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Evaluation of the Distress Brief Intervention Pilot Programme

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1 Executive Summary

1.1 Distress Brief Intervention Programme

Distress Brief Interventions (DBI) are ways to support people who are in distress. The aim and content of the Scottish Government DBI programme emerged through direct engagement with people who had experienced distress, with front-line service providers, and from a literature review. Within DBI, distress was defined as,

> "An emotional pain for which the person sought, or was referred for, help and which does not require (further) emergency service response (NHS Scotland 2017)."

The DBI programme aims to provide a framework for improved inter-agency coordination, collaboration and cooperation across a wide range of care settings, interventions and community supports for people who present in distress.

The DBI programme has two Levels. Level 1 is provided by trained front-line staff from Police Scotland, the Scottish Ambulance Service, NHS Accident & Emergency (A&E) departments and Primary Care. Level 1 staff are trained to provide a compassionate response and offer individuals in distress the opportunity to be referred to a brief (around 14 days), compassionate, community-based problem-solving intervention, known as DBI Level 2. Following a referral from Level 1, Level 2 staff attempt to make contact with the individuals within 24 hours. They are empowered to deliver support beyond 14 days, in-line with the person-centred approach, based on individual need and where appropriate.

The Level 2 intervention is provided by specially trained third sector staff; it is not a clinical intervention. While some individuals receiving DBI may have mild to moderate mental health problems, DBI is not designed for those with more severe or enduring mental illness or complex psychosocial needs. As part of their problem-solving approach, Level 2 practitioners work with individuals to develop a personalised distress management action plan (D-MaP). When necessary, individuals are signposted or referred to statutory or non-statutory services at the end of DBI for follow-up support tailored to their needs.

The Scottish Government conducted the original DBI pilot programme from November 2016 to March 2021 in four pilot sites: Aberdeen, Inverness, Lanarkshire and Scottish Borders. The DBI programme has expanded in location and scope since it was first launched. The evaluation commenced during the original pilot of DBI when the service was targeted at those aged 18 and over and then incorporated a small number of under 18's following the extension of the pilot to those aged 16 and 17 in May 2019 in Lanarkshire and

Scottish Borders and July 2019 in Aberdeen and Inverness (See footnote 3, page 24).

1.2 Evaluation aims

The overarching aims of this evaluation were:

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

1.3 Methods

To meet our evaluation aims, we used a mixed-method approach, undertaking various forms of data collection and analysis between 1st January 2019 and 30th April 2020. We gathered, analysed, and synthesised data that were collected as a routine part of the DBI programme and that were publicly available. We asked individuals who had received DBI to complete questionnaires at the start, end and three months after they had completed DBI and linked this to their routine DBI data. We also interviewed people who delivered DBI at Levels 1 and 2, key stakeholders who managed DBI and related services, and people who had received a DBI intervention. We used a research approach known as realist evaluation (Pawson & Tilley 1997). This enabled us to explore both the way that DBI was delivered and understood and the extent to which it worked as intended (Creswell et al. 2011). Our realist evaluation approach provided insight into what aspects of DBI worked, for whom, and under what circumstances. Throughout our evaluation, we fed back findings to the DBI programme to enable them to make informed decisions about improvements they could make.

1.4 Key Findings

1.4.1 Implementation of the DBI programme

Overall delivery of the DBI programme was successful. The pilot programme DBI was successfully adapted, where appropriate, to different local contexts while maintaining the core elements of the DBI programme. Referrals to DBI were mostly appropriate, with ongoing work throughout the pilot to find solutions to decrease less appropriate referrals, such as individuals with highly complex needs. As DBI referral numbers grew, this necessitated some services to change their staffing and other resources, such as premises. The aim of attempting to contact each referral from Level 1 within 24 hours was met in 100% of cases. Two-thirds (65%) of individuals were contacted within 24 hours, rising to 86% in the following days. Findings suggest that the time to contact was not associated with individuals' eventual outcomes.

As the DBI pilot programme progressed, more emphasis was placed on the importance of providing as much practical and emotional support as possible within the initial Level 2 contact, including use of the D-MaP. The guideline of up to 14 days of DBI Level 2 contact was met for 58% of individuals who took up more support than just one initial supportive call, with length and intensity of support (number of sessions) varying by pilot site. Although around a third (30%) of individuals participating in the evaluation thought the guideline of 14 days was not enough, the length and intensity of DBI Level 2 support were not found to be associated with individual outcomes. Generally, individuals engaged well with DBI Level 2 with some reporting 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. Individuals referred by Primary Care and mental health unscheduled care teams were more likely to take up any support from DBI Level 2 than those referred by A&E services, Police Scotland and the Scottish 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.

1.4.2 Factors contributing to and impeding implementation success

While not originally envisaged as a core component of DBI, the role of DBI Central (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 constructive leadership of the DBI programme manager who led DBI Central and championed the DBI programme was central to this.

Cross-sectoral delivery of DBI was enabled and enhanced by DBI Gatherings (where key staff from each pilot region and national partners came together); and by local implementation groups (where an 'open door' ethos enabled (a) joint acknowledgement of where implementation was less effective and (b) joint solution generation). Local DBI implementation groups allowed problem-solving at a local level and successfully enhanced inter-agency engagement.

Contextual factors that challenged DBI implementation included where people in existing local services doubted the added value of DBI and viewed it as a potential replacement for more specialist services that they considered to be of greater value. Also, some Level 1 practitioners felt that addressing individuals' mental health issues was outwith their role. A further challenge was where existing frontline operational systems could not be adapted to incorporate DBI referrals. In some areas, this considerably impeded the smooth running of the referral process.

Most practitioners found that Level 1 and Level 2 training prepared them well to effectively implement DBI. However, one in seven (15-16%) of the Level 2 practitioners felt their training had not adequately prepared them with the skills or confidence required for the job. Delivery of Level 1 training varied across pilot sites but face-to-face training was broadly the preferred mode of delivery.

Some Level 1 practitioners (e.g. ambulance clinicians) found making time for training difficult.

Some of the clinically trained Level 1 practitioners felt their clinical training provided them with more advanced specialist skills than those provided by DBI, particularly when it came to identifying distress and responding compassionately. However, around half (45%) of practitioner evaluation participants reported that following DBI training they were more likely to treat someone fairly who was seeking help with their distress. This may consequently have reduced the chance of those in distress feeling stigmatised by those they approached for help.

1.4.3 Meeting individuals' needs

A key strength of DBI was its flexibility to be tailored to individuals who received DBI Level 2. This resulted in it being appropriate for the needs of a wide range of individuals in distress who presented with an array of different characteristics, life circumstances and problems. Relationship issues were the most frequently 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).

A large proportion of individuals who accessed DBI were signposted to, or a supported connection was made by the DBI Level 2 service (assisting by making initial contact with an appropriate post-DBI service, on behalf of the person to initiate contact) to other services [hereinafter referred to as 'supported connection']. Almost one in three people (29%) who had a successful contact at Level 2 were signposted to statutory services. Approximately three-quarters (73%) of people who had a successful contact at Level 2 were signposted to non-statutory services. Around one in ten (11%) were provided with a supported connection to statutory services and a quarter (25%) were provided with a supported connection to non-statutory services.

The DBI Level 1 response had direct, immediate benefits for the individual, with most reporting that their Level 1 provider had helped them cope with their immediate distress (mean rating = 7.8, where 0 = 'not at all' and 10 = 'completely') and the more they were able to do this, the less distressed individuals were when they began Level 2. Although most individuals felt they were treated with a high level of compassion by Level 1 practitioners, younger people, those with higher levels of distress, and those presenting to A&E were more likely to give a lower rating of compassion than others. This may, in part, be explained by the likelihood that some people attending A&E were likely to be in greater or more acute distress than individuals attending other settings.

DBI is working well for most individuals, with nine out of ten showing 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. One in ten evaluation participants revealed that they may have attempted suicide or continued with suicidal thoughts if DBI had not been offered to them.

Although the extent of change in distress within individuals was not associated with age, gender, area deprivation or the main presenting problem, differences were seen in how individuals rated Level 2 practitioners in terms of compassion. Individuals who rated the Level 2 providers more highly tended to achieve greater decreases in their distress. It is important to note that Level 2 practitioner compassion ratings were fairly high overall and most of the individuals who experienced worsening distress during Level 2 felt that they had been treated with a fairly high level of compassion. When controlling for distress levels at the start of Level 2, women were likely to have a slightly higher distress level at the end of Level 2 than men. This suggests that for some reason DBI Level 2 may be working less well for women than for men. It is not clear why, but the difference is significant and merits further consideration. Another finding that merits further investigation is that, when controlling for distress levels at the start of Level 2, younger adults, particularly those aged under 35, were likely to have lower distress by the end of Level 2 than older adults (by 2.5 - 3 points on the CORE-OM 5 distress scale). This may indicate that DBI Level 2 works better for younger adults at least in the short term. There was also evidence that when DBI practitioners helped individuals to improve their understanding of why they feel distressed, this had an important influence on reducing their distress level.

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.

1.5 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.

When considering the future rollout of DBI services careful consideration should be given to choices about the organisation of resources and modes of service delivery. Future provision of DBI should consider the availability of community services in local areas and the risks of increased demand for services and the impact on their waiting lists as a result of DBI interventions.

1.6 Key Recommendations

Key recommendations based on our findings are set out below.

1.6.1 Roll-out

1. The national roll-out of DBI should continue, ensuring that core DBI elements (contact within 24 hours, guideline of 14-day intervention, use of D-MaP etc) 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.

1.6.2 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 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).

1.6.3 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 improved 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.

1.6.4 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.

2 Introduction

2.1 Establishment of the Distress Brief Intervention (DBI) Programme

Improving the response to people in distress was identified as a key priority in the Scottish Government's Mental Health Strategy 2017-27 (Scottish Government 2017), building on the Suicide Prevention Strategy for 2013-16 (Scottish Government 2013) and in response to calls from NHS practitioners and service users (Scottish Crisis and Acute Care Network, 2013).

Brief intervention as an approach to providing a timely and compassionate response to supporting people in distress has been gaining national and international interest. The Scottish Government sought the views of communities and partners and developed a proposed specification for a DBI. Simultaneously, a Scottish Government review of international research literature on brief interventions and similar pilot approaches in Scotland was conducted, concluding that there was some evidence that DBIs may have some impact on reducing the frequency of self-harm (Scottish Government 2015).

In 2016, the Scottish Government launched a Distress Brief Intervention programme, to test out a new approach to provide better support to people presenting in distress but who do not require further emergency service involvement. Within the DBI Programme, distress is defined as: "An emotional pain for which the person sought, or was referred for, help and which does not require (further) emergency service response" (Scottish Government 2017).

The University of Glasgow's Institute of Health & Wellbeing developed a DBI training programme and associated materials to support the implementation and delivery of the programme (see Chapter 5).

The pilot phase of DBI was planned to run from 2016 to 2021. The DBI programme began controlled implementation in the first of four pilot sites in June 2017. Delivery was incrementally extended to five delivery teams operating in four pilot sites: Aberdeen, Borders, Inverness and Lanarkshire (which has two teams). Full implementation was achieved by April 2018. The evaluation commenced during the original pilot of DBI when the service was targeted at those aged 18 and over and then incorporated a small number of under 18's following the extension of the pilot in May 2019 in Lanarkshire and Scottish Borders and July 2019 in Aberdeen and Inverness (See footnote 3, page 24). During the evaluation period, the DBI service was also expanded to other geographic areas (the associate programme) but these are not included in the evaluation.

2.1.1 Overview of DBI approach

The DBI pilot programme was a unique, time-limited approach to supporting those in distress who present to front-line services. The intervention is delivered at two levels.

DBI Level 1 is provided by front line staff (hereafter referred to as Level 1 practitioners) and involves a compassionate response to those who present in distress, signposting to other support available and offer of referral to a DBI Level 2 service. The main frontline services involved in the four pilot sites were:

- A&E departments
- Police Scotland
- Primary Care practices
- Scottish Ambulance Service

Individuals who were referred at Level 1 were then attempted to be contacted by Level 2 practitioners within 24 hours to offer their intervention. DBI Level 2 consisted of around 14 consecutive days of community-based, person-centred support with a problem-solving focus. Individuals who took up support from DBI Level 2 were offered assistance in identifying the source and triggers of their distress and identifying existing sources of support available to them. DBI Level 2 practitioners helped individuals to explore strategies to alleviate the issues causing them distress and supported them to develop a D-MaP, which individuals could use to help manage any future instances of distress. A key aspect of the DBI Level 2 intervention was to connect individuals with a wide variety of community and statutory services and support tools relevant to their needs. The DBI Level 2 practitioners signposted and/or supported individuals in distress to connect them with relevant follow-up support and assisted the individual in engaging with this support.

DBI Level 2 was provided by commissioned and trained third sector practitioners (hereafter referred to as DBI Level 2 practitioners) in four pilot sites:

- Richmond Fellowship and Lanarkshire Association for Mental Health (LAMH) in South Lanarkshire, and Lifelink in North Lanarkshire
- Penumbra in Aberdeen
- Support in Mind in Inverness
- Scottish Association for Mental Health (SAMH) in the Scottish Borders

2.1.2 DBI programme governance and oversight

The DBI programme was intended as a model of interagency joint working across frontline settings, third sector agencies and community-based support. DBI 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, with the shared goal of providing a compassionate and effective response to people in distress.

Implementation and ongoing development of DBI was supported by a considerable infrastructure. The Scottish Government set up a national DBI Programme Board comprised of senior practitioners and/or leads from NHS Lanarkshire, Public Health Scotland, the third sector and front-line

organisations delivering DBI, and the University of Glasgow. The DBI Programme Board provided oversight of the whole programme and met regularly to discuss the implementation of DBI.

A central management team called DBI Central was established within NHS Lanarkshire. DBI Central had a critical role in implementing the DBI programme. The team was responsible for sharing knowledge with other parts of Scotland and developing effective processes, tools and systems in support of the future implementation of the programme across Scotland. The DBI Central team was composed of a programme manager, programme administrator, clinical leads, a communications officer and two data analysts from Public Health Scotland. This team maintained close contact with local pilot site coordinators who oversaw the effective implementation of DBI in the respective pilot areas.

Local DBI Implementation Boards, each led by a DBI Level 2 pilot site coordinator, brought frontline services and relevant stakeholders together regularly to discuss how and where implementation could be supported and developed. The DBI coordinator in each area also acted as a liaison between both Level 1 and Level 2 services to monitor and promote the use of DBI.

2.1.3 Improvement science approach

An improvement science approach (Christie et al. 2017) was embedded throughout the DBI programme's implementation activities. This included opportunities for DBI practitioners, partners and other key stakeholders to come together to share learning and best practice. This included sharing emerging evaluation findings with DBI Central and practitioners to inform continuous improvement (see Section 3)

A national-level twice-yearly DBI Gathering brought together stakeholders and DBI Level 1 and Level 2 services. The Gathering provided a forum for sharing experience, consolidating local and national networks and allowing all those involved in DBI to share ownership of the ongoing improvement of the programme as a whole. The Gathering was not an intrinsic part of the DBI intervention, but it appears to have played an important role in achieving high cross-sectoral engagement and subsequent delivery of the programme. Therefore its impacts have been taken into consideration in this evaluation.

The DBI Central team also set up the DBI Level 2 provider forum. This provided an opportunity for Level 2 practitioners to come together for peer support, feedback and reflection and allowed discussion around issues and suggested improvements to the Level 2 service. DBI aims and intended outcomes.

The overarching aim of the DBI programme is to provide a compassionate and effective response to people in distress, within a framework of improved inter-agency coordination, collaboration and co-operation across a wide range of care settings, interventions and community supports.

The intended outcomes for the DBI programme, as set out in its published Theory of Change (NHS Scotland 2017), were developed by the Scottish Government and NHS Health Scotland, with input from the pilot sites and University of Glasgow (see Appendix A).

DBI Central, with the support of analysts from Public Health Scotland (formerly NHS Health Scotland), developed a centralised routine data collection and monitoring system to collect data on service use and outcomes. This data was collected by the DBI pilot sites and collated by the DBI Central Team. This enabled continual monitoring and adaptation of the DBI programme over the four-year pilot period.

2.2 Evaluation aims and approach

The overarching aims of the evaluation were to:

1. Determine the extent to which the Distress Brief Intervention programme was implemented as intended, identify variation and any associated impacts.
2. Determine the impacts of the DBI programme on services, practitioners and individuals.

The DBI evaluation design was guided by the DBI programme evaluability assessment (NHS Scotland 2017). While the evaluability assessment outlined a range of evaluation options, the evaluation procurement guidance for this document stated that a trail-based design, with a control group, was not desired. We, therefore, adopted a broadly realist evaluation methodology (Pawson and Tilley 1997). This approach focussed data collection on gaining insights into what worked, for whom, when and under what circumstances. This enabled aspects of the DBI programme that were working well, together with aspects that presented challenges, to be fed back to services on an ongoing basis, as well as informing the final report. A notable limitation of this design is the absence of a comparator – a relevant alternative to which DBI can be compared. While costs will be assessed and presented, with comparisons being made across the pilot areas, they cannot be brought directly together with outcomes observed.

The evaluation addressed the following overarching research questions:

1. Did frontline level 1 and level 2 practitioners feel empowered to provide a compassionate and constructive, effective response?
2. Who is the DBI programme effective for and why (this includes both individuals and practitioners)?
3. Who is the DBI programme less effective for and why?
4. What are the contextual factors that may impede or facilitate meeting the DBI aims and objectives?
5. What kinds of referrals were made for what needs and how appropriate were these referrals within and from DBI?
6. Did the DBI service meet its implementation targets (e.g. speed of response, appointments attended)?

7. What impact does DBI have on other service users and is this more efficient for services and appropriate for the individual's needs?
8. Did individuals benefit in the short (Level 1), or medium (Level 2) term? If so how and if not, why not?

An interim evaluation report (Duncan et al 2020) was published in January 2020. Recommendations from the interim evaluation included improving feedback loops between DBI Level 1 and Level 2 services on the appropriateness of referrals for individuals, further consideration of risk management of people who have been involved with the criminal justice system, review of 14 days as a time limit for support and enhanced and equitable provision of psychological and emotional supervision to DBI practitioners. The recommendations informed DBI's continuous improvement programme.

2.3 Structure of this report

This report sets out the summative findings of the DBI pilot programme evaluation. We present our findings following the DBI implementation and delivery pathway: from practitioner training and preparation; to delivery of DBI and the associated impact on individuals accessing the service; to referrals and signposting. Appendices that are lettered are available at the end of this report. Technical appendices are numbered and are available as a separate publication on the Scottish Government website.

3 Methodology and research methods

This mixed-method evaluation of DBI combined analysis of administrative DBI data, quantitative pre, post and follow up surveys with individuals who received a DBI, qualitative research with DBI practitioners and individuals who accessed DBI, and an economic evaluation. We adopted a realist evaluation approach (Pawson & Tilley 1997) to explore both the way that the intervention was delivered and understood and the extent to which it worked as intended (Cresswell et al. 2011). Our research design was chosen to fit with the specification criteria of the Scottish government DBI evaluation tender. This did limit some of the questions we were able to answer. Identifying a meaningful control group for a DBI study was identified in the Evaluability Assessment as highly challenging, and potentially unethical (NHS Scotland 2017). This meant that a controlled trial of DBI was not viewed as feasible. Consequently, while the selected realist evaluation design enabled an in-depth evaluation, the questions and scope of the evaluation in describing the effectiveness and the health economic analysis were limited.

Analysis of the service usage of individuals that were referred to the DBI programme was not possible at it was outwith the scope of the funded evaluability study. This means we are unable to draw any firm conclusion on what impact the DBI programme has had on NHS service usage. We also surveyed agencies that individuals who completed DBI had been referred to, but despite sending reminders we gained very few responses. At the beginning of the evaluation, we piloted a novel mobile phone method of collecting data from individuals who had refused referral to DBI Level 2 but did not progress with this arm of data collection as we were unable to gain any respondents.

The evaluation team worked collaboratively with DBI sites and the DBI Central Team to inform the development of procedures to:

- Identify and access existing data collection and reporting processes.
- Map out core elements of the DBI service system and regional variations.
- Gather views on DBI practitioners and management's needs and expectations from the evaluation.
- Agree on processes and tools for evaluation data collection.

Throughout the evaluation, the study team met together and with DBI practitioners, managers and stakeholders at DBI Gatherings and DBI Programme Board meetings and the DBI Level 2 Providers Forum (see Glossary of Terms) to share insights from our analysis.

We gathered data from the following sources:

- DBI Level 1 and 2 practitioners (on training and implementation)
- Individuals accessing DBI (on experience and impact)
- DBI routine activity data (on individual characteristics and service use)

- Agencies referred to by DBI (on appropriateness and outcomes of referrals and impact on services)

Evaluation data collection began on 1st January 2019 and was planned to continue until 30th May 2020. Data collection from service users was suspended in April 2020 due to COVID-19 restrictions.

3.1 Qualitative data collection

We collected data through semi-structured, face-to-face or telephone interviews and face-to-face focus groups (Appendix 1). Participants for staff focus groups and interviews were selected according to a convenience sampling framework, in which we endeavoured to recruit similar numbers of participants according to their role and geographical location. We were unable to further sample according to gender or age due to low numbers of eligible participants and low levels of agreement to participate in data collection. The breakdown of participants is presented in Table 3.1. Despite working hard to interview similar numbers of participants by role, Police Scotland are overrepresented and Primary Care professionals are underrepresented.

We also collected qualitative data from open-ended questions in the surveys (described below in the section on quantitative data collection).

Table 3.1: Qualitative interview and focus group overview

Group	No. of participants	No. by role	No. by site
Level 1 Frontline Service Practitioners	43 (37 people in 8 focus groups; 6 individual interviews)	SAS: 4 A&E/MH Crisis Teams: 18 Primary Care: 4 Police: 17	Grampian: 7 Highland: 17 Lanarkshire: 14 Borders: 5
Level 2 Practitioners	26 (individual interviews)	LAMH/ Lifelink/ TRF: 14 Penumbra: 3 SAMH: 4 Support in Mind: 5	Borders: 4 Grampian: 3 Highland: 5 Lanarkshire: 14
Individuals referred to DBI	19 (individual interviews)	N/A	Borders: 2 Grampian: 3 Highland: 4

		Lanarkshire: 10
Service leads	7 (individual interviews)	NHS: 4 Police: 1 3rd Sector: 2

3.1.1 Interviews and focus groups with professionals

We held interviews and focus groups with a wide range of practitioners involved in delivering DBI, including representatives from all Level 1 services, Level 2 practitioners and DBI service leads (national and local DBI service managers). We also conducted a small number of interviews (either on the telephone or face-to-face) where this was more convenient or appropriate for the practitioners involved. Interviews and focus groups explored key issues that might impact on successful implementation of DBI including training, referrals, staffing and resources, and the challenges and adaptations to local delivery within each context.

3.1.2 Interviews with individuals accessing DBI

Individuals who participated in DBI and had been referred to Level 2 services took part in telephone interviews (n=19) between November 2019 and March 2020. These interviews explored their experience of DBI from the incident that led to referral at Level 1 through to their experiences of Level 2 and the referral process. Information was sought on the perceived impact of DBI on distress, interaction with professionals and the participants' views of what worked, as well as any suggestions for how the experience of DBI could be improved at each stage.

3.2 Quantitative data collection

The data collection tools were designed in consultation with DBI practitioners to ensure they were brief, appropriate and would not interfere with DBI practice. The evaluation team worked with DBI Central to ensure that no data were collected twice. Details of data collection tools can be found in Appendix 2.

3.2.1 Data collection from individuals using DBI

The quantitative data collection captured the experience of the DBI programme and its impact (at DBI Levels 1 and 2, repeated at 3 months following the end of Level 2), considering both individual characteristics and circumstances as well as other demographic, geographic and service-based contextual factors. We collected survey data from individuals between 1st January 2019 and 31st March 2020 via paper or online surveys, as people moved through the DBI pathway. The surveys covered their experience of accessing and using the DBI service and the impact of this on them, using questions specifically designed for this study and validated tools. Further

information on the outcome measures (the Distress Thermometer (Mitchell, 2007), CORE-OM 5 (Evans et al., 2002) and CARE Measure (Mercer et al., 2004)) that are referenced throughout this report is provided in Appendix B. We linked the survey data for each individual to their routine DBI data collected by DBI practitioners. The linkage created a rich dataset that enabled a complex analysis of the factors contributing to individual outcomes.

Table 3.2 Quantitative data collection overview

Group	Data collected	N	Timescales
Individuals receiving Level 1 and Level 2 DBI who participated in evaluation	First Level 2 session survey	575	1st January 2019 to 30th April 2020.
	Final Level 2 session survey	499	All individuals referred to DBI from 1st January 2019 to 30th April 2020 were eligible to participate. This data collection was originally planned until 31st May however due to Covid-19 the deadline was brought forward.
	Level 2 3-month follow-up survey	102	
	DBI routine data for linkage to individual survey data	499	
DBI practitioners delivering Level 1 and Level 2 DBI	Online survey		4th March 2020 to 22nd March 2020
	Level 1 practitioners	172	
	Level 2 practitioners	29	
All individuals receiving Level 1 and Level 2 DBI	Aggregate routine monitoring data from those referred to DBI.	5316	1st January 2019 to 30th April 2020
Agencies referred to by DBI level 2 practitioners	Online survey	9	21st November 2019 to 17th December 2019

3.2.2 Aggregate routine DBI data

NHS Scotland provided the evaluation team with routine DBI data (captured by Level 1 and Level 2 DBI practitioners) on all individuals accessing DBI

between 1st January 2019 and 30th April 2020 in pseudonymised aggregate form (that is non-identifiable summary data).

3.2.3 Aggregate Level 1 practitioner training evaluation data

The University of Glasgow developed a brief evaluation of practitioners' confidence to deliver Level 1 to be completed immediately before and after training. NHS Health Scotland provided the evaluation team with confidence ratings for a total of 997 frontline practitioners (including police, ambulance service, A&E, Primary Care, Social Work and community and crisis mental health team staff) who were trained between October 2017 and December 2020.

3.2.4 DBI practitioners' survey

Level 1 and Level 2 DBI practitioners were invited to complete a survey focusing on their DBI training, skills and confidence.

3.2.5 Survey of agencies referred to

We surveyed agencies to which individuals were referred to by DBI to examine the appropriateness of referrals, engagement with individuals, perceived outcomes and the overall impact of DBI on other agencies in terms of demand and joint working relationships. Despite sending reminders we gained very few responses.

3.3 Data analysis

The analysis drew on a convergent mixed methods approach where analyses are merged into a single narrative, drawing on different datasets as appropriate. The qualitative and quantitative datasets were analysed separately then results were merged (where possible), guided by research questions. This included the results of the health economics analysis (see Section 3.4), which were also merged into an overall narrative.

3.3.1 Qualitative data analysis

We had all the audio-recorded interviews and focus groups transcribed and entered into QSR NVivo (v12), a qualitative data analysis computer software package, to support analysis. We analysed our qualitative data using a case study approach (Yin 2013), drawing on techniques of framework analysis (Ritchie & Spencer 2002). Analysis was guided by the Consolidated Framework for Implementation Research (Keith et al. 2017), which lists key factors related to implementation that contribute to effective or unsuccessful programme implementation, including acceptability, characteristics that facilitated effectiveness and suggestions for improvement. The framework analysis linked closely to research questions, especially concerning the impact of DBI on individuals' distress as well as broader questions around the process and delivery of the intervention.

We coded the qualitative data collected via survey open questions separately and synthesised these findings with the information gathered from the larger body of qualitative findings.

3.3.2 Quantitative data analysis

We inputted data from paper surveys electronically and securely downloaded data from online surveys to SPSS and/or MS Excel for analysis following editing and data cleaning in line with ScotCen's Quality Management System. Quantitative data analysis consisted of descriptive statistics and crosstab analysis. We conducted significance testing of the quantitative surveys using regression analysis in SPSS to determine whether there was a difference in the dependent variable in the mean score, or in the category of interest, between the separate categories of the break variable. Where a significant difference is discussed in the text, this is significant at the 5% level. It should be noted that these significance tests are for guidance only as the surveys were not based on random samples. We could not do any significance testing on the aggregate routine data supplied by Public Health Scotland because access to the raw datasets was beyond the scope of our agreed evaluation remit.

It should be noted that the sample of participants who completed outcome measures at the end of Level 2 (n=499) was 14% of the overall number of people who took up DBI. However, the demographic profiles of all referrals to Level 2 and the sample of individuals participating in the evaluation (based on gender, age, area deprivation measured by SIMD and distress thermometer score at Level 1) were similar.

3.4 Economic analysis

The economic analysis presents the costs and outcomes of the DBI programme components in a form similar to that of a cost consequence analysis (CCA). This is a type of economic evaluation where disaggregated costs and a range of outcomes are summarised together in a 'balance sheet' table (Drummond et al. 2005). It was not possible to conduct a full economic evaluation because of the absence of a relevant alternative to which DBI could be compared. To answer questions about value for money a comparator would be required. The inclusion of a comparator group in the evaluation study design was specifically excluded from the Scottish Government DBI evaluation tender specification. The economic analysis of the DBI programme's resource use, associated costs and outcomes provides useful information for people involved in planning, implementing, establishing or maintaining DBI services.

Due to the nature of the intervention and the available data, a public sector payer perspective was taken in the economic analysis. Adopting this perspective meant that only costs that fell into the public sector were considered. The evaluation did not consider personal costs, such as absence from place of employment, or other societal costs, as these were outside the scope of the evaluation project. Given the importance of centralised management of such a diverse and large government initiative, the focus of the economic analysis was on both the pilot areas and DBI Central.

We obtained data on the resources required for the delivery of DBI Central activities and the Level 2 providers from DBI Central. We obtained data on the resources required for the development and initial rollout of Level 1 and Level 2 training from the University of Glasgow. Using these data, we calculated the annual cost for 2019-2020 for each pilot area and DBI Central costs, which are presented separately. Further detail on the methods, unit costs and data analysis are presented in Appendix C.

3.5 Ethical approvals

Approval for the DBI evaluation study was provided by the West of Scotland Research Ethics Service in September 2018, with further amendments approved in June 2019 and October 2019. The Health and Social Care Public Benefit and Privacy Panel[1] granted approval for the data linkage element of the study from November 2020. We collected all evaluation data following informed consent (Appendix 2). Protocols were established to support any individuals who became distressed during the evaluation.

[1] The Health and Social Care Public Benefit and Privacy Panel is a patient advocacy panel that scrutinises applications for access to NHS Scotland health data for non-direct care. Its role is to ensure that applicants have thought through the public benefit and privacy implications of the proposal. Further information is available at: Who are the public benefit and privacy panel and what do they do?

4 Overview of DBI activity in the evaluation period

In this section, we provide an overview of DBI delivery during the evaluation data collection period, which ran from 1st January 2019 until 30th May 2020. We draw on routine DBI data as well as financial information provided by DBI Central.

DBI Central went through various stages of development from the beginning of the DBI programme until today. It started in a Development and Start-Up phase between 2016 and 2018 and then entered a Delivery and Growth stage between 2018 and 2021. Total spending per year at DBI Central has changed accordingly over the years rising from approximately £60,000 per year in 2016-2017 to over £300,000 per year in 2019.

In terms of personnel, DBI Central consisted of a programme manager, programme administrator, clinical leads, a communications officer and two data analysts from Public Health Scotland. For more details on when each role became active and respective grades see Appendix C.

4.1 Referral demographics

During the evaluation data collection period (1st January 2019 to 30th April 2020), 5316 referrals were made to DBI.

Almost half of all referrals came from Lanarkshire (48%), with 19% coming from Aberdeen City, 18% from Scottish Borders and 15% from Inverness City. This reflects the relative population sizes from each of these areas, with the combined populations of North and South Lanarkshire accounting for 63% of the entire population covered by the four pilot sites. However, Inverness City had the highest number of referrals relative to its population size (16.8 referrals per 1000 population), followed by Scottish Borders (8.3 referrals per 1000 population). Referral rates were lower in Aberdeen City (5.0 referrals per 1000 population) and Lanarkshire (4.1 referrals per 1000 population).[2]

Women accounted for 58% of total referrals and men accounted for 42% of total referrals. Four of those referred were recorded as 'other' gender. These individuals are not included in further sub-analysis analyses due to their small number. Individuals referred were most commonly aged between 16[3] and 44

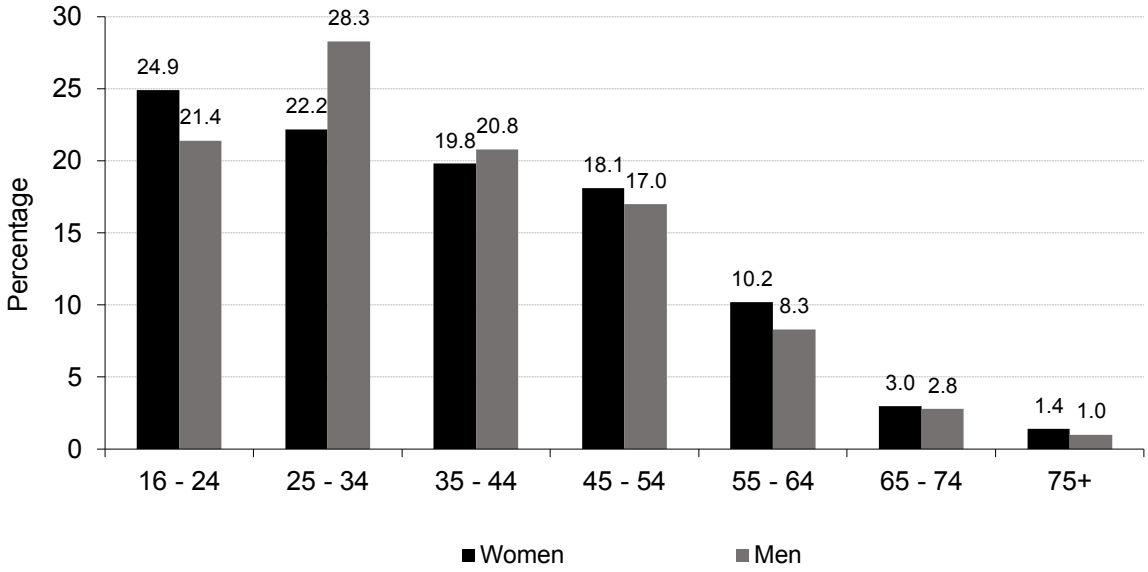
[2] Population estimates taken from Scottish Census 2018, available at Scotland's Population 2018 - The Registrar General's Annual Review of Demographic Trends

[3] This evaluation commenced during the original pilot of DBI when the service was targeted at those aged 18 and over and incorporated the extension to those aged 16 and 17 in May 2019 in Lanarkshire and Scottish Borders and July 2019 in Aberdeen and Inverness. There are 147 referrals of individuals aged between 16 and 17 in the aggregate routine DBI level 2 data provided to the evaluation team (this represents 2.7% of the total for the January 2019 to April 2020 time period).

(68%). Among women, the highest proportion of referrals were from the 16-24 age group (25%) while, among men, the highest portion of referrals was from the 25-34 age group (28%) (Figure 4. *1*).

Almost 60% of individuals referred lived in the two most deprived quintiles, as measured by the Scottish Index of Multiple Deprivation (SIMD). Only half of the individuals referred to DBI gave their ethnicity. Of those, over 98% were white (including white Scottish, white other British, white Irish and white Polish). Further data is available in Appendix 3, Table 4.1.

Figure 4. 1 – All referrals to DBI level 2 by gender and age, as a proportion of all women and men referred[1] (n=5316, Source: DBI routine data for all referrals; 1st January 2019 to 30th April 2020)



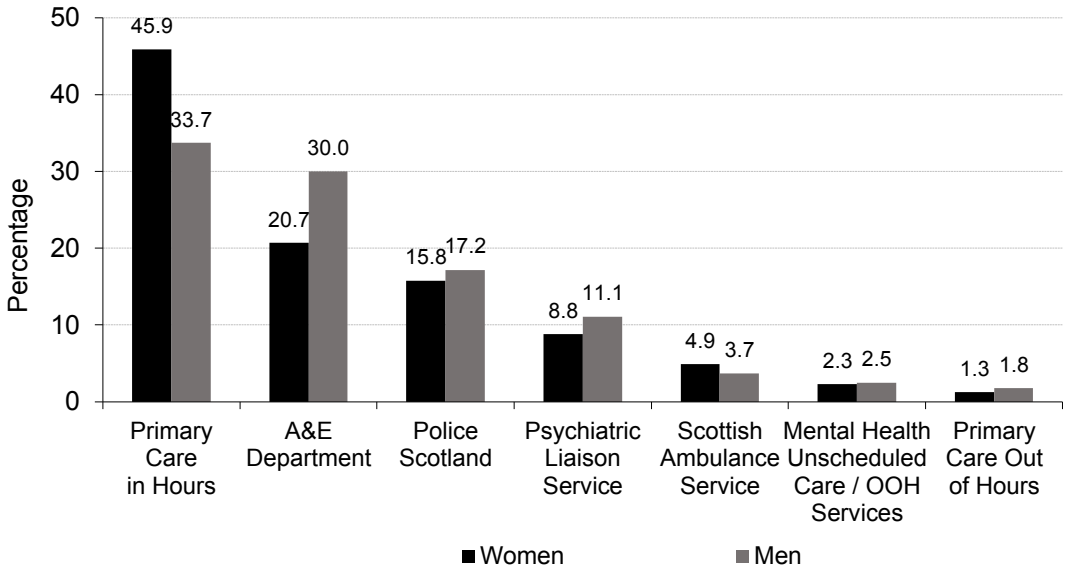
[1] Excluding individuals who selected “other gender” and age. These are not recorded as the numbers are too small (n=24).

4.2 Referral sources

The greatest proportion of referrals to DBI came from Primary Care in Hours (41%) followed by the A&E department (25%), Police Scotland (16%) and psychiatric liaison service (10%). The smallest proportion of referrals came from Scottish Ambulance Service (4%), mental health unscheduled care and out of hours services (2%) and primary care out of hours (2%).

Men were more likely than women to be referred by A&E and women were more likely to be referred by Primary Care in Hours (Figure 4. *2*). There was little difference in the age profile of those referred by different Level 1 referrers. Further data is available in Appendix 3, Tables A4.2 and A4.3.

Figure 4. 2 All referrals to DBI Level 2 by Level 1 referrer and gender as a proportion of all women and men referred[1] (n=5316, Source: DBI routine data for all referrals; 1st January 2019 to 30th April 2020)



[1] Excluding Level 1 referrer not recorded (n=2). Social work referrals are not presented in the chart (n=9).

4.3 Presenting problems and contributory factors

Individuals referred to DBI presented to Level 1 and Level 2 practitioners with a wide range of presenting problems (Figure 4.3) and factors which contributed to their distress. Multiple presenting problems and contributory factors could be identified and recorded for each individual. Feeling depressed/having low mood was the most commonly recorded presenting problem, recorded in 61% of all referrals (60% of women; 63% of men). Presenting problem differed by gender, with women more likely than men to present with stress/anxiety (61% of women; 45% of men), and men more likely than women to present with suicidal thoughts (28% of women; 39% of men) and suicidal behaviour (7% of women; 10% of men).

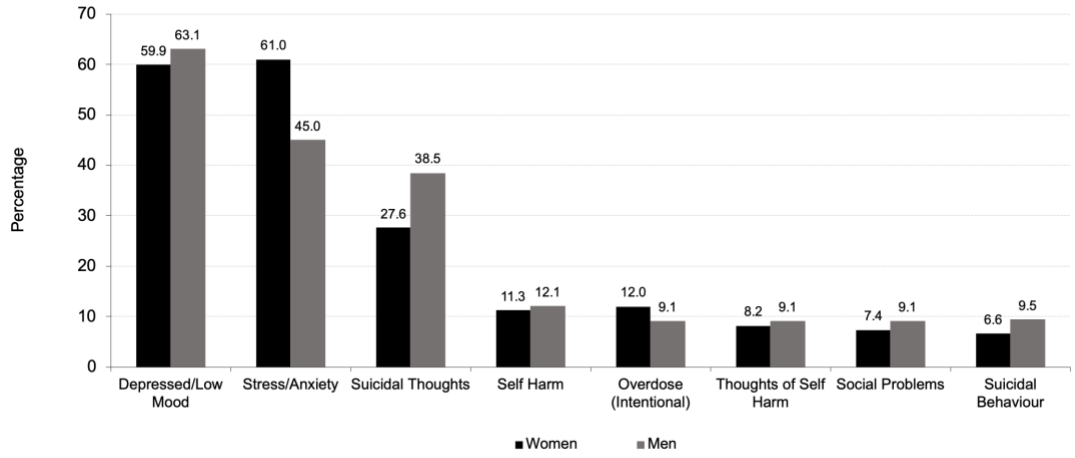
Relationship issues were the most commonly recorded contributory factor for both men and women, recorded in 48% of all referrals. Other common contributing factors included alcohol use (22%), life coping issues (21%) and money worries and unemployment (18% each). Alcohol use was recorded as a contributory 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%).

Alcohol use was most common among those referred by A&E (35%) and Scottish Ambulance Service (32%), less common among those referred by mental health unscheduled care/out of hours services (22%), primary care out

of hours (16%). Recorded use of alcohol was lowest among those referred by primary care in hours (10%). Substance use was most common among those referred by A&E (23%) and Psychiatric Liaison Service (20%), less common among those referred by Police Scotland (9%) and Primary Care Out of ours (8%) Recorded substance use was again lowest among those referred by primary care in hours (5%).

Further data is available in Appendix 3, Tables A4.4, A4.5a, and A4.5b.

Figure 4.3 - Presenting problem for all referrals to Level 2, by gender[1] (n=5316, Source: DBI routine data for all referrals; 1st January 2019 to 30th April 2020



[1] Presenting problems which were recorded in 5% or fewer of all referrals (Physical Health; Sleeping Issues; Panic Attacks; Crisis Call; Behaving Strangely) are not shown.

4.4 Contact within 24 hours

A key component of the DBI approach was that contact was made between DBI Level 2 and the individual within 24 hours of referral from Level 1. A contact attempt was made within 24 hours for all referrals made to DBI. 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. In cases where no contact could be made, Level 2 practitioners sent a letter to the individual and their GP explaining that contact attempts had been unsuccessful.

There was no difference in successful contact within 24 hours by gender. However, older age groups were successfully contacted within 24 hours slightly more often than younger age groups.

Successful contact within 24 hours varied by pilot site. The proportion of referrals successfully contacted within 24 hours was highest in Inverness (72%) and Scottish Borders (70%), average in Aberdeen City (65%) and lowest in Lanarkshire (60%).

Further data are available in Appendix 3, Table A4.6.

4.5 DBI Level 2 outcomes and throughput

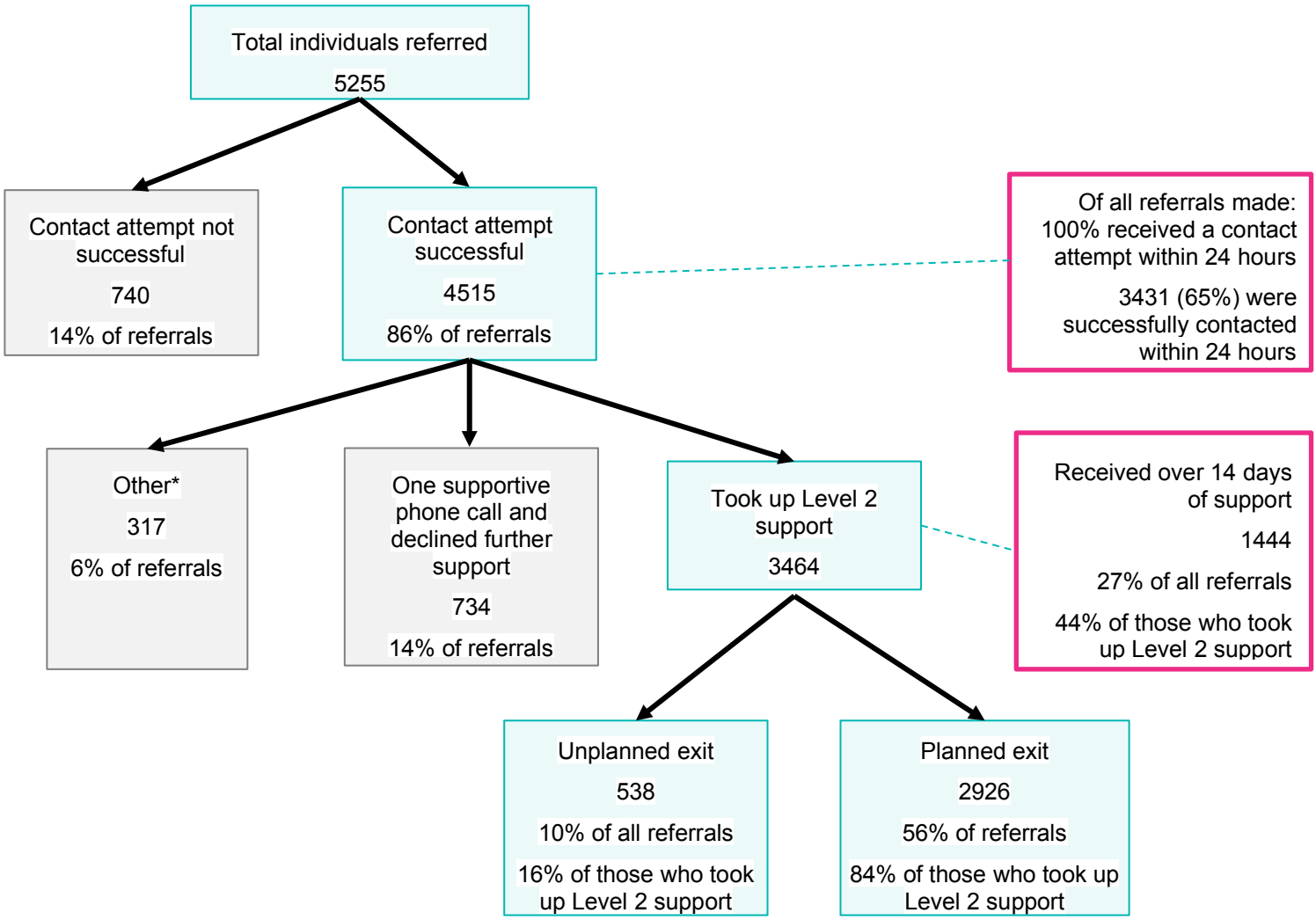
During the initial contact between a referred individual and a DBI practitioner, the individual was offered up to 14 days of compassionate, community-based, problem-solving support, with wellness and distress management planning. As shown in Figure 4.4 (overleaf), 3464 (66%) of those referred to DBI by Level 1 took up this support from DBI Level 2. A further 14% of referrals received one supportive phone call from a DBI practitioner but declined further support and 6% did not receive support from DBI due to escalating level of risk, inappropriate referral or ongoing inpatient care. The remaining 14% of all referrals could not be contacted by DBI practitioners.

Of those individuals who took up support from DBI, 84% were supported to a planned exit from the service, while the remaining 16% of those who took up support from DBI exited the service in an unplanned way (e.g. stopped attending appointments or responding to contact from DBI).

More women than men took up Level 2 support through to planned exit (women 59%; men 51%) and more men than women did not respond to contact attempts from DBI (women 12%; men 16%).

The proportion of referrals taking up any Level 2 support (that could range from one supportive phone call, to ongoing support over and above one supportive phone call, and Level 2 support with a planned exit) varied by pilot site. The highest proportion of referrals was taken up in the Scottish Borders (any support 86%; any Level 2 80%; support to planned exit 70%) and the lowest in Lanarkshire (any support 76%; any Level 2 62%; support to planned exit 49%).

Figure 4.4 – DBI outcomes for all referrals to Level 2 between 1st January 2019 and 30th April 2020.

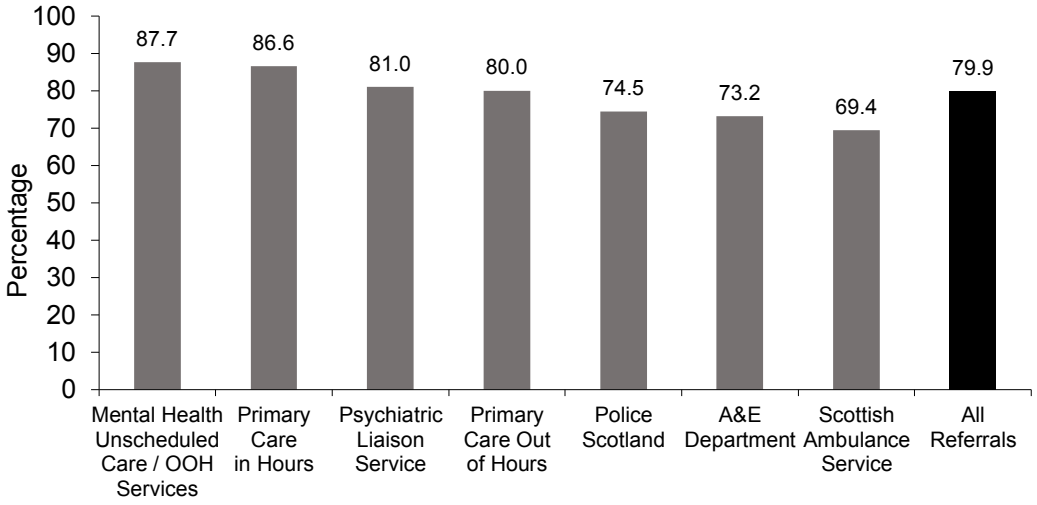


Source: Public Health Scotland. * Includes DBI stopped due to escalating level of risk, inappropriate referral or Level 2 cannot proceed due to ongoing inpatient care.

Those referred by Primary Care in hours and mental health unscheduled care/out of hours services were most likely to take up any support, while those referred by A&E, Police Scotland and Scottish Ambulance Service were less likely to engage.

Further data is available in Appendix 3, Tables A4.7 and A4.8.

Figure 4.5 - Uptake of support at Level 2 for all referrals to Level 2 between 1st January 2019 to 30th April 2020[1]. Source: NHS Health Scotland



[1] Missing values (n=61, outcome not recorded).

4.5.1 Length and intensity of support

DBI level 2 offers individuals up to 14 days of support as a guideline. However, from the outset of the DBI programme, all Level 2 providers were enabled to provide support beyond the 14 days, dependent on individual need. During this time, individuals are offered a series of support sessions. A support session includes any contact with an individual accessing Level 2 where the individual received support (i.e. not administrative contact). This includes in-person sessions, phone calls and conversations by text message.

Of all referrals to Level 2 (n=5255): 27% received over 14 days of support, 38% received up to 14 days of support; 14% received one supportive phone call and did not take up further support from DBI, and 14% could not be contacted. The remaining 6% did not receive support from DBI due to escalating levels of risk, inappropriate referral or ongoing inpatient care (see Figure 4.4). So, of the 3464 individuals who took up more support than just one supportive call, 58% (2020) received 14 or fewer days of support. Of all individuals who took up support from DBI Level 2 to planned or unplanned closure, 42% received over 14 days of support.

There was variation by pilot site in the proportion of individuals who took up support from Level 2 and received over 14 days of support. The proportion was highest in Aberdeen City where 71% of individuals who took up Level 2 support received over 14 days of support. The proportion of individuals

receiving over 14 days of support was lower in Lanarkshire (44%) and Inverness City (36%) but lowest in Scottish Borders at only 14%.

On average, individuals who took up support from DBI Level 2 received 4.1 support sessions. There was also variation across pilot sites in the average number of support sessions delivered per individual. Aberdeen City and Inverness City delivered, on average, the lowest number of support sessions (3.1 sessions and 3.2 sessions per individual, respectively). Lanarkshire delivered an average of 4.4 sessions per individual and Scottish Borders delivered the highest number of support sessions (6.8 sessions). Some of this variation may be accounted for by the different ways in which sites recorded the number of sessions. Some pilot sites may have recorded a brief phone call or text messaging exchange as a session while others may not.

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. There was no difference in the average number of sessions received per person as the length of support increased. Those who received between 15 and 21 days of support received an average of 5.1 sessions, those who received between 22 and 28 days of support received an average of 5.1 sessions and those who received more than 29 days of support received an average of 5.2 sessions.

There was no clear difference in the number of support sessions by age or gender, although older adults (aged 45 and over) did seem to have more support sessions on average than younger adults (4.6 to 5.0 mean sessions compared with 4.2-4.3 mean sessions respectively).

Further data is available in Appendix 3, Tables A4.9 and A4.10.

5 Training

5.1 Level 1 training delivery, modes and content

The DBI Level 1 training course aimed to provide Level 1 practitioners with the skills and confidence required to make appropriate referrals and deliver the DBI programme as planned. With no existing training for people in distress available during the set-up of DBI, the University of Glasgow adopted an integrative, biopsychosocial approach to the intervention, drawing from best practice in other areas of mental health and suicide prevention (O'Connor & Kirtley, 2018, Kok et al., 2016). Up to the end of December 2020, 997 frontline staff had received either the DBI Level 1 e-learning module or trainer-facilitated classroom training across all four pilot sites (by March 2021 this had risen to n=1,816).

The way training was delivered varied across pilot sites and across different Level 1 services. Training was delivered both online and in the facilitated face-to-face sessions. On occasion, Level 2 DBI practitioners were brought in to support Level 1 training. Additional brief top-up training, described as 'buzz sessions', was developed and provided at each site by local lead agencies. These additional training sessions enabled practitioners to answer questions, share experiences on delivering DBI and reflect on issues such as the appropriateness of different types of referrals. There was no fixed structure or frequency of buzz sessions; they were developed and delivered according to local implementation needs. Individuals who had undertaken online training particularly valued the buzz sessions, as they enabled relationships to be developed between Level 1 and Level 2 agencies.

5.1.1 Online Training

Online training for Level 1 frontline practitioners was generally delivered through a learnPro module, an online learning platform commonly used by the NHS. The module lasted for around 1 hour and focussed on providing a compassionate response, the DBI definition of distress and the basic practicalities of making a referral. Online learning was initially the main delivery format in most NHS settings and met with a mixed response. Some practitioner interviewees considered it optimal, especially where there were time constraints, whereas others felt it was more of a 'tick-box exercise' and did little other than introduce basic processes. Practitioners in some Level 1 services, particularly Primary Care practices, saw the learnPro module as a disincentive to engage with the training.

> "There'll be a number of people that if they were unable to access DBI without doing the learnPro there would probably a greater uptake in the actual accessing and use of it which sounds a bit odd given it wasn't too onerous, but it was still the mental step of having to log in to do, … in the general practice world people are under pressure and stressed and

> stuff like that means that they'll push things to 'I'll do that later." Level 1 practitioner, primary care

Over the course of this evaluation, the learnPro training was refined by adding additional top-up training. Glasgow University trained some practitioners to be trainers. There was an expectation that trainers should be familiar with and immersed in the DBI programme, which permitted Level 2 providers, where appropriate, to deliver training to Level 1 providers. This allowed face-to-face delivery of Level 1 training to more people and enabled the enthusiasm and experience of existing Level 2 practitioners to be shared with new trainees.

> "The training package is one of the best training packages that I've been involved in, but it's the quality and delivery of that training as well. If you're just standing there with a PowerPoint letting somebody read that or handing them a workbook and just saying, read that, that's not going to be beneficial to that person. Every session that I do is an interactive session, we have dialogue, we have a discussion, every session runs over the time that I'm usually given, but do you know what, that's the sessions that make a difference, that's the sessions that somebody will remember as opposed to sitting reading the workbook." Level 1 service Lead

Time was not made available for ambulance practitioners to complete their online training during working hours therefore they were expected to complete it in their own time. Some practitioner interviewees felt this made completing training more challenging and acted as a disincentive to their participation, a finding also reflected in the relatively low total numbers of ambulance practitioners trained.

5.1.2 Face-to-face training

There was a consensus among Level 1 practitioner participants that discussions occurring during face-to-face training which drew on experiences from actual cases and hypothetical scenarios, made it the preferred delivery mode. Police Scotland opted for face-to-face training from the beginning, as this was their organisation's preferred mode for any training delivery. The training was co-delivered with Level 2 practitioners and uptake among Police Scotland was high. The police formed the highest proportion (49% - almost half) of Level 1 practitioners trained.

> "We've seen with the police training being delivered face-to-face and in partnership with our Level 2 staff actually you get a lot of police referrals, that they have that relationship between the police and the Level 2 staff because they've met at training so they're confident and comfortable in putting forward a referral." Level 1, service lead

When Level 2 practitioners were brought in to support Level 1 training, it strengthened connections between Level 1 and 2 services and their practitioners and further encouraged Level 1 practitioners' engagement with the DBI programme. In some areas, Level 2 services directly approached local

GP surgeries to ask if they wished to be involved as a Level 1 service. This was a highly effective recruitment strategy, but a resource-intensive approach.

DBI Level 1 training has impacted upon the wider service system by highlighting gaps in existing practices and acted as a catalyst to developing further training in managing distress and assessing the level of risk. This occurred within emergency NHS settings but could be extended to other services to address concerns about making judgements without the appropriate skills.

> "And also when I did the face-to-face we also covered how are we going to properly triage someone to determine their level of mental health risk." Level 1 practitioner, A&E

Some practitioners, particularly if they were clinically qualified, felt that the Level 1 training sections on identifying distress were unnecessary; they felt their clinical training gave them specialist skills beyond those outlined in DBI Level 1 training.

5.2 Level 1 pre and post-training confidence ratings

University of Glasgow developed a brief evaluation of practitioners' confidence to deliver Level 1, to be completed immediately before and after training. NHS Health Scotland provided the evaluation team with confidence ratings for a total of 997 frontline practitioners. This included those working within the police, ambulance service, A&E, Primary Care, Social Work and community and crisis mental health teams who were trained between October 2017 and December 2020 (Table 5.1). Of these 997, all police (n=490) and 176 healthcare staff in Lanarkshire completed the training via facilitated face-to-face sessions; the remaining 331 completed their training via the learnPro online training course.

Table 5.1 Level 1 training from October 2017 to December 2020

Organisation/Sector	No. Practitioners Trained	% of Total
Police Scotland	490	49
Primary Care in Hours	193	19
A&E Department	137	14
Scottish Ambulance Service	80	8
Psychiatric Liaison/Crisis Service	43	4

Third Sector Provider	11	1
Out of Hours Social Work, Primary Care Out of Hours, Substance Misuse Service	14	1
Other (unknown)	29	3
Total	997	100

Overall, the training increased practitioners' confidence to understand distress, deliver a compassionate response, make referrals and understand what was involved in Level 2 support (Table 5.2).

Table 5.2. Level of confidence in delivering Level 1 intervention

	Median Rating (1 = Low, 10 = high)	
Level 1 Training Confidence ratings (n=997)	**Pre-training**	**Post-training**
Understand distress	6	9
Deliver a compassionate response	7	9
Make a DBI referral	3	9
Understand Level 2 support	3	9

5.3 Level 1 skills, competencies and confidence in delivering DBI

In March 2020 we invited DBI Level 1 and 2 staff by email to participate in an online training survey (issued by the DBI evaluation team) to examine the longer-term impact of the DBI training in terms of skills, competencies and usefulness of the training when delivering support as well as any additional training needs (see Appendix 4). Overall, the survey suggests that Level 1 training was generally well-received; among Level 1 staff responding to the survey (n=172), most found it relevant to their role (94%), engaging (81%) and enjoyable (73%).

The majority reported that it had provided them with the knowledge, skills and confidence to carry out a DBI Level 1 intervention (80%) and felt committed to

delivering Level 1 as a result of the training (85%). A similar proportion (79%) reported that they had made use of what they learned in the Level 1 training when delivering a Level 1 intervention. A minority (9%) agreed with the statement “I did not learn anything new from the DBI Level 1 training”.

Although confidence was generally high following training, some Level 1 practitioners who were interviewed reported that they doubted their ability to safely judge whether DBI alone was enough for an individual whose level of risk of self-harm was elevated.

Just over half (53%) of the Level 1 practitioner survey respondents agreed[4] that their DBI training enabled them to more consistently provide a compassionate response to people in distress. More participants (72%), agreed that, as a result of the DBI Level 1 training, they were more able to provide a constructive response to people in distress. So, while the DBI training played an important role in helping practitioners to provide a more consistent compassionate response, participants perceived it was even more effective in equipping them to provide a more constructive response to meet the needs of those presenting in distress.

Correspondingly, Level 2 practitioner interviewees noted changes in frontline practitioners’ approach to supporting individuals in distress following training.

> “The police or the ambulance are not just turning up, dealing with the situation in hand and going away, they're showing empathy and compassion for the situation that the people have found themselves in and offering them some kind of solution.” Level 2 practitioner

DBI training also changed perceptions about the nature of distress among Level 1 practitioners. There was evidence to suggest that their training led to a reduction in the stigma previously associated with distress-related behaviour where it was associated with mental health issues. To explore the impact of the DBI Level 1 training on potential direct stigma, respondents were asked the extent to which they agreed that they were more likely to treat someone fairly because they were seeking help for their distress. Just under half of the respondents (45%) agreed that as a result of the training, they were now *more* likely to treat someone fairly who was seeking help for their distress, indicating a possible reduction in stigmatising behaviour amongst this group. Thirty-four percent of respondents selected neither agree nor disagree with regards to this statement, and 22% disagreed[5]. This suggests perhaps that these respondents felt that they already treated people in distress fairly and that the Level 1 training had little or no impact on this.

Similarly, in the interviews and focus groups, Level 1 practitioners often mentioned that the perceived emphasis on teaching compassion could be a barrier to engaging in training. A sub-set of Level 1 practitioners felt that some

[4] Agreed represents ‘slightly agree’ and ‘strongly agree’ responses combined.
[5] Disagreed represents ‘slightly disagreed’ and ‘strongly disagreed’ responses combined.

aspects of training (e.g. focusing on compassion in the Level 1 training) did not add to their current knowledge. They felt it was potentially patronising and made them feel less engaged with the DBI programme. GPs and mental health practitioners saw this as an existing component of their routine practice and its inclusion in the training could be perceived as suggesting that current practice lacked compassion.

> "You think as a doctor that you give a compassionate response so why would you need to go and understand what it is to give a compassionate response because you would always do that anyway…" Level 1 practitioner, primary care

Level 1 training also drew attention to how distress might underpin other negative behaviours, which was particularly resonant with some respondents.

In the early implementation stages, there were concerns that the Level 1 training was not clear enough on the appropriate level of distress for a DBI referral, leading to individuals being referred unnecessarily or when DBI was insufficient to meet their needs. Level 2 practitioners fed back when there had been inappropriate referrals and delivered additional training updates (buzz sessions) to provide clarity on the appropriate distress level for DBI referrals. This appeared to help reduce the number of inappropriate referrals.

> "When we first started, especially the police, I didn't think they quite understood, you know, we were getting people who were in a complete and utter crisis and sometimes it was an inappropriate referral, so what we done was we started attending the training just so that we were able to say it doesn't have to wait until someone's at the complete and utter crisis, it could be someone who's having a neighbour dispute or his ongoing thing, you know, it doesn't have to be that someone's being turned up to hospital as a suicide attempt, you know. So, I think once we were able to give them a bit of that reassurance of what a person in distress is, cause I think perhaps our understanding of distress and their understanding of distress was maybe a bit different at times. And then I feel like after we attended a few of the training we were getting more appropriate referrals and the referrals actually started streaming in." Level 2 practitioner

5.4 Level 1 unmet training needs

The Level 1 practitioner survey respondents were asked to provide details of any unmet training needs they felt they had, as well as any additional training they had undertaken which was helpful to them in delivering DBI. Around one in seven (15%) cited additional training needs which they felt they would benefit from, including:

- A refresher session on the original training.
- Training on the DBI referral systems, including learning about the support that other agencies can offer.
- Opportunity to shadow Level 2 practitioners.

- Training on mental health.
- Solihull training[6].

A similar proportion (15%) said that they had received relevant additional training including:

- Mental health training such as Mental Health First Aid, mental health awareness and self-harm awareness.
- Suicide prevention training such as ASIST[7].
- DBI Train the Trainer provided by the University of Glasgow.
- Training on gender-based violence.

5.5 Level 2 training delivery, mode and content

The two-day Level 2 DBI training programme was initially delivered by the University of Glasgow. From February 2018, the training was transferred to established local site managers and coordinators who received a facilitator training pack to deliver DBI Level 2 training. Most Level 2 practitioners highly valued the training and practitioner interviewees noted that it had increased understanding of compassion, distress and the evidence-base underpinning the DBI intervention. Overall, Level 2 training survey respondents agreed or strongly agreed that they had enjoyed the training (83%) and that it was engaging (87%) and relevant to their role (86%).

> "The information that's there is really worthwhile and really balanced. I think that it's given me a lot of credibility to be able to kind of pull information from the slides and things like that that I wouldn't have had before, you know, about research and things like that. So it's great because it's all backed up and I can kind of give the credit to Glasgow University and say, look, I'm here delivering but this is where it's coming from and it's giving that kind of a bit of credibility." Level 2 practitioner

Following the introduction of a facilitator training pack for Level 2 training, new practitioners often had informal on-the-job training, delivered by Level 2 practitioner trainers followed by a shorter in-house formal training session. Some Level 2 practitioner interviewees commented that this approach to training gave them practical knowledge, which was useful, but the background information and more general elements should have been given at an earlier stage.

> "We'd done a little mini training almost between me and the local coordinator when I first came in and I done a lot of shadowing, but because I think they wanted to do a bigger training session instead of

[6] The Solihull Approach supports mental health and wellbeing in parents, children, schools, older adults and high-stress workplaces through an evidence-based model in training, online courses and resources.

[7] Applied Suicide Intervention Skills Training (ASIST) is an accredited two day, interactive suicide intervention training programme. See: https://www.asisttraininguk.co.uk/

> just it being myself and my other colleague, then I felt like the training was something I was doing already, you know, I was doing this already but I guess it helped me know that I'm doing exactly what I'm meant to be doing in my job, but before that I spent a lot of time with the local coordinator, especially when it first started, going over distress management plans, going through all the toolkits, you know, shadowing, done a lot of shadowing, a lot of reading." Level 2 practitioner

Some practitioners said they would welcome a stronger emphasis in the training on the reality of implementing the DBI Level 2 intervention and self-care.

> "The DBI training, in the first instance, could have included more of what was actually expected during a face-to-face DBI. It can be quite stressful to be a DBI practitioner so possibly more training on self-care and understanding of how to continually deal with other people's distress. Also training in the changing issues that people are dealing with, i.e. with the universal credit roll-out, this can change the issues that people are attending with so in the event of large scale changes like that training would be best put in place. (Felt that they weren't contributing to outcomes)." Level 2 practitioner

Almost all Level 2 practitioners had previous experience in providing support work with people in distress and/or with mental health issues. They perceived that the experience and knowledge they brought with them had been essential in their new DBI role. Many of these practitioners reported using techniques learnt in previous roles to support individuals referred to DBI. These DBI practitioners also reported advantages of being familiar with local services which enhanced their ability to effectively sign-post.

Some Level 2 practitioner interviewees noted that the Level 2 training enhanced their existing skills and changed their approach, especially around listening to individuals. However, some DBI Level 2 interviewees expressed reservations about the quality of delivery and lack of emphasis on practical elements during the training when it was delivered by in-house practitioners.

> "My experience of the training and the original team's experience of the training were two totally different experiences. So, this is no slight on any of my colleagues or anything like that but mines was very much sitting in a room and listening to people reading off a script. I don't feel it was very practical the training, as in 'this is how you would fill out a D-MaP, this is what we're trying to get out of the D-MaP' that sort of thing." Level 2 practitioner

As DBI was rolled out, anonymised case studies of how individuals had been managed were shared at initial training, refresher training, buzz sessions, and DBI Gatherings. Some Level 2 practitioners suggested creating top-up online training which could feature some of the most relevant anonymised cases.

"We now have actual cases that we've worked on, so to use the experience from these and the knowledge from these as training schools. You know, like case studies, like to be able to see...because I think it would be really good to have like an online thing where practitioners could go in and practice different things, and that would be a good tool for this type of thing to see what services you could connect them into, what tools you could give them, that type of thing." Level 2 practitioner

5.6 Level 2 skills, competencies and confidence in delivering DBI

By March 2020, a total of 107 staff across the six DBI Level 2 provider organisations were trained in DBI Level 2. Overall, DBI Level 2 practitioners felt that the training had given them the knowledge, skills and confidence to deliver the DBI level 2 intervention. In the Level 2 practitioner survey, agreement was highest for the statements 'DBI Level 2 training gave me the knowledge I needed to deliver DBI Level 2 interventions' (89%) and 'I make use of the learning I gained at the DBI training when carrying out DBI Level 2 interventions' (89%).

It should be noted, however, that 16% disagreed that the DBI Level 2 training had given them the skills to deliver DBI Level 2 interventions, and 15% disagreed that the DBI Level 2 training had given them the confidence to deliver DBI Level 2 interventions. This suggests that a sizable minority of Level 2 practitioners felt that the Level 2 training had not adequately prepared them for the job.

The majority of Level 2 practitioner survey respondents agreed that they were more able than before to provide a more constructive (69%) and more compassionate (65%) response to people in distress as a result of the DBI training. To explore the impact of the DBI Level 2 training on potential direct stigma, respondents were asked the extent to which they agreed that they were more likely to treat someone fairly because they were seeking help for their distress. Agreement with this question was lower for Level 2 respondents (45%) than for Level 1 respondents (58%); however a similar proportion of Level 1 (22%) and Level 2 (19%) practitioners disagreed - again suggesting that these respondents felt that they already treated people in distress fairly.

At Level 2, some practitioners felt that their previous training in supporting people with suicidal thoughts or behaviour was highly important and some suggested it should be incorporated into DBI training. Equally, some felt that training in managing trauma-related distress would be beneficial, as this was often a contributing factor to individuals' distress.

5.7 Training costs

Initial training for Level 1 and Level 2 providers took place in 2016-2017. The University of Glasgow was awarded a contract, in the region of £225,000, to develop the training and deliver it in the four pilot areas. Approximately half of

this money was spent on staff costs for developing and delivering the training to Level 1 and Level 2 practitioners and the rest was spent on travel, materials and organising the in-person group training sessions. The above total training cost was spent on Level 1 and Level 2 training in approximately 60%-40% division. Materials for in-person training included training packs with slides and other handouts.

The activities to set up and deliver the training involved: 1) Desk work: literature and evidence review, governance, obtaining approvals, administrative tasks; 2) Engagement and consultation with DBI pilot programme members, other stakeholders, local implementation partnerships; 3) Interviews and focus groups: frontline services staff; 3rd sector services staff; individuals with experience of distress, service use and help-seeking; 4) DBI Level 1 and Level 2 training programmes: content development, drafting and preparation; iterative programme review and revision; and 5) Organisation, travel and delivery of facilitated training sessions for DBI Level 1 frontline services practitioners and DBI Level 2 services. There was additional spending of £10,000 to build the learnPro training platform and make the platform accessible to Level 1 staff.

Initial training on DBI Level 1 for the Health Care Practitioners (Primary Care in hours, A&E, Scottish Ambulance Service) was estimated to take 537 person-hours. Police Scotland conducted separate training and data was not provided on the total number of hours. The initial training for the DBI Level 2 practitioners was estimated to take 616 person-hours. A detailed breakdown of the set-up and maintenance (ongoing) training costs along with the number of personnel trained and investment in personnel hours at Level 1 and 2 across the 4 pilot sites is presented in Appendix C.

6 Delivery of DBI

In this section, we present data on the delivery of DBI at Level 1 and Level 2, variations in the delivery of DBI across pilot sites, the staffing and cost implications of delivering DBI Level 2 interventions, how individuals who received DBI accessed further and future support, and the importance of the role and activities undertaken by DBI Central.

6.1 Delivery of DBI Level 1

6.1.1 Variations in implementation and delivery of DBI Level 1

Overall, DBI Level 1 was implemented with incremental roll-out across frontline service as intended. Across the pilot sites, the frontline services were engaged to differing degrees, reflecting local contexts and relationships. There was considerable variation in the delivery of DBI Level 1, much of which was related to the wide range of services involved and their role in delivering frontline care. DBI was successfully adapted to different contexts.

Some DBI staff, at different levels and in different pilot areas, became so involved that they acted as champions for the intervention. In doing so they promoted DBI and overcame implementation challenges both within and between organisations. These champions oversaw the feedback loops between Level 1 and Level 2 to ensure that awareness of appropriate DBI referrals was increased. Champions also acted as role models within services, embodying the DBI principles of compassion in their work and allowing the benefits of DBI to be seen by others. Feedback on the continued success of implementing the 24-hour contact requirement at Level 2 increased trust in the programme and confidence among Level 1 practitioners that they were offering a compassionate and effective response to individuals in distress. This supported the implementation of DBI and reduced concern among Level 1 practitioners regarding their accountability for the wellbeing and safety of people who presented in distress.

Where Level 1 practitioners doubted the added value of DBI, this acted as a key barrier to implementation. A few Level 1 practitioners working in frontline services perceived DBI as a threat to services that were already operating and which they considered to be of greater use and expressed concern that DBI would replace these. Level 1 practitioners in frontline services who considered addressing mental health issues to be outwith their role were also more reluctant to adopt the programme.

In frontline services where DBI was perceived as an additional task, this appeared to pose a barrier to its use. For example, for police officers, making a DBI referral meant that the person also had to be entered into the Vulnerable Persons Database. Before the introduction of DBI, this person would not automatically have been entered into the Vulnerable Persons Database, meaning that DBI had created additional processes for some frontline services.

> "She'd been having ongoing issues with her husband etc. and other members of the family and she appeared quite distressed. Now I wasn't concerned by her situation but she was distressed so I offered her a DBI but then I also had to submit a VPD [Vulnerable Persons Database entry]. Now I had no concern for her or her wellbeing in the environment she was in but I could see that she probably wanted to speak to somebody that was out of the family situation. So it's kind of I was doing a VPD just because it's supposed to be done." Level 1 practitioner, Police Scotland

6.1.2 Provision of a compassionate, constructive and effective response at DBI Level 1

Both those working in frontline services and individuals who received support from DBI described the DBI Level 1 response as compassionate and effective.

Overall Level 1 practitioners reported feeling empowered by DBI to offer a more compassionate and constructive response. They recognised that they had always aimed to be compassionate, but had felt constrained by an inability to offer distressed individuals they encountered any tangible support. The ability to offer a practical and timely solution was perceived as being of benefit to many of the individuals presenting to frontline services, but also offered Level 1 practitioners comfort and reduced some of the frustration previously felt with the lack of options.

> "It still allows us to put something in place with that and it gives you a bit a nicer feeling that I'm not just abandoning that person to, you know, just some immediate treatment." Level 1 practitioner, Scottish Ambulance Service

When asked to rate their agreement with statements on the impact of the DBI pilot on frontline services overall, the majority of Level 1 practitioners survey respondents (86%) agreed that DBI provided a more efficient way for their services to respond to people in distress (with 57% strongly agreeing) (Appendix 4). However, frontline Level 1 staff did recognise the limitations of the DBI service and some interviewees doubted DBI's effectiveness in reducing the number of calls to attend people who frequently used their service and who were often perceived to present with more severe and enduring mental health conditions.

Individuals who accessed support from DBI also reported experiencing a compassionate response at Level 1, with some variation in perceived compassion by Level 1 referrer.

6.1.3 Referral to Level 2

Individuals who were deemed suitable for a DBI Level 2 intervention were referred by Level 1 practitioners using a specifically developed referral form. Overall, Level 1 practitioners considered DBI referral forms to be relatively straightforward to complete, adding few additional processes to existing work. However, the paper or telephone referral process to Level 2 created an

additional step that did not always fit well with frontline services' existing procedures. For some, notably the Scottish Ambulance Service, this created a barrier to making referrals. A specific referral challenge was the submission of incomplete referral forms. This appeared to be a particular issue if the referring individual had not undergone DBI Level 1 training (in theory only people who were trained in DBI Level 1 could refer to a Level 2 service, but our data suggests this was not always the case in practice). DBI Level 2 practitioners reported that referrals from Police Scotland were often the most detailed and complete.

It is important for future roll-out that new areas implementing DBI ensure they can capitalise on existing local systems and networks to allow a faster and/or more effective referral process. This may have a resource implication for planning stages to identify which systems are in place and any additional software or personnel time required to streamline the referral process.

Where multiple services were involved, issues occasionally arose regarding whose responsibility it was to make the referral to DBI Level 2. This was resolved by allowing the service with the most straightforward referral process to make the referral. On other occasions, Level 1 practitioners reported that the same individual may be referred by more than one service. This did not appear to cause a significant issue for the Level 2 service.

> "If the police and ambulance go out and attend to an incident, and decide that, no they don't need to bring them to ED [Emergency Department]. But if there are some things that this person could do with some help with, they will themselves make a referral. We have had situations where, the police have made a referral, actually, where the patients come to ED … and we've made a referral." Level 1 practitioner, Mental Health Crisis Team

Where local changes to systems and networks were possible, these enabled the referral process to work well. In one area, local protocols were developed that involved use of a local 'hub' used by all local emergency services, which enabled the Scottish Ambulance Service to call immediately and securely pass on an individual DBI Level 2 referral. This allowed a more efficient referral process from Level 1 to Level 2 for the Scottish Ambulance Service in this area. Other pilot areas did not develop similar local protocols and in these areas the Scottish Ambulance Service Level 1 practitioners found the referral process to be more challenging.

Individuals who accessed DBI generally found the referral process straightforward, although their initial awareness of the support they would be offered in Level 2 varied between frontline services. Individuals referred from GPs usually clearly understood the purpose of the DBI Level 2 referral and, frequently, the immediacy of the Level 2 contact was met with surprise and welcomed. Individuals referred to DBI Level 2 from emergency services were often less clear about the reasons for their referral - and the role that a DBI service could have was less well understood. These individuals appeared to

have less understanding of DBI and the referral process. This appeared to impact on individuals' ongoing engagement with DBI. In some cases, this challenge was addressed by frontline staff leaving personalised written information with an individual describing which services had been involved in the crisis situation and why the referral to DBI had been made. This appeared to result in improved engagement with the service and distress reduction during the DBI Level 2 intervention.

> "The GP explained it very clearly and said that somebody would call me about it within the next 24 hours, and they did call I think within…I think they called that afternoon actually so it was just about…maybe about four hours later they called and then arranged the first appointment. I can't remember the timescale, but it was very quick." Individual

In the early stages of the project, feedback from DBI Level 2 services that some referrals were inappropriate may have dented the confidence of some Level 1 practitioners. Although they felt that their training had provided them with the basic skills and competencies to make referrals, they were less certain that their referrals were always appropriate in practice. Over the implementation period, the rate of inappropriate referrals seems to have fallen. Level 1 practitioners reported receiving constructive feedback and support from Level 2 practitioners that helped them identify individuals who were unsuitable for DBI. Some Level 1 practitioners suggested that they became more selective about referrals over time, as they valued the service and wished it to be as effective as possible to allow it to continue. The most notable increase in referrals was from GPs. DBI Level 2 practitioners stated that this may be due to DBI providing an additional pathway to prevent patients' problems from developing into a crisis level that required emergency service intervention.

> "One of the biggest inputs we now have are from GPs, those are the ones that we went out and developed and spoke to practices and brought them on, and if anything the quality of the referrals from the GP is higher." Level 2 practitioner

6.2 Delivery of DBI Level 2

6.2.1 Variations in implementation and delivery of DBI Level 2

The core elements of DBI Level 2, namely contact within 24 hours, a supportive first contact, the offer of up to 14 consecutive days of person-centred support and completion of a D-MaP, were implemented as intended across pilot sites and third-sector partners.

While the core elements were adhered to, Level 2 staff felt that the flexibility allowed in implementing DBI was a strength. This also allowed Level 2 practitioners to go above and beyond the basic process to optimise the service offered, where possible.

> "It's a real strength that the openness allows for the character of the person who is doing a particular delivery to be part of that and therefore

> for it to be a more authentic intervention. That's a really good thing because so many manualised approaches which are deemed to be low intensity now are manualised within an inch of their lives and they are not…they don't allow for the authentic inclusion of the person who is doing the delivery." Level 2 practitioner

Adaptations have largely been led by a focus on delivering a person-centred approach. Some Level 2 practitioners noted, however, that adaptations based on feedback from one area may not be appropriate to other areas where existing processes worked well. This might suggest that a menu of options should be made available, allowing areas to pick and choose which adaptations might be suitable to their context.

> "Some of the stuff that other teams have suggested aren't going to work for us, for example. Again, different areas, different geographical places we're covering and things like that – just different people in general, i.e. talking about service users and things – they're just not going to work for us. So I think implementing a change across the board isn't going to work for everybody." Level 2 practitioner

The key variations in the implementation of DBI Level 2 were identified as initial contact with individuals following referral, length and intensity of support and the settings in which Level 2 was delivered. These are discussed in more detail below.

6.3 Contact with individuals following referral

6.3.1 Contact within 24 hours

One of the core elements that was consistently executed in accordance with the DBI implementation plan was the commitment for Level 2 practitioners to attempt to contact the referred individual within 24 hours. As shown in Section 4.4, this was achieved for all referrals, and successful contact was made within 24 hours in 65% of referrals. Largely achieving this has surprised some frontline services and individuals and contributed to building their trust in DBI as a service.

> "The fact that they do exactly what they say they do on the tin. Because I think, you do, you can stick in a referral at ten o'clock at night, and the next morning they're phoning up saying, oh we've got more information about that person, and we're just about to go and see them, and you think, blooming hell. It's excellent, it's really excellent." Level 1 practitioner, Police Scotland

> "Because when you are feeling that low, that you are considering, obviously, taking your own life, and you get told, oh well, we can see you in 12 weeks' time, it feels like you're not really valued. It feels like you're sort of just being given a number and being told, oh we'll see you when we can. But it felt really personal, and the fact that it felt like they were actually wanting to help get you out of that stage." Individual

Level 2 providers had protocols in place for making the first contact with individuals within 24 hours. However, the success of these could be affected by the availability of the individual, particularly if drugs or alcohol issues affected their recall of being referred to DBI, or if they were in hospital overnight. Some Level 2 providers mentioned the benefit of adapting to processes that worked better for individuals, such as not making contact before 10am, as individuals had often been in hospital through much of the night:

> "We now don't phone anybody before ten o'clock, only because a lot of people could have been in hospital until one o'clock the previous night or the previous morning and then phoning them at nine o'clock is a wee bit early…" Level 2 practitioner

The majority of individuals who completed the first session DBI Level 2 individual impact survey (See Section 3.2.1) (79%) were contacted by the Level 2 provider within 24 hours of referral. Nearly all respondents to the second session survey (See Section 3.2.1) (97%) thought that contact within 24 hours from the Level 2 intervention provider was just about right. Level 2 practitioners felt that delays in follow-up after the initial contact had an adverse effect on the person in distress. However, this was not borne out by the individual-level survey data. Whether contact was made within 24 hours appeared to make no difference to the reduction in distress levels over the time of the Level 2 intervention, with similar outcomes for those who were contacted within 24 hours and those who were not (Appendix 3, Table A6.1).[8]

Individuals recognised that a prompt follow-up to the first contact could make a positive difference to engagement:

> "That was so hard, that was literally, like, cause I was there first thing on Friday morning so the whole of Friday night, Saturday and Sunday I was just an absolute mess and it's like when I'm feeling like that I get irrational thoughts as well, so I was thinking oh, you know, maybe he's not even referred me and it's like maybe they won't even phone me, am I even going to get help? Yeah, it was a hard weekend, I'm not even going to try and deny that. Come Monday I got the phone call but I was a wee bit disheartened cause it was like they couldn't see me until the following week, the end of the week." Individual

6.3.2 Supportive first contact

The first contact between a DBI Level 2 provider and an individual who had been referred tended to consist of clarifying the reason for the referral and purpose of DBI. This was an important step in managing individuals' expectations, especially regarding the short-term nature of the intervention. Individuals' perceptions of what should be covered at the first contact varied. Some hoped for an opportunity to talk in a counselling-type approach. Others

[8] As measured by changes in distress thermometer score and CORE-OM 5 score.

felt that the first was more of an explanation of the service and more detailed talking sessions should follow when a degree of trust in the DBI Level 2 practitioner had been developed. Where the first contact focused on administrative detail, some individuals felt disappointed:

> "I kind of felt as if it was going to be like a bit of counselling to kind of help me talk about what I had done and what I had been through and what kind of led me to doing what I had done but it wasn't like that. It was more…the chap that spoke to me was more interested in me filling out forms about…for himself, basically." Individual

As DBI implementation progressed, some Level 2 services appointed administrative support to take the details on initial contact from the Level 1 referrer. This appeared to increase the potential of making contact within 24 hours. However, having administrative support as the first contact limited the potential for the provision of emotional support from a trained DBI Level 2 practitioner. To overcome this issue, one service trained its administrative practitioners as Level 2 practitioners, so that they can offer a level of support from the first contact.

> "Those two guys who do the admin, they are now Level 2 trained. So, what it allows them to do is when they take…they bring a referral in and they make the packs up and they will make everything all kind of streamlined. They can then do that initial call. Start populating the D-MaP and then allow the colleagues who will be delivering the interventions to pick that up and they can then take that care on." Level 2 practitioner

6.3.3 Uptake of support following first contact

There was wide variation by Level 2 provider in how and when the first contact was followed up. This was often client-led but could also be affected by Level 2 practitioners' availability. Assessment of risk was considered in determining the location and the number of Level 2 practitioners involved in the first face-to-face encounter.

Individuals who accessed support from DBI were generally willing to engage in any service that offered support without being placed on a waiting list. However, those interviewed were largely individuals who had engaged beyond the first contact.

Some individuals felt that they had recovered enough by first DBI Level 2 contact to not need the service and felt that their decision not to engage may free appointments for those more in need. Fourteen percent of all referrals to DBI received one supportive phone call and opted not to receive further support (Figure 4.4). Police officers interviewed expressed some concern that this may happen more often when alcohol or drug use has been involved, with the individual in distress feeling more able to cope when they become sober again. Level 2 practitioners noted that some individuals who had exhibited high levels of alcohol or drug abuse were less likely to recall that they had

been referred and therefore needed further explanation of the nature and purpose of the DBI intervention. There was a perception that this group of individuals were more likely to feel that DBI was not what they were looking for and thus disengage. Over time, pilot sites introduced elements of the Distress Management Action Plan on first contact to ensure that individuals had some form of support even if they chose not to engage with DBI Level 2 practitioners beyond that contact.

Some Level 2 practitioners perceived particularly vulnerable people as being hard to engage, suggesting that referring them could lead to further disappointment, which could be harmful:

> "People whose depression is really quite severe, you know, they're not able to lift themselves enough to be proactive in doing things. Addictions is another difficult one as well, if they're there as well, you know, that's always the priority; or other ones would probably be when the housing situation's really bad cause that really should be taken care of first so they're not in a position to, you know, if they're homeless and they're living in the homeless unit which is quite chaotic, they're probably not really in the position where the techniques that you're giving them are going to really help at the moment till they get a roof over their head and they feel safe." Level 2 practitioner

Level 2 practitioners mentioned that some individuals who had not engaged on their first referral, did so after further referrals, suggesting it was important to continue with offers of support until the individual was ready to engage.

6.3.4 Variation in length and intensity of Level 2 support

Variation in the length and intensity of support provided by the pilot sites is reported in Section 4.5.1. There was also variation across pilot sites in the number of support sessions delivered and the total time for an intervention: Aberdeen City delivered the fewest average support sessions (although they had the highest proportion of support that went over 14 days, see section 4.5.1) and Scottish Borders delivered the highest average number of support sessions. Some of this variation may be accounted for in the different ways in which sites recorded the number of sessions but these findings reflect the person-centred approach of DBI support. The total time required for each person receiving a DBI Level 2 intervention comprised of contact time with each individual plus associated administrative time. A quarter of cases (26%) took no more than four hours in total, while 62% took between four and seven hours in total, and 12% more than seven hours in total.

Level 2 practitioners suggested the length and intensity of DBI sessions were person-led, taking individuals' circumstances and needs into account. However, data from those who took part in the evaluation surveys indicate that differences in completion time or total time for the intervention were not associated with characteristics of the individual or the nature and level of distress (Appendix 3, Table A5.3). This suggests that differences in length of

support were due almost entirely to the different practices, and perhaps different interpretations of person-centred approach, of the Level 2 providers.

While individuals who accessed DBI generally described the offer of 14 days of support as about right, a substantial minority (30%) of individuals who responded to the surveys felt it was not enough. Individuals who felt they had become less distressed[9] during the course of the intervention were more likely to say that two weeks was about right. However, neither higher numbers of hours of support beyond 4 hours nor intervention periods beyond 14-days of support resulted in significant additional improvements on levels of distress (Appendix 3, Tables A6.5 and A6.6).[10]

Some Level 2 Practitioners mentioned a tapering off period, where support was more intensive in the first week, then reduced in the second week. This allowed the individual to adjust to the end of the service.

> "We just work our way through it for the 14 days and try and get as much of the work done within the first seven days with them and get it into place as much as we possibly can because you don't really want to just be flipping the rug out from somebody's feet after 14 days, so the second week try and tell them that so that maybe the support isn't as intense on the second week so you're kind of weaning them back off getting all the support so it's not as if 'oh 14 days, I've seen you every day and I've had a phone call every day for 14 days and now it's all just disappeared." Level 2 practitioner

However, comments from some individuals who had accessed DBI suggested that they felt they had fewer sessions than expected or these were more spread out due to organisational issues within Level 2 services. One individual felt that the ending of the sessions was a little abrupt:

> "And then I rang up and they said we'll have another meeting which I couldn't attend cause I had double-booked, and then I went to another meeting with the DBI and then he said 'right that's you, you've given me this information, go there, there or there' and you're out the door." Individual

6.4 Provision of a compassionate, constructive and effective response at DBI Level 2

Level 2 practitioners generally perceived DBI as an effective way for services to respond to people in distress and as beneficial to those who engaged (See Appendix 3, A6.13). DBI was seen as an empowering service that reduced the

[9] Those who reported a decrease from moderate or high distress (10 or above on the CORE-OM 5 scale) to low distress (less than 10 on the CORE-OM 5 scale) were more likely to say the 14 days was about right (82%, compared with 66% of those who did not achieve this level of change).

[10] As measured by either the distress thermometer or CORE-OM 5.

risk of dependency arising from long term contact with a service and provided rapid and intensive support to the individual recovering from immediate distress. There was recognition that DBI may have had less impact on individuals who repeatedly access services, often with severe and enduring mental health conditions. However, DBI still played a role in supporting these individuals to some extent.

> "Even the smallest of change can be a huge thing for something, like, just somebody even having the confidence to decide whether they want to have a cup of tea or a cup of coffee, that is huge to get somebody to actually have the confidence that they can make their own decision and their own choice, and that's what I like about the DBI, it's putting the empowerment back onto the person to make the choices, to get them to take control of their own self-management of their mental health and their own wellbeing and signposting them or getting them access into other services that can complete and fulfil the rest of it for them." Level 2 practitioner

> "We do get quite often a lot of referrals from police for people who already fall into that category of revolving door, you know, because they'll mention in the police…in the referral that, you know, this person phones regularly because of this issue or because of this issue. And I think that, you know, I have to narrow…I was very optimistic for DBI preventing that behaviour developing, but I was very pessimistic about it changing any of that behaviour. But some of the cases we've had come through I have to admit it does seem very positive, the outcome. So, yeah, I do think there is evidence it's working." Level 2 practitioner

The Level 2 intervention was acceptable to most of the individuals who engaged in the programme and generally met their immediate needs, offering an opportunity to talk without being judged. Overall, individuals who accessed support from DBI Level 2 reported experiencing high levels of compassion from their Level 2 practitioner and very positive impacts of the DBI Level 2 intervention on their ability to self-manage their distress. Findings discussed fully in Section 7.2.2 suggest that the more compassionate the response at Level 2, the better the outcomes for individuals.

> "To be honest with you I'm quite easy talking to people so I was kinda glad. I wanted it to go down that route, I mean, I wanted… when I was in prior to that I wanted to go see someone as opposed to getting put on sleeping pills. So yeah I was quite happy to do it. Yeah, I was glad, I was glad that I was going to get to speak to someone." Individual

Misconceptions regarding what the Level 2 service could offer led to a negative response from some individuals. These misconceptions included expectations on the part of some individuals interviewed that they would be receiving a counselling or therapeutic service, which led to disappointment at the short term and more practical focus of DBI. Some individuals overestimated the level of support they would receive, expecting it to help

them address their issues in full, rather than providing signposting to other services.

> “I think I expected something a bit more like counselling. And what happened to me was a very extreme PTSD [post-traumatic stress disorder] reaction to a situation. And it was really…which is very scary for me ‘cause I hadn’t actually experienced anything on that scale before. It was very extreme. And I was really scared about it. And I think I would have liked a bit more information about PTSD and a bit more reassurance that what I was feeling was normal. And I didn't really get that to be honest.” Individual

> “To be quite honest, to me it just felt like a palm off. They said 'right, this is all you're entitled to, you don’t have to come back to us again but if you want to contact there, there, there or there you're more than welcome to, but your sessions with us are finished' and I felt quite low at that point, because I thought you were going to sort everything out for me, like, talk to you and, like, distress. But it wasn’t, it was just to see what was on my mind and go to these other organisations.” Individual

Most individuals accepted the Distress Management Action Plan as a useful approach to work through triggers and coping mechanisms. Some DBI Level 2 practitioners felt that the Distress Management Action Plan was an overly manualised approach, and its use needed to be centred on an individual’s emotional state. Some DBI Level 2 practitioners felt that some individuals were not ready to begin this process until they had been able to talk about their distress and build trust in the relationship.

> “I think a third of service users are not completing them. I think they feel it’s a paperwork overload. They feel there’s too much paperwork. We’ve had a lot of feedback of that, that they are feeling that it’s a paperwork overload.” Level 2 practitioner

6.5 Staffing and cost implications of Level 2 delivery

The staffing required to deliver DBI is presented here because it is important to acknowledge the number and composition of staff required to meet the demand for DBI services and to know how this has changed over the rollout of the DBI programme.

Table 6.1 Total estimated staff resources required to provide DBI L2 in pilot sites April 2019 - March 2020.

Financial Year 2019-2020	**South Lanarkshire**	**North Lanarkshire**	**Aberdeen**	**Inverness**	**Scottish Borders**
		Lead/Co-ordinator			
Statutory sector lead	1.0 AfC Band 8A	Joint with S.Lan	no	no	0.6 AfC[1] Band 8B
Third sector lead	no	no	yes	yes	no
		Practitioners (FTE*)			
DBI Manager/ Co-ordinator	1.00	0.13	1.00	1.00	0.85
DBI Senior Practitioner	0.00	1.00	0.00	0.00	1.00
DBI Practitioner	6.40	5.40	5.50	3.60	2.65
DBI Sessional Practitioner	0.50	0.00	0.12	0.00	0.00
Administrative Support	0.50	1.15	0.50	0.71	0.85
Other staffing	0.00	0.00	0.00	0.20	1.00
Total Number of staff**	12	11	9	8	8
Total staff by FTE*	8.40	7.68	7.12	5.51	6.35

[1]AfC: Agenda for Change: circular informing NHS Scotland employers of changes to staff pay covered by the Agenda for Change agreement from 1 April 2020.

*FTE, full-time equivalent (35.0 hours per week)

**not including sessional practitioners or lead co-ordinator

DBI was implemented in four pilot areas (Aberdeen, Inverness, Lanarkshire and Scottish Borders) and included a managing organisation, DBI Central. Aberdeen and Inverness were led by third sector partners, and Lanarkshire and Scottish Borders by statutory partners (North & South Lanarkshire Health & Social Care Partnership and NHS Lanarkshire, and Scottish Borders Health & Social Care Partnership respectively). There were differences in the way the DBI programme was implemented in the respective council areas of North and South Lanarkshire. These two areas are similar in size to the other pilot areas, each serving big populations of approximately 300,000 people. We present North and South Lanarkshire separately here, to highlight the differences in implementation and costing implications between the two parts of Lanarkshire.

As shown in Table 6.1 a range of staff were required to provide DBI within each site. Each pilot site employed a manager who oversaw local operations and was the point of contact with DBI Central to report back outcomes and other data. Initially, the development and set-up of this role required limited investment at 10% to 50% of full-time equivalent (FTE). Pilot sites employed DBI senior practitioners, DBI practitioners and DBI sessional practitioners. The latter were employed on an as-needed basis. The difference between practitioners and sessional practitioners is that the former were solely employed in DBI on an annual contract but the latter were paid by the hour and possibly were involved in non-DBI activities too. Senior practitioners supported the manager at each site, managed practitioners, worked as practitioners and oversaw the operation of DBI referrals. In South Lanarkshire, the DBI Manager and senior practitioner posts were subsumed into part of an existing team manager post and were funded from elsewhere. These are therefore not shown in Table 6.1.

Clinical leads were employed in Lanarkshire and the Borders to coordinate all aspects of the DBI programme, ensure linkage across all pathways, systems and other local programmes and coordinate Level 1 and Level 2 training. In the case of Lanarkshire, the clinical lead had to coordinate three different organisations which offered DBI Level 2 services across North and South Lanarkshire.

The total number of staff varies across sites; this reflects the size of the population that each site serves and also the stage of implementation. The change in the staffing requirements for DBI Central since its inception in 2016 is presented in Appendix 5 (Table 4.3). Incremental growth of DBI and the changing staff numbers can also impact on other resource requirements such as space, with Scottish Borders DBI locating to new premises in December 2019. There was similar spending across the sites in infrastructure which included premises rental costs, travel and subsistence costs, promotional materials, IT support and other necessary equipment to perform all DBI related tasks and spending in utilities and other bills. Rental costs were kept at a minimum by sharing facilities with other services (Appendix 5, Table 4.4,).

Some Level 2 practitioners found the administrative load of delivering DBI Level 2 burdensome.

> "In DBI, you know, you've got huge amounts of admin in terms of processing referrals, writing GP letters, collecting data, actually providing your interventions and then the result of that sometimes is you have to follow safeguarding protocol, you have to do incident reporting, you have to do safeguarding protocols, so just the volume and the quantity and the range of work is a lot to ask of people." Level 2 practitioner

Each pilot site had administrative staff to support the delivery of the DBI service. This ensured that DBI practitioners spent their time providing services to individuals in need rather than spending time on administrative tasks. These admin roles provide value, with their contribution increasing over time towards roughly equivalent of one full-time role.

At times, some services reported being very busy and approaching the capacity of what they could deliver. Some individuals felt that this placed the quality of the service they delivered at risk.

> "We've had quite a few times when we've nudged capacity and if that were to persist for any period of time I would say that probably the quality of the service would be quite quickly affected because of things like meetings and supervision and things having to go out of the window in order to physically meet sort of like the 24-hour contact thing and the needs of the service users." Level 2 service lead

6.6 Post DBI: accessing further and future support

6.6.1 Signposting and supported connection to statutory and non-statutory services

An option for Level 2 practitioners at the end of a DBI was to support the individual into another service. Individuals could be either signposted towards more support or actively introduced to other services, including mental health support, through a supported connection to the service. Signposting implies that the person was provided with the details of the particular service and then the person is responsible to make contact with that service. Supported connection implies that the DBI Level 2 service assisted the person with actually making contact with the service, e.g., called the service on behalf of the person to initiate contact. Examples of signposting or supported connection to non-statutory services included apps or other online supports, Breathing Space (a confidential phone line for anyone in Scotland over the age of 16 who is feeling low, anxious or depressed), counselling services and national or local helplines. Examples of signposting or supported connection to statutory services included GP services, NHS 24, social work, and welfare support teams.

A large proportion of individuals who accessed DBI were signposted to, or actively supported to access other services. The majority (85%) of people across all of the pilot sites who had a successful contact at Level 2 were signposted to non-statutory services and 42% of these were provided with a

supported connection to the service by Level 2 staff. Just under a third (29%) were signposted to statutory services and 57% were provided with a supported connection to the service by Level 2 staff. This data highlights the importance of having services within the locality to support people beyond DBI Level 2 (Appendix 3, Tables A6.7, A6.8, A6.9, A6.10).

Future provision of DBI should consider the availability of these types of services within the community and the risks of increased demand for services and the impact on waiting lists.

The vast range of services to which individuals were signposted indicates that interventions were tailored to the individual. Signposting to non-statutory services was much more common than to statutory ones (Appendix 3, Tables A5.7 and A5.8).

There was considerable variation between Level 2 providers in the use of signposting to statutory services, ranging from 61% of cases from LAMH, South Lanarkshire and 55% from Lifelink, North Lanarkshire, to 8% from Penumbra, Aberdeen. Conversely, signposting to non-statutory services was lowest from LAMH (65%) and Lifelink (67%), and above 90% from Penumbra (94%), SAMH, Scottish Borders (96%) and the Richmond Fellowship, South Lanarkshire (92%). Differences in signposting practices partially reflect differences in presenting problems in the different areas. However, this does not appear to account for all variations in signposting. The Richmond Fellowship, for example, signposted a smaller proportion of cases to statutory services (23%) than the other Lanarkshire providers, despite a similar profile of users.

Men were more likely to be signposted to statutory services than women (36% compared with 26%). This possibly related to the type of problem they presented with: men were more likely than women to present with self-harm or thoughts of self-harm and suicidal behaviour or thoughts of such, while women were more likely to present with stress or anxiety. Individuals whose main presenting problem was self-harm or thoughts of self-harm (40%), suicidal behaviour or thoughts of suicidal behaviour (41%) or an intentional overdose / self-poison (48%) were more likely to be signposted to statutory services than those whose main presenting problem was depression / low mood (20%) or stress/anxiety (25%) (Appendix 3, Tables A6.7 and A6.8).

There were also differences between Level 2 providers regarding the degree of actual introduction and support individuals received in making initial contact with the service to which they were signposted. Overall, 37% of individuals receiving a Level 2 intervention were actively introduced to non-statutory services. However, this varied from 10% of those receiving an intervention from LAMH to 82% from SAMH. One in six (17%) were actively introduced to statutory services, with this also being high from SAMH (28%), as well as from Lifelink (27%) and LAMH (26%) where signposting to such services was much higher. At Penumbra and Support in Mind, Highlands, active introduction to

statutory services was much less common (both 5%) (Appendix 3, Tables A6.9 and A6.10).

The three-month follow-up survey asked about the uptake of services, but because of the small sample size (n= 102), findings should be treated with caution. Of those who answered the question regarding referral to another service (n=58), 52% stated they were referred to another service. Slightly more people stated they were signposted to a service (55% for statutory and 59% non-statutory) or actively introduced to a service (63% for statutory and 65% non-statutory), although several people did not recognise this signposting as a referral (Appendix 3, Table A6.11). Of those who did report being referred, 83% said they took up the service.

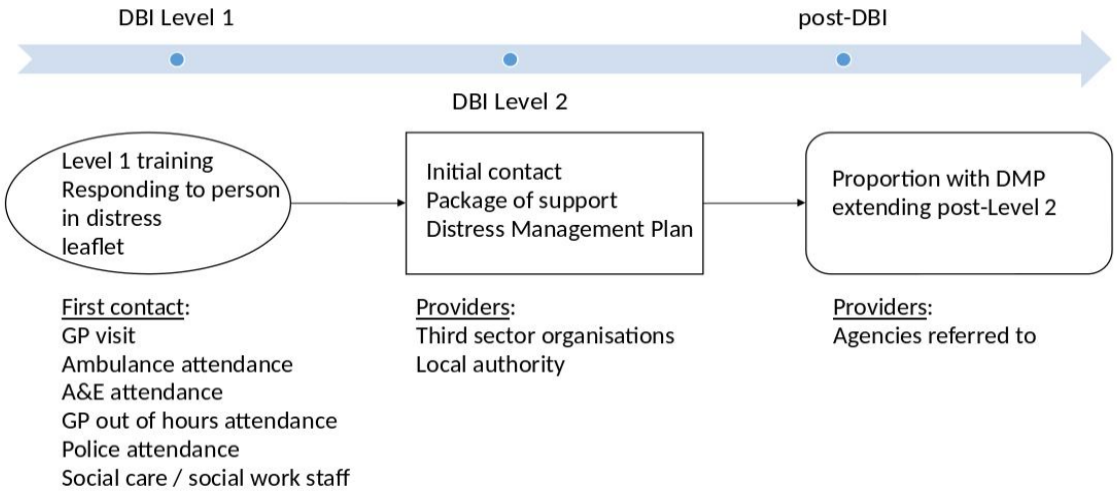
6.6.2 Re-presentation to frontline services in distress

The follow-up survey found that in the three months since their last contact with DBI, 47% of respondents reported that they had been in contact with the police, ambulance, their GP, A&E or another emergency service because they were in distress (Appendix 3, Table A6.12). With a lack of a comparator group, it is not possible to say whether this indicates a reduction in such contacts, although other indications from the follow-up survey suggest that those going through DBI have been using what they learned during the intervention to help them manage their distress.

6.7 DBI Programme pathways

Delivery of DBI depends on people appropriately responding to individuals in distress, and on services being available and able to respond in turn. This pathway is standardised - however, there are choices about the organisation of resources and modes of delivery (which in turn affect resource use). Figure 6.1 shows the typical pathway that individuals in distress accessing DBI may end up taking.

Figure 6.1: Typical pathway for an individual through a DBI



Data from the evaluation, specifically about locality, reason for referral, Level 1 referral agency, number of hours and days attending the Level 2 service and post DBI signposting or initiation to other services, were used to construct three scenarios that represent typical pathways through the DBI programme.

6.7.1 Using the scenarios

Three scenarios are presented below. The purpose of these scenarios is to highlight observations about successful configurations, and of challenges, in organisation and use of resources. Unit costs (Curtis et al. 2020) have been added to the scenarios for information with the focus being on Level 2, which is the core component of DBI from the individual user perspective. Where applied, unit costs are presented in parenthesis and use data presented in Appendix 5, Table 4.2. It is also assumed that without DBI, the frontline service would have responded to the individual e.g. Police Scotland would have attended a call out or an individual would have attended a GP appointment, so no additional cost is incurred as a result of providing a compassionate response at DBI Level 1 response and referring onto a DBI Level 2 provider.

The constructed scenarios set out below follow the individual user pathway, drawing on data from the evaluation data set for context. Key decision points on resource use are indicated at the end of each scenario. The decision points also draw on findings from the wider evaluation to illustrate where choices need to be made in the further development and rollout of DBI, including physical space, staff training and onward support. Although they are presented under specific scenarios, they should be considered in any setting where DBI is being delivered. Presenting these scenarios transparently can aid realistic and feasible decisions about delivering DBI to be applied by decision makers in their local context.

6.7.2 Scenario 1

In Lanarkshire, 54% of Level 2 referrals came from A&E and out of these 32% of referrals were for reasons of (thoughts of) self-harm and 43% with suicidal thoughts or behaviour. For those individuals who received Level 2 support from LAMH, 77% of participants had at least seven hours of support and 42% received support of 15-21 days at Level 2.

In this scenario, an individual presents at A&E in Lanarkshire with thoughts of self-harm. The A&E clinical contact (Level 1 practitioner) provides a compassionate response and suggests a referral to a Level 2 DBI service. The individual views this positively and confirms they would like to be referred and the Level 1 A&E practitioner completes the referral paperwork.

The next day the individual receives a call from the Level 2 provider, LAMH. The sessional practitioner provides more detail about the programme and sets up a further appointment (£3.43) for the individual with the Level 2 trained specialist. The individual goes on to receive 10 hours of support (£152.40) over the next 18 days in which they have high levels of engagement. The

practitioner who provides this service is supported by admin support which is available at the Level 2 provider (£6.50).

At the end of the 18 days, the Level 2 provider recommends several non-statutory services within the local community that the individual could follow up with themselves; the Level 2 provider also contacts a statutory service (£3.81) on behalf of the individual to set up an appointment for further support post-DBI Level 2.

The DBI related cost of this scenario is £166.14.

Key decision points illustrated in this scenario are:

- Who makes the first Level 2 contact. In this scenario we make the assumption it is the session practitioners who makes the first contact but the use of administrative staff to make the first contact with the individual increases the probability of making contact within 24 hours and can free up Level 2 practitioners to be providing DBI but may risk the individual wanting more emotional support that is not provided.
- Is there sufficient, safe space that is accessible to the individuals receiving the Level 2 DBI or does additional space need to be identified and how is this managed depending on levels of demand.

6.7.3 Scenario 2

In this scenario, an individual in distress comes into contact with DBI in Aberdeen through Police Scotland. We have chosen this scenario since Aberdeen was the area with the most Police Scotland related referrals to DBI at 14%. In Aberdeen, 72% of cases required between 4-7 hours of support at Level 2.

As soon as Police Scotland are called to an incident in Aberdeen, the officers who are trained in DBI recognise that the individual is experiencing an episode of distress. They provide a compassionate response and ask the individual if they would like to be referred to a Level 2 DBI service. The individual views this in a positive way and confirms they would like to be referred. The police officer completes the referral paperwork.

The next day the individual receives a call from the Level 2 provider Penumbra who provides more detail about the programme and sets up a further appointment for the individual with the Level 2 trained specialist (£3.43). The individual goes on to receive six hours of support (£91.44) over the 14 day follow up period. The individual completes a Distress Management Action Plan with the Level 2 provider and they identify that further support is needed at the end of the DBI Level 2 process. The Level 2 provider signposts (£2.44) the individual to local community non-statutory services such as online support services.

The DBI related cost of this scenario is £94.87.

Key decision points illustrated in this scenario are:

- The mode of training for the Level 1 frontline staff. Delivery of Level 1 training via an online platform has the potential to reduce cost compared to face-to-face if additional facilities and trainers are required. However, there were concerns this may lower the overall effectiveness of the training. Police Scotland in particular stressed the importance of face-to-face training for all staff in Level 1.
- Feedback on the role and use of the D-MaP was generally positive from individuals highlighting the importance of communication from Level 2 practitioners on the need and purpose of the D-Map.
- Post DBI support is crucial, and most individuals (73%) are at least signposted to non-statutory services. Consideration is needed on the availability of statutory and non-statutory services within the community and the risks of increased demand for services and the impact on waiting lists.

6.7.4 Scenario 3

A GP in the Borders has a standard appointment with an individual. In the appointment, the individual reports feelings of stress and anxiety and appears in distress. Data have shown that 77% of all referrals for stress and anxiety took place at the GP level. In this case, the GP provides a compassionate response and offers to the individual a referral to a Level 2 DBI service.

The individual is contacted within 24 hours by the Level 2 provider (£3.43) and receive 6 hours of support over the 14-day period (£91.44). The individual's situation was particularly challenging requiring a senior practitioner to also be involved providing two hours of supervision to the practitioners regarding this case (£36.92). Following discussion between the Level 2 practitioner and the individual, the Level 2 practitioner contacts both statutory and non-statutory services (£7.62) to set up appointments for the individual to receive further support at the end of the Level 2 DBI.

The DBI related cost of this scenario comes at £139.40.

Key decision points illustrated in this scenario are:

- Within the Level 2 services decisions are needed on staffing composition to ensure a range of skills and experience to meet the needs of a wide range of service users.
- An assessment is needed for each individual to determine if there is a need for paired staff members, such as when dealing with a particularly challenging case, or if different materials are required for each Level 2 user.

6.8 DBI Central – role and activities

DBI Central supported pilot sites' delivery of DBI and ongoing DBI development, coordinating activities, administration and service developments. Overall DBI services perceived the role of DBI Central in

coordinating services and enabling open communication and information sharing as an essential component of the DBI programme.

> "It's definitely needed, a central point, definitely. Sometimes you're like is it kind of tokenistic central leads and the areas just get on with this and report directly but I think it's very much needed to keep the focus going, information being shared appropriately and I think that has also stopped people just kind of being quite rogue, you know, just going off and doing their own thing which is never done in a bad sense, I don't think… I think because they listen to us and that informs how then they lead all of us, I think it just feels really…it's working extremely well having a central team." Level 2 Service Coordinator

DBI staff reported that the constructive leadership of the DBI programme manager was particularly central to the overall success of the DBI programme.

> "…the DBI central team. As much as I don't actually know everybody or anything, but when he [DBI Programme Manager] comes out and does his… We meet up every now and again and he pops into the office to see how we're getting on and he actually…I've never worked with anybody, and I don't know why, that actually listens and takes on board what we're saying and then goes and changes it." Level 2 Practitioner

6.8.1 The Gathering

A specific DBI Central activity was the organisation of twice-yearly national events known as Gatherings. The Gatherings brought together key stakeholders, Level 1 and Level 2 services and provided a forum for sharing practice experiences, consolidating local and national networks and allowing all those involved in DBI to share ownership in the programme as a whole. The Gathering also provided a forum for the evaluation team to share interim evaluation findings and to gather further information to inform the evaluation process. The Gathering was not developed as a core part of the DBI intervention; however, stakeholders considered it to play a vital role in achieving cross-sectoral delivery of the overall DBI programme.

> "…it was actually partnership in action, and you could actually feel the difference you were making just by actually putting those boundaries away and working together and I think the openness and the honesty, people have been very candid. I'm not coping with this. I don't understand what you're saying. I don't really agree with that. How does that work? You know, and we were very open about the fact we've made a complete pig's ear of recruitment, somebody's going to have to help us." Level 2 service lead

The Gatherings 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.

> “You have the support from the central team and part of that really is through the DBI Central manager and his attitude to all of this and his attitude to problem solving and getting people to work together, it's real compassion actually across the piece.'” Stakeholder

6.8.2 Local implementation groups

Each pilot site created a local implementation group comprising key local stakeholders. While engagement across local stakeholders had occurred before, DBI services reported their impression that these local implementation groups engaged more agencies than many had previously experienced.

> “The only other thing that’s really surprised me is the will on the part of organisations which are really stretched. When we have our implementation groups I’m always really sort of tickled about the fact the manager of the out of hours social work team will come and, you know, they’re out of hours. They don’t work 9.00 to 5.00 or that the police will find time to come and meaningfully attend. Those things have really surprised me.” Level 2 service lead

7 Impact of DBI on Individuals Experiencing Distress

7.1 Impact of DBI Level 1 on individuals

Findings on the impact of the DBI Level 1 on individuals, including perceptions of a compassionate response, impact on their ability to cope, their distress levels and the factors that could be identified as influencing these are presented below.

7.1.1 Perceptions and impact of the compassionate response

Overall, individuals felt that they were treated with compassion by DBI Level 1 practitioners. Those who completed the first session evaluation survey at the start of their Level 2 intervention were asked to select the number (from 0: 'not at all to 10: 'completely') that best described how much they felt that the Level 1 provider who referred them to the DBI Level 2 service treated them with compassion. Most indicated they felt treated with a fairly high level of compassion (a mean of 8.6). Younger adults tended to provide slightly lower ratings, although still high (a mean of 8.2 for those aged 16-24 and 8.3 for those aged 25-34, compared with 8.7 to 9.1 for older age groups) (Appendix 3, Table A7.1).

Those who showed the lowest levels of psychological distress at the start of Level 2 (that is, those with a low score on the CORE-OM 5) were more likely to rate the compassion of the Level 1 provider very highly. Those with a CORE-OM 5 score of 0-10 at the start of Level 2 (indicating low levels of distress) gave a very high mean rating of 9.9 but this fell to 8.4 for those with a CORE-OM 5 score of 32-40 (indicating severe levels of distress).

Mean ratings of being treated with compassion at Level 1 were highest for those who presented to the police (9.3) and lowest for those who presented at an A&E department (7.7). Those presenting to A&E did not present with higher levels of distress than those presenting to the other Level 1 providers (see Appendix 3, Table A7.2) and the reduction in distress levels between contact with the Level 1 referrer and the Level 2 DBI service was lowest for those coming through A&E or the psychiatric liaison service (Appendix 3, Table A7.3). This may explain the relatively lower compassion scores for Level 1 in Lanarkshire (8.2) compared with other pilot areas. In Lanarkshire higher proportions of evaluation respondents (more than 50%) presented at an A&E department than in other pilot sites (between 0% and 2%).

Some individuals interviewed noted that the compassionate response they received from frontline practitioners in services participating in DBI differed from their previous experiences of those services.

> "Usually they just get you in the ambulance and don't bother but they really were awful nice." Individual

On occasion, a referral to DBI was enough to alleviate their distress without further support from clinical or other services. For some of those interviewed, DBI served a highly useful purpose in providing an alternative or complement to medication or being placed on waiting lists for clinical intervention as a response to their distress.

> "I was too accustomed in the past to seeing GPs about mental health problems and then just being given drugs and told to go away basically. So, I was actually pleasantly surprised…very pleasantly surprised that it wasn't just a case of, okay, here's some medication. For once there was, you know, something else that was actually…some other form of help that was actually being offered to me straightaway for free." Individual

Level 2 practitioners commented that DBI Level 1 formed the base for individuals' further engagement with services, attributing this effect to Level 1 practitioners having broken down barriers to seeking/accepting help and perhaps reducing the self-stigma associated with distress by offering a compassionate response. DBI Level 1 practitioners felt that their provision of a compassionate response validated the individuals' distress and this may have helped the individuals not to become more distressed.

> "I don't know if it's the level one response has already opened the kind of floodgates because quite often, I'll walk into the room and say 'right, so tell me a wee bit about what's happening?' and they just breakdown ... I was quite astounded by it… so I think there's a connection there that they've already started to break down the barriers…" Level 2 practitioner

7.1.2 Impact of Level 1 on individual distress levels

Those who completed the first session evaluation survey were also asked to rate (from 0: 'not at all to 10: 'completely') how much they thought that the Level 1 provider helped them to cope with the immediate distress they were feeling. Most indicated a fairly positive score (a mean of 7.8), although there were a range of scores, with one-in-five respondents (19%) providing a score of five or less (Appendix 3, Table A7.4).

The mean 'helped to cope' score was lower for younger adults (7.2 for those aged 16-24 and 7.6 for those aged 25-34, compared with 8.0 to 8.4 for older age groups). It was lowest for women aged 16-24 (6.9), although the difference between men and women of this age was not significant.

Mean 'helped to cope' scores were highest for those presenting to the police (8.6) and lowest for those presenting at an A&E department (7.1), the same pattern noted above for ratings of the compassion of Level 1 providers. This was also reflected in the lower scores in Lanarkshire, where respondents were much more likely to have presented at A&E.

There were similar results for the two measures, CORE-OM 5 and the Distress Thermometer (Appendix B) when they were used at the same time

points. However, because they measure slightly different things and they were administered differently (the CORE-OM 5 was completed by individuals themselves in the surveys and the Distress Thermometer was completed with or by the DBI staff member), there were some differences in results. For example, a few individuals scored high distress on one of the measures and lower distress on the other.

The CORE-OM 5 scores suggest that the support Level 1 practitioners give is important in helping individuals to cope with their immediate distress, and the more they can do this, the less distressed individuals will be when they arrive at Level 2. 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 (9.2 for a CORE-OM 5 score of 0-10, falling to 7.5 for those with a CORE-OM 5 score of 32-40).

Eight out of ten (80%) Level 1 practitioner survey respondents agreed that as a result of the Level 1 training they believed they were contributing to better outcomes for the individuals who present to them in distress (see Appendix 4, Figure D). Level 1 provider interviewees felt that they could now give individuals a tangible offer of help which could prevent them from going on to express their distress in more harmful ways.

> "People have expectations when they come to see you. And nine times out of ten, it would be admission to hospital, because they have a problem. And then, when you turn around and say, well in actual fact, your problem is a social one, you need to deal with it, they feel kind of, oh, I'm not getting admitted then, and you're giving me a blooming phone number, what good is that you know. But if you can say, right, you've got this problem, somebody can sit down and work it out with you, there you go, there's a referral, and they're a lot happier. Whereas before, they would have just said, well I'll show you the problem I've got, and I'll go and take a few paracetamols, and it would escalate." Level 1 practitioner, Mental Health Crisis Service

Respondents to the first session evaluation survey were asked whether they were left with a clear understanding from the person who had provided the Level 1 intervention of what would happen over the next 24 hours. Five in six (83%) said that they were left with a clear understanding of what would happen, with no clear differences between subgroups (Appendix 3, Table A7.5).

Level 1 service interviewees reported that individuals seemed to respond well to being offered such a prompt source of support. Some individual interviewees who took up the referral to Level 2 services suggested they were not entirely clear as to what support would be given and suggested this may need to be explained more consistently in the future.

Some practitioner interviewees from the police felt that DBI may be less beneficial for individuals with more enduring problems who made repeated

contact with them and more beneficial for those presenting to them for the first time.

> "It seems to work best for people who are only in contact with the police maybe once or in a short period of time and the repeat callers that I've offered it to and even if they've accepted, it's not really seemed to make that much difference cause they just keep phoning the police or whoever they're phoning is then contacting the police again, but there are obviously people who are just having an incidence of distress and it's got to the point where they've come in contact with the police and they seem to get a bit more benefit of it, or certainly we don't really hear from them again so we hope that they get benefit from it." Level 1 practitioner, Police Scotland

7.2 Impact of DBI Level 2 on individuals

Findings on the impact of DBI Level 2 on a range of individual outcomes including distress levels, ability to self-manage, self-stigma and help-seeking and general wellbeing, and the factors that could be identified as influencing these are presented below.

7.2.1 Impact of Level 2 on individual distress levels

Across both distress measures, for most individuals, distress decreased during the course of the entire DBI intervention (from Level 1 to end of Level 2). This suggests that DBI is working well for most individuals, including those presenting with lower and higher levels of distress but around one in ten had increased distress levels by the end of Level 2.

As measured by the Distress Thermometer, distress decreased during the course of the entire DBI intervention (from Level 1 to end of Level 2) for most individuals (93%), with just 7% showing an increase in distress. On presentation at Level 1, the majority of individuals (82%) reported being in high distress (a score of 7-10), with a mean score of 7.8. At the start of Level 2, generally within 24 hours of referral, this proportion had fallen to 53%, and the mean score was 6.5. By the end of Level 2, the proportion in high distress had fallen further to 15%, and the mean score was 3.9. While there may be a certain degree of regression to the mean within these figures – with random variation, a high distress score is more likely to fall further towards the average score than a lower distress score – these figures go well beyond what would be expected, showing a continued decrease over the period of the intervention (Appendix 3, Tables A7.2, A7.6, A7.7 and A7.8).

The CORE-OM 5 provided similar findings. It measured a decrease from 29% in high distress (a score of 32 to 40), and a mean score of 25.9 at the start of the Level 2 intervention to 7% in high distress and a mean of 16.8 at the end of the Level 2 intervention. Of those who showed a decrease in distress on the CORE-OM 5, 64% had a decrease in their score of 5 or greater (indicating the reliable change that exceeds what might be expected by chance alone or measurement error) and 20% saw a decrease in their score taking them to a

CORE-OM 5 score of less than 10 indicating a distress level lower than that of a typical 'clinical' population after therapy (Appendix 3, Tables A7.9, A7.10 and A7.11).

Of those completing the first and final Level 2 session evaluation forms, however, 11% of respondents showed an increase in psychological distress, highlighting that the intervention had not been successful for everyone in terms of reducing distress. There were no clear patterns in the characteristics or nature of the intervention received to distinguish this group and so the reasons for worsening distress remain unclear. In Section 7.2.2 below we discuss factors that were found to have influenced changes in individual distress levels.

7.2.2 Factors influencing change in individual distress levels

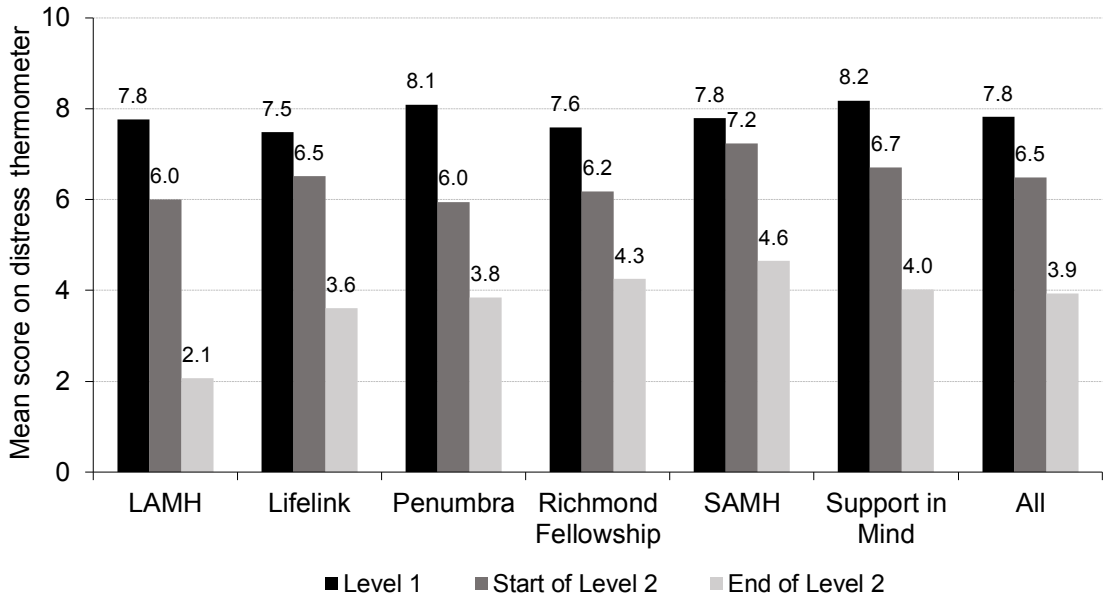
This section sets out the factors that our analysis suggests are associated with changes in distress levels of individuals between the start and end of their DBI intervention. Factors considered include individual characteristics, presenting problem and level of distress, provider and individual perceptions of how they were treated and the impact of the intervention on how they perceived their distress.

Neither the length nor the intensity of the intervention was associated with changes in the level of distress as measured by either the distress thermometer or CORE-OM. Also, individuals who felt they had improved during the course of the intervention were more likely to say that two weeks was about the right duration for the intervention.

We conducted a regression analysis to determine the factors independently associated with distress levels, when controlling other factors, or more simply, those most strongly associated with levels of distress at the end of the level two intervention. In this analysis, while the length of the Level 2 intervention seems to be linked to the distress level at the end of Level 2 (Appendix 3, Table A7.12) this is off-set in the statistical model by the fact that LAMH had the second highest proportion of Level 2 interventions of over 14 days and the highest proportion of interventions of a total of more than seven hours of support. Interpretation of this type of analysis is more complicated when the factors entered into the model are not independent of each other. This is exemplified by the length of the intervention and the level two provider. While the model appears to show that length of intervention is significantly associated with distress levels, this needs to be considered along with the reverse finding for those for whom DBI was provided by LAMH. Taken together, there is no real association between length of intervention and level of distress, nor between the provision of DBI by LAMH and level of distress.

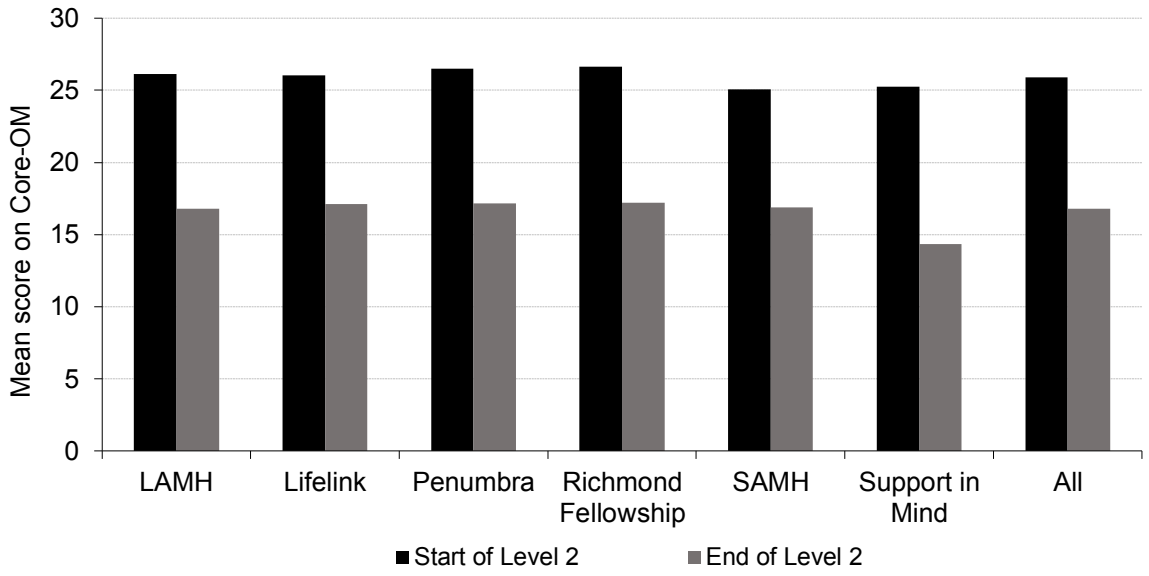
Figures 7a and 7b below illustrate that the decrease in distress scores are universal across all providers using both measures, although there is some variation in the size of the decrease.

Figure 7a Mean scores on the distress thermometer, by Level 2 provider



Sources: DBI routine data for Level 1, individual evaluation participant surveys for start and end of Level 2.

Figure 7b Mean scores on the CORE-OM 5, by Level 2 provider



Sources: Individual evaluation participant surveys for start and end of Level 2.

Those who completed the final session evaluation survey at the end of their Level 2 intervention were asked to select the number (from 0: 'not at all' to 10: 'completely') that best described how much they felt that the Level 2 provider treated them with compassion. Most indicated they felt treated with a very high level of compassion (a mean of 9.7) (Appendix 3, Table A7.13).

Although the level of change in distress within individuals was not associated with age, gender, area deprivation or the main presenting problem, differences were seen in how individuals rated Level 2 practitioners in terms of compassion and on the Consultation and Relational Empathy (CARE) Measure (Mercer et al. 2004). Those who rated the Level 2 providers more highly tended to achieve greater decreases in their distress on both the distress thermometer and the CORE-OM 5 scales. This does not necessarily indicate that more compassionate providers achieved better results, as the direction of causality between change in distress and the individual's rating of their practitioner is not clear (Appendix 3, Tables A7.8 to A7.11). It is important to note here that compassion ratings were fairly high overall and most of the individuals who experienced worsening distress over the course of the intervention felt that they had been treated with a fairly high level of compassion.

Individuals' level of distress at the start of Level 2 was associated with their level of distress at the end of Level 2 (on both the Distress Thermometer and CORE-OM 5), but distress at Level 1 was not significantly associated with the final outcome. This demonstrates that if an individual was still in high distress at the start of Level 2, they were more likely to have high distress at the end of Level 2. This emphasises the importance of the Level 1 practitioners helping the individual cope with their distress at the referral point. Varying levels of distress at the start of Level 2 could also be related to the underlying cause of an individual's distress, which could influence the extent to which their distress would be likely to decrease by the commencement of Level 2 (Appendix 3, Tables A7.12, A7.14 and A7.15).

When controlling for distress levels at the start of Level 2, women were likely to have a higher distress level at the end of Level 2 than men (+0.5 on the Distress Thermometer). This suggests that for some reason DBI Level 2 may be working less well for women than for men; it is not clear why, but the difference is significant and merits further consideration (Appendix 3, Table A7.14).

Also, when controlling for distress levels at the start of Level 2, younger adults, particularly those aged under 35, were likely to have lower distress by the end of Level 2 than older adults (by 2.5 - 3 points on the CORE-OM 5), suggesting that DBI Level 2 is may be working better for younger adults at least in the short term, and merits further investigation (Appendix 3, Table A7.12). This is despite the finding that the mean 'helped to cope' score was lower for younger adults (see 6.1.2 above) at Level 1. It is not clear what this means. It could be that i) Level 2 practitioners are better prepared or trained to work with young adults or; ii) that the Level 1 setting is less conducive to supporting young adults to cope or, iii) that younger adults have less well-developed coping skills than older adults. This merits further exploration.

There is clear evidence that when DBI practitioners helped individuals to improve their understanding of why they feel distressed, this had an important influence on reducing distress levels. Individuals who agreed that DBI had

improved their understanding of why they feel distressed were likely to have a lower distress rating at the end of Level 2 (by 1 point on the Distress Thermometer and by 5 points on the CORE-OM 5) (Appendix 3, Tables A7.12 and A7.14).

The above findings on practitioner care are also reflected in the responses of some individual interviewees whose distress was reduced at the end of Level 2. According to them, the combination of practical support to address issues that were causing their distress, and emotional support to validate their feelings and expression of distress, were central to reducing their distress.

> "Everything that happened to me was all positive. There was nothing I came away with and said 'd'you know what, that was an absolute waste of time', cause I went into the whole thing going, you know, pretty much I can't be bothered with anything, I just don't want to deal with anything, you know, and it was affecting everything, no presence about myself, I didn't have any fun, … so for that kick start that it took me to actually turn round and say this is what I need or think that I need and go through with things, you know, so everything that happened to me from that point of going to the doctor, receiving the first phone call, receiving the visits, the action plan, you know, everything was all positive for me." Individual

> "I just wanted to feel like, like you're worth something, like, life is worth living. And that you had, that you have meaning, and that it's okay to feel the way that you feel. I think, especially as a man, there's a lot of stigmatising in media, and in just the way our society is run, that men are just supposed to feel like, you're supposed to just man up and get on with it. But I feel like that's a very wrong approach to be taking, and that's probably why men, sadly in this country, have such a high rate of suicide. I think we need more services like this that tell you that it's okay to feel how you feel." Individual

Others recognised the benefit of immediate support.

> "I think it made a difference to me in the short term because I was very, very ill and it was really…it was…even though maybe the meetings didn't go exactly how I expected them to go, it was still reassuring to me in the state that I was in, which was a very anxious state. And it was just, like, the state of abject terror, that I…you know, somebody was texting me and saying, okay, you're coming to meet me on whatever day, and that was something to hold on to." Individual

7.2.3 Inappropriate referral and individual outcomes

For those with more severe and enduring mental health problems, such as recurring depression or Post-Traumatic Stress Disorder, DBI may be less appropriate, although, for some of those interviewees, their distress levels were still reduced. Some individual interviewees with such problems suggested that they were '*bombarded*' with information by DBI Level 2 at a

point where they were too vulnerable to take much in. Those individuals recognised that there were limits to the support that could be offered by DBI within the guideline 14 days and expressed a preference for counselling or more clinical support.

> "A problem I did have with it was that I was almost bombarded with information and I know that it's better than no information but I…my criticism of the experience would be that the particular individual I saw didn't take in to account that I was in a very vulnerable state and…in terms of my anxiety level was through the roof, you know, it was really high. And I couldn't process all the information that was thrown at me. I just couldn't. I was too anxious." Individual

Some referred to an awareness that DBI could not provide a 'miracle' but expressed some disappointment that it hadn't lived up to expectation, nonetheless.

> "The only complaint I would've had, I kinda thought that I was… it's not even a complaint, but I kinda thought it'd be more like a therapist type thing, but I kinda realised fairly quickly that it wasn't really like that." Individual

Some Level 2 practitioners echoed this concern. Although nearly four in five (77%) Level 2 practitioners who completed the practitioners' survey agreed that they were contributing to better outcomes for individuals as a result of their DBI training, around one in seven (15%) disagreed, one of them commenting:

> "I feel we are still receiving referrals which are not for people in distress but rather due to drug and alcohol misuse, and ongoing mental health issues. I also think a lot of the people being referred on are being misled about what support they will receive at DBI Level 2, e.g. counselling, medical interventions." Level 2 practitioner

These findings merit further exploration and may highlight a tension between the option of providing a referral to DBI on the one hand where a quick response is guaranteed, and in referring to more appropriate supports such as counselling or other talking therapies who are not able to respond quickly due to widespread long waiting times. However, the finding may highlight a weakness in the Level 1 referral assessment practices leading to inappropriate referrals. Section 5 highlighted that additional training updates would improve clarity on the appropriate distress level for DBI referrals to help reduce the number of inappropriate referrals to DBI.

Not being able to see the same DBI practitioner consistently or as much as expected in cases where holidays or sick leave impacted on the contact had a negative impact on satisfaction with the Level 2 service. In some cases, individuals had missed early contacts or confused timings and felt no allowance was made for this.

> “She obviously knew my story, like, the woman that was dealing with me was talking about me, but I felt like she didn’t know my story if that makes sense, she wasn’t there the whole time, like, she just came in and was, I don’t know, giving me things that I thought 'that’s not what I talked about, that’s not what happened'. I would've preferred it if I waited.” Individual

7.2.4 Impact of Level 2 on self-management, help-seeking and self-stigma

Individuals completing the final Level 2 session evaluation survey (n=499) tended to report very positive impacts of the Level 2 intervention on their ability to self-manage their distress:

- 90% agreed that DBI had given them the tools and skills to manage their distress.
- 97% agreed that DBI has helped them to find out where they can access support if they feel distressed.
- 86% agreed that DBI has improved their understanding of why they feel distressed.
- 87% agreed DBI has helped them to recognise when they start to become distressed.
- 94% agreed DBI has helped them make plans to improve the situations in their lives which are causing distress.

Subgroup analysis showed the same pattern for all five questions, with no significant differences by age, gender, SIMD, main presenting problem or pilot site. Large differences were noted in response to all the above questions when broken down by the rating of the Level 2 practitioner in terms of compassion and an individual’s scores on the adapted Consultation and Relational Empathy (CARE) Measure (Mercer et al. 2004). Individuals rating compassion and practitioner care more highly were more likely to agree with the above statements. The differences were more pronounced for DBI improving understanding of why they feel distressed and for DBI helping them to recognise when they start to become distressed. This reinforces what was discussed above in terms of the importance of individuals’ perceptions of practitioner care and compassion and the changes in their level of distress. The findings suggest that the more the practitioner shows compassion, interest, understanding, makes the person feel at ease, is positive, clear and enabling, the better the outcome for the individual (Appendix 3, Table A7.16)

Many individual interviewees reported that they found that DBI enhanced their ability to cope with their distress and many found that it developed their confidence to connect or reconnect with services they were signposted to. This seemed to be partially due to being listened to in a non-judgemental and relaxed environment, where Level 2 practitioners had not judged individuals’ previous failures to maintain contact with community services. Interviewees reported that this led to reducing self-stigma around seeking support and for

some individuals, those services went on to provide sustained support which helped reduce future episodes of distress.

7.2.5 Perceived outcomes if DBI had not been offered

In their Level 2 final session, survey respondents were asked an open question “If DBI had not been offered to you, what would you have done instead?” One in ten (10%) revealed that they may have attempted suicide or continued with their suicidal thoughts. This represents a considerable number of people whose lives, in the short term at least, could have been very different in the absence of DBI.

One in seven (14%) answered that they would have returned to their GP or other frontline medical services, while a slightly smaller proportion (12%) said that they would have tried to access counselling or other formal support. Others thought that their distress would have become worse, that they would have self-harmed, or used potentially harmful coping strategies such as alcohol or isolating themselves, with many saying they did not know what they would have done (Appendix 3, Table A7.7).

7.2.6 Longer-term impact of DBI on individual outcomes

Respondents to the three-month follow-up survey (n=102) were asked an open question on what they had hoped to achieve from DBI when they were referred to it. The most common answers were that they had hoped to get skills and techniques to manage their distress (28%); they wanted to talk about their problems / be listened to without judgement (26%); they wanted to feel better / feel more positive / feel less distressed (16%); they wanted to get help (15%); and they wanted insight / greater understanding of their distress (11%) (Appendix 3, Table A7.18).

Half of the respondents (51%) felt that the intervention had helped them fully achieve their aims, with a further 40% saying that they had partially achieved their aims. Small base sizes in the follow-up survey make it difficult to drill down further into these findings (see Table A7.19).

Views on the longer-term impact of DBI were mixed among the individual interviewees. Some described how DBI had helped them to feel valued and rediscover a focus, with positive outcomes. The follow-up survey findings suggest that many of those going through DBI may have been using what they learned during the intervention to help them manage their distress, with four in five (79%) stating that they had used the plans or strategies from their D-MaP to manage their distress (Appendix 3, Table A7.20). This is a good outcome but it is possible that individuals with a more negative experience were less likely to return their follow-up questionnaire and that the survey findings were biased. Among interviewees, individuals described how even in difficult situations, coping techniques offered through DBI were recalled and used. Among interviewees, there was often little recall of completing the D-MaP without prompting by the interviewer, although this could have been to do with how the document was referred to.

For some, particularly where individuals had an existing mental health diagnosis, DBI may have had a less positive longer-term impact. Some individuals were left feeling quite low as they had appreciated the contact for the 14 days of DBI and then felt isolated while awaiting further support.

> "They did listen and I was able to tell my story and at the end of the meeting, they said 'right, that's you finished with us now, go away and phone these numbers up' and of course I never phoned the numbers up, I just went back into my house and I had other people come round and I just sort of… I reclused for about four/five weeks inside my house, didn't eat or nothing and then, I can't even remember what happened then, oh someone from AA come round, one of my friends from AA come round and they brought me back out into the world again." Individual

> "It might have not changed how I felt at that point in time, but it felt nice to say something about it to somebody rather than just not saying anything to anybody. So because I didn't have that anymore it resulted in me having more episodes because I legit had absolutely nobody cause I was waiting on referrals and stuff like that, and that didn't come until months, so by that time I was in hospital for about four, three times in that time gap that I had absolutely nobody to speak to." Individual

For many, however, referral to appropriate community support or service appears to have led to more positive longer-term outcomes with over half of the 3-month follow-up survey respondents reporting that they were referred to other services by their DBI provider and four out of five of those reporting they had taken up the service. Among the individual interviewees, there were examples of DBI successfully bringing individuals into contact with both statutory and non-statutory services and this had, on occasion, led to re-engagement with work or previous activities, in addition to offering a longer-term support mechanism.

> "It gave me the stepping stone to go to [service X][11] and then from [service X], through another friend, to [service Y] and out of everything, I will have to say that, and I've said it to [name of leader] on a few occasions of which he's told me to shut up, you were embarrassing him, but if it wasn't for [3rd sector organisation], I don't think I'd be here today." Individual

> "They gave me the number and that was one of the biggest things as well because I was sitting arguing with them that I didn't want to go to [3rd sector organisation], I didn't want to be that woman who's abused and I didn't want to tar my husband with that brush, I kinda argued that quite a lot and then I ended up just doing it and it was probably the best thing I did, to be honest." Individual

[11] Service names have been removed to protected anonymity.

There was also evidence from interviewees of the effectiveness of being signposted to other services in helping to cope with further episodes of distress.

> "I can manage better in myself than I, better by myself, than I could before. But I feel like I also know where to go if I feel like I do need support. Whereas, before, I wasn't very sure if you should, like, phone Samaritans, or if you should go and arrange counselling, and stuff. It feels like you know better what to do if you need that help" Individual

Overall, DBI has proved to be successful in offering support to those in distress, with most receiving a compassionate and practical response that has contributed to their ability to manage and reduce their distress in the short and longer-term. However, DBI has worked less well for some and referrals were not always appropriate. As indicated in Section 7.2.1 for individuals whose distress increased, we are not able to offer definitive conclusions as to what factors may be associated with this. It is clearly of some concern and should be addressed as a priority in future research.

8 Key Findings

This section brings together the key findings from across the evaluation, relating to the overarching research questions and anticipated DBI outcomes. A high-level synthesis of these findings is in Appendix C which presents a synthesis of the results from all three elements: summarising the key findings, and considerations for delivery and resourcing decisions.

In this section where appropriate, summary findings known as Context Mechanism and Outcome (CMO) configurations are reported in a box towards the top of each section. These causal explanations describe what works in DBI, for who, why and in what circumstances, according to each section topic. Implications arising from the key findings are also presented.

8.1 Impact of DBI on individuals

Immediate referral and 24-hour contact (C) validated and reassured people that their needs were recognised (M), which decreased self-stigma and self-perceived levels of distress (O)

Increased perception of Level 2 practitioners' compassion and engagement (C) made individuals feel empowered (M), which led to individuals feeling less distressed at the end of the intervention (O).

Referrals of people with severe and enduring mental health or addiction needs (C) can create unrealistic expectations of what DBI can offer and lead to disappointment among some individuals (M) which may exacerbate distress (O).

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 scored as highly as 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 and agreement that DBI had helped them to recognise when they start to become 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 a short-term, problem solving, and practical service. Feedback from Level 1 and 2 providers and individuals 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.

The reach and impact of DBI suggests that it is contributing towards improved population wellbeing, including appropriately managing distress and may be contributing to preventing some suicidal behaviour.

8.2 Preparedness of practitioners to effectively deliver DBI

Level 1 practitioner training (C) generally increased DBI Level 1 practitioners' awareness, confidence and ability (M) which enabled them to provide a consistent and compassionate response.

Level 2 practitioner training (C) generally enhanced knowledge, skills and confidence (M) to enable the delivery of the DBI level 2 interventions (O).

Face-to-face training with Level 2 staff, focused delivery of practical examples and regular refresher sessions (C) encouraged engagement in training and cross-sector relationships (M) which improved the perceived value of Level 1 training (O).

Overall, most practitioners found that Level 1 and Level 2 training prepared them well to effectively implement DBI. The delivery of training varied across pilot sites and Level 1 frontline services - but face-to-face was broadly the preferred delivery mode. However, training via an online platform has the potential to reduce cost compared with face to face training. It is worth noting that the training evaluation was conducted before the COVID-19 pandemic when online activities became more normalised. It may be that practitioners' perceptions of online training have altered as a result.

However, for some the training was unnecessary in certain respects and lacking in others. A sizable minority, one in seven (15-16%) of Level 2 practitioners felt their training had not adequately prepared them with the skills or confidence required for the job. Level 2 practitioners who received informal 'on the job' training felt that they needed the formal DBI training at an earlier stage. Frontline practitioners who had not received Level 1 training but referred people to Level 2 were likely to make mistakes in the referral process. Some Level 1 practitioners felt their clinical training already gave them specialist skills beyond those in DBI training, particularly on identifying distress and responding compassionately. In addition, some encountered barriers to accessing training. Many ambulance clinicians had to complete training in their own time and others struggled to make time within their busy working day to log in to online training.

An important impact of the DBI Level 1 and 2 training was that many practitioners reported that it changed their perceptions of people in distress; this may have consequently reduced the likelihood of individuals in distress feeling stigmatised by those whom they approached for help. Around half of practitioner participants reported that following their training they were more likely to treat someone fairly because they were seeking help for their distress.

Some Level 1 practitioners suggested they would benefit from the chance to shadow a DBI Level 2 practitioner and not all received regular refreshers or buzz sessions. Level 2 training improvements suggested included: more emphasis on the impact on practitioners of dealing with distress and self-care techniques; area specific information on local services to sign-post to; more focus on the practicalities of the job, such as completing a Distress Management Action Plan; and more use of real case studies, especially on supporting people with suicidal thoughts or behaviour.

8.3 Implementation of the DBI Programme model

Embedding delivery of training within organisations' usual training/work routines (C) led to staff having enhanced engagement with DBI (M), which resulted in increased numbers of appropriate referrals (O).

Level 2 practitioner involvement in Level 1 training and feedback from Level 2 on inappropriate referrals (C) led to staff having enhanced understanding of and engagement with DBI (M), which resulted in increased numbers of appropriate referrals, increased inter-agency working and a shared commitment to the values of DBI (O).

Flexibility in delivery of the intervention (M) enabled individuals' complex and varied circumstances (C) to be addressed (O).

DBI delivery has successfully adapted, where appropriate, 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 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 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 Distress Management Action Plan) 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.

Initiation, where the DBI practitioners set up a call or meeting with a further service was more commonly made to non-statutory services (25%) than to statutory services (11%).

8.4 Contextual factors influencing DBI implementation success

DBI Central with enthusiastic and respected change management leadership (C) enhanced stakeholder adoption and facilitated cross-sectoral planning (M), which resulted in sustained engagement and enhanced reach of the intervention (O).

The DBI Gatherings and local implementation groups (C) facilitated "partnership in action" across agencies and services (M), which increased sharing of best practices, challenges and solutions (O).

Adaptions responding to grass-root feedback (C) developed a synergy between DBI Central and pilot sites (M) which led to continuous improvement of implementation processes (O).

Contextual factors were not associated with individual outcomes. Changes in individuals' level of distress following DBI Level 2 were not associated with area deprivation, Level 1 referrer, Level 2 provider or length or intensity of the intervention.

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.

8.5 Impact of DBI on the wider service system

The impact of DBI on the wider service system seems to be largely positive. Less is known about the overall impact on the use of unscheduled care by those in distress and the impact that DBI onward referrals have on these agencies' capacity to meet demand. Across frontline staff and Level 2 practitioners, the majority of respondents 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. Practitioner feedback suggests that DBI is providing Level 1 services with an opportunity to contribute to better outcomes than before for those presenting to them in distress. DBI training highlighted gaps in some existing Level 1 practices and acted as a catalyst to developing further training in managing distress and assessing the level of risk. For most individuals, DBI is a step towards recovery from distress and connects them (often for the first time) mainly with community-based voluntary sector services and for around a third to statutory services appropriate to their needs. Feedback on the continued success of implementing the 24-hour contact requirement at Level 2 has increased trust in the programme and Level 1 practitioners' confidence that they are offering a compassionate and effective response to individuals in distress. This perpetuates DBI's use and reduces concern about accountability amongst frontline practitioners.

9 Conclusions

The overarching aims of this evaluation were to determine the extent to which the DBI programme was implemented as intended; identify variation and any associated impacts; and determine the impacts of the DBI programme on services, practitioners and individuals. Overall, DBI has proved to be successful in offering support to those in distress, with most individuals receiving a compassionate and practical response that has contributed to their ability to manage and to reduce their distress in the short term, and for some in the longer term. This is particularly encouraging given that the background to the development of DBI was a recognition that current supports did not meet the needs of many people, which could lead them to feel let down, vulnerable or at risk.

9.1 Meeting individuals' needs

A key strength of DBI is its flexibility to be tailored to the individual, resulting in 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. It is compelling that DBI meets the needs of many, but it has worked less well for some (e.g. young adults at Level 1) and referrals were not always appropriate. Although inappropriate referrals were reduced through review and re-training, the findings suggest that there were still people who were experiencing high levels of distress, who did not meet the threshold for a more specialist service but for whom the short term DBI was not the right approach, and was not intended to be, as they require a more therapeutic intervention. This could lead to such people feeling even more stigmatised and not listened to, and suggests a persisting inequality in access to support.

Focusing efforts on delivering a compassionate response to distress appears to be having a positive impact. Individuals' perception of Level 2 practitioner compassion and care validated their feelings of distress and contributed to reductions in self-stigma. This is key to reducing inequalities in access to services that are compounded by self-stigma acting as a barrier to help-seeking. Three fifths (60%) of those accessing DBI were from the two most deprived area quintiles, indicating a further contribution of the service to reducing health inequalities. Being helped to understand why they felt distressed was also positively associated with helping them to understand why they become distressed, to recognise when they start to feel distressed, and with greater decreases in self-reported distress levels. There is also evidence that DBI may be contributing to suicide prevention.

Impacts of DBI were reported at both Level 1 and Level 2. The DBI Level 1 response had direct, immediate benefits for the individual. Most individuals thought that the Level 1 provider had helped them cope with their immediate distress. Level 2 worked well for most individuals, with nine out of ten individuals' distress levels continuing to decrease over the period of their Level 2 intervention, and the same proportion felt it had given them the tools

and skills to manage their distress. We were unable to identify any demographic or DBI delivery context factors associated with changes in individuals' level of distress as a result of DBI Level 2. However, we did find that 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, but the reasons for this are uncertain.

However, DBI does not work equally well for everyone. Level 1 was less successful for younger adults, those with higher levels of distress and those presenting to A&E. Some individuals who received DBI had hoped that the service would provide more intensive therapeutic intervention. Feedback from DBI providers and individuals who received DBI suggests that DBI is less appropriate for the needs of those with severe and/or enduring mental health problems and/or addictions. For individuals whose distress increased, we are not able to offer definitive conclusions as to what factors may be associated with this.

9.2 Supporting successful delivery

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 constructive leadership of the DBI programme manager who led DBI Central and championed the DBI programme was central to this process.

DBI delivery successfully adapted, where appropriate, to different local contexts whilst maintaining the core elements of DBI. As the DBI programme expanded within an area, the staffing numbers increased and a mix of staffing including administrative support was required to deliver the service. The guideline of a contact attempt for each referral within 24 hours was met, and around two-thirds of people referred were successfully contacted within 24 hours, rising to 86% in the following days. 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.

Signposting and initiating referrals to other services following Level 2 DBI was common and was seen as an important step to support people post DBI. Going forward, consideration is needed on the availability of statutory and non-statutory services within the local community and the risks of increased demand for services and the impact on waiting lists. There was a sense of an abrupt end and loss among some individuals at the end of their DBI intervention. This suggests a need to consider a more tapered withdrawal for those who need it and/or a more co-ordinated approach to minimise the gap between Level 2 and any ongoing support - and perhaps a more consistent approach to 'supported connection', where DBI Level 2 practitioners support individuals to make contact with non-statutory services.

9.2.1 Looking forward

Areas setting up a new DBI service will have choices about the organisation of resources and modes of delivery within the core DBI delivery model that suit their local service systems. These will affect resource use. The scenarios presented in Section 6.7 outline typical pathways through DBI, illustrate their associated costs and highlight the key decision points on resource use that need to be made in the further development and rollout of DBI.

It is uncertain whether DBI will reduce demand on frontline services who will still be required to attend call-outs and to conduct appointments. However, DBI does provide them with another referral option and that - coupled with the enhanced compassion skills - may help to ease the emotional task of assisting an individual in distress.

9.3 Recommendations

Key recommendations based on our findings are set out below.

9.3.1 Roll-out

1. The national roll-out of DBI should continue, ensuring that core DBI elements (contact within 24 hours, guideline of 14-day intervention, use of D-MaP etc) 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.

9.3.2 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 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; this should include interaction with Level 2 practitioners (where possible face-to-face).

9.3.3 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 improved 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.

9.3.4 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 some deaths by suicide; and the factors associated with increased distress among some individuals at the end of Level 2.

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11 Glossary

DBI Central Team: Hosted by the lead delivery agency for the DBI Programme, Health & Social Care North Lanarkshire and South Lanarkshire Health & Social Care Partnership. Consists of the DBI Programme Manager, the DBI Principal Information Analyst, the DBI Administrator and the DBI Communications Officer.

DBI Gathering: Twice yearly event, providing a forum for knowledge exchange and information sharing for all those involved in the DBI programme nationally and locally, along with key collaborators.

DBI Level 2 Providers' Forum: Forum to provide peer support and facilitate the sharing of knowledge, experience and solutions across commissioned Level 2 providers.

DBI Programme Board: Oversees implementation of the programme in line with agreed objectives. Reports to the Scottish Government.

D-MaP (Distress Management Plan): Resource to guide the DBI Level 2 process and allow notes to be recorded on the individual's current and future management of their distress.

Mixed method approach: Combines quantitative and qualitative research and allows the synthesis of data based on statistical information with more in-depth data from interviews and focus groups.

VPD: Police Scotland's Vulnerable Persons Database.

12 Appendices

Appendices that are *lettered* are available at the end of this report. Technical appendices are *numbered* and are available in separate files published on the Scottish Government's website.

Appendix A - DBI theory of change and intended DBI programme outcomes

Appendix B - Outcome measures used in the evaluation

Appendix C - Resourcing implications table

Technical Appendices

Appendix 1 - Interview and Focus Group data collection tools

Appendix 2 – Outcome measurement data collection tools

Appendix 3 - Individual and aggregate data analysis

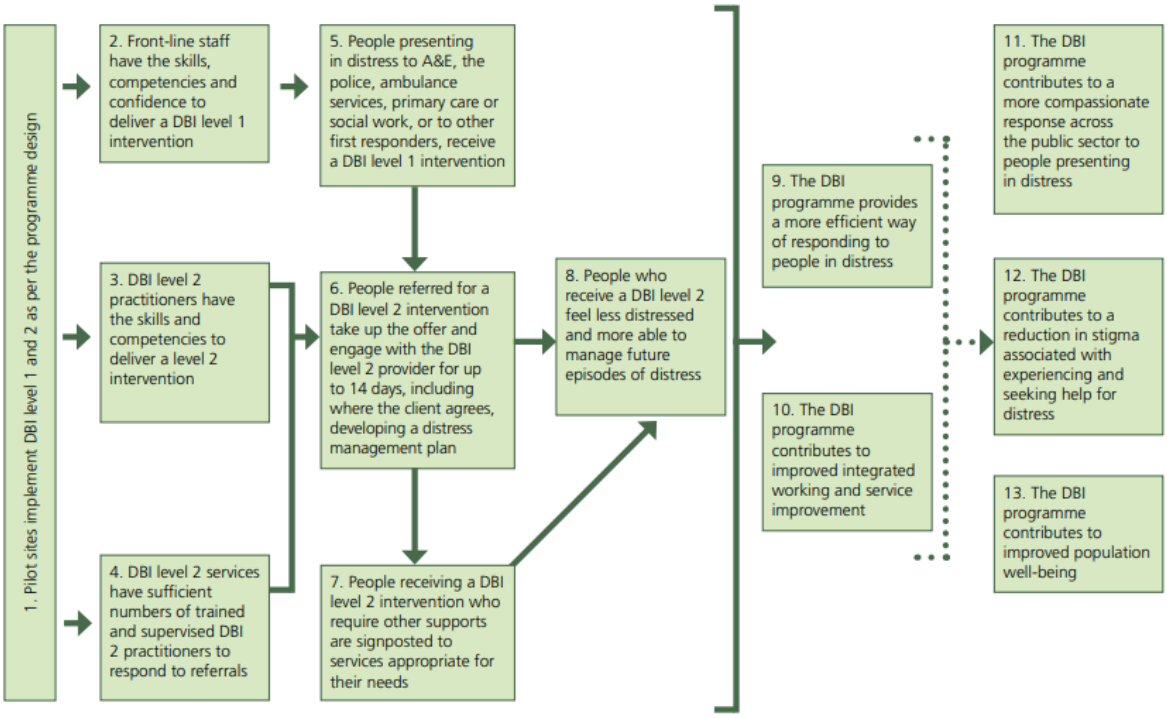
Appendix 4 - Staff training survey findings

Appendix 5 - Economic data summaries

13 Appendix A – DBI Theory of Change and Programme Outcomes

The following are taken from the Evaluability Assessment of the Distress Brief Intervention Programme in Scotland (NHS Health Scotland, 2017):

Distress Brief Intervention Programme: Theory of Change



Distress Brief Intervention Programme: Intended Outcomes

Outcome 1: Pilot sites implement DBI levels 1 and 2 as per the programme design.

Outcome 2: Front-line staff in A&E, police and ambulance services, primary care who have undergone DBI level 1 training have the skills, competencies, and confidence to deliver a DBI 1 level intervention.

Outcome 3: DBI level 2 practitioners have the skills and competencies to deliver a level 2 intervention.

Outcome 4: DBI level 2 services have sufficient numbers of trained and supervised DBI level 2 practitioners to respond to referrals within the timeframe set out in the programme design.

Outcome 5: People presenting in distress (as per the programme definition) to A&E, police, ambulance services, and primary care receive a DBI level 1 response.

Outcome 6: People referred for a DBI level 2 intervention take up the offer and engage with the DBI level 2 provider for up to the guideline of 14 days including, where the client agrees, developing a distress management plan.

Outcome 7: People receiving a DBI level 2 intervention who require other support are signposted to services appropriate for their needs.

Outcome 8: People who receive a DBI level 2 intervention feel less distressed and more able to manage future episodes of distress.

Outcome 9: The DBI programme provides a more efficient way of responding to people in distress who present to A&E, police and ambulance services, primary care, and other first response services.

Outcome 10: The DBI programme contributes to improved integrated working and local service improvement.

Outcome 11: The DBI programme contributes to an even more compassionate response across the public sector to people presenting in distress.

Outcome 12: The DBI programme contributes to a reduction in the stigma associated with experiencing and seeking help with distress.

Outcome 13: The DBI programme contributes to improved population wellbeing, including to appropriately manage distress.

14 Appendix B – Outcome Measures

The following outcome measures were used in routine DBI data collection and evaluation surveys:

Distress Thermometer (Mitchell 2007)

DBI practitioners used the Distress Thermometer at three time points: at Level 1, and at the start and end of the Level 2 intervention. This used a simple 10 point score where 0 = no distress and 10 = extreme distress reported by the individual to the practitioner as to their perceived level of distress.

CORE-OM 5 (Evans et al. 2002)

CORE-OM 5 is a five-item measure of psychological distress adapted from the validated CORE-OM 34-item full measure, which was designed for use in tracking recovery and improvement. It is intended to give an indication of psychological distress level and any change in distress which can be measured over the course of the intervention. It was selected in consultation with DBI programme practitioners due to its length and ease of use. It builds up a broader picture of psychological distress than the Distress Thermometer.

The CORE-OM 5 question scale was self-completed by individuals in the first and final Level 2 session evaluation surveys. Each response to CORE-OM 5 is assigned a score, the average score is calculated and then multiplied by 10 to give the **final score**. A score of less than 10 indicates very low distress (a distress level lower than that of a typical 'clinical' population after therapy) and a score of 10 or greater, up to a maximum of 40, indicates psychological distress. A score of more than 25 indicates severe distress, a score of between 20 and 25 indicates moderate to severe distress, and a score of 15 to 19.9 indicates moderate distress.

Consultation and Relational Empathy Measure (CARE) (Mercer et al. 2004)

The Consultation and Relational Empathy (CARE) Measure (Mercer et al. 2004) is a person-centred process measure that was developed and researched at the Departments of General Practice at the University of Glasgow and University of Edinburgh. The CARE Measure is a quick, clear and easy to complete questionnaire. It measures empathy in the context of the therapeutic relationship during a one-on-one consultation between a practitioner and an individual.

For this evaluation, we used an adapted version of the original measure. To ensure consistency of rating scales in the surveys for individuals accessing DBI, the scale used for this evaluation was changed from the original 'How was the doctor at..', (with each item rated either poor, fair, good, very good, excellent or does not apply), to 'Please read each statement and indicate how much you agree or disagree with it…', (with each item rated either strongly

agree, agree, neither agree nor disagree, disagree, strongly disagree). This measure was embedded in the Level 2 final session questionnaire, which was delivered at the final Level 2 support session. The ten measure items were each scored 1 (strongly agree) to 5 (strongly disagree). Adding the scores for each item together gives a scale of 10 (strongly agree) to 50 (strongly disagree). We used three analysis categories: 1) a score of 10; 2) a score of 11 to 20 (which represents an average of 1.1 to 2, or at least agreeing to all the items); and 3) a score of 21 or more.

15 Appendix C – Resourcing Implications and Recommendations

Drawing on results from all three elements of the evaluation, we summarise in Table 8.1, resourcing implications and recommendations for future delivery of DBI below. Using a tabular format, findings from the evaluation, considerations for the delivery of DBI and associated resourcing implications are presented vertically by stage of DBI (training, Level 1, Level 2, wider system) and horizontally by classification. Practitioners working within a specific stage of DBI will wish to read the table vertically. The columns have been shaded to help with this, for example if you are a Level 2 DBI practitioner you can see the different findings and recommendations in the shaded Level 2 column. Decision makers such as commissioners of DBI services will wish to read the table horizontally.

Table 8.1: Supporting the organisation of resources and modes of delivery in respect to the DBI Programme pathways

Training	**Level 1 DBI**	**Level 2 DBI**	**Implications for the wider system**
Findings from the evaluation			
· Between October 2017 and December 2020, 997 staff received training in Level 1 DBI. [Sections 5.1, 5.2] · Delivery of online training for Level 1 raised concerns that online lowers the effectiveness of training about compassionate response and preference was expressed, particularly by police responders, for face-to-face	· No impact on resources (staff time) required to respond to individuals in distress (Level 1 DBI). [Section 6.1.3] · 86% of staff in the Level 1 survey agreed that DBI was useful when responding to an individual in distress (Level 1 DBI). [Section 6.1.2]	· Manager level support was required in each locality to oversee rollout, delivery and reporting of the Level 2 service. This person was also the main point of contact with DBI Central. [Section 6.5] · The high level of success in attempting (100%) and achieving (65%) a first contact within 24 hours of referral from Level 1 developed support and trust in the system. [Section 6.3.1] · A quarter of cases receiving DBI Level 2 (26%) took no more than four hours, 62% took between four and seven hours, and 12% more than	· Limited evidence (< n=30) is available on the repeated use of front-line services where distress is reported in the three months post DBI Level 2. [Section 6.6.2, Appendix 3, Table A7.19]

training. [Sections 5.1.1, 5.1.2]		seven. [Section 6.3.4, Appendix 3, Table A6.3] · Highest proportion of all referrals to Level 2 in all sites was from Primary Care 'in hours'. [Section 4.2, Appendix 3, Table A4.5] · Approximately 27% of participants who had a successful contact at Level 2 (n=3,431) were signposted to statutory services, 73% were signposted to non-statutory services, 11% had a supported connection to statutory services and 25% had a supported connection to non-statutory services (note that the options were not mutually exclusive). [Section 6.6, Appendix 3 Tables A6.7-A6.10] · Flexibility in staff appointments for the delivery of Level 2 services to ensure requirements for first contact within 24 hours. [Section 6.3.2]	
Considerations for the delivery of DBI			
· The mode of training for Level 1 is important for staff engagement and for decisions on training delivery. [Section 5.1]	· Developing feedback mechanisms between Level 2 and Level 1 providers can help identify cases that are not suitable for DBI and reduce inappropriate referrals. [Section 5.5]	· The core elements of Level 2 DBI, such as the D-MaP or contact within 24 hours, were adhered to, but flexibility was allowed in implementing Level 2 DBI and was viewed as a strength, building on the existing asset base of practitioners' skills. [Section 6.2.1] · The purpose and level of support provided in Level 2 should be clearly communicated in the first session to manage expectations for individuals who may be expecting a counselling	· Feedback from Level 1 and 2 providers and individuals suggests that DBI is less appropriate for those with severe and/or enduring mental health problems and/or addictions. [Section 6.3.3,

		or therapeutic service or longer term support. [Section 6.2.1]	Appendix 3, Table A67.4] · This may highlight a tension or problem in accessing more appropriate supports, such as counselling or other talking therapies, quickly.
Resourcing implications			
· Encouragement of DBI 'Champions' at all levels within and between organisations can lead to DBI training and delivery being implemented as a tool which can help to address issues identified within the service and not as an add-on.	· No impact on resources (staff time) required to respond to individual in distress (Level 1 DBI).	· Delivery of DBI Level 2 (exclusive of training and DBI Central Costs) was estimated to cost £219 per referral and £339 per successful contact that led to support being provided. (See Appendix 5, Table 4.6) · The option of Level 2 DBI provides a useful referral pathway for frontline services responding to individuals in distress who are not in immediate crisis danger. · Employing administrative staff allows DBI practitioners to spend their time in providing services to individuals in need rather than spending time on administrative tasks.	· The support from DBI Central to assist frontline services, co-ordinate Level 2 DBI providers' contracts, and to co-ordinate national government interest, was estimated to cost £328,000 in FY2020-2021 (details provided in Appendix 5).
Resourcing recommendations			
· Delivery of Level 1 training via online platform has the potential to reduce cost compared to face-to-face if additional facilities and trainers are required.	· Level 1 referral forms and process for submitting to Level 2 providers should capitalise on existing (online) processes and	· To ensure requirements for first contact within 24 hours are met, flexibility in staff contracts for the delivery of Level 2 services may need to be considered. Administrative support staff were employed in each pilot site to support the practices in delivering the DBI service. The	· DBI is unlikely to reduce demand on frontline services who will still be required to attend call-outs and to

· Regular review and updates to training materials will be required and refresher training arranged for all staff.	systems where possible to reduce time taken and ensure all required data is captured. [Section 6.1.3]	use of administrative staff to also make the first contact with the individual increases the probability of making contact within 24 hours but may raise the risk of the client wanting more emotional support that is not provided. [Section 6.3.2]. This may have implications for administrative staff roles and responsibilities, training and support. · Additional facilities may be required for the delivery of Level 2 services if providers do not have readily available and accessible private space. Rooms in GP surgeries or community facilities may need to be hired. · Signposting and initiating referrals to other services following Level 2 was common and seen as an important step by DBI practitioners to support people post DBI. Consideration is needed on the availability of statutory and non-statutory services within the community and the risks of increased demand for services and the impact on waiting lists. · Implication for commissioning DBI services to recognise the need for risk assessment, particularly for in person appointments (for example, may require two people to attend, additional space required etc).	conduct the surgery appointments, but DBI does provide them with another referral route option and that - coupled with the enhanced compassion skills - may help to ease the emotional task of assisting an individual in distress.

social research

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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