialist physical health service

Nurses working in one of the community teams talked about the development of a specialist role to ensure that service users received the physical healthcare they needed. There were comments from some service users that this was not a model they liked, for example one participant stated *"it would be better if folk had access to a GP service"* [SU, C].

Theme 4: Keeping busy

All the service users that we spoke to valued physical and recreational activities (which we explored in interviews as an opportunity to promote physical health). Both service user and nurse groups said that being involved in these activities kept them connected with "*normal life*" [SU, I] and was helpful in promoting the physical and mental wellbeing of service users.

Subtheme (4a): keeping busy on the ward

On study wards it was occupational therapists and recreational officers that were predominately responsible for organizing activities on the wards. Before service users were able to engage in activities a nurse needed to make a referral and a number of service users complained that this took time and led to frustration and boredom. Even though the wards had implemented Protected Engagement Time (PET), where time is set-aside for service users and nurses to engage in a meaningful activity, this did not appear to routinely happen. One

nurse told us *"a big problem is the staffing level, because, you know, as a nurse on this ward we have so many roles to fulfill"* [N, I]. Nurses talked about how engagement time was not yet fully embedded into practice:

"It [PET] is definitely working towards… kind of promoting more activities and things for patients to do on the ward" [N, I].

"That's [PET] probably not working in here because everything's great on the paper, but then what happens when you don't have the staff team?" [N, I]

Service users' perceived nurses as busy and inaccessible, they talked about their more meaningful professional relationships on the ward being with OTs, *"I speak to them more than I probably do the nursing staff"* [SU, I]

Subtheme (4b): keeping busy in the community

Nurses described how their team (that included care staff), working with voluntary organizations, were responsible for implementing community based activity programs. One nurse described how *"support staff… are basically doing the brunt of the work that would be done in a hospital setting"* [N, C]. There was a strong sense of frustration from community nurses that the size of their caseloads resulted in them having more of a brokerage, rather than care delivery role. Service users made positive comments about being involved in activities. For example *"I get help with cleaning, I get help with cooking; and I've got a lot of support with recreation as well…"* [SU, C].

Theme 5: horrible hospital food/living on take-aways

Hospital food was described by both participant groups as being unhealthy and unappetizing. Nurse participants working in the inpatient environments talked about trying to ensure that food was healthy but said that they were not very successful in achieving this because of limited resources. Nurses also reported that they felt frustrated about their lack of knowledge about nutrition *"…you're updated because you're watching TV, you're reading about it and it's more in the fore now"* [N, I]. The effect that medication, a lack of ward structure, and mood

had on service users' appetite was also discussed by nurses. They described how service users often turned to comfort food (chocolate and crisps) and take-aways (Chinese food, chips). Participants in this study talked openly about struggling with their weight. There was a sense from the nurses that more input from dieticians was required to address their poor diets, for example one nurse said *"the dietician service I think is quite poor… we can wait for ages and ages for one…"* [N, I]

Theme 6: Motivation to change

Nurses acknowledged that to improve physical health there was a need for service users to change engrained patterns of behavior (smoking, diet, exercise). The challenge of helping people address this was discussed by one nurse *"it comes down to the patient group, it's one of the things that they find most difficult… motivating themselves and maintaining the motivation in doing things, that they're physically healthy. And that's where we have a hurdle that's probably difficult to cross"* [N, C]

Sub-theme (6a): smoking

There seemed to be a tolerance towards smoking from the nurses we interviewed. Whilst outwardly they acknowledged that it was an undesirable behavior when challenged there was a strong belief that smoking played an important therapeutic and social role in service users lives. The researcher sensed that nurses who were more recently qualified were much less tolerant of service users smoking. One nurse describing it as a *"cultural thing that needs to change"* [N, I]. Service users that we talked to were, on the whole, not particularly motivated to stop. Inpatients that expressed a desire to quit could be referred to a smoking cessation nurse. Nurses expressed frustration that this service was not integrated with their clinical work:

"They're [the smoking cessation service] here for 45 minutes, then they go away again" [N, I];

"They don't really fill in the staff on what they're doing. So unless you speak to the patient, you don't know" [N, I]

Meta-theme

Overall we felt that these themes could fit under an overarching meta-theme of unmet physical health need among service users.

Discussion

The aim of this study was to examine (from both the service user and MHN perspective) the practice of nurses in promoting physical health in people with SMI. We interviewed 15 service users and 18 nurses from both inpatient and community settings. That service users' physical health needs were not being effectively met was consistent with previous research by Happel et al (2013). It seemed to us that physical health programs that may be helpful (e.g. wellbeing/education programs and health checks) and are recommended in practice guidelines were not being provided as part of routine care.

Nurses that participated in this study did not consistently consider service users' physical health a priority for them. This observation is consistent with the role ambiguity reported by Blythe & White (2012), however, it is somewhat at odds with more recent surveys where nurses have generally been positive about extending their role to address this need (Robson et al., 2013). It may be that because the researcher on this project took time to build a rapport with nurses before he interviewed them, they were comfortable expressing their views. In a survey there is pressure to give what might be perceived to be "the right answer".

From the interviews, many potential enhancements to practice emerged that might positively impact on service users' wellbeing. They included improving the quality of food on the inpatient units, enabling service users to get off the ward,

ensuring there is a programme of ward activities and better communication with primary care colleagues.

Some service users reported that the clinical team sometimes ignored side effects from medication. Monitoring the effects of medication is an important part of routine mental health care (NICE, 2014). It may be that we sampled an atypical service user group who were particularly keen to talk about their frustration on this issue. We have no particular reason to think that this might be the case. We note similar finding have been reported by Brown and Gray (2015) in their medication management research.

The need for nurses to develop their physical health skills has been highlighted in a number of previous studies and is not a novel observation (Blythe & White, 2012). In the UK where the fieldwork for this study was undertaken, there has been considerable debate about whether a move to a generic model of nursing might be helpful in meeting the needs of a population where multimorbidity is the norm (Coffey et al, 2015; Gray, 2015; McKeown & White, 2015). There is a pressing need to ensure that mental health nurses have and maintain skills in addressing prevalent physical health problems in this group of service users.

It was disappointing that clearer suggestions about how to improve physical health care did not emerge from the interviews. It is possible that we did not probe the issue sufficiently during the interviews with participants.

Study limitations

The limitations of our study need to be considered when interpreting our findings. Recruiting service users, in particular, was challenging and it is important that we consider if this may have produced a distorted or biased sample. This is especially true as nurses were involved in the recruitment of service user participants. We worked hard to promote the study and invite as many service users and nurses as possible from the participating clinical environments to take part. It is not uncommon for service users with SMI to be

reticent to be audio recorded and we acknowledge that this may have influenced participation rates.

In hindsight it was an error not to collect demographic data about participants, our fears that participants would have identifiable in the data seems unlikely.

It was not possible to invite participants to check identified themes; doing so would have strengthened our findings.

A male researcher conducted all of the interviews. That we did not gender match researcher and service user participants is an important limitation. It is possible that female service users may have been reluctant discussing certain aspect of their physical health with a man. We note that there were few comments about sexual health made by participants (of both genders) when there is evidence that these issues are prevalent in this group of service users (Hughes et al., 2015). Were we to repeat the study we would seek to gender match researchers/participants.

Conclusion

This study sought to examine the work of mental health nurses in promoting the physical health of service users with SMI. Our overarching meta-theme is of unmet physical health need among service users with SMI. Our observations challenge the view that mental health nurses are motivated to address service users' physical health.

Implications for clinical practice

There is a need for MHNs to engage more fully in promoting service users physical wellbeing. This will require strong clinical leadership and additional training and supervision.

Acknowledgements

The study was funded by NHS Lothian Health Services Research Programme. We are grateful to Hugh Masters who conceived and setup the project and to Gerard

O'Neil who carried out the fieldwork for this study. We also acknowledge the contribution of Lawrie Elliott and Ann Claveirole.

Author contribution

Hugh Masters, LE and RG developed the project. AC managed the project. Gerard O'Neil conducted the fieldwork. Lorna Martin, David Budd and Isabel Gillies attended study steering group meetings. RG wrote the paper.

Conflicts of interest

RG has received no financial support from any pharmaceutical company since 2014. Previously RG has received honoraria for speaking and provided consultancy to AstraZeneca, Bristol-Myers Squib, Wyeth, Pfizer, Jannsen Cilag, Eli Lilly and Co and Otsuka Pharmaceutical Europe Ltd. RG originally developed the Health Improvement Profile (HIP) for use with service users with SMI.

References

Blythe, J., & White, J. (2012). Role of the mental health nurse towards physical health care in serious mental illness: An integrative review of 10 years of UK Literature. *International Journal of Mental Health Nursing*, *21*(3), 193–201. http://doi.org/10.1111/j.1447-0349.2011.00792.x

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. http://doi.org/10.1191/1478088706qp063oa

Brown, E., & Gray, R. (2015). Tackling medication non-adherence in severe mental illness: where are we going wrong?. *Journal of psychiatric and mental health nursing*, *22*(3), 192-198. DOI: 10.1111/jpm.12186

Coffey, M., Pryjmachuk, S., & Duxbury, J. A. (2015). The shape of caring review: what does it mean for mental health nursing? *Journal of Psychiatric and Mental Health Nursing*, *22*(9), 738–741. http://doi.org/10.1111/jpm.12254

Crump, C., Winkleby, M. A., Sundquist, K., & Sundquist, J. (2013). Comorbidities and Mortality in Persons With Schizophrenia: A Swedish National Cohort Study. *American Journal of Psychiatry*, *170*(3), 324–333. http://doi.org/10.1176/appi.ajp.2012.12050599

DeHert, M., Correll, C., Bobes, J. et al (2011) Physical illness in patients with severe mental disorders. Prevalence, impact of medication and disparities in health care. *World Psychiatry,* 10, 72-77

Eldridge, D., Dawber, N., & Gray, R. (2011). A well-being support program for patients with severe mental illness: a service evaluation. *BMC Psychiatry*, *11*(1), 46. http://doi.org/10.1186/1471-244X-11-46

Gray, R. (2015). Transforming nurse training to address multi-morbidity: the missed opportunity of the shape of caring review. *Journal of Psychiatric and Mental Health Nursing*, *22*(9), 653–654. http://doi.org/10.1111/jpm.12268

Happell, B., Scott, D., Nankivell, J. et al (2013) Screening for physical health? Yes! But…: nurses' views of physical health screening in mental health care. *Journal of Clinical Nursing*. 22, 2286-2297

Howard, L., & Gamble, C. (2011). Supporting mental health nurses to address the physical health needs of people with serious mental illness in acute inpatient care settings. *Journal of Psychiatric and Mental Health Nursing*, *18*(2), 105–112. http://doi.org/10.1111/j.1365-2850.2010.01642.x

Hughes, E., Bassi, S., Gilbody, S., Bland, M., & Martin, F. (2015). Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness: a systematic review and meta-analysis. *The Lancet Psychiatry*. http://doi.org/10.1016/S2215-0366(15)00357-0

Hyland, B., Judd, F., Davidson, S., Jolley, D., & Hocking, B. (2003). Case managers' attitudes to the physical health of their patients. *The Australian and New Zealand Journal of Psychiatry*, *37*(6), 710–714.

McKeown, M., & White, J. (2015). The future of mental health nursing: are we barking up the wrong tree? *Journal of Psychiatric and Mental Health Nursing*, *22*(9), 724–730. http://doi.org/10.1111/jpm.12247

National Institute for health and care excellence (2014) Psychosis and schizophrenia in adults: prevention and management, NICE guidelines [CG178]

Robson, D., & Gray, R. (2007). Serious mental illness and physical health problems: A discussion paper. *International Journal of Nursing Studies*, *44*(3), 457–466. http://doi.org/10.1016/j.ijnurstu.2006.07.013

Robson, D., Haddad, M., Gray, R., & Gournay, K. (2013). Mental health nursing and physical health care: A cross-sectional study of nurses' attitudes, practice, and perceived training needs for the physical health care of people with severe mental illness. *International Journal of Mental Health Nursing*, *22*(5), 409–417. http://doi.org/10.1111/j.1447-0349.2012.00883.x

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357. http://doi.org/10.1093/intqhc/mzm042

WHO | Comprehensive mental health action plan 2013–2020. (n.d.). Retrieved 9 December 2015, from http://www.who.int/entity/mental_health/action_plan_2013/en/index.html

Table 1: Themes and subthemes

	Theme		**Subtheme**
1	The work of mental health nurses?	1a	Joint multidisciplinary care planning
		1b	Fractured responsibility
2	The physical effects of psychiatric drugs are ignored	-	-
3	Need to up skill	3a	A specialist physical health service
4	Keeping busy	4a	Keeping busy on the ward
		4b	Keeping busy in the community
5	Horrible hospital food/living on take-aways	-	-
6	Motivation to change	6a	Smoking