

Evaluation of a new mental health liaison team in a general hospital. Part 2: exploring the themes and their effect on practice

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Evaluation of a new mental health liaison team in a general hospital. Part 2: exploring the themes and their effect on practice

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Abstract

Hospitals and emergency departments (EDs) are caring for increasing numbers of patients who present with underlying mental health issues. Managing these patients can be challenging for clinical staff who often lack the specialist knowledge and skills required to provide appropriate care. This article, the second of a two-part series on the evaluation of a newly formed mental health liaison team (MHLT) working in a general hospital, explores three themes derived from the interview data. It

also considers the effect of these themes on practice, and the relationship between MHLT members and staff in EDs and the wider hospital.

emergency nurse, integrated care, mental health liaison nursing, nurse education, parity of esteem, stigma

Introduction

Part one of this two-part series [add ref] explored the literature on mental health liaison teams (MHLTs), and the context in which they work. The researchers conducted a series of interviews with members of the MHLT, and staff in other clinical areas and services whose work is connected to the team. The data were analysed [add ref], and the main sub-themes, working together, knowledge, skills, and attitudes, and role boundaries, are discussed below.

Findings

Theme 1: working together

members of the MHLT were sometimes critical of their general hospital clinical colleagues, and referred to them and the wider hospital environment using language that implied a separation of purpose and function. For example, when discussing 'ownership' of patients with mental health problems, in terms of where and with whom the responsibility for their care lay, one participant said: 'I don't think they (general hospital staff) view the parity of esteem between physical and mental health, and that's something that's become apparent over there when we've had people on the wards' (participant 36).

This sense of detachment was shared in the MHL team. During a discussion about the possibility that having a separate team dedicated to mental health liaison might reinforce the distinction between mental and physical health, a medical member of the team said: 'I think by virtue of the fact that we are not the same trust, and we are very separate, it definitely does. I can't go over there and see someone on the ward and say: "this person's depressed", and prescribe them an antidepressant, because I don't work for that trust' (participant 64).

The phrase 'over there' suggests a divide between the MHLT and the hospital. One participant told us '...you feel sometimes that you're deskilling them over there by your presence, because we get occasional referrals for something as simple as, this person had a stroke last week and they're a bit depressed.... It's something that you wouldn't necessarily refer them to a psychiatric team for if they were in the community' (participant 64). Again, the term 'over there' is used to differentiate between staff groups.

Griffith and Glasby (2015) suggest there must be some physical connection, not just in the hands-on aspects of service delivery, but also in administrative support, for an integrated service to be successful, and emphasise the need for shared access to patient notes. One MHL team member

participant highlighted this as a problem, saying '(there are) ... huge communication difficulties by fact that we don't use the same computer system. So, I can't type something on here, upload it, and then they have access to it' (participant 65).

The apparent tensions could be explained, to some extent, by the fact that the team had only existed for 15 fifteen months before the evaluation. Yet the lack of integrated methods of working reflects issues highlighted in the literature.

[It would be interesting to know how the non-MHLT staff feel about working together. You only seem to have given examples from the MHLT. Can you explain why?]

Theme 2: knowledge, skills, and attitudes

As well as working with patients with acute mental health problems, part of the MHLT's remit is to work with patients at various stages of dementia diagnoses. Providing care for these patients is challenging for general ward staff. For example, one MHL team member said

'... we thought we were going to see a gentleman with dementia who was increasingly agitated. And the scenario that we got to was a gentleman... naked in bed with the window open, and just a very thin sheet on him. He'd got poor venous control, and he'd got nasty sores, ulcers all up and down his leg... we got the palliative care team involved, because the pain management had not been addressed. And then we went back the day after and it was a different gentleman. He was sat up in pyjamas, he was smiling and talking. The palliative care team had been, and prescribed him proper analgesia for his leg pain. So, we actually didn't need any intervention from a mental health perspective, but we kind of signposted the team onto the right area' (participant 36).

Patients who experience acute episodes of mental ill health do not always make their distress known. The following quote describes a scenario that illustrates the challenges of recognising what is, and what is not, a mental or physical health issue. In this case a member of the MHLT, purely by chance, come across a patient known to the service, who had been admitted to hospital, and was being treated for malnourishment and dehydration. The hospital staff were addressing her physical health needs, and did not intend to contact the MHLT: '... I said, "Oh I know that lady (from working in services). Are you referring her?" "Oh no", they said. "No, she's fine". I said," Oh, is it all right if I say hello?" "Yeah, no problem". And she was actively psychotic. The reason she wasn't eating and drinking was because the "cameras" were telling her not to, and the demons had told her to empty her fridge - and they'd (hospital staff) missed that' (participant 61).

These two scenarios illustrate the challenges non-specialist staff face when caring for patients whose mental health does not present in easily recognisable forms. Such instances might reduce over time, as ward staff become more familiar with the client group and learn to discriminate between signs and symptoms of mental and physical ill-health and so treat accordingly. [how will

this reduce scenarios like this?]. But there is another side to mental health care where lessons need to be learned faster, for legal reasons. For example, one subject that attracted comments from members of the MHLT was the apparent lack of knowledge, displayed by a range of general hospital staff, about the differences between the Mental Health Act (1983), and the Mental Capacity Act (2007). In a discussion about providing education to the wider hospital staff group one member of the team said: '... we want to engage, we want to do work around mental capacity stuff, and also the Mental Health Act, because there are procedural issues that we need to explain to the senior staff in the general hospital' (participant 52).

Another team member talked about the difficulties associated with ensuring clinical staff were compliant around the legislation when dealing with patients [is this clearer now? not sure what you mean]: '...I find it very difficult to make them (doctors on the general hospital side) understand and practice on that [on what?]. I mean most of the patients coming there [where?], particularly with the dementia and everything, they treat in the Medical Capacity Act, and the best interest, but that's not documented anywhere' (participant 65).

(edited) Crowley (2000) argued that the way EDs are organised can conspire, unintentionally, to attribute low status to mental health issues. This happens because a lack of specialist mental health knowledge displayed by ED staff can erect barriers that undermine optimal patient care, and contribute to a siloed accumulation of expertise that establishes professional territory.

This leads to the final theme which suggests that skills and knowledge deficits appear to underline the differences between professionals, when evidence suggests closer integration leads to better patient care.

Theme 3: role boundaries

This sub-theme, perhaps more than the others, gets to the core of the dualism that seems to pervade the operation of mental health liaison in general hospital settings. There are role boundaries between different grades and disciplines of staff, and across the whole healthcare spectrum, enforced by professionalism, clinical specialism, and geography. Care delivery in hospitals is hugely complex, and organisation of that care relies on collaboration between many different professions and specialisms, spread across numerous departments and buildings.

However, participants from the MHLT were clear about what they regard as their general hospital colleagues' failure of understanding about mental health issues. For example, one said: '... a lot of the general hospital staff have a poor understanding of what mental illness is and our role. And will refer difficult problematic patients to our service expecting that we will address their behaviour' (participant 37).

Issues associated with role boundaries are perhaps most obvious when comparing the MHLT team's work with that of their general hospital colleagues. But there are also boundaries between

the hospital, as a site for assessment and treatment, and 'the community'. One MHLT member said: '... we work only in the hospital, so we're relying [on what?] - one of the boundaries that's been quite difficult is when we see someone in A&E who we feel needs home treatment, we've found it really difficult to get them treatment on board with that...' (participant 64). [I'm not clear about what this quote is saying. Can you explain?]

Role boundaries are emphasised by the physical separation of staff teams. During the evaluation, the MHLT operated from separate premises on the hospital site, but a new ED is being built, that will house the team alongside ED colleagues. One of the participants was very optimistic about the potential of the new arrangements to improve patients' experiences and to facilitate learning between the MHLT and ED nurses. For example, sometimes ED staff call for MHLT assistance when faced by a patient with a mental health diagnosis. The MHL team member told us 'And we have quite a lot of, if people won't go, "refer them to mental health ... It's a mental health issue." It's not a mental health issue that they're refusing to leave hospital. We're not bouncers. And trying to get them (general hospital staff) to understand that is really difficult ... ' (participant 61).

The same participant is hopeful that the new arrangements, which will mean the MHL and ED teams will work in close proximity, will help them get to know each other better, professionally and clinically, which in turn will improve patients' experiences: '...if someone comes in, and the triage nurse says "Oh they're suicidal", and then we say, "Well, we know this patient, we know that when this, this, and this happens that they'll come and say this, so we are not concerned". But having that face-to-face discussion... that triage nurse would calm down straightaway, because they'll take that, all the body language and stress that, we'll be looking on the system, the triage nurse will be able to look on the same system, because you'll be sat side by side' (participant 52).

The role boundaries between the MHLT and their colleagues in the wider hospital are as necessary as they are inconvenient. [why? answered in the next sentence?] They are based around clinical knowledge and specialism and are evident in the physical geography of patient care. Clarke et al (2014) remarked on the perceived inappropriateness of the ED as a locale for treating people with mental health issues. They conclude by saying 'This in turn was thought to influence attitudes towards consumers with mental health problems'. [how does this link with the rest of this para?]

(edited) The three sub-themes coalesce around two principal ideas. First, the divisions in nurse education, which produce discrete specialisms, are perhaps too heavily emphasised post-qualification. This also applies to medical staff. This early specialism leads to a general ignorance about the health and social care needs of people whose diagnosis places them beyond the sphere of

knowledge within which a clinician operates. Second, members of the MHLT perceive that their specialism and their target patient group are both undervalued by their general hospital colleagues. Concomitant issues around stigmatising attitudes and diagnostic over-shadowing were discussed in part one.

Discussion

The discussion is structured around the two principal ideas described above. Nurse education in the UK is divided into four fields of practice, adult, child, mental health, and learning disability. This instils a necessary degree of specialism into practitioners' work. However, it also means that practitioners cannot easily access opportunities to develop their understanding of the needs of patients perceived as belonging to a different field. Ryan et al (2015) note that specialisation of knowledge within the four fields of nursing is a necessity, but argue that it can be potentially harmful if it compartmentalises patients and negatively affects their care and treatment.

Shefer et al (2014) advocate expanding ED staff education and training to enable them to recognise underlying mental health issues, and communicating their observations to colleagues. However, they concede that 'this goes against the current trend of increasing specialisation and differentiation in basic nurse training'.

This is supported by one participant in this evaluation, who described difficulties in engaging with ED staff, who often discharged patients with mental health problems more quickly than was clinically indicated. This sense of passing on responsibility for care to other professionals extends to dementia care. People with dementia require a holistic approach. However, Clissett et al (2013) concluded that person-centred care is unlikely, when so many ward-based staff are underprepared for the challenges associated with this patient population.

The second contextualising idea relates to the value placed on the MHLT's work by others, and to the team members' sense of worth. **The MHLT's work is regarded positively by many clinicians, students, patients and their families, and by those working outside the hospital setting, for example social workers, third sector employees, and some GPs**. This much was evident from the in-house evaluation the Acute Trust ran and from our conversations with other clinical staff. A discharge co-ordinator, commenting on the speed and efficiency of the team when responding to calls for an assessment of a patient called them 'absolutely fantastic'. The Assistant Chief Nurse was more specific. They told us 'We would struggle if the team wasn't there. Our patients would suffer [because] we don't have the knowledge'.

A study by Wand et al (2015) found similarly that 'the benefits of the new (liaison) service were rapidly recognised by the organisation. Interviewed staff and patients clearly valued the MHLN team

and were confident with the specialist knowledge and skills of individual team members. Overall, the MHLN role was highly regarded...'(2015:6).

And yet the team members themselves tend not to see the benefits of their work to the overall care of patients, or to the economy of the hospital. This could be because the MHLT is employed by one trust, but works on the premises, and with patients of, a different trust, and do not receive information about improving service targets. Although the trust plans to integrate the MHLT team by accommodating them in the new ED, the team reported feeling professionally isolated, and a sense of lacking control. This could be because it was commissioned to work for the foundation trust on its premises, with its patients, leading them feeling that their status has been reduced from 'partners' to 'hired hands'. One participant said: 'Like I say they, don't want us in the department, unless they want us in the department' (participant 62).

It further appears that some ward-based staff see the MHLT as an 'on-demand' service, to be accessed in times of crisis, which can leave team members feeling that they are called on, and dismissed, on a sessional basis. This situation not only applies to acute care, but also to care of people with dementia. One participant said: 'There's loads and loads and loads of different work I think that could be done for looking after people with dementia on a general ward' (participant 30).

Limitations

The evaluation does not include interviews with patients, and their perceptions of the service would have added to our understanding. We did, however, have access to an in-house survey, which gave patients the opportunity to comment on the service. The isolation felt by this MHLT might not be evident across the sector [do you mean it might just be how this team feels?]. yes

Implications for practice

The three sub-themes reinforce the argument that, in this setting, the MHLT is isolated, both professionally and ideologically, by the organisational arrangements. This was apparent in the physical location of services, in the way that the distinct knowledge and skills of each field of nursing can segregate practice, and in the way that roles function to maintain these barriers. The King's Fund (2016) emphasises the operational aspects that need to be addressed to create more harmonious working relationships: 'Integrated service models can support this by facilitating skills transfer, and shifting notions of who is responsible for what'.

The notion of responsibility is critical. Although the MHLT's work is valued by colleagues see edit above], team members have little control over the service they were co-opted into, or over the timing and nature of the interventions expected of them. Therefore, their responsibilities are constrained, as their patient contact is characterised by unplanned encounters, rather than by pre-

planned care. Noblett et al (2017) suggest a way round this problem is by 'diluting' the team, and spreading the individuals around the ward areas, giving them a more visible presence.

Conclusion

This evaluation has revealed some conceptual or ideological difficulties that appear when two different ways of thinking, and approaches to care, are brought together. Segar et al (2013) refer to this tension in a discussion of the importance of 'professional roles, identities, and notions of trust', and it was apparent in the views expressed by participants. An ED staff nurse in a study by Goode et al (2014), who examined how ED staff feel when confronted by psychiatric patients, said: 'Because I know so little, I am a bit scared (of patients with mental health issues). I would like to have more information, and more knowledge and skills'. This, we suggest, is where mental health liaison teams come in.

Finally we refer to a more existential interpretation. Colleagues working in practice will appreciate the need to work as part of a 'team'. The French philosopher Jean-Paul Sartre is widely, if apocryphally quoted as saying 'In football everything is complicated by the presence of the opposite team'. The work of the mental health liaison team does not equate to a game of football but we must concede that to talk of a 'team' can imply an 'opposition'. This may not be the way to foster collaborative working practices.

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