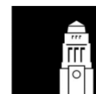

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How do general hospitals respond to people diagnosed with a 'personality disorder' who are distressed: A qualitative study of clinicians in mental health liaison

Abstract

Introduction

Literature on 'personality disorder' and the general hospital has to date primarily focused on emergency departments. Research on how general hospital inpatient wards respond to people diagnosed with a 'personality disorder' has been long overdue.

Aim

Qualitative telephone interviews were undertaken to explore the views and perspectives of clinicians working in mental health liaison in this final strand of a mixed methods explanatory sequential study.

Method

Participants were recruited via social media and professional networks by snowball sampling. Data were analysed using a framework approach.

Results

Four themes were identified: Knowledge, understanding, skills and discriminatory practice; Alliances, diplomacy, care and treatment of people diagnosed with a ‘personality disorder’; Achieving parity of esteem in a disparate healthcare system; and Organisational stress, mismatched expectations and service led decision making.

Discussion

There were unjust and avoidable differences in the care and treatment received by people diagnosed with a ‘personality disorder’ in the general hospital. People were discriminated against and routinely over and under medicated.

Implications for practice

Clinicians working in mental health liaison need capacity for partnership working, clinical capability spanning mental and physical health, credibility and influence, and high level interpersonal skills to address the entrenched discrimination of people diagnosed with a 'personality disorder'.

Accessible summary

What is known on the subject?

- People diagnosed with a personality disorder might be more likely to have physical health problems and be admitted to hospital. Treatment in hospital might be complicated by mental health crises or self-injury, and barriers to NHS care may increase the risk of developing further illness with serious consequences.

- Literature on 'personality disorder' and the general hospital has to date primarily focused on emergency departments. Research on how general hospital inpatient wards respond to people diagnosed with a 'personality disorder' has been long overdue. Thirteen clinicians

working in mental health liaison in the general hospital were interviewed as part of a sequence of research studies.

What this paper adds to existing knowledge

- This study identified unjust and avoidable differences in the care and treatment received by people diagnosed with a ‘personality disorder’ in general hospitals. People with a ‘personality disorder’ diagnosis were discriminated against and over and under medicated.

- Mental health liaison clinicians reported limited understanding and skills among general hospital clinicians. People working in general hospitals were fearful of the ‘personality disorder’ diagnosis. Poor care was accepted because general hospital clinicians did not consider themselves to be ‘mental health trained’

What are the implications for practice?

- Clinicians working in mental health liaison need credible knowledge of mental and physical health, and medicines.

- Capability, influence, and high level interpersonal skills are needed to successfully work across mental health services and the general hospital.

- More advanced and consultant level nursing roles in more mental health liaison teams are needed to strengthen this specialist workforce.

Keywords

Personality disorders, psychological distress, emotional distress, mental health, parity of esteem, advanced practice, hospitals.

INTRODUCTION

The drive to treat mental health equally and to the same standard as physical health is known in England as ‘Parity of esteem’ (HM Government, 2011). Achieving parity of esteem in the National Health Service (NHS) has been mandated in the Health and Social Care Act (2012) and the NHS Constitution (Department of Health and Social Care, 2015). General hospitals must provide mental health care, which meets nationally recognised quality standards (Care Quality Commission, 2020). A systematic review, which evaluated the general hospital care of people with

severe mental illnesses (SMI) concluded that people with SMI generally receive ‘lower quality’ care (Reeves, Henshall, Hutchinson, & Jackson, 2018).

Safeguarding the physical health of people with mental illnesses has become an international priority due to the premature mortality associated with mental illness, and the personal, social and economic burden of suboptimal physical health (Firth et al., 2019). To date, improvement initiatives have commonly overlooked the ‘personality disorder’ diagnosis (Sanatinia, Middleton, Lin, Dale, & Crawford, 2015), although ‘personality disorder’ has been reported to be highly comorbid with physical illnesses (Quirk et al., 2015; Quirk et al., 2017; Yang, Coid, & Tyrer, 2010).

An increasing number of professionals and survivors contest the legitimacy of the ‘personality disorder’ diagnosis (Johnstone, 2019; Koehne, Hamilton, Sands, & Humphreys, 2013). In her seminal work, Kaplan (1983) argued that misogynistic assumptions about healthy behaviour in women have shaped the diagnostic and treatment patterns related to ‘personality disorders’. Through a feminist lens, adverse life experiences and survival strategies have been pathologised; non-conforming women have been diagnosed with ‘personality disorders’,

stigmatised and treated with contempt (Kaplan, 1983; Nicki, 2016). However, there is little dispute that many people diagnosed with a ‘personality disorder’ have experienced severe difficulties requiring access to services (Wivescare, 2019).

Hospital admissions, related to circulatory, respiratory, digestive, musculoskeletal, nervous and endocrine systems have been found to be three times higher in people diagnosed with a ‘personality disorder’ compared to the general population (Fok, Chang, Broadbent, Stewart, & Moran, 2019). Accounts of diagnostic overshadowing and inverse diagnostic overshadowing experienced by people diagnosed with a ‘personality disorder’ in UK general hospitals have been particularly concerning (Sharda, Baker, & Cahill, 2021).

Hospital treatment might be complicated by mental health crisis or self-injury, and barriers to NHS care may increase the probability of developing further comorbidities (Public Health England, 2018; Reilly et al., 2015). People with a diagnosis of ‘personality disorder’ have been reported to experience relatively worse physical health outcomes (Fok et al., 2014; Frankenburg & Zanarini, 2004; Powers & Oltmanns, 2012).

Literature on ‘personality disorder’ and the general hospital has to date primarily focused on emergency departments e.g. Cases, Lafont Rapnouil, Gallini, Arbus, and Salles (2020) and Vandyk, Bentz, Bissonette, and Cater (2019). Research on how general hospital inpatient wards respond to people diagnosed with a ‘personality disorder’ has been long overdue. A mixed methods explanatory sequential study was conducted in the United Kingdom comprising: a scoping review of the literature; a web-based survey of people diagnosed with a ‘personality disorder’ with embedded qualitative interviews (Sharda et al., 2021); a web-based survey of general hospital clinicians and this qualitative interview study, which explored the unique views and perspectives of clinicians in mental health liaison.

AIM

To explore how general hospitals respond to people diagnosed with a ‘personality disorder’ who are distressed from the perspective of clinicians working in mental health liaison.

METHODS

Design

A qualitative telephone interview study of clinicians working in mental health liaison. The participants were recruited on social media and via professional networks by snowballing sampling. The data were analysed using a framework approach. The findings are reported thematically.

Data collection

Ethical approval for the study was obtained from the University of Leeds, School of Healthcare, ethics committee.

Clinicians working in mental health liaison teams were sought on Twitter, Facebook and via professional networks during spring 2018. The use of an online, nonprobability, snowball sampling method, including two different social media platforms was considered the most pragmatic option to recruit participants. The approach enabled views and perspectives from clinicians working in diverse liaison services all over the United Kingdom to be sought. Potential participants contacted the lead researcher via telephone or email, and an electronic participant information sheet was provided via email. The information sheet provided

detail about the telephone interviews and the risks and benefits of taking part.

The interview questions were informed by the previous strands of the research. All interviews were undertaken by the lead researcher (LS), a female Registered Nurse in Mental Health, who has clinical experience of working in mental health liaison. A topic guide was used to structure the interviews. Participants were asked to talk about their background, referrals to mental health liaison, their role in the referral process, how service provision met the needs of people, what organisational factors enabled them to undertake their liaison role, the barriers encountered, expectations of the general hospital, how clinicians accessed education and training and the sources of information available, as well as views on future priorities.

No demographic details were captured to preserve anonymity in a relatively small specialty. Participants were encouraged to speak freely and the interview duration was not curtailed by the lead researcher. The interviews were audio recorded and professionally transcribed. Any identifying information was removed during transcription. All participants who agreed to take part were experienced clinicians. Participants were working in mental health liaison services of different sizes and

configurations in UK general hospitals. Thirteen qualitative telephone interviews with: a consultant nurse (n=1), consultant psychiatrists (n=5), a mental health pharmacist (n=1), and mental health liaison nurses (n=7) were conducted before informational redundancy (Lincoln & Guba, 1985) was achieved.

Data analysis

The interview transcripts were checked, identifying information removed and imported into Nvivo Version 11. The framework method of analysis followed Furber's approach (Furber, 2010) and involved familiarisation with the interview data, the identification of a thematic framework, and the indexing, charting, mapping, and interpretation of data. The use of the framework approach was compatible with the overarching mixed methods design and supported synthesis and a staged process across the project (Creswell & Plano - Clark, 2011; Lalor et al., 2013).

Identification of a thematic framework

The interview data were read until they were understood and became familiar. Notes were made on a large sheet of paper and in the margins of the transcripts. Similar themes were grouped together. The themes identified inductively from the data were

considered in conjunction with the aims and objectives of the a priori project themes. A series of data labels and descriptors were identified and used to develop a draft thematic framework.

Indexing

The data labels and descriptors identified were entered into Nvivo version 11 as a codebook and the related framework was indexed to nodes. The data labels and descriptors and the draft framework were continually refined during this process. On completion of the indexing, the indexed data were re-checked to explore the fit with the framework, referring back to the source, and ensuring the context of the data was not lost (Furber, 2010).

Charting and mapping

The framework matrix function in Nvivo version 11 was used to automatically organise the indexed interview data into a thematic chart. It was necessary to continually move between the chart and the original source in Nvivo to ensure the fit of the data was maintained. The data chart was printed out and reviewed by all authors. The themes were reviewed and revised following discussion, relating to overlapping, interpretation, and reporting of the themes.

Interpretation

Descriptive summaries were produced and developed into explanatory accounts, which involved moving between the data summaries and the original data to ensure the explanatory accounts remained grounded in the original data. The explanatory accounts were reviewed by all authors.

This qualitative study was designed and implemented with due consideration of the key methodological assumptions, principles, and practices underpinning qualitative research. The analysis was pragmatic, sought to uncover ‘what the text says’ (Spencer, Ritchie, Ormston, O'Connor, & Barnard, 2014 p.271), and grounded in what could be done to find realistic solutions. The report was prepared in accordance with the standards for reporting qualitative research (SRQR) (O' Brien, Harris, Beckman, Reed, & Cook, 2014). The project objectives, data analysis, and the interpretation of the findings were shaped by pragmatism and the lead researcher’s experience.

RESULTS

Four themes typified the mental health liaison perspective on how general hospitals respond to people diagnosed with a

'personality disorder' who are distressed. These were knowledge, understanding, skills, and discriminatory practice; Alliances, diplomacy, and the care and treatment of people diagnosed with a 'personality disorder'; Achieving parity of esteem in a disparate healthcare system; and Organisational stress, mismatched expectations and service led decision making. The analysis indicated no variation in the views and perspectives of clinicians based on region or service configuration.

Theme one: Knowledge, understanding, skills, and discriminatory practice

This theme focused on the perceived knowledge, understanding and skills of general hospital clinicians and the role of mental health liaison clinicians in addressing discriminatory practices. In the general hospital setting the 'personality disorder' diagnosis was not perceived to have any utility for care or treatment. However, the general hospital clinicians were perceived to be forthcoming with using the term to label people who were considered to be difficult. There was a sense that general hospital clinicians were habitually condemnatory but were oblivious:

'I get frustrated all the time, she's a PD, or they'll say, it's one of yours. It's absolutely mad, bonkers, yeah, that kind of terminology that's quite derogatory.'

(Participant 6, Liaison Nurse)

Basic communication skills were considered to be hampered by gross misperceptions. Half of the participants and most of those at the consultant level emphasised the importance of chipping away at the discrimination, enabling development of the tacit knowledge, understanding, and skills needed to talk to people in distress. A recurrent theme across the interviews was that responding to distressed people was nothing new to general hospital clinicians. The liaison clinicians believed that caring for people with a 'personality disorder' diagnosis did not automatically require sophisticated expertise. The participants talked about their successes supporting general hospital colleagues to develop confidence:

'A lot of these, kind of, slightly lower level or less concerning situations might be managed now in house by the general nursing staff or they might request a little bit of assistance or for somebody to come across and perhaps just speak to the patient and often that would be enough, but I think my colleagues are really, really skilled in deescalating these situations.' (Participant 3, Consultant)

Some participants described their accomplishments in developing knowledge and understanding of legislation such as the Mental Health Act (2007) and Mental Capacity Act (2005).

While others considered understanding of mental health legislation in general hospitals remained lacking. Some participants explained that determining decisional capacity was nuanced and complex with people diagnosed with a 'personality disorder', and there was additional reflection that inexperienced clinicians could make ill informed decisions:

'My only concern with a non-mental health clinician, so a staff nurse or a junior doctor, who's not experienced in mental health, assessing the capacity of a patient, with a mental health diagnosis is, it would probably be more difficult for them to pick up on the nuances of whether that patient's mental health needs are impacting on their capacity.'

(Participant 10, Liaison Nurse)

The analysis indicated greater clarity about mental health legislation, rights, and responsibilities was needed to avoid unlawful detentions and tragic outcomes. A mental health nurse (Participant 2) questioned the professional knowledge, understanding, and skills of some mental health liaison nurses. It was proposed that as a profession, mental health nurses had 'let themselves down terribly'. The participant reported it was not unusual to hear remarks such as 'people who deserve care should be having my time, not these people who are time wasters'. There were no similar disclosures from the liaison psychiatrists.

Theme two: Alliances, diplomacy, and the care and treatment of people diagnosed with a 'personality disorder'

This theme expanded on the care and treatment of people diagnosed with a 'personality disorder' and explored the diplomatic role of mental health liaison. Participants were keen to point out that not all people with a 'personality disorder' diagnosis required a referral to mental health liaison. However, those people who needed support were perceived to be extremely distressed. The liaison clinicians accepted that the general hospital would not necessarily involve them when there was a problem. The analysis indicated that high level influencing, mediation, and relationship building skills were necessary to persuade the general hospital to make mental health referrals:

'I've invested most of my time, in that time, trying to improve the relationships with the referrers, because it doesn't matter how psychiatrically literate the referrers are, if they don't pick up the phone and refer the patients, we can't do anything (…) So, knowing our place, is the first thing, and then negotiation at other times, is important.'

(Participant 5, Consultant)

Carefully cultivated alliances with general hospital clinicians were used to subvert harm, and the impression was given that much of the interpersonal work was surreptitious. Most of the participants described extensive work to establish mutually

acceptable thresholds for referrals, which they balanced against the safety and comfort of people.

' It's a bit of a sort of diplomacy role'

(Participant 1, Consultant)

Despite strong relational working, mismanagement of medicines was repeatedly flagged as a concern. Participants reported that general hospitals commonly stopped psychotropic medicines and while there was some suggestion that psychotropic drugs were not always available, a mental health pharmacist (Participant 8) stated this was usually incorrect. Most reported psychotropic medicines were not a priority in general hospitals.

'Acute hospitals have a terrible habit, of just taking people off all their mental health medication when they come into hospital. That's not always a good thing to do.'

(Participant 4, Consultant)

However, the opposite scenario, the administration of excessive medicines was also described and some of the participants believed that general hospital clinicians tried to medicate away 'personality disorder' and distress. The participants raised concerns about the safe use of hypnotics, anxiolytics and opioids in the general hospital setting:

'Some doctors won't prescribe anything at all. They're very reluctant to prescribe anything at all, especially because they say everything's behavioural, and then some will prescribe an awful lot of medication, such as benzodiazepines, sometimes at very high dosages which aren't really warranted'

(Participant 9, Liaison Nurse)

Experienced mental health liaison clinicians were considered requisite to supporting the general hospital with the safe and timely use of medicines, especially in the event of a mental health crisis or emergency. However, the nature of the liaison role was that they could only offer advice. One mental health liaison nurse participant (11) talked about difficulties convincing the general hospital that a person needed medicine as a nurse. However, it was believed that all liaison clinicians regardless of discipline needed to be careful not to overstep their role. They judiciously deferred to their general hospital colleagues to retain relationships and influence.

Theme three: Achieving parity of esteem in a disparate healthcare system

This theme focused on the policy and service challenges related to achieving parity of esteem in the general hospital. The participants considered there was little parity between

‘personality disorder’ and other conditions. One participant (2) believed that the National Institute for Health and Care Excellence (NICE) guidelines were insufficient, and the expected standards of care were low. Another participant (11) described long term difficulties accessing community services for people with a diagnosis of ‘personality disorder’, who were admitted to the general hospital in crisis. People with a ‘personality disorder’ diagnosis were considered to be too ‘risky’ and were reportedly repeatedly denied access to community services and psychological therapies. The outcome was that the general hospital became the primary contact for some people.

These findings suggest that in the absence of any real alternative, the general hospital delivered de facto mental health crisis care when people excluded from mental health services were admitted during a mental health crisis. However, some wards were perceived to make minimal effort to respond to mental health needs. Participants considered their general hospital colleagues believed not being mental health trained justified their omissions. Mental health assessment skills were considered to be poor among some general hospital clinicians. Participants imagined those general hospital clinicians were not concerned as mental illness was a problem for somebody else:

'You don't hear the mental health nurse saying, I'm not general trained. If there's a critical health problem that you come across during your assessment, you go and seek advice. You don't react in the same way. This is your patient.'

(Participant 13, Liaison Nurse)

Newly qualified clinicians were believed to be more educated about the issues related to parity of esteem, and the data suggested that some trusts had excellent leadership, and championed the National Confidential Enquiry into Patient Outcome and Death NCEPOD (2017) agenda. However, achieving parity of esteem for people diagnosed with a 'personality disorder' was considered to be a long way off, even in hospitals with established mental health liaison services. The level of need in the general hospital meant that waiting for mental health liaison to provide inpatient mental health care was unfeasible:

'I have this belief that we need to skill up people as much as we possibly can, to be able to deal with things in the moment. Because I think, when 70 percent of people in an acute hospital, have got a mental health need, that's the kind of average statistic, there's no way that, even when you've got a team of X people, that you're going to be able to deal with all of those X beds, which is what we have.'

(Participant 4, Consultant)

The participants believed failure to integrate mental and physical healthcare was likely to result in adverse outcomes. However,

mental health liaison teams were considered to be under resourced. The precarity of the relationships with the general hospital, and the importance of the interpersonal work, were not always acknowledged by the funders. Several participants stated much of their work, i.e., the role modelling, relationship building, and peer support went unspoken and was difficult to demonstrate as a return on investment. It was considered that commissioners responsible for assessing, planning, purchasing and monitoring services (NHS, 2022) required a good understanding of mental health liaison services to fund them comprehensively.

Theme four: Organisational stress, mismatched expectations and service led decision making

Organisational stress; mismatched expectations and service led decision making characterised the stress and strain observed in individuals and at the organisational level. Participants explained that general hospital clinicians were intensely anxious about working with people with a 'personality disorder' diagnosis and were afraid. The anxiety experienced by clinicians was reported to create an emotional ripple effect. Participants identified that supporting the general hospital to reduce organisational stress was as important as supporting people in hospital.

'I think that patients perceive that they are treated slightly differently. I suspect that many of them perceive that sometimes the wards are a bit anxious about them. I think they perceive that the wards are slightly less interested in them. And I strongly suspect that the patient's perceptions of that approach, simply drives any of the communication difficulties, which were already there, and a vicious circle is very quickly begun.' (Participant 5, Consultant)

Anxiety and fear amongst the general hospital clinicians were considered to elicit over and under reactions to presenting clinical situations. Some participants stated it was not uncommon for general hospital clinicians to become frantic, seeking advice and support, with desperation. However, the liaison clinicians reported it was impractical to respond to continuous phone calls or to provide one on one care to all of the distressed people, which was sometimes the expectation:

'They are very, very scared as I said, even approaching them when they're self harming or being chaotic because they just don't know what to say because they're worried that they'll make the situation worse.'

(Participant 11, Liaison Nurse)

Participants explained that there was some expectation grounded in anxiety, that mental health liaison would assume responsibility for any person who had a 'personality disorder' diagnosis, regardless of the situation. Participants were under the impression that many of their colleagues believed mental health

units were for mental health, and not the general hospital. The mismatch of expectations, anxiety and distress was reported to lead to interprofessional conflict:

'I'd come back from days off and this lady hadn't been seen for a couple of days, I walked onto the ward and there was two doctors and the nurse in charge shouting at me up the corridor, that's the kind of thing that we have to avoid.' (Participant 2, Liaison Nurse)

Mental health liaison nurses, in particular, reported that they clashed with the general hospital over inpatient care. For example, one participant (12) described a care plan which was implemented to support a person following self-harm. As soon as self-harm occurred, the care plan was abandoned and there was a 'vicious cycle' of disregarding advice, emotional contagion and repeatedly contacting mental health liaison. The analysis indicated that emotional contagion led to service led decision making and contributed to organisational stress. The outcome was substandard care.

DISCUSSION

Discrimination related to 'personality disorder' in the inpatient general hospital setting has commonly been reported anecdotally but has rarely been flagged in the published literature. General

hospital clinicians were perceived to respond negatively to people diagnosed with a 'personality disorder'. This finding is comparable to studies conducted in the emergency department (Clarke, Usick, Sanderson, Giles-Smith, & Baker, 2014; Commons Treloar & Lewis, 2008), community (McGrath & Dowling, 2012) and in inpatient mental health settings (Bodner et al., 2015).

Attitudes observed in the general hospital by the liaison clinicians were often dismissive and denigrating. An important contextual issue identified in this study was that some general hospital clinicians were immensely scared of the 'personality disorder' diagnosis. It is well understood that clinicians under threat adopt defence mechanisms leading to irrational decision making, and dehumanisation (Moore, 2012). The future nurse proficiencies set out a requirement for nurses in all fields of practice to demonstrate communication and relationship management skills, which promote equal access to care (Nursing & Midwifery Council, 2018). Support and engagement to deliver on this proficiency in this context appears long overdue.

'Personality disorder' has commonly been neglected in the physical health research context in comparison to other serious mental illnesses (Sanatinia et al., 2015). Major problems with the

‘personality disorder’ construct may have impeded such research. The ‘personality disorder’ diagnosis has been linked to considerable stigma and discrimination e.g. (Bodner et al., 2015; Dickens, Lamont, & Gray, 2016; King, 2014) and people may understandably choose not to disclose it in a physical health setting. In the absence of data, large scale improvement initiatives may be challenging to justify. The lack of research may have contributed to the disparities experienced by people with this diagnosis being overlooked.

People with a diagnosis of ‘personality disorder’ experiencing co-occurring physical and mental health needs may be more likely to be admitted to the general hospital than might be believed or prepared for given a meta-analysis calculated prevalence in the general adult population of western countries as 12.2% (Volkert, Gablonski, & Rabung, 2018). The practice issues in the general hospital setting may be distinct from other settings, e.g. use of security as a first line intervention might be commonplace in general hospitals and unlike mental health settings there may be a limited focus on reducing or justifying the use of restrictive interventions.

The general hospital may be the only healthcare contact for some people with a diagnosis of ‘personality disorder’, particularly

those deemed too ‘risky’ to access other services. This study points to a considerable level of acuity in the apparently unprepared general hospital. The interrelationship between physical health and mental health and the co-occurring treatment needs in the general hospital seem to introduce additional complexity, for example, the need to understand holistic risk factors in order to implement treatment plans for co-occurring difficulties and to safely prescribe.

One of the most concerning findings from this study was that people diagnosed with a ‘personality disorder’ were routinely over and under medicated in the general hospital. People diagnosed with a ‘personality disorder’ reported considerable setbacks following abrupt discontinuation of psychotropic medicines in a companion study (Sharda et al., 2021). Although, people with a range of mental health problems may be considered ‘somebody else’s business’ in this setting (Foye, Simpson, & Reynolds, 2020), psychotropic drugs have been regularly prescribed to people with a diagnosis of ‘personality disorder’ ‘off licence’ (Sugarman, Mitchell, Frogley, Dickens, & Picchioni, 2013) and particularly careful negotiation with the general hospital may be required.

The findings of this study suggested strong working relationships were necessary to overcome discrimination and inspire safer practices. Similarly, an extensive qualitative study, of the barriers and facilitators of integrated mental and physical healthcare (Keeble et al., 2019), identified that partnerships and working relationships were key to liaison work, across diverse types of liaison services. Keeble et al. (2019) explained that demonstrable competence and credible knowledge of both physical and mental health were pivotal to forming effective relationships with the general hospital. In this study clinicians at the consultant level recounted more success in working relationally.

A key issue, which emerges, is that the extent to which, practitioner level liaison nurses believed they could establish sufficient credibility to influence was varied. Clinical recommendations made by liaison nurses were sometimes ignored. An implication of this is that competency frameworks e.g. Eales, Wilson, and Waghorn (2014) may need to reflect the negotiation and influencing skills required of the liaison nursing role. However, what stands out is the potential inequality and lack of parity when service delivery is dependent on the influence of senior clinicians.

The role of mental health nurses in progressing the parity of esteem agenda, and reducing the mortality and morbidity risk of people with mental illness by tackling physical health has been well publicised (Suggett, Foster, Lakra, Steele, & Furness, 2021). However, there does not appear to have been the same focus on improving mental healthcare in physical health settings. The findings from this study indicated a substandard level of service was accepted because some clinicians did not consider themselves to be ‘mental health trained’.

Education and training have commonly been purported to be the solution to reducing discrimination against people diagnosed with a ‘personality disorder’ (Bodner et al., 2015; Clarke et al., 2014; Commons Treloar & Lewis, 2008; McGrath & Dowling, 2012). However, brief training sessions have been reported to have had very little impact on reducing discrimination against this group (Dickens et al., 2016). The prejudice and unconscious types of discrimination described in this study, might not be abated by education (Byrne & Tanesini, 2015).

Identikit teaching sessions around ‘personality disorder’ appear unlikely to reduce the anxiety, the professional conflict and the emotional ripple effect, attested to in this study. Known as emotional contagion, this unconscious phenomenon is not

unusual in circumstances in which there are strong responses, no emotional outlet, and a lack of structured support (Campling, 2015; Moylan, 1994). Instead of quick win efforts to raise awareness of 'personality disorder' there appears to be a more convincing case for facilitating reflection and feedback (Byrne & Tanesini, 2015; Wright, Haigh, & McKeown, 2007).

The recommended interpersonal approach accords with the strong influencing, diplomacy, and relationship building skills described by liaison clinicians to surreptitiously break down defences and misperceptions and promote relationally based care. This study showed that liaison clinicians, particularly those at a more senior level, spent considerable time building confidence and attempting to contain anxiety. Time poor junior clinicians and security personnel may struggle to work relationally.

Clinicians working in mental health liaison appeared to require advanced interpersonal skills to enable them to work with individuals and whole teams, in conjunction with a considerable level of clinical and cultural competence. Although, there is momentum to deliver mental health liaison in every general hospital and to expand the liaison workforce, enabling the delivery of high quality NICE recommended care, twenty four

hours per day (NHS England; The National Collaborating Centre for Mental Health; and the National Institute for Health and Care Excellence, 2016), there should be additional focus on the workforce required to deliver on aspirations.

What this study adds to the existing evidence

Although 'personality disorder' is heavily contested and the legitimacy of the label is increasingly rejected (Johnstone, 2019; Koehne et al., 2013; Nicki, 2016; Wivescare, 2019), the related health inequalities remain (Wivescare, 2019). 'Personality disorder' is reported to be highly comorbid with physical illnesses (Quirk et al., 2015; Quirk et al., 2017; Yang et al., 2010) and people with a diagnosis of 'personality disorder' experience relatively worse physical health outcomes (Fok et al., 2014; Frankenburg & Zanarini, 2004; Powers & Oltmanns, 2012).

Hospital admissions across a range of specialities are reported to be three times higher in people diagnosed with a 'personality disorder' compared to the general population (Fok et al., 2019). Treatment in hospital might be complicated by mental health crisis or self- injury, diagnostic overshadowing and inverse diagnostic overshadowing (Sharda et al., 2021). While, to date, the literature on 'personality disorder' and the general hospital has primarily focused on emergency departments e.g. Cases et

al. (2020) and Vandyk et al. (2019) this research flags unjust and avoidable differences in the care and treatment of people with a diagnosis of ‘personality disorder’ on inpatient wards. Barriers to NHS care may increase the probability of developing further comorbidities (Public Health England, 2018; Reilly et al., 2015).

Limitations

A pragmatic approach to achieving a research sample of sufficient size and diversity had to be taken due to time and budgetary constraints. The mental health liaison clinicians who took part were relatively experienced clinicians, which benefitted the study. However, the views of less established liaison clinicians, had they been accessible, may have offered a different perspective. It may have been useful to interview general hospital clinicians. Unfortunately, only one midwife was willing to take part in an interview in a parallel study, and it was considered unethical to interview a single general hospital clinician. There is a need to conduct further research in this area.

Implications for practice.

Mental health liaison is a specialist area, requiring autonomy and skill. There is a need to recruit and retain experienced nurses who

have high level interpersonal skills, credible knowledge encompassing mental and physical health, and medicines, and the capability and influence to navigate competing priorities at the interface between general hospitals and mental health trusts. There appears to be a strong case for more advanced and consultant level nursing roles, in more mental health liaison teams.

RELEVANCE STATEMENT

This research highlighted the challenging role of the mental health liaison team in navigating the stress and strain of individuals and teams to improve outcomes for people diagnosed with a ‘personality disorder’. Education is commonly proposed to improve care. However, it is argued that partnership working, ongoing feedback, and reflective practice are more likely to promote parity of esteem. The mandate to treat mental health equally and to the same standard demands clinical capability spanning mental and physical health, credibility, influence, and high level interpersonal skills to address the entrenched discrimination against people diagnosed with a ‘personality disorder’.

REFERENCES

Bodner, E., Cohen-Fridel, S., Mashiah, M., Segal, M., Grinshpoon, A., Fischel, T., & Iancu, I. (2015). The attitudes of psychiatric hospital staff toward hospitalization and treatment of patients with borderline personality disorder. *BMC Psychiatry, 15*(1), 2. doi:10.1186/s12888-014-0380-y

Byrne, A., & Tanesini, A. (2015). Instilling new habits: addressing implicit bias in healthcare professionals. *Adv Health Sci Educ Theory Pract, 20*(5), 1255-1262. doi:10.1007/s10459-015-9600-6

Campling, P. (2015). Reforming the culture of healthcare: the case for intelligent kindness. *BJPsych bulletin, 39*(1), 1-5. doi:10.1192/pb.bp.114.047449

Care Quality Commission. (2020). *How are people's mental health needs met in acute hospitals, and how can this be improved?* Retrieved from England:

Cases, C., Lafont Rapnouil, S., Gallini, A., Arbus, C., & Salles, J. (2020). Evidence of practice gaps in emergency psychiatric care for borderline personality disorder: how can this be explained? *BMC Psychiatry, 20*(1), 476. doi:10.1186/s12888-020-02892-7

Clarke, D., Usick, R., Sanderson, A., Giles-Smith, L., & Baker, J. (2014). Emergency department staff attitudes towards mental health consumers: A literature review and thematic content analysis. *International Journal of Mental Health Nursing, 23*(3), 273-284. doi:10.1111/inm.12040

Commons Treloar, A. J., & Lewis, A. J. (2008). Professional attitudes towards deliberate self-harm in patients with borderline personality disorder. *Australasian Psychiatry, 42*(7), 578-584. doi:10.1080/00048670802119796

Creswell, J. W., & Plano - Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed.). Los Angeles, London, New Delhi, Singapore, Washington DC,: Sage.

Department of Health and Social Care. (2015). NHS Constitution for England. Retrieved from https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england#patients-and-the-public-your-rights-and-the-nhs-pledges-to-you

Dickens, G. L., Lamont, E., & Gray, S. (2016). Mental health nurses' attitudes, behaviour, experience and knowledge regarding adults with a diagnosis of borderline personality disorder: systematic, integrative literature review. *Journal of Clinical Nursing, 25*(13-14), 1848-1875. doi:10.1111/jocn.13202

Eales, S., Wilson, N., & Waghorn, J. (2014). *A competence framework for liaison mental health nursing*. London Liaison Mental Health Nurses' Special Interest Group. UK. Retrieved from

http://eprints.bournemouth.ac.uk/21701/1/A%20Competence%20Framework%20for%20Liaison%20Mental%20Health%20Nursing%202014.pdf

Firth, J., Siddiqi, N., Koyanagi, A., Siskind, D., Rosenbaum, S., Galletly, C., . . . Stubbs, B. (2019). The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness. *The Lancet Psychiatry, 6*(8), 675-712. doi:10.1016/S2215-0366(19)30132-4

Fok, M., Chang, C.-K., Broadbent, M., Stewart, R., & Moran, P. (2019). General hospital admission rates in people diagnosed with personality disorder. *Acta Psychiatrica Scandinavica, 139*(3), 248-255. doi:10.1111/acps.13004

Fok, M., Hotopf, M., Stewart, R., Hatch, S., Hayes, R., & Moran, P. (2014). Personality disorder and self-rated health: a population-based cross-sectional survey. *J Pers Disord, 28*(3), 319-333. doi:10.1521/pedi_2013_27_119

Foye, U., Simpson, A., & Reynolds, L. (2020). “Somebody else’s business”: The challenge of caring for patients with mental health problems on medical and surgical wards. *Journal of psychiatric and mental health nursing, 27*(4), 406-416. doi:https://doi.org/10.1111/jpm.12596

Frankenburg, F. R., & Zanarini, M. C. (2004). The association between borderline personality disorder and chronic medical illnesses, poor health-related lifestyle choices, and costly forms of health care utilization. *Journal of Clinical Psychiatry, 65*(12), 1660-1665.

Furber, C. (2010). Framework analysis: a method for analysing qualitative data. *African Journal of Midwifery and Women's Health, 4*(2), 97-100. doi:10.12968/ajmw.2010.4.2.47612

HM Government. (2011). No health without mental health. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/138253/dh_124058.pdf

Johnstone, L. (2019). Do you still need your psychiatric diagnosis? Critiques and alternatives. In J. Watson (Ed.), *Drop the disorder*. UK: Sage.

Kaplan, M. L. (1983). A woman's view of DSM-III. *American Psychologist, 38*(7), 786-792. doi:10.1037/0003-066X.38.7.786

Keeble, J., Walker, A., Guthrie, E., Trigwell, P., Quirk, A., Hewison, J., . . . House, A. (2019). Integrated liaison psychiatry services in England: a qualitative study of the views of liaison practitioners and acute hospital staffs from four distinctly different kinds of liaison service. *BMC Health Services Research, 19*(1), 522. doi:10.1186/s12913-019-4356-y

King, G. (2014). Staff attitudes towards people with borderline personality disorder. *Mental Health Practice, 17*(5), 30-34. doi:10.7748/mhp2014.02.17.5.30.e803

Koehne, K., Hamilton, B., Sands, N., & Humphreys, C. (2013). Working around a contested diagnosis: borderline personality

disorder in adolescence. *Health (London), 17*(1), 37-56. doi:10.1177/1363459312447253

Lalor, J. G., Casey, D., Elliott, N., Coyne, I., Comiskey, C., Higgins, A., . . . Begley, C. (2013). Using case study within a sequential explanatory design to evaluate the impact of specialist and advanced practice roles on clinical outcomes: the SCAPE study. *BMC Medical Research Methodology, 13*(1), 55. doi:10.1186/1471-2288-13-55

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Newbury Park: Sage Publications.

McGrath, B., & Dowling, M. (2012). Exploring registered psychiatric nurses responses towards service users with a diagnosis of borderline personality disorder. *Nursing Research and Practice, 2012*, 10. doi:10.1155/2012/601918

Mental Capacity Act. (2005). Code of practice. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Mental Health Act. (2007). Retrieved from https://www.legislation.gov.uk/ukpga/2007/12/contents

Moore, E. (2012). Personality disorder: its impact on staff and the role of supervision. *Advances in Psychiatric Treatment, 18*(1), 44-55. doi:10.1192/apt.bp.107.004754

Moylan, D. (1994). The dangers of contagion: projective identification processes in institutions. In A. Obholzer & V. Z. Roberts (Eds.), *The unconscious at work. Individual and organisational stress in the human services*.

NCEPOD. (2017). Treat as one: Bridging the gap between mental health and physical healthcare in general hospitals. Retrieved from https://www.ncepod.org.uk/2017mhgh.html

NHS. (2022). Commissioning. Retrieved from https://www.england.nhs.uk/commissioning/

NHS England; The National Collaborating Centre for Mental Health; and the National Institute for Health and Care Excellence. (2016). *Achieving better access 24/7 urgent and emergency mental health care*. Retrieved from England:

Nicki, A. (2016). Borderline personality disorder, discrimination, and survivors of chronic childhood trauma *International Journal of Feminist Approaches to Bioethics, 9*(1), 218-245.

Nursing & Midwifery Council. (2018). Future nurse: standards of proficiency for registered nurses. In. UK: NMC.

O' Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research. *Academic Medicine, 89*(9), 1245-1251.

Powers, A. D., & Oltmanns, T. F. (2012). Personality disorders and physical health: A longitudinal examination of physical functioning, healthcare utilization, and health-related behaviors in middle-aged adults. *Journal of personality disorders, 26*(4), 524-538. doi:10.1521/pedi.2012.26.4.524

Public Health England. (2018). Severe mental illness (SMI) and physical health inequalities: briefing. Retrieved from

https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing#smi-prevalence

Quirk, S. E., El-Gabalawy, R., Brennan, S. L., Bolton, J. M., Sareen, J., Berk, M., . . . Williams, L. J. (2015). Personality disorders and physical comorbidities in adults from the United States: data from the National Epidemiologic Survey on Alcohol and Related Conditions. *Social Psychiatry and Psychiatric Epidemiology, 50*(5), 807-820. doi:10.1007/s00127-014-0974-1

Quirk, S. E., Stuart, A. L., Berk, M., Pasco, J. A., Brennan Olsen, S. L., Koivumaa-Honkanen, H., . . . Williams, L. J. (2017). Personality disorder is an excess risk factor for physical multimorbidity among women with mental state disorders. *Psychiatry research, 257*, 546-549. doi:10.1016/j.psychres.2017.08.010

Reeves, E., Henshall, C., Hutchinson, M., & Jackson, D. (2018). Safety of service users with severe mental illness receiving inpatient care on medical and surgical wards: A systematic review. *Int J Ment Health Nurs, 27*(1), 46-60. doi:10.1111/inm.12426

Reilly, S., Olier, I., Planner, C., Doran, T., Reeves, D., Ashcroft, D. M., . . . Kontopantelis, E. (2015). Inequalities in physical comorbidity: a longitudinal comparative cohort study of people with severe mental illness in the UK. *BMJ Open, 5*(12), e009010. doi:10.1136/bmjopen-2015-009010

Sanatinia, R., Middleton, S. M., Lin, T., Dale, O., & Crawford, M. J. (2015). Quality of physical health care among patients with personality disorder. *Personality and Mental Health, 9*(4), 319-329. doi:10.1002/pmh.1303

Sharda, L., Baker, J., & Cahill, J. (2021). A mixed methods study of the healthcare received by patients diagnosed with a personality disorder on acute general hospital wards. *J Adv Nurs, 77*(4), 2002-2011. doi:10.1111/jan.14797

Spencer, L., Ritchie, J., Ormston, R., O'Connor, W., & Barnard, M. (2014). Analysis principles and processes. In J. A. Ritchie, J. Lewis, C. McNaughton Nicholls, & R. Ormston (Eds.), *Qualitative research practice: a guide for social science students and researchers* (2nd ed.). Los Angeles, London, California, New Delhi, Singapore: Sage.

Sugarman, P., Mitchell, A., Frogley, C., Dickens, G. L., & Picchioni, M. (2013). Off-licence prescribing and regulation in psychiatry: current challenges require a new model of governance. *Ther Adv Psychopharmacol, 3*(4), 233-243. doi:10.1177/2045125312472530

Suggett, J., Foster, K., Lakra, V., Steele, M., & Furness, T. (2021). Natural cause mortality of mental health consumers: A 10-year retrospective cohort study. *Int J Ment Health Nurs, 30*(2), 390-400. doi:10.1111/inm.12797

Vandyk, A., Bentz, A., Bissonette, S., & Cater, C. (2019). Why go to the emergency department? Perspectives from persons with borderline personality disorder. *International Journal of*

Mental Health Nursing, 28(3), 757-765. doi:https://doi.org/10.1111/inm.12580

Volkert, J., Gablonski, T. C., & Rabung, S. (2018). Prevalence of personality disorders in the general adult population in Western countries: systematic review and meta-analysis. *The British Journal of Psychiatry, 213*(6), 709-715. doi:10.1192/bjp.2018.202

Wivescare, S. (2019). Beyond the borderline. *The Lancet Psychiatry, 6*(3), 187. doi:10.1016/S2215-0366(19)30051-3

Wright, K., Haigh, K., & McKeown, M. (2007). Reclaiming the humanity in personality disorder. *International Journal of Mental Health Nursing, 16*(4), 236-246. doi:10.1111/j.1447-0349.2007.00480.x

Yang, M., Coid, J. W., & Tyrer, P. (2010). Personality pathology recorded by severity: national survey. *The British Journal of Psychiatry, 197*(3), 193-199. doi:10.1192/bjp.bp.110.078956