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J Noblett, A Caffrey, T Deb, A Khan, E Lagunes-Cordoba, O Gale-Grant, C Henderson

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Liaison psychiatry professionals' views of general hospital care for patients with mental illness

The care for patients with mental illness in the general hospital setting

Health Service and Population Research Department, King's College London, Institute of Psychiatry,
Psychology and Neuroscience.

J Noblett MBBCh, A Caffrey Mb ChB, T Deb BMBCh MA, A Khan, E Lagunes-Cordoba MD MSc, O Gale-
Grant MBBS, C Henderson PhD

Corresponding Author:

Dr Joanne Noblett

Croydon MAP West Team, The Crescent, Salcot Crescent, New Addington, CR0 0JJ

Email: joanne.noblett@kcl.ac.uk

Mobile: 07540958561

Abstract

Objective: Explore the experiences of liaison psychiatry professionals, to gain a greater understanding of the quality of care patients with mental illness receive in the general hospital setting; the factors that affect the quality of care; and their insights on interventions that could improve care.

Methods: A survey questionnaire and qualitative in depth interviews were used to collect data. Data collection took place at the Royal College of Psychiatrists Faculty of Liaison Psychiatry Annual conference. Qualitative analysis was done using thematic analysis.

Results: Areas of concern in the quality of care of patients with co-morbid mental illness included 'diagnostic overshadowing', 'poor communication with patient', 'patient dignity not respected' and 'delay in investigation or treatment'. Eleven contributing factors were identified, the two most frequently mentioned were 'stigmatising attitudes of staff towards patients with co-morbid mental illness' and 'complex diagnosis'. The general overview of care was positive with areas for improvement highlighted. Interventions suggested included 'formal education' and 'changing the liaison psychiatry team'.

Conclusion: The cases discussed highlighted several areas where the quality of care received by patients with co-morbid mental illness is lacking, the consequences of which could be contributing to physical health disparities. It was acknowledged that it is the dual responsibility of both the general hospital staff and liaison staff in improving care.

Key words: diagnostic overshadowing, general hospital, mental illness stigma, physical health disparity

Introduction

Over recent years the access to and quality of physical health care provided to patients with mental illness has been increasingly under scrutiny, with physical health disparities between people with and without mental illness being widely acknowledged. One consequence is that the life expectancy of people with certain mental illness diagnoses is 15 to 20 years less than the general population in high-income countries [1]. A possible explanation for this is diagnostic overshadowing: the process whereby physical symptoms are misattributed to mental illness [2]. Diagnostic overshadowing is thought to increase the risk of delay in diagnosis, treatment of primary pathology and possible complications [3]. Two recent studies investigated the experiences of staff in emergency departments in the UK and their views on diagnostic overshadowing related to people with mental illness [4,5]. It was found that diagnostic overshadowing was a "significant issue" with complex presentations, poor communication, time pressures and stigmatising attitudes being identified as contributing factors [5].

Previous work regarding diagnostic overshadowing has focused on emergency departments and primary care where consultation times are short, but, since 25% of inpatients in general hospitals have co-morbid mental illness [6], potential diagnostic overshadowing in general hospital inpatient wards requires further study. Therefore a study with both qualitative and quantitative methodology was designed to explore the experiences of liaison psychiatry professionals, to gain a greater understanding of the quality of care patients with mental illness receive in the general hospital setting, the factors that affect the quality of care and their insights on interventions to improve care.

Method

This was a study where quantitative data via a questionnaire and qualitative data via semi-structured interviews were collected during the Royal College of Psychiatrists Faculty of Liaison Psychiatry Annual Conference, 13 to 15 May 2015, at the Royal College of Psychiatrists in London.

Ethics

The study was approved by the Psychiatry, Nursing and Midwifery Research Ethics Committee of King's College London. The completion of the questionnaire implied that the participant consented to its use. Written consent was obtained from each participant who took part in the interviews.

Sample, settings and recruitment

The Royal College of Psychiatrists Faculty of Liaison Psychiatry Annual Conference is a national conference, but also attracts international delegates, thus provided an opportunity for participants from a variety of geographical areas to be included within the research sample. The conference is primarily attended by doctors, but also nurses, psychologists and peer support workers, see table I.

Any conference attendee who worked for a liaison psychiatry department was considered eligible for the study. Prospective participants were given a copy of the questionnaire at time of registration or during the coffee breaks by one of the researchers, with a verbal explanation about the research and interview format given. The front sheet of the questionnaire included information on the research project and contact details of the principal investigator. The final question of the questionnaire provided an option to agree to partake in an individual interview during the conference. If they agreed to take part in the interview they were requested to include their contact details so the researchers were able to contact them in order to offer one of the multiple time slots available during the three day conference.

Questionnaire

The questionnaire was used to obtain data regarding the general views of conference attendees about the quality of care that patients with co-morbid mental illness receive whilst inpatients in the general hospital wards. The questionnaire was anonymous and began with, 'Have you ever been concerned about the quality of care patients with mental illness have received while an inpatient in a general hospital? Yes or No'. This was then followed by a multiple-choice question on how frequently the participant was concerned. The next questions focused on specific incidents in which the participant was asked to mark the frequency of each incident: 'At least weekly', 'At least 6 monthly', 'Less frequently than 6 monthly', 'Never'. An example of one of these specific incidents was 'Have you observed any of the following - Failure to give psychotropic medication?', see table II. This questionnaire was developed by the research team then administered to members of the liaison psychiatry service at King's College Hospital, London. Their feedback led to additional questions being added to the questionnaire.

Interviews

The topic guide was created by JN, AC, TD, AK, OG, EL and CH. JN is a specialist registrar in general adult psychiatry, who has 22 months experience in working in liaison psychiatry and has attended training on qualitative research through the National Institute of Health Research. AC is a specialist registrar in general adult psychiatry, who has 18 months experience working in liaison psychiatry. TD is an academic clinical fellow in psychiatry who is currently using mixed methods to evaluate medical student training on stigma. AK is a medical student and OG is a core psychiatry trainee who has 10 months experience in liaison psychiatry. ELC is a consultant psychiatrist who is currently undertaking a PhD and CH is a clinical senior lecturer and honorary consultant who has previously worked in liaison psychiatry. She led research on barriers to diagnosis of people with physical complaints and comorbid mental illness in emergency departments [4,5,7], the results of which were used to design the current study. The interviewer for one of these studies, Guy Shefer, [5,7] assisted in the development of the topic guide.

All interviews were conducted during the conference in private meeting rooms and were audio recorded. Interviews were conducted by JN, AC, TD, AK and EL. Participants were asked to provide information about their current role within their liaison psychiatry service and experience within this sub-speciality. They were asked to describe a specific case when they were concerned about the quality of care a patient with co-morbid mental illness received as an inpatient in a general hospital. Van Nieuwenhuizen et al [4] found that asking participants to describe particular cases was a useful method to obtain the required data, as participants found it an easier way to recall information rather than answer more specific questions. This was followed with questions regarding their general view of how this group of patients is cared for in the general hospital setting and whether patients with a particular diagnosis tend to receive poorer quality of care than others. They were also asked to recall a specific case that demonstrated good clinical care.

Data Analysis

Descriptive analysis was used to summarise the data collected from the questionnaires.

The interviews were transcribed verbatim and then compared with the recordings to ensure accuracy. Thematic analysis was used following the methods of Braun and Clarke [8] to analyse interview data. A combined deductive and inductive approach was taken, using the topic guide questions while not being limited to these. Transcripts were reviewed by two researchers (JN, AC) to identify and develop a coding framework and to

identify themes. Both researchers reviewed the framework after the initial coding so similar codes could be arranged into themes and subthemes. Themes used in the analysis of the data included ‘diagnostic overshadowing’, ‘complex diagnosis’ and ‘formal education’. NVivo software was used to assist in the coding process.

Results

Questionnaire Results

Ninety-five conference delegates returned their questionnaires to research staff, giving a response rate of 36%. Two questionnaires were only partially completed but included in the results. Table I gives the demographic details of all the 267 delegates.

Table II shows the proportion of respondents who reported each problem and the approximate frequency in which they observed the said problem. Ninety nine percent of those who completed questionnaires reported concern about the quality of care that patients with co-morbid mental illness receive as an inpatient in a general hospital; 44% reported observations of troubling care on a weekly basis. Over half of the participants recorded a frequency of at least 6 months for 11 of the 16 problems. The most common problem reported weekly by the majority of participants (76%) was ‘an unsatisfactory amount of information given to liaison psychiatry on referral e.g. lack of past psychiatric history and medication history’. Examples that described lack of attention to hygiene and physical observations were reported least frequently: 42% of participants stated that this never occurred and 24% said it was observed yearly.

Interview Results

Twenty-four conference delegates were interviewed during the conference: 22 doctors, 1 nurse and 1 clinical psychologist. Nine were female (7 doctors, 1 nurse, 1 psychologist) and 15 were male (all doctors). Fifteen doctors were consultant liaison psychiatrists, 1 was retired; 3 were specialist registrars, 3 were associate specialists, and 1 was a core trainee. The length of professional experience in liaison psychiatry spanned 6 months to 30 years.

Cases of concern and their consequences

Out of the 24 interviews, the majority of the discussed cases involved diagnostic overshadowing. Eight cases described patients whose delirium was misdiagnosed as a psychiatric illness.

'I had a gentleman who was admitted within an acute confusional state[...]He was not known to have a pre-existing cognitive impairment. He did not touch alcohol. Nevertheless because his liver function tests were found to be deranged, when he came into hospital it was written on his case notes that this was purely a psychiatric difficulty and he was an alcoholic[...]In the end he was found to have an abnormally high iron load in his blood.' Consultant Liaison Psychiatrist

These cases of diagnostic overshadowing often led to a delay in the patient receiving appropriate investigations or treatment. Other cases were described where this delay occurred for other reasons, including patient refusal or the patient presenting with challenging behavior. Two more cases described patients who experienced a delay in investigation or treatment because their co-existing mental illness was considered a contraindication, with one of the interviewees describing the following case:

'...a man in his 70s who had Alzheimer's dementia, who had a heart attack on the dementia ward and was transferred across to the general hospital [...] The medical team looking after him didn't feel that he warranted any form of treatment on the basis that he had dementia.' Consultant Liaison Psychiatrist

Cases were described where the treating team planned to discharge the patient home or transfer a patient to a psychiatric ward inappropriately. These cases, as well as those that involved diagnostic overshadowing or a delay in management, caused a deterioration in the patient's physical health and in, 2 cases, their mental health. One interviewee described the consequences of a case where the medical team failed to recognise that a patient was suffering from depression, believing her presentation was solely due to her recent stroke:

'This patient could have died. This patient was emaciated. [...] Electrolyte imbalance. She refused to eat. And after we had to crush with her consent the Amitriptyline, using the tube, she came back to life and she was eating.' Liaison Psychiatry Specialist Registrar

There were other cases where the liaison team felt the communication with patients by the inpatient team was poor, for example, when management plans were not discussed with patients or patient's wishes were disregarded. Four interviewees described cases in which the patient's dignity was not respected.

'The nursing staff allowed him to wander semi-clad and totally undressed at times.' Consultant Liaison

Psychiatrist

Factors Contributing to failure to provide adequate care

We identified 7 contributing factors, which can be divided into three categories; professional level factors, patient-professional interactions and environmental factors.

Professional Level Factors

Knowledge of diagnosis and management of mental illness and delirium

Lack of knowledge of certain aspects of mental illness, delirium, psychotropic medication, psychiatric ward set up or mental capacity were described in 17 of cases. Difficulty in differentiating delirium from an acute mental illness was commonly described in cases of diagnostic overshadowing.

'Working in the general hospital environment, the most common diagnosis that we encounter is delirium. And one knows the association between prognosis and delirium and so often the delirium is inappropriately investigated, not treated, and the common referral is "Medically fit for discharge. This is Psychiatric. Please transfer." That is a very common scenario. The issue really is around knowledge of delirium, [...]the assumption that delirium is only caused by infection: 'If there are no infectious markers, it can't be delirium.' The assumption is that these, usually older people, really are blocking beds and they, their families, everybody is told, and it generates guilt, it generates distress' Consultant Liaison Psychiatrist

Stigmatising attitudes towards specific mental health diagnoses

Patients with specific mental health diagnoses were found to experience poorer quality of care compared to others, half of the 24 interviewees stated this to be the case for patients with a psychotic illness. The second most commonly identified diagnosis was dementia, followed by personality disorder.

'A lot of anxiety is generated around people who have a diagnosis of a psychotic illness, usually generated by the staff looking after them' Consultant Liaison Psychiatrist

Stigmatising attitudes of staff towards patients with co-morbid mental illness

Sixteen cases included accounts of general hospital staff demonstrating stigmatising attitudes towards the patient involved. The way the attitudes presented varied, some described staff using derogatory statements when

referring to the patient:

'the ward manager said "Oh you've come to see the nutter."' Consultant Liaison Psychiatrist

One interviewee alleged that patients were refused appropriate management for their illness due to their comorbid mental illness.

'I remember a chap who need ... I think he'd been alcoholic and he needed a new liver. But he clearly had lots of personality issues. He had a degree of learning disability. And they didn't agree to it for psychiatric reason, saying he wouldn't be able to manage the regime. And I didn't agree with that. I thought it was the stigma.'

Consultant Liaison Psychiatrist

Many interviewees also described a general attitude that mental illness was not the responsibility of the inpatient team leading to psychotropic medication being missed, lack of assessment of psychiatric symptoms, risk assessments not being completed and reduced communication with patients from the inpatient staff.

'I mean, just 'You come and deal with them. They're being aggressive.' kind of thing. You go up and it's just that they haven't explained their intervention properly. There's a lot to do with time, but particularly with people who've got dementia, you know: 'This is one of yours' when they come in intoxicated, which isn't necessarily the case.' Psychiatric Liaison Nurse

Patient-professional interactions

Perceived challenging behaviour of the patient

Eight cases described patients who presented with challenging behaviour. Challenging behaviour was described in the context of the patient being agitated, physically or verbally aggressive, or refusing an aspect of care. The consequences of the challenging behaviour included the patient being avoided by inpatient staff with certain aspects of care being missed.

'She was verbally challenging, grumpy. She refused to do a lot of stuff. But rather than, I suppose, still look at the need that she presented, it seemed easier to just kind of leave her.' Consultant Liaison Psychiatrist

Complex Presentation

A common theme in the majority of the cases was the presence of both acute physical and psychiatric

symptoms. This increased the complexity of the case, leading to possible delays when forming a management plan. The lack of appreciation that illness can present with both psychiatric and physical symptoms often led to differential diagnoses that were focused on either the physical or the psychiatric symptoms. There were also cases where the general hospital staff were unable to differentiate between true psychiatric illnesses and the psychological aspects of a physical illness.

'...someone has had a stroke and they have been referred to therapies team for rehabilitation, and the therapies team pop along and they are having a bad day emotionally. They are referred to us as 'Do they have a mental illness?' [...] When in fact, they are just really struggling to adjust to the idea that they've now got a physical limitation.' Consultant Liaison Psychiatrist

Emotional reaction to the patient

This factor was often described in conjunction with other contributing factors. Interviewees reported that the staff felt anxious when caring for patients who presented challenging behaviour. Those interviewed believed this often caused the patient to be avoided, which in turn led to further neglect of certain aspects of care such as physical observations and personal care.

'I have loads of places where I can go and talk about how distressing it is for me to see him sometimes and it is usually quite often. My medical colleagues have no outlet for that, and what they end up doing is avoiding him.' Consultant Liaison Psychiatrist

Interviewees also described cases in which the underlying stigmatising attitudes of staff members, combined with a lack of knowledge of the psychiatric illness, contributed to negative emotional reactions towards patients.

'[W]hereas personality disorders in general, and in particular borderline, people lose their temper. They get angry. You know, [general hospital staff] have trouble understanding some aspects of it.' Consultant Liaison Psychiatrist

Environmental Factors

The majority of interviewees believe that the general hospital does not provide an appropriate environment to manage patients with co-morbid mental illness. Patients are often moved to several wards throughout their hospital stay and may be managed by a different clinical team daily. These factors lead to a lack of continuity of care as well as increasing confusion and anxiety amongst patients. The ward environment itself can be chaotic

and poorly equipped to manage patients with complex needs, particularly those who suffer from delirium or dementia. One interviewee describes these difficulties:

'I'll see someone who comes into the A&E department, then they go to the A&E observation ward, they'll go to the acute medical unit, they may go from the acute medical unit and at some point perhaps it's established they've got a surgical problem, so they go to the surgical ward, and then finally they'll go to care of the elderly if they have long term rehabilitation problems[...] Now that would be confusing for anyone, let alone someone who has cognitive impairment..' Consultant Liaison Psychiatrist

General overview of care

The general overview of care could not be categorised into positive and negative responses. However, 2 of the responses were clearly positive, with one example outlined below:

'The facilities, the services are getting better. The stigmatisation of mental health issues is getting better'
Clinical Psychologist

Twelve of the respondents described care as 'varying', which depended on the level of access the inpatient wards had to a liaison psychiatry service. They held the view that the liaison service provided a vital role of support to inpatient staff by providing the best possible care for patients with co-morbid mental illness. Two felt that quality of care varied and was dependent on the inpatient staffs' knowledge of mental illness.

'I think it depends on who the consultant is, who the person looking after you is, how much knowledge and understanding of mental illness they have.' Consultant Liaison Psychiatrist

Four were negative in their views about the quality of care received; this was often related to lack of knowledge, negative attitudes and staff anxiety.

'There is just a lack of knowledge, a lack of understanding, and, as consequence, people deal in hearsay and whispers and anxiety and, you know, the label of, say, schizophrenia, or bipolar, or just 'mental health problem' is what is conveyed at handover and it can mean anything.' Consultant Liaison Psychiatrist

Interventions

A wide range of system level interventions were suggested by interviewees as possible ways to improve the quality of care that patients with co-morbid mental illness receive as inpatients in a general hospital. We have

divided them into four categories: formal education, reflective practice, changing the liaison psychiatry team and early clinical exposure to psychiatry.

Formal Education

Interviewees who identified a gap in mental health knowledge amongst inpatient staff primarily suggested education. Most recommended case-based discussion and teaching sessions. There was a general agreement that the best forums for an education-based intervention were those already attended by general medical inpatient staff, for example, grand rounds, departmental meetings, or staff induction:

'As liaison psychiatrists we have a role to educate and we could use examples like this in the Grand Round for the hospital: not to name and shame but actually to teach' Consultant Liaison Psychiatrist

Reflective Practice

Reflective practice was identified as an intervention by four of the interviewees, all of whom believed that this would help reduce staff anxiety and stigmatising attitudes:

'So I think more reflective practice, psychological practice, within the general medical specialties and surgical specialties would be useful.' Consultant Liaison Psychiatrist

Changing the Liaison Psychiatry Team

Changes to the way the liaison team currently works were also suggested by interviewees. The main area of change was for the team to be more visible on the ward; whether attending ward or board rounds on acute assessment units, attending more departmental meetings or having face to face discussion about potential referrals.

'[H]aving Liaison Psychiatrists visible at consultant meetings or at ward rounds. Every day on the [Acute Medical Unit] in our hospital they have what they call a 'board round' where they just look at the board and they say, you know, they go through all 20 patients in 20 minutes[...]if you have members of the mental health team there, when you hear about the case you can actually get a sense of if this looks like a psychiatric referral in the making.' Consultant Liaison Psychiatrist

Some interviewees believed that a more visible liaison team would provide general hospital staff with more opportunities to observe and model their own communication skills and general approach to patients with co-

morbid mental illness on that of the liaison psychiatry staff:

'And it is also about leading by example. It's about being visible and being seen to be managing patients in a certain way. I think that it's not just about delivering teaching. I think it's about [general hospital] clinicians seeing what we are doing and seeing how we manage patients and how we communicate with them and how we think about the problems and we manage them in a holistic way.' Consultant Liaison Psychiatrist

Early Clinical Exposure to Psychiatry

This intervention refers to doctors. Interviewees believed that clinical placements early in doctors' clinical training would help them to develop the knowledge and skills required to provide the care patients with co-morbid mental illness require in a general hospital setting.

Discussion

The themes identified from the discussed cases mirrored the most frequently reported problems from the questionnaires. Both highlighted several areas where the management of patients with co-morbid mental illness in the general hospital setting can be deficient. The consequences included delay in investigations, patient distress and deterioration in physical or mental health; all of which contribute to the ongoing physical health disparity in patients with mental illness. Several causal factors were identified, and it was acknowledged that it is the dual responsibility of both general hospital staff and liaison staff to tackle them.

Diagnostic overshadowing, which leads to misdiagnosis and delay in investigations, was the most commonly reported problem. Most of these cases concerned patients with complex presentations who had a combination of acute psychiatric and physical symptoms, which often led to a psychiatric focus in the differential diagnosis. Through the interviewing of both liaison psychiatry professionals and emergency department staff, Shefer et al [5] also identified complex presentation as a contributing factor. Interviewees from the liaison team recounted cases where the presentation was simplified to mental illness if the initial physical examinations did not indicate a physical health problem. The emergency department staff reported an awareness of the importance of ruling out organic causes for presentations that consisted of acute psychiatric and physical symptoms, but were against conducting intrusive investigations on patients they perceived as low risk of having an organic cause of their presentation. They were, however, willing to consider investigations suggested by liaison staff if there was a clear rationale [5].

Implications for training and practice

Our data reflects the need for organisational and system level changes to support the efforts of individual health professionals. Improving knowledge and the basic skills required to assess and diagnose mental illness was suggested to help reduce the occurrence of diagnostic overshadowing. Providing clinicians with first-hand experience of working in mental health services early in their training was also among the identified interventions. Consistent with this recommendation, a report from Medical Education England, which evaluated the Foundation Programme, acknowledged that many specialities involved managing patients with co-morbid mental illness and therefore exposure to psychiatry during the Foundation years would provide a good ‘grounding’ [9].

The contributing factor, ‘emotional reaction to patient’, was interlinked with the majority of the other identified contributing factors. These emotional reactions are not exclusive to general inpatient staff and have been widely acknowledged amongst mental healthcare workers [10]. Within psychiatry the importance of reflecting on emotional reactions is encouraged through case-based discussion groups, including Balint groups [11], and Schwartz rounds [12]. Similar reflective practices were also suggested by participants for general hospital staff as an intervention to improve staff interactions with this cohort of patients.

However, change and interventions cannot be focused solely on the general hospital staff; interviewees highlighted the need for a more visible, wider resourced liaison service. The consensus was that the liaison team needs to play a key role in changing the knowledge, attitudes and behaviour of general hospital staff by providing support, reassurance and education. Interviewees also highlighted the need for the liaison and general hospital teams to work in a collaborative way in order to ensure the patients receive the care they require. At times most clinicians can be guilty of having a reductionist approach to clinical care; collaborative and parallel working can assist clinicians in ensuring a more holistic approach is provided for the patient. Shefer et al [7] reinforced this view, highlighting a case where, as a result of parallel working between emergency department and psychiatry staff, a physical cause for the patient’s presentation was discovered. In view of this case and others, the paper recommended clearer guidance on parallel working of emergency and liaison psychiatry staff as well as the need for liaison and emergency staff to gain some training in their respective disciplines. This is something that could be replicated in the general hospital inpatient environment.

The questionnaire and interviews demonstrated that general hospital staff did not communicate effectively with patients with co-morbid mental illness and, on occasion, the patients' dignity was not preserved. Interviewees highlighted modelling behaviour through the inpatient staff's direct observation of the liaison staff's communication and care for this group of patients. This is an intervention that has not been effectively studied with respect to its potential to reduce stigma-related outcomes. It is worth considering as part of the work necessary to improve the quality of care for patients with mental illness.

Strengths and Limitations

The staff within a psychiatry liaison team vary between hospitals but the minimum specification of clinical staff recommended by Mental Health Partnerships is 13 nurses, two trainee doctors and two consultant liaison psychiatrists [13]. Therefore, although the response rate for the questionnaire was adequate, since the majority of interviewees were doctors the results may not be fully representative of the liaison psychiatry teams within the UK.

Undertaking the research at a national conference enabled access to a sample of clinicians from many hospitals across the UK. However, due to this setting, purposive or maximum variation sampling was not possible for the qualitative interviews as we were limited to those willing to take the time out of the conference to participate in the interviews.

Caution needs to be exercised when generalising the results, because the data may be subject to cognitive distortions and recall bias. The cases recalled were not 'typical' cases but those that stood out to those who were interviewed. However, the participants' views of the overall quality of care were also obtained from the general questions asked within the interviews and from the questionnaires. Also, one of the interviewees was retired, this brings into question whether his experience was reflective of current practice. Future studies may wish to overcome these limitations using observational methods.

The interviewees' suggestions of how to improve the quality of care were comprehensive, but very little information about their implementation was obtained. Research to evaluate the recommended interventions should therefore be considered.

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Competing Interest Statement

All authors have completed the Unified Competing Interest form at http://www.icmje.org/coi_disclosure.pdf and the authors have no competing interests to report.

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Table I - Demographics of Conference Attendees

	All (n=267)
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Gender, n(%)	
Female	140(52.4)
Male	127(47.6)
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Country, n(%)	
England	180 (67.4)
Scotland	7(2.6)
Wales	6(2.2)
Republic of Ireland	4(1.5)
Northern Ireland	4(1.5)
Outside UK	8(3.0)
Not stated	58(21.7)
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Career Status, n(%)	
Core trainee doctors year 1-3	13(4.9)
Specialist trainee doctors year 4-6	32(12.0)
Staff grade and associate specialist doctors	16(6.0)
Consultant	134(50.2)
Retired	2(0.7)
Student	4(1.5)
Not stated	66(24.7)

Table II - Questionnaire Results

Question 1, n(%)	Yes	No	Total, n		
Have you ever been concerned about the quality of care patients with mental illness have received while an inpatient in a general hospital?	94(98.9)	1(1.1)	95		
			Less frequently than 6 monthly		
	At least weekly	At least 6 monthly	At least 6 monthly	Total, n	
Question 2, n(%)					
How often are you concerned about the quality of care patients with mental illness have received while an inpatient in a general hospital?	42(44.6)	40(42.6)	12(12.8)	94	
			Less frequently than 6 monthly		
	At least weekly	At least 6 monthly	At least 6 monthly	Never	Total, n
Question 3, n(%)					
a. How often has a psychiatric disorder interfered with the diagnosis of physical illness?	38(40.0)	44(46.3)	10(10.5)	3(3.2)	95
b. How often have you observed an examination being unnecessarily delayed?	26(27.4)	46(48.4)	16(16.8)	7(7.4)	95
c. How often have you observed a treatment being unnecessarily delayed?	29(30.5)	46(48.4)	13(13.7)	7(7.4)	95
d. How often have you observed a failure to investigate symptoms fully?	34(35.8)	43(45.3)	12(12.6)	6(6.3)	95
e. How often have you observed a failure	25(26.3)	38(40.0)	22(23.2)	10(10.5)	95

to give adequate medication e.g.
analgesia?

f. How often have you observed a failure

to give psychotropic medication?	32(33.7)	35(36.8)	19(20.0)	9(9.5)	95
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g. How often have you observed an

unsatisfactory amount of information

given to liaison psychiatry on referral e.g.

lack of past psychiatric history and

medication history?	71(76.3)	15(16.1)	5(5.4)	2(2.2)	93
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h. How often have you observed a request

for early transfer back to a psychiatric

ward despite already being advised that

their physical health problems cannot be

managed there?	48(51.6)	38(40.9)	4(4.3)	3(3.2)	93
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i. How often have you observed a failure

to assess capacity?	53(56.4)	31(33.0)	7(7.4)	3(3.2)	94
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j. How often have you observed rudeness

about a patient with mental illness when

talking to you?	18(19.1)	49(52.1)	17(18.1)	10(10.6)	94
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k. How often have you observed rudeness

directly aimed towards a patient with

mental illness?	11(11.7)	32(34.0)	35(37.2)	16(17.0)	94
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l. How often have you observed avoidance

during the daily ward round?	14(15.1)	32(34.4)	26(28.0)	21(22.6)	93
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m. How often have you observed

avoidance of completing routine tasks

such as changing bedding, bathing,

physical observations etc?	6(6.5)	26(28.0)	22(23.7)	39(41.9)	93
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n. How often have you observed staff not

engaging the patient in discussion around	27(29.0)	44(47.3)	14(15.1)	8(8.6)	93
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their management plan?

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o. How often have you observed the					
patient's views being disregarded?	20(21.5)	40(43.0)	22(23.7)	11(11.8)	93
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p. How often have you observed a patient					
being unnecessarily isolated from others					
on the ward, such as being put in a					
cubicle?	18(19.4)	24(25.8)	25(26.9)	26(28.0)	93
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q. How often have you observed loss of					
confidentiality around their psychiatric					
diagnosis e.g. disclosure to other patients					
on the ward?	13(14.0)	20(21.5)	22(23.7)	38(40.9)	93
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Highlights

- Management of inpatients with comorbid mental illness can be deficient.
- The most commonly reported problem was diagnostic overshadowing.
- Consequences include deterioration in physical or mental health.
- The main contributing factor was the patient having a 'complex presentations'.
- Better collaborative working between liaison and general hospital staff required.
- The liaison psychiatry team needs to play a key role in initiating changes.