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Evaluation of a new mental health liaison team in a general hospital. Part 1: background and literature review

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Evaluation of a new mental health liaison team in a general hospital. Part 1: background and literature review

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Abstract

Hospitals, and emergency departments (EDs), are caring for increasing numbers of patients who present with underlying mental health issues. Management of these patients can be challenging for clinical staff, who often lack the specialist knowledge and skills required to provide appropriate care. A mental health liaison service (MHLT) was introduced in Rotherham Hospital in April 2015, (that's the correct date) as part of a two-year pilot. The aim was to provide assessment and treatment for adults with mental health problems admitted to the hospital. An evaluation of the new MHLT was undertaken, to assess the effects of the service. This article, part one of two, reviews the literature,

Introduction

There is increasing pressure on staff to respond appropriately to the needs of patients with mental health problems who present to emergency departments (EDs), and/or are admitted to hospital wards. Around 28% of acute hospital inpatients have a mental health diagnosis, and the figure rises to 60% when older adult patients are included, in whom delirium and dementia are more prevalent (Plumridge and Reid 2012).

The cost of managing patients with mental health conditions in hospital is approximately £6 billion a year in the UK (Parsonage et al 2012). Further, general hospital staff often lack the knowledge, skills, and training required to meet the needs of patients with mental health problems. For example, Rayner et al (2014) highlight that 'mental disorders frequently go undetected and untreated', which can induce 'stigmatising attitudes' in staff, and inhibit discussion of psychological aspects of care.

The Joint Commissioning Panel for Mental Health policy guidance (2013) highlighted the lack of a coherent mental health liaison service model across the UK, and stated: 'Where such services exist, they are often provided by the local mental health trust within the estate of the acute hospital trust, which may present logistical and operational challenges'. The Royal College of Psychiatrists (2013), meanwhile, suggested that 'liaison psychiatry is a critical service that should be integral to all acute hospitals'. It appears, therefore, that hospitals in general, and EDs in particular, need to plan for admission of patients whose mental health status may cause additional challenges for clinicians.

This issue is not confined to the UK. In Australia, Giandinoto and Edward (2015) found that ward staff face problems when caring for patients with co-morbid physical and mental illness, while in the US Chang et al (2012) and Weiss et al (2012) highlighted the extra time required to manage patients who exhibit psychiatric symptoms in EDs, and the pressure this places on hospitals as a whole.

Houghton et al (2016), in Ireland, point out the global effects of dementia on health services, including the pressure resulting from large numbers of patients which leads to inadequate care. The authors call for better leadership to instil 'the values needed to care for this client group in an effective and person-centred way. Meanwhile, Canadian researchers, Ross and Goldner (2009),

reported worldwide evidence of poor attitudes displayed by nurses when managing patients with known psychiatric diagnoses.

There is agreement in the literature that the number of patients in hospital systems, who have co-morbid mental health problems, is increasing. The reasons for this vary, and include that more people with psychiatric problems are self-presenting through EDs (Hepworth and McGowan 2015), self-harm has increased (Clements et al 2016), and dementia diagnoses are rising (Prince et al 2013). The introduction of mental health liaison teams (MHLTs) in general hospitals can help address these problems.

Literature review

Law (2008) reported that a mental health liaison (MHL) nursing presence improves general hospital staff's skills in communication, understanding, and managing the behaviour of patients with overlying psychiatric conditions. However, Dewing and Dijk (2014) suggest there is a lack of evidence to support the introduction of specialist roles as a way of improving ward staff's skills, and that '…there is a risk that such short-term specialist roles deskill general staff in the longer term'.

Fossey and Parsonage (2014) claim that liaison psychiatry provision is patchy in geographical terms, and of variable quality where it does exist, while the Mental Health Taskforce (MHT) (2016) notes that 'comprehensive liaison mental health services are currently available in only one in six (16%) of England's 179 acute hospitals'. The MHT makes several recommendations, as part of a five-year strategy to improve the care and treatment of people with mental health problems, including that all acute hospitals should have all-age MHL services in EDs, and inpatient wards, by 2020/2021. This suggests that the question is not whether such initiatives are worthwhile, but rather how they should be implemented.

There appears to be a lack of clarity about what exactly MHL services do. Guthrie et al (2016), for example, noted that while liaison psychiatry is well received, 'there has been a struggle to capture the range and type of clinical interventions that they provide'. There have been calls for better integration of psychiatric liaison work in general hospital settings since the early 80s. Lipowski (1983) took as a starting point the growing number of older patients who exhibit signs of delirium and/or dementia, and suggested their care should be managed by dedicated consultants operating in what was referred to as 'geropsychiatry'. More recently, Smith (2009) considered the 'growing realization that presentation with multi-morbidity, of both physical and psychiatric disorders, is the norm', and suggested that services should respond to this through 'integration of care rather, than integrated care by a single physician'.

Integration is important for successful management of mental health in acute hospital settings, through different models of service provision, [but what is the best way to assess the effectiveness of MHLTs?]

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Integration is therefore important for the successful management of mental health in acute hospital settings, through different models of service provision. But how best to assess the effectiveness of approaches to managing mental health in these settings remains open to question.

Gillies et al (2015), for example, explored liaison psychiatry, but did not examine the perceptions of staff who provide the services. Ignoring the lived experience of staff could increase the sense of professional isolation, dissatisfaction, and frustration described by participants in this evaluation (see Part 2).

There is also dissatisfaction among patients. For example, Ross and Goldner (2009) reviewed numerous surveys that suggest patients with mental health issues, who present to general hospitals, are poorly treated by clinical staff. The authors state that stigmatising attitudes displayed by general healthcare staff can prevent access to good care, even when patients' presentations are not related to mental health issues.

The implications for practice, arising from stigmatising attitudes, can be described as 'diagnostic overshadowing'. Shefer et al (2015), in a study conducted in four London EDs, in which a MHLT was present, found that because team members lacked an adult nursing qualification, they felt limited in their own ability to contest what they believed might be misdiagnoses. This hesitancy allowed superficial diagnoses, based on the presence of mental health problems as the overriding explanatory factor, to (mis)direct subsequent care.

On the other hand, Shefer et al (2015) showed that adult nurses believe they have to defer to the MHL team, and noted that while the liaison team's presence was '… useful in many ways, it can have adverse consequences, in particular in creating a reduced sense of responsibility of emergency staff for patients they see as belonging to another team'. This illustrates the gulf that characterises much of the interaction between mental health specialists and their colleagues.

The problems inherent in applying two, sometimes competing, models of nursing knowledge [to the same patient cohort?] yes to the edit are not confined to the risk of misdiagnoses, but also affect 'parity of esteem'. This is a complex concept, but in simple terms it means giving mental health equal value to physical health, for example through equal access to effective care, and equal efforts to improve the quality of care.

The literature highlights a system that is complex because of the nature and demands of the patient population, and that is further complicated by the different knowledge base of the various staff groups involved [in caring for people with mental health conditions in general settings?] yes to the edit

Service evaluation

The authors were invited to conduct an evaluation of a MHLT that had been introduced in Rotherham Hospital in 2015 and to assess its effects on the wider service. To do this, the authors interviewed six members of the MHLT, and seven members of staff in other clinical areas and services, whose work was connected to the team. The interviews were conducted on an opportunistic basis, to accommodate work schedules, therefore the participants were a self-selecting convenience sample. A report produced from the information generated was presented to hospital management, to inform future funding decisions.

The evaluation was conducted from a qualitative methodological position, in keeping with the organisation's desire for an in-depth understanding of the subject, and to gain a range of opinions. [Part two examines the MHLT participants' perceptions, and discusses] yes, ok three sub-themes generated from the data.

Mental health liaison team

The setting is a 500-bed regional hospital that provides a range of medical and surgical services, including paediatric, obstetric/gynaecological, and emergency, to a population of approximately a quarter of a million. To cater for the growing number of patients who present with mental health problems, the hospital trust partnered with the local community trust to form a MHLT, which would provide assessment, treatment, and management of adults with mental health problems in the hospital or the ED.

The team comprises mental health field specialist nurses, who divide their time between managing patients with acute mental health problems (three full-time nurses), and those with dementia, who are usually older people, and are predominantly on the wards (four full-time nurses). The nurses are supported by two clinical managers, two part-time psychiatric consultants, and a physician trainee. They operate the service between 0800 and 2000, seven days a week. Care is managed by the crisis team outside these hours. The liaison team is based at the hospital, and work to a one-hour response time. At the time of the evaluation, the team had been functioning for 15 months.

Methods

The authors interviewed 13 people, seven of whom are part of the MHLT, and six who work in the hospital, and have frequent contact with the MHLT (Box 1).

Box 1: Participants

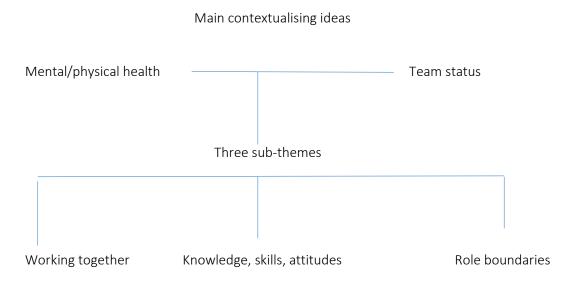| Job title	Involvement with liaison team
Mental health liaison practitioner (3)*	Direct/hands on
Care navigator *	Discharge planning
Discharge coordinator (orthopaedic unit)	Discharge planning
Consultant psychiatrist*	Oversight of diagnosis and treatment
Associate psychiatric specialist*	Oversight of diagnosis and treatment
Alcohol liaison team worker	Involved with patients where alcohol is a contributing factor
Crisis pathway manager	Coordinates out of hours service
Named nurse adult safeguarding	(Shared) responsibility for implementation of Mental Capacity Act, and Mental Health Act
Manager of liaison team (older adults)*	Day to day responsibility for the liaison team
Assistant chief nurse (with responsibility for patients diagnosed with dementia)	Involved when dementia is part of the presenting condition
Dementia lead nurse	Involved when dementia is part of the presenting condition

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Sheffield Hallam University ethics committee approved the evaluation. Qualitative data were generated by two members of the research team during semi-structured, one-to-one interviews, conducted with staff on site. We followed a topic guide informed by a rapid review of the literature, which included the context of the service, patient referral processes, admission to the hospital and/or service, and anticipated staff training needs.

The interviews lasted between 30 and 45 minutes. Participants were given an information sheet outlining the purpose of the interview, and asked to sign a consent form indicating their understanding of the arrangement. Participants were informed that their contribution would be confidential, and information used in the evaluation would be anonymised. The interviews were recorded on a portable digital machine, and independently transcribed. Electronic recordings and transcripts are held on a secure drive on the university IT system.

Adopting an iterative approach, data analysis started with the first set of interviews. Subsequent data collection was informed by previous analyses, to ensure that emergent, participant-generated themes were explored fully. The data were then subjected to a more detailed analysis using Nvivo (version 10), which allowed for electronic coding. The research team held a 'data clinic' to discuss the emerging themes, to ensure methodological rigour and trustworthiness of the findings, consistency of coding, and agreement on the main themes. Once agreement was reached one researcher coded the transcripts. A second 'data clinic' was held once coding was complete, to ensure agreement on the main themes that emerged from the data.

A variety of thematic analyses was adopted (Vaismoradi et al (2013), which operates from a broadly constructionist position to accommodate the different perspectives of the participants. Thus, context is emphasised, and this acts to balance interpretation and description, promoting the lived experience of the interviewees, and allowing the researchers room for analytical manoeuvre (Sandelowski 2010). From this, two main ideas were identified, which contextualised three sub-themes, and are represented in Figure 1. The sub-themes and contextualising ideas are examined in part two.

Figure 1: Contextualising ideas and sub-themes

Main contextualising ideas

Mental/physical health ——————————————— Team status

Three sub-themes

Working together   Knowledge, skills, attitudes   Role boundaries

Summary

The literature reveals that the 'problem' of patients with mental health issues, who access care in general hospitals through EDs or the wards, as a result of physical illness or disease processes, is an international concern. The number of these patient presentations are growing, not least because of increasing diagnoses of dementia, but there are also challenges associated with the way in which

hospital staff respond to this patient population. The introduction of MHLTs in the UK, as a response to the situation, is progressing.

Part two of the evaluation, [subs to add when this will be published], discusses the results of the evaluation, [focusing mainly on MHLT participants' responses] yes to the edit, and the implications for practice.

Chang G, Weiss A, Orav E et al (2012) Bottlenecks in the emergency department: the psychiatric clinicians' perspective. General Hospital Psychiatry. 34, 4, 403-409.

Clements, C., Turnbull, P., Hawton, K., Geulayov, G., Waters, K., Ness, J. & Kapur, N. (2016). Rates of self-harm presenting to general hospitals: a comparison of data from the Multicentre Study of Self-Harm in England and Hospital Episode Statistics. BMJ open, 6(2), e009749.

Dewing J, Dijk S (2014) What is the current state of care for older people with dementia in general hospitals? A literature review. Dementia. 15, 1, 106-124.

Fossey M, Parsonage M (2014) Outcomes and Performance in Liaison Psychiatry: Developing a Measurement Framework. Centre for Mental Health, London.

Giandinoto J, Edward K (2015) The phenomenon of co-morbid physical and mental illness in acute medical care: the lived experience of Australian health professionals. BMC Research Notes. 8, 1, 295.

Gillies, D., Buykx, P., Parker, A. G., & Hetrick, S. E. (2015). Consultation liaison in primary care for people with mental disorders. The Cochrane Library.

Guthrie E, McMeekin A, Thomasson R et al (2016) Opening the 'black box': liaison psychiatry services and what they actually do. BJPsych Bulletin. 40, 4, 175-180.

Halter M (2008) Perceived characteristics of psychiatric nurses: Stigma by association. Archives of Psychiatric Nursing. 22, 1, 20-26.

Hepworth I, McGowan L (2015) Understanding the management of people seeking voluntary psychiatric hospitalization who do not meet the criteria for inpatient admission: a qualitative study of mental health liaison nurses working in accident and emergency departments in the north of England. Archives of Psychiatric Nursing. 29, 1, 26-32.

Houghton, C., Murphy, K., Brooker, D., & Casey, D. (2016). Healthcare staffs' experiences and perceptions of caring for people with dementia in the acute setting: Qualitative evidence synthesis. International journal of nursing studies, 61, 104-116.

Joint Commissioning Panel for Mental Health (2013) Guidance for Commissioners of Liaison Mental Health Services to Acute Hospitals.

www.jcpmh.info/resource/guidance-for-commissioners-of-mental-health-services-for-people-with-learning-disabilities/ (Last accessed: 29 August 2017.)

Law E (2008) Delirium and dementia in acute hospitals: assessing the impact of RMN input. Nursing Older People. 20, 9, 35-39.

Lipowski, Z. J. (1983) The Need to Integrate Liaison Psychiatry. American Journal of Psychiatry, 140, 1003-1005.

Mental Health Taskforce (2016) The Five Year Forward View for Mental Health. A Report from the

Independent Mental Health Taskforce to the NHS in England. www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf (Last accessed: 29 August 2017.)

Parsonage M, Fossey M, Tutty C (2012) Liaison Psychiatry in the Modern NHS. Centre for Mental Health, London.

Plumridge N, Reid S (2012) Liaison psychiatry can bridge the gap. Health Service Journal. 6, 24-26.

Prince M, Bryce R, Albanese E et al (2013) The global prevalence of dementia: a systematic review and meta-analysis. Alzheimer's and Dementia. 9, 1, 63-75.

Rayner, L., Matcham, F., Hutton, J., Stringer, C., Dobson, J., Steer, S., & Hotopf, M. (2014). Embedding integrated mental health assessment and management in general hospital settings: feasibility, acceptability and the prevalence of common mental disorder. General hospital psychiatry, 36(3), 318-324.

Ross C, Goldner E (2009) Stigma, negative attitudes, and discrimination towards mental illness within the nursing profession: a review of the literature. Journal of Psychiatric and Mental Health Nursing. 16, 6, 558-567.

Royal College of Psychiatrists (2013) Liaison Psychiatry for Every Acute Hospital. Integrated Mental and Physical Health Care. College Report CR183. RCP, London.

Sandelowski M (2010) What's in a name? Qualitative description revisited. Research in Nursing and Health. 33, 1, 77-84.

Shefer G, Cross S, Howard L et al (2015) Improving the diagnosis of physical illness in patients with mental illness who present in emergency departments: consensus study. Journal of Psychosomatic Research. 78, 4, 346-351.

Smith, G. C. (2009) From consultation–liaison psychiatry to integrated care for multiple and complex needs. Australian & New Zealand Journal of Psychiatry, 43(1), 1-12.

Vaismoradi M, Turunen H, Bondas T (2013) Content analysis and thematic analysis: implications for conducting a qualitative descriptive study. Nursing and Health Sciences. 15, 3, 398-405.

Weiss A, Chang G, Rauch S et al (2012) Patient-and practice-related determinants of emergency department length of stay for patients with psychiatric illness. Annals of Emergency Medicine. 60, 2, 162-171.