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A mixed methods study of the healthcare received by patients diagnosed with a personality disorder on acute general hospital wards

ABSTRACT

Aim

The study examined concurrent mental and physical healthcare received by patients diagnosed with a personality disorder on acute general hospital wards. The specific objectives were i) to conduct a web based cross sectional survey and ii) to explore experiences and perspectives with a subsection of the survey sample, using telephone interviews.

Design

A convergent parallel mixed methods design, which comprised a web based cross sectional survey (n=65) with embedded qualitative telephone interviews (n=12). Participants were social media users, with a self reported diagnosis of personality disorder, admitted to an acute general hospital in the UK in the previous two years.

Methods

Participants were recruited on social media between May 2017 and August 2017 by snowballing. Mixed data were integrated at the stage of analysis using a framework approach. Findings are reported thematically.

Results

Most of the participants surveyed (94%, n=61) reported distress during admission to the acute general hospital. However, the findings indicated the hospital environment was not conducive to mental health. Four interrelated themes were identified and related to: patient distress; the workforce; service delivery; and service design.

Conclusion

Findings indicated that patients with a personality disorder diagnosis received disadvantaged healthcare, might be at considerable risk of treatment non completion, and were languishing in the gaps between mental and physical health services.

Impact

This is one of the first studies to collect primary data on the concurrent mental and physical healthcare received by patients diagnosed with a personality disorder on acute general hospital wards. Ad hoc training and education focused on raising awareness of 'personality disorder' would not seem sufficient to address the deficits.

This research may be of interest to people who use mental health services, acute general hospital and liaison clinicians, hospital managers, and researchers.

Keywords

Mixed methods, personality disorders, psychological distress, emotional distress, acute hospital, acute care, nursing, discrimination, parity of esteem

INTRODUCTION

Personality disorder is formally characterised by 'problems in functioning of aspects of the self' e.g., identity, self-worth, accuracy of self-view, self-direction and/or difficulties in interpersonal relationships (World Health Organisation, 2019, Personality Disorder, Para 1). Whilst, use of the diagnosis has facilitated practice, research, and education, enabling epidemiological knowledge and the development of targeted interventions (Royal College of Psychiatrists, 2020; Royal College of Psychiatrists, Royal College of Nursing, The Royal College of Emergency Medicine, & The Royal College of Physicians, 2020), the validity of the diagnosis is heavily refuted. Given evidence that patients labelled with a personality disorder are treated pejoratively (Tyrer, Reed, & Crawford, 2015), this is problematic and controversial.

Patients diagnosed with personality disorders have commonly endured incomprehensible life experiences including neglect, abuse, and prolonged misery (Craissati et al., 2011). If health professionals and institutions reject, ignore, judge or dismiss a person who has experienced psychological distress, there is a risk that invalidation and dehumanisation experienced in the past, is replicated during everyday interactions with caregivers.

When communication patterns mirror the perpetration of abuse or trigger emotions, similar to those experienced during prior abuse or traumatic life events (Aiyegbusi & Tuck, 2008), interactions with care providers can be fraught with difficulties (Dowsett & Craissati, 2008).

There has been renewed emphasis globally on the value of humanity, compassion and interpersonal relationships in healthcare (Jones & Seager, 2019; Vandewalle et al., 2020). There has also been a substantial drive towards treating mental and physical health problems equally and to the same standard (HM Government, 2011). However, care of people with a range of mental disorders has been found lacking in acute general hospitals (NCEPOD, 2017). A consensus statement has been issued calling for widespread improvements (Royal College of Psychiatrists et al., 2020).

To date, research and best practice guidelines on integrated mental and physical healthcare have focused on the emergency department e.g., The Royal College of Emergency Medicine (2019) or the short term management of self harm e.g., NICE (2020). Research and guidance on personality disorder and broader expressions of emotional and psychological distress appear absent in the acute general hospital setting.

BACKGROUND

Most studies in the area of personality disorder and inpatient care have been conducted in mental health settings. However, with emerging data on poor health outcomes (Fok et al., 2014; Frankenburg & Zanarini, 2004), research in the acute general hospital setting seems overdue. The life expectancy of a cohort of people diagnosed with a personality disorder using secondary mental health services was estimated to be 18.7 years shorter for males (95% CI: 2.17–5.47) and 17.7 years for females (95% CI: 3.15–7.45) than the general population in England and Wales, with an overall standardised mortality rate (SMR) of 4.2 (95% CI: 3.03–5.64) (Fok et al., 2012).

Higher standardised mortality ratios were calculated for people diagnosed with a personality disorder based on data from the Swedish national registers; SMR was reported as 6.1 (95% CI 5.8–6.4) for women and 5.0 (95% CI 4.7–5.2) for men (Björkenstam, Björkenstam, Holm, Gerdin, & Ekselius, 2018). About half of the deaths reported in the Björkenstam et al. (2018) study were from 'natural' causes i.e., patients did not die by suicide, undetermined intent, homicide, traffic accidents or similar.

Large cohort studies indicate people diagnosed with a personality disorder have higher rates of conditions such as cardiovascular disease (Moran et al., 2007), arteriosclerosis, hepatic disease, hypertension, gastrointestinal disease, and arthritis (El-Gabalawy, Katz, & Sareen, 2010). One United Kingdom (UK) study found hospital admissions, related to circulatory, respiratory, digestive, musculoskeletal, nervous, and endocrine systems were three times higher in people diagnosed with a personality disorder compared to the general population (Fok, Chang, Broadbent, Stewart, & Moran, 2019). Although, the retrospective cohort design used by Fok et al. (2019) was reliant on the accuracy of National Health Service (NHS) records and did not address potentially confounding variables, such as lifestyle and psychiatric comorbidity; the study highlighted disparities that have to date, received very little attention.

THE STUDY

Aim

The study examined concurrent mental and physical healthcare received by patients diagnosed with a personality disorder on acute general hospital wards. The specific aims were i) to conduct a web based cross sectional survey and ii) to explore

experiences and perspectives, with a subsection of the survey sample using telephone interviews.

Design

This was a convergent parallel mixed methods design (Noyes et al., 2019), which comprised a web based cross sectional survey with embedded qualitative telephone interviews. The quantitative survey data and qualitative interview data were collected concurrently, to answer a single research question. The integration of the quantitative survey data and qualitative interview data at the stage of analysis to form a single dataset enabled breadth from the quantitative data and depth from the qualitative data, to produce a synergistic effect, greater than the component studies (Creswell & Plano - Clark, 2017). As such, providing a useful approach for eliciting a more complete understanding of the views and perspectives of a marginalised group (O'Cathain, Murphy, & Nicholl, 2007).

Participants were recruited on social media via the distribution of a web based survey using a snowballing approach. Qualitative interviews with a self selecting subset of the survey sample were undertaken in parallel. The quantitative data were analysed using descriptive statistics. The descriptive statistics were integrated with the qualitative data and analysed using framework analysis,

with equal priority given to the quantitative and the qualitative data (Bazeley, 2009). The integrated findings are reported thematically.

Participants

The web based survey was distributed on social media. A drop box hyperlink directed participants to an electronic information sheet, which fully explained the aims of the research. Eligible participants were asked to self-select if they were aged between 18-65, had been diagnosed with a personality disorder, and admitted to an acute general hospital in the United Kingdom in the previous two years (limiting participation aimed to reduce the risk of recall bias). Potential participants were able to make contact via email or social media and were encouraged to consider taking part if they had a diagnosis of personality disorder, regardless of their views on the validity of that diagnosis. Qualitative interviews were undertaken with a self-selecting subset of the survey sample and recruitment continued until saturation was achieved. This research focused on acute general hospital wards and the emergency department was excluded.

Ethical considerations

Approval for this research was given by the University of Leeds Research Ethics committee on the 25th April 2017. The survey was designed to be completed in less than 15 minutes and the interview was scheduled for completion in 30 minutes to maximise participation. Interviews were not curtailed if the participant wished to continue beyond the scheduled 30 minutes.

DATA COLLECTION

Web based survey

The cross sectional survey was developed using the Bristol online survey platform (Jisc, 2017) and distributed online between May 2017 and August 2017. Recruiting participants who have experienced invalidation from society has historically been challenging (Sadler, Lee, Lim, & Fullerton, 2010). The survey was designed to maximise response, coverage and measurement, enhancing representativeness (Fielding, Lee, & Blank, 2017).

Participants in the survey were asked to provide essential demographic information and to respond to a series of questions around their experiences of the acute general hospital and

receiving concurrent mental health care. Searches of Medline, PsychINFO, EMBASE, AMED, BNI, Cochrane library, Cinahl, Sociological abstracts and ASSIA (2005 to 2015) were undertaken (Sharda, 2019) to locate relevant studies from which to develop the survey questions (Table 1) Ordinal data was collected using five point Likert scales. Participants were given the option to contribute linked free text responses.

Table 1 Summary of web based survey questions

In the UK, mental health liaison services operate at the interface between mental health services and acute general hospitals. NICE and NHS England (2016) have recommended the use of a patient reported experience measure (PREM) comprising nine questions, to evaluate patient experiences of using mental health liaison services. These questions were included as part of the web based survey and are available in Figure 1.

The web based survey comprised 25 questions and yielded sixty five responses. All participants finished the survey except for one participant who left the survey following question 22. Survey participants were invited to provide an email address if they were interested in being contacted about taking part in a telephone interview. The survey reopened in October 2017, for

an additional one month period, ending in November 2017 to enable saturation to be achieved in the qualitative interviews.

Telephone interviews

Potential interview participants were provided with a further information sheet via email. The sheet provided information about the interviews and described the risks and benefits of taking part in the research. Participants were able to make contact with any queries before deciding to take part. A topic guide was used to focus the interview. Participants were encouraged to talk in depth, about their background, their experience of being referred for treatment, the hospital, perceptions of education and knowledge, care outcomes, and their recommendations. All interviews were conducted by the first author, a female Registered Nurse in Mental Health (LS) who has a background in mental health liaison. Twelve qualitative interviews were conducted before saturation was reached. Transcription of the audio recorded interviews was undertaken by a professional transcription company.

DATA ANALYSIS

Integrated Quantitative and Qualitative analysis

The interview transcripts and the survey data were checked and all identifying information was removed. The anonymised quantitative survey data was imported into a Microsoft Excel 2016 spreadsheet, enabling the generation of descriptive statistics for the quantitative data items. Missing data was less than 5% for all quantitative items and considered inconsequential to the research aims and objectives (Dong & Peng, 2013). The free text survey responses and the interview transcripts were imported into Nvivo Version 11 and considered side by side with the Microsoft Excel 2016 spreadsheet. A framework method was used to enable familiarisation with the data, the identification of a thematic framework and the indexing, charting, mapping, and interpretation of data (Furber, 2010; Pope, Ziebland, & Mays, 2006).

The entire data set was read until the data was understood and familiar. A series of questions were identified and used to develop a draft framework. The data were indexed to the framework and checked to explore the fit, referring back to the source, and ensuring the context of the data was not lost (Furber, 2010). The framework matrix function in Nvivo version 11 was

used to organise the indexed interview data into a thematic chart. Summarised survey data was entered manually into the same chart. The data chart was reviewed by all authors.

The themes were reviewed and revised following discussion, relating to overlapping, interpretation, and reporting of the themes. Descriptive summaries were developed into explanatory accounts, which involved moving between the data summaries and the original data to ensure that the explanatory accounts remained grounded in the original data set. The explanatory accounts were reviewed by all authors.

Validity and Reliability/Rigour

The study was designed and implemented with due consideration of the methodological assumptions, principles, and practices underpinning the qualitative and quantitative strands (Curry & Nunez - Smith, 2015). The report was prepared in accordance with GRAMMS (O'Cathain, Murphy, & Nicholl, 2008) and provides a transparent and defensible account of the decisions taken.

RESULTS

Sixty-five people completed the survey. Eighty-three percent of the survey participants were female (n=54), eight percent were male (n=5) and nine percent were non binary (n=6). The majority of participants were aged between 18 and 45 (n=55). Participants were admitted to a range of wards including acute admissions, medical, gynaecology, maternity, and surgical wards.

Eleven females and one male took part in the telephone interviews. No demographic details were captured during the telephone interviews to preserve anonymity. The quantitative findings were summarised using descriptive statistics and reported in the corresponding thematic context, alongside the qualitative results. Four themes were identified: patient distress; workforce: knowledge, understanding, skills, and discriminatory practice; service delivery: missed care and treatment; and service design: separation of services.

Theme One. Patient distress

Most of the participants surveyed (94%, n=61) reported they had experienced distress during their admission to the acute general hospital. Although sixty percent (n=39) of those surveyed stated

an emergency or crisis treatment was needed, the qualitative data indicated that the hospital environment was typically not conducive to mental health. There were accounts of emotional and psychological distress, conflict, self-harm, and leaving the hospital early or against medical advice. Participants explained that being admitted to the hospital exacerbated psychological distress because of a perceived lack of privacy and support:

'I had no space. There were nurses in and out, by the bed.'
(Participant 4, Interview)

Participants experienced a range of difficult emotions in the hospital, which were most commonly expressed as feeling distressed and fearful. There were a range of manifestations of psychological and emotional distress, including becoming withdrawn, experiencing anxiety attacks, dissociation, shouting and screaming. Participants explained that sometimes responses to distress in the acute general hospital were helpful. However, some participants felt more able to negotiate the hospital system than others, and some felt there were many more unhelpful responses to distress. The data indicated that being able to acknowledge the distress and talk about it was useful.

In the absence of support from professionals, distress could escalate and result in a deterioration of mental state. One

participant explained that to be taken seriously and gain help it was necessary to resort to extreme measures. There was a sense of distress escalating in the acute general hospital and in some instances, increased self-harm. A range of expressions of self-harm were described, including cutting, hitting, tying ligatures, vomiting, and not eating in the context of considerable distress. Two related reasons for distress were identified in the context of self-harm. First was that participants engaged in self harm in the context of mental ill health. Second, it was identified that specific characteristics of the hospital environment increased distress and self harming was intensified. However, paradoxical to the level of support, which was available, participants believed self-harm in the acute general hospital led to the professionals being hesitant to facilitate discharge, prolonging the experiences of being unsupported and of mental health needs not being met.

Some participants reported that conflict occurred when they tried to communicate individualised needs. When they did not behave in the manner which was required by the system, it was perceived that professionals believed the behaviour must be 'managed', with correctional strategies such as behaviour plans and security guards. There was a sense that conflict with healthcare professionals occurred when they resisted being passive recipients of care. Participants found themselves in

conflict because the acute general hospital had fixed rules and regulations and despite sound reasoning the rules could not be relaxed. Mental health needs and concerns were reported to be repeatedly dismissed until conflict ensued. Participants explained that they needed health care professionals to reframe conflict in the context of lived experience and distress:

'It's really difficult because you're like actually, you're going to get really angry and you're going to get annoyed because you're not being listened to. You're basically being told that you're not actually worth being listened to or treated as a person, and I think that's the main issue with a lot of these things. That if you're going to treat someone like that, they're not going to respond well to it ever. No one will. It doesn't matter if they don't have a diagnosis of anything ever.'

(Participant 6, Interview)

Twenty six percent of participants surveyed (n=16), approximately one in four, reported leaving the acute general hospital without waiting to be discharged by the acute general hospital team. Waiver or discharge against medical advice (AMA) forms were said to be commonly used. The qualitative data offered insights into the possible reasons why. Leaving against medical advice was sometimes related to the mental state of participants. The mental state factors, which participants reported compelled them to leave before completion of treatment included: experiencing dissociation, psychosis, and paranoia. However, overwhelmingly their reason for leaving was because

they perceived their basic needs were not met. The situation in the acute general hospital was found to be unbearable, and participants described feeling distressed by the paternalistic or dismissive responses and the barriers to getting the treatment and care needed.

Theme Two. **Workforce: Knowledge, understanding, skills, and discriminatory practice**

There was a consensus among the participants of a lack of knowledge, understanding and skill in responding to patients diagnosed with a personality disorder in the acute general hospital. Only a small number reported being treated with kindness and empathy by professionals who were responsive to their needs and overall, it was believed that the acute general hospital workforce treated them inhumanely and unfairly:

> *'I felt I was treated very well up until the point I told them about my PD diagnosis. After that, I was treated as a hypochondriac and dismissed.' (Participant 43, Survey)*

Professionals were considered to make assumptions, which centred around being: untrustworthy, neurotic, manipulative, attention seeking, and having anger issues. Professionals were not considered to exercise professionalism or show any compassion or care following self-harm or overdose, and the

professionals were perceived to be oblivious of what it might be like to be vulnerable in hospital, having experienced psychological trauma. Participants described feeling unsafe and dejected because of the general lack of recognition of trauma and the implications of being asked to remove clothing:

'I was aware of something going on, […] straight away I was shunted into an area and it was a male doctor that came and he basically wanted me to strip all my clothes off the top, and obviously straight away I was freaking out, I'm like there's no way I'm doing that.'

(Participant 9, Interview)

Forty nine percent of survey participants (n=30) who reported being distressed believed that the acute general hospital had a very important role in providing support. Although, the majority did not consider that health professionals working in acute general hospital settings needed to develop sophisticated skills in mental health care. The participants wanted to be treated with compassion and humanity the same as any other patient.

Theme Three. Service delivery: Missed care and treatment

Missed care and treatment included missed medicines, diagnoses, treatment, and nursing care. In context, seventy three percent (n=47) of those surveyed perceived that their mental health was of equal or greater importance than their physical

health at the time of admission to the acute general hospital. However, fifty four percent (n=35) of the survey participants reported being unable to access their usual treatment for their mental health while in hospital: 37% (n=24) reported their specific treatment for their mental health was unavailable in the acute general hospital and 17% (n=11) stated that their specific treatment was available, but they were unable to get it. Themes of missed, interrupted and omitted pharmacological treatments were echoed in the qualitative data. Substantial difficulties were described in getting regular medicines prescribed in the acute general hospital and considerable effort was expended in communicating the necessity to receive medicines for mental health. A common view was that medicines prescribed for mental disorders were not a priority in the acute general hospital:

'They told me they don't do psychiatric medication in this ward. The withdrawal effects were awful.'

(Participant 15, Survey)

The participants believed that missed, interrupted and omitted pharmacological treatments resulted in deteriorating physical and mental health. There were extensive accounts of diagnostic and treatment overshadowing. There were difficulties being seen by some specialities because the personality disorder diagnosis diminished the credibility of referrals. Participants explained

dismissals resulted in repeat referrals. However, often their challenges, appeared to reflect an inverse diagnostic and treatment overshadowing, with mental health ignored, while the professionals focused exclusively on physical health.

Another reported missed opportunity was one on one nursing care, which elicited some confusion. The sense of somebody sitting watching arbitrarily, without any meaningful engagement was questioned. Participants were uncertain about the purpose of one on one support and considered that there was often a lack of appropriate justification for the decision. Commenting on their care plan, one of the participants stated:

'It seemed a little strange that they should go to the lengths of observing me overnight without offering any psych assessment the next day.'

(Participant 46, Survey)

Theme Four. Service design: Separation of services

Participants flagged several concerns, which related to the separation between mental and physical healthcare including the role of the mental health liaison team and the configuration of services. Forty five percent of the survey sample (n=29)

completed the mental health liaison PREM (NICE and NHS England, 2016).

Figure 1. Experiences of patients diagnosed with a personality disorder of using mental health liaison

Fifty five percent of those (n=36) surveyed, reported that mental health liaison did not see them during their admission. Disruption in routine mental health care was commonly reported, as contact with community mental health teams stopped during hospitalisation, a time when the participants believed they needed services the most:

'I could feel myself going, and I said, I need to see someone from mental health urgently. And, you know, they said, you don't need to see anybody from mental health, there's nothing wrong with you.'

(Participant 5, Interview)

There was a sense that mental health services were 'administered' reactively, following incidents, which might offer some explanation about why more than half of the participants were not seen. However, even following critical incidents, a lack of support from mental health services was reported. Participants described feeling frustrated at the

signposting and assessment offered by mental health liaison and indicated that more practical interventions to support psychological wellbeing were needed:

'Having a mental health liaison service whose purpose is solely to check you don't need to be admitted to a mental health hospital is not good enough.' (Participant 38, Survey)

Participants believed that mental health liaison teams were in an awkward position in the acute general hospital: with under resourcing of the wider mental health services in the UK, there were limited opportunities for onward referrals. One interview participant articulated that the lack of resources must be demoralising for mental health liaison workers and believed they were consequently becoming burnt out. Participants wished services were better integrated and argued that there should be more joined up thinking between providers.

Participants were uncertain what services were available and when, and some needed additional support to navigate the very complicated healthcare systems. Of those surveyed, 58% (n=36) reported that they were dissatisfied with their care. Participants reported it was challenging to let people know when they had received poor care and treatment and believed that responses were unsatisfactory when complaints were made. Those who had

experience of the complaints process found that it was invalidating. Participants believed they were not afforded the same considerations as other patients with regards to making complaints and stated they were dismissed, based on unsubstantiated assumptions of mental disturbance.

Participants called for overarching improvements to the interface between mental and physical health services. These data demonstrate the urgency of making improvements, 46% (n=30) of those surveyed, stated there was a strong possibility of being readmitted to the acute general hospital in the next 12 months, a further 34% (n=22), stated they were unsure, indicating a strong possibility of readmissions amongst the participants.

DISCUSSION

Although evidence of compassion was located in the data, the majority of participants described an unresponsive workforce, which responded with disdain. The psychological and emotional distress reported by almost all participants was severe, but they perceived they were considered to be difficult, rather than in a crisis. While, there was recognition that responding to distress might be difficult for non specialist services, failure to respond to mental illness and crises will likely result in needless deaths

(Department of Health and Concordat Signatories, 2014). Despite the considerable distress described, the systems and responses to risks such as self harm, suicide and violence appeared underdeveloped. Adopting relational approaches may improve connectedness and compassion, equipping hospitals to respond more functionally to distress and risk.

The participants provided detailed accounts of diagnostic and treatment overshadowing. Participants also reported an inverse treatment overshadowing (Noblett, Lawrence, & Smith, 2015) in which their mental illness and the required treatment for that mental illness was completely ignored, while professionals focused on exclusively on physical health. To date, inverse diagnostic and treatment overshadowing has received little attention in the literature. Discussion of inverse, reverse, or opposite, diagnostic overshadowing has been mainly confined to the literature relating to primary care (Menchetti, Murri, Bertakis, Bortolotti, & Berardi, 2009) and intellectual disabilities (Singh, 2016). Notably, diagnostic overshadowing and inverse diagnostic overshadowing have been linked to negative attitudes and prejudice (Noblett et al., 2015).

Approximately one in four survey participants reported leaving the acute general hospital without waiting to be discharged.

Participants provided accounts of disorganised and inconsistent decision making and the perfunctory use of discharge against medical advice (AMA) forms. The participants believed AMA forms were used unthinkingly and offered a sense that the practices described would not withstand legal challenge (Devitt, Devitt, & Dewan, 2000). These reports appear concerning given the emerging data on poor health outcomes among this group (Björkenstam et al., 2018; Fok et al., 2012; Fok et al., 2014; Frankenburg & Zanarini, 2004).

The study participants considered that mental health liaison services were not sufficiently integrated into acute general hospitals, or adequately resourced, and nearly half of the survey participants reported that mental health liaison was difficult to access. Participants who had experience of liaison services described a checking service, with limited offers of emotional support. The principles of clear communication, dignity, equality of access and side by side working, fundamental to the liaison role (Royal College of Psychiatrists et al., 2020), were not reflected in the data, highlighting the need for additional focus on the needs of this group.

Although, over half of the participants surveyed reported that services were unsatisfactory, the complaints process was

perceived to be unaccommodating. Some participants described complaints, which were dismissed, based on presumed mental impairment. Failure to listen to patient complaints and concerns was one of the key issues highlighted in an extensive UK based inquiry into systemic failings in care (Francis, 2013). Hearing complaints and concerns has far reaching implications for understanding systematic difficulties in hospitals and to improving patient safety and outcomes (Francis, 2013). It appears of particular importance to listen to marginalised groups.

Limitations

The use of a web based cross sectional survey was considered to provide an economical means to access primary data covering a broad geographical area. While, the pragmatic sample size is acknowledged and cross sectional designs have been criticised for providing a 'snapshot' (Caruana, Roman, Hernández-Sánchez, & Solli, 2015), the integration of the quantitative and qualitative methods to produce a 'whole greater than the sum of the parts' (Barbour, 1999 p.40) was considered to mitigate the critique. The absence of any service user or carer involvement limited this study. Most emphasis was placed on services, rather than the lived experience, which shaped the analysis and interpretation of the findings. Coproduction may have changed or enhanced the conceptualisation, analysis, and interpretation

stages of this study, particularly given the nursing background of the first author.

CONCLUSION

The findings indicated that patients with a personality disorder diagnosis received disadvantaged healthcare, might be at considerable risk of treatment non completion, and were languishing in the gaps between mental and physical health services. Ad hoc training and education, focused on raising awareness of 'personality disorder' would not seem sufficient to address the deficits. There needs to be a sustained commitment to improving governance structures, which support professionals to provide compassionate care and treatment to people experiencing psychological and emotional distress. However, as a starting point, listening to concerns, learning lessons, and affording mental health liaison teams the time and platform to deliver practical training across the acute general hospital wards, around relational approaches to risk, how to respond compassionately to distressed patients, and the safe and therapeutic use of psychotropic medicines may be valued.

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