Brighton and Hove Local Involvement Network

A&E Treatment of Self-Harm and Suicide Attempts at Royal Sussex County Hospital

Agreed 18th April 2012

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ACKNOWLEDGEMENTS

- Those who have used the services at A&E in the Royal Sussex County Hospital who were kind enough to contact the LINk and share their experiences
- Mind and Mindout for providing information from their focus groups
- All organisations that provided comments for the report: representatives from Sussex Oakleaf, Grassroots Training, Rethink and the LINk mental health action group
Comments from local organisations

‘This report is very welcome, it highlights the main themes and issues between the interface of people experiencing mental health crisis and the hospital accident and emergency service. I am pleased to be able to support and endorse this report, as having an extremely valuable set of recommendations, which if addressed could see significant improvements for vulnerable people during periods of mental health distress.’ – Chair of mental health action group/ CVSF well-being & health representative

‘A&E, for many people, is a crucial first point of entry to mental health support when they don’t know where else to turn. It is a tragic indictment that the very professionals a person needs help from in a time of crisis can make you feel worse about yourself, ashamed and sent away feeling unsupported. How many people don’t make it back to A&E because of that?’ – CEO Sussex Oakleaf (Mental health and substance misuse crisis support)

‘Vulnerable people who have self-harmed or have attempted suicide, for the first time or after a series of past attempts need to be met with empathetic staff who can offer some understanding about their needs. The report outlines a helpful point that for some people, presenting at A&E is their first point of contact following a suicide attempt. The support some people receive at accident and emergency can tend to their physical needs well, but in some cases, the mental health of the person is not prioritised and this shows in the findings of the report. Vulnerability needs to be met with safety- the findings highlight that this is not always the experience for some people, and through the SOS project we have occasionally received the same feedback from referrals we get from A&E. I feel that accident and emergency staff should be trained in ASIST, information should be offered or send out to their addresses of further support in the area, such as SOS at Rethink.’ – Group lead, Rethink survivors of suicide (group support, crisis intervention, outreach and signposting)

‘We welcome this report, which sadly echoes many of our participants’ reported experiences at A&E. The report reflects the impact of deeply-running stigma towards people who self-injure and behaviours around this. Whilst we recognise improvements have been made, we think there is always room for more lessons to be learned. We teach workshops on understanding and working with self-injury, and are happy to collaborate with the hospital to train key staff in this area.’ – Director of Grassroots Training (Training in suicide intervention, mental health awareness and self-injury)
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Background
As need rises and funding decreases for support services around mental health\(^1\), a rise in A&E attendance for people in mental health crisis has been predicted by local and national service providers. With Brighton & Hove already having a high prevalence of mental health issues\(^2\) and suicide attempts compared to the rest of the UK, further rises would put increasing pressure on all remaining services, particularly Royal County’s Accident and Emergency (A&E) department.

For many people in mental health crisis, A&E is the first point of entry into the mental health system. People presenting with physical self-harm injuries related to a suicide attempt are deeply vulnerable psychologically as well as in need of physical treatment. Upon contact with A&E, patients need understanding, empathetic staff and a safe, calm environment to wait in and seek further help. In order to prevent the physical harm reoccurring, those in crisis crucially need a system which supports their mental health needs and directs them to appropriate resources and support services outside of A&E. It is the finding of this report that these needs are not always met at Royal Sussex County Hospital, which may lead to repeat admittance and unnecessary distress in some situations.

Method and justification
Last year the LINk completed a short documentary on mental health stigma in Brighton & Hove, in conjunction with the University of Brighton\(^3\). Through a large range of interviews with people in Brighton, a reoccurring theme emerged of people’s negative experiences in A&E after self-harming or suicide attempts. It was decided to investigate this finding further, to gain more detail regarding the specific nature of people’s experiences. With the permission of service managers, an advertisement was placed in a range of mental health services in Brighton and Hove. The advertisement invited people to contact Brighton and Hove LINk with their experiences of Royal Sussex County Hospital’s treatment of self-harm and attempted suicide in their Accident and Emergency department.

\(^1\) An article on the increasing need for mental health services and decreasing services [http://bit.ly/ruWbPl](http://bit.ly/ruWbPl)
\(^2\) Mental health prevalence for Brighton & hove compared with the rest of the UK [http://bit.ly/GRzoUN](http://bit.ly/GRzoUN)
15 issues were logged in total, many referring to multiple examples of both personal experience and experiences of supporting friends and family in mental health crisis. Issues more than 2 years old were not included in the findings. The topic has stimulated more logged issues for Brighton & hove LINk than any other to date. 2 focus groups co-incidentally held by voluntary sector professionals also contributed to the report. The Mind Live project, run by Mind Brighton and Hove, supports its members to be involved in improving local mental health services. They held 2 focus groups around the topic of out-of-hours services, the discussion and recommendations of which focused on A&E services. 7 service users attended. MindOut provide advocacy, advice and weekly support groups to those in the LGBT community who have mental health problems. Their focus group on the same subject included 3 service users, one of which was a person from the transgender community. In total, 25 individuals with lived experience contributed their experiences and ideas to this report. The following groups the accounts into themes and includes recommendations from mental health providers and service users. ‘Accounts’ refer here to a mention of a particular topic; accounts of multiple aspects of service at A&E might be present in any one person’s experiences.

Findings
For many people A&E will be their first contact with services presenting with a mental health problem or episode of poor mental health. Patients often expect that that this first contact in a time of crisis will be sensitively handled and help them get the support to recover. Contributors felt that often this expectation is not met and that physically based health emergencies are prioritised over mental health crises.

‘I could hear the nurses discussing me. They said “if you think the cuts on her stomach are bad you should see her arms”’

Sensitivity to an individual’s mental state is essential to provide proper care, yet the insensitive sharing of patient information has been accounted several times at Royal Sussex County’s A&E department. People in mental health crisis stated that they often overheard staff comparing the severity of a patient's self-harm injuries in a
colloquial and casual manner which has caused offence and upset. During staff handovers patients who had self-harmed or attempted suicide were identified loudly in front of other patients present, leading to feelings of embarrassment and public shaming for those affected. In the cases where staffs were challenged on confidentially issues by their patients, some staff were reported as withdrawing from communication with the patient, resulting in a further breakdown in relationships. Self-harming and suicide attempts are commonly related to a high level of self-stigma and occur at times of low self-esteem. At a time of such high vulnerability experiences like this can be very upsetting. These experiences have caused some to actively avoid seeking medical help in Brighton & Hove after a self-harm injury or overdose.

‘You've gone to A&E for safety and it doesn't feel safe at all’

There is often a desire to be around familiar people and places when in crisis, making the decision to go out to A&E a very difficult one for some. The environment that people are in is often cited as a key element in the calming or exacerbation of their mental state. A busy public space with strangers who do not fully understand a person’s condition can add to stress and panic for those in mental health crisis. 13 individual accounts were provided of incidences where patients felt unsafe and threatened in the A&E environment, triggering a worsening of their mental condition. These often occurred in conjunction with being identified in front of other patients as being in mental distress. Many people with mental health problems have come from a background of trauma, having the presence of loud and sometimes intoxicated people around them can lead to heightened mental distress and a desire to leave which is not always acknowledged or understood by staff. 2 accounts referred to self-harming in A&E toilets due to the frustration and negative experiences there, leaving the department without being checked on by staff.

‘Professionals seem to forget that it isn't easy to talk about what's going on inside your head’
Some accounts suggested that those who are still feeling vulnerable and in an unsafe state are sent home with little or no resources to support them in their time of crisis. There was a sentiment that staff were ill equipped to deal with mental health patients and so left them alone until a psychiatric doctor could attend, often waiting for very long periods of time. Accounts mentioned the effect of sleep deprivation and hours of uncertainty on their mental state as some reported waiting up to 24 hours to be seen by a professional following an incident of self-harm. Despite this large range of stresses, becoming agitated or asking to leave was sometimes implied to be childish and timewasting. Patients that responded to us said they felt like a burden to the staff and would end up going home in vulnerable and delusional states. In one account a patient was sent home whilst explicitly stating that they felt unsafe and at risk, which lead to a repeat overdose. These accounts suggest this is not uncommon. Those who are told to go to their GPs the next day face a night in mental health crisis with more uncertainty and waiting. Beyond this there are many accounts of people being moved ‘from pillar to post’ for a long period of time with little or no outcomes eventually being achieved. With every new doctor or psychiatric liaison, patients had to answer long personal questions multiple times, which led to the feeling that the services were not being properly co-ordinated and that they were not being treated with enough sensitivity.

79% respondents commented on the negative attitudes of A&E staff towards them during a mental health crisis. Staff attitudes led to A&E attendees feeling segregated, like burdens and sometimes in a more anxious and confused state than on entry to the hospital. Many felt there was a lack of empathy and compassion. 8 accounts expressed instances where staff made those in crisis feel like they were wasting time and resources of A&E that should be used on physically ill patients. This was conveyed by attitude and action and, in some cases, through staff directly stating that they felt this was the case. Many expressed an impression that they should not have sought help at all following self-harming or suicide attempts. This has led to attitudes of active avoidance of medical help in times of crisis, or attitudes that self-harm and overdose should be severe enough for staff to acknowledge the intensity of their mental state.
‘A person was asked by nurses what was the point was of her keeping on coming up to the hospital and wasting all their resources time after time’

Care and compassion, such as talking to the patients or making eye contact, were reported as routinely absent from communication with mental health patients, although these remained present for those with physical health problems. Those who had self-harmed felt like they were being punished for their actions, some felt that being put in corridors instead of beds was an extension of this. One patient heard a doctor instructing nurses to sit a patient with self-harm injuries on a chair because ‘we don’t give beds to self-harmers’. This behaviour clearly demonstrates a prioritiisation of physical health over mental health, and stigmatises self-injury. Accounts have also pointed to doctors being less understanding and more accusatory than other A&E staff in general. All of these behaviours are detrimental to the mental state of already very vulnerable people.

Those with negative experiences stated that at the time of crisis they did not have the mental strength to challenge or formally complain about the level of service they had received. Many felt that their complaints would go unheard even if they were able to voice them. One account recalled being called “paranoid” when trying to make a complaint about her care, a small example of the subordination that some have experienced.

Conclusion
It is a standard practice to recommend that in times of mental health crisis and high risk, people should go to A&E to seek help. Yet in terms of physical space, attitudes and actions everyone who contributed to the report felt A&E is an unsuitable place for those in crisis to be in its current form. Staff attitudes towards self-harming at Royal Sussex County were highlighted some time ago in the mid-nineties through a series of patient and staff interviews\textsuperscript{4} which were presented to the hospital. The poor attitudes highlighted in that report sadly still seem to be a part of the culture in A&E today. To the people who contributed to this report it seems that the system is

unsympathetic and unsupportive both on the ward and in terms of providing resources to prevent reoccurrence of crisis. With the clinical commissioning group aiming for a 15% reduction in A&E admittance in the near future, it is operationally, as well as ethically essential, to be more sensitive to and supportive of the needs of this population.

A large amount of the negative experiences that we recorded can be attributed to poor staff attitudes towards mental distress, self-harming and attempted suicide. It appears that at times there is an active prioritisation of physical over mental health problems. There also appears to be a lack of understanding about mental illness, leading staff to believe those in distress are attention seeking or ignorable by definition of their mental condition. This exacerbates the problem and leads vulnerable people to feel more isolated and desperate than ever, particularly as they are exposed to these poor attitudes for prolonged periods of time waiting for psychiatric staff to attend to them. For these reasons training in mental health awareness in A&E staff, both nurses and doctors, is essential in helping to avoid such damaging experiences happening again in the future.

The physical environment of A&E can also exacerbate negative experiences. Focus groups discussed alternatives to A&E, but concluded that because of the physical treatment that is needed, emergency services should remain hospital based. However, the focus group’s agreed solution was a separate space within A&E for those in crisis; with trained staff available and optional peer support with a possible advocacy role. Resources for people once they have left A&E are an essential element of care and reducing readmissions. Pre and post crisis support spaces outside of A&E are also very important and should be signposted to anyone leaving the ward.
Recommendations
On the basis of the aforementioned experiences, Brighton & Hove LINk is making the following recommendations to Brighton and Sussex University Hospitals NHS Trust:

**Shorter term Recommendations**

1. All staff who work in A&E should demonstrate better mental health awareness, in particular with attempted suicide and self-harm through training (see resources section)
2. As standard practice upon discharge from A&E, those in mental health crisis should be given information and contact details for local crisis resources
3. Resources should be available in the waiting room for patients and their relatives/carers on mental health issues such as suicide and self-harm (see resources section)
4. A commitment to keeping patients informed if waiting time exceeds expected limits, and an awareness of the anxiety and uncertainty patients are facing

**Longer term recommendations**

5. Create a separate, quieter and safer area needs to be made available in A&E for those in mental health distress
6. Investigate a carefully supported voluntary peer support network in A&E, which would provide extra support and help to those in crisis to help reduce isolation.
7. Have psychiatrists available in A&E in order to reduce waiting times, frustration and worsening of conditions while they wait to see specialist staff bought in from outside the hospital
Resources

- Local training in self-harm, suicide intervention and mental health awareness
- A short film about mental health stigma in Brighton & Hove
- Free factsheets around all mental health issues http://bit.ly/wCYyT7
- Booklet on how to cope with suicidal feelings http://bit.ly/AwMT2Q
- Key facts about self-harm http://bit.ly/x8UVSI
- List of online self-help resources for self-harm and self-injury. email
  office@grassroots.org.uk