Proposal for an Out of Hours Crisis Café for North East Glasgow

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Executive Summary

This report proposes an Out of Hours Crisis Café for the North East of Glasgow, this would provide a non-clinical place of safety for those in crisis and an alternative to A&E when medical intervention is not required.

The report highlights the following points:

- People living in socioeconomically deprived areas are at higher risk of suicide and North East Glasgow is one of the most deprived areas of Scotland.

- There are very limited supports for people feeling at risk of suicide ‘out of hours’. Samaritans’ walk-in ‘listening ear’ service is not available after 10pm and does not have the physical capacity to deal with the numbers that are requiring support. The Out of Hours NHS Community Triage Service provides a clinical response only and is mainly a telephone based service.

- An Out of Hours Face to Face Service was a recommendation from ‘Listen and You Might Learn’ Report (Wood, 2016), this community engagement research asked local people what was needed to help them and their community be safer from suicide.

- Safe Haven in Aldershot, Hampshire (The Safe Haven Aldershot Evaluation Report, 2015) is an award-winning example of an Out of Hours Crisis Café with a further five Safe Havens now opened across Surrey.

- In 2016, 856 individuals presented 1124 times to A&E at Glasgow Royal Infirmary (GRI) presenting with either suicidal attempt, suicidal ideation or self-harm, 39% of these attendances were discharged with no follow up.

- 267 people attended 299 times to A&E at GRI presenting with suicidal ideation only, 34% of these attendances were discharged with no follow up.

- 69% those attendances presenting with suicidal ideation occurred out of hours.

- There are significant differences in terms of outcomes for those patients presenting with suicide attempt, suicidal ideation and self-harm to A&E at GRI compared to Queen Elizabeth University Hospital (QEUH) with 23% less attendances being admitted or transferred for treatment and 14% more discharges with no follow up.

- The costs of an out of hours crisis café could potentially be off-set by the reduction in the number of people attending A&E during the night along with the reduction in Police time spent looking after people at risk of suicide, which on average is a minimum of 4 hours for each intervention. No data is available regarding the total cost to policing of supporting people in suicidal distress.
Background

The latest statistics from a report from the Scottish Suicide Information Database (ScotSID) on deaths by suicide\(^1\) show that the suicide rate in Scotland has been steadily decreasing for the last five consecutive years. Although no analysis has as yet been published as to the reasons for this downward trend, it can be assumed that the collective efforts of communities and Choose Life partnerships across Scotland has contributed to this.

However, this report also shows that the suicide rate for the population as a whole is three times higher in the most deprived areas, compared to the least deprived areas. A recent report by the Samaritans ‘Socioeconomic Disadvantage and Suicidal Behaviour: Dying from Inequality’\(^2\) (2017) highlighted that more needs to be done around inequality and suicide in the UK and Ireland. A key finding from this report states that ‘in the UK, socioeconomically disadvantaged individuals are less likely to seek help for mental health problems than the more affluent, and are less likely to be referred to specialist mental health services following self-harm by GPs located in deprived areas.’

Currently people who feel at risk of suicide outside of normal working hours (9am-6pm) within Glasgow can:

1. call a national helpline: NHS24 or Breathing Space
2. call the Out of Hours Psychiatric Helpline
3. call 999
4. call Samaritans or go into the branch until 10pm
5. present at A&E at Queen Elizabeth University Hospital (QEUH) or GRI*

*A&E Out of hours’ service operates from 6pm to 8am, Monday to Friday; and 24 hours a day, Saturday, Sunday and public holidays.

There are very limited options to go to a physical place to get support and therefore many people present at A&E looking for support and a safe place. People feeling at risk of suicide are in a state of desperation and are in an emergency, but A&E with its high demand and clinical environment, frequently does not meet the needs of people in emotional distress.

‘What would have been helpful would have been knowing that there is a place to go where there will be someone, not necessarily to talk to, but even just to give you a space to sit and calm down and talk things through if you want to. At the moment, the only thing close to that is A&E but that isn’t the place you want to be going when you feel that way. You feel like you are wasting their time, you feel like everyone is judging you, you feel guilt that someone who is more sick might be having to wait because of you and the worst is not being taken seriously by the staff.’

(Service User, Listen & You Might Learn’ Report\(^3\), 2016)
Negative attitudes towards those presenting with suicidal ideation exist within services. A study by Heron et al. in 2001 looked at attitudes towards suicide prevention in front line health staff, they focused on four groups: G.P.’s, A&E Nurses, Community Psychiatric Nurses and Psychiatrists in training. What they discovered was a significant difference in attitudes across the professional groups. More negative attitudes were associated with those who did not have previous training in suicide risk assessment, those not working in the community, and those who were not mental health professionals.

Negative attitudes still exist within services, in 2011 an inquiry commissioned by Mind found many examples of people being treated with a lack of respect and even rudeness at times. This is also evident anecdotally through the author’s work within the community and as an ASIST Trainer. Combine these attitudes with high work pressures and a focus on physical illness then there is a much higher chance for people presenting at A&E with suicidal ideation and self-harm to not receive appropriate or adaptive responses such as safety planning, negotiation of responsibility with patients and Carers, and containing distress. In a paper published in The Lancet in 2015, Smith et al. discuss the underlying causes of maladaptive or dysregulated responses, such as decision making that is ad-hoc, abrupt, and inconsistent; negative feelings about patients; and focusing on diagnosis and risk assessment in an inappropriately narrow way; and what the impact of this is on the management of suicide risk and self-harm in clinical practice. In an Editorial in The Lancet in 2016, this highlighted ‘the timeless need for empathy and kindness’ when it comes to suicide prevention.

To understand the level of demand on services at the two main A&E departments in Glasgow which has a population of 593,245 in 2016, there were 84,816 A&E attendances to the Glasgow Royal Infirmary (GRI) and 92,798 to the Queen Elizabeth University Hospital (QEUH).

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* Adaptive response: an appropriate reaction to an environmental demand.

* Maladaptive response:
  Unsuitable or counterproductive; for example, maladaptive behavior is behavior that is inappropriate to a given situation.

Source: http://medical-dictionary.thefreedictionary.com
The Scottish Government has committed to improving responses to people in distress and is currently piloting a Distress Brief Intervention (DBI) programme across four sites in Scotland. This approach was born out of the work carried out by the Scottish Government on Suicide Prevention and Mental Health Strategies with many stakeholders advocating the need for a different approach to people in distress.

Distress is defined as ‘an emotional pain for which the person sought, or was referred for, help and which does not require (further) emergency service response’.

The DBI approach is time limited and centred on supportive problem solving and providing a compassionate response. There are two tiers to the DBI approach: Level 1, through frontline staff response, signposting or referring on to a DBI Level 2 service, and then Level 2 through Third Sector or commissioned services who see someone within 24 hours and work with them for up to 14 days, focusing on:

- compassionate, community problem solving support
- wellness and distress management planning
- supported connections
- signposting

The four pilot areas are North and South Lanarkshire, Inverness, Aberdeen and the Borders and the DBI approach will be piloted from June 2017 to March 2021. Greater Glasgow & Clyde (GG&C) NHS is not involved in this pilot but instead is focusing on the ‘development of their broader multiagency distress collaborative programme’ therefore this report should inform the work being carried out in GG&C.

**Aim**

The purpose of this report is to explore possible alternatives to A&E presentation for people experiencing suicidal ideation or intent who do not require medical intervention and to make the case for an Out of Hours Crisis Café for the North East of Glasgow.

In the latest Scottish Index for Multiple Deprivation, published in 2016, the 10 most deprived areas of Scotland were identified of which four are in North East Glasgow, these are Carntyne West and Haghill; North Barlanark and Easterhouse South; Old Shettleston and Parkhead North.

An Out of Hours Crisis Café would provide a community based, non-clinical place of safety for those in crisis and an alternative to A&E when medical intervention is not required.
'Suicidal behaviour is not inevitable but concerted action across a wide range of disciplines will be required to reduce the risk of suicide, attempted suicide and self-harm among socioeconomically disadvantaged individuals, families and communities.'

(Dying from Inequality, 2017)

This report has been born out of:

1. Needs identified in the report ‘Listen & You Might Learn’, community engagement research carried out in North East Glasgow in 2016 by Pure Potential Scotland commissioned by Health Improvement North East Locality, Glasgow City HSCP.

2. Out of hours’ Crisis Cafés set up in other areas:
   - The Safe Haven, Aldershot, Hampshire (6 more Safe Havens have now been set up in Surrey)
   - The Well-bean Hope in a Crisis Café, Touchstone Support & Leeds Survivor-Led Crisis Service
   - The Dragon Café, London
   - Tooting & Sunshine Recovery Café, South West London & St. Georges’ Mental Health NHS Trust (recently opened in April 2017)

When looking at the possible solutions to provision of support for Out of Hours crisis the following criteria are being considered in this report, based on the evidence from local and national research showing what people experiencing a mental health crisis say they need:

- Compassionate response
- Physical safe place to go
- Peer support
- Out of hours
- Non-clinical

Limitations

This report is limited in its scope and can be used as an initial inquiry into the potential for an out of hours’ crisis cafe for North East Glasgow. The analyses of A&E attendances that are used within this report are indicators of potential issues and they are used primarily to raise questions. The report is about opening up this discussion, to challenge the current situation for out of hours’ crisis support, present ideas for a potential solution and make recommendations for ways forward.
Listening to Local People

‘Listen and You Might Learn’ report came from community engagement research which was carried out in North East Glasgow in 2016 by Pure Potential Scotland. This report provided an analysis and evaluation of the identified needs of local people in North East Glasgow and potential solutions in terms of making suicide safer communities.

‘There isn’t anywhere to go when you are in crisis... you feel like you need to jump through hoops to get support.’

‘When I go into crisis I isolate myself from all caregivers. The one time I got myself to a resource centre the way the reception staff treated people was appallingly, it was a humiliating experience, I felt de-valued.’

One of the recommendations from this report was an out of hours, face to face service which would address four out of the seven priority areas identified in the report:

1. Access to Immediate Support – Suicide specific / Safe Space

   ‘What’s needed is a Suicide Response Team 24 hours as an alternative to A&E... an immediate response.’

2. Really Being Listened To

   ‘You need empathy, honesty and to be treated as a human being.’

3. Involving People with Lived Experience

   ‘I want to meet others who have been through what I’ve gone through as they know what it’s like and we can help each other.’

4. Support for Allies & Supporters

   ‘I have been supporting my daughter for 8 years this has been a constant struggle trying to get her help, she is on another waiting list. At the moment, I feel I am the only one here for her and I want to be, but where’s the backup plan for me?’

This report highlighted the need for people to have a ‘one stop shop in the community for suicide prevention’, somewhere they could walk into, without a referral, if they defined themselves as being in a crisis, and be made welcome.
An Example of Good Practice: The Safe Haven, Aldershot in addition to the published evaluations, the author spoke to its’ manager, Stanley Masawi on 20 March 2017.

The first Safe Haven café opened in Aldershot in Hampshire in March 2014. It was set up to provide an alternative to A&E and to support those people who are or may be developing a mental health crisis and is a partnership between Surrey and Borders Partnership Foundation NHS Trust (SABPF), Maidstone Community Care Housing (MCCH) and Surrey Alcohol and Drug Advisory Service (SAdAS)*. The café won the national Positive Practice in Mental Health Award for Improving Care for People Experiencing Mental Health Crisis in 2015. From its success, a further five Mental Health Safe Havens opened across Surrey in 2016.

The original project was needs led and conceived from national and local research. In 2011, Mind commissioned independent research into acute and crisis mental health services ‘Listening to Experience’. They found examples of good acute and crisis care with good illustrations of well designed environments, helpful and courteous staff and quality care, as well as examples of a different kind of response than those from the NHS, that were more directly accessible provided through some voluntary sector services. But they also found many examples of poor care provision and people feeling traumatised from these experiences, such as waiting for hours in A&E with security guards minding them, crisis calls being unanswered or being put ‘on hold’, or people being informed that they were not ill enough to be eligible for help. They identified four key areas for services to focus on so that their service provision is at its best, these were:

- **Humanity** – people wanted to be treated in a respectful, warm and caring way regardless of how they came into contact with services.

- **Commissioning for people’s needs** – understanding that one service delivery model does not fit all and encouraging creative and flexible service provision which meets the needs of the targeted community.

- **Choice and control** – people wanted to define when they were in crisis and have choice and say in their care.

- **Reducing the medical emphasis in acute care** – people described needs that did not need a clinical response - someone to listen, to care, provide safety and something to do.

In 2012, an independent organisation, UsCreates, carried out research in North East Hampshire with service users, Carers, statutory and third sector providers into why people go to A&E for their mental health needs. The research found that people wanted a physical

* SAdAS Southern Addictions Advisory Service has changed its name to Catalyst (Catalyst Support Ltd)
place to go that provided a safe environment and where they could access support and advice when they needed it, operational outside of normal working hours (9-5).

In 2011, Surrey and Borders Partnership Foundation NHS Trust (SABPF) made a series of recommendations after carrying out a full review of the pathway for urgent assessments. One recommendation clearly stated an:

‘Introduction of alternative support models which align with the Social Inclusion strategy to prevent and manage crisis e.g. Peer Support networks, ‘Safe Havens’ (Jan 2012).

In 2014, the Mental Health Crisis Care Concordant19 was published ‘Improving outcomes for people experiencing Mental Health Crisis’ which highlighted the need for multi-agency partnership working when helping people in mental health crisis, defining good practice and principles that should be followed.

This was the basis from which the philosophy and management for the Safe Haven Café was developed. The Safe Haven concept is about supporting people to self-manage and to be able to identify early warning signs. It is about going back to basics to see how individuals can keep themselves well and what to do if they notice they are becoming unwell.

“It’s a very friendly atmosphere and there are volunteers who have used mental health services themselves” (service user)

“Nobody judges you” (service user)

“When you’re feeling down, depressed or in a crisis, you just come in and the staff will help you.” (service user)

“Coming in here... it’s literally been a lifesaver.” (service user)

Stanley Masawi, Safe Haven Manager, highlights the importance of the open-door access. He says first and foremost that the centre’s atmosphere communicates: ‘You are welcome’ and supports the concept of self-management. It encourages people to identify when they feel they need support and to know that they can access it straight away. In this way people can get support to prevent their crisis from escalating. This is an environment where individuals’ concerns are taken seriously.

Once in the Safe Haven Café, people can just sit and have a cup of tea, talk to peers or staff, or if they choose, they can engage in more in-depth support. The environment is relaxed, informal and above all, non-judgmental.

Carers and family members are also welcome in Safe Haven, as they can also become
isolated and are in need of support and understanding themselves. Carers UK\textsuperscript{20} found in their latest research that 8 in 10 Carers have felt lonely or socially isolated as a result of their caring responsibilities and 57\% of Carers have lost touch with friends and family as a result of caring.

The open-door access of the Safe Haven does create demand and this is something that needs to be monitored and managed to ensure that all visitors are safe. The original Safe Haven have changed a few key parts to their café set up, in order to ensure that the primary reason for attending Safe Haven is because someone is in crisis.

It was found that a significant minority of visitors were regularly attending with the primary purpose being for social reasons. It was agreed that the staff would ask the visitors who used Safe Haven about what they wanted the café to be there for and from this they decided to focus on the regular visitors and their needs.

Originally staff were spending much of their time making food but when asked, visitors stated they would prefer staff spend more time providing emotional support and less time preparing food.

Some regular visitors identified that they were coming mainly for social reasons, this was creating a pressure on capacity within Safe Haven. It was agreed to support regular visitors to look at:

- Why am I here?
- What can I do elsewhere?

Workers supported these visitors to look at reconnecting with newly made friends elsewhere and to reduce the number of times these individuals accessed Safe Haven in a week.

The initial funding for the Safe Haven café was provided to relieve pressure in the A&E department along with other Emergency services. Initial evaluations have shown that there has been a positive impact, but Stanley Masawi points out that it will be in the longer term that they will really be able to see the benefits of this service. For example, the Safe Haven has been supporting individuals who regularly had inpatient admissions and no longer do. Independent research\textsuperscript{21} by Mental Health Strategies found that in the first six months after the Safe Haven opened, psychiatric admissions from the cafe’s catchment area fell by 33\%.
Andy Erskine, Director of Mental Health at Surrey and Borders Partnership NHS Foundation Trust, said:

“We know from the research that not only is the café supporting people to stay well, it is also providing them with an alternative to A&E.”

An Evaluation Report\textsuperscript{22} written in February 2015 shows the numbers of people attending and the reasons for attending the café. There is a significant increase in the attendance rate in January and February and this may be because the service was widely promoted during early January as part of the A & E Winter Pressures Communication strategy. The majority of attendances were ‘to help maintain wellbeing during difficult times’ and the second largest proportion of attendances ‘reported use as an alternative to A&E’. (Appendix 1)
Analysis

An exploratory analysis was carried out through ISD Unscheduled Care (NHS National Services Scotland) on A&E attendances identified as relating to suicide ideation, attempted suicide or intentional self-harm in Glasgow in 2016.

The data is only indicative due to the way A&E attendances are coded for these areas. (Appendix 2)

The analysis included data for Queen Elizabeth University Hospital (QEUH) in Govan, in the South of Glasgow and this provided the ability to do a comparison with this hospital and Glasgow Royal Infirmary (GRI) in Townhead, which is the main A&E site for North East Glasgow.

Through this exploratory analysis there were 1124 attendances at A&E in GRI in 2016, and in total there were 856 individual patients making up those attendances. Therefore 24% of these attendances, are repeat attenders.

How did those 1124 A&E attendances get referred to GRI?
What was the outcome for these attendances?

433 attendances to A&E to GRI were discharged with no follow up, that is 39%.

**Suicidal Ideation**

At arrival, 299 attendances were identified as experiencing suicidal ideation only and of these 267 were individual patients, therefore 11% of these attendances, were repeat attenders.
A recent progress report on Mental Health in Emergency Medicine Project by Devlin et. al 2015, funded by the Scottish Government, evaluates the use of a Mental Health Triage and Assessment Tool that was implemented in A&E departments across Greater Glasgow & Clyde between 2011 to 2014.

One of the areas explored is repeat attendances to Emergency Medicine for 1). alcohol and addictions and 2). mental health. The study focussed on patients with more than two A&E presentations in the preceding 6 months who were current patients of Adult & Elderly Community Mental Health Teams (CMHT) or Addictions services.

In February 2011, a Mental Health Triage and Assessment Tool was developed within Emergency Medicine and in 2013, a revision of this Triage Tool was made along with the development of a Training Package which was then delivered in Emergency Departments across Greater Glasgow & Clyde later that year.

By September 2014, the Mental Health Triage Tool had been introduced to all areas across GG&C to support repeat attenders to Emergency Medicine for all mental health and addiction presentations. What this meant in practice was that, when an individual attends A&E more than twice in a 6-month period and has been referred to a CMHT or an Addictions Service, an alert is triggered and a message is sent to the patient’s care manager to alert them to this. This then provides an opportunity for the care manager to review the individual’s care plan and address the issues that caused them to access A&E services.

The progress report concludes that:

‘In the last 3 years, there has been a 90% reduction in repeat attendances for those mental health patients who attend more than 5 times, and an 85% reduction in those attending 5 times.

The reduction has been across all ranges of repeat attendance, the most significant decrease being in the group of patients attending more than five times.

The delivery of the reports to local Mental Health team leads has proved extremely useful in relation to clinical practice.’

Data suggests that individuals with suicidal ideation, in emotional crisis, are attending A&E services looking for support.
At Glasgow Royal Infirmary, 22% of attendances with suicidal ideation were admitted or transferred to another hospital for care and 75% were discharged, some with follow up or a referral and others with no follow up.

While the data does not communicate if these individuals were seen by a mental health professional while at A&E, anecdotally, attendees at the minimum would have been seen by a junior doctor and only then if assessed as appropriate, would they be seen by a mental health professional and given a psychiatric assessment.

Importantly, 102 attendances (including some repeat attenders) would not be receiving any follow up although suicidal ideation had been present within the last 12 hours, that is 34% of all attendances presenting with suicidal ideation.

69% of these attendances occurred out of hours.
Suicidal Ideation Attendances - In & Out of Hours/Days of the Week

The mean number of attendances to A&E in 2016 across the whole of GG&C in working hours (8am-6pm) is 58 and for Out of Hours is 108 attendances.

The busiest times for attendees presenting with suicidal ideation only are for Out of Hours on Saturday, Sunday and Monday, with the next largest attendance rate being Friday Out of Hours.

If we look at all attendances to A&E in 2016 across the whole of GG&C the attendances are higher during ‘in’ hours.
Different outcomes for attendances at GRI and QEUH

Looking initially at the analysis for all those attendances presenting with suicidal attempt, suicidal ideation or self-harm.

At GRI there were 23% less attendances to A&E admitted or transferred for treatment and 14% more discharges with no follow up compared to QEUH.

In terms of referral source comparing GRI with QEUH, 8% more referrals came via the Police, 3% more self-referrals and 9% less referrals from 999 emergency services.

If we look at those attendances presenting with suicidal ideation only, the figures are not quite as stark but still show a difference in numbers attending and outcome for attenders.

Out of the total attendances for those presenting with suicidal ideation, suicide attempt or intentional self-harm, 27% of those attendances to GRI were exclusively suicidal ideation compared to 18% of those to QEUH.
At GRI there were **6% less attendances to A&E admitted or transferred for treatment** and **7% more discharges with no follow up** compared to QEUH.

In regards, to those attendances that were *brought in by the Police*, at GRI there were **11% more discharges with no follow up** compared to QEUH.

**Case Study**

**Tara Maguire, Coordinator, Glasgow NE Foodbank**

Glasgow NE Foodbank state on their website: ‘We don’t think anyone in our community should have to face going hungry. That’s why we provide three days’ nutritionally balanced emergency food and support to local people who are referred to us in crisis. We are part of a nationwide network of foodbanks, supported by The Trussell Trust, working to combat poverty and hunger across the UK.’

‘I didn’t think when I took this job I would be dealing with all that side of stuff (mental health and suicide) as well, you know you think ‘I’ll get to feed people’, no, it’s everything else that goes along with it, the food is just really a tiny part of what we do here.’
Tara Maguire is the Coordinator for Glasgow NE Foodbank and has had many experiences at the Foodbank of people arriving feeling suicidal and in a crisis.

‘We had an incident, Mr X came in, he was rolling about on the floor, he was going to throw himself out of the window, that was it, he was done. He was a 50 year old man, so it was really difficult to watch that and to see that. I was trying to get on to Parkhead hospital (he had been a patient in there), to his G.P., at 4 o’clock on Friday and nobody’s about, ended up myself and a board member took him to A&E, the suggestion was to phone the Police but he had had issues with the Police anyway, so no, we were going to lose him, so we took him to A&E and we sat with him until about midnight before he was assessed, so that was from about 5 o’clock. I’ve got a family, I’ve got kids at home, but what else do you do? This person was serious and I had my cousin kill himself the year before, so in my head it was like I was going to save him.’

Tara had been told he would be seen straight away but it took 7 hours before he was assessed. From there he was to be sent back to Parkhead in a taxi, so instead Tara and her board member took him there in their car, after this he had a week’s stay in Stobhill Hospital.

The outcome of this story is positive as Mr X is now doing well, but the whole process that was involved in getting him help does raise some serious questions about people who are feeling at risk of suicide and the A&E set up.

What would have happened to this man if he had nobody to take him or wait with him?

Tara stated it would have been much better if there had been somewhere safe for him to go to, where they could have waited that was less clinical and less chaotic.

It was after this incident that Tara decided that herself and the volunteers needed some extra support and training so now they have a Samaritan Volunteer in on Fridays to support them.

‘After that we did ASIST training, we had safeTALK which was amazing, and we are going to do Samaritans (training) this week and next week, so we are trying to build up on the raft of knowledge about suicide and not to be scared of it.’

Tara feels very strongly from her experiences that extra support is required out of hours when most services are closed. She found most of the people presenting at Foodbank who feel suicidal do so on a Friday between 4 and 6pm.
‘There are massive gaps especially if there is an addiction involved...I felt I was losing people in here...there should be more there, there should be a better safety net than coming into a food bank and sitting with somebody for an hour and trying to fix it, so anything that can be done would be amazing.’
Discussion of analysis

What can we surmise from these data?

Those attendees who presented with either suicidal ideation, suicide attempt or intentional self-harm and were discharged with no follow up, would have been deemed not to be at any immediate risk to themselves.

If risk had been identified this would have required action dependent on the level of risk assessed, either immediate or follow up as part of the discharge plan, this process can be seen in the Emergency Department Mental Health Triage and Risk Assessment found in Appendix 1 of the report by Devlin et al.23

If discharged with no follow up, the main course of action, anecdotally, is for individuals to be given a crisis number to call if they think they are going to do anything to hurt themselves so we could surmise that this may have been the outcome for these 433 attendances.

We understand that about a quarter of all the attendances presenting with suicidal ideation, suicide attempt or intentional self-harm, are repeat attenders and we know that specific follow up action is required as discussed in Devlin et al. Should all individuals who present with suicidal ideation, suicide attempt or intentional self-harm to A&E have a follow up to check on their wellbeing?

Why is this not happening?

A report ‘Right Here, Right Now’24 published by the Care Quality Commission in 2015 explored the responses people received during a mental health crisis. They found that 37% of respondents who had come into contact with A&E services had felt that their concerns were taken seriously and listened to and 35% said they were treated with warmth and compassion, this is in stark comparison to 86% and 88% respectively of those respondents who had come into contact with volunteers or a charity.

In the recommendations, it states:

‘It is not just about making sure that people are physically safe, it is about preventing unnecessary mental distress to people when they are vulnerable.’

Looking at the attendances presenting with exclusively suicidal ideation, we saw that 75% (226 out of the total 299) attendances were seen and then discharged, some with follow up
by Primary care, some with a referral and others with no follow up. We know that 11% of the total 299 attendances were repeat attenders.

A&E departments have been shown to not meet the needs of people who are experiencing a mental health crisis (Mind, 2011; Care Quality Commission, 2015). Could these attendances have received care in an alternate environment?

There were 47 attendances to GRI who presented with suicidal attempt, suicidal ideation or self-harm who left before their assessment was complete and did not receive any intervention. This may be for multiple factors that may include the individual being under the influence drugs or alcohol, but we need to acknowledge that long waiting times and the A&E environment not being conducive for their condition, may have been factors in this. In the Care Quality Commission report, only 35% respondents who attended A&E in a mental health crisis stated that they received the help they needed in a timely way and only 33% felt they were not judged for what they had done or how they felt.

Significantly 69% of all attendances presenting with suicidal ideation attended out of hours and this is in contrast to attendances not related to mental health crisis. This adds weight to the argument that there is a need for an out of hours, accessible, face to face service for people experiencing mental health crisis.

We also need to consider why those attendances to A&E at GRI who present with suicidal ideation, suicide attempt or intentional self-harm are statistically more likely to be discharged with no follow up than those attendances to QEUH.

The percentage differences are significant in terms of outcome for these patients and warrant further investigation: 23% less attendances to A&E to GRI admitted or transferred for treatment and 14% more discharges with no follow up compared to QEUH.

This raises the question: Is it that the patient pathway is significantly different in GRI compared to QEUH?

We know that the Glasgow Royal Infirmary serves some of the most deprived communities in Scotland. One factor of multiple deprivation is poor health therefore the demand on services will be higher and this could increase pressure on staff working within services. Although there are proportionately more attendances for suicidal ideation, suicide attempt or intentional self-harm to QEUH than GRI (3% compared to 1% of ALL attendances to A&E); of those coded attendances in this analysis, there are 9% more attendances to GRI who present with exclusively suicidal ideation. Are those people attending A&E with feelings of suicide being taken seriously?
Current Alternatives & Options

There are some current alternatives that are available to support people experiencing mental health crisis out of hours in Glasgow:

2. Glasgow Samaritans Drop-in at 210 West George Street in the city centre.

Community Triage Service – NHS Greater Glasgow and Clyde Crisis Out of Hours CPN Service (CTS)

NHS Greater Glasgow & Clyde have run an ‘Overnight Psychiatric Crisis Service’ since 2001.

This service is:

The overnight Mental Health Service for NHS GG&C

- The first point of contact for all referrals for mental health crisis.
- Able to facilitate admission to psychiatric hospital if deemed necessary.
- Able to provide certain medication options via General Practice Out of Hours Service
- A nurse led service comprising Senior Crisis Practitioners (band 6 nurses) & one band 7 Team Leader.

In an annual state of policing report, Sir Tom Winsor stated that the Police were regularly being required to deal with at risk individuals where there was no crime being committed. Due to this, a significant proportion of Police time was being spent on non-criminal activity and resulted generally in unsatisfactory outcomes for people and repeat callers with no improvement. This report is for England but to date there is no equivalent report for Scotland.

In 2015, a 6-month pilot was delivered as a shared response between the Police and NHSGG&C. The aim of the pilot was ‘to demonstrate that Community Triage leads to more timely intervention by Mental Health professionals when required, avoiding unnecessary detention either in a police station or hospital. The process is followed only where there is no immediate danger or threat to life.

An evaluation showed that the pilot was very successful, out of the 234 occasions the Community Triage Service (CTS) was used:

- 92 % of users (215) accepted telephone consultations:
85% (184) were deemed fit and well with no need for further intervention at that time
15% (31) had further face to face consultations

- Out of a total of 38 face to face consultations, 9 were required to go to hospital
- 6 people were reported for offences (after assessment)

The pilot also showed that 68% of the incidents were dealt with in less than 2 hours. This represents a time saving of at least 50% as Police estimated each A&E visit took a minimum of four hours.

The CTS has continued to run in Greater Glasgow and Clyde since the 2015 pilot and meets the needs of the Police for out of hours’ mental health crisis support. In conversation with a Chief Inspector they stated that what is needed is crisis support during the day, which they state is still lacking and therefore Police are forced to take at risk individuals to A&E.

This information conflicts with the data in the exploratory analysis from ISD A&E datamart, this shows that in 2016 the Police attended GRI 104 times with an individual with suicidal ideation and 79 of these attendances were during out of hours. We know that there were no referrals from Prison in this cohort and so can assume that all arrived through Police Transport.

Nearly 50% of these attendances were discharged with no follow up.
In QEUH, a similar picture emerged but with 36% being discharged with no follow up.

In terms of evaluating the CTS against the criteria above, the CTS service ticks the box of only two:

- Out of hours
- Compassionate response – this is assumption due to the reported numbers of service users not requiring further intervention beyond the initial phone call, but to-date there is no service user feedback.

It does not provide:

- Physical safe place to go
- Peer support
- Non-clinical
Glasgow Samaritans Drop-in at 210 West George Street

Samaritans have been in existence for 60 years offering non-judgemental support for anyone, anytime and call themselves ‘the listening experts’.

Glasgow Samaritans is open to receive callers at the door between the hours of 9:00am - 10:00pm. Generally, one caller can be seen at a time and there is a waiting area for callers to sit in if it is busy.

‘They allow you to sensitively discuss your options and explore your own feelings. After all, you’re best placed to solve your problems.’

(Caller, Samaritans’ website)

From the community engagement research carried out in the North East Glasgow in 2016 people were not aware of this drop-in facility so more could be done to promote this face to face support in local communities within Glasgow.

In terms of evaluating Glasgow Samaritans Drop-in support against the criteria above, it is successful in:

- Compassionate response
- Physical safe place to go
- Out of hours
- Non-clinical

It does not provide:

- Peer support

But the capacity issue is very important and although Samaritans offers a physical place to go to, it is not set up as a group drop-in space.
Cost-Benefit

A&E Costs

The average cost to A&E in the GRI between April 2015 and March 2016 was estimated at £129 per attendance.\(^\text{27}\)

If a psychiatric assessment was required and this was out of hours then this would incur a further cost of the Out of Hours CPN Service which would be a Band 6 or 7 nurse with out of hours’ payment on top of this.

Take the 433 attendances with no follow up: 433 x £129 / A&E attendance equals £55,857 per year. Then on to this may be the added cost of a psychiatric assessment by Liaison Psychiatry or an Out of Hours CPN.

We do not know if the above 433 attendances required medical attention but by the outcome they were not assessed as requiring any follow up, so one could surmise that if they did require medical attention that this would have been minimal or time limited.

What we can see is that there were 102 attendances with suicidal ideation that were discharged with no follow up, if we take these attendances: 102 x £129 = £13,158

Added to this would be the cost of a psychiatric assessment by either Liaison Psychiatry or an Out of Hours CPN for an unknown number of these. Out of Hours CPN would be a Band 6 or 7 Nurse, the average income for a Band 6 Nurse is £29,264\(^\text{28}\) plus there would be an out of hours’ payment on top of this, employers’ costs and for Liaison Psychiatry staff the costs would be significantly higher.

It has not been possible to obtain local costs for Liaison Psychiatry or Out of Hours CPN input however the cost analysis in the Evaluation Report on the Safe Haven in Aldershot, estimated (using national average costs) for each A&E attendance with Psychiatric Liaison a cost of £321.

If all 102 attendances received a Psychiatric assessment this would assume a cost of £32,742.

After consulting with a Nurse within CMHT, it seems unlikely that all attendances would have been deemed in need of a Psychiatric assessment at A&E, so these costs range from £13,158 to £32,742.
These are the costs that we can assume could have potentially been diverted elsewhere for more appropriate care as they were attendances that presented with suicidal ideation only and were discharged with no follow up.

There are other costs that we cannot account for at this time, which include the costs of inpatient admission.

**For the true costs to A&E, further analysis is required.**

**Police Costs**

**Police time** for supporting an individual to A&E- this would consist of two Police Officers and on average would take four hours.

The average salary of a Police Constable is £31,971\(^2\) therefore total cost for two Police Constables to take an individual to A&E averages at £141 excluding employer’s costs.

37 attendances with suicidal thoughts were brought to A&E out of hours by Police Transport.

37 attendances \( \times \) £141 = **£5,217**

**Rough estimated staffing costs for crisis café**

The Out of Hours Crisis Café could operate 6pm-11pm 4 evenings per week (Friday, Saturday, Sunday and Monday).

A minimum of 3 staff would be required, one staff member may be a Senior Worker, and this would be pooled from three potential partners – NHS, Third Sector Mental Health service and Third Sector Addiction service. The plan would be to also have Volunteer Peer Support Workers but they would always be additional to the 3 staff members.

Staffing hours for the café would be 6 hours per evening including over 4 evenings/week equaling 24 hours per staff member and then a further 6 hours for café development, any follow up work and staff support and supervision, which would total 30-hour week and therefore have 3 x Part Time (4 days/week) positions.

Worker A: The average salary of a Part Time (30 hours) Senior Crisis Worker based on a NJC Scale S02 (£27,924 - £29,558, av.£29,558) is **£23,646**\(^3\) (plus employer’s costs of appx 28%)
Worker B: The average salary of a Part Time (30 hours) Crisis Worker based on a NJC Scale 6.26 – S01 (£22,937 - £27,123, av. £25,030) is £20,024\(^{(x2)}\) plus employer’s costs of appx 28%

Staffing hours for the café would be 6 hours including over 4 evenings/week equaling 24 hours per staff member and then a further 6 hours for café development, any follow up work and staff support and supervision, which would total 30-hour week and therefore have 3 x part time (4 days/week) positions.

**Salary costs = £63,694**

Total costs would include non-pay costs such as promotion and publicity and any running costs.

It would be useful to explore the possibility of sharing space within an already existing community hub to promote accessibility and increase the potential for social opportunities for individuals at alternative times.
Conclusion

It is very positive to read that there is action being taken to support repeat attenders to A&E in mental health crisis. But this does not mean that alternative crisis support is not required.

The data from A&E and people’s experience of using A&E when feeling suicidal, all point to the conclusion that there is a gap in services for people who identify themselves in a crisis but are not assessed as at immediate risk and do not require medical treatment. These are the people that are either discharged with no follow up or with a phone number, crucially for these people no immediate support, apart from the clinical assessment, was available.

What people say they need above anything else, is someone who will listen and take them seriously, as soon as someone is assessed and told they do not warrant an admission or follow up appointment, people may feel their experience is being minimised. Evidence from the Safe Haven evaluations and from the author’s knowledge and experience of crisis, is that people are more likely to escalate their crisis because their concerns are not taken seriously.

Beds in hospital are limited, individuals need to be extremely unwell to be considered for inpatient admissions and hospital is not proven to always be the best option and evidence is pointing towards alternative interventions. But individuals who feel in crisis and are experiencing emotional dysregulation and need to be contained in some way and supported.

Containment in mental health terms used to be referred to as someone being locked in a psychiatric hospital. But if we are to understand the word containment in a therapeutic sense, it is the environment/atmosphere that is created by caring others that conveys a sense of safety, allowing the individual to more comfortably move through their emotions.

Therefore, this type of containment can be created in an accessible place within the community supported by caring individuals and positive strong boundaries. A safe therapeutic space is created by paying attention to both the physical and the psychological aspects of that space.

With the current state of out of hours support the only ‘places’ people can go is A&E or Samaritans. Those who work within A&E, and those attending, know that the A&E environment is not designed to provide an emotionally safe, therapeutic space. The drop-in at Samaritans, although excellent in providing an important listening ear service, is extremely limited in its capacity.
More and more services are understanding the need for more informal and non-clinical types of support as highlighted in the Mental Health Crisis Care Concordant (2014). In Glasgow, people are asking for this as reported in the Listen & You Might Learn Report (2016). A recent example of this is within the Glasgow Drugs Crisis Centre (GDCC), a Turning Point Scotland service, which now has a café style drop-in from 6-8pm that is open seven nights per week. This offers an informal, safe, social space for drug users where information and support is on-hand if they want it.

Creating an Out of Hours Crisis Café would meet the needs of many individuals who are looking for a safe space when they deem themselves in need, a place where they are not going to be judged, where support is on hand from both professionals and their peers.

Building links with other supports, like the café at GDCC, would ensure that individuals will have their needs met appropriately and in a timely manner. Ensuring that the Out of Hours Crisis Café is a partnership with NHS and third sector mental health and addiction services would create a holistic response to those at risk of suicide.
Recommendations

The following recommendations are made by the author and the North East Glasgow Health Improvement Team:

- Carry out a full feasibility study for an Out of Hours Crisis Café including economic evidence of its potential benefit.

- Join up working with other Suicide Prevention research and initiatives in Glasgow, i.e. DBI and the Evaluation of Mental Health in Emergency Medicine Project.

- Explore local community hubs as organisations to partner with to provide this Out of Hours Crisis Café.

- Invite potential partners and stakeholders, Service Users and Allies & Supporters to a meeting to discuss the current situation and the potential for an Out of Hours Cafe.

- Present this report to mental health services, Community Planning Partners and elected members in the North East Glasgow area to raise awareness and discussion.
References

1 Scottish Suicide Information Database (ScotSID), 2016. *A Profile of deaths by suicide in Scotland 2009 - 2014*, s.l.: Scottish Suicide Information Database (ScotSID).


13 Distress Brief Intervention Programme Briefing Issue 2, Scottish Government, December 2016. [Online] Available at:

14 Scottish Index of Multiple Deprivation, Scottish Government, 2016.


19 Mental Health Crisis Care Concordant: Improving outcomes for people experiencing Mental Health Crisis, Department of Health and Concordat, 2014.

20 Carers UK, 2016. [Online]

21 Surrey and Borders Partnership NHS Foundation Trust, 2015. [Online]


27 HOSPITAL RUNNING COSTS, 2016. S.L.:ISD SCOTLAND NATIONAL STATISTICS.
28  NHS *Pay Scales, 2016-17*, s.l.: Royal College of Nursing.


## Appendices

### Appendix 1

<table>
<thead>
<tr>
<th>Month</th>
<th>Total Attendances</th>
<th>Reported use as an alternative to A &amp; E</th>
<th>To help maintain wellbeing during difficult time</th>
<th>For social reasons</th>
<th>Total Numbers of people attended the project</th>
</tr>
</thead>
<tbody>
<tr>
<td>October</td>
<td>252</td>
<td>48 (includes 2 regular attenders)</td>
<td>172</td>
<td>32</td>
<td>81</td>
</tr>
<tr>
<td>November</td>
<td>201</td>
<td>41</td>
<td>138</td>
<td>22</td>
<td>57</td>
</tr>
<tr>
<td>December</td>
<td>211</td>
<td>45</td>
<td>148</td>
<td>18</td>
<td>59</td>
</tr>
<tr>
<td>January 2015</td>
<td>314</td>
<td>51</td>
<td>235</td>
<td>28</td>
<td>92</td>
</tr>
<tr>
<td>February 2015</td>
<td>319</td>
<td>58 (18%)</td>
<td>235 (74%)</td>
<td>26 (8%)</td>
<td>102</td>
</tr>
</tbody>
</table>

(The Safe Haven Evaluation Report, 2015)
Appendix 2

A&E Exploratory Analysis 2016

Source: ISD A&E datamart

Data Quality

Background notes: There is no national standard coding list for diagnostic coding at A&E departments in Scotland.

For sites which return episode level information at least one of the following should be recorded and submitted to ISD:

- Diagnosis code: list of 20 high level codes based on the ICD10 codes
- Diagnosis text: This is a free text field
- Disease code: ICD10 codes, these are usually mapped from Diagnosis text where a pick list has been used

In addition the patient’s presenting complaint can be submitted as free text.

Diagnosis recording in A&E is a mixture of symptoms and diagnoses. The intent of the injury may not be recorded.

Methodology:

A&E datamart

Type of attendance  New and unplanned returns
Age  16 and over

Disease Codes (ICD 10)  
R458  Other symptoms and signs involving emotional state
X60 - X84  Suicidal ideation (tendencies)

Intentional Self-harm

Diagnosis text, presenting complaint  
Free text terms  Suici, DSH, self harm

Exclusions:  
Free text terms  ANDSH; BLEEDSH; BLOODSH; DSHOULDER; DSHIVER; DSHALLOW; DSHARP; DSHUNT; DSHAPT; DSHINGLE; RNEDSHE; DSHAK; KIDS; NEEDSHIS; DSHOCK; DSHORT; WOUNDSH; DSHIFT; COULDSHE; DSHOUDER; BEDSHEET; DSHEAD; NEEDSHELP; DSHIGH; DSHIN; DSHOUSE; DSHAMPOO