For some time now, I have increasingly and latterly more overtly argued the need for a transformation in how we conceptualise, plan, develop and deliver services that respond to the distress and poor mental health of people living (and challenged by living) lives in this new millennium. Voices for transformational change have gradually shifted from activists and the fringes of more established thinking, to the forefront of current discussion, debate and strategic thinking.

“Doing” transformational change is inherently a difficult task. For example, those who would lead transformational change need also to be prepared to understand and own how their own ways of thinking and acting need to change as well. It is an extraordinarily challenging task to conceive, articulate, grasp and apply. A big reason is illustrated in the story of a fish, who is asked by another fish, “How’s the water?”. The fish stares back blankly, and then says, “What’s water”.

For myself, IIMHL exchanges consistently remind me of the importance of being values led; of being a more reflective leader. Am I being a help or a hindrance to people and /or the organisation’s capacity and ability to achieve goals? IIMHL exchanges are unique in that they have consistently offered participants the opportunity to gain knowledge. More critically exchanges enable participants to be exposed to new ideas and discussion, to participate and engage in new experiences, to realise new possibilities and potentials… unencumbered by our assumptions and “givens”; our “water of transformational change”1.

This was very much reinforced throughout my exchange in Glasgow. The exchange was headed “ask once, get help fast”; based in the development of a Distress Brief Intervention (DBI) pilot.

My fellow participants in the exchange were from Australia and the UK. Our initial round of introductions was an illuminating experience where we shared local priorities, perspectives (from service providers and people needing to use services); there were many similarities.

"Primary mental health care is currently a mess..."; "Health and community partnerships... a complex landscape and very much a work in progress."; "We need to...prevent and treat mental health problems with the same commitment and determination applied to physical...

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1 The Water of Systems Change, Jogn Kania, Mark Kramer, Peter Senge, 2018
Building a collaborative culture was very much the core theme, principle and work priority that was at the heart of the DBI pilot. Working beyond traditional front line boundaries and hierarchies, to build connected, compassionate support for people in distress was the primary imperative driving the development of DBI. For example, it was recognised that Police often see an “enhanced” picture of a person’s life whereby they may have had previous contact, they may have entered the person’s home, have contact with family, knowledge of other circumstances that might be contributing to distress. Shifting from “this is / should be our role [alone]” or “this is not / shouldn’t be our role” to an approach where the benefits (actual and potential) of partnering were recognising required a culture change. A national stakeholder decision making model was being adapted to support this work where multiple agencies are involved.

Distress Brief Interventions (DBIs) is an initiative that emerged from the Scottish Government’s Suicide Prevention and Mental Health strategies. Work on implementing these strategies indicated that responses to the needs of people in distress would be far more effective if there was improved coordination across multiple agencies, far quicker access to support and more consistency in the care, support and compassion they are offered.

The DBI pilots do share some similarities with the Awhi Ora (primary mental health) pilots being offered through the Waitemata and Auckland DHBs. They are both interested in providing prompt, short term responses to people experiencing significant distress in their lives. Whether intentional or not, challenge of some existing concepts, practices, and language typically associated with mental health service provision has emerged in both pilots. Genuine enthusiasm and commitment is clearly evident in all staff; as well as a clear determination “make this work”, and to ensure responsiveness to people’s needs. In both situations there is an awareness of the [welcome] potential of these new service options to contribute to change - even transformation of how mental health services are offered generally.

There are some differences.

By contrast Awhi Ora appears more based in, led by and designed against a national (primary mental health care) strategy. Awhi Ora is principally structured around a GP practice / medical centres, as a means of connecting people (through an introduction) with support services. While building relationships with the GP practices is a core element of service development and delivery, processes to date are strongly transactional (and arguably, compared with DBI, could be more relational). GPs in general, seem relatively passive in the day to day provision of Awhi Ora - and certainly so in regard to further development.

DBI appears to more represent a collaborative human response to distress, built in a shared interest, commitment and vision across quite discrete, but complementary agencies. The partner agencies (Police Scotland, Scottish Ambulance Service, A and E departments, GPs, NGOs, University of Glasgow, NHS Mental Health Services) are demonstrably committed with a clear, shared interest in this area. A Programme Board (governance group) comprising representatives from all partners was regarded as absolutely essential and pivotal to the success and effectiveness of the DBI pilot[s].
Development of DBI focused upon combining **What** (key actions/content of the service model), and **How** (how should it be implemented most effectively, with **Why** (why should it work; what need to be the mechanisms of impact?). Essential to the development was the involvement of those with experience and perspectives in distress. These included: individuals with experience of distress, frontline/NGO staff experienced in responding to distress, and other stakeholders.

There is less focus upon determining mild, moderate, severe illness; instead the focus service is distress a person might be experiencing.

The initiative defines “distress” as “an emotional pain for which the person sought, or was referred for, help, and which does not require [further] emergency service response.” What is impressive is that all responses are expected to take place within 24 hours of an offer of referral being accepted.

Probably the most vivid “take away” was the example of what can be achieved through genuine commitment partnerships that reflect both commitment and a shared vision. The powerful sense of partnership between the parties was especially tangible. This was not a case of signing an MoU, and then returning to “business as usual”, with some differences. The partnerships were regarded and acknowledged as powerful moderators and informants of a new “business as usual” for each partner.

The ability to establish and maintain effective, mutually supportive relationships based in shared interests is commonly regarded as an essential element (principles) of good mental health.

It is refreshing and innovative (and just a little ironic!) that the DBI pilots model such fundamental principles as a foundation of such a potentially transformative initiative.

DBI clearly stands out as a very real, powerful and potent change agent; this transformative potential we discussed. Translating and exporting a successful pilot with all its inherent energy, excitement and commitment into a transformed, contemporary “business as usual”, is not always an intuitive, inevitable nor straight-forward process. A pilot sitting to one side of, and distinct from established structures, thinking, and models of practice can thrive because of this. For example, a pilot does not need to concern itself too much with shifting existing conditions that may be holding the problem in place. If this pilot is to be extrapolated and introduced to others sites/jurisdictions, ALL of the conditions that have contributed to its success must be appreciated, and included in planning.

As is noted above the partnerships and the quality of these are demonstrably and strongly at the heart of DBI and any success it has enjoyed. Establishing and maintaining strong effective partnerships (particularly across sectors) is not a skill we are yet able to boast about. This pilot does offer room for quite tangible optimism however; transforming systems is really about transforming the relationships between people who make up the system. In this regard, the potential for DBI is clearly transformative; the evidence of the success of DBI illustrates the absolute potency of such a transformation.

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