



Embedding an exercise professional within an inpatient mental health service: A qualitative study



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ABSTRACT

Background: Integrating exercise professionals into mental health settings is a key strategy in addressing the physical health inequalities of people living with mental illness. Workforce culture surrounding physical health may impact the utilisation of exercise professionals across inpatient settings.

Aims: To evaluate clinician perspectives regarding the implementation of an exercise professional at the mental health service in a large, urban hospital in Sydney, Australia.

Methods: A qualitative study using semi-structured interviews with a purposive sample of mental health staff was conducted. Data were analysed using thematic analysis.

Results: Fourteen mental health clinicians (approximately 35% of all eligible staff) participated in interviews. Three themes emerged regarding the role of the exercise professional; i) drivers and facilitators; ii) support from leadership; and iii) directions for future practice.

Conclusions: An exercise professional within a mental health service was identified as an effective strategy in improving consumer health outcomes while increasing the knowledge and confidence of mental health clinicians regarding the provision of physical health care. Exercise professionals should be recognised as important members of the standard multidisciplinary mental health team for in patients being treated for mental illness.

1. Introduction

People living with mental illness can experience a multitude of benefits from engaging in regular physical activity. For example, the adverse cardiometabolic health risks such as hypertension, altered lipid profile, and obesity associated with pharmacological treatment (Correll et al., 2017) can be significantly reduced through improvements in cardiorespiratory fitness (Rahman et al., 2018; Stubbs, Rosenbaum, Vancampfort, Ward, & Schuch, 2016; Vancampfort et al., 2017). Additionally, engagement in physical activity can assist in attenuating antipsychotic-related weight gain when combined with dietary interventions (Teasdale et al., 2016). Improvements in physical fitness can result in symptom reduction for a range of mental illnesses including schizophrenia (Firth et al., 2017), bipolar disorder (Firth et al., 2018),

major depressive disorders (Schuch et al., 2017), post-traumatic stress disorders (Rosenbaum et al., 2015) and anxiety disorders (Stubbs et al., 2017). Additionally, the structured subset of physical activity; exercise, improves sleep quality in people living with mental illness (Lederman et al., 2018). Given the multitude of potential benefits, recommendations for physical activity to be included as part of standard mental health treatment are emerging. For example, recommendations to include physical activity are evident in guidelines developed by the Canadian Network for Mood and Anxiety Treatments (CANMAT), the National Institute for Health and Clinical Excellence (NICE), and the Mental Health Commission of NSW (Mental Health Commission of NSW, 2016; Ravindran et al., 2016; Stanton & Reaburn, 2014). Despite this, people living with mental illness face a number of barriers to engaging in physical activity including negative symptoms, pain and

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medication side effects (Stubbs, Williams, Gaughran, & Craig, 2016) and, despite demonstrated effectiveness (Bartels et al., 2015; Daumit et al., 2013), physical activity interventions are not yet considered as routine care in mental health treatment settings.

Embedding clinicians that specialise in physical activity within mental health settings can assist in better integrating activity based interventions to expand the range of care options available to mental health consumers (Stanton, Rosenbaum, Lederman, & Happell, 2018). Exercise professionals are clinicians that administer the assessment, prescription and delivery of exercise and physical activity interventions (Stubbs & Rosenbaum, 2018). Physiotherapists have performed such roles in the U.K. and some European countries, particularly in inpatient settings (Stubbs & Rosenbaum, 2018). In Australia, Accredited Exercise Physiologists (AEPs) are ideally placed to prescribe and deliver evidence-based physical activity interventions for people living with mental illness, as a result of their tertiary education and clinical experience (Lederman et al., 2016). In the Australian mental health sector, AEPs are employed across a variety of settings including in-patient (Stanton, Happell, & Reaburn, 2015a), forensic hospitals (Wynaden, Barr, Omari, & Fulton, 2012), community health care centres (Rosenbaum et al., 2014), non-government organisations and in private practice.

Increasing levels of physical activity amongst individuals with severe and persistent mental illness is critical in addressing the mounting health disparities that affect these populations. The integration of exercise professionals is a key strategy to address the multiple health challenges associated with low physical activity, sedentary behaviour and metabolic syndrome (Stanton et al., 2015a) particularly given the previously mentioned unique barriers to physical activity engagement that face people living with mental illness (Firth et al., 2016; Stanton, Reaburn, & Happell, 2015b). Given that exercise professionals may act as instigators of culture change regarding physical health within mental health settings (Rosenbaum et al., 2018), evaluating their role within the multidisciplinary mental health care setting may help to bridge the gap from research to clinical care. A recent qualitative study (Furness, Hewavasam, Barnfield, McKenna, & Joseph, 2018) described the processes and outcomes of adding an exercise professional within a mental health unit. The staff interviewed within the mental health unit identified the role of the exercise professional as key in improving the physical health of people living with mental illness on the inpatient unit while reducing workloads of other staff in terms of physical health care.

To extend research in this area, this study aimed to investigate, through qualitative thematic analysis, staff perspectives regarding implementation of an exercise professional at the mental health service in an urban hospital in Sydney, Australia, using interviews with staff working in a multidisciplinary treatment team.

2. Methods

2.1. Research design

This exploratory research project was conducted using a framework based on qualitative guidelines (Malterud, 2001). A qualitative framework was chosen to explore and gain insight into clinician attitudes and practices. This framework has been used in similar studies examining clinician attitudes to physical health within mental health settings (Furness, Hewavasam, Barnfield, McKenna, & Joseph, 2018; Furness et al., 2018). The Consolidated Criteria for Reporting Qualitative Research guidelines was implemented in the design of this study (Tong, Sainsbury, & Craig, 2007). Interviews were conducted in small groups (for participants of the same profession) or in one-to-one sessions for those who preferred or could not attend scheduled group times. A total of two small groups were performed with the remainder conducted as one-to-one sessions, due to participant personal preference. Data collection was deemed to be complete when data saturation had been reached as determined by two researchers (HF and SR) (Saunders et al.,

2018). The research was approved by the Human Research Ethics Committee at the Sydney hospital where the project was undertaken (LNR/18/SVH/123).

2.2. Setting

The mental health service in this study is located in inner-city Sydney, Australia serving a diverse population characterised by large amounts of homelessness, drug use, and complex mental health needs. The service averages 1400 inpatient stays annually across its 27-bed inpatient ward (with both high dependency and acute areas) and a 6-bed Psychiatric Emergency Care Centre (PECC) for shorter stays. The community service provides triage, case management, acute care, rehabilitation, early intervention and a day clinic; with more than 7500 contacts annually. Specialist services are available through an Older Persons Mental Health Service, Consultation Liaison Service, and the Anxiety Disorders Clinic.

The exercise professional, an AEP, commenced in mid-2017, contracted for seven hours per week for three years to work across the 27-bed inpatient ward and the community service. This individual worked alongside a health education officer, whose role was to educate staff and clients about taking control of their health by devising and implementing health policies and programmes. Together, they both co-ordinate referrals and appointments for physical activity consultations and sessions that are guided by the exercise professional along with the support of exercise physiology university students. The gym space is a small, covered outdoor space that was fitted out with gym equipment largely via donations to the service. Clients could be referred to the exercise professional for physical activity prescription by mental health staff working in both inpatient and community settings of the local health service. Typically, clients underwent an individualised initial assessment with the exercise professional, including a risk assessment and a standardised fitness assessment. Following this an individualised physical activity program was developed for them by the exercise professional. Prior to the establishment of the role there had been no exercise professional employed within the mental health service.

2.3. Participants

Interviews were conducted with a purposive sample of multidisciplinary staff working at a mental health hospital. Purposive sampling can be utilised to understand important issues that are central to a research problem as the procedure aims to enlist information-rich cases (Patton, 2002) and this process has been utilised in similar qualitative studies (Furness, Hewavasam, Barnfield, McKenna, & Joseph, 2018; Furness, Wallace, et al., 2018). There are approximately 150 full-time equivalent (FTE) staff working in the mental health service, of which approximately 40 staff have the potential to work with and refer to the exercise professional. Sample sizes in qualitative analysis can be guided by comparable studies (Mason, 2010) and as such, a sample size was determined from a comparable qualitative study which included seven participants (Furness, Hewavasam, Barnfield, McKenna, & Joseph, 2018). The criteria for inclusion was for participants i) to be currently employed in the mental health service St Vincent's Hospital, Sydney, in an area serviced by the exercise professional and ii) to understand and accurately describe the role of the exercise professional within the mental health service. A purposive sample of 15 staff members were sent an email inviting them to participate sent by the health education officer. The health education officer chose these staff members due to her knowledge of them having regularly interacted and engaged with the exercise professional. Of the 15 staff that were emailed, 14 staff agreed to participate (n = 1 participant did not meet the inclusion criteria as they had not worked with the exercise professional and reported they did not understand or accurately describe the role).

2.4. Data collection

Semi-structured interviews lasted approximately 30 min and were conducted in a one-to-one or focus group setting. One researcher (HF) who was not employed by the hospital and not known to the participants conducted the interviews. They were mostly conducted on-site at the mental health inpatient ward in a private meeting room; however some participants opted for a phone interview due to convenience. The interviews were conducted using narrative inquiry, a research methodology which captures the perspective of participants constructing a narrative of events considering the relationship between their personal experience and cultural context (Clandinin & Connelly, 2000; Giacomini, 2010, pp. 125–156). Questions were semi-structured, open-ended and were initiated by the researcher. Participants were encouraged to guide the conversation with personal stories relating to the topics asked. Interview questions included enquiry into the development and initiation of the exercise professional role, the development over time of the role, and the provision of physical health care within the service. Some example questions included “describe the role and responsibilities of [the exercise professional]” and “describe the provision of physical health care within the service”. Participants were asked to “describe the pathway of care for a client of the mental health service when working with [the exercise professional]”. All interviews were recorded on a smart-phone voice recorder application (Apple iPhone 6 Model A1688).

2.5. Data analysis

Data analyses were performed using a qualitative analysis software program, NVivo 12.1. Data from interviews were transcribed and read independently by two researchers (HF & SR). Qualitative analysis was performed using guidelines incorporating systematic text condensation, an explorative method for analysis focusing on common themes arising in participant interviews (Malterud, 2012). This procedure consists of coding data and creating categories of information. These categories were then summarised into themes which were supported with verbatim quotes from the participant interviews. Coding and theme accuracy were verified by a second researcher (SR).

3. Results

3.1. Sample description

A sample of 14 multidisciplinary staff (approximately 35% of the staff currently working with the exercise professional) provided written informed consent to participate. The participants represented varying disciplines including; psychologists (n = 3), registered nurses (n = 2), psychiatric registrars (n = 2), occupational therapists (n = 2), social workers (n = 2), a peer support worker (n = 1), an exercise professional (AEP) (n = 1), and a staff member working in executive management (n = 1). The exercise professional employed by the service was the same one interviewed for their perspectives in this study. Most participants were female (71%) and had been employed in mental health services for between two months and 25 years.

3.2. Qualitative findings – thematic analysis

Three main themes, one with sub-themes, were derived from participant interviews. The first theme was ‘drivers and facilitators’ and included three sub-themes of; (i) development of the role, (ii) support from leadership and (iii) importance of a dedicated practitioner. The second theme was ‘perceived barriers to the exercise professional role’. The third theme was ‘directions for future practice’.

3.3. Drivers and facilitators

Recurring statements from all participants identified stakeholders who were purposeful and emerged as advocates in facilitating the development and integration of the exercise professional role. Participants noted that, as there had been no prior physical activity specialist role, having support from the exercise professional positively influenced others within the mental health team by creating awareness of physical health issues. This in turn, resulted in a greater number of referrals by the mental health team to the exercise professional.

3.4. Development of the role

The exercise professional role was conceived and developed by hospital management with support from the health education officer and a consultant psychiatrist. The exercise professional undertook a clinical training placement at the hospital and approached management about utilising his skills in an ongoing employed position after the placement concluded. Management recognised the importance of having specialised input regarding the physical activity of mental health clients from a clinician who could be solely dedicated to this task, leading to the establishment of the position through philanthropic funding.

“He came to us as a student exercise physiologist at the time and he was just fantastic, and the team really saw great benefit from a consumer’s point of view and how it would help them improve their mental state and physical fitness. They really enjoyed working with him so when his student placement finished, we approached our philanthropic arm of the business which is a foundation who then agreed that they would fund an [exercise professional] position for a period of 3 years on a fixed term part-time basis. We do have a metabolic clinic as well so him being here was to help subsidise that and we had some equipment donated. So, it all came to fit together, a really worthwhile project to pursue.”

(Executive management)

Having an exercise professional on staff meant that other mental health staff felt clients would have the opportunity to benefit from tailored physical health monitoring and exercise prescription from an expert, and that physical health advice being given would be current and safely prescribed, something that many staff admitted they were not sometimes not confident in providing to patients.

“I think its brilliant because they can sit down and do a whole number of functional assessments with people, that we know nothing about – the safety and the kind of exercises that you know particular people should do or shouldn’t do, can do or can’t do, and will benefit from in that really appropriate way that the rest of us can’t do ...”

(Psychologist 2)

3.5. Support from leadership roles within the hospital

The exercise professional role was developed and supported by physical health ‘champions’: a consultant psychiatrist and the health education officer at the hospital. The exercise professional identified that having the support of such health professionals who were well regarded by other staff within the hospital contributed greatly to the success of the exercise physiology program.

“... it’s taken a while for a lot of the other colleagues to go OK, we can trust him. I think it wasn’t until I had the support from the health education officer and a consultant psychiatrist who really pushed my role and they would explain to a lot of other departments what I could do. So now it’s been really good that a lot of people do know my role, they know our space. To have that support from a lot of different clinicians I don’t think the role could have evolved to what it is now

(Exercise Professional)

Given this was the first time an exercise professional had been employed within this mental health service, it was expected that many staff may lack understanding of the role. Education prior to the role commencing from the 'champions' was viewed as being highly valuable. These 'champions' provided information to staff within the service regarding the role of the exercise professional and how this role would fit within the mental health service.

"We were informed by the staff educator. She mentioned there was a big effort to try and get an [exercise professional] and that there would be a role and that there would be equipment to be used specifically for that purpose, a designated area, and they told us how it was going to work. They explained the role and what it meant and how it could help clients with mental illness."

(Social Worker 1)

3.6. Importance of a dedicated practitioner

All participants identified the benefits of having an exercise professional as part of the mental health team. Staff repeatedly mentioned the importance of having a dedicated professional on site to provide specialised monitoring of the physical health of clients and identify clients at risk of physical health comorbidities. Physical health focused conversations could then arise from these interactions to highlight any concerns to consumers.

"I think what's been really good is they've been doing a lot of the physical health screens and taking a lot of the metabolic measures. That really just means that there's more consistency in those health screens being done, that's what I've noticed since they've come on board and they have spoken a lot about the impact of some of the antipsychotics and putting on weight, so that's been really helpful ..."

(Registered Nurse 1)

Staff recognised that having the exercise professional whose sole role was to discuss physical health and who was an expert in the field meant that consumers could feel confident that the advice and direction they were receiving was correct, and the exercise professional was viewed as a trusted source of expert knowledge.

"I think it's helpful having someone other than their treating psychiatry team talking about this stuff. I think partly because the dynamic between us and the patients at times is completely confrontational because there can be conflicting agendas. There are disagreements and there's just not often a positive therapeutic way to talk about this sort of stuff. But then it is super common for me to have a really short review with someone and it doesn't go really well but then they will spend an hour with [the exercise professional] and have a really productive and fruitful conversation. So, I think there's this idea that this person can get a lot further than me and someone who is better at developing a more individualised approach."

(Psychiatrist Registrar 1)

Staff spoke about the increased capacity of the exercise professional to deliver exercise interventions to clients and tailor individualised exercise programs to client needs. Through the use of their specialist skills, staff felt that the exercise professional was in a better position to motivate consumers to engage in physical activity programs.

"I think its motivation ... I think the key to mental health clients is they need the support to actually access and participate in exercise. I find part of the struggle is when people are experiencing mental health struggles that it's very hard to reach that level of motivation and the bigger picture and they've almost got to have someone take a stand for them to encourage them and that's where I see the [exercise professional] role and that's a very valuable part."

(Psychologist 1)

For those consumers that had continued engagement in services provided by the exercise professional, staff commented on the

improvements to both their physical and mental health.

"... and for many of our clients who have worked with [the exercise professional] I can see they are improving. Not just in that they are losing weight and improving their cholesterol and blood pressure. But a real change in their mood and symptoms"

(Social Worker 2)

Having a dedicated member of staff to work with clients specifically in regards to their physical health relieved some of the burden from other mental health clinicians, who admitted that time pressures negatively affected their capacity to address physical health issues. Staff stated that while they understood the importance of discussing physical health with clients, they felt they didn't always have the time to thoroughly discuss these issues with them or that they didn't feel confident in providing such education.

"Having someone who is there and that is their priority to keep trying [to improve physical health and exercise] is really helpful because for me it's not a topic I would bring up repeatedly but if you've got this person who you can say this is their speciality and they will try harder to engage; harder than I would, and try a lot harder and more persistently than I would."

(Peer Support Worker)

3.7. Perceived barriers to the exercise professional role

An emerging topic that participants spoke of was service barriers affecting the ability of the exercise professional to perform their role as well as barriers to consumers being referred to the physical activity program. Staff identified that while these challenges existed, they were not necessarily because of negative attitudes toward the role but rather financial limitations and lack of knowledge of staff regarding the exercise physiology program. The most commonly mentioned challenge was related to funding limitations. The exercise professional role is only funded part-time and staff reported this influenced the number of clients that could be referred to the program. Restricted funding was also cited as a barrier to the exercise professional performing their role as exercise and physical health monitoring equipment was limited as well as not having a larger designated gym space.

"A barrier would be the funding limitations. Probably if we had more money or finance available, we would have him doing some more sessions because he only works a couple of days a week. I guess that would be one of the barriers we basically have ... and more equipment would be great."

(Registered Nurse 2)

Lack of education regarding the importance of physical activity in mental health as well as the role of the exercise professional meant that referrals to the program were not made by all mental health clinicians. While staff 'champions' who were involved in the establishment of the position had provided in-services and education to staff prior to the commencement of the role, some staff stated that not everyone attended these and as such, some staff in the service did not fully understand the exercise professional role, or even know it existed.

"I only knew about [the exercise professional] through our consultant psychiatrist - she would be saying in handover that this person would be a good referral for [the exercise professional] and I would need to check out what that meant. We certainly didn't get any introduction in a formal orientation. There wasn't any other information about trying to get into contact or referring and there wasn't a way to know how to do it. Like a pathway you would take. And during the orientation we didn't actually get told about it."

(Psychiatrist Registrar 2)

Staff stated that educational in-services education sessions had been given by the exercise professional after commencing in the role and

staff that attended these sessions had been more engaged with referring consumers. The sessions had outlined the role of an exercise professional within mental health settings, the benefits of physical activity for people living with mental illness and how to refer clients. However not all staff attended these sessions, and those who missed out were less informed about the process.

“Sometimes, different parts of the service don't make as many referrals to [the exercise professional] or don't know about the service. More in-services to new staff during orientation would help to show those who have physical health issues. I would say some parts of the service know this program better than the rest. [The exercise professional] is already doing some education and in-service already which has helped.”

(Registered Nurse 1)

3.8. Directions for future practice

When discussing recommendations for exercise professionals in mental health settings, a common theme emerged regarding the importance of providing thorough education to mental health clinicians regarding the role of an exercise professional and the benefits of engaging in exercise for consumers. Staff felt that not all staff in the service were properly instructed about who the exercise professional was and how they could refer clients. If there was a greater focus on education and in-services prior to and during the initial stages of an exercise professional commencing in a mental health service, staff believed this could contribute to greater success of the physical health program.

“I think as well providing some level of education to the nurses on the ward as well, because often they have more conversations about people's goals than we do, so there are plenty of times where someone will say I think this person will be really good for the gym and I didn't think about that. And for the community-managed clients I think the case managers wouldn't know about the service and a lot of their clients would want to use it but again if they don't know about it, they won't. Making the referral pathway clear beforehand would be key.”

(Psychiatrist Registrar 2)

Many staff mentioned that while they recognised the benefits of the service for consumers, they felt it was limited because of lack of funding and limited availability of the exercise professional to provide treatment. It was widely recognised that physical activity services should be more widely accessible for mental health consumers and that management should aim to create more positions in the future.

“Personally, I'd like to have [exercise professionals] accessible in all departments within mental health. It would be great to have our services accessible by everyone so we would need to have the structure to meet their demands. That means having a bigger gym space, having more time for [the exercise professional] to work throughout the week to address any potential clients that need assistance, I guess a more streamlined role. I think that the [physical activity] program at St Vincent's could really go far but they just have an issue of funding, availability and space for that to occur”.

(Occupational Therapist 1)

4. Discussion

This qualitative study examined the implementation of an exercise professional within an inpatient hospital mental health service. Our results highlighted the barriers and facilitators to implementing clinical exercise services and have important implications for other mental health services aiming to integrate exercise interventions as part of routine inpatient care for people living with mental illness.

Staff participants highlighted the critical role of the exercise professional in improving adherence of their clients to exercise programs.

It was noted that the specialist nature of the role meant that the exercise professional could utilise their knowledge regarding exercise to increase client engagement in physical activity sessions. Having a sole practitioner who could dedicate time to client engagement in exercise was identified as critical to the success of the program. This is evidenced in a recent meta-analysis which noted the important role of qualified exercise professionals in enhancing adherence to physical activity programs for people living with schizophrenia (Vancampfort et al., 2016). Additionally, staff believed that the exercise professional was able to provide specialised physical activity interventions to clients at a higher standard than other mental health clinicians. This reflects attitudes from nurses in mental health settings who feel they are not well trained in physical health care, particularly regarding exercise and physical activity; and that whilst specialised cardiometabolic health-care nurses are appropriately trained; there are few such positions in most settings, so an exercise professional is a preferred multiskilled option (Stanton et al., 2015a, 2015b).

The participants in our study often referred to the education sessions and in-services that the exercise professional provided to staff, that helped to improve their knowledge of the role and services provided to consumers. There have been calls by mental health nurses for more formalised training and education in physical health monitoring and exercise prescription (Stanton et al., 2015a). Improving resource development and designing educational in-service training are approaches that exercise professionals can use to improve knowledge and confidence regarding exercise of other staff, and to facilitate referrals to physical activity programs (Fibbins et al., 2019). A number highlighted that not all staff in the mental health service were fully briefed on the nature of the exercise professional role, an increased focus on initial information sessions is desirable when implementing such a position.

Physical activity promotion within inpatient mental health settings can positively impact health outcomes in response to both short-term and long-term interventions (Stanton & Happell, 2014). Exercise programmes that are directed by exercise professionals have high engagement rates for inpatient mental health consumers and have high rates of satisfaction from those who attend (Stanton, Donohue, Garnon, & Happell, 2016). A common comment by study participants was the positive influence the exercise professional had on client's physical health measures such as weight loss, in addition to improving mood. These statements support those of previous quantitative studies demonstrating the beneficial effects of physical activity for people living with mental illness. While consumer voices and associated health outcomes were not assessed for this current study, a common theme from staff members was the improved physical and mental health outcomes of consumers that engaged with the exercise professional.

Despite identified benefits of inpatient mental health consumers participating in physical activity programs, barriers exist to their engagement. Mental health nurses working on inpatient wards have reported that insufficient training, conflicting priorities and low consumer motivation impact their ability in prescribing exercise to consumers (Stanton et al., 2015a). Additionally, mental health nurses report that lack of confidence and conflicting views regarding their responsibility to discuss exercise affect their prescription practices (Howard & Gamble, 2011). Similarly, in our study, participants noted that prior to the employment of the exercise professional, time and lack of confidence were cited as reasons why discussions of physical health and exercise were not a common occurrence. Other studies have reported that exercise professionals embedded within mental health settings can not only provide physical health monitoring and exercise prescription (Lederman et al., 2017; Stanton et al., 2015a), but can also educate other mental health clinicians to improve their knowledge and confidence (Fibbins, 2018; Poole, Rossimel, & Fibbins, 2018).

A common theme that emerged was the limited funding which restricted the exercise professional role to part-time. Staff noted that this impacted the number of patients that could engage with the service. Low levels of funding towards physical activity programming in mental

health services is well documented (Chwastiak, 2015; O'Donnell, Williams, & Kilbourne, 2013; Stumbo et al., 2015), A position statement (Pratt et al., 2016) from the Society of Behavioural Medicine and The American College of Sports Medicine included recommendations to increase funding for exercise services within mental health services. The statement urged that lifestyle interventions, including physical activity programs, should be expanded and supported by health care insurance companies and universal health care programs. Given the cost-savings that are likely to occur from including exercise programmes as part of mental health treatments (Economics, 2015; Lobelo, Stoutenberg, & Hutber, 2014) recommendations such as these should be considered in future mental health policy directives.

4.1. Limitations

While effort was made to capture a broad sample of staff participants from varying disciplines, our sample's views may not be representative of all mental health service staff. Given the sample of participants involved in the study were those who had engaged with the exercise professional, this may indicate potential bias towards a positive view of the physical health service. Future studies could evaluate staff perspectives from counter points, for example, those who had not regularly interacted or engaged with the exercise professional. Future qualitative studies should also examine the role of physical health services in mental health settings should aim to include the views of current or previously engaged consumers living with mental illness and their carers.

5. Conclusions

Mental health services implementing physical activity interventions should consider the facilitators and barriers we identified when implementing exercise professional roles within such settings. An exercise professional within an inpatient mental health service was universally identified as beneficial in improving consumer health outcomes while increasing the education of mental health clinicians regarding physical health. Management should play a key role in educating staff members about the role of an exercise professional prior their commencement in addition to how the role will assimilate into the service. Funding allocation for physical activity specialists should be allocated by health executive management and health insurance providers to facilitate high quality physical health services for consumers living with mental illness.

Declaration of competing interest

None.

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