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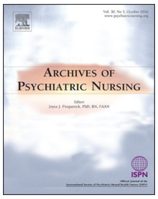

Mental health care professionals' accounts of actions and responsibilities related to managing physical health among people with severe mental illness

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ABSTRACT

Background: Life expectancy of people with severe mental illness (SMI) is greatly shortened compared to the general population, and despite extensive research, this issue is unsolved. Although it is widely recognised that people with SMI need support from health care services to manage health related issues, profound health inequalities exist within provision of health care. The aim of this study was to examine how mental health care professionals accounted for their actions and responsibilities related to managing physical health issues among people with SMI.
Methods: Three focus groups were conducted with 22 mental health care professionals, employed at three mental health care locations. Participants' situated accounts were subjected to discourse analysis.
Results: Participants accounted for actions and responsibilities in three typical ways; 1) by positioning people with SMI as difficult to motivate and actively resisting intervention, 2) by positioning people with SMI as so impaired that intervention was futile, and 3) by arguing they are undertreated for physical conditions and might have physical illnesses that staff are not aware of because of prominent mental illness. These discursive strategies seemed to legitimise situations where participants described not responding to physical health issues, and to downplay potential trouble in situations where participants described not succeeding in facilitating lifestyle changes or promoting compliance to treatment of physical conditions.
Discussion and conclusion: Mental health care professionals need to increase their awareness of latent discriminating attitudes towards people with SMI. Such attitudes are suggested to reinforce barriers for people with SMI receiving physical health care.

Introduction

Research from recent decades have shown unacceptable levels of excess mortality among people with severe mental illness (SMI) when compared to groups in the general population as their life expectancy is shortened by 13–30 years (De Hert et al., 2011; Laursen & Nordentoft, 2011; Nielsen, Uggerby, Jensen, & McGrath, 2013; Saha, Chant, & McGrath, 2007; Wahlbeck, Westman, Nordentoft, Gissler, & Laursen, 2011). This excess mortality is explained by unnatural deaths like suicide and accidents, but also by physical illness (De Hert et al., 2011; Laursen, Nordentoft, & Mortensen, 2014; Wernlund & Aagaard, 2015). Studies have shown high prevalence of physical illness among people with SMI and an overrepresentation of risk factors related to life style, which constitute a major contributor to onset of physical illness (McCloughen, Foster, Huws-Thomas, & Delgado, 2012; Parks, Svendsen, Singer, & Foti, 2006; Scott & Happell, 2011; van Hasselt

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et al., 2013). Further, the presence of poor physical health among young people with SMI underline the urgency for interventions targeted prevention of physical illness and promotion of health within this group (McCloughen et al., 2012).

People with SMI are among the most vulnerable and disabled groups in society. Many struggle with instability in everyday life due to relapse and worsening of mental illness. Symptoms such as lack of motivation, ambivalence and difficulties engaging in social interactions might delay detection and treatment of physical illness among people experiencing these challenges. Cognitive deficits may have negative impact on executive functioning and organisational skills and contribute to difficulties in managing everyday life. Furthermore, inequalities related to allocation of resources in the health care sector, and deficiencies within the organisation of health care provision are described as factors contributing to poorer access to treatment of physical illness among people with SMI (De Hert et al., 2011; Lawrence & Kisely, 2010; Leucht, Burkard, Henderson, Maj, & Sartorius, 2007; Marmot, Friel, Bell, A J Houweling, & Taylor, 2008; Mesidor, Gidugu, Rogers, Kash-MacDonald, & Broadman, 2011; Nash, 2013). People with SMI need intensive support from the health care system to manage health related issues. However, there are profound health inequalities within health care services which seem to contribute to poor physical health outcomes among people with SMI (Lawrence & Kisely, 2010; McNamee, Mead, MacGillivray, & Lawrie, 2013). In addition, the process of health care professionals wrongfully attributing symptoms of physical illness to mental illness (known as 'diagnostic overshadowing') has been suggested as a contributing factor in diagnosis and treatment delays (Jones, Howard, & Thornicroft, 2008; Nash, 2013). Potential causes of this includes stigma and negative attitudes towards people with mental illness among health care professionals (Nash, 2013).

Several studies have examined the roles of professional and their presumed responsibilities related to the provision of physical health care in different mental health care settings. Some with specific focus on professional groups such as case managers, psychiatrists (De Hert, van Winkel, Silic, Van Eyck, & Peuskens, 2010), general practitioners (Beecroft et al., 2001; De Hert et al., 2010; Oud et al., 2010; van Hasselt et al., 2013), and mental health nurses, see for example (Blythe & White, 2012; Happell, Platania-Phung, & Scott, 2014; Happell, Scott, Platania-Phung, & Nankivell, 2012). Especially mental health nurses are reported to acknowledge the management of physical health issues as part of their professional role. However, studies also report expressed ambiguity related to whether mental health nurses should take on these tasks or not, and uncertainty related to whether mental health nurses possess the needed skills and knowledge to take action (Blythe & White, 2012; Happell et al., 2012; Wynaden et al., 2016).

Recent studies have suggested that mental health care professionals' (MHCP) delivery of preventive services has increased, but that the level of care provision remain suboptimal as MHCPs provide inadequate assessment of physical health status, give insufficient health related advice to people with SMI, and do not refer to external collaborators if needed (Bartlem et al., 2014; Bartlem et al., 2016; Crawford et al., 2014). Recent research has suggested that preventive interventions solely focused on changing lifestyle behaviour to promote health might not be effective (Jakobsen et al., 2017; Speyer et al., 2016). Further, persistent efforts to make targeted groups comply with health norms of contemporary society might lead to unintended consequences inflicting feelings of shame, defeat and powerlessness on people who does not succeed in making lifestyle changes (Moltke, 2017). Attitudes among MHCPs towards providing services related to physical health care are reported as generally positive; however, MHCPs' perception of people with SMIs lack of interest in changing risky health related behaviour and the lack of time resources in daily practice to perform these tasks remain barriers in this area of care provision (Bartlem et al., 2016).

Despite many years of research and intervention within this area, the challenges with severe mental illness and comorbid physical illness seem overwhelming. The excess mortality among people with SMI remains an unsolved problem and the gap of lost years between this group and the general population continues to increase (Laursen et al., 2014; Saha et al., 2007). In this paper, we will approach these issues through a social constructivist approach, which can provide alternative insight into MHCPs understandings of their everyday practices and their verbalised motives and intentions related to dealing with physical health issues among people with SMI.

Theoretical perspective

This study builds on a social constructionist approach to discourse analysis developed in social psychology (Edwards & Potter, 2001; Potter & Wetherell, 2007). This approach investigates details of language-in-use as activities in social interaction and is appropriate for studying verbal communication between people embedded in institutional settings. The focus is on action-orientation of talk and on the discursive resources used in these practices (Edwards & Potter, 2001; Potter & Wetherell, 2007). Within this perspective, discourse is understood as all written texts and talk. It is treated as a domain of action in its own right as it does not simply mirror or describe a pre-fixed representation of the world, but rather is used to produce different versions of the social world to construct the lived reality of the speaker (Potter & Wetherell, 2007). When analysing social talk and texts, three features needs to be taken into account; discourse is (1) *action-oriented* as it is always serving an action-related purpose (e.g. requesting, accusing or persuading), (2) *situated* in three ways, a) in a sequence of talk, b) in an institutional context, and c) rhetorically, which all are of importance to the analysist, when trying to understand, what is going on, and (3) *constructed/constructing*, as it is *constructed* by the speakers use of linguistic resources and at the same time *constructing* different versions of the social world through use of different versions of accounts (Edwards & Potter, 2001).

The aim of this study was to examine how mental health care professionals account for actions and responsibilities in their everyday work related to managing physical health issues among people with severe mental illness. Accounts are discursive strategies used when explaining unusual, or untoward actions or unanticipated behaviour, and serve to neutralise potential consequences. By examining situated accounts, we can gain insight into the MHCPs' understanding of their practices of accepting responsibility of actions or attempts to disclaim or shift responsibility elsewhere (Edwards & Potter, 2001; Potter & Wetherell, 2007; Scott & Lyman, 1968).

Materials and methods

The study was designed as a qualitative focus group study.

Focus groups and participants

Data were generated through three focus groups (Bloor, 2001) conducted at three mental health care locations in the North Denmark Region. Participants were recruited from two mental health care settings; two mental health residential facilities and one outpatient clinic; all run by regional authorities. In both settings, multi-professional teams provide comprehensive care to people with SMI; the main part of the target population being people with schizophrenia. All health care staff members at the two settings were invited to participate in a focus group and planning of the focus groups were done in close collaboration with local managers. The purposive, non-probability sample included 22 MHCPs participants. All but five were women. Participants' employment at the included locations ranged from 5 months to 38 years. Table 1 provides information on the focus groups and the participants.

In focus groups, the interactions between participants give access to situated accounts reflecting group norms and descriptions (Bloor, 2001; Halkier, 2010). To facilitate the discussions, participants were asked to

Table 1
Focus groups and participants.

Focus group	Setting	Duration (h:min)	Participants (n)	Occupational groups (n)	Age Median [IQR][a]
1	Residential facility A	1:27	9	Registered nurse (1), Nursing assistant (1), Social education worker (1), Residential support worker (1), Social and health care worker (4), student (residential support worker) (1)	55.5 [55–59][b]
2	Residential facility B	1:38	7	Registered nurse (1), Residential support worker (2), Social and health care worker (3), student (social and health care worker) (1)	38 [32.5–47.5][c]
3	Outpatient clinic	1:44	6	Registered nurse (3), Psychologist (1), Occupational therapist (2)	48.5 [35–51]
Total		4:50	22		51 [36.5–55]

[a] IQR = Interquartile range.
[b] Information on age of 3 participants was not available.
[c] Information on age of 2 participants was not available.

prioritize and discuss six themes related to the management of physical health issues among people with severe mental illness. The themes were developed based on previous focus group studies focusing on mental health care professionals' and patients' perspectives on managing physical health issues in a mental health care setting (Happell et al., 2012; Kristiansen et al., 2015). Additionally, they were based on experiences gained during participant observation conducted by the first author at all three mental health care locations prior to the focus groups. Themes covered in the current study included areas such as MHCPs involvement in everyday management of physical health issues, their experiences of assessing physical health status among people with SMI, their views on how people with SMI are able to perceive, understand and act on symptoms of physical illness, and on their ability to manage physical health issues in general.

The focus groups were conducted from late 2016 to early 2018. All focus groups were moderated by the first author. At every occasion an observer was also present and took notes on the interaction of the groups.

Ethics

The Danish Data Protection Agency and the regional Research Ethics Committee were notified about the study and rules and regulation regarding data storage were followed. Local managers authorised the study to take place and participants received written and oral information about the study and gave written informed consent before participating. Extracts from the data material that are presented below have been modified to protect the identity of individual participants.

Analysis

Typically, the analysis within the tradition of discursive psychology does not follow a pre-fixed pattern. Rather, it follows certain areas of interest put forth by the researcher about what is accomplished through talk (Potter & Hepburn, 2005). The current analysis focus on the thematic content as well as on discursive strategies used by MHCPs to account for actions and responsibilities related to their engagement in management of physical health issues among people with SMI (Scott & Lyman, 1968). This included basic analysis of participants' tacit reasoning procedures, that is participants' procedures of producing and making sense of talk (Hutchby & Wooffitt, 1998).

The focus groups were audio recorded and transcribed verbatim with indication of basic interaction. The analysis was done in three phases. Phase one, entailed repeated reading of the data material and memo writing related to developing initial themes and gaining insight into the patterns of discursive strategies used in MHCPs' accounts. During this phase memos and themes were continually discussed among the first, second and last author. In the second phase, final themes were developed and illustrative sections of the data material were selected for detailed transcription and thorough analysis of discursive components such as speech delivery and building analytic claim about what is going on in participants' discussions (Hutchby & Wooffitt, 1998). Detailed transcriptions included indication of several interactional and pronunciational features (Jefferson, 2004; Potter & Wetherell, 2007). The last phase entailed the process of writing up the findings and providing contextual examples. The final themes are presented below as three typical ways for MHCPs to account for actions and responsibilities related to management of physical health issues in their everyday work. They are illustrated in detailed analysis of three data extracts. These extracts were selected to represent the discursive strategies, which were dominant throughout the whole data set. In this phase, the extracts used in the presentation of results were translated from Danish to English by the first and last author.

Findings

The focus group discussions reflected an on-going negotiation among the participating MHCPs about their responsibilities and obligations in relation to management of physical health issues among people with SMI. They accounted for professional actions and responsibilities in three typical ways: 1. By positioning people with SMI as difficult to motivate and actively resisting intervention, 2. By positioning people with SMI as so impaired that intervention was futile, and 3. By arguing that people with SMI are undertreated for physical conditions and might be suffering from undetected physical illnesses that staff are not aware of because of prominent mental illness. Such accountings were used to legitimise descriptions of not taking action on physical health issues. Likewise, it seemed to downplay the potential trouble related to situations where they described not succeeding in facilitating lifestyle changes or promoting optimal compliance to treatment of physical conditions.

People with severe mental illness are difficult to motivate and resist interventions for lifestyle changes

According to the MHCPs, motivational work was a primary aspect of their work related to management of physical health issues among people with SMI. This involved providing information about potential risks and consequences of having what MHCPs described as unhealthy lifestyle and about necessary precautions related to living with comorbid physical illness. Unhealthy lifestyle was described as poor eating habits, lack of physical exercise, social isolation, smoking and drug abuse. It was depicted as a time-consuming task, which in many cases ended up being unfruitful due to what MHCPs depicted as active resistance towards making such changes. MHCPs described different dilemmas and frustrations related to this work. One concern was that they would have to be careful not to become too paternalistic or intrusive when trying to push or nudge people with SMI towards lifestyle changes. Some MHCPs were very aware not to portray themselves as "holy" on these matters and repeatedly raised concern about the risk of them "preaching morality" in their efforts to motivate lifestyle changes. They were concerned that by using such efforts they would risk ruining already fragile interpersonal relationships. To MHCPs in the outpatient clinic, broken relationships would mean people with SMI disengaging from their services and them losing all leverage in relation to providing both mental and physical health care.

In relation to their actions and responsibilities, MHCPs across the focus groups described that if the individual with SMI was not prepared to make the suggested lifestyle changes or did not acknowledge their importance despite motivational efforts, then the MHCPs could not do anything and they would "give up" and step back. This was typically justified by claims of accepting the personal choice of the person in question e.g. if a lifestyle-related goal (weight loss, smoking cessation, increasing exercise) had been targeted for some time without achieving any results. By using such justifications, MHCPs in effect declined taking responsibility for dealing with the physical health issues, even though not taking action might result in a worsening of the individual's physical health status. A negotiation between participants around this issue is illustrated in Extract 1 (Fig. 1). The speakers P1–P4 are participating MHCPs. Prior to the extract, P1 has been pushing the others towards presenting concrete solutions to these very complex issues by posing questions about what they can actually do beyond providing information to clients. The others have suggested keeping up their efforts despite clients' resistance and trying different approaches to boost motivation, but without providing arguments that satisfied P1.

P1 begins by stating how they do not disagree on the matter [about their obligations] (line 1), then hesitates before completing the statement with "as such" (line 5). Using the "as such" construction might suggest some reservation and seem to contradict the claim of being in agreement. P2 and P3 acknowledges with "no" (line 3–4), most probably agreeing not to disagree. P1 explains how they "have to respect" the individual "right to make decisions about their own life" (lines 5, 7 and 9). A false start (repeating line 5 in line 7) and pause (line 5) might indicate P1s awareness of the potential disagreement embedded in using this point to justify not taking action on physical health matters. By emphasising keywords "have", "respect", "everybody" and "right" including stretching of "o:wn", P1 seem to underline the moral aspect embedded in not respecting individual choice. P2 responds with "of course of course" (line 10) indicating a mutual understanding about their obligation to respect the right to autonomy, however not necessarily to agree on this as justification for stepping back.

P1 exemplifies a frustration by explaining how "if people want to smo:ke" or are overweight and "you" have told them about the dangers of doing so (line 13), but then "they just smoke any:↓way" (line 15). This statement, mildly caricaturises the frustration related to their motivating efforts being unfruitful by emphasising and stretching of "v:e:ry" and "dangerous". This is further emphasised by the rhetoric construction in line 15, which might imply people with SMIs continued smoking as an act of defiance.

P1 continues to explain how they at some point "have to" leave the choice with the individual, underlining this using direct speech and emphasis on keywords ("this (.) is your choice", "also your right") (line 17–18). At the end, P1 brings matters to a head stating an argument that no one can disagree with: that they cannot coercively "take the cigarettes" away (line 18–19) or "ban or whatever" (line 22). Speaking simultaneously, P2 responds in agreement, but also strongly rejects the thought of using such intrusive measures (line 20–21).

MHCPs across the focus groups depicted this motivational work as a balancing act between accepting an individual's right to autonomy and at the same time risking to fail helping people with SMI by providing insufficient support. Some expressed a very strong obligation to keep trying to motivate changes in the lifestyle in situations where continued

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 1  P1  but I really do not think we dis[agree (.)
 2  P2                                  [°m::°
 3  P2  no[
 4  P3    [no
 5  P1  as su[ch (.) well the situation where I think that you you also have to re (.) well (1.2)=
 6  P2       [°m::°
 7  P1  =well the situation where I think you also have to respect (.) everybody [has the right to=
 8  P2                                                                           [yes yes
 9  P1  =make decisions about their o:[wn ↓life and if people they want to smo:ke=
10  P2                                [of ↓course °of course°]
11  P1  =and they are over[weight and you say well it is v:e:ry dangerous to smo:ke there i:s=
12  P2                    [↑yes
13  P1  =risk of early death [and arteriosclerosis and all those things
14  P4                       [°m::°
15  P1  e:r but they (.) ju:st smoke any:↓way
16  P2  °m::°
17  P1  ↑then (.) then at some point you also have to sa:y (1.5) this (.) is your choice (.) we::ll then it it is also
18      your right to to be a smo:ker if that s: (.) vi cannot take the
19      cigarettes [with us or::
20  P2             [↑no no=
21  P2  =I really do not think at [all we:: we:: (.) that we should Linda
22  P1                            [ban o:r or whatever (.) it just might be (.) you would th[ink=
23  P2                                                                                      [nho]
24  P1  =that would be much be[tter if you did that
25  P2                        [m:
```

[from focus group 3, time: 0:43:59-0:44:33]

Conventions used in transcripts: (.) indicates pause < 1 second, (x.0) indicates pause in x seconds, = indicates latching between utterances, [indicates interruption and simultaneous speech, ::: indicates stretching of sound, sti*h*ll indicates breathiness, sti(h)ll indicates the word is said while laughing, emphasis, °spoken quieter°, ↑ indicates rising or ↓ falling intonational shift. Linda is a fictional name of P1.

Fig. 1. Extract 1.

risk behaviour would potentially worsen the physical health state. These MHCPs would also reject the claim, that their job was sufficiently done, by making sure that people with SMI were made aware of the consequences of their lifestyle behaviour. In some of these accounts, the illustrations of the difficulties related to living with SMI also became the justification for keeping up persistent efforts focused on physical health issues. However, several participants described difficulties in succeeding with their motivational efforts.

People with severe mental illness are so severely impaired that interventions are futile

Across the focus groups, severity and persistence of mental health problems were depicted as major barriers for achieving lifestyle changes among people with SMI and as having profound negative impact on illness behaviour among those with comorbid physical illness. Symptoms of behavioural character, e.g. lack of ability to apply to normal conduct, and social norms were depicted as influential on behaviour in everyday situations. An example used by MHCPs in the institutional setting was related to behaviour of people with SMI when participating in communal meals. In these situations, some people with SMI were depicted as "savage" or "greedy" and as eating in an "unnatural" and "out of control" manner if they were not restricted. The strong words used in these explanations seemed to justify MHCPs' use of somewhat intrusive measures when trying to prevent the otherwise excessive intake of food.

Besides behavioural symptoms MHCPs described bizarre delusions, hallucinations, disrupted bodily experiences, and cognitive deficits as very impairing. MHCPs explained how they would sometimes choose not to take action on physical health issues, because it seemed in vain to try to reason with a person in such a poor mental state. These accounts also entailed examples of pronounced psychosis, which served to legitimise MHCPs choice not to take actions on physical health matters. In other cases, MHCPs used examples of severity of mental illness to depict how symptoms of physical illness could be misinterpreted by people with SMI as being caused by other factors than physical illness. Extract 2 (Fig. 2) illustrates this scenario. In this part of the focus group, MHCPs have been explaining how some people with SMI with disrupted bodily experiences might interpret their experience of pain differently than people without mental illness and how this in combination with delusions might affect their way of perceiving physical symptoms in general. In Extract 2 (Fig. 2), P5–P8 are the participating MHCPs and M is the moderator.

P5 begins by stating how "it is just difficult" if people with SMI are not able to feel symptoms, because then the symptoms "are ignored" (line 1 and 3). Hesitation halfway through this statement (line 1) might indicate awareness of the seriousness embedded in this fact. In line 6–7, P5 provides another observation; that symptoms "are interpreted" and references an example given by a colleague earlier (line 7). The interposed sentence "I think we all experience as well" (line 6) suggest the intention to depict this as a common understanding. P5 elaborates by depicting what might be going on: that it is "probably true that they [teeth] do not really work" and that "they may hurt" and how the person with SMI will not be worried about it, because new teeth will grow out. After pausing (line 12) P5 describes the bizarre, paranoid delusions that some people with SMI experience by explaining how physical symptoms are misinterpreted as being caused by external agents, such as receiving radio signals through the teeth or having microphones implanted in the teeth and this being the cause of pain. The repeated use of "right" (line 10, 12, 13) might indicate further attempts to establish this as an agreed matter. The absurdness of such delusional beliefs is used to depict the impossible scenario they are facing. This is further emphasised by P5 slightly laughing while speaking (line 13). P5 concludes that this is "difficult to compete with" (line 18) because "you cannot convince" a person who is paranoid that the delusions are not true (line 20). Emphases and shifts in intonation in key words underlines this impossible scenario and provides justification for not trying to achieve changes or improved illness behaviour with people who are in such a mental state. After pausing (line 20) P5 repeats the first comment, but this time, with stronger emphasis by adding the word "damn". Accounts such as these and the severity of psychosis that was depicted, served as a common discursive strategy for MHCPs to legitimise not taking action even though they observed risky lifestyle or illness behaviour that posed potential risk of worsening the physical health of the individual.

People with severe mental illness are undertreated for physical conditions and present conditions are difficult to detect

Some participants voiced the opinion that people with SMI were generally undertreated for physical health conditions. They believed this to be a consequence of on-going stigmatisation within the health care system and depicted how people with SMI faced hardship because physical complaints were dismissed as being part of their psychosis.

1	P5:	bu:t it is just difficult if they are not able to fee:l them (.)
2	M:	m::
3	P5:	then they are ignored
4	M:	°yes°
5	P6:	°.hh° ((clears throat))
6	P5:	and then they can also (.) e: that I think we all experience that they are interpreted (1.3) so that
7		exactly just like Ben is saying there some ne:w teeth will grow out
8	M:	yes[
9	P7:	[m:::
10	P5:	right (.) because it is probably tr[ue that they do not really work] and they may hurt=
11	P8:	[((clears throat))]
12	P5:	=but new ones will grow out ↑right (1.6) and it can just might be:: (.) I have also experienced people
13		who receive ra(h)dio mos(h)kow in their ↑teeth because there is a toothache ↑right
14	M:	m:
15	P7:	°y*h*es°
16	P5:	then there are micro↑phones and ↓all that (.) so
17	P7:	°y*h*es°
18	P5:	and that is just difficult to compete with
19	M:	yes
20	P5:	because (.) you cannot ↑convince someone who has paranoia that this does not exist (1.3) that is just
21		↑damn difficult

[from focus group 1, time: 0:47:09-0:47:46]
Ben in a fictional name of P7.

Fig. 2. Extract 2.

Further, they provided examples of how some were denied proper care and treatment for physical conditions because their mental health problems could not be handled within the somatic health care services. MHCPs described these situations as unfair and potentially harmful to the physical health of people with SMI and explained how they would sometimes intervene to make sure that patients were taken seriously and received proper treatment. In both settings, MHCPs reflected on how they sometimes unintentionally contributed to the stigmatisation of people with SMI. They explained that being employed in mental health care made them focus on psychiatric issues and not physical health issues. These accounts reflected MHCPs' insecurities about putting enough effort into dealing with health risk behaviour and inappropriate illness behaviour.

To further emphasise the challenges they faced when dealing with issues of poor physical health in their work, MHCPs described how some people with SMI were unable to articulate the symptoms of physical illness. This particularly became an issue among those with severely disrupted bodily experiences. MHCPs employed in the outpatient setting explained how they used screening tools in assessing symptoms and monitoring physical health among their clients. They explained how the thorough questioning about experienced physical symptoms helped them detect physical conditions, which they would otherwise have overlooked. The MHCPs employed at the psychiatric institutions explained how they in these cases typically based their assessment of physical health on personal knowledge about the individual and primarily took action if the behaviour was "different than normal" or if something was visibly wrong. Extract 3 (Fig. 3) provides a typical example of MHCPs accounts on these practices. Prior to the extract, the MHCPs have been discussing how people with SMI react in different ways when experiencing ill physical health.

At the beginning, P10 states that it is "a problem" when people with SMI "are not able to verbalise" their physical conditions (line 1). Hereby, acknowledging the difficulties they [MHCPs] face in these situations. The quietly spoken interposed sentence "you could say" might indicate an attempt to downplay the potential trouble embedded in this. P12 joins in providing another view on the matter; that "they are able to feel it" [physical symptoms] (line 5). The turn is taken over by P10 (line 6), who explains how "sometimes you can also see" referring to their practice of assessing physical health. P10 interrupts herself and agrees with P12 with an emphasised "yes", then continues to explain how they "interpret" certain behaviours as related to physical health issues (line 7, 10–11). Hesitation and rephrasing of the sentence (line 7) might indicate some insecurity about how to present this practice. Emphasising keywords "punches", "ache", and "clenched" in the example (line 10, 11) might serve to underline the point about the obvious connection between behaviour and potential symptom, hence justifying this approach. Then P10 explains how "it is very often of the basis of su:ch" "things" they "interpret" (line 14, 17). Stretching of "su:ch" and hesitation before continuing with "things" suggest awareness of the trouble embedded in this somewhat vague description of practice. Providing another reason for their interpretative practice, P10 explains how "it is not out spoken" (line 17) because the person does not do that. P10 concludes that the resident is a "huge challenge (1.0) in being heard", although leaving it unclear whether the challenge is on the resident or them.

Even though these situations were recognised as challenging, the approach illustrated in Extract 3 (Fig. 3) seemed to be accepted as typical in this setting. A dilemma related to this was embedded in a mismatch MHCPs experienced between the intensions and values of in care provision, the available resources and the support needs of people with SMI. MHCPs described how their field of work during recent years had become more goal-oriented and controlled by rate-based systems. From their point of view, this meant fewer resources for dealing with non-psychiatric issues. It was depicted how, in the extreme, the limited time resources caused by the goal-oriented regulation of their work would only allow them to focus on the issues that they were "paid to deal with" – that being mental health issues.

Discussion

This study examined MHCPs' situated accounts about their actions and responsibilities in relation to managing physical health issues among people with SMI. The study builds on previous focus group studies conducted with professionals and patients dealing with physical health issues in mental health care settings (Happell et al., 2012; Kristiansen et al., 2015). These studies reported findings in keeping with the ones found in the current study: awareness of the presence of severe physical health issues among people with SMI; awareness of patients' needs of support from staff trained within mental health in making healthy lifestyle choices in everyday life; lack of resources to deal with physical health issues which seem to reinforce fragmentation of health care provision; and staff experiences of people with SMI deprioritising physical health issues and resisting lifestyle changes. Furthermore, the studies uncovered role ambiguity and uncertainties about responsibilities among MHCPs and identified needs for continued improvement within physical health care provision (Happell et al., 2012;

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 1  P10:   bu but it ↑is a (.) a °problem you could [say]° that they are not e:r (.) able to verbalise it o:r (.)
 2  P11:                                            [m::]
 3  P12:   °m:: °
 4  P10:   °yhes°
 5  P12:   because I [believe  they  are  able  to feel it ]
 6  P10:             [well sometimes you can also see] (.) yes but but someone like Henry also sometimes we
 7         can (.) ↓yes in (.) well we interpret (.) when he is exasperated a:nd
 8  P12:   m::
 9  P13:   m::
10  P10:   punches himself in the stomach that it is because he has a stomach ache or (0.6) when he had trouble
11         with his teeth [you could also see how clenched his teeth were and
12  P14:                  [m:::
13  P12:   m::
14  P10:   but it is very often of the basis of su:ch (.)
15  P15:   yes
16  M:     m::
17  P10:   things that we interpret (.) well you see it is not °out spoken° (.) it is because (.) he [does not do=
18  P12:                                                                                             [m::
19  P10:   =that °but° (1.6) °yes° (.) so in that way he is a huge challenge (1.0) in being heard
```

[from focus group 2, time: 0:31:33-0:32:03]
Henry is a fictional name of a resident

Fig. 3. Extract 3.

Kristiansen et al., 2015). These previous studies focused on analysing thematic content of the focus group discussions. In the current study, the discursive psychological approach to analysing both thematic content and discursive strategies, contributed with deeper insight into MHCPs' understanding of their roles, actions and responsibilities related to the provision of physical health care. This approach has provided insights into continued presence of well-known issues within the included mental health care settings, but also into how attitudes among MHCPs are verbally enacted in discussions among colleagues. The analysis showed how examples of severe and persistent mental illness was used by MHCPs as part of discursive strategies to depict the comprehensive support needs of people with SMI in relation to managing everyday life. Moreover, these strategies underlined the almost impossible scenarios MHCPs described related to trying to achieve changes towards healthier lifestyle and more optimal illness behaviours.

The accounts of how MHCPs would sometimes choose not to take action on physical health issues due to the severity and persistence of the mental problems among residents and clients might reflect a latent discriminating attitude towards people with SMI embedded in the local cultures. Participants to some extent confirmed this in their sporadic reflections about their contribution to continued stigma against people with SMI, even though this was depicted as unintentional. Recent research has reported that negative and discriminating attitudes among MHCPs pose a barrier for treatment and recovery for people with mental illness (Horsfall, Cleary, & Hunt, 2010; Knaak, Mantler, & Szeto, 2017). Such untoward attitudes among staff is a well-known issue in mental health care and general health care, and it has been described how MHCPs tend to be less optimistic about the outcomes of people with SMI (Henderson et al., 2014; Horsfall et al., 2010; Thornicroft, Rose, & Kassam, 2007). Negative attitudes among staff and staff being unaware of their presence contributes to stigma and may have severe consequences as they influence the help-seeking behaviour of people with SMI, leads to poorer quality of care, poorer compliance to suggested treatment and poorer outcomes (Knaak et al., 2017). Another implication related to such negative attitudes embedded in clinical practice could be that people who are diagnosed with severe and persistent mental illness, who needs the support related to physical health issues the most, might not receive optimal care. Measures to increase staff awareness and acceptance of the presence of such negative attitudes, including a focus on promoting positive attitudes, seem to be essential in order achieve changes, as positive attitudes among staff members towards their role in providing preventive care and the possible outcomes, have been reported to increase the likelihood of clinicians providing such care (Bartlem et al., 2016).

Insights gained from this study also points to aspects of current mental health care that needs continued focus. As suggested in previous research, MHCPs need to be actively involved in a process of increasing awareness of potential discrimination or stigma against people with mental illness, and of challenging such beliefs in order to change attitudes (Horsfall et al., 2010). Continued education of MHCPs is fundamental to increase awareness of discrimination, stigma and the potentially damaging effects such attitudes can have on outcome of people experiencing mental health problems (Happell et al., 2014; Horsfall et al., 2010; Knaak et al., 2017). The application of a humanist, person-centred approach has been suggested as a way to minimise potential discrimination and stigma. This approach would include working with people with SMI as equal partners in different aspects of health care (Horsfall et al., 2010). Advocates of this approach to health care provision also voiced their opinion in our focus group discussions. However, the accounts related to not taking action predominately entailed descriptions of non-partnership relationships with residents or clients, as MHCPs most commonly described making decisions based on what they believed to be in the best interest of the person with SMI.

Resent research have suggested that interventions based on narrow understandings of what health promotion entails are not only ineffective (Jakobsen et al., 2017; Speyer et al., 2016), but might also increase the risk of a boomerang effect leaving already vulnerable groups of society with feelings of shame, lack of acknowledgement and defeat if they do not succeed in achieving the proposed lifestyle related goals (Moltke, 2017). To improve effectiveness of health promoting interventions, it has been suggested that attention need to change from the traditional focus on inequality in health and illness towards a broader perspective focused on structural issues related to improving equality in life possibilities and increasing social investment (Barr, Higgerson, & Whitehead, 2017; Link & Phelan, 1995; Moltke, 2017). In this context, the narrow lifestyle perspective that was reluctantly promoted by the study participants can be seen as limiting rather than meaningful and effective. A way forward for the MHCPs might be to collaborate with health care authorities to develop and implement structural interventions that reach beyond the individual level (Link & Phelan, 1995).

Continued reports of the presence of stigma and negative attitudes among staff employed in health care services, indicates that these issues might be systemic in nature and related to organisational culture (Henderson et al., 2014; Knaak et al., 2017). To achieve systemic change, there is a need to work with comprehensive organisational interventions including the aspects of overall priorities related to health care provision, general perceptions of people with mental illness and continued staff education (Bartlem et al., 2016; Henderson et al., 2014; Knaak et al., 2017).

Several limitations need to be mentioned related to the current study. Due to practical reasons (e.g. limited access to MHCPs during their workdays), participants were recruited through principles of convenience sampling. A purposive sampling strategy would have been preferred, as it could have resulted in participants who were specifically interested in the area of managing physical health among people with SMI. Furthermore, the participants were grouped with day-to-day-colleagues. If participants had been mixed across settings this might have facilitated different negotiations and descriptions of their everyday practice. Conversely, the participants' familiarity with each other seemed to create a trusting environment, which made it safe for them to share, disclose, and discus their work experiences and viewpoints. Finally, the findings were based on analysis of situated accounts and these cannot be understood as being equal to the MHCPs' actual clinical practices.

In conclusion, this study reports three typical ways that MHCPs accounted for their practices related to managing physical health issued among people with SMI. Furthermore, the study provides insight into latent discriminating attitudes that might reinforce some well-known barriers for people with SMI receiving physical health care. Based on these insights and knowledge on access mortality among people with SMI being a continued and unresolved issue, we suggest that change in the current conditions might not only rely on a change of attitudes, but also include taking a step further back to work on increasing awareness of potentially discriminating attitudes and stigma within mental health care settings. Highlighting these results, we have no intentions of claiming that MHCPs' accounts represent a clear image of their actual actions and professional practices, however we urge MHCPs to increase awareness of the presence of discriminating attitudes and to engage actively in a process towards changing them. Such attitudes reflect issues related to staff motivation to take on managing physical health issues despite any previous, unsuccessful attempts.

Declaration of interest

The authors report no conflicts of interest.

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