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Evaluation of the Distress Brief Intervention Pilot Programme: Summary of findings

HEALTH AND SOCIAL CARE

social research

Contents

Background

Distress Brief Interventions (DBI) have been developed to support people experiencing distress. There are two levels to this approach:

- Level 1: Trained frontline staff provide a compassionate response and offer referral to the DBI (Level 2). Level 1 frontline staff are from Police Scotland, the Scottish Ambulance Service, NHS Accident and Emergency departments, and Primary Care.
- Level 2: On receiving a referral, specially trained staff from third-sector organisations attempt to make contact with the person within 24 hours. The staff then provide the DBI over around 14 days (in line with individual need). The intervention is community-based and includes a problem-solving intervention, as well as including distress management action planning and signposting to further support. The DBI is not a clinical intervention, and is not designed for those with severe or enduring mental illness, or complex psychosocial needs.

The Scottish Government initially set up pilots of the DBI programme between November 2016 and March 2021 in four areas (Aberdeen, Inverness, Lanarkshire and Scottish Borders) – and initially targeted those aged 18 and over. The pilots expanded during this period to other geographic areas, and to include those aged 16 to 17.

The DBI programme represents a national and regional collaboration between health and social care, Primary Care, emergency services (Police Scotland, Scottish Ambulance Service and A&E Departments) and the third sector.

Evaluation

The Scottish Government commissioned an independent evaluation of the DBI pilots. The evaluation only covered the four initial areas in which the DBI programme was piloted, and focused on those aged 18 and over[1].

Aims

The aims of the evaluation were to determine:

- The extent to which the DBI programme was implemented as intended, identifying variation and any associated impacts.
- The impacts of the DBI programme on services, practitioners and individuals.

Approach

The evaluation adopted a mixed-methods approach. Data were collected between 1st January 2019 and 30th April 2020 from the following sources:

[1] A very small number of service users aged 16 and 17 were included in aggregate routine Level 2 data.

- DBI Level 1 and 2 practitioners – through interviews and focus groups, and a survey
- People accessing DBI – through surveys (at the start of the DBI, at the end, and follow-ups 3 months afterwards), and interviews
- DBI service leads – through interviews
- Aggregate routine DBI data
- Agencies referred to by DBI Level 2 practitioners – through a survey

The evaluation also included a health economics analysis, which summarised the disaggregated costs together with a range of outcomes.

Ethical approval was obtained from the West of Scotland Research Ethics Service. The Health and Social Care Public Benefit and Privacy Panel granted approval for data linkage, which was an element of the evaluation.

Findings

Overview of activity

During the evaluation period (January 2019 to April 2020), 5316 referrals were made to DBI.

Breaking down these referrals:

- The largest proportion of referrals came from primary care in hours (41%), A&E department (25%), Police Scotland (16%) and psychiatric liaison service (10%).
- 58% were women, and 42% were men.
- 68% were from individuals aged between 16 and 44.
- Most individuals (almost 60%) lived in the two most deprived Scottish Index of Multiple Deprivation (SIMD) quintiles.
- Over 98% of individuals who indicated their ethnicity identified as white (including Scottish, British and Polish).
- The most commonly recorded presenting problem was feeling depressed/having low mood (61% of individuals referred).
- The most commonly recorded contributory factor was Relationship issues (61% of individuals referred).

Level 2 staff achieved the DBI programme's aim of attempting to make contact with all referrals within 24 hours. Successful contact was made with individuals within 24 hours in 65% of cases. A further 21% were successfully contacted beyond 24 hours of their referral. The remaining 14% could not be contacted by DBI practitioners.

Of all referrals made to Level 2:

- 66% took up the offer of Level 2 support.
- 14% received one supportive phone call but declined further support.

- 6% did not receive support due to an escalating level of risk, inappropriate referral or ongoing inpatient care.
- 14% could not be contacted.

Of those who received support, 84% were supported to a planned exit from the service, with the remaining 16% exiting in an unplanned way (e.g., not attending appointments, not responding to contact).

Training

The DBI training programme was developed and led by the University of Glasgow.

Level 1 training

Between October 2017 and December 2020, 997 practitioners received Level 1 training, which was delivered online through an e-learning module, or face-to-face through facilitated classroom training.

The Level 1 training was found to increase practitioners' confidence in understanding distress, delivering a compassionate response, making a DBI referral, and understanding Level 2 support. The majority of practitioners found it relevant to their role, engaging and enjoyable, and had provided them with the knowledge, skills and confidence to provide the Level 1 DBI. Level 1 practitioners were more likely to view the training as making them more able to provide a constructive response to distress, than a compassionate response.

Level 2 training

The Level 2 training was initially delivered by the University of Glasgow, and then taken over by local site managers and coordinators, who received a facilitator training pack. Most Level 2 practitioners indicated the training was relevant to their role, engaging and enjoyable, and had provided them with the knowledge, skills and confidence to provide the intervention. However, a minority of practitioners (around 15%) indicated that the training had not given them confidence or skills to deliver the intervention, and so had not adequately prepared them for their role. Level 2 practitioners often had previous experience of working with people in distress and/or with mental health issues, and found that this experience was helpful in their DBI role (e.g. knowledge of local services).

Delivery of DBI

DBI delivery has successfully adapted to different local contexts, whilst maintaining the core elements of DBI. As the delivery of DBI Level 2 services within an area increases, this will necessitate changes in staffing and other resources, such as premises. During the delivery phase, all sites were employing senior practitioners and administrative support.

Referrals to DBI were largely appropriate, with ongoing work throughout the pilot to find solutions to decrease inappropriate referrals. Level 1 practitioners reported that

when they received constructive feedback and support from Level 2 practitioners on referral appropriateness, they were able to streamline and be more appropriately selective in the referrals they made.

The guideline of a contact attempt for each referral within 24 hours was met. Most (five in six) individuals were left with a clear understanding of what would happen in 24 hours of their referral to Level 2. As the pilot progressed, more emphasis was placed on the importance of providing as much practical and emotional support as possible within that initial contact, including the use of the Distress Management Action Plan (D-MaP). Successful contact was made with individuals within 24 hours in around two-thirds of cases. rising to 86% in the following days. The analysis of outcomes suggests that this was not associated with eventual outcomes for individuals.

The 14-day Level 2 intervention guideline was met for just over half of those taking up support, with length and intensity of support provided varying by pilot site. Forty-four percent of all individuals who took up support from DBI Level 2 to planned or unplanned closure received over 14 days of support. Individuals who received up to 14 days of support received, on average, 3.1 sessions, while those who received more than 14 days of support received an average of just over 5 sessions. Although a third of individuals thought the guideline of 14 days was not enough, analysis of outcomes suggests that the length and intensity of DBI Level 2 support were not associated with either change in distress or distress levels at leaving Level 2.

A key strength of DBI is its flexibility to be tailored to the individual, resulting in its being appropriate to the needs of a wide range of individuals in distress who present with an array of different characteristics, life circumstances and problems. Relationship issues were the most commonly recorded contributory factor for both men and women, recorded in 48% of all referrals. Other common contributing factors included alcohol use (22%), life coping issues (21%) and money worries and unemployment (18% each). Alcohol use was recorded as a contributory factor in a higher proportion of men (29%) than women (16%). Substance misuse was also a contributory factor in a higher proportion of men (19%) than women (7%). Recorded alcohol and substance use were lowest among those referred to primary care in hours (10% and 5% respectively) and highest in A&E (35% and 23% respectively).

Generally, individuals engaged well with DBI Level 2, with some using plans and strategies developed with their DBI practitioner (including the D-Map) up to three months beyond the end of their Level 2 intervention. Those referred by Primary Care and mental health unscheduled care were more likely to engage with DBI Level 2 than those referred by A&E, police and the ambulance service. This may be due in part to individuals referred from emergency services having less clarity during the referral process and hence less understanding of what DBI was about, as indicated in evaluation participant feedback.

The majority of those accessing DBI Level 2 were sign-posted on to follow-up services, with practice varying by pilot site. Signposting to non-statutory services (85%) was much more common than to statutory (29%). There was considerable variation between Level 2 providers in the use of signposting to statutory services.

The differences in signposting practices partially reflect differences in presenting problems in the different areas.

Impact of DBI on individuals experiencing distress

The DBI Level 1 response has direct, immediate benefits for the individual. Most individuals thought that the Level 1 provider had helped them cope with their immediate distress. Those in less distress at the start of their Level 2 intervention were more likely to rate the Level 1 provider highly in terms of helping them to cope. This suggests that Level 1 provider intervention is important in helping individuals to cope with their immediate distress.

Level 1 worked less well for younger adults, those with higher levels of distress and those presenting to A&E. Although most individuals felt they were treated with a high level of compassion by Level 1 frontline practitioners, this varied - with younger people, those with higher levels of distress, and those presenting to A&E more likely to give a lower rating of compassion than others. Although most thought that the Level 1 provider had helped them cope with their immediate distress, this was not valued as highly as a compassionate response. Younger people and those presenting to A&E reported a lower level of help from Level 1 practitioners to cope than others.

DBI Level 2 is working well for the majority of individuals. Nine out of ten (90%) of individuals showed a continued decrease in their distress over the period of the Level 2 intervention. However, for around one in ten individuals their distress level was higher at the end of the Level 2 intervention.

Changes in individuals' level of distress following DBI Level 2 were not associated with age, gender, area deprivation, the main presenting problem, Level 1 referrer, Level 2 provider or length or intensity of the intervention. Level 2 may be working less well for women but better for younger adults in terms of their final level of distress at the end of Level 2.

Delivering compassionate care at Level 1 and Level 2 was central to helping individuals to understand their distress and reduce it. Individuals' perception of Level 2 practitioner compassion and care was positively associated with greater decreases in distress and agreement that DBI had helped improve understanding of why they felt distressed. In turn, being helped to understand why they felt distressed was positively associated with an individual's decrease in distress.

Practitioners and individuals felt that a combination of compassionate response and practical support helped to validate people's distress and break down barriers to seeking help, thereby reducing self-stigma.

Level 2 helped most individuals to manage their distress. Nine out of ten individuals agreed that DBI had given them the tools and skills to manage their distress. Findings also suggest that those going through DBI have been using what they learned during the intervention to help them manage their distress in the longer term.

DBI may also be contributing to suicide prevention. One in ten individual evaluation participants revealed that they may have attempted suicide or continued with suicidal thoughts if DBI had not been offered to them.

Level 2 seemed to work less well for some of those with long-term enduring mental health or addiction needs. Level 2 did not meet the needs of individuals when their expectations of what the programme offered were misaligned with the reality of DBI being a short-term, problem solving, practical service. Feedback from Level 1 and 2 providers and individuals also suggests that DBI is less appropriate for the needs of those with severe and/or enduring mental health problems and/or addictions. The desire to facilitate quick access for support, even when referral to DBI was inappropriate, may highlight gaps in existing services to provide immediate support to people with more enduring mental health problems. Notwithstanding these limitations, some individuals who repeatedly access unscheduled care appear to have positive outcomes from DBI.

Less is known about the longer-term impact of DBI on individuals and experiences seem mixed. Three months since their last contact with DBI around half of the evaluation participants had been in contact with the police, ambulance, their GP, or A&E because they were in distress. Half of the evaluation participants reported at 3 months that they were referred to other services by their DBI provider and four out of five of those reported they had taken up the service. For some individuals, this had led to re-engagement with work, as well as offering a longer-term support mechanism. Some reported feeling isolated and lost following DBI and awaiting further support.

Contextual factors influencing DBI implementation success

The role of DBI Central in coordinating services and enabling open communication and information sharing was perceived as an essential component of the DBI programme. The constructive leadership of the DBI programme manager was recognised as being particularly central to its success.

DBI Gatherings and local implementation groups enabled cross-sectoral delivery of DBI. The success of these events was perceived as stemming from the ‘open door’ offered by DBI Central and their continuous efforts to listen to stakeholders, acknowledge where implementation was less effective, and address issues in conjunction with those delivering the service.

Local DBI implementation groups were strong contributory factors to successful implementation at a local level. These groups enable problem-solving at a local level and were reported by some of the stakeholders involved to have successfully engaged more agencies than previous inter-agency events had managed. Champions acted as role models within services, embodying the principles and allowing the benefits to be seen by others. Where frontline existing referral systems could be used or adapted, this facilitated referrals to Level 2.

Contextual factors that impeded DBI from meeting its aims and objectives included where DBI practitioners doubted the added value of DBI and viewed DBI as potentially replacing services that are considered to be of greater use. Where Level 1 practitioners considered addressing mental health issues as being outwith their role, this also impeded implementation. A further barrier was where frontline existing referral systems could not be adapted to incorporate DBI referrals, considerably impeding the referral process.

Conclusions

Overall, DBI has proved to be successful in offering support to those in distress. Most individuals received a compassionate and practical response that contributed to their ability to manage and reduce their distress in the short, and for some, in the longer term. This is particularly encouraging as the rationale for the development of DBI was a recognition that previous services did not meet the needs of many people, which could lead them to feel let down, vulnerable or at risk.

A key strength of DBI is its flexibility to be tailored to the individual, thus meeting the needs of a wide range of individuals in distress who present with an array of different characteristics, life circumstances and problems. However, while DBI met the needs of many, it worked less well for some.

While not originally envisaged as a core component of DBI, the role of DBI Central in coordinating services, facilitating effective and efficient inter-and intra-agency networking, enabling open communication, information sharing, and problem-solving was an essential component of the DBI programme's success.

The impact of DBI on the wider service system seems to be largely positive. Level 1 and Level 2 practitioners, who took part in the evaluation agreed that DBI provides a more effective way for services to respond to people in distress and that DBI has improved integrated working across frontline services, however, consideration should also be given to ensure connectivity between other community services, ensuring capacity and demand.

Key Recommendations

Roll-out

1. The national roll-out of DBI should continue, ensuring that core DBI elements (e.g. contact within 24 hours, guideline of 14-day intervention, use of Distress Management Plan) are adhered to, along with the continuation of the central leadership, coordination and management function.
2. New DBI services should be aware that DBI may be perceived as a threat to, rather than complementary to, existing services. This may need to be overcome to ensure good engagement with and uptake of the programme amongst local delivery partners.
3. The evaluation findings should be used to inform the roll-out of the DBI programme and disseminated widely to share learning, encourage debate and further uptake of the DBI model.

DBI practitioner preparedness, training and development

4. Level 1 and 2 practitioners should not commence work on DBI until they have completed the standard DBI training.
5. DBI Level 2 training should note practitioners' previous experience and training and acknowledge practitioners' potential existing awareness and understanding of identifying distress and the importance of compassion.
6. Standard DBI training updates should be communicated to all trained practitioners, and local or service-specific top-up ('buzz') sessions should be encouraged.
7. It is recommended that Level 1 practitioners spend 1 hour of their paid work time to undertake regular DBI training (we suggest every 2 years); this should include interaction with Level 2 practitioners (where possible face-to-face).

DBI practice

8. To facilitate uptake and adoption of DBI, referrals to Level 2 should be incorporated within existing frontline services' processes.
9. Review the evaluation findings that the DBI Level 1 experience is not working as well for younger people and those attending A&E - and explore whether their experience can be improved.
10. Consider how DBI Level 2 is described and delivered as a brief intervention for those using the services and practitioners. Strategies such as leaving more expansive written information for the person being supported than is currently available could be helpful in the most challenging circumstances (e.g. when individuals are highly distressed, disoriented or affected by drugs or alcohol).
11. DBI management and practitioners should continue to work to refine the appropriateness of referrals and review whether inappropriate referrals are highlighting service gaps or unmet needs.
12. DBI management and practitioners should look for opportunities to build on the finding of the importance of helping individuals to understand why they become distressed and to recognise when it starts, as this seems key to improve reduction in distress.
13. Consider whether DBI has a potential role in offering follow-up support or contact to individuals following a planned exit (i.e. because waiting for follow-up support can be a difficult time). A more tapered withdrawal may be beneficial for some and/or checking whether individuals feel able to initiate contact with follow-up services themselves.
14. Within the Level 2 services, decisions are needed on staffing composition to ensure a range of skills and experience that will meet the needs of a wide range of service users.

Research

15. Further research is recommended on the following: the level of uptake of follow-up services after DBI Level 2; the longer-term impact of DBI on individuals and the wider service system; whether and how DBI might help prevent suicide; and the factors associated with increased distress among some individuals at the end of Level 2.

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The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

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