Suicide Prevention Strategy 2013 - 2016

Theme A: Responding to people in distress

Distress Brief Intervention – description and proposed specification

10.4.15

Introduction

A better response by services to individuals in distress is seen as a key component in supporting people at risk of non-fatal self-harm, future suicide prevention and mental health services. This is evidenced by work in relation to Commitment 19 of the Mental Health Strategy (2012 – 2015) mentioned below.[1]

This paper seeks to better define the concept of a Distress Brief Intervention (DBI) building on the previous concept paper delivered to the Scottish Suicide Prevention Strategy Implementation and Monitoring Group on 14.11.14. It also recognises the challenges of providing a compassionate response from first line responders and of connecting individuals to the range of local services and facilities.

The vision we have is that the DBI will consist of 2 components. Firstly, a frontline assessment and signposting and secondly, where appropriate further contact within 24 hours for a 14 day maximum period of community problem solving and support.

DBI referral will provide an additional option for front line staff. DBI would allow contact within 24 hours with a trained worker who will explore an individual's problems that are leading to the distress in a non-judgemental and supportive way, signposting and supporting the person as appropriate to specialist services and documenting this in a shared distress plan.

Furthermore, we consider it important that as part of a DBI vision, general change would take place happens to improve the response of all people to distress. This would consist of a population level increased understanding and empathetic response with simple 'mental health first aid' skills of listening and problem solving support.

Alcohol brief interventions (ABI) is a model which has been influential in the development of DBIs. However there are some important differences between ABIs and the proposed DBI
- ABI was rolled out along with significant investment and Health Board delivery targets as part of a National Alcohol strategy.
- An established evidence base of effect supported ABI development and clinical buy in to delivery.
- ABIs were defined as single, opportunistic contacts where a person's alcohol problem was identified and then information given with the intent of persuading the

[1] http://www.scotland.gov.uk/Publications/2012/08/9714

person to reduce their drinking and to seek further help. DBIs are conceptualised as having 2 components – an initial one of assessment and signposting and a secondary , next day community package time limited package of support and problem solving.

Strategic and Policy Background – why is this important in Scotland?

Commitment 19 of the Mental Health Strategy says
" We will take forward work , initially in NHS Tayside, but involving the Royal College of General Practitioners as well as social work, the police and others, to develop an approach to test in practice which focuses on improving the response to distress. This will include developing a shared understanding of the challenge and appropriate local responses that engage and support those experiencing distress, as well as support for practitioners. We will develop a methodology for assessing the benefits of such an approach and for improving it over time."

Commitment 1 of the Suicide Prevention Strategy says
" We will take forward further work on self-harm as part of the publication of a document on responding to people in distress. This work will take into account feedback from the public engagement process which helped inform the development of this strategy, the current work in Tayside in relation to Commitment 19 of the mental health strategy and the Scottish Government's report Responding to self-harm in Scotland: final report.

Commitment 3 of the Suicide Prevention Strategy says
" We will map existing arrangements for responding to people in distress in different environments and localities and will use this information to develop guidance which supports safety and person-centredness.

A better approach by services to individuals in distress would also help

- management of the high prevalence of mental health issues presenting to emergency services including police and Accident and Emergency departments (A&E).
- management of repeat attenders to A&E where this is contributed to by an underlying emotional component, with the aim of reducing the need for re-attendance in future.
- support cultural change in response to feedback from individuals about the need for improved compassionate response to them when they are in crisis.
- reduce self-harm and suicide.
- better identify mental health, social and substance misuse problems to allow better and more timely connection to appropriate specialist services and other community supports.
- provide an additional option for front line services in managing and supporting presentations of distress where there is an emotional component.
- provide an evidence based toolkit for workers to apply in situations of mental health distress.

It is intended that the improvements outlined above should be introduced across Scotland, with local area implementing actions according to local need and local circumstances.

Evidence base – why do it?

NHS Education Scotland are doing a literature review of psychotherapeutic approaches to distress. We hope to extend this review using an academic working group commissioned by the Suicide Prevention Strategy Implementation and Monitoring Group.

A wide variety of interventions have been tried to reduce suicide rates and separately to reduce self-harm. Analysis of accident and emergency department attendances shows the high prevalence of emotional / stress associated problems, especially in repeat attenders. The police also report similar problems commonly presenting as a feature of their emergency work.

Experience in related pilot work in NHS Tayside has shown what is important to people who have experienced distress. In particular people did not want to wait for a further intervention. However it must be recognised that assessment and problem solving in distress is best delayed a few hours to allow any emergency situation to be assessed and managed and to allow a more controlled, safe 'cold light of day' timing that may allow a person in distress to recover from any intoxication or have some sleep before they explain and discuss their problems.

What is the definition of distress?

General distress is something everyone recognises. It is defined in the Oxford dictionary as "*extreme anxiety, sorrow or pain*"[2]. It is an emotional response to physical or mental pain. It can present with obvious external evidence of feeling including crying and shouting but also can present with behaviours such as self-harm, aggression, violence and withdrawal. The phenomenon of somatisation - where a person feels a physical symptom in their body as the expression of internal psychological conflict - means that emotional distress can also present as medically unexplained symptoms.

Distress intervention therefore applies across a wide variety of situations. At its most general it is about a compassionate, listening and problem solving response by everyone when they encounter distress. This is at the level of social attitude change and is best considered alongside work that is being done on mental health stigma – the See Me campaign[3] - and on public awareness and individual response to suicidal ideas.

[2] http://www.oxforddictionaries.com/definition/english/distress
[3] https://www.seemescotland.org/

A more specific Distress Brief Intervention (DBI) is proposed for a smaller subset of distressed people. The definition of distress appropriate for DBI intervention for these individuals would be

- *distress not requiring immediate emergency service involvement (beyond contact such as transport, first aid or specialist hospital admission) but with an emotional component that includes risk to the individual or to others*.

How is risk defined?

There is UK-wide debate about the best approach to assessing and managing risk in mental health services. “Check list” tools exist and are used in services. These recognise the different dimensions of risk in a mental health context and the factors raising or reducing it. There are, for example, a number of types of risk which might be associated with distress:

- risk to self from self harm and suicidality.
- risk to others through violence.
- risk to self from neglect.
- risk to others (dependants) from neglect.

In acute settings, other aspects of risk are considered e.g. risk of falls in the elderly and infirm, risk of bed sores in the immobile etc.

There is concern that the simple assessment of risk does nothing to reduce it. Instead, what is important is how risk assessment leads to creation and modification of a risk management plan for an individual. Risk also must be seen as a dynamic process and needs considered at all clinical contacts. Staff tend to do this intuitively but the use of standardised assessment and risk management tools seeks to formalise the dimensions considered, acting as an ‘aide memoire’ and allowing standard documentation and communication.

Risk assessment and management in Scottish services must connect to and relate to legislation - in particular:

- Mental Health (Care and Treatment) (Scotland) Act 2003 – where risk to self or others is a necessary factor in detention.
- Adults with Incapacity (Scotland) act 2005 – where risk in incapable adults is considered.
- Adult Support and Protection (Scotland) Act 2009 – where risk of vulnerability in capable adults is considered.
- Children and Young People (Scotland) Act 2014 - where specific risk to children under the age of 16 is considered

In DBI assessment it needs to be recognised that delivery would be by non-specialists but the option would always exist for additional specialty service involvement. DBI practitioners would therefore need a simple understanding of the dimensions of risk as above with the expectation of prompt and low threshold referral to other services as appropriate. It would be envisaged that the default process

would be a communication and discussion of any concerning immediate risk with primary care, or social work services as appropriate.

Engaging the person in distress in assessment and consideration of risk would be an essential part of the dialogue of the DBI. Self-awareness and management of risk would be a key part of the process and would support the mutual creation of a future crisis management plan that would avoid distress presentations in future. A DBI would not be done to a person, it would be done with them.

Who is it for?

- Anyone aged 16 and above.
- People in the community presenting to any front line service - including Primary Care, A&E, Police, Local Authority and Third Sector services - in distress that fulfils the above definition.
- **All presentations of self-harm** that do not require emergency specialist referral or admission.
- Repeat attenders to A&E where the reason for attendances are not primarily due to physical health problems – or for "medically unexplained symptoms". More than 3 such presentations in a month would trigger a DBI referral.
- People already attending specialist mental health services, including substance misuse teams. Communication would be essential to ensure the services and the DBI service were aware, to allow them to coordinate their support.
- Representations of distress who have not had a DBI within the past 6 months.

Front line providers uncertain whether or not to refer for the ongoing next day DBI component could discuss with seniors in their team, or with on call mental health services, or with individual's GP. If emergency issues have been dealt with and there is still doubt about the person's distress, they would be encouraged to refer.

Who is it not for?

- Children and Young people under the age of 16. These are excluded as DBI interventions for under 16s would require a different skill set with different challenges in relation to the involvement of parents or other carers. It would be hoped that following any successful roll out of over 16 DBIs features of the approach might be modified to allow extension of the idea to younger age groups.
- People who have had the next day, up to 14 day, component of DBI within the past 6 months,
- People who need specialist referral – DBI would not provide an alternative to specialist mental health and addiction services. It would not be a substitute for good psychiatric assessment and access.

What would happen at an initial presentation of distress?

- Generic distress of any sort requires an empathetic front line response.
- Emergencies would be dealt with no differently from current practice.
- Routine advice, signposting and referral to specialist and support services would be dealt with no differently from current practice. This means that front line response would engage the person, screen and refer them on, provide information and expect the person to take some further steps themselves. This first component of DBI would need enhanced training to front line providers building on existing training on mental health first aid and ASIST training.
- DBI ongoing referral to the next day component provides an additional option for front line staff that allows contact within 24 hours with a trained worker who will explore an individual's problems that are leading to the distress.

How does a first line responder refer someone in distress for a DBI?

Front line assessment would be no different from current practice (excepting a hopeful general upskilling of empathetic approach in all services). The option of DBI referral to next day practitioners would be additional to existing management and disposal options. The first line service responder would need to form an opinion that the person presenting fulfilled the criteria for a DBI and would discuss it with the individual presenting - and, with the individual's consent, with any relevant carer or relative accompanying them. DBI referral for next day contact would only be made for individuals who agreed to referral. A short standard referral form would be emailed to the DBI service securely. The form would also be emailed to the person's GP as well as to any other relevant currently involved service e.g. a community mental health team.

The referral form would include:

- the person's contact details, including phone numbers for next day follow up by DBI service.
- the nature of the emergency presentation of distress and its immediate management and assessment of risk.
- the details of the referrer and their service.

The individual in distress would be given a leaflet explaining DBI, what to expect from it, and relevant contact numbers for the DBI service and for other relevant sources of support (e.g. NHS24, Breathing Space, Samaritans).

Who delivers the DBI and where?

The first component would be delivered by front line workers in a variety of settings

- Police settings
- Ambulance services
- Emergency departments
- GP surgeries

The second component of DBIs would happen in the community at the level of primary care and voluntary organisations. Local services would need to identify resources at that level which related across to primary care. Different providers and models could exist and local flexibility is important e.g.

- Primary care workers in health centres.
- Primary care mental health team workers – e.g. Glasgow PCMHT service
- Commissioned and / or agreed voluntary organisations e.g. Addaction equivalent in Glasgow alcohol services provision.

It would be envisaged that on receipt of a community referral, a DBI worker would make telephone contact with the individual and negotiate a time and safe place for assessment. This might be at a health centre, through a home visit or at another suitable premises.

DBI contact would be limited to within 9am to 5pm, 7 days a week. If additional supports out with those times were needed, specialist crisis and mental health services would be informed and would be able to provide support to the person in broadly the same way as they would at present.

What is a DBI?

A DBI is a time limited, assertive, supportive and problem solving contact between an individual in distress and a service provider. It would include:

First component

- Initial empathetic assessment, risk assessment and signposting as necessary with a further decision whether to refer onto the next day community DBI local service.

Second component

- Empathetic problem focused assessment – physical, psychological and social.
- Recognition of past trauma and attachment in the person's life and how these affect the present.
- Risk assessment and self-management.
- Identification of existing supports and assets.
- Exploration of strategies to help resolve problems.
- Information and supported signposting to specialist services and other community resources.
- Creation of a future plan – how to identify and avoid triggers, what to do.
- Exploration of the possibility of local connection of the individual with a peer support worker.

The contact between the individual and the provider would be limited to 14 calendar days and this would be highlighted at first contact.

It would be important to align the training components of a DBI with those already being used in suicide prevention (e.g. ASIST and STORM) and 'mental health first aid'. These training packages would need to connect to each other using common approaches and tools where possible.

How is it documented and communicated?

The front line first component would be documented and communicated as currently happens for all emergency presentations.

For the second component, at first contact, an initial draft DBI plan would be created with the individual and communicated as appropriate with the person's GP during the 14 days of contact. If it was agreed necessary, the plan would be shared with relevant A&E, CMHT etc. Throughout the 14 days the plan would be considered a draft to allow it to be extended and modified until the last meeting of the individual with the provider, when the plan would be finalised and then always copied for the GP and any involved appropriate service. Copies of it would always be kept
- by the person in distress
- by their GP in their primary care record
- by the DBI service in an electronic database.

With the consent of the person in distress, copies might also be kept
- by a relative or carer
- by local A&E departments
- by local community mental health services in the psychiatric case record
- by local community substance misuse services in their case record
- by a social worker involved with the person and therefore in local authority records.
- by police and ambulance services.

How is it evaluated?

The following outcome measures would be applied to the second ongoing community component:

Individual measures

- Measure of distress and unhappiness at first and last contact e.g. Derogatis 1993 brief symptom inventory, Wolpe 1969 Subjective units of distress scale or similar.
- The individual's experience of DBI service questionnaire at discharge.
- Service provider clinical global impression (CGI) rating at discharge. Although this is a clinical rating scale its use could be modified to allow DBI practitioners to apply it.

Aggregate measures

- Total local DBI service activity survey monthly reports – number and source of referrals.

- Signposting and referral activity to other local services and whether these were used by the person in distress or not.
- Audit of repeat attenders to local A&E department.
- Audit of Scottish Ambulance Service callouts
- Audit of Police Scotland callouts.

What would governance arrangements be?

A DBI pilot would report to

- The Scottish Government Mental Health and Protection of Rights Division and through that to the Scottish Suicide Prevention Strategy Implementation and Monitoring Group.
- Local Health and Social care partnership management.

Outline of key tasks in taking this forward and some timescales

1. Literature review to establish evidence base and use others' experience to modify service specification and outcome measurement. The literature review can provide us with information on components of the intervention, such as definition, examples of service delivery, length of intervention, evaluation and outcomes, training elements, issues related to risk. This is being undertaken by NES and is expected to be completed in late April/ early May 2015.
2. Identify training components and establish training pack for first and second components building on existing training opportunities.
3. Create templates for referral form, DBI leaflet, DBI plan. Agree risk assessment approach.
4. Agree specific outcome measures.
5. Focus groups for further refinement – May/June 2015.
6. Summit (as agreed with Police Scotland) - September 2015.
7. Identify pilot site(s) – ideally within boundary of HSCP and project leads. - Agree funding criteria within context of Innovation Fund May – June 2015
8. Advertise funding opportunity July / August 2015
9. Assess funding applications in Sept 2015
10. Allocate funding – Oct / Nov 2015.
11. Train, deliver and monitor from Dec 2015 / Jan 2016
12. Modify specification as consequence of pilot experience. Quarterly reports March 2016, June 2016, Sept 2016, Dec 2016.
13. Nationally promote model with guidance document on specification in 2017-
14. Publish experience - 2017
15. Evaluate sustainability options of savings generated by DBI feeding back into employment, training and delivery - mid 2017

Questions for Focus groups to consider – to include:

- Comments on definition of distress?
- Comment on 2 components of DBI and how they connect?
- Who is DBI for?

- Who is DBI not for?
- Who would provide it?
- Where would it be provided?
- Comments on risk – to whom, what? Assessment of risk?
- When should initial assessment / take place?
- Total Duration of DBI?
- After what interval can it be repeated?
- Comments on who handles /shares the info?
- Comments on evaluation options / possibilities?