'Somebody else's business': The challenge of caring for patients with mental health problems on medical and surgical wards

Abstract:

Introduction: Evidence shows that patients with mental health problems have poorer physical health outcomes, increased mortality and experience poorer care during surgery and medical admissions. Issues related to lack of training, stigmatising attitudes, fear or hopelessness may help understand these poor outcomes.

Aim: To explore the experiences of staff in providing care for people with mental health problems.

Method: A qualitative service evaluation approach was used. Participants working in an acute care hospital in inner city London were recruited across professions and job levels using a self-selection sampling method. A total of thirty participants took part in semi-structured interviews (n=17) and two focus groups (n=13), and data were thematically analysed. Relevant organisational documents and service use data was utilised to inform the evaluation.

Results: Key themes were organised across the macro, meso and micro levels to understand the levels of disconnection and silence around mental health in acute care. Themes include systemic factors surrounding the institutional culture, ward cultures and collaborative working, and individuals' sense-making of mental health and personal well-being.

Implications for Practice: These findings signpost the growing need for greater mental health nursing input on medical and surgical wards and within these teams to provide informed knowledge, support and supervision.

Accessible Summary

What is known on the subject? People with mental health problems have higher rates of physical health concerns and hospital admissions than those without mental health problems. These patients have poorer outcomes from surgery and have worse experiences of care when admitted for medical or surgical procedures.

What the paper adds to existing knowledge? This paper looks to understand why care may be poorer for patients with mental health problems by speaking to staff providing care in these settings. We spoke to 30 general hospital staff about mental health on the wards and found that a lack of leadership and ownership for prioritising mental health led to people not seeing it as their job, and that it was somebody else's business to manage that side of care. We also found that the emotional effect of caring for people who had attempted suicide or had self-harm injuries was difficult for staff, impacting on staff well-being and leading them to distance themselves from providing care in those cases.

What are the implications for practice? There is a need for staff to be supported from the top-down, with management providing clear leadership around issues and pathways for mental health needs so they know the best way to provide care and encourage collaborative working. In addition, bottom-up support is needed to help staff personally manage their own well-being and mental health, including supervision and debriefing from mental health specialists to improve understanding from the patient's perspective and to provide emotional support to manage difficulties.

Relevance Statement: This paper places focus on the care of patients with mental health problems in medical and surgical care settings highlighting the interplay between mental and physical health from

a perspective that is less often explored. This paper provides insights into the multidisciplinary nature of nursing and the need for integrated care. This provides findings that build a picture of how mental health nursing specialism is needed beyond psychiatric wards and within medical and surgical settings.

Introduction

There is a growing recognition that people with mental health problems experience higher rates of physical illnesses than the general population (*Reeves Henshall, Hutchinson & Jackson, 2018; Sprahl, Dernovsekm, Wahlbeck & Haaramo, 2017*). Those with severe mental illness (SMI) have significantly higher rates of chronic long-term conditions, including respiratory disease (*Burke, Hay, Chadwick, Siskind & Sheridan, 2018*), kidney disease (*Iwagami et al., 2018*) and diabetes (*Vancampfort et al., 2016*). While this has been recognised within healthcare policy and research, there remain significant inequalities with estimates suggesting a 15 to 20-year mortality gap between those with mental health problems and the general population (*Ashworth, Schofield & Das-Munshi, 2017*). Many reasons have been cited as increasing the risk of poor physical health for patients with mental health problems including lifestyle behaviours, side effects of medication and diagnostic overshadowing (*Reeves et al., 2018*).

Compared to the wider population, people with mental health problems also face difficulties accessing treatment for physical health, resulting in three times the utilisation of hospital treatment (*Hansen, Lambert & Forman, 2002*). Consequently, it is more likely that they will be admitted to acute care as an emergency via ambulance rather than receive planned care (*Reeves et al, 2018*). Additionally, rates of readmission to acute, medical and surgical care are higher for patients with mental health problems (*Hanrahan, Bressi, Marcus & Solomon, 2016*). Patients with mental health problems also have significantly longer rates of stay during non-psychiatric hospital admissions in comparison to the general population (*Buller, Best, Klina & Barsoum, 2015; Prina et al., 2015*).

It is understood that while patients with psychiatric conditions make up an estimated four per cent of patients on acute care wards, they require a disproportionate amount of resources such as additional medication, additional staff time or other interventions (*Kabbabiran et al., 2008*). In circumstances where workload is reduced and staffing levels are improved, care for patients with mental health needs is improved, with lower mortality and reduced length of stays being reported as a result (*Kutney-Lee & Aiken, 2008*).

Beyond resource implications, nurses' experiences of caring for patients with mental health problems in acute settings has an emotional impact that can affect the attitudes staff have towards patients, and thus the care provided to those patients (*Brunero, Ramjan, Salamonson & Nicholls, 2018).* For example, caring for patients who have attempted suicide are associated with increased burnout, increased stress and fear, as well as feelings of hopelessness and guilt amongst staff (*Hagen, Knizek & Hjelmeland, 2017*). Lack of professional and work satisfaction has been linked to this sense of hopelessness that staff can face when caring for patients with mental health problems and may mitigate sustaining physical health gains achieved in the hospital (*Zolnierek & Clingerman, 2012*). These individual aspects have a real-life impact, with findings suggesting that patients with mental illness may receive differential care from general hospital staff and that stigmatising attitudes among professionals may influence care practices (*Hildebrandt & Marcolan, 2016; Minas, Zamzam, Midin & Cohen, 2011*).

A mediating factor within this discussion has been the level of training that general hospital staff receive in relation to mental health problems. With forty-two per cent of staff working in UK medical and surgical settings reporting that they have never had any training in relation to mental health (*Mind, 2016*), it is unsurprising that nurses experience a lack of knowledge and skills to support their ability to manage the comorbid needs of patients (*Alexander, Ellis & Barrett, 2016*). As a result, 82 per cent of nursing staff have reported feeling ill-equipped for this challenge (*Mind, 2016*). Similar trends exist for medical doctors with many believing that they have inadequate knowledge of mental health to ensure appropriate diagnosis and care, particularly with older patients (*Griffiths, Knight, Harwood & Gladman, 2014*). Such low levels of training and knowledge have a very real impact on both the staff member and patient. Staff report feeling a lack of confidence related to caring for patients with mental health needs (*Zolnierek, 2009; Ross & Goldner, 2009*) as well as fear in caring for these patients, particularly in younger staff who have limited experience in practice (*Ihalainen-Tamlander, Valahiemi, Loyttyniemi, Souminen & Valimaki, 2016*). The result on patients' care may be that needs related to mental or physical health care may be overlooked or that staff may fail to recognise and act on such needs (*Ewart, Bocking, Happell, Platania-Plung & Stanton, 2016*). While the educational preparation of nurses varies internationally, there is evidence to suggest that even where nurses receive a 'generic' nursing education, incorporating mental health, that graduates lack the specialist skills and knowledge to meet the mental health needs of patients in acute settings (*Moxham et al 2011*).

In England, recent guidance and policy aims to address such inequalities (*NHS England, 2016; Naylor et al., 2016*), but it is important to investigate such issues from the perspective of staff on medical and surgical wards to ensure that we fully understand the complexity of the issues.

1.1. Aim

This paper aims to explore the experiences of staff in providing care for people with mental health problems.

Study Questions

- What challenges are faced by staff caring for patients with mental health needs on medical and/or surgical wards?

2. Methodology

2.1. Design

This paper is a report of a service evaluation that was undertaken as part of a wider service improvement project developed as a response to the reported challenges encountered by staff and the desire to develop a greater understanding of how these challenges are managed across the organisation. This service evaluation acts as the first step to informing wider quality improvement needs to understand what the challenges that can help to later inform an intervention. To achieve this, an exploratory approach utilising qualitative methods was employed. Without a precedent established by research, qualitative research is needed to develop a rich and comprehensive appreciation of beliefs and experiences (*Strauss & Corbin, 1998*). This information was commissioned to generate theories on factors influencing the care of patients in general hospitals that could be used by the local health service for planning and quality improvement and to inform further research. To achieve this, we conducted a range of qualitative interviews and focus groups with staff across a range of medical and surgical wards and teams within the general hospital and conducted a document review of policies, statistics and guidelines surrounding the topic of mental health within the Trust.

2.2. Ethics

In accordance with Health Research Authority (HRA) guidelines (*2013*), the study was a service evaluation and formal ethical review was not required. This was confirmed by the University Proportionate Review Committee (Ref: ETH1819-0614). Approval was provided by the host organisation to undertake the evaluation and to publish these findings, which have been presented as part of an internal report and presentations to senior managers and staff.

The study team provided all participants with an information sheet detailing the project, providing information related to why the study was happening, aspects of confidentiality (and their limits), and what will happen with the data, including publication of anonymised quotes. It was clearly stated that any immediate concerns for the safety or wellbeing of patients or others would be discussed with relevant service managers. Staff could decline to take part or withdraw at any stage.

2.3. Setting

This study took place in a large inner-city hospital in England defined as a major trauma centre, consisting of over 800 beds and over 100 surgical and medical wards. The hospital serves a diverse population of over 300,000. Mental health services for this hospital were provided by an outsourced mental health liaison team commissioned from the associated local mental health service provider.

2.4. Participants

A total of thirty participants took part in the qualitative interviews and focus groups conducted during the study. The majority worked on acute wards for a single hospital site (n=26, 87%) while a subset of participants worked for mental health services commissioned to work at this site (n=4, 13%). Participants were recruited across a wide range of professions and job levels including doctors (n=1), matrons (n=3), ward managers (n=3), staff nurses (n=6), healthcare assistants or support workers (n=2), psychologists (n=1), mental health staff (n=4) and allied health professionals, e.g. physiotherapists and occupational therapists (n=10). While recruitment was focused on four wards selected due to their high rates of enhanced care requirements, many participants reported experience of working on additional wards in the hospital or working across all wards as part of their role.

2.5. Interviews & Focus groups

A total of seventeen one-to-one interviews took place with participants across a range of ward settings and job type. Due to time constraints facing staff, two wards requested that the interviews were conducted as focus groups to lessen the time that staff were required off the ward. As a result, two focus groups were conducted, one consisting of three participants and one with ten participants.

A semi-structured interview schedule was developed by the study team to cover three key areas related to firstly participants' experience of caring for patients with mental health problems, secondly the key issues that have been experienced or observed when caring for this patient group, and lastly what outcomes and changes would participants like to see made in this area. These key areas were identified following discussions with the Director of Nursing to identify why the service evaluation was

required. This schedule of questions was used by the researcher conducting the interviews or focus groups to direct the participants towards the key research questions, employing a flexible approach to allow a more conversational tone, providing a safe space for participants with the opportunity to extend their answers and pursue any particular areas of interest.

2.5.1. Sampling and Recruitment

The sampling method used for this study was a non-probability, self-selecting approach (*Bryman, 2004*). By allowing for self-selection, this method allowed for recruitment to focus on understanding the experiences of staff who have had contact with patients with mental health problems. In addition, this method was selected for time-management purposes to help reduce the burden that this study may place on the wards' resources (e.g. time and staffing levels).

To allow the study to effectively map the processes and experiences related to the care of people with mental health difficulties on acute wards, participants were recruited from wards that experienced higher admission rates of patients with mental health problems. These wards, focused on trauma, gastroenterology and critical care, were identified by senior management based on their understanding of the challenges faced by staff and rates of enhanced care provided by registered mental health nurses (MHNs). A member of the research team conducted interviews with key ward staff on four wards identified and used a snowball sampling method to recruit further staff on these wards, and on additional wards and across staff at varying levels. Recruitment was closed when all staff who had self-selected had been interviewed. Attention was placed on ensuring recruitment occurred on all identified wards.

2.5.2. Procedure for interviews and focus groups

The Director of Nursing for the Trust, who was responsible for leading the commissioning of this service evaluation, made initial contact with the ward managers and matrons across services to inform them about the work being conducted and provided contact details of wards and service managers to the team. Following the granting of permission, contact was sought with key managers and supervisory staff in each ward for a member of the evaluation team to gain access to the ward to provide additional details on the process and to contact the wider staff team.

Information sheets were circulated to staff working on key wards by email and as paper copies via ward managers and in team meetings. Staff self-selected to participate in the study by contacting the researcher directly via email to arrange interviews, or directly with the researcher when they attended

wards to circulate information sheets and provide additional details in person. Participants were then invited to take part in a semi-structured interview at a time and date that was convenient to them, within a private office located on their ward to ensure confidentiality could be maintained. Interviews were scheduled to take one hour with an additional fifteen minutes allocated before and after to gather consent and allow participants to have any questions answered. Where staff identified time constraints related to staffing or resources, a focus group method was offered to aid engagement in the project. Two wards identified their desire to use focus groups rather than one-to-one interviews. These groups were conducted using the same approach as the one-to-one interviews, taking place in a private office on the ward and were scheduled to take place across a two hour period to allow time for each participant to have time to ask questions and have a chance to share their experiences. All interviews and focus groups were audio-recorded and transcribed by a member of the research team for analysis. Participation was voluntary and participants were free to withdraw at any time during or after the data collection.

2.6. Document Review

To provide context to the interview and focus group data, the team conducted a document review of all salient policies and guidelines developed and used by the local Trust. We also utilised descriptive statistics and data supplied through personal communications from the local Trust to provide a framing for the study and interview data. These included local enhanced care policies, local mental health pathways, and descriptive data relating to delayed transfers of care (DTOC), referrals to the mental health liaison Rapid Assessment Interface and Discharge service (RAID) and use of enhanced care nursing shift numbers and associated costs. Data presented within this paper will focus on documents and descriptive statistics associated with enhanced care provision.

2.7. Analysis

Thematic analysis was used to analyse the qualitative data collected following the thematic analysis phases outlined by Braun and Clarke (*2006*). Initially, we familiarized ourselves with the data. Guided by the overarching study aim to explore the experiences of staff in providing physical health care for people with mental health problems, a member of the team read over the transcripts and then re-read them, noting aspects of interest. Following this a list of codes were generated. Codes were defined as a single idea associated with a segment of data, identifying what is of interest in the data (*Braun & Clarke, 2009*). We used Nvivo12 (*QSR 2018*) to record the extracted chunks of data and associated codes. Following initial coding, related codes were sorted, grouped, and labelled as preliminary themes, defined as the central concepts that capture and summarise the core point of a

coherent and meaningful pattern in the data (*Braun & Clark, 2006*). Themes were checked and discussed with other members of the team (AS, LR) to ensure they were capturing something significant or noteworthy in the data related to nurses' experiences, determined by prevalence in the data or whether it captured an important aspect relative to the research goal (Braun & Clark, 2006). To check for quality, the themes were re-reviewed as a group in relation to the coded data and to discuss the entire dataset. To ensure the analysis was robust and credible, we used independent analysis by more than one researcher, and verbatim quotations. In the analysis presented within this paper, we will use general descriptors of frequency around a theme or meaning. Extracts of data illustrate each of them and key analytic points.

3. Findings

Following Bronfenbrenner's (1979) ecological theory, key themes were organised across the three levels of the macro, meso and micro systems to provide a framework to help understand the complexity and interconnectivity of the issue being explored and to allow an understanding of the research questions from the systematic/ organisational perspective, local on the ground perspective, and the individual perspective. These are outlined in figure one.

[insert Fig 1 here]

3.1. Macro level

3.1.1. Enhanced mental health nursing care

At the time of data collection, figures reflected increased numbers of patients with mental health problems presenting on acute medical and surgical wards. Additional mental health care was provided by Mental Health Nurses (MHNs, termed by some staff as RMNs), who were employed as agency or bank staff to provide 'enhanced care observation' (*NICE, 2015*). Growing demands were reflected in the increased "RMN" shifts reported between October 2017 and October 2018 with an average of 387 shifts recorded per month, with an increase of 113% in one month. In total, the cost of this enhanced care between 2017/18 and 2018/19 increased by 43.16%. This demonstrates the increased levels of demand being faced on wards and was the best indicator for this increasing resource demand. While higher rates of diabetes and cardiac problem reported in mental health populations (*Reeves et al, 2018; Vancampfort et al., 2016)* may suggest that renal or cardiac wards would require higher enhanced care required, it was observed that these wards were using less enhanced care while wards such as trauma and orthopaedic surgery had a higher reported level of enhanced care. This was thought to be due to the nature of injuries and illnesses observed within this patient group, e.g. higher rates of patients admitted as a result of serious self-harm or suicide attempts.

3.1.2. Leadership

A perceived lack of visible leadership was identified as a key issue when tackling the topic of mental health in general hospital wards. Staff reported a lack of guidance and support from management in relation to the management of patients with mental illness. The lack of a mental health manager to lead this work was viewed by staff as a reason why improvements in the care for the mental health needs of patients were not happening, and that momentum and motivation to tackle this issue was low on the agenda;

> *"We don't have a mental health lead here as far as I know… the issues keep plugging along. [Mental Health] is supposed to be run by particular people but isn't really happening." [Ward manager]*

It was highlighted that there appeared to be a sense of disconnection from the leading ward staff and the topic of mental health; that it was not something staff saw the ward managers taking seriously or visibly backing as an issue to address;

> *"The leadership also need training in mental health I think, when I have done Mental Health Act stuff you don't get the ward managers and sisters, they send their juniors along." [Mental health liaison team member]*

Some staff with training or experience working with mental health problems reported that they felt that mental health issues were either invisible to general ward staff or it was not seen as part of their job. These factors led to staff becoming disconnected from engaging with patients who presented with a mental health problem. Within these discussions, participants felt that the introduction of people in higher leadership positions championing mental health would help elevate these issues and help move the hospital culture towards taking this issue seriously.

3.1.3. Institutional Culture and Power

Many participants felt that the focus of management was on targets placed on wards as a result of payment systems and regulatory bodies such as the Care Quality Commission (CQC), rather than on a values-based system of care. This was felt to create a culture in which data were central. As a result, nursing staff reported feeling that there was a '*blame culture'* around mental health regarding serious incidents, such as patients absconding from the ward. A key driver for change was felt to lie in response to SIs, and within these responses staff were often held responsible. Staff felt caught

between being blamed for patients absconding and being in a position where they were legally unable to act to detain a patient;

> *"We have no power… our nurses end up putting themselves at risk, sometimes physical risk if the patient kicks off but we have good security support but they put themselves at risk of restraining or holding a patient when they have no legal holding to do so. There is little we can say if there is legal action. We have their best interest in mind but still we don't have the legal backing to do what we are doing at that time and that is a huge issue." [Ward Manager]*

This was seen to lead to general ward staff feeling they were in a position of powerlessness. Staff felt they had grown reliant on the externally provided mental health liaison team and their schedules. Ward managers suggested that efforts to empower staff to manage these issues themselves and to build staff confidence were likely to be more helpful than continuing this dependence. Staff felt that to achieve this, management needed to facilitate change and ensure that systems were put into place to help build staff skills and empower them to manage mental health-related issues on the ward.

> *"I think permanent staff and people we invest in then relationships can grow and then you train up this amazing RMN and other people will watch like ward staff, watch what they do and then filter out and they will learn more skills and think oh she is running down the corridor with no clothes on and this is how I can manage them, but at the moment its reliance on RAID." [Matron]*

3.2. Meso level

3.2.1. Ward culture

It was reflected that to care for patients with mental health problems on medical wards, there was a degree of collaborative working and a multidisciplinary approach required. Ward staff were required to work with the psychiatric liaison team, who were employed by a neighbouring NHS Trust, and with the 'enhanced care' bank/agency mental health nurses. However, collaborative working often did not take place, partly because of a lack of clarity regarding pathways and the different roles involved.

> *"We don't work collaboratively and it's just we get them medically cleared and that's it." [Ward Nurse]*

This limited collaboration across staff working on the acute wards and mental health services was felt to lead to a sense of 'othering' or distancing from patients with mental health presentations, alongside a feeling of disempowerment in managing difficult situations that arose when patients with mental health problems were on the wards.

3.2.2. "It's not part of my job"

For many staff working with patients with mental health problems, it was not something they were prepared for and not something they wanted within their role, *"not to this extent".* The skills needed to manage mental health needs were something that wasn't felt to be part of the general nurse role, causing a conflict when they were expected to manage this additional aspect of care. Staff "*went along"* with the needs of mental health patients but did so with resistance or referred straight to mental health services to manage.

> *"I deal with anything from the neck down but from there up is your department." [Ward nurse]*

This led to the reasoning that mental health "*isn't my job*". This was demonstrated in the opinion expressed that physical health was the focus of the acute staff role while anything else is the mental health nurses' job. Staff related this to experiencing more anxiety or fear in relation to dealing with mental health problems, which resulted in avoidance of and disengagement from patients and being more risk adverse. This was exemplified in the making of unsuitable referrals to the psychiatric liaison team, including referrals for human factors such as patients expressing emotions;

> *"A nurse wanted to refer someone who was crying at night… this guy is in a horrible situation, but I think people are deskilled in some ways or if they ever had the skill. I don't think [adult] nurse training covers that much. And a lot of people resist the idea of having mental health in general nursing training." [RAID Nurse]*

3.2.3. Institutional Memory

The memory of patients with mental health problems on the ward that had posed serious challenges vastly shaped the perception of mental health within staff. This was observed across the hospital with the same two very challenging examples of mental health patients being cited on every ward during interviews (e.g. one experience of a patient engaging in repeated self-harm on the various wards and one patient who was very distressed following a traumatic and severe suicide attempt) . This memory of what mental illness looks like was very powerful, with these same two examples being cited across

professional roles and levels of staffing. While such experiences were rare and did not represent the majority of mental health patients receiving care on the wards, the powerful memory that linked mental illness with violence and aggression felt embedded on these wards.

"There has been a particular experience in the Trust and everyone is scared." [Doctor]

Staff reported limited formal support, debriefing or reflective practice following serious incidents such as attempted suicides on the wards and felt that it became something that **"***nobody talks about"* officially. Instead, we observed that these examples of serious incidents are informally discussed and shared within and between staff and wards. Such memories created fear in staff, prompting anxiety and nervousness when faced with potential "*challenging situations*" based on the perception that mental health patients are difficult and aggressive (due to the institutional examples embedded on the wards).

3.3. Micro level

3.3.1. Fear of 'Mental Health'

Many participants, across a range of professions, acknowledged their fear around working with mental illness, often referred to erroneously as 'mental health';

"Our medics are terrified of mental health… there is an anxiety and a nervousness that our acute physicians are terrified of it… you think 'I haven't a clue' so you have that anxiety because you think I can say the wrong thing and trigger something uncontrollable." [Senior Ward Manager]

This fear was particularly felt around the use of detentions or 'sectioning' as this was something that staff reported that they knew very little about, felt unable to learn, and were unable to control situations as a result. In contrast, some patients were aware of such legal issues and left staff feeling overwhelmed by the growing demand that mental health issues on wards had created and the resultant extension to the staff's role:

"[Patients] know the system and you will get patients quoting the Mental Health Act to my staff and they have us over a barrel because we don't know, we can't possibly learn it... they know what section they will be detained under and will learn it." [Matron]

Furthermore, staff reported disengaging from patients who were at high risk of self-harm or suicidal intent to avoid hearing upsetting disclosures and "telling me you want to kill yourself". The anxiety associated with hearing patients in mental distress was often amplified by the memories of previous incidents. The avoidance protected the staff from the fear and distress that such disclosures created and helped them maintain their own wellbeing.

> *"Fixing someone is very easy, you can do it in half an hour, but the other issues are different. Then you have the burden of the families as well, and the burden of the friends that they will show off to. Then you have the 2 o'clock cries and you think no I'm not your mother now." [Ward Nurse]*

3.3.2. Staff well-being

Facing a range of emotionally laden situations created a situation in which staff required various support systems in place to avoid burnout and a negative impact on their own mental health. Staff reported that they didn't feel there were protocols or services in place to ensure that within these situations staff were supported. Staff across wards suggested that "*what seriously needs looking at in this organisation is that knock on effect of our mental health to our staff*" [ward manager].

Staff related their reports of emotional heaviness to the considerable additional demands that caring for people with mental health problems on the ward created. Examples included having additional staff to manage (e.g. MHNs) and chasing-up referrals to mental health services, as well as managing potential risks such as self-harm. One participant referred to this environment as a 'pressure pot' of ever-growing demands. Staff were '*boiling over'* becoming overwhelmed. One member of staff said they would *"dread"* coming into work, while others talked about having panic attacks coming into work or would cry on the way home.

> *"I think please don't say the magic word you are going to kill yourself… just praying please don't say please don't say. It's so heavy. And then they are not here but you are constantly calling to check they are okay, are you okay, it's a personal burden because you know about it." [Ward Nurse]*

The impact of having to make sense of situations related to suicide was reported as having a very real impact on the staff's own well-being, an issue that was felt to be insufficiently contained or managed

within their professional role due to the limited support and supervision offered in these circumstances;

> *"I pay for my own therapy. Why do I have to pay £70 a week? 99.9% of what I talk about is work, why do I have to think of it out of work?" [Ward Nurse]*

4. Discussion

This study aimed to investigate the factors that may impact on the care of patients with mental health problems in acute medical and surgical wards. Key themes identified included macro-level systemic factors surrounding the institutional culture, meso-level ward cultures and collaborative working, and the micro-level of healthcare staff's sense-making of mental health and their personal well-being. This paper provides evidence that the role of frontline healthcare staff is evolving and demands greater focus on supporting staff to engage in mental health care, the development of a more supportive hospital and ward culture and greater emphasis on developing integrated care. Based on the findings reported within this paper it is evidence that Cartesian dualism remains a key challenge within healthcare (*Mehta, 2011*), with mental health problems being categorised as '*challenging'* and '*someone else's business'*, rather than as part of holistic care for the individual. This may be linked to the limited integration of these two areas of health at undergraduate level which develop our future nursing staff to be inadequate prepared to meet the needs of people with serious mental illness who also require acute general care, a need that is widely acknowledged within the field (*Reeves et al., 2018; Sprahl et al., 2017*). This directly defies the increased national and local drive towards parity of esteem for mental health and the increased policies to alleviate such dualism (*World Health Organization, 2018; Department of Health, 2011; World Health Organization, 2002*), therefore signifies the importance of understanding the underpinning factors that continue such cultures.

An overarching theme within the study was leadership and its impact on the overall culture of the hospital. There is a wealth of literature that links leadership to quality of care (*Thorne, Cox & Baker, 2019; Kline 2019*), with its importance exemplified as one of the five key questions explored during care quality inspections (*CQC, 2018*). The reported lack of leadership and guidance led to a culture of mental health problems being delegated to the psychiatric liaison team or additional agency mental health nurses expensively employed to provide 'enhanced care'. This devolution of care establishes a message and culture at ward level that mental health is 'someone else's business'. Additionally, the delegation of mental health care to other teams or staff not working as core members of the ward team, creates complicated care pathways, additional workload for ward staff and reinforces a belief

that patients' mental health needs can be seen as entirely separate to their physical health care. These findings support recommendations from the King's Fund (*Naylor et al., 2015*) regarding the need to support collaborative working between physical and mental health services.

In the UK, the requirements by the Nursing and Midwifery Council (*NMC 2018*) for the new pre-registration educational curricula have recognised the need for greater confidence in managing mental health difficulties amongst all nursing staff. Wider healthcare policy now recognises the need for addressing the complex health needs of our communities (NHS England, 2016). Our findings suggest that nursing staff working on wards with high rates of mental health needs would benefit from reflective practice, supervision and ongoing support following particularly challenging events but also in more routine day-to-day practice, as that is likely to help provide high quality holistic care as standard and reduce the likelihood of challenging events happening (*Driscoll et al 2019; Snowden et al 2019*).

Focusing on the individual level, it is important to understand the emotional cost that providing such care has for staff, whether in managing aggression as a result of psychosis or attending to patients who have attempted suicide or serious acts of self-harm. Attitudes expressed by some participants raise concern due to their stigmatising and unacceptable nature, however we feel that it is important that these comments must be considered within the structural context described above as well as placing these attitudes in line with the emotional burnout that were often paired with such attitudes. Such attitude appear across the literature, with studies having found that nurses providing such care may experience anger, frustration, and hopelessness, perceiving themselves to lack competence and confidence (*Doyle, Keogh & Morrissey, 2007; Gibb, Beautrais & Surgenor, 2010; Happell et al., 2012*). With a focus on the aftercare of patients who had attempted suicide, it has been found that staff are likely to disengage as a result and become more task-focused and tokenistic (*Barnfield, Cross & Mccauley, 2018*). This may reflect compassion fatigue resulting from providing such care with limited support and training. This distancing can be linked to the early work of Menzies Lyth (*1960*) in which this act was conceptualised as a defence mechanism to protect themselves from unresolved trauma and anxiety through 'splitting' or avoidance of contact with patients. Within this work staff indicated that without the appropriate support systems, it becomes easier to develop a 'busy walk' and distance themselves from potential distress as a coping mechanism. This has been seen within recent work in which patients have felt that the task-oriented nature of nursing in modern care leads to staff being 'too busy to talk', thus becoming inaccessible and distanced (*Terry & Coffey, 2019).* While there are indeed factors such as low staffing and resource cuts contributing to this sense of being too busy,

aspects of emotional labour and compassion fatigue are often reported within the literature where staff feel the need to distance themselves from others, withdrawing and shielding themselves from emotional connection with patients and families (*Nolte, Downing, Temane & Hastings-Tolsma, 2017; Hochschild, 1983*).

The findings from this study spark serious concerns in relation to the emotional impact that caring for patients who had engaged in violent suicide attempts has on the mental health and well-being of staff. The experiences of those interviewed for this study reflect the wider national picture in which levels of burnout in healthcare staff appears increasingly problematic, with increased levels of poor mental health and well-being as well as higher rates of depression being reported (*Dyrbye et al., 2017; Hall, Johnson, Watt, Tsipa & O'Connor, 2016*). This issue is likely to only increase with a recent UK survey of NHS trusts and foundation trusts reporting that 39.8% of staff had felt unwell in the past 12 months as a result of work-related stress—the worst result in five years (*Thornton, 2019*). Stress has been reported as one of the leading reasons that nurses are leaving nursing (*NMC, 2019).*

While issues of burnout link to managerial concerns of retention within an already pressed workforce, the findings reported by staff within this study highlight the costs to individuals' own mental health reflected in reported distress felt by staff as well as the alarming reports of suicidal feelings in staff directly linked to their work. Figures released by the Office of National Statistics reveal that nursing staff have high levels of suicide in comparison to other occupations (*ONS, 2017*), however a recent NHS staff survey revealed that less than a third (28.6%) said that their organisation took positive action on health and wellbeing, down from 31.8% in 2017, which the British Medical Association described as "worrying" (*Thornton, 2019*). Perhaps greater attention to the mental health of our staff may also help them be more understanding and empathic towards the mental health needs of their patients.

5. Limitations and future directions

While the study provides insight into the factors that may impact on the quality of care for patients with mental health problems on acute care wards, there are some limitations to consider. Primarily, this study was carried out in a single hospital, therefore the findings are limited to the contextual settings of these wards and this organisation. Furthermore, accounts of care were self-reported from a self-selecting participant group which may bias the perception of the data towards these voices. As such, this study only presents staff experiences and is limited in its understanding of the care patients receive.

Future research should consider exploring patients experiences of care in these settings to ensure that both sides of the experience are understood and reported within the literature. Methodologies such as participant observation and ethnographies of care for people with mental health problems in general hospital settings may provide an additional layer of understanding as to why these issues exist, how they are maintained, and how they play out in everyday hospital settings. We also need to start researching and testing potential solutions.

6. Recommendations for practice

Findings from this work signposts to the growing need for greater mental health nursing input on medical and surgical wards and as an integrated part of ward teams to provide specialised knowledge, support and supervision to help tackle the key issues outlined within this paper. There is a need for staff to be supported from the top-down, with management providing clear leadership around issues and pathways for mental health so staff know the best way to provide care and encourage collaborative working. In addition, bottom-up support is needed to help staff personally manage their own well-being and mental health, including supervision, debriefing and role modelling from mental health nurse specialists to improve understanding of the patients' perspective and to provide emotional support when managing difficulty situations. In our view, simply bolting-on staff training will be insufficient to bring about significant change.

Considering the increased challenges reported by staff when caring for patients with mental health problems, as well as appreciating the increased pressures on services and the increasing demand for enhanced mental health care on specific wards, it is clear that integrated approaches to physical and mental health cannot be delivered solely by specialists such as mental health nurses, liaison psychiatrists or clinical health psychologists but rather require collaborative approaches. The need for closer integration does not imply that staff need to become experts in the area of mental health but rather require support and resources to feel competent and confident in delivering care for this patient group.

7. Conclusion

The findings presented in this paper provide insight into the challenges that face staff on acute hospital wards when caring for patients with mental health problems. By understanding the issues faced by staff working on these wards and the factors that underpin these challenges, we are better equipped to work towards improving the quality of care provided to this group of vulnerable patients. Not only

do these issues have financial costs for the NHS but also come with a human cost. These findings suggest that there is a need to address the culture surrounding mental health within the institution as institutional memory around serious incidents has had an impact on how staff make sense of mental health problems on the wards as well as impacting on employees own mental health. Guidance and championing for more inclusive understanding of mental health through leadership around this topic may help support a more positive institutional culture.

References

- Alexander, V., Ellis, H. & Barrett, B. (2016). Medical-Surgical Nurses' Perceptions of Psychiatric Patients: A Review of the Literature with Clinical and Practice Applications. *Archives of Psychiatric Nursing, 30,* 262-270.
- Ashworth, M., Schofield, P. & Das-Munshi, J. (2017). Psychical health in severe mental illness. *The British Journal of General Practice, 67 (663),* 436-437.
- Barnfield, J., Cross, W. & McCauley, K. (2018). Therapeutic optimism and attitudes among medical and surgical nurses towards attempted suicide. *Int J Ment Health Nurs, 27 (6),* 1826-1833.
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77-101.
- Braun, V., & Clarke, V. (2009). Special Issue: Coming out in higher education. *Lesbian & Gay Psychology Review, 10*(1), 3-69.
- Bronfenbrenner, U. (1979). The ecology of human development: Experiments by nature and design. Cambridge, MA: Harvard University Press.
- Brunero, S., Ramjan,L.M., Salamonson, Y. & Nicholls, D. (2018). A constructivist grounded theory of generalist health professionals and their mental health work. *Int J Ment Health Nurs. 27 (6),* 1816-1825.
- Bryman, A. (2004). *Social research methods (2nd Ed)*. New York, NY: Oxford University Press.
- Buller, L. T., Best, M. J., Klika, A. K. & Barsoum, W. K. (2015). The influence of psychiatric comorbidity on perioperative outcomes following primary total hip and knee arthroplasty; a 17-year analysis of the National Hospital Discharge Survey database. *The Journal of Arthroplasty, 30,* 165-170.
- Burke, A.J., Hay, K., Chadwick, A., Siskind, D. & Sheridan, J. (2018). High rates of respiratory symptoms and airway disease in mental health inpatients in a tertiary centre. *International Medicine Journal, 48 (4),* 433-438.
- Department of Health (2011). *No health without mental health*. UK: Department of Health, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766 [Accessed 26/11/19].
- Doyle, L., Keogh, B. & Morrissey, J. (2007). Caring for patients with suicidal behaviour: an exploratory study. *Br J Nurs, 16 (19),* 1218-22.

- Driscoll J, Stacey G, Harrison-Dening K., Boyd, C. & Shaw, C]T. (2019) Enhancing the quality of clinical supervision in nursing practice. *Nursing Standard*. doi: 10.7748/ns.2019.e11228
- Dyrbye, L.N., Shanafelt, T.D., Sinsky, C.A., Cipriano, P.F., Bhatt, J., Ommaya, A., West, C.P. & Meyers, D. (2017). Burnout Among Health Care Professionals: A call to explore and address this underrecognized threat to safe, high-quality care. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC. https://nam.edu/burnout-among-health-careprofessionals-a-call-to-explore-and-address-this-underrecognized-threat-to-safe-high-quality-care. [Accessed 28/06/19].
- Ewart, S.B., Bocking, J., HJappell, B., Platania-Plung, C. & Stanton, R. (2016). Mental Health Consumer Experiences and Strategies When Seeking Physical Health Care: A Focus Group Study. *Global Qualitative Nursing Research, 3,* https://doi.org/10.1177/2333393616631679.
- Gibb, S.J., Beautrais, A.L. & Surgenor, L.J. (2010). Health-care staff attitudes towards self-harm patients. *Aust N Z J Psychiatry, 44 (8),* 713-20.
- Griffiths, A., Knight, A., Harwood, R & Gladman, J.R. (2014). Preparation to care for confused older patients in general hospitals: a study of UK health professionals. *Age Ageing, 43 (4),* 521-7.
- Hagen, J., Knizek, B.L. & Hjelmeland, H. (2017). Mental Health Nurses' Experiences of Caring for Suicidal Patients in Psychiatric Wards: An Emotional Endeavor. *Archives of Psychiatric Nursing, 31,* 31-37.
- Hall, L.H., Johnsom, J., Watt, I., Tsipa, A. & O'connor, D.B. (2016). Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review. *PLoS ONE,* 11(7): e0159015. doi:10.1371/journal. pone.0159015.
- Hanrahan, N.P., Bressi, S., Marcus, S.C. & Solomon, P. (2016). Examining the impact of comorbid serious mental illness on rehospitalization among medical and surgical inpatients. *General Hospital Psychiatry, 42,* 36-40.
- Hansen, N. B., Lambert, M. J., & Forman, E. M. (2002). The psychology dose-response effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice, 9,* 308-327.
- Happell, B., Dares, G., Russell, A., Cokell, S., Platania-Phung, C. & Gaskin, C.J. (2012). The relationship between attitudes toward seclusion and levels of burnout, staff satisfaction, and therapeutic optimism in a district health service. *Issues Ment Health Nurs, 33 (5),* 329-36.
- Health Research Authority (2013). Defining Research: NRES guidance to help you decide if your project requires review by a Research Ethics Committee. Available at: https://researchsupport.admin.ox.ac.uk/sites/default/files/researchsupport/documents/media/defining-research.pdf [Accessed: 11/11/19].
- Hildebrandt, L.M. & Marcolan, J.F. (2016). Conceptions of nursing staff about psychiatric care in general hospital. *Rev Rene, 17 (3),* 378-85.
- Hochschild, A. (1983). *The Managed Heart*. University of California Press, Berkeley.
- Ihalainen-Tamlander, N., Vahaniemi, A., Loyttyniemi, E., Suominen, T. & Valimaki, M. (2016). Stigmatizing attitudes in nurses towards people with mental illness: a cross-sectional study in primary settings in Finland. *J Psychiatr Ment Health Nurs, 23 (6-7),* 427-37.

- Iwagami, M., Mansfield, K.E., Hayes, J.F., Walters, K., Osborn, D.P., Smeeth, L., Nitsch, D. & Tomlinson, L.A. (2018). Severe mental illness and chronic kidney disease: a cross-sectional study in the United Kingdom. *Clinical epidemiology, 10*, 421-429.
- Kabbabiran, M., Deshpande, S., Walling, A., Alagarsamy, J., Protheroe, D. & Trigwell,P. (2008). Cross-sectional survey of disturbed behaviour in patients in general hospitals in Leeds. *Postgraduate Medical Journal,* 84, 428-431.
- Kline, R. (2019) Leadership in the NHS. *BMJ Leader*. Published Online First: 23rd September 2019. doi:10.1136/leader-2019-000159
- Kutney-Lee, A. & Aiken, L.H. (2008). Effect of nurse staffing and education on the outcomes of surgical patients with comorbid serious mental illness. *Psychiatr Serv, 59(12),* 1466-9.
- Markstrom, U., Gyllensten, A.L., Bejerholm, U., Bjorkman, T., Brunt, D., Hansson, L., Leufstadius, C., Sandlund, M., Svensson, B., Ostman, M. & Eklund, M. (2009). Attitudes towards mental illness among health care students at Swedish universities- a follow-up study after completed clinical placement. *Nurse Educ Today, 29 (6),* 660-5.
- Mehta N. (2011). Mind-body Dualism: A critique from a Health Perspective. *Mens Sana Monogr., 9,* 202–209.
- Menzies Lyth, I. (1960). Social systems as a defense against anxiety: An empirical study of the nursing service of a general hospital. In. E. Trist and H. Murray (eds.) The Social Engagement of Social Science Vol. 1: The Socio-Psychological Perspective. London: Free Association Books, pp. 439–462.
- Minas, H., Zamzam, R., Midin, M. & Cohen, A. (2011). Attitudes of Malaysian general hospital staff towards patients with mental illness and diabetes. *BMC Public Health, 11,* 317.
- Mind (2016). *Better equipped, better care: improving mental health training for GPs and practice nurses.* Available from: https://www.mind.org.uk/media/5063246/find-the-words-report-better-equipped-better-care.pdf [Accessed: 21/01/19].
- Moxham, L., McCann, T., Usher, K., Farrell, G. and Crookes, P. (2011) Mental health nursing education in preregistration nursing curricula: A national report. *International Journal of Mental Health Nursing, 20(4),* 232-6.
- Naylor, C., Parsonage, M., McDaid, D., Knapp, M., Fossey, M. & Galea, A. (2012). *Long-term conditions and mental health: the cost of co-morbidities.* The King's Fund, London, UK.
- NHS England (2016). *Improving the physical health of people with mental health problems: Actions for mental health nurses.* Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/532253/JRA_Physical_Health_revised.pdf [Accessed: 21/01/19].
- NICE (2015). National Guideline 10: Violence and aggression: short-term management in mental health, health and community settings. Available from: nice.org.uk/guidance/ng10 [accessed 28/06/19].
- Nolte, A.G.W., Downing, C., Temane, A. & Hastings-Tolsma, M. (2017). Compassion fatigue in nurses: A metasynthesis. *J Clin Nurs, 26,* 4364-4378.
- Nursing & Midwife Council (2019). The NMC register, available from: https://www.nmc.org.uk/globalassets/sitedocuments/other-publications/nmc-register-data-march-19.pdf [accessed: 14/08/19].

- O'Connor, K., Brennan, D., O'Loughlin, K., Wilson, L., Pillary, D., Clarke, M., Casey, P., Malone, K. & Lane, A. (2013). Attitudes towards patients with mental illness in Irish medical students. *Ir J Med Sci., 182 (4),* 679-85.
- QSR (2018) *NVivo qualitative data analysis software*; QSR International Pty Ltd. Version 12, 2018.
- 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. *International Journal of Mental Health Nursing, 27,* 46-60.
- Ross, C.A. & Goldner, E.M. (2009). Stigma, negative attitudes and discrimination towards mental illness within the nursing profession: a review of the literature. *J Psychiatr Ment Health Nurs, 16 (6),* 558-67.
- Semrau, M., Evans-Lacko, S., Koschorke, M., Ashenafi, L. & Thornicroft, G. (2015). Stigma and discrimination related to mental illness in low- and middle-income countries. *Epidemiology and Psychiatric Sciences,* 1-14. DOI: 10.1017/S2045796015000359.
- Snowdon, D.A., Leggat, S.G. & Taylor, N.F. (2017) Does clinical supervision of healthcare professionals improve effectiveness of care and patient experience? A systematic review. *BMC Health Services Research, Nov 28*;17(1):786. doi: 10.1186/s12913-017-2739-5.
- Sprah, L., Dernovsekm M.Z., Wahlbeck, K. & Haaramo, P. (2017). Psychiatric readmissions and their association with physical comorbidity: a systematic literature review. *BMC Psychiatry*, 17:2, DOI 10.1186/s12888-016-1172-3.
- Strauss, A. & Corbin, J. (1998). *Basics of qualitative research. Techniques and procedures for developing grounded theory.* Sage Publications: Thousand Oaks CA.
- Terry, J. & Coffey, M. (2019). Too Busy to Talk: Examining Service User Involvement in Nursing Work, *Issues in Mental Health Nursing,* 40:11, 957-965.
- Thornton, J. (2019). NHS staff survey: just 29% of organisations take health and wellbeing seriously. *BMJ, 364:* 1924.
- Vancampfort, D., Correll, C.U., Galling, B., Probst, M., De Hert, M., Ward, P.B, Rosenbaum, S., Gaughran, F., Lally, J. & Stubbs, B. (2016). Diabetes mellitus in people with schizophrenia, bipolar disorders and major depressive disorder: a systematic review and largescale meta-analysis. *World Psychiatry, 15 (2),* 166-74.
- World Health Organization (2018). Guidelines for the management of physical health conditions in adults with severe mental disorders. Geneva: World Health Organization.
- World Health Organization (2002). Innovative care for chronic conditions: building blocks for action: global report. Geneva: World Health Organization.
- Zolnierek, C.D. & Clingerman, E.M. (2012). A medical-surgical nurse's perceptions of caring for a person with severe mental illness. *J Am Psychiatric Nurses Associ, 18 (4),* 226-35.
- Zolnierek, C.D. (2009). Non-psychiatric hospitalization of people with mental illness: systematic review. *Journal of Advanced Nursing, 65 (8),* 1570-1583.

Figure one legend

Figure one: Overview of themes organised across macro, meso and micro levels of understanding