The Scottish Government

DISTRESS BRIEF INTERVENTIONS: RATIONALE AND EVIDENCE

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1. Background and rationale

Research and debate since the early 1990s has looked at the ways in which health services deal with people presenting with self-harm or in 'distress' (Smith 2015, Saunders in press). Some commentators argue that health services can respond poorly or unhelpfully to people's emotional demands, or that their needs may be neglected, and that these responses can have profound effects on patients, staff and organisations. In a number of countries 'Brief Contact Interventions' (BICs) or 'Distress Brief Interventions' (DBIs) have been developed and evaluated to help address this.

NHS staff and service users in Scotland are advocating the need for an improved service response for people presenting to services in *distress* (Scottish Crisis and Acute Care Network 2013). Accident and Emergency Departments, GP surgeries, the Ambulance Service and the Police report dealing with people experiencing distress. Overall, there is an increasing interest in the potential for distress brief interventions in Scotland and a commitment in the Scottish Strategy for Mental Health to explore this further.

To support the further development of a distress brief intervention in Scotland we have:

1) Reviewed the international research literature to understand more about the common characteristics of these interventions and the emerging evidence about their appropriateness and effectiveness. We looked *specifically* at evaluations of 'Distress Brief Interventions' (DBIs) and 'Brief Intervention and Contact' or (BICs), not at the wider literature on suicide prevention and reducing self-harm.

2) Reviewed recent evaluation and performance reports of similar services being piloted in Scotland. These are 'grey' literature produced by the NHS and/or third sector organisations in Scotland.

2. Distress brief interventions – key characteristics

DBIs and BICs are generally low-resource interventions which aim to reduce deliberate self-harm, suicide attempt, and suicide. Different models and modalities have been used internationally, but there are some common characteristics:

- They generally aim to ensure a compassionate and appropriate response at first contact. Such a response is considered to be critical.

- They generally seek to maintain longer-term contact, in some way, with patients rather than offer additional therapies or treatment, although they often offer a route back into services.

- Those delivering the intervention do not need to be mental health specialists, psychiatrists, psychologists or social workers (De Leo 2010), they simply need to express genuine concern and support.

- They are usually structured and scheduled, and are delivered over a sustained period of weeks or months, but the intervention is invariably time limited.

- They commonly employ direct ongoing contact using a variety of different modes (e.g. postcard, telephone calls) and can offer the possibility of re-contact with health and social services if required. A combination of modes is often used. Only some involve personal contact.

- They have mostly been used with clinical populations following an episode or episodes of self-harm or suicide attempt. However, they have also been tried in other populations, including after-care for psychiatric hospital inpatients (Motto et al 2001) and young people seeking mental health treatment (Robinson et al 2012).

3. The evidence

There is an extensive international literature on treatments and interventions for self-harm and suicide. However, the evidence base on interventions for DBIs and BCIs is relatively small in comparison. Nonetheless, recent reviews and a meta-analysis, alongside individual studies, are potentially helpful in planning and implementing such an intervention in Scotland.

A systematic review of brief contact interventions (Luxton 2013) looked at the effectiveness of these interventions in *reducing suicidal behaviours*. This review included 11 studies and concluded that brief interventions might be a promising intervention in reducing suicidal behaviour, but further research was required. Of the 11 studies in the review, five found a significant reduction in suicidal behaviour, while a further four studies showed mixed results and two showed no effect.

The most recent review of brief contact interventions (Milner 2015) encompassed a *broader range of outcomes,* including deliberate self-poisoning, self-harm and attempted suicide. The interventions studied differed in modalities used (including telephone calls, postcards, Green Cards and crisis cards) and varied in the intensity and length of follow-up.

The authors conducted a meta-analysis combining the results of 12 eligible studies. Using pooled odds ratios the meta-analysis showed:

- a non-significant reduction of repeat self-harm in the intervention group
- a significant reduction in the number of repetitions of self-harm (or suicide attempts) over time in the intervention group
- a non-significant reduction in deaths from suicide in the intervention group

They also concluded that studies have shown some differences between specific population groups, but they are inconsistent. While some studies have shown differences between first time suicide attempters and those who have attempted suicide previously, the results differ across studies. Some studies have shown intervention benefits for women, but not men, however others have found no

difference by gender.

Crucially these studies were conducted in different countries and cultural contexts. What the control group may receive in terms of 'treatment as usual' is likely to have varied considerably. Further the cultural attitudes towards suicide and self-harm and the stigma involved in presentation, treatment and participation in a study are likely to vary widely.

4. Interventions and individual studies

If we look at individual studies included in the meta-analysis we can clearly see the differences in interventions, country and health settings and results. These interventions have been studied world-wide including in the UK, Australia, New Zealand, Taiwan, Sweden and a WHO multi-centre study (India, Iran, Brazil, Sri Lanka and China).

The interventions evaluated actually vary quite markedly in terms of their content, human contact, and follow-up. They also differ in their target groups, including some studies looking specifically at those who self-harm by self-poisoning and two looking specifically at young people (under 16 years and 15-24 years).

The trials of the interventions also vary in their sample sizes, attrition rates and outcome measures, making comparisons challenging. The outcomes measured across studies include suicide mortality, actual and threatened self-harm, suicide ideation, frequency of self-harm events, treatment adherence and other measures of mental health and wellbeing.

The key studies, associated interventions and their key characteristics are set out in Table 1 below. For our interests, this table also includes two other UK studies not included in the meta-analysis (Bennewith 2002 and Kapur 2013). The Bennewith study was excluded from the meta-analysis because it was a practitioner focus intervention (though very similar to other interventions), the Kapur study because it was a feasibility trial. The UK studies are shaded for easy reference.

Table 1: Study characteristics and key findings in chronological order

Lead author	Intervention	Setting	Target group	Follow-up	Key finding
Morgan et al (1993)	Green card indicating on-call doctors availability	Hospitals, United Bristol Healthcare Trust, UK	No previous history of DSH	12 months	Significant reduction in actual and seriously threatened DSH in experimental group
Cotgrove (1995)	Standard management plus a token allowing readmission on demand	Five hospitals and their child/adolescent clinics in England	Adolescents aged 16 years or younger discharged from hospital following a suicide attempt (1987-1990)	12 months	Differences between groups do not reach level of statistical significance, but suggest lower rates or repeat attempts in the intervention group
Cedereke (2002)	Telephone interventions at 4 and 8 months to increase motivation for professional treatment	University Hospital in Lund, Sweden	All patients treated after a suicide attempt	12 months	Telephone interventions seemed to have an effect on patients who at their suicide attempt had other treatment than psychiatric and in those with no treatment.
Bennewith (2002)	Letter from a GP offering patient consultation	Primary Care, Avon, Wiltshire and Somerset Health Authorities	Attenders at Accident and Emergency for deliberate self-harm	12 months	Incidence of repeat episodes of deliberate self-harm was not significantly different in the intervention group.
Evans (2005)	Crisis card offering 24 hour crisis telephone consultation after standard treatment	General hospital, Bristol, UK	Those admitted to general hospital following self harm	12 months	No overall benefit of the intervention
Vaiva (2006)	Telephone call at 1 month or 3 months after discharge	13 Emergency Department in the North of France	Those presenting at Emergency Departments after attempted suicide by deliberate self poisoning	13 months	Participants contacted at one month were less likely to report reattempting suicide at follow-up
Fleischman (2008) – also later reported in Bertolote below	Brief intervention and contact (BIC) – standard 1 hour follow-up and periodic contact thereafter	Emergency Departments in Brazil, India, Sri Lanka, Iran and China	Suicide attempters	18 months	Reduction in suicide mortality in the BIC group

Bertolote (2010)	Brief intervention and contact (BIC) – standard 1 hour follow-up and periodic contact thereafter	Emergency Departments in Brazil, India, Sri Lanka, Iran and China	Suicide attempters	18 months	Repeat suicide attempts were similar in experimental and control groups – though some differences between countries
Beautrais (2010)	Six postcards mailed over 12 months	Emergency Services, Christchurch Hospital with self-harm or attempted suicide	Adults aged 16 years and over presenting	12 months	This intervention did not reduce further self-harm – it may be effective only for selected sub-groups.
Hassanian-Moghaddam (2011)	Eight postcards at 1,2,3,4,6,8,10, 12 months after discharge and on birthday including an addressed envelope to reply	Poison Centre, Tehran, Iran	Patients over 12 years of age admitted to the Loghman-Hakim Poison Hospital for self-poisoning	12 months and 24 months	This postcard intervention reduced suicidal ideation and suicide attempts among those who self-poison
Robinson (2012)	12 postcards sent monthly to young people following presentation to a mental health youth service	Specialist mental health youth service in Melbourne, Australia	Young people aged 15-24 years following presentation to the service	12 months	No significant effect on suicide risk, though patients reported that they like receiving and used the recommended strategies
Carter (2013)	2013 Series of 8 postcards sent in a sealed envelope at ,1,2,3,4,6,8,10,12 months after discharge in addition to treatment as usual	Hunter Area Toxicology Unit, covering all of greater Newcastle area, New South Wales	All individuals who self poisoned who presented to the Hunter Area Toxicology Unit, New South Wales	5 years	The post-card intervention halved self-poisoning events (for women) and reduced psychiatric admissions by a third after 5 years.
Kapur (2013)	Information leaflet (emailed) and two telephone calls and subsequent letters (developed using qualitative research)	Emergency Departments in Manchester, UK	Those presenting at Emergency Departments with self-harm	12 months	Pilot study that showed methods were feasible, recruitment challenging and (crucially) an indication that repeat self-harm was more common in intervention group
Chen (2013)	A single crisis postcard (tailored to the client based on case managers assessment) sent 3 months later	Kaohsiung, Taiwan	Referred cases, including hospitalised patients and those identified by police and fire	6 months	The intervention did not significantly reduce subsequent suicidal behaviour

5. UK Studies

The results of five studies conducted in the UK may be of particular interest. These are set out in grey above. Indeed one of the earliest studies was in the UK evaluating a 'green card' which set out what times an on-call doctor would be available if further problems arose (Morgan). This was to address issues of non-compliance in the study group, focusing on those presenting for the first time for DSH. This study did show a significant reduction in actual or seriously threatened DSH in the experimental groups at 12 month follow-up.

This was followed by a study by Cotgrove and colleagues published in 1995 of a token allowing readmission on demand for adolescents under 16 years of age. It showed no statistical significance between groups, but suggested lower levels of repeat suicide attempts among those who received a token for re-admission on demand. The sample sizes in the control and intervention groups were small. This study also showed that the token was not used excessively, but appropriately, allaying concerns among health professions that had been expressed in advance of the intervention.

A further study based in the UK in 2002 was conducted in a primary care setting in England (Bennewith). This was a clustered randomised controlled trial of 98 GP practices. This was not included in the meta-analysis because it was considered to be a practitioner focused intervention. The intervention was a letter from the GP inviting the patient to a consultation. Patients were eligible for the study if they were registered on a case register for deliberate self-harm. The incidence of repeated episodes of deliberative self–harm at 12 months was not significantly different in the intervention group. There was some evidence that the treatment was beneficial for people with a history of deliberative self-harm, but may be associated with an adverse effect in people whose indexed episode was a first episode.

In 2005, Evans and colleagues examined the impact of a crisis-card among those presenting with self-harm to a general hospital in Bristol on preventing repetition of self-harm. They concluded that there was no overall effect, despite some indications at the 6 month period that those with a first episode of self-harm might be benefitting. This was not found at 12 month follow-up. However, although this study was relatively large, it did not have the statistical power to exclude an important effect for those presenting following a first episode.

The most recent study in the UK was a pilot in Manchester by Kapur and colleagues in 2013 is interesting and raises concerns about adverse effects. It was a pilot randomized controlled trial of Manchester residents who presented with self-harm. The intervention was developed using a series of qualitative interviews and focus groups with potential service users and providers. There was an information leaflet mailed, two follow-up telephone contacts and 6 follow-up letters. It showed the trial was methodologically possible, although recruitment was a challenge. The trial was small, but did show that those who received the intervention appeared to be more likely to repeat self-harm than those who received treatment as usual. The authors of the meta-analysis set out earlier ran their model again with the Kapur study included and it made no difference to the overall result.

6. International studies

The largest study to date has been a WHO multi-centre study in five countries (Fleishman 2008, Bertolote 2010, and country level reports e.g. Vijayakumar 2011). This study assessed the

effectiveness of Brief Intervention and Contact (BIC), an adaptation of an alcohol brief intervention model. This involved a one hour session as close as possible to discharge, followed by periodic follow-up contacts. The first results from this study suggested that the BIC intervention reduced subsequent suicide deaths in the following 18 months. However, while there were some differences between countries, repeat attempts at suicide over the next 18 months were similar in the BIC and control groups.

The study with the longest follow-up period (5 year follow-up) was led by Carter and colleagues in New South Wales (Postcards from the Edge). They found no difference for any repeat episode self-poisoning admission. However, there was a halving of self-poisoning *events* and a reduction in psychiatric hospital admissions by a third after 5 years. Crucially the first effect was limited to women. Two things potentially set this study apart from others. Firstly, the intervention was arguable more 'intense' (8 in 12 months in addition to treatment as usual). Secondly, the target recipients had been admitted for self-poisoning specifically.

This was also the case in the study based in Tehran by Hassanian-Moghaddam and colleagues, all patients had been admitted for self-poisoning. This large study showed a postcard intervention sustained period (which included an expression of on-going concern, and the offer of contact was successful in reducing subsequent suicidal ideation and suicide attempts. A significant reduction in suicide ideation was found for men and women, however a significant reduction in suicide attempts was found for females only.

However, some studies in different countries have shown no effect, or only for selected sub groups. For example, Beautrais (2010) found that their postcard intervention in New Zealand did not reduce self-harm, despite interim findings that the intervention was associated with a large and significant reduction in self-harm re-presentations. This appears to be because the interim findings did not include re-presentations to Emergency Departments (only psychiatric emergency services) and interim data were not adjusted for a history of self-harm. A methodological weakness of this (and other) studies appears to be differences between control and intervention groups at baseline, despite randomization.

Similarly Chen (2013) in Taiwan found their single postcard intervention (tailored to the patient after case management) did not significantly reduce subsequent suicidal behaviour. However, again there appeared to be some differences between intervention and control groups in terms of their history of suicide attempt and some in the intervention group did not read the postcard, potentially underestimating the effect of intervention.

7. Children and young people

Only two studies were specifically aimed at young people. A study of an intervention with 15-24 year olds was published by Robinson and colleagues in 2012. Participants were recruited after presentation at a specialized mental health youth service. This concluded that there was no significant effect of their 12 postcard intervention over 12 months, although participants reported that they liked receiving the postcards and that they (over half) used the strategies. The authors note that their population was a particularly morbid one, with high rates of mental health conditions, suicide-related and self-harming behaviours. They suggest that the intervention might be more effective among a less unwell cohort.

The other study of an intervention with young people under 16 years (Cosgrove 1995) is now over 20 years old. As mentioned earlier, it showed no statistical significance between groups, but suggested lower levels of repeat suicide attempts among those who received a token for re-admission on demand.

8. Scottish pilots and evaluations

While there are no large scale trials and evaluations in Scotland of interventions to address distress, a number of Scottish pilots and tests of change have been completed, or are underway, to help people presenting to services in distress and/or having self-harmed. Interestingly, these are much more likely to involve direct person contact than the studies reviewed in the international literature and more likely to involve cross-agency partnership.

The Sources of Support (SOS) service in Dundee began as part of the Equally Well programme in Dundee (CHRE 2015). It aimed to address the personal and social circumstances that affect patients' health and wellbeing that GPs have neither the time, nor necessarily the skills, to tackle. Three link workers across 4 practices were appointed to help people identify the issues they wished to address and support them to access local services. Between 2010-2014 there were 656 referrals.

The interim report produced some promising findings, including 87% of patients completing the four initial consultations and 72% of goals set by patients being met. A key challenge was keeping people engaged with the programme. The report produced 5 patient 'typologies' that may be helpful in future service planning and delivery – the 'resistant', 'challenging', 'vacilitator', 'dependent' and 'focused'. Also crucial for service development are the facilitators identified including the important role of family and friends, the tenacity and local knowledge of the link worker and a flexible service response around the SOS service.

Another interesting series of 'tests of change' took place in Dundee during 2013 (Early Screening Group). This was partly in response to people appearing in A&E with distress or self-harm. The task was to consider how to better respond to mental health problems. Overall the tests found that people, if given the opportunity, will take up the offer of a confidential listening ear. Further, and interestingly, this appears to be more successful at later follow-up rather than immediately at crisis point (e.g. liaison psychiatry, policy custody). Crucially, this seems to work well if delivered at the '*right places at the time, by the right people with the right attitude*'.

Lothian Health Board is expanding Interpersonal Therapy (IPT) for Acute Crisis across a number of sites and partnership areas in Scotland after an early test of concept (Graham et al 2015). IPT is the preferred response to people in distress because of its strong evidence base and its psychosocial focus and inter-personal problem solving approach. It has also been tried in various settings across Scotland since 1996. IPT is a systematic, but brief, support and triage. After three sessions the therapist and participant make a decision about further support. An evaluation of the expanded service is underway.

A further service in Lothian, Patient Experience and Anticipatory Care (PACT) service, aimed to support and protect adults at risk of harm defined in the ASP Act 2007 presenting at A&E, including the Scottish Ambulance Service (SAS), out of hours services and minor injury units (NHS Lothian

2014). Increasing numbers of NHS Boards have expressed interest in becoming involved. The review of this work concluded that the Scottish Government should identify ways of responding to adults in distress who do not seem to come under the ASP legislation, or are judged not to meet the criteria.

Finally, a recent pilot between Police Scotland and NHS Greater Glasgow and Clyde developed partnership working between the police and the existing Crisis Out of Hours CPN Service. Police Officers across the pilot area used the Community Triage Service on 234 occasions in the first 6 months of 2015. Each of these incidents involved one person who appeared to the officers either to be in distress or suffering from a mental health related issue. Over 90% of individuals accepted telephone consultations with CPN's. Following their telephone consultations, CPNs conducted a total of 31 (14% of the telephone consultations) face to face assessments. Overall the pilot showed that most police related incidents were satisfactorily dealt with and concluded by a telephone consultation between the individual concerned and a CPN. This largely obviated the need for the police to take them to hospital.

9. Key observations and implications for Scotland

- On balance, the evidence and meta-analysis would point to DBIs and BICs as potentially promising interventions. In particular there is some evidence that they may be effective in reducing the frequency of self-harm. However, the number of available studies internationally is small, individual studies are relatively small-scale and a variety of outcome measures are used making comparison and aggregation challenging. Overall, some caution is required.

- Of particular concern is the evidence from a small number of studies, including the recent pilot in Manchester (Kapur), about potential adverse effects. This may be because repeat contact may remind people of the problems they have been experience and potentially revive suicide ideation. This would need closely monitored in any piloting or evaluation of a DBI in Scotland.

- There are methodological challenges noted in a number of papers that may affect the results. Studies reported baseline differences in the control and intervention groups, under-powered studies and/or challenges with attrition. Further, it can be difficult to ascertain 'compliance' in the intervention group, particularly where there is little direct human contact, so the effects of the intervention may be under-estimated.

- The design and nature of the intervention may be critical. 'DBIs' or 'BICs' are a range of different interventions, often pre-designed by health professionals and researchers. Kapur's study in Manchester appears to be the only intervention that has involved potential service users in design. However, Evans also concludes that further qualitative research might be required to better understand first time self-harmers in particular. The focus on co-production of services in Scotland might make that an important first step.

- The 'intensity' or 'dosing' of an intervention may play a role in determining effectiveness. The postcard interventions that included 8 or more interventions demonstrated positive results, although critically these interventions were with those admitted for self-poisoning specifically. It is suggested by a number of authors that the intensity and length of DBI and BICs could be incorporated into future research studies and trials.

- Further, while it is difficult to conclude this from the studies reviewed, other research suggests that the human touch may be important. Some authors suggest the 'logic' underpinning these interventions is that they provide a sense of social connectedness. However, many of the interventions studies had little direct human contact at follow-up, they simply involved letters and postcards. Nonetheless, some DBIs evaluated had some initial direct contact, telephone follow-up, tailored messages and offers of support. The pilots and test of change conducted in Scotland to date almost invariably have, or offer, some human contact.

- A small number of authors note that their population of study was a particularly morbid one, with high rates of mental health conditions, suicide-related and self-harming behaviours. It is plausible that the interventions offered may be more effective among a less unwell cohort.

- Clearly some of these studies data back to the 1990s, again highlighting the need for caution in interpreting these results. There have been major changes in mental health service provision across the UK and specifically in Scotland since then. Indeed Scotland has seen a reduction in suicide mortality since the 2000s.

- This is further evident in the modalities used in the interventions examined in this paper. The rise of social media and digital technologies may open up further the scope for low cost interventions. Other services, including, for example, sexual health services, are now using digital technologies to contact and follow-up patients.

- Overall, the conclusion from this review is that Scotland should explore further the potential for a co-designed, low cost, distress brief intervention for those presenting with distress. Crucially, feasibility testing and piloting should be accompanied by robust evaluation, in particular to ensure there are no adverse effects from intervention.

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