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ORIGINAL ARTICLE

Mental health consumers' with medical co-morbidity experience of the transition through tertiary medical services to primary care

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ABSTRACT: *Medical comorbidity in people with long-term mental illness is common and often undetected; however, these consumers frequently experience problems accessing and receiving appropriate treatment in public health-care services. The aim of the present study was to understand the lived experience of mental health consumers with medical comorbidity and their carers transitioning through tertiary medical to primary care services. An interpretative, phenomenological analysis approach was used, and semistructured, video-recorded, qualitative interviews were used with 12 consumers and four primary caregivers. Four main themes and related subthemes were abstracted from the data, highlighting consumer's and carers' experience of transition through tertiary medical to primary care services: (i) accessing tertiary services is difficult and time consuming; (ii) contrasting experiences of clinician engagement and support; (iii) lack of continuity between tertiary medical and primary care services; and (iv) Mental Health Hospital Admission Reduction Programme (MH HARP) clinicians facilitating transition. Our findings have implications for organisational change, expanding the role of MH HARP clinicians (whose primary role is to provide consumers with intensive support and care coordination to prevent avoidable tertiary medical hospital use), and the employment of consumer and carer consultants in tertiary medical settings, especially emergency departments.*

KEY WORDS: *augmented care, consumers and carers' experience, experience-based co-design, medical comorbidity, Mental Health Hospital Admission Reduction Programme, transition.*

INTRODUCTION

Medical comorbidity is common in mental health consumers (hereafter, consumers), but is often a barrier to effective treatment in public health-care services (Lambert *et al.* 2003; McDaid & Smyth 2015). Medical comorbidity is connected with a more severe progression of mental illness, poor quality of life, and untimely mortality (De Hert *et al.* 2011b; Fagiolini & Goracci 2009; Newcomer 2009). For instance, in the USA, life expectancy in people with mental illness is approximately 30% less than the general population (Fagiolini & Goracci 2009). The primary causes of reduction in consumers' lifespans are premature coronary heart and cerebrovascular diseases (Short *et al.* 2009), with up to 60% of this excess mortality being attributable to common preventable and treatable medical conditions (Tse *et al.* 2011). To illustrate, consumers with schizophrenia are more likely to experience obesity, dyslipidaemia (McDaid & Smyth 2015), type 2 diabetes mellitus, and diabetogenic complications than the general population (Schoepf *et al.* 2014), and medical comorbidity accounts for 60% of premature deaths unrelated to suicide in these individuals (Lambert *et al.* 2003).

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There are three key issues associated with medical co-morbidity – prevention, early and appropriate detection, and effective treatment – the latter two of which are a focus of this paper. Even though the link between mental illness and medical comorbidity has been long established, the latter persist in being underdiagnosed and undertreated (Fagiolini & Goracci 2009). Four main factors contribute to medical comorbidity. First, the effect of the consumer's mental illness (e.g. cognitive impairment and poor communication skills), lifestyle, unhealthy eating habits, and a possible genetic vulnerability to medical conditions (Fagiolini & Goracci 2009). Second, delayed or absent help seeking, which can be primarily attributable to community stigma and/or clinicians' negative and stigmatising attitudes towards people with mental illness (Keating & Robertson 2004; Link *et al.* 1999), and consumers' dissatisfaction with the treatment provided (Thornicroft *et al.* 2007). Third, poor access to primary and tertiary medical care; concern about the quality of care, including underdiagnosis and inadequate screening; assessment and treatment of serious illnesses (De Hert *et al.* 2011a; Fagiolini & Goracci 2009; Kilbourne *et al.* 2006; Mitchell *et al.* 2009; Thornicroft *et al.* 2007); and general practitioners' (Pinfold *et al.* 2003b; Pinfold *et al.* 2003a) and medical clinicians' (Kilbourne *et al.* 2006; Lambert *et al.* 2003) reluctance to care for consumers with serious mental illness. In addition, 'diagnostic overshadowing', a misattribution of medical symptomatology to coexisting mental illness, also results in underdiagnosis or delayed diagnosis and inappropriate or delayed treatment of medical conditions (Clarke *et al.* 2007; Thornicroft *et al.* 2007). Fourth, harmful side-effects of most psychotropic medications (Fagiolini & Goracci 2009; Tek *et al.* 2015) (especially second-generation antipsychotics (McDaid & Smyth 2015)), some of which are associated with metabolic side-effects, such as short- and long-term weight gain and body mass index increase, dyslipidaemia, and hyperglycaemia (McDaid & Smyth 2015; Newcomer 2009).

In light of the increasing focus on addressing medical comorbidity, it is valuable to understand if the experience of consumers, and that of their carers, has changed in this situation as they transition through tertiary medical to primary care services. Findings from this study might provide clinicians with an insight into how they can support consumers and carers as they navigate these services. The aim of the present study was to understand the lived experience of mental health consumers with medical comorbidity and their carers transitioning through tertiary medical services to primary care. It was abstracted from a larger experience-based co-design study of consumers (and their carers) accessing, receiving treatment and support from, and progressing through these services (Cranwell *et al.* 2015).

METHOD

Interpretative, phenomenological analysis (IPA) was adopted to inform data collection and analysis. The key features of IPA are hermeneutics, phenomenology, and idiography (Smith *et al.* 2009). The approach is based on hermeneutics, the theory of interpretation, where 'the researcher is trying to make sense of the participant trying to make sense of what is happening to them' (Smith *et al.* 2009, p.3). The approach is phenomenological because of its emphasis on understanding participants' key life experiences and how they comprehend these experiences. The approach is also idiographic in light of the prominence given to commencing with participants as the unit of analysis and then progressing to abstract themes from the data. IPA is particularly helpful in facilitating understanding where the problem is new or underresearched, and in complex areas or settings (Eatough & Smith 2006), as in the present study of the experience of consumers and their carers transitioning through tertiary medical services to primary care.

Participants and recruitment

Consumers and their carers were recruited through the Mental Health Hospital Admission Reduction Programme (MH HARP), an augmented care programme at the tertiary medical service in Melbourne (Vic, Australia). The programme was introduced by the Australian Intergovernmental Agreement on Federal Financial Relations in 2013 for 4 years as a pilot scheme. The programme operating in this tertiary medical service was one of three pilot schemes introduced in the state of Victoria in Australia. The programme was established for consumers with medical comorbidity problems who had two or more emergency department presentations within the preceding 12 months, with a view to prevent avoidable tertiary medical hospital use. It provides eligible consumers with intensive support and care coordination for a period of up to 6 months, to link them with appropriate community services and to develop their self-management capacity.

MH HARP clinicians, primarily mental health nurses, who accessed hospital records about eligible MH HARP participants, made initial contact with consumers and their carers to establish their interest in participating. If interested, they were followed up by a researcher who explained the study and obtained consent. Purposive sampling was used to inform data collection (Parahoo 2014). Inclusion criteria were: (i) consumers (and their carers) with complex medical care needs; (ii) previous recipients of the MH HARP service; (iii) aged over 18 years; and (iv) able to communicate in conversational English. The exclusion criterion

was if the consumer was currently experiencing an acute episode of mental or medical illness. MH HARP clinicians determined if the consumer was experiencing an acute episode of mental or medical illness.

Twelve consumers (9 women and 3 men) and four primary caregivers consented to participate, representing more than half those approached initially. The mean age of the participants was 60.2 years, ranging from 24 to 86 years. Two participants (1 consumer and 1 carer) were from culturally- and linguistically-diverse backgrounds.

Procedure

Data collection took place in private in consumers' homes. Semistructured, video-recorded interviews were undertaken, each lasting from 45 to 60 min; all interviews were conducted in English without the need for interpreter support. Video-recordings were used because excerpts from these interviews were incorporated subsequently in a 20-min video that was used in the larger experience-based codesign study referred to earlier.

The following broad questions were asked initially, and answers were probed and scrutinised further:

1. Please tell me how and why you came into contact with these services in the first instance?
2. Tell me your initial impressions about when you first came into contact with these services?
3. Tell me about the way staff communicated or shared information with you about your condition and these services?
4. In what way, if any, were you involved in discussions and decision-making about your condition and these services?
5. In what way, if any, were your family or friends involved in discussions and decision-making about your condition and these services?
6. Tell me about your good experiences, if any, moving from one service to another.
7. Tell me about any difficulties/problems, if any, you experienced in moving from one service to another.
8. Overall, how satisfied are you with your experience of moving between these hospital and community services?
9. Overall, how satisfied are you with the contribution of the HARP mental health service in supporting you to access this treatment?
10. Overall, how satisfied are you with the contribution of the HARP mental health service in supporting you to self-manage your condition?
11. Overall, what things, if any, work well in your experience of dealing with the HARP service?

12. Overall, what things, if any, need to be improved in your experience of dealing with the HARP service?

At the conclusion of each segment of the interview, the researcher summarised each participant's answers to ensure that her/his experience was expressed and comprehended properly, a corroboration process that strengthened the credibility of the study (Guba & Lincoln 2005).

Data analysis

KC and MP made separate detailed written notes of the main content of the video-recorded interviews. These were then compared and discussed prior to combining into a single, agreed data set. Smith and Osborn's (2008) IPA method was used to guide the subsequent analysis. Data were read and reread to obtain a broad appreciation of their transition through the services. Manual coding was undertaken using Nvivo (version 10; QSR International, Doncaster, Victoria, Australia). Initially, *in vivo* coding was used, as this helps prevent researchers superimposing preordained theories and beliefs on the data (Holloway & Wheeler 2010). Next, codes were clustered into conceptual themes, which were then grouped into themes and associated subthemes. Concurrently, data reduction took place with preliminary themes inadequately grounded in the data being omitted. Then, a more detailed analytical reordering and fine tuning of themes and abstracting them to a higher level occurred (Smith & Osborn 2008). Initial thematic analysis was undertaken by KC and MP, followed by an independent review of the process by TMcC, a process that enhanced the rigour of the study (Mays & Pope 1995).

Ethics approval

Ethical approval to conduct the study was provided by Melbourne Health Human Research Ethics Committee and the tertiary medical service's Office for Research. Participants were informed that refusal to take part or to participate and then withdraw from the study would have no detrimental effects on current or future care. Participants gave written consent to participate.

RESULTS

Four main themes and related subthemes were abstracted from the data, reflecting consumers and carers' experience of transition from tertiary medical to primary care services: (i) accessing tertiary services is difficult and time consuming; (ii) contrasting experiences of clinician engagement and support; (iii) lack of continuity between tertiary medical

and primary care services; and (iv) MH HARP clinicians facilitating transition.

Accessing tertiary services is difficult and time consuming

Accessing services is a difficult and time-consuming process for consumers and carers. Their difficulty was characterised by long waiting times for appointments, a perceived lack of support from services, and a feeling that adequate support was provided only when consumers reached a crisis point with their well-being:

> Those appointments are usually few and far between. They stretch them out. 'We'll make an appointment for you, we'll contact you', and then 2 or 3 weeks later, sometimes longer, they'll come for one visit. There's not a lot of support, until it comes to the crunch. (Carer interviewee 3, male)

The time-consuming process for appointments meant that some consumers had to wait, what seemed to them, unreasonably lengthy periods of time because of long waiting lists for treatment:

> So there are problems with the services being available, and also it's the waiting lists. You wait. Like, I've waited to do this rehabilitation class I'm going to be doing…I've waited since last year…so, yeah, you wait. (Consumer interviewee 8, female)

Not only was it time consuming to access services, participants found it confusing when they encountered and had to try to navigate the wide range of services provided by the tertiary medical service. Unfamiliarity and uncertainty with services was reinforced by their coexisting mental health and medical problems:

> There was a bit of confusion there, like with the services. There's so many, and at the time, you know, you're a bit confused already, and then make it even more confused. (Consumer interviewee 4, female)

> And then having to sift through all the information, and if not all that information is there and stuff's missed, it just causes so much more trauma and stress, and already you're up to here with stress and anxiety (carer interviewee 1, male)

Contrasting experiences of tertiary medical clinician engagement and support

Participants commented that when they accessed services, they experienced contrasting levels of engagement by, and support from, tertiary medical clinicians, especially in emergency department and inpatient wards. This is reflected in two contrasting subthemes: 'tertiary medical clinician engagement enhancing transition' and 'tertiary medical

clinicians' lack of engagement and stigmatisation undermining transition'. As such, these contrasting experiences served to enhance or compromise their experience of, and transition through, the services.

Tertiary medical clinician engagement enhancing transition
Tertiary medical clinicians were perceived as engaging and supportive if they took the time to ascertain if participants understood their treatment, took time to explain things, and were supportive. In addition, by making themselves accessible to consumers and carers, this reinforced the perception of clinicians' willingness and helpfulness to engage with participants:

> It was, 'Everything going alright?'. She talked it over with me and she said, 'You think you're right to handle it?', and she said, 'Any time you need to, you can get in touch with me'. I've got the number, so no problems that way. (Consumer interviewee 3, male)

Tertiary medical clinicians' lack of engagement and stigmatisation undermining transition
In contrast to clinician engagement and support enhancing transition, other consumers and carers commented about a lack of engagement and stigmatisation by clinicians, especially those in emergency departments. This in turn undermined their experience of, and transition through, the services. Lack of engagement encompassed participants feeling daunted because they perceived they were being instructed, rather than consulted, about their treatment:

> Pretty intimidating, actually…yeah, I felt intimidated because I wasn't asked. I was told what was going on, rather than asked what was going on. (Consumer interviewee 5, male)

> I wasn't consulted about that. They just did it. Nobody told me anything about it, they didn't ask, they didn't explain… so I was disappointed there. (Consumer interviewee 9, female)

Lack of engagement incorporated participants perceiving that, because of the day-to-day routine of the work of dealing with patients, clinicians showed a lack of sensitivity and empathy towards consumers:

> It was a lot like, you know, for them it was just a normal everyday thing. They go through it every day. They've watched this kind of behaviour in other patients all the time, but for the person who's looking after that family member and trying to do the right thing by that family member, more compassion and empathy needs to come from the staff. (Carer interviewee 1, female)

Lack of engagement also extended to clinicians communicating with participants in a condescending and stigmatising manner, treating them as though they lacked intelligence and in an overtly judgmental way because of their mental illness:

> Sometimes, although they treat you, you get sarcasm. Yes, I've had sarcasm used against me. I'm not dumb and I'm not deaf. I'm not blind. I mightn't say anything at the time, but I hear things, I see things. (Consumer interviewee 10, female)

> Maybe it's possible to not be so blatantly judgmental right off the bat….They owe a duty to their patients to still treat them like people. (Consumer interviewee 2, female)

Lack of continuity between tertiary medical and primary care services

Participants were dissatisfied and frustrated about what they perceived as a lack of continuity of care between tertiary medical and primary care services, which undermined their transition. Lack of continuity was attributable to poor discharge planning, which heightened uncertainty in participants, because they were unsure about the nature and type of follow-up treatment they should receive. Participants perceived that poor discharge planning was influenced in part by a lack of assertiveness on their behalf with clinicians:

> They just discharged him. They never discussed with us what's the follow-up plan, so we were a bit confused. We thought that maybe he should have acted a bit more psychiatrically unwell…like, you know, threatening to harm himself or talk a bit more, but he was just a bit timid. He wasn't like one of those aggressive type of suicidal person; he's more passive. (Carer interviewee 4, female)

Lack of continuity was also attributable to a communication breakdown between tertiary clinicians' discharge planning assurances and a lack of follow up by primary care clinicians. As a result, this communication breakdown had, at times, severe adverse consequences for participants:

> Well, he said somebody would contact me, and they didn't, and that really put me right down. I was really in a mess then. I just sat and cried all day, because I didn't know what to do. (Consumer interviewee 8, female)

Another aspect of lack of continuity between services was that participants were provided with inconsistent or incorrect information at times. Implications of this situation they created considerable difficulties, distress, and uncertainty in participants:

> So it's kind of confusing, because the person that came to see me said that I should try, if I'm going to the northern suburbs to stay with my mum for a little while, try and get into the (service). So I tried to get into the (service), but they said I can't because I don't live there. Like, I kept getting told all these different things, and days and then a week would go by and then I'd have to wait until the next week when he (the primary care clinician) was working….I was actually ringing and trying to find out what was going on. (Consumer interviewee 12, female)

MH HARP clinicians facilitating transition

The MH HARP was introduced to reduce the number of emergency department representations by consumers with medical comorbidity problems; thus, these clinicians were expected to play a key role in bridging the gap between tertiary and primary care services. Participants' perspectives about these clinicians are reflected in two interrelated subthemes: 'initial uncertainty about connecting with MH HARP clinicians' and 'MH HARP clinicians as engaging and supportive to the transition between tertiary medical and primary care services'.

Initial uncertainty about connecting with MH HARP clinicians

As the programme was a relatively new initiative, and consumers and carers had no prior knowledge of, or contact with, these clinicians, it was unsurprising that they were somewhat anxious and circumspect when meeting with these clinicians initially. Their anxiety and caution were evidenced in the questions they asked about the nature and purpose of the programme:

> Very nervous to begin with, 'cause I thought, 'Here's a complete stranger, coming into my life, and I have to tell them everything'…that sort of thing. So it made me very anxious, very nervous to begin with. (Consumer interviewee 2, female)

> I was feeling anxious because I didn't know what it was all about, and so I was taking notes and I was interviewing her in effect, and trying to find out what the service was that she provided and what the organisation provided. (Consumer interviewee 1, male)

MH HARP clinicians as engaging and supportive

Participants' initial anxiety and uncertainty subsided progressively as they realised that MH HARP clinicians were engaging and supportive. There was also acknowledgement that these clinicians played a pivotal role in facilitating their transition between tertiary and primary care services:

> He was really nice, take the time to talk to me and calm me down, even send someone to talk to me right away to calm me down at that time…it was really great service. (Consumer interviewee 4, female)

I haven't got to where I am now without her helping me because I was just a 'cot' (hopeless) case…they could have scooped me up and carried me away, and it didn't happen, and I'm sure it was because she (MH HARP clinician) was coming at that stage every week. (Consumer interviewee 8, female)

Moreover, MH HARP clinicians' role extended beyond being a conduit to facilitate transition between these services; it also included engaging therapeutically with consumers to help them address their mental health problems:

She would talk to me about my issues, talk to me about my problems, and then she would help me try and strategise ways of improving things or getting better, that sort of thing. So that was really helpful. (Consumer interviewee 2, female)

DISCUSSION

In this qualitative study, we provided an in-depth insight into, and understanding of, the phenomenon of being a mental health consumer with medical comorbidity problems and their carers transitioning between tertiary medical and primary care services in an augmented care programme. Transitions are 'a change in health status, or in role relationships, expectations, or abilities' (Meleis 2012, p.100). They are processes that indicate movement, development, and flow; a sequence of how events occur. Several transition typologies exist; the most commonly recognised are developmental, situational, health–illness or illness–wellness, and organisational (Meleis 1997; Meleis 2010; Schumacher & Meleis 1994).

Four main themes were identified in the data in the present study, signifying consumers' and carers' transition between tertiary medical and primary carer services in an augmented care programme: 'it was a difficult and time-consuming process to access tertiary services', 'there were contrasting experiences of clinician engagement and support', 'there was a lack of continuity between tertiary medical and primary care services', and 'MH HARP clinicians played an important role in facilitating transition'. The consumer participants (and indirectly, their carers) in the present study were undergoing two transitions simultaneously. They were experiencing an illness–wellness transition, which is related to situational transitions, and can involve either acute or long-term illness experiences (Murphy 1990). This transition necessitated them initially accessing the tertiary medical service with medical comorbidity problems. They were also experiencing an organisational transition, the primary focus of this paper, as they transitioned through tertiary medical and primary care services. The transition process contains five properties: process or direction, disconnectedness, perception, awareness, and patterns of response (Chick & Meleis 1986), all of which are relevant to the participants in the current study. Consumers (and their carers) were engaged in a process that is not necessarily unidirectional; thus, they were included in the MH HARP because they had two or more recent presentations to the tertiary medical service's emergency department. They were undergoing two overlapping periods of disconnectedness from their usual day-to-day lives of living with reasonably manageable mental health and medical comorbidity, and disconnectedness associated with the organisational transition they were experiencing between the tertiary medical and primary care services. Disconnectedness is the most ubiquitous property of transition (Chick & Meleis 1986). Two main factors contributed to the present group of participants' disconnectedness: their perceived lack of engagement and stigmatisation by clinicians, and lack of continuity of care between the services. Clinicians' lack of engagement with consumers, reflecting a power differential between clinicians and consumers and their carers, was also reported in a US study of augmented care for individuals with serious mental illness (Nover 2013). In the present study, clinicians' stigmatising attitudes towards people with mental illness, more so than the lack of continuity of care, weighed heavily on their thoughts, as they struggled to navigate the confusing and, at times, hostile and unfriendly services. There has been long-standing disquiet about the quality of care provided to consumers in tertiary medical settings, and in the findings of the present study. Evidence of poorer quality care was highlighted in a systematic review of 31 comparative studies (Mitchell *et al.* 2009), which found that, frequently, there were differences in the care provided to consumers with medical comorbidity compared to those with medical problems only; however, the magnitude of this disparity varied markedly. Poorer quality care is associated with clinicians' negative attitudes towards people with mental illness and 'diagnostic overshadowing' (Clarke *et al.* 2007; Thornicroft *et al.* 2007). Multifactorial influences affect clinicians' attitudes in these situations, such as their educational preparation, length of experience, and age. For instance, McCann *et al.* (2006b), in a survey of emergency department nurses' attitudes towards people who engaged in self-harm, reported that most respondents had received no educational preparation about the care of these patients, and those who had participated in professional development education on this issue had more favourable attitudes than non-participants. Furthermore, older and more experienced nurses had more favourable attitudes than those who were younger and less experienced. In the present

study, a potential implication of disconnectedness, attributable to clinicians' negative and stigmatising attitudes and poorer quality of care, especially in emergency departments (Clarke *et al.* 2007; Mazeh *et al.* 2003), is that it can lead to low rates of subsequent tertiary medical help seeking and greater medical comorbidity and mortality in consumers (Thornicroft *et al.* 2007).

The pattern of responses, observable and non-observable, of consumers and carers in the current study displayed throughout their transition were not random reactions; rather, they were a combination of individual responses, and sociocultural and organisational influences (Chick & Meleis 1986). The meanings that individuals attach to transitions can be positive or negative, or alternatively, positive and negative (Meleis 2010; Meleis & Trangenstein 1994; Schumacher & Meleis 1994). In the present study, there were positive and negative indicators of organisational transition, reflecting participants' experience of lack of continuity between services, clinicians' favourable/unfavourable attitudes, and participants' favourable impressions of MH HARP clinicians. In particular, the favourable impression of MH HARP clinicians highlights the benefits of this augmented care programme, which was introduced to improve the quality of care and transition of consumers with medical comorbidity between tertiary medical and primary care services, and to prevent avoidable tertiary medical hospital use. As well as facilitating transition, these clinicians engaged therapeutically and were supportive of consumers and carers. The benefits of augmented care in this situation was also reported in the US study by Nover (2013), where consumer recipients commented favourably about the support they received, and the care coordination between medical and mental health providers.

LIMITATIONS

This study has some limitations. As this is a qualitative study, the findings are context bound to the participants and services in which the study was conducted (Hutchinson 1993). While generalisability is not a predominant consideration in qualitative research (Sandelowski 1993), the themes can be substantiated and are relevant to mental health consumers and carers transitioning between tertiary medical and primary care services in other settings(Green 1999). Another limitation is that MH HARP clinicians might have been selective in recruiting participants, and their experience of this transition might be different from others who are not connected with this programme. A final limitation is that only participants with conversational English were recruited; therefore, the findings might not apply to other MH HARP consumers and their carers who were unable to communicate in English.

CONCLUSIONS

Our study sheds light on how mental health consumers with medical comorbidity and their carers have conflicting experiences of their transition through tertiary medical and primary carer services. They have difficulties accessing tertiary services, and after accessing them, have contrasting experiences of the way clinicians engage with them and provide support. In particular, they encounter negative and stigmatising attitudes, which might have adverse implications for subsequent help seeking from these services. Participants' unfavourable experiences also extend to their transition between tertiary and primary care services. However, despite some initial hesitancy, they have favourable experiences about the way MH HARP clinicians facilitate their transition though these services. In essence, a key finding of this study is that the introduction of an augmented care programme was perceived as beneficial, engaging, and supportive by consumers and carers.

There are five main implications of our study's findings. First, the findings of this initial study suggest that this type of augmented care programme is beneficial in improving consumers' and carers' transition between tertiary medical and primary carer services, and the programme should be retained. Second, organisational change is needed to help transform the practice culture about caring for consumers with medical comorbidity and their carers. Ways to do this is include, but are not limited to, developing and implementing evidence-based policies that support consumers and carers and address shortcomings in the care of, and attitudes towards, the former's medical comorbidity. Coupled with policy development and implementation is the provision of appropriate ongoing professional development education for clinicians. Third, while MH HARP clinicians' contributions are valued, there is room to expand their scope of practice so they can adopt a more prominent role in consumers' (and their carers') transition, especially in enabling them to access tertiary medical services and in changing practice cultures of negative and stigmatising attitudes towards these consumers. There is also scope for MH HARP clinicians to be more actively involved in providing ongoing professional development, education, and support to tertiary medical service clinicians, and in role modelling how to engage with and meet the unique needs of this group of consumers and carers. Fourth, consideration should be given to introducing consumer and carer consultants (McCann *et al.* 2006a) in tertiary medical settings, especially in emergency departments. As such,

they could be employed to instil a consumer and carer perspective into clinicians' professional development education, provide support and advocacy for this group of participants, and facilitate constructive dialogue between these participants and clinicians (McCann *et al*. 2006a). Finally, translatable research is needed, particularly randomised, controlled trials that incorporate a process evaluation (McCann & Lubman 2014), to critically evaluate the effectiveness of such initiatives in enhancing consumers' and carers' transition, and in changing organisational and practice culture towards consumers with medical comorbidity. In particular, such trials need to evaluate if MH HARP actually results in better physical health for consumers with comorbid medical illness, and if the intervention can be translated readily to 'usual care'.

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