The Scottish Government

Suicide Prevention Strategy 2013 - 2016

Theme A: Responding to people in distress

Distress Brief Intervention – description and proposed specification following stakeholder engagement

14.12.15

Contents *Page Number*

Summary

- The proposal for a distress brief intervention (DBI) has emerged from work on the Suicide Prevention and Mental Health strategies. The need to improve our response to distress has been strongly advocated by service users and front line service providers. By intervening early at primary care level, the DBI seeks to better engage and equip people in managing their own health. The DBI proposal uses learning from alcohol brief interventions and falls prevention.

- The proposal is for a 2 level approach delivered to all presentations of distress (including self-harm) that have an emotional component and associated risk and that do not require alternative emergency service involvement.

- Level 1 is the first response at the time of distress. It would be delivered by existing front line staff in all emergency services and in primary care. Level 2 is a 14 day maximum contact, initiated within 24 hours. It provides supportive problem solving and signposting, done *with* the person in distress. It would be delivered at a primary care level, probably by a governed and supervised voluntary organisation. It would fit well into integrated local approaches to population wellbeing and health improvement.

- This paper describes the proposal in detail, building on extensive engagement with - and comment from - a range of stakeholders. Review of the international literature and learning from national projects also support the proposal. The paper sets the policy, strategic and evidence base context, and defines the process and its evaluation. Pilot work is now intended, with resources coming from a mixture of the Scottish Government's innovation fund, and additional funding announced by the Scottish Government on 24 May 2015. Several Boards and organisations have expressed interest in involvement and the next stage consists of agreeing who delivers the pilot and where.

- 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. DBI would not be delivered by specialist mental health services and would be applicable to a wider range of people, whether in contact with specialist mental health services or not.

- Future sustainability would rely on the model delivering for Integrated Joint Boards. It is anticipated that savings potentially released through reduction in mainstream service use may present opportunities to pay for continuing service delivery.

- There are various existing supports that could be aligned with a national standard approach. Training tools already exist and would need only slight adjustment. Third sector organisations already have experience that could be used.

- The process is being governed through the Scottish Government Suicide Prevention Strategy Implementation and Monitoring Group.

Introduction

A better response by services to individuals in distress is seen as a key component in supporting (1) people at risk of non-fatal self-harm; (2) future suicide prevention and (3) mental health services. This is evidenced by work in relation to Commitment 19 of the Mental Health Strategy (2012 – 2015) [1] mentioned below (p4).

This paper seeks to better define the concept of a Distress Brief Intervention (DBI) building on the previous concept paper discussed by the Scottish Government's Suicide Prevention Strategy Implementation and Monitoring Group on 14.11.14, 6.3.15 and 11.9.15 . 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 Appendix includes material on care pathways and relationship to national clinical guidelines.

We envisage the DBI providing a framework for improved inter-agency co-ordination, collaboration and co-operation across a wider range of treatments and community supports towards the shared goal of providing a compassionate and effective response to people in distress, making it more likely that they will engage with and stay connected to services or support that may benefit them over time.

The DBI will consist of 2 levels. Firstly, a relatively simple 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. These were originally described as "components" but the term "levels" was agreed as being more helpful as it connects to the Fall Prevention model [2] (see below p4) in terms of language and does not imply that both parts are necessary to always be delivered for a full DBI.

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 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.

[1] http://www.scotland.gov.uk/Publications/2012/08/9714
[2] http://www.gov.scot/Resource/0045/00459959.pdf

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

National work on Falls has significant parallels with this approach. The Scottish Government in 2014 published "The prevention and management of Falls in the Community" (ref above) and its associated Framework for Action. To prevent serious fractures in the elderly - with associated poor outcomes, a National approach has been defined with front line assessment of all falls (level 1) that identifies high risk individuals for onward more specialist assessment and intervention (level 2). Cognitive impairment and bone health have been identified as the two most important predictors of outcome for incorporation in level 1 screening. Level 2 intervention consists of creation of a personalised 'Fall and Fracture Prevention Action Plan'. It should be emphasised that level 1 and 2 Falls assessment and intervention is intended to be delivered by health and social care community staff, not by specialist secondary services. This is parallel to our proposals on Distress where assessment and intervention is not intended to be delivered at specialist mental health service level.

This proposal therefore does not intend any 'medicalisation' of distress - instead it recognises its multifactorial and social nature.

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.

The better, standardised management of distress in Scotland would support the Scottish Government's 2020 vision where

- We have integrated health and social care.
- There is a focus on prevention, anticipation and supported self-management.
- Care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions.
- There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of readmission.

We anticipate that the DBI model delivery will be facilitated by integration of health and social care and provides an example of where integrated service provision could work to improve local population health and wellbeing.

The DBI approach is all about equipping people with the skills and supports to manage their own health and to prevent future crisis. A DBI is not done to a person, it is done with a person.

DBIs would be delivered at primary care level by a range of people, including staff at GP surgeries, social care staff and third sector staff. Their delivery would not be about 'medicalising' distress.

We anticipate that a better approach by services to individuals in distress may 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 and to primary care 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 identification of 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 – subject to an initial pilot phase - the improvements outlined above should be introduced across Scotland, with local areas implementing actions according to local need and local circumstances.

Evidence base – why do it?

The evidence for DBI has come from several sources, including:

- Lived experience testimony
- Pilot experience in a variety of settings and geographies
- NHS Education Scotland literature review of psychotherapeutic approaches to distress.
- Academic opinion sought by the Suicide Prevention Strategy Implementation and Monitoring Group.
- Literature review by the Scottish Government's Health Analytical Services Division.

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.

Different approaches have been tried in different Scottish settings to better address the issue of distress. Examples include
- Dundee Sources of Support Service. Their recent evaluation of 100 cases between 2011 and 2014 helpful identified 6 'patient typologies". They provided link workers to 4 GP practices with a broad remit to help patients create an assets based action plan to address any issues in their life they wished to.
- closer Police Scotland and NHS Scotland collaboration in responding to people in the community who present with mental health issues
- Lanarkshire Association for Mental Health in-reach to local emergency department.

England and Wales have agreed "crisis concordats" which are multiagency principles around better mental health crisis response, including that to people in distress.

Feedback from National Focus Groups, stakeholders and other sources – what do people think?

In several stakeholder engagement events run by the Scottish Government in 2014 and 2015, there was strong support for a national approach to respond to distress and the concept of a DBI. Specific debates around aspects of the proposal are described below.

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*"[3]. 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 – for example through the See Me programme[4] - and on public awareness and individual response to suicidal ideas.

A more specific Distress Brief Intervention (DBI) is proposed for a smaller subset of distressed people. This group of people is sometimes identified as 'hard to help', when in fact they find the help they need difficult to access. We want to ensure that people in distress can access and benefit from safe, effective, person-centred care and, if required, appropriate treatment through a pro-active, collaborative approach that prioritises engagement, follow up and agreed action by both professionals and people in distress. The definition of distress appropriate for DBI intervention for these individuals was debated through the engagement events. There was general acceptance of 3 parts to the definition and agreement around the inclusion of somatisation. The important avoidance of medicalization of distress was emphasised.

The final definition was

- *An emotional state of distress, that includes risk to the individual or others, and which does not require further emergency service involvement.*

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

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 simply assessing 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 must also 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 for assessment when detention is being considered.
- 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 distressed person 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. As indicated above, a DBI would not be done *to* a person, it would be done *with* them.

There was broad agreement that DBI practitioners' assessment of risk would be at a simple level with the expectation that they would pass on any concerns as appropriate rather than attempt to further assess or manage them. There was consensus that any service referring a person to DBI should not expect the DBI service to contain or manage risk. DBIs would therefore not remove the need for front line services to refer to specialist services. DBIs would be best perceived as an additional, helpful support that may provide an additional disposal option for the management and help of distressed people.

What is a DBI?

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

Level 1

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

Level 2

- Empathetic problem focused assessment – physical, psychological and social.
- Identification of existing supports and assets.
- Recognition of past trauma and attachment in the person's life and how these affect the present.
- Risk assessment and self-management.
- 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. There was broad consensus around this as described above.

It would be important to align the training components of a DBI with those already being used in suicide prevention -e.g. (but not limited to) ASIST; STORM; and Mental Health First Aid. These training packages would need to be connected to each other using common approaches and tools where possible. These existing resources and their application are described above.

Who is the DBI for?

- Anyone aged 18 and above. This was subject to considerable debate, including discussion at the engagement events. There was an aspiration that

DBI should not be limited to any age group or demographic on equality principles. There was an alternative view that recognised that presentations, services and legislation were significantly different for children and young people. It was noted that most child and adolescent services now have 18 rather than 16 as the cut-off age. The emerged consensus was that it seemed sensible to limit early pilot work and delivery to over 18s before an aspiration of extending the DBI approach to younger years.

- 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 reasons 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. This was supported and there was little debate about the number or frequency of re-attendance.
- Repeat attenders to primary care where the reason for attendances are not primarily due to physical health problems – or for medically unexplained symptoms. A frequency threshold of presentations was not thought to be necessary, instead the referral for DBI was thought to be best left to clinical judgement by primary care staff.
- People already attending specialist mental health services, including substance misuse teams. Communication would be essential to ensure that the services and the DBI service were aware, to allow them to coordinate their support.
- Representations of distress where the person has not had a DBI within the past 6 months. This was subject to considerable debate, with no emerged consensus. Some people felt there should be no restriction on repetition however others recognised that it might reinforce dependence and would have resource issues.

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 the person'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 18. These are excluded as DBI interventions for under 18s 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 18 DBIs, features of the approach might be modified to allow extension of the idea to younger age groups. As indicated above, consensus emerged about over 18s with an aspiration that future work should attempt to deliver the model to all ages.
- People who have had the next day, up to 14 day, component of DBI within the past 6 months. As indicated above there was no consensus.
- 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. This was supported. There was some confusion about the difference between mental health specialist crisis services and distress brief interventions. In this proposal they are considered to be separate. Crisis interventions are considered to be delivered through specialist mental health services to people with mental health problems involved with mental health services. Distress interventions would not be delivered by specialist mental health services and would be applicable to a wider range of people, whether in contact with specialist mental health services or not.

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 e.g. Mental Health First Aid and ASIST training. It was recognised that a wide variety of resources for appropriate training exist, including compassionate listening 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 general up-skilling 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 local contact numbers for the DBI service and for other relevant sources of support (e.g. NHS24, Breathing Space, Samaritans).

There was debate about the possibility of doing more at the first presentation. It was agreed that specific DBI workers at the front line 24 hours a day would provide significant help and support, allowing seamless connection to ongoing DBI level 2 work and engaging the person from the outset. Examples of this were described specific to services. The resource practicalities of this were however recognised to be significant. There was also sympathy with the argument that DBI level 2 engagement would be better deferred beyond the immediate hours of distress presentation to allow the distressed person to sober up or sleep and to allow the initial level 2 work to start when the distressed person is more able to attend and concentrate on the task.

Who delivers the DBI and where?

Level 1 would be delivered by front line workers in a variety of settings

- Police settings
- Fire and rescue services
- Ambulance services
- Accident and Emergency departments
- GP surgeries

Level 2 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.
- Commissioned and / or agreed voluntary organisations.

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 outwith 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.

There was broad debate about the practicalities of creating and maintaining a local DBI workforce. Issues of recruitment, training, supervision and governance were all emphasised. It was widely recognised that the work of DBI practitioners would be stressful and demanding and these individuals would need good support from supervisors and peers. Boundary issues between the distressed person and the DBI practitioner were recognised as being fundamentally important. For this reason there was consensus that a DBI must be a short, time- limited contact. It must be explicit to

all involved that if a person requires a longer term support or counselling arrangement then this should be provided by a different service. 14 days was considered a reasonable period of contact.

Comment from the Scottish Association for Mental Health (SAMH) indicated that there is Scottish experience and expertise in creation, training and management of an appropriate third sector workforce. It was recognised that many different services currently provide aspects of a Distress service and these workforces might be built upon. This mirrors the different training opportunities that have been developed. There was therefore acknowledgement that, subject to dedicated funding and commitment by integrated joint boards in health and social care partnerships, a DBI workforce could be created to deliver the model.

How is it documented and communicated?

The front line level 1 would be documented and communicated as currently happens for all emergency presentations.

For level 2, 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.

There was broad agreement with this approach and no specific issues raised of concern in relation to information sharing. It was emphasised that the person in distress would need to understand from the outset that the contact would be documented in the above way and that sharing of the DBI plan with the person's GP and in an electronic database would always happen.

How is it evaluated?

The identification of intended outcomes allows the consideration of indicators to measure these. The effect of delivery of DBIs would impact on service user, service providers, service utilisation and potentially on population health and wellbeing.

Effect would be demonstrable by experiential feedback, and by measurement comparisons before and after DBIs were available to an individual and – potentially - to a population. Comparison of contemporaneous populations where one has access to a DBI service and one does not (or is given a different response to distress) may also provide evidence of effect (subject to standardisation of populations). It would be important to look for short term, medium term and longer term effect.

Evaluation of Cost Effectiveness would be necessary to allow future DBI commissioning decisions. A challenge would be that the potential savings of DBI delivery may be to a wide variety of services e.g. criminal justice, health and social care, substance misuse. Effects on reducing stigma at a service and population level would be valuable to measure if possible. Longer term effects e.g. on improved parenting on the development of children would be very difficult to measure.

Part of the Scottish Government Project for DBI delivery would need to explicitly agree and commission an evaluation. The Scottish Government's Health Analytical Services are providing advice on this.

outcomes	**Short term - level 1**	**Medium term - level 2**	**Longer term - 6 months later**
Improved service user experience – feeling cared about.		questionnaire about level 1 and 2 experience at discharge	structured telephone interview questionnaire by DBI worker
Reduced distress		rating scales as below	rating scales as below
Increased number of people with distress plans shared across services			number shared DBI plans
Improved service provider experience – feeling better equipped.	service providers sample questionnaire	Service providers questionnaire	sample questionnaire
Reduced MH stigma	service providers sample questionnaire	service providers sample questionnaire	population and service providers sample questionnaire, Scottish attitudes survey.
Fewer repeat attendances to emergency services			audit of presentations to A&E, Police, fire and rescue, ambulance.
Fewer admissions following distress presentation	admission rates to acute medical and psychiatry	admission rates to acute medical and psychiatry	admission history of person over last 6 months

			compared to 6 months before DBI
Fewer presentations of medically unexplained symptoms			attendances to primary care and A&E over last 6 months with MUS compared to 6 months before DBI
Reduced suicide			Scotsid population data
Efficient use of DBI services	Awareness by questionnaire and ratio of referrals to presentations	uptake and use of contact with level 2 DBI worker	
Efficient use of other services		referral to and uptake by other specialist supports and services	

The following rating scales are examples of measurement tools that could be used:

- Measure of distress and unhappiness at first and last contact e.g. Derogatis 1993 brief symptom inventory, Wolpe 1969.
- Service provider clinical global impression (CGI) rating at discharge modified for non-clinicians.
- Clinical Outcome in Routine Evaluation measures (CORE).

Due to the relatively small numbers of suicides in any local area over time and due to the multiple confounding factors affecting suicide rates it would extremely difficult to justify that any apparent change in suicide numbers was due to DBIs. It would be hoped, though, that DBI provision could add to the effect of other suicide prevention work that is ongoing so it is still considered worth tracking crude suicide numbers through the pilot and beyond.

What would governance arrangements be?

A DBI pilot would report to:

- A DBI Project Board
- The Scottish Government Mental Health and Protection of Rights Division and through that to the Scottish Suicide Prevention Strategy Implementation and Monitoring Group.

Within Scottish Government the following Divisions would have an interest in DBIs as the intended response to distress and its effect would have wide policy interest. The following departments / policy areas would be invited to be involved throughout:

- Primary Care
- Substance Misuse, Alcohol Misuse.
- Health Improvement and Equality

Appendix – Current Care Pathway

There is much important information already widely available with regard to appropriate responses to people who present with self-harm and distress. The following quote explains something of the phenomenon of self-harm and underlines the importance of early intervention.

"Self-harm is very common and involves a wide range of methods, the most common being self-poisoning with prescribed or over the counter medicines, or by cutting. People self-harm for numerous reasons, and although self-harm is not usually an attempt at committing suicide, it is a way of expressing deeper emotional feelings, such as low self-esteem, the emotional results of previous abuse and hurts. However, people who self-harm are much more likely to die by suicide, and many suffer from long term physical effects of self-injury and self-poisoning, as well as psychiatric problems such as depression. It is very important that we help identify people who self-harm sooner and to help them come to terms with the underlying problems and access treatment when they need it…"[5]

A key source of information are the two NICE Guidelines on Self-Harm - one is on the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care in the first 48 hours of having self-harmed[6]; and the other is clinical guidance on the longer-term treatment of self-harm[7].

Among the priorities for implementation[8] in treating people for self-harm within the first 48 hours is the requirement on healthcare professionals to take full account of the likely distress associated with self-harm. Also, clinical and non-clinical staff who have contact with people who self-harm in any setting should be provided with appropriate training to equip them to understand and care for people who have self-harmed.

---

[5] Professor Tim Kendall, Director, National Collaborating Centre for Mental Health (NCCMH) Medical Director, Sheffield Health and Social Care Trust; Consultant Adult Psychiatrist quoted in "Self-harm: longer-term management, Issued: November 2011, NICE clinical guideline 133" National Institute for Health and Clinical Excellence, Manchester, 2011. CF footnote 5 for link

[6] http://www.nice.org.uk/guidance/cg16/chapter/1-Guidance

[7] http://www.nice.org.uk/guidance/cg133/resources/new-nice-guidance-for-the-longerterm-management-of-selfharm

[8]

In the recommendations on long term treatment of self-harm, health and social care professionals working with people who self-harm are required to develop a trusting, supportive and engaging relationship with them, be aware of the stigma and discrimination sometimes associated with self-harm and ensure that people are fully involved in decision-making about their treatment and care.

Another valuable source of information is the 2013 study, by the Confidential Inquiry into Suicides and Homicides, about Boards/Trusts that implemented more and less than 10 Inquiry recommendations or service changes. Those Boards/Trusts that implemented more than 10 Inquiry recommendations had lower suicide rates than those that implemented 10 or fewer recommendations.[9] The 17 recommendations and service changes covered ward safety, specialist community mental health teams, information sharing, multi-disciplinary review of suicides, NICE guidance of self-harm, depression and schizophrenia. The study yielded the following key messages for mental health services to improve safety:

- provide specialist community services such as crisis resolution/home treatment, assertive outreach and services for patients with dual diagnosis;
- implement NICE guidance on depression;
- share information with criminal justice agencies;
- ensure physical safety, and reduce absconding on in-patient wards;
- create a learning culture based on multi- disciplinary review.

[9]http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/impact_of_service_changes.pdf