Treat as one: care of physically ill patients who also have a mental health condition

As the understanding of mental health conditions, their causation and diagnostic characteristics has improved, so has their recognition in the population. A survey in 2014 found a prevalence of 26% in England (Bridges, 2015). The life expectancy of patients with severe mental illness is reduced by 10–25 years (World Health Organization, 2015). This rise in mortality is associated with medical conditions like heart disease at a younger age, linked to smoking and obesity (Harris and Barraclough, 1998).

The Department of Health (2012) reported that, in 2011, 30% of the general population was living with one or more physical health-related long-term conditions. These patients have a 2–3-fold increased risk of developing mental illnesses like depression. Having understood that mental and physical health conditions are interlinked and need to be managed with the same priority, health programmes have been launched to address issues like smoking and physical inactivity.

In hospitals, the quality of care for physical illness provided to patients with mental health conditions can vary significantly. A systematic review in 2009 concluded that even though patients with severe mental illness have more frequent contact with their physical health-care providers, they experience disparities in care (Mitchell et al, 2009). Most of the studies in this systematic review analysed large databases.

Dr Vivek Srivastava, Lead Coordinator, National Confidential Enquiry into Patient Outcome and Death, Consultant in Acute Medicine, Guy's and St Thomas' Hospital, London SE1 7EH

Dr Sean Cross, Consultant in Liaison Psychiatry, South London and Maudsley NHS Foundation Trust, London

Dr Hannah Shotton, Clinical Researcher, National Confidential Enquiry into Patient Outcome and Death, London

Correspondence to: Dr V Srivastava (vivek.srivastava@kcl.ac.uk)

NCEPOD enquiry

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) study on care of patients with physical illness who also have a mental health condition (Cross et al, 2017) is based on review of case notes and allied clinical data. It aimed to identify remediable factors in the care provided to patients with significant mental health conditions who were admitted to general hospital with physical illness. Hospitals were asked to provide details of clinical structures, policies and protocols (including liaison psychiatry services) for managing patients with coexisting mental health conditions. In addition, clinical staff were invited to complete an online survey assessing their knowledge and confidence in managing patients with coexisting mental health conditions. Further details of the study protocol and methods are available in the report (Cross et al, 2017).

Five sets of case notes of admissions between 13 October and 13 November 2014 were selected from all general hospitals in the UK, except Scotland, if they represented one of the following groups:

- One patient admitted with self-harm
- One patient who died in hospital or who was admitted to critical care
- One patient who was admitted from and/or discharged to a mental health facility
- Two patients who had a hospital stay of more than 72 hours.

A total of 552 case notes were peer reviewed along with structured questionnaires provided by the discharging consultant and liaison psychiatrist (where available).

Findings

The majority of patients (351/552; 63.6%) presented to the emergency department, while 14.5% (80/552) were referred to hospital by their GP. Emergency department notes should have mentioned the mental health condition in 96 out of 351 patients (27.3%) but were found only in 49 out of 351 patients (13.9%) at triage, which rose to 73 out of 351 patients (20.8%) at senior review. A similar lack of documentation of mental health condition was noted in the GP letter and in the medical clerking on the ward.

Liaison psychiatry

Of the patients seen in the emergency department, 55 out of 351 (15.7%) were referred to liaison psychiatry but another 55 would have benefitted from a referral at this stage. Of those referred, 33 of the 55 patients (60%) were seen by liaison psychiatry in an appropriate timeframe. The lack of, or delay in, liaison psychiatry review affected the overall quality of care in 20 patients.

After admission, 103 of 458 patients (22.5%) were referred to the liaison psychiatry team. Lack of timely referral compromised care in another 10% (30/301) of cases. Assessment of mental capacity is important in some patients but was not assessed in 66 of 479 patients (13.8%) at initial assessment. During in-hospital care some patients may need 1 to 1 mental health observations (sometimes called specialling). This was found to be inadequate in 151 out of 222 cases (68%) , primarily because it was given to staff members not adequately trained in that role.

The ward assessment by liaison psychiatry was significantly delayed in 74 out of 199 cases (37.2%) , which adversely impacted the quality of care in some. The most common reason documented for delay was: 'the liaison psychiatry team would not attend until the patient was declared medically fit'. This practice should be discouraged in favour of joint assessment and collaborative management of physical and mental health.

A comprehensive liaison psychiatry review should include mental health risk assessment but was recorded in 161 out of 476 cases (33.8%). An adequate risk management plan should then be available to the treating team, but was provided in only 106 out of 224 cases (47.3%).

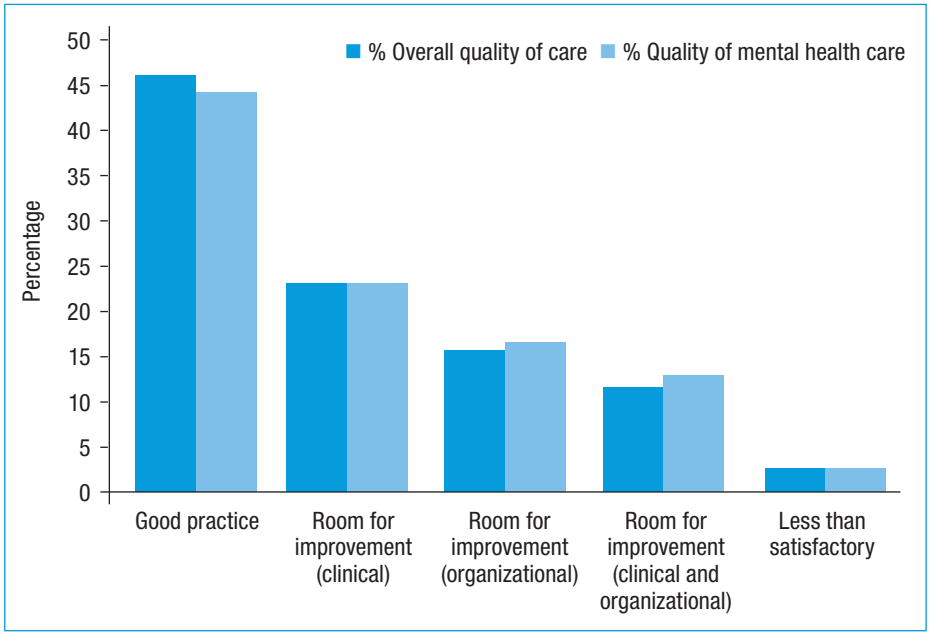

Figure 1. Overall quality of care and mental health care based on opinion of case-note reviewers.

Further hospital treatment

Only a small proportion of patients admitted to general hospital require detention using mental health legislation. Appropriate procedures and documentation should be used on each occasion. In this study, 65 out of 541 patients (12.0%) were detained using mental health legislation and in 23.1% of these patients (15/65) the documentation of the process was not up to standard.

Surgery, or an interventional procedure, was undertaken in 135 out of 552 patients (24.5%). There was room for improvement in the consent process in 24 of 109 cases (22%), and seeking help from liaison psychiatry in such situations may be useful.

Discharge

Multidisciplinary team discharge planning has an important role in the care of patients with complex physical and mental health needs. However, it took place in only 209 out of 423 discharges (49.4%), with liaison psychiatry involvement in only 54 out of 209 cases (25.8%). The value of the multidisciplinary team is highlighted by the evidence that clinical management plans were influenced by the team in 70.3% of cases.

Discharges from hospital were delayed in 14.7% of cases (65/443). Discharge letters lacked the mental health diagnosis in 95 out of 343 cases (27.9%) and details of the mental health medications in 90 out of 308 cases (29.2%). None of the discharge letters were copied to the patient's psychiatrist.

The study found good quality care in 46.0% (252/548) of cases reviewed, as shown in *Figure 1*. Room for improvement in both the clinical and organizational aspects of care was noted in another 11.7% (64/548) of the cases. However, 23.7% (130/548) had room for improvement in clinical care and 16.1% (88/548) had room for improvement in the organization of care.

Conclusions

Severe mental illness impacts physical health and long-term medical conditions increase the risk of mental illness. However, they are not being dealt with in a joined-up fashion when patients are admitted to hospital. This NCEPOD report highlights some of the challenges that contribute to the gap, such as organization of services (e.g. liaison psychiatry) and training of general hospital staff. It is time to take heed of the recommendations in the report so these conditions are treated as one. **BJHM**

KEY POINTS

- Co-existing mental health conditions should be documented and assessed along with other clinical conditions.
- National guidance should be developed regarding referral to liaison psychiatry services.
- Liaison psychiatry review should provide clear and concisely documented plans in the general hospital notes at the time of assessment.
- Liaison psychiatry services should be fully integrated into general hospitals. The structure and staffing of the liaison psychiatry service should be based on clinical demand.
- Record sharing between mental health hospitals and general hospitals needs to improve. Patients should not be transferred between hospitals without copies of all relevant notes accompanying the patient.

Bridges S (2015) Mental health problems. In: Health survey for England 2014. Health and Safety Executive, London (http://content.digital.nhs.uk/catalogue/PUB19295/HSE2014-ch2-mh-prob.pdf accessed 23 February 2017)

Cross S, Srivastava V, Shotton H, Protopapa K, Butt A, Mason M (2017) *Treat as One: Bridging the gap between mental and physical healthcare in general hospitals.* National Confidential Enquiry into Patient Outcome and Death, London

Department of Health (2012) Long Term Conditions Compendium of Information: Third Edition. www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition (accessed 22 February 2017)

Harris EC, Barraclough B (1998) Excess mortality of mental disorder. *Br J Psychiatry* **173**(1): 11–53. https://doi.org/10.1192/bjp.173.1.11

Mitchell AJ, Malone D, Doebbeling CC (2009) Quality of medical care for people with and without comorbid mental illness and substance misuse: systematic review of comparative studies. *Br J Psychiatry* **194**(6): 491–499. https://doi.org/10.1192/bjp.bp.107.045732

World Health Organization (2015) Information sheet: Premature death among people with severe mental disorders. www.who.int/entity/mental_health/management/info_sheet.pdf?ua=1 (accessed 21 February 2017)