Guide to implementing and sustaining a brief intervention clinic

PROJECT AIR
A PERSONALITY DISORDERS STRATEGY

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Definitions

Personality disorder

Personality disorder is a mental health disorder recognised by the International Classification of Diseases (ICD), and the Diagnostic and Statistical Manual of Mental Disorders (DSM). Personality disorder refers to problems in identity and interpersonal functioning. This includes difficulties in understanding of self (e.g., identity integration, integrity of self-concept, self-directedness of life goals) and others (e.g., empathy, intimacy and cooperativeness, complexity and integration of representation of others). Emotional dysregulation, self-harm and suicidal risk may be part of the experience of those struggling with these challenges.

Virtual mental health care

This term refers to modes of therapy where the therapist and client are not face to face in the same room. Virtual mental health care can include a range of connectivity platforms. Technology is used to connect the therapist and client usually via a computer, phone or other telehealth platform. Virtual mental health care may be provided exclusively via the virtual platform, or across a hybrid model of care where some contacts are face to face based on clinician considerations and client/carer preference.

Introduction to this guide

This guide aims to support managers, leaders, coordinators and clinicians in establishing a stepped care brief intervention clinic for people with personality disorder within their service. This resource supports the interpretation of clinician manuals describing the brief intervention. This current guide considers how to establish and maintain a clinic by providing guidance to clinic coordinators and senior leaders on stepped care service redesign. It does not include information on the therapeutic skills and strategies within sessions. These are outlined in these clinical guidelines:

Project Air Strategy for Personality Disorders (2015). *Brief intervention manual for personality disorders*. Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute. (Available here)

Project Air Strategy for Personality Disorders (2019). *Adolescent brief intervention manual for complex mental health issues: Responding to emerging personality disorder, trauma history, self-harm and suicidal behaviour*. Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute. (Available here)

Other resources that may be of particular help include:

Project Air Strategy for Personality Disorders (2015). Guidelines for Commissioning a Personality Disorder Service. In *Treatment Guidelines for Personality Disorders* (pp. 44-45) 2nd Ed. Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute. (Available here)

Pigot, M., Miller, C. E., Brockman, R., Grenyer, B. F. S. (2019). Barriers and facilitators to the implementation of a stepped care intervention for personality disorder in mental health services. *Personality and Mental Health, 13*, 230-238. (Available here)

Project Air Strategy for Personality Disorders (2023). Virtual Gold Card Clinic Manual. Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute. (Available here)

Service redesign: Implementing change

The Project Air Strategy aims to improve treatment pathways for people with personality disorder through a whole of service redesign. This includes training all mental health staff in effectively working with people with personality disorders, specialist training for staff with intensive contact with this population group, and the implementation of stepped care, including a brief intervention clinic. The whole of service approach has been reported elsewhere (e.g., Grenyer, Lewis, Fanaian & Kotze, 2018; Grenyer & Bailey, 2024).

The implementation of a stepped care approach to the treatment of personality disorders is often novel and requires services to consider new concepts and research findings, new approaches to working with this population group, new referral pathways, and new ways to work together. It is essential that change theory and implementation science is applied for the successful and sustainable redesign of personality disorder services.

A research article outlining the facilitators and barriers to successful implementation of the brief intervention has been published (Pigot, Miller, Brockman & Grenyer, 2019). Key facilitators include:

- Clear and accountable leadership commitment at the level of senior clinical staff
- Establishing and supporting clinical governance outlining pathways to specific treatment clinics
- Clinician support structure
- Ensuring sufficient penetration of training to all staff, including ongoing training opportunities
- Training managers, senior clinical staff and clinical champions on how change occurs and factors associated with success or barriers
- Development of prospective plans for evaluating and disseminating outcomes of implementation.

All of these key facilitators are outlined in this guide to support successful implementation.

Implementation science

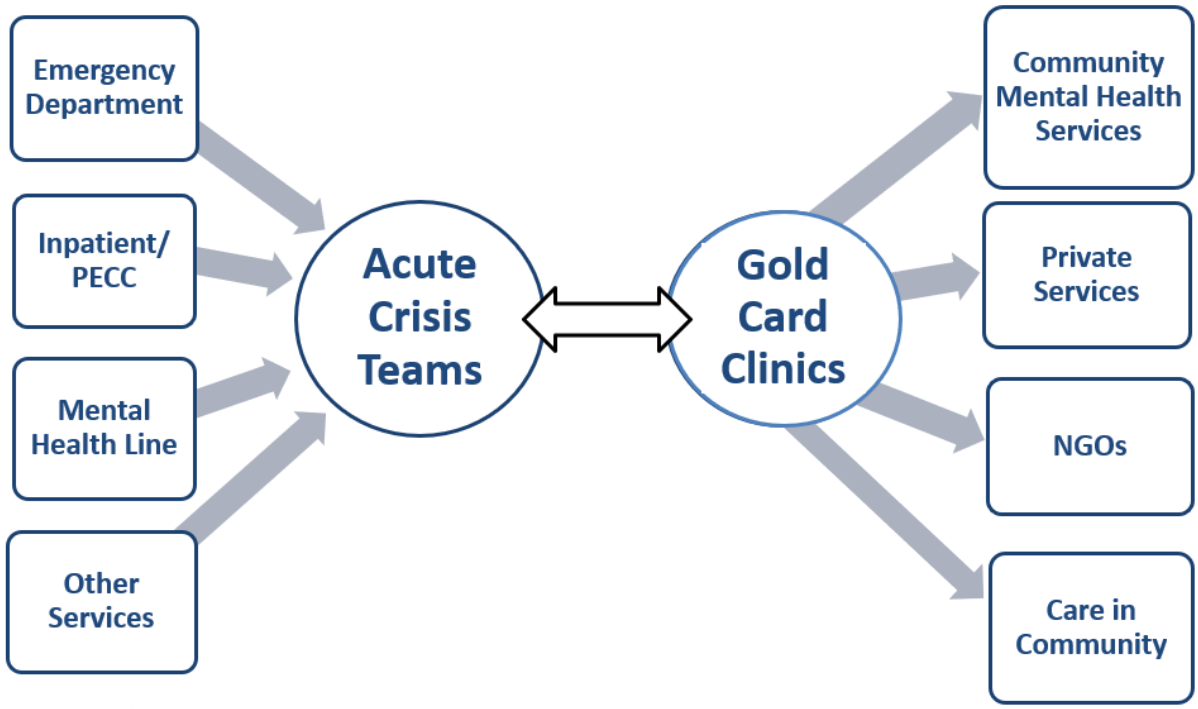
The redesign of services requires careful consideration of a number of factors, all contributing to the success of implementation and sustainability. Implementation science guides champions and clinical leaders on the key initial and ongoing considerations to support redesign.

It can be useful to consider the PRISM (Practical Robust Implementation Sustainability Model) framework to guide your implementation science approach (see https://re-aim.org). PRISM focusses on the multilevel perspective (e.g., organisational, client, community) of the program, recipient, implementation, sustainability and environmental contextual factors to support successful implementation. The PRISM framework informs the implementation model provided in this guide.

Introducing a stepped care model for personality disorders

This guide is designed to assist services in the effective implementation of a whole of service stepped care approach to personality disorders. Community based psychological therapy is the treatment of choice for personality disorders and brief interventions can be an important part of these therapies. Stepped options can provide pathways of care that are responsive to the client's needs and can enhance access and ensure service availability.

Many services struggle to provide adequate and timely care for people with personality disorder. Although emergency departments and acute care services may be available and responsive to crisis, there is often a 'gap' between these services and longer term care in the community. Delays, long waitlists, and inaccessible pathways to care are common. This stepped care approach is designed to move people quickly from crisis services into brief interventions to deliver therapy and plan the recovery journey. For further information on the model, see Grenyer (2014).



Brief intervention service redesign

Implementing stepped care options to the treatment of personality disorder often requires service redesign. To support successful implementation, it can be useful to consider the practical application of the intervention from a range of perspectives; at the organisational, client and community level.

From the organisational perspective, this may include readiness for change, whether the program meets the needs of frontline staff, the existing evidence-base, the costs and burdens associated, and the utility and adaptability to local settings. Specific to the brief intervention, this may include considerations such as:

- Redesign of the service in a way that integrates the brief intervention into existing models of care and compliments available step-up and step-down treatment options
- Streamlined referral pathways

- Broad dissemination of training and information regarding the aims and evidence-base
- Allocation of resources, including time allocation for the coordinator to establish and maintain the clinic
- Adaptation of the intervention to meet the local needs and context
- Timing of the implementation, including considerations such as staffing levels, competing priorities and workload capacity.

From the client or community level, this may include whether the program enhances choice, person-centered care, increases access, and provides opportunities for feedback. Specific to the brief intervention, this can include considerations such as:

- Accessibility of the brief intervention
- Options for step-up or step-down care pathways
- Options of modality, including face to face, virtual or hybrid
- Experience feedback pathways
- Opportunities to connect with the client's support person
- Opportunities to consult with the client's community (e.g., school, general practitioner, other support services involved in the client's care).

The brief intervention

The brief intervention provides a rapid and structured intervention that may:

- Provide brief, time-limited interventions aimed at addressing the immediate crisis that led to a deterioration in functioning
- Provide an alternative to hospitalisation or facilitate early discharge
- Promote early intervention and provide rapid psychological care to reduce the risk of escalation to severe incident
- Act as an intermediate point between acute settings and longer-term treatment programs
- Ensure positive messages are provided to clients, carers and health staff with regards to treatment for personality disorders.

The brief intervention may:

- Provide psychotherapy to help the client manage their immediate needs
- Provide psycho-education to help the client understand their problems
- Provide clinical services aimed at helping the client solve their problems
- Help the client change unhelpful behaviours when in crisis
- Clarify short and longer-term goals and some actions towards these, creating a sense of momentum and hope
- Help the client to identify existing coping skills, which may have been forgotten at time of crisis
- Reduce risk for the client through the development of a collaborative care plan that can assist to better anticipate, prevent and address future crises
- Ensure the client is properly integrated into care by reinforcing and identifying relevant key support people
- Provide treatments with an evidence-base that are effective with personality disorders.

Features of the brief intervention, when used well, are that a client:

- Is seen quickly, for example they may be offered an appointment within one to three days of first presentation, crisis presentation, or re-presentation with immediate treatment needs, or hospital discharge
- Obtains a positive experience of a psychological therapy service, helping to challenge assumptions based on past experience of care
- Has their care needs better coordinated, between acute services and longer-term treatment options
- Develops an understanding of how engagement and retention in treatment programs may be of benefit
- Develops an understanding of their diagnosis and the options for treatment
- Increases compliance with follow-up after discharge from hospital.

The brief intervention can help family, carers, partners and relatives by:

- Connecting with family and carers to provide information and support relevant to their role
- Providing tools and strategies to help the carer take care of themselves and the client in the event of future crises
- Providing psycho-education to help the carer understand the issues and navigate the service
- Providing basic connection and affirmation with carers, with an opportunity to voice their concerns and needs
- Understanding carers' needs, including possible need for other services where necessary.

The brief intervention model can benefit services by:

- Helping services manage high volumes of client presentations, reducing waiting times, and providing triage and referral to other services based on changing needs
- Provide a structured approach to rapid follow up for patients presenting in crisis, which can be delivered by multidisciplinary staff
- Reduce service cost by providing a step-down option from inpatient admissions and facilitating earlier discharge
- Offers an opportunity for the consideration of treatment needs
- Generate stronger links with other community-based referral and treatment pathways for people with personality disorders
- Upskill staff in effectively working with people with personality disorders
- Ensure that service delivery for people with personality disorders is firmly grounded within an evidence and guideline-based treatment model.

The brief intervention was developed using the Project Air Strategy relational model and fits into a broader system of care (Grenyer, 2014). The model advocates an integrative collaborative approach to personality disorders treatment. It focuses not only on the person with personality disorder but also supports carers, health services and clinicians. In the relational treatment model, the person's problems are seen as stemming from problematic and dysfunctional relationship patterns that have developed over time (Grenyer, 2012). These relationship patterns are considered both intrapersonal (how the person relates to themselves, including their feelings and thoughts) and interpersonal (how they relate to others, and how others relate to them). The principles of guideline-based good clinical care have been influential in the development of this approach. Therefore, it is consistent with the dynamic principles of general psychiatric management (Gunderson & Links, 2008), and the Clinical

Practice Guideline for the Management of Borderline Personality Disorder (National Health & Medical Research Council, 2012).

The treatment aims to help the client understand and modify any unhelpful relationship patterns in order to more effectively get their needs met. The model recognises that responsibility for effective relationships also rests with others involved in the client's life. Therefore, clinicians, case managers, carers, youth and support workers, teachers, school counsellors and the broader community have a role to respond effectively to the person in a way that is helpful and encouraging.

There is growing recognition that service systems need to work holistically in an integrated fashion, rather than particular sectors working in isolation. Therefore, this brief intervention is one part of a larger system of care, including acute psychiatric consultation, longer-term treatments, and care options in the wider community. These are all important steps of care. Providing brief immediate psychological care may better support young people and adults who are at risk of significant harm. There needs to be a shared approach to keeping vulnerable young people and adults safe.

Some evidence for the stepped model of care

The brief intervention is designed to be a rapid therapeutic intervention at the client's time of need. Brief interventions provide a useful episode of care which can improve the client's acute distress. In some cases, the brief intervention can also function as a conduit between crisis (inpatient and acute) and longer-term services (either in the public health service or in the community). It is recognised that many people may not require further specialised mental health intervention following the brief intervention.

Clinical research has shown that the implementation of the brief intervention clinic reduces demand on health services, has high attendance rates and is associated with significant improvement in mental health outcomes. In a cluster randomised controlled trial, the brief intervention stepped care approach resulted in reduced bed days, re-presentation rates and overall service costs for clients with personality disorder (Grenyer, Lewis, Fanaian, & Kotze, 2018). In addition, clients attending the brief intervention reported a significant reduction in borderline personality disorder symptom severity, distress and suicidal ideation, and increased quality of life following the intervention (Huxley et al., 2019). The largest effect size of these improvements was on suicidal ideation, suggesting that the brief intervention clinic effectively functions as a suicide prevention program for people with complex mental health needs.

A recent independent study (Bartsch et al., 2024) evaluated individual and system-level outcomes of the brief intervention implementation across South Australia. Analysis comparing service utilisation data for participants (n=332) 6 months pre and post-engagement in the brief intervention showed significant reductions in presentations at the emergency department (63%), inpatient admissions (65%) and bed days (82%). Patient outcomes (n=115) were also improved significantly from the first to last session of the brief intervention on domains including borderline personality disorder symptom severity, general distress, depression, anxiety, risk factors for suicidality, and psychosocial functioning. Carers (n=33) also reported that the session with them improved their hope, confidence and knowledge.

Research has shown that most clients who utilise the brief intervention are then referred to external services, with only a small proportion (about 13%) requiring internal pathways of care. Most of the clients retained by the public health service were stepped on to group or individual psychological treatment, and very few were stepped up to acute care services. Importantly, about half of the clients

who engaged in the brief intervention clinic did not require a referral for follow up. This suggests that the brief intervention met most of the clients at their time of need, and no further intervention was required. Most of the clients who did require further treatment were referred to other health providers (e.g., private psychologists, or their primary health care provider; Huxley et al., 2019).

Brief intervention adaptation and fidelity

Whilst the implementation of the brief intervention is adaptable to the local context and need, there are some essential elements that will guide fidelity. The *Brief Intervention Clinic Manual* (2015a; as referenced above) provides an overview of the clinical structure and skills required of the brief intervention. The essential clinical elements include:

- Rapid follow up
- Establishment of the frame at the outset
- Use of the Care Plan (interwoven throughout the client sessions)
- Collaborative review of the most current crisis
- Providing person-centred psychoeducation (e.g., about diagnosis, general information regarding emotion dysregulation, particular skills, treatments available, etc.)
- Includes a person-centred selection of skills-focus (might be offering new skills or troubleshooting existing skills, however a minimum focus on building skills use)
- Demonstration of therapeutic stance (e.g., balancing supportive and expressive approaches to integrate both acceptance and change-based techniques)
- Family and carer engagement – includes at least an attempt to engage a support person and, if successful, the Carer Plan during the carer session
- In recognition of the multidisciplinary professional backgrounds and experience level of clinicians contributing to the brief intervention:
    - It is not medication review
    - It is not case management
    - It is not supportive counselling
    - It is not exclusively peer support (although peer support workers may be able to contribute to or deliver the intervention)

Whilst operationalisation of the brief intervention is locally determined, there are some essential core elements that support adherence:

- Having an identified coordinator to oversee the clinic
- Having Business Rules that are formally endorsed by the executive to demonstrate senior leadership support
- Integrated opportunities for supervision / debriefing
- Consideration of quality assurance and opportunities for feedback (e.g., collection and analysis of measures, tracking service utilization and throughcare, etc.).

Principal mechanisms of action

Adaptations to the model allow flexibility, innovation and opportunities to maximise local application. Understanding the principal mechanisms of action provide guidance to support adaptation:

Determinant	Implementation strategy	Mechanism	Implementation outcome
Enhance accessibility to best-practice and evidence-based treatment	Rapid follow up; brief therapeutic approach; broader stepped-care model; identified step-up and step-down pathways of care; flexibility in modality; provision of further referrals as agreed	Timely therapeutic engagement in the community; deeper understanding of crisis challenges and treatment options available, engagement of family, support person or carer (and Carer Plan); demonstration of therapeutic stance	Reduced crisis re-presentation rates and utilisation of inpatient services (Grenyer, Lewis, Fanaian, & Kotze, 2018; Bartsch et al., 2024); improved pathways of care (Huxley et al., 2019); increased engagement with community-based treatment options; integration of the brief intervention into a broader stepped model of care
Enhance opportunities to develop client agency	Brief intervention grounded within Key Principles of Working with People with Personality Disorder (see Brief Intervention Clinic Manual, 2015a)	Joint understanding of the aims and expectations of the approach through clear orientation and frame setting, collaborative development of a Care Plan, collaborative review of most recent crisis; providing a person-centred approach to session focus; providing appropriate referral options	Improved client mental health and quality of life (Huxley et al., 2019; Bartsch et al., 2024) and confidence in managing relapses
Upskill mental health workforce	Provision of a manualised model of care; identification of a co-ordinator to be a local expert; provision of training and community of practice opportunities	Championing of the approach by senior leaders, co-ordinator and local clinicians; broad multidisciplinary clinician engagement; integration of reflective supervision and community of practice	Improve mental health staff confidence in working with people with personality disorder and associated concerns, reduce stigma, enhance accessibility to best-practice treatment (Grenyer & Bailey, 2024)

Pre-launch implementation planning

Prior to implementing a redesign strategy, it can be helpful to scope the existing service structure, conduct a gap analysis, and understand the target intervention population. This understanding will inform the implementation by providing essential information to shape redesign.

On an organisational level, characteristics including culture, morale, change burnout or previous success or failure in redesign may contribute to implementation outcomes. The opportunities and barriers to organisational change need to be considered across executive management, middle management, and frontline staff. Strengths in communication, strong leadership, shared goals, training and support, resources and incentives assist to promote implementation success. Specific to the brief intervention clinic, this may include:

- Local service culture and experience in managing change
- Executive support and endorsement
- Formalisation of the intervention through Business Rules
- Ongoing training opportunities for new and existing staff
- Integrated supervision, debriefing, mentoring, or community of practice opportunities
- Integrated service indices in the electronic medical record to track service utilisation
- Regular opportunities to communicate across all levels of leadership and frontline staff
- Clear expectations and monitoring of outcomes.

Client or community-based factors can also influence the success of the implementation. This may include beliefs regarding the program, competing demands, demographics of the target population, and whether clients are supported to engage in interventions. For the brief intervention, this may include:

- Clear eligibility criteria and alternate pathways of care as needed
- Clear information about the clinic through advertising materials (e.g., posters and brochures)
- Flexibility with appointments or modality to minimise barriers to engagement
- Consideration of how to adapt the intervention for any diversity needs (e.g., culturally and linguistically diverse clients, indigenous or first nations populations, rural and remote communities, mild cognitive deficits).

Gap analysis

An important first step is to consider what service gap the brief intervention will fill and how it can complement other treatment options provided by the service as part of a broader stepped model of care. This includes how the brief intervention will be integrated into existing models of care, and will inform the pathways for referral into, and through-care out of, the brief intervention clinic. In addition to the features and benefits of the brief intervention outlined above, the clinic can fulfil a range of additional roles including:

- Standardising care for crisis follow-up
- As a suicide prevention pathway
- Assisting services to meet required targets regarding contact and re-presentation after a crisis
- Improving transition to community following inpatient discharge
- Providing a service option for people with personality disorders
- As a step in a broader roll out of a stepped model of care
- As part of a staff training program.

The gap analysis may also include consultation with clients or carers with lived experience, and their feedback on improved service delivery.

Project management

Implementation Plan

Service redesign requires the guidance of clear and comprehensive project management strategies to ensure success. The gap analysis may inform the broader project structure, including development of an implementation plan. This document may include:

- A summary of the gap analysis and case for change (including how the redesign fits with broader organizational or political strategies and priorities)
- Aims of the implementation plan and project objective
- The scope of the project (including the assumptions, constraints, and external dependencies)
- Project team and/or Steering Committee (this may include the project sponsor, clinical lead, project lead, redesign lead or nominated coordinator, champions, lived experience voices and leaders in co-design, etc.)
- Defined governance, roles and responsibilities
- Phases of the project, including the aims, steps, deliverables, milestones, progress and timeframes
- Evaluation plan (see 'Quality Assurance' section below)
- Budget and resources (where appropriate)
- Risk and issues log (this may include risks such as culture, morale, staffing stability, resistance to change, other priorities, etc.)
- Communication plan to engage all stakeholders (this may include rationale, frequency, who is responsible, the priority, and the delivery modality of communication)
- Gantt chart of the project phases, deliverables and timeframes.

Existing implementation plan documents may guide the development of localised approaches. As an example, the NSW Health Agency for Clinical Innovation provides a range of templates that may be useful (Available here).

Phased re-design

Service redesign is an enduring and complicated process. It is likely that the contextual factors impacting success or barriers to implementation and sustainability will change over time. Planning for a phased redesign in the implementation plan will allow integration of change, adaptations, and learning from feedback to ensure a relevant and sustained model of care. Each phase of redesign may need to consider:

- Rationale for changes required
- A timeframe (start and end date of the phase)
- Specific aims and goals for the phase
- Methods to measure targets
- Reportable deliverables and performance review indices
- Communication plan to disseminate phase outcomes
- Planned opportunities for phase review

- Planning for the next phase.

Service redesign with the brief intervention stepped care model often includes phases such as:

- Gap analysis (review of current model of care and any previous relevant implementation documents, discussion with primary stakeholders, identification of facilitators and barriers to implementation, seeking feedback from people with lived experience, building a case for change)
- Generating support (identifying a project sponsor, engaging primary stakeholders, disseminating information about the project plan, generating buy-in and identifying areas of resistance to change, developing a local Steering Committee where appropriate)
- Formalizing the implementation plan (this may include developing a documented phased approach to the redesign with pre-determined aims, goals, timeframes and deliverables as per above)
- Development of localised Business Rules and/or Model of Care (including how the redesign will be integrated into the existing service structure, and overarching organizational policies and procedures, how referral pathways will be determined, endorsed by the project sponsor or executive to demonstrate senior leadership support)
- Soft launch (some services prefer to commence operationalization beginning with a 'soft launch' with internally identified clients and senior clinicians to road-test the localized approach, and identify any additional considerations or requirements prior to official launch)
- Launch phase (includes local promotion of the service to referral pathways, in-services to disseminate information broadly about the aims and objectives of the project, organizing/providing training opportunities close to launch to maximise clinician confidence, acceptance of referrals and implementation of the intervention, commencement of support structures for clinicians including localised community of practice or supervision meetings, gathering quality assurance data to contribute to the phase outcomes)
- Review and sustainability phase (review of the initial implementation including gathering feedback from clients, carers and clinicians, integration of feedback into revised Business Rules and/or Model of Care as required, ongoing stakeholder engagement and championing of the approach, consideration of innovations or adaptations, broadening referral pathways, ensuring opportunities for ongoing training and supervision to ensure motivated and sustained clinician staffing, integration of succession planning, monitoring of service changes and any risks to the redesign, ongoing review periods and reporting of deliverables)
- Re-launch (if issues of sustainability have resulted in the need to re-launch, considerations may include the facilitators and barriers to the previous operationalization, review of the previous Business Rules and identification of any adaptations that will be required to ensure future success, careful consideration of local change culture and generation of strong support).

The timeframes of each phase should be locally determined, and considerate of the resources allocated to the project, the barriers and facilitators of change, and organisational need. For example, it may be likely that a service who has a history of successful change implementation, has a well-resourced coordinator position, and minimal resistance may be able to progress to launch within a shorter timeframe. However, a service with a complex model of care, with a history of unsuccessful change management, competing priorities, high workload and fractionally resourced coordinator role may require greater energy and time in the initial phases of generating support and formalising a thorough implementation plan prior to progressing to launch.

Implementation: From initial considerations to launch

It is essential to consider the existing and changing infrastructure to support initial intervention adoption, implementation, and sustainability over time. This process requires regular review due to the dynamic nature of services. This includes performance review and adjustments to policies and procedures as necessary.

Initial considerations in establishing a brief intervention clinic

Initial intervention adoption

Success of the initial adoption of the intervention can be enhanced by broad and collaborative consultation. This will assist to generate support from key stakeholders and understand areas of resistance. Broad training and dissemination of the evidence-base can enhance buy-in. Identifying senior project sponsors will provide leadership support to the project and may assist to understand the local facilitators and barriers to change.

Generating support

Lived experience Clients and their carers with lived experience should be at the heart of the redesign project. This may include providing education about evidence-based treatments, facilitating focus groups for clients and carers to have a voice in the redesign, or providing opportunities for clients to provide feedback and evaluation data. This may also include involving client or carer peer workers in co-design or implementation of the stepped model of care.

Champions Support from other senior and ground-level clinicians also assists to broaden the transfer of knowledge and motivation for change. This includes the self-identification of 'champions' who are willing to promote organisational change required for the project. Champions require the support of management to promote change.

Leadership It is essential that senior managers are consulted from the outset to obtain support for the project. This includes the support from key medical staff who are integral to promoting referral and uptake of the intervention. Leaders need to demonstrate support for the redesign and promote organisational change. This includes allowing staff to take the time out of direct service delivery to plan and promote change.

Clinicians It is essential to generate support from the clinicians who will be contributing to the brief intervention, either directly or through referral pathways. Broad dissemination of information and training can assist to increase motivation and engage clinicians. Whilst training is beneficial, clinicians also need hands-on experience to build confidence in the intervention. The timing of the training is important to maximise confidence.

Resistance Working with and addressing resistance is essential. Resistance to change can occur at all levels of the organisation and can potentially threaten the redesign. Addressing resistance can include providing accurate information, being transparent and openly discussing the concerns, and actively engaging the person to be involved by drawing on their skills and knowledge. Sometimes resistance will remain despite best efforts to engage. In these circumstances the impact of the resistance on the redesign needs to be considered, including any potential modifications that need to be made to the implementation plan.

Training and orientation

Training in the delivery of the brief intervention model is recommended to be scheduled close to the anticipated launch date of the clinic (e.g., 1 to 2 weeks prior) to maximise clinician confidence in utilising the model and skills. At times, staff may also benefit from a 'booster' training as a refresher on the model if some time has elapsed between training and involvement in the intervention. Regular ongoing training opportunities for new staff are essential to the sustainability of the clinic. Some clinics also include mandatory re-training after a certain period of time (e.g., every 2 years) to ensure ongoing best-practice and fidelity to the model.

Some brief intervention clinics find it beneficial to orient newly trained staff to the brief intervention clinic by providing opportunities for co-therapy or mentorship with a more senior clinician. Such approaches can increase confidence and fidelity to the model of care. Local orientation may also be provided by the coordinator to familiarise new clinicians to the local operationalisation of the brief intervention clinic.

Implementation

Implementation readiness includes key considerations that should be guided by the initial gap analysis and implementation plan.

Governance

Clinical governance will need to be negotiated within the service. Often, governance has been established through acute care or community mental health teams.

The development of adapted and endorsed Business Rules is an important initial aspect of planning the clinic to meet the local needs. These rules aim to clearly outline the policies, procedures, structure and parameters of the clinic. Ideally, Business Rules for the brief intervention clinic will be well integrated into existing broader procedures and policies. See Appendix A and B for two example Business Rules. The Business Rules provide a scaffolding for the brief intervention clinic, and a safety net for the clinicians, clients, carers, and the service. It is recommended that the Business Rules are endorsed at the senior management level prior to the launch of the clinic.

Core components of a brief intervention clinic Business Rule include:

- Overview, rationale, and aims
- Clinical governance (team responsible, review process)
- Referrals (sources, eligibility, exclusion criteria)
- Referral procedures and intake
- Brief intervention process
- Non-attendance procedures
- Risk escalation and referral to crisis services
- Discharge procedure
- Documentation
- Specific modality (e.g., virtual) procedures as required
- Supervision arrangements
- Quality assurance requirements
- Staffing and rostering.

Whilst the Business Rules are able to define many aspects of the brief intervention clinic, there may be some instances that require case-by-case clinical consideration, often in consultation with the brief intervention multidisciplinary team, consultant and/or management. Examples include repeat referrals to the brief intervention clinic. At times, people who have previously accessed the brief intervention may be re-referred with similar or changed personal circumstances (e.g., clinical symptoms, readiness for change, treatment providers). Previous engagement with the brief intervention clinic does not usually preclude a client to re-engage. This may involve reviewing the previously generated Care Plan in the context of the new crisis, and evaluating what did and didn't work. However, repetitious referral may require further clinical consideration. Other examples may include the threshold of concurrent drug and alcohol issues, intellectual disability, or lowest acceptable age considerations in youth-oriented services depending on the client's capacity.

Location and resourcing

The physical location of the clinic is another important consideration. This includes whether the clinic will be based at a public community mental health centre, embedded within the acute care team, or at an acute service location (e.g., in-reach to the hospital, Emergency Department or Assessment Unit). This also includes whether there will be one implementation site or multiple across the region. Location will also need to consider the accessibility of the clinic, including any geographical, catchment and contextual concerns. Initial considerations may also include physical resourcing of the clinic, including access to therapeutically-oriented confidential rooms and/or videolink technology.

What will it be called?

Gold Card Clinic (GCC) is the standard name applied to the clinic, where the 'gold card' refers to the card with appointment details provided at the point of referral (see Appendix C). These cards can be a useful option for clinics with strong direct referral links from the local acute care team or Emergency Department and may be provided even when the appointment details are not yet available. Clients often find it comforting to have a card with the details of the clinic providing the brief intervention. However, other names have been applied to the brief intervention clinics to suit the local context.

What will be the modality options for the clinic?

Recent years have required increased flexibility from mental health services on the modality of treatment. Many services are now well resourced and practiced in delivering interventions flexibly across face-to-face and virtual modalities (including via phone, and online real-time videolink platforms). Some brief intervention clinics may decide to establish a purely virtual or face-to-face approach, whereas others may develop a hybrid model of care to promote greater accessibility based on clinical need, client/carer preference, geographic, demographic, resourcing or other considerations. Emerging evidence demonstrates the acceptability and efficacy of the brief intervention when delivered via virtual modalities (Bailey, Knowles & Grenyer, 2023). It can be useful to consider the modality of the clinic from the outset to ensure administrative, clinical and ethical considerations of all possible modalities are thoughtfully applied. Additional Business Rule adaptations may need to be considered should the brief intervention clinic include virtual mental health care. See the Project Air Strategy for additional advice on virtual brief intervention clinic considerations (Project Air Strategy for Personality Disorders, 2023).

Referral pathways

Identifying referral pathways and treatment options, both public and private, is an important aspect of embedding the clinic within the broader service. Depending on local operationalisation, referral pathways to the brief intervention may be limited to a particular team (e.g., via the acute care team only), or broadened to accept referrals from a variety of sources (e.g., directly from the Emergency Department or inpatient unit, from primary health care providers, or school counsellors and principals). Often referral pathways are increased in a graded or phased way, allowing for monitoring of optimal referral numbers whilst balancing service capacity. The identified referral pathway teams may require education regarding the brief intervention to facilitate appropriate referral. This may need to be repeated if key staff move on from the referring service (e.g., psychiatric registrars on rotation) to ensure new staff are aware, and existing staff are reminded, of the brief intervention option.

Discharge through-care referral options might include private psychology and psychiatry, drug and alcohol services, domestic violence services, relationship counselling, eating disorder services, non-government agencies, or within the public community mental health service.

Staffing

The model of staffing for the brief intervention clinic includes multi-level considerations. This includes three integrated roles:

- Consultant: Provides senior leadership and championing, step up/step down consultation and medication review, psychotherapy and consultation.
- Clinic coordinator: See below.
- Clinicians: Provide psychotherapy and peer consultation.

The coordinator role

Appointing a clinic coordinator is essential to successful implementation by providing project management, administrative and oversight support. The coordinator role may be attached to a pre-existing role (such as a team leader position) or be held by a clinician interested in the treatment of personality disorder. It is recommended that the coordinator role and responsibilities are clearly defined at the outset, for instance when developing the local brief intervention implementation plan or Business Rule.

This position may be shared among multiple coordinators where necessary, with a division across multiple part-time positions, or a division of roles (e.g., one coordinator managing referrals and rostering, the other working with clinicians regarding the intervention and providing supervision). Examples of coordinator tasks are provided in Table 1, and example selection criteria are provided in Table 2.

The coordinator role fulfils a number of essential functions that may include:

- Operationalisation support:
    - Involvement in the overall project management for the redesign and implementation plan
    - Ensuring localised Business Rules are developed, endorsed, available to staff, and updated as necessary
    - Maintaining seamless referral pathways and through-care step-down options

    - Meeting with relevant stakeholders, championing the brief intervention clinic and ongoing generation of support
    - Being a point of contact for clinicians with questions about the clinic
    - Providing in-services promoting the brief intervention clinic referral option
    - Receiving referrals and checking for eligibility, or facilitating in-house identification of suitable clients during intake meetings
    - Monitoring client throughcare
    - Allocating clinicians/appointment availability
    - Room bookings (depending on the appointment model)
    - Clinician rostering
    - Arranging training for new staff
    - Attending the Air Academy community of practice forums and sharing learnings with the local team (see *Air Academy* section below for more details)
    - Liaising with other local services to identify gaps and opportunities for innovation
    - Monitoring quality assurance and maintaining statistics about service utilisation (e.g., by use of tracking tools, checklists or integrated pre/post clinical measures and feedback opportunities; see Appendix D and E for examples)
    - Reporting on the brief intervention outcomes to senior managers regularly, and at the conclusion of phased redesign as per the implementation plan
    - Ensuring fidelity to the model of care
    - Arranging and facilitating team meetings
    - Attending local or region-wide Steering Committees as appropriate to support integration of the implementation into the broader model of care
    - Continuing to assess changes within the service and how they relate to the implementation, including any adaptations required.
- Clinical support:
    - Providing opportunities for regular debriefing/supervision (individual and/or group)
    - Facilitate a localised community of practice through regular group meeting opportunities
    - Co-therapy and mentoring of newer staff to increase confidence
    - Orientation to how the brief intervention is locally operationalised for new staff
    - Where ongoing training isn't available for new staff, the coordinator may provide a train-the-trainer function
    - At times, coordinators may also have an allocated caseload of brief intervention clients.

Table 1: Example brief intervention clinic coordinator tasks

Coordinator Tasks
Example 1
The brief intervention clinic coordinator will be responsible for facilitating the successful introduction of the brief intervention model into Community Mental Health by: • Overseeing the design and implementation of a clinical governance process and treatment pathway for this clinic. • Creating and chairing a regular planning/implementation meeting with relevant stakeholders. • Drafting appropriate work practices and protocols. • Administering the brief intervention. • Keeping relevant statistical data to enable good quality evaluation of the program.

• Maintaining a roster of clinicians to undertake this work. • Providing a quarterly report about the brief intervention clinic to the Community Mental Health Managers Group.
Example 2

• Ensure client care is delivered within professional, organisational, legal and ethical boundaries and reflects evidence-based, best practice knowledge.
• Provide patient-centred clinical interventions and advice to clients, carers, families and other health care professionals to ensure delivery of the Project Air Strategy stepped care model.
• Ensure that the brief intervention clinics provide evidence-based care that maintains fidelity to the Project Air Strategy stepped care model.
• Be able to exercise independent professional judgement in solving problems and managing complex situations.
• Demonstrate clinical reasoning skills in the provision of clinical care and operate independently with minimum direct clinical supervision.
• Provide a consultative service to clinicians across [the district] to promote the consistent provision of safe high quality person-centred care.
• Identify opportunities and contribute to continuous improvement activities to improve clinical care provided to clients of the brief intervention clinic and seek opportunities to participate in evaluation and/or clinical research of service provision.
• Provide advice to managers on clinical service delivery development, practice and redesign to ensure that the needs of the target audience and service delivery are met and actively communicate future issues and new directions for the service to ensure appropriate notification and escalation of issues impacting on clinical practice and care delivery.
• Maintain administrative systems/data entry related to the booking, scheduling and counting/recording of client contact characteristics as required for mandatory reporting and as required by management for planning, quality or research.
• Ensure professional responsibilities are met including:
  ○ Engaging and contributing to ongoing education/training activities
  ○ Participation in regular professional practice supervision
  ○ Educating and supervising less experienced professionals and students to ensure their ongoing professional growth
  ○ Enhanced application of clinical knowledge as per [the district] Supervision Policy.
• Document all aspects of care including education, progress notes and referrals to health care providers.
• Communicate appropriately with clients/families/health care workers at all times.
• Facilitate and promote client participation and feedback to ensure the service is meeting their needs.

Table 2. Example selection criteria for a brief intervention coordinator

Selection Criteria
Example 1
1. Must hold an appropriate degree in psychology, nursing, occupational therapy, or social work alongside registration and recognition of professional qualifications. 2. Demonstrated clinical knowledge, skill and clinical experience in mental health services.

3. Demonstrated knowledge and skills in the Project Air stepped care model as well as demonstrated skills in working with families.
4. Experience and demonstrated ability in building and maintaining professional and therapeutic relationships through the application of written and verbal communication skills, interpersonal, negotiation and conflict resolution skills.
5. Demonstrated ability to apply and share expert knowledge with colleagues and other health professionals to enhance service delivery.
6. Demonstrated experience and ability to identify opportunities and innovatively lead the planning, implementation and evaluation of service delivery incorporating continuous improvement, evidence-based practice and research.
7. Demonstrated experience in the provision of clinical supervision, mentoring and development of junior staff and students.
8. Demonstrated high level organisational, prioritisation and time management skills in an environment of competing clinical/administrative demands.
9. Excellent negotiation, decision making and advocacy skills including collaborative stakeholder consultation.

Example 2

1. Demonstrated experience working as a mental health clinician with a good understanding of treatment for personality disorders. Specifically, trained in and able to deliver Project Air brief intervention treatment.
2. Demonstrated capacity to work effectively with a variety of stakeholders, to lead the design and successful implementation of a new service initiative.
3. Full-time permanent employee of Mental Health Services, located in the region.

Clinician staffing profile for the brief intervention clinic

The staffing profile for the brief intervention clinic often varies as a function of context, governance, interest and availability. Clinics may be staffed by acute care staff, community mental health staff, or both. Some brief intervention clinics also encourage contribution from students on placement (e.g., psychology interns, psychiatry registrars, etc.) following training and under appropriate supervision. Models of staffing vary as determined by the service:

- Interest-based model Staff are trained and involved in the brief intervention based on self-selection and interest. This model of staffing promotes the engagement of staff who are motivated to work effectively and compassionately with people with personality disorders and their carers. Sometimes this model can also promote professional development and workforce capacity building, with the opportunity to 'borrow' staff from other associated services and units to contribute to the brief intervention. However, this model of staffing can experience sustainability issues if a core champion or clinician/s move on from the service or experience an increase in time or work pressures, as the brief intervention can be seen as an 'add on' rather than core business. Staffing numbers depend on the context of the clinic, interest of available staff, and expected volume of referrals.
- Whole-of-team approach The whole team is trained in the brief intervention and contribution to the clinic is considered core business as an integrated part of the role. This model of staffing is highly sustainable in integrating the brief intervention into the broader service and recognising the treatment of people with personality disorder as everyone's responsibility.

However, this model may encounter increased difficulties with resistance from some staff and may require strong leadership directives to establish new expectations. This approach also requires thoughtful consideration of ongoing training opportunities for new staff.

- Integrated approach The brief intervention clinic can be integrated into the core business of longer-term treatment programs (e.g., within the Dialectical Behaviour Therapy team), and function as both an initial step in the overall model of care and an opportunity to assess for eligibility for referral to the longer-term program. This staffing profile may ensure that the brief intervention is well integrated into a larger stepped model of care and facilitate seamless referral through-care options. However, this staffing profile may also limit participation from mental health professionals outside of the specialised team and may contribute to the perception that people with personality disorders are not core business across broader mental health services.
- Stand-alone brief intervention clinic There have been a small number of sites that have resourced dedicated brief intervention clinic positions to function as the coordinator and primary clinician offering the model of care. Where the funding is permanent and ongoing, this can be a sustainable option and strong demonstration of commitment from the executive. However, this may again contribute to the perception that the treatment of people with personality disorders are not core business across the broader mental health service and may experience difficulties if the position becomes vacant.

It can be useful to note that the brief intervention provides a stepped model of care for clients who are already accessing the service and require follow up. Therefore, it does not result in increased workload, and in many cases does not require increased staffing. Rather, it provides a manualised, evidence-based and structured framework of an effective time-limited intervention based on the here-and-now crisis, allows assessment of the client needs and readiness for further intervention, and referral to other appropriate community-based services. As such, the brief intervention provides a structure for clinicians to use with the clients they are already seeing in the service.

The brief intervention can be delivered by a variety of practitioners, including psychologists, school counsellors, case managers, social workers, mental health peer workers, mental health nurses, psychiatrists and family therapists. Clinicians implementing the brief intervention should be adequately qualified, trained and be engaged in regular clinical supervision.

Clinician rostering and appointment schedule

Services have successfully adopted various approaches to rostering the sessions of the brief intervention depending on the staffing structure. Some examples are:

- Structured clinic approach Set appointment times are established in the brief intervention calendar (e.g., 11am on a Tuesday and Thursday) for the first session, then clinicians arrange the subsequent appointments. Clinicians are rostered to an initial appointment time based on a queue system. Referrals may be managed with direct access to a calendar for referrers or by the team administering the clinic. This option can facilitate increased engagement (e.g., the client can be offered an appointment whilst at the Emergency Department) and ensure availability of resources (e.g., permanent booking of a therapeutically-oriented room for the nominated session date/time). However, this approach can result in longer waiting times for an initial appointment (e.g., if both appointment times are already booked for the week), and lower clinician confidence (e.g., if a client does not show to the initial appointment and the clinician then needs to wait until their next rostered clinic, depending on the team size this can result in an extended time between brief intervention clients). This approach also requires

careful monitoring by the coordinator to ensure rostered clinicians are available at the nominated appointment time.

- Informal or standard allocation Clients eligible for the brief intervention clinic are identified in-house during the routine allocation meeting or triage system. Allocation is then determined by clinicians volunteering, or a queue system. It is then the clinician's responsibility to contact the client and arrange an initial and subsequent appointment time. This system can be beneficial in enhancing appointment flexibility and ensuring rapid follow up. However, voluntary allocation can result in difficulties identifying clinicians to accept referrals if other workload pressures take priority.
- Core business approach The intervention is treated as a core treatment option and allocated along with all other referrals in the standard allocation meeting as per the usual process. This rostering system usually corresponds to a whole-of-team staffing profile. This approach can increase flexibility in appointment opportunities, enhance rapid follow up, and can be particularly beneficial in ongoing sustainability. However, this approach retains some of the issues in possible resistance from some staff, in particular during the initial redesign phase. This approach often requires strong executive support, and ongoing engagement with the whole team to ensure that the brief intervention clinic is integrated into core business in a successful and sustainable way.

Sustainability: Thinking long-term from the start

Planning for sustainability

Planning for sustainability of the brief intervention clinic at the outset is vital to the successful establishment of the model. This may include ensuring clear and endorsed operationalisation, coordinator succession planning, clear data dissemination and communication pathways, and ongoing recruitment and training of clinicians to contribute to the intervention.

Sustaining change in the long-term requires monitoring and maintenance. Barriers to ongoing implementation need to be identified and addressed over time. Change agents may benefit from feedback, recognition, or encouragement to continue to champion the project. Long-term sustainability may also benefit from diversifying ownership of the redesign, to ensure all levels are engaged and committed to continuing the project. This may include formalising the redesign and stepped care model through the generation of endorsed Business Rules, establishing a regular Steering Committee or reporting framework, allocating dedicated group supervision opportunities, and thoughtfully considering how the redesign will fit into the broader service including establishing strong links with referral pathways and any new projects and innovations that arise. Continued efforts to engage and formalise the redesign will ensure sustainability if key champions should move on from the service.

Succession planning for key roles

Planning for succession may assist to sustain a brief intervention clinic in the event of staff absence or turnover. Key roles to consider in integrating succession planning include key champions, such as the coordinator and the consultant psychiatrist as required for governance.

Succession planning for the coordinator role

Succession planning for the coordinator role is essential to maintain a sustained model of care. Examples may include:

- Ensure localised Business Rules are developed, endorsed and available to be handed over to a new coordinator
- Offer the opportunity for staff to shadow the coordinator role
- Consider rotating the coordinator role for a pre-determined period (e.g., every year) to upskill staff
- Offer opportunities for other staff to temporarily fill the coordinator role during periods of absence.

Succession planning for governance roles

Strong leadership support is essential across the continuum of the brief intervention clinic. This includes executive support, and governance structures often via a consultant psychiatrist. Succession planning can include:

- Ensure localised Business Rules are developed and endorsed by the senior executive to demonstrate support for the clinic
- Consider gathering support from consultant psychiatrists in other areas who may be willing to provide consultancy and governance support during periods of need

- Integrating the brief intervention clinic into existing community or acute mental health care team structures to ensure ongoing consultant governance
- Arrange regular (e.g., yearly) reporting meetings with senior management, including outcomes on service utilisation, quality assurance and outcomes.

Quality assurance

Evaluation data and lived experience feedback regarding the benefits of the redesign can assist in promoting sustainability, providing opportunities for review, quality assurance, and reporting to senior management on the implementation outcomes. Evaluation data can also assist in advocating for continued prioritisation of the brief intervention clinic and additional resourcing as needed. Among other outcomes, this may include cost-benefit analysis, staff satisfaction, and client and carer feedback.

Project Air Strategy continues to evaluate the effectiveness of the brief intervention clinic in various ways. Previously, this has included the use of measures of distress, suicidal ideation, symptom severity and quality of life (see Huxley et al., 2019; Bartsch et al., 2024). Outcome analysis has also used chart review, hospital admission and acute service presentation rates (see Grenyer, Lewis, Fanaian, & Kotze, 2018; Bartsch et al., 2024). Other research has also used open-ended questions or interviews (see Grenyer & Bailey, 2024; Bailey, Knowles & Grenyer, 2023).

Services may wish to collect data to evaluate the brief intervention clinic implementation and overall stepped model of care locally for quality assurance and reporting purposes. This may include monitoring the rate of referrals and attendance, how quickly the client is able to be seen in the brief intervention clinic, how many clients are retained by the service, and what through-care referrals are provided. An example tracking tool is provided (see Appendix D). Qualitative and quantitative measures are often helpful in seeking client feedback and clinician satisfaction in the brief intervention model and service redesign.

It can be helpful to consider existing frameworks to support the evaluation approach. One example is the RE-AIM framework, which proposes evaluation across 5 dimensions (reach, efficacy or effectiveness, adoption, implementation, and maintenance) occurring at multiple levels (individual, clinic/organisation, community; see https://re-aim.org/):

- Reach: The representation of individuals willing to engage in the intervention (and those who are not)
- Efficacy or effectiveness: The impact of the intervention on important indices of improvement either in optimal controlled conditions (efficacy) or real-world applications (effectiveness)
- Adoption: The number of settings (e.g., sites, clinics) and agents (e.g., clinicians) that have implemented the intervention
- Implementation: Fidelity to the intervention's key components and consistency of delivery, and any adaptations
- Maintenance: The integration of the intervention into routine practice as a sustainable model of care. Also refers to the maintained benefits of the intervention for the client.

Supervision and case consultation

Current guidelines (Project Air Strategy for Personality Disorders, 2015b; National Health and Medical Research Council, 2012) emphasise the importance of supervisory processes for staff who are involved in the care of people with personality disorders. It is recognised that many disciplines have their own processes for the provision of supervision, however dedicated case consultation in working with people with personality disorder in the brief intervention clinic is beneficial. Weekly, or at a minimum, fortnightly individual supervision or case consultation is recommended. Group clinical supervision and peer consultation is also recommended to develop a localised community of practice. This can assist with the management of personal reactions and effective communication within teams. Planning supervisory or case consultation processes from the outset of clinic development can be useful to enhance clinician motivation and retention. Alternative models of supervision, such as mentoring or co-therapeutic approaches can also assist in developing staff confidence and fidelity to the model.

Resources to support implementation and sustainability

Contextual factors that influence the successful implementation of redesign are varied. These may include updates to clinical practice guidelines, funding or political priorities, policies and regulations, and integration with community resources.

Specific to the brief intervention, this may include:

- Ensure the intervention is consistent with clinical practice guidelines, including local implementation and sharing of new best practice principles
- Adaptation to compliment new alternative pathways of care
- Ensure the intervention fits within the broader organisational policies
- Engage local community resources in supporting the intervention, including joint consultation as needed, cross-referrals, opportunities for step-up or step-down referrals
- Engage with families and carers to support the client in attending the brief intervention
- Disseminate broad information about the aims of the intervention, access and referral pathways, and evidence-base.

Brief interventions are supported by the Project Air Strategy who ensure that the model is consistent with contemporary evidence-base and best-practice guidelines. Project Air Strategy also supports the brief intervention clinics through a range of resources to ensure successful implementation and sustainability, adherence and relevancy, and connection to a larger network of brief intervention clinics outside of the local region.

Air Academy

The Project Air Strategy Air Academy is a community of practice forum for brief intervention coordinators and senior leaders to meet and discuss implementation including sharing expertise and local solutions. The Air Academy provides support to ensure brief intervention clinics are sustainable, adherent, and continues to deliver leadership and support to ensure best practice. The Air Academy provides an opportunity for local brief intervention coordinators to access professional development, updates on evidence-base and scientific findings, enhance clinical knowledge, access resources, and opportunities for consultation that they can then convey back to their broader team.

The Air Academy, organised on a hub and spoke model, is served by a central coordinating service at the Project Air Strategy headquarters, and engages with health service senior executive, service managers, clinical directors, coordinators of stepped care and brief intervention clinics, personality disorder services and provides ongoing guidance and leadership to support best-practice.

The Air Academy helps to:

- Maintain strong links between the Project Air Strategy team and local brief intervention clinic coordinators
- Provide an opportunity for coordinators to meet each other, share their expertise and local solutions
- Provide access to training and train-the-trainer resources to support local staff development and training needs within the clinics
- Provide updates on evidence-based practice, scientific findings, and opportunities for consultation and professional development
- Motivate staff to maintain compassionate care for clients and their families with personality disorder and complex needs.

The Air Academy provides a number of supports and resources. Examples include:

- Connects a community of practice, linking coordinators with a broader network to support best-practice, and share resources and projects
- Access to bespoke support to provide individualised guidance and resources for launch, re-launch, and sustainability via the Project Air Strategy Implementation Coordinator
- Provides professional development specific to Academy Fellows, including train-the-trainer resources, to ensure local implementation teams have the resources to support clinicians on the ground
- Access to latest research and treatment developments through invited attendance at the Project Air Strategy annual conference
- Opportunities to contribute to ongoing research to inform service development and evidence-based practices
- Ongoing access to e-learning professional development, webinars and online resources through the Project Air Strategy website.

Resources

See the Project Air website (www.projectairstrategy.org) for manuals, guidelines, factsheets, worksheets, e-learnings, webinars, videos and other useful resources.

Service promotion

The accompanying *Brief Intervention Clinic Manual* (2015a) provides an example poster for display in acute and community services waiting rooms. This is also available in brochure format (see Appendix F). Further resources regarding the promotion of brief intervention clinics through in-services are provided to coordinators via the Air Academy.

References

Bailey, R. C., Knowles, N. G., Grenyer, B. F. S. (2023). Efficacy and recommendations for the delivery of telehealth psychotherapy for people with personality disorder. *Australasian Psychiatry, 0* (0), 1-10.

Bartsch, D. R., McLeod Everitt, C., Bednarz, J., Ludbrook, C., & Cammell, P. (2024). A state-wide initiative to improve health system responses to people with borderline personality disorder symptoms in crisis: A retrospective audit. *Journal of Personality Disorders, 38* (1), 87-108.

Grenyer, B. F. S. (2014). An integrative relational step-down model of care: The Project Air Strategy for Personality Disorders. *The ACPARIAN*, *9*, 8-13.

Grenyer, B. F. S., & Bailey, R. C. (2024). Implementing a whole-of-service stepped care approach to personality disorder treatment: Impact of training and service redesign on clinician attitudes and skills. Personality and Mental Health, 1–14. https://doi.org/10.1002/pmh.1612

Grenyer, B .F. S., Lewis, K. L., Fanaian, M., & Kotze, B. (2018). Treatment of personality disorder using a whole of service stepped care approach: A cluster randomized controlled trial. *PLoS ONE, 13* (11).

Huxley, E., Lewis, K. L., Coates, A. D., Borg, W. M., Miller, C. E., Townsend, M. L., Grenyer, B. F. S. (2019). Stepped care whole of service model for personality disorder. *BMC Psychiatry, 19*, 341.

Pigot, M., Miller, C. E., Brockman, R., Grenyer, B. F. S. (2019). Barriers and facilitators to the implementation of a stepped care intervention for personality disorder in mental health services. *Personality and Mental Health*, *13*, 230-238.

National Health and Medical Research Council (2012). *Clinical practice guideline for the management of Borderline Personality Disorder*. Melbourne: National Health and Medical Research Council.

Project Air Strategy for Personality Disorders (2015a). *Brief intervention manual for personality disorders*. Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute.

Project Air Strategy for Personality Disorders (2015b). *Treatment guidelines for personality disorders* (2nd Ed.). Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute.

Project Air Strategy for Personality Disorders (2018). *Adolescent intervention: Guide for clinicians*. Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute.

Project Air Strategy for Personality Disorders (2019). *Adolescent brief intervention manual for complex mental health issues: Responding to emerging personality disorder, trauma history, self-harm and suicidal behaviour*. Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute.

Project Air Strategy for Personality Disorders (2023). Virtual Gold Card Clinic Manual. Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute.

Appendix A: Example Brief Intervention Business Rule – 1

Modified by manual developers for use as an example

Referrals:

- Access to the brief intervention clinic is via referral to the acute care team.
- The acute care team is responsible for decision making regarding suitability and booking initial appointments. This will be done through the standard clinical review processes involving the multidisciplinary team and consultant psychiatrist.
- Upon referral to the acute care team, referring parties may identify the brief intervention as a possible referral option but should not set firm expectations of this with clients, as determination of suitability will be done by the acute care team.
- The acute care team's position within the health service, as the assessment site for acute presentations in the community, remains unchanged. The brief intervention is one follow up option.
- The team leader will be responsible for managing the list of brief intervention clinicians. Both the team leader and staff during daily handover will identify suitability of clients to participate in the brief intervention.

Clinic Appointments:

- The brief intervention program allows for 3 x weekly sessions, plus the option for a 4th session which is for the client's carer.
- An appointment will be given to a client and the brief intervention clinician is allocated via the clinician queue list.
- Initial appointment times will vary dependent on clinician requirements.
- When the clinician has accepted the client for the brief intervention, it is the clinician's responsibility to book the appointment and room with the client.
- It is the allocated clinician's responsibility to check their respective clinic times and to be prepared for bookings at short notice.
- Follow-up appointments are negotiated between client and clinician – these appointment times are to be updated on the electronic medical record system.
- If a clinic is cancelled, it is the brief intervention clinician's responsibility to contact the client to re-schedule.

Care Management:

- A list of current clients receiving follow-up via the brief intervention will be maintained alongside the acute care team client list through the electronic medical record system. Names will be entered on to this board by the acute care team upon booking the initial brief intervention appointment, and discharge in the electronic medical record following clinical review at the end of brief intervention involvement.

- The clinician allocated for the initial appointment becomes the key worker. This role involves coordinating subsequent appointments, being the contact person during office hours, updating information on the electronic medical record, and initiating clinical reviews at appropriate points.
- If an allocated brief intervention clinician is not available in a reasonable timeframe, responsibility for follow up will revert to the acute care team.
- It is an expectation that clients should not require clinical contact between brief intervention sessions. If a client is having multiple contacts with the allocated brief intervention clinician and/or the acute care team, this is reasonable grounds for the clinician to initiate a clinical review and consider follow up options alternative to the brief intervention clinic.

Clinical Review:

- The acute care team consultant psychiatrist provides clinical governance for the brief intervention clinic.
- A clinical review is a discussion with the acute care team consultant to discuss and confirm risk status and treatment plan. It may or may not involve the full multidisciplinary team.
- Clinical review is completed by the acute care team prior to booking to determine suitability for the brief intervention.
- Subsequent clinical review should occur between the allocated brief intervention clinician and acute care consultant psychiatrist as needed, including discussion as soon as it is deemed appropriate for the client to be discharge from the brief intervention clinic.
- Clinical review should occur when:
    - The final brief intervention appointment has been completed
    - Risk escalates
    - The client does not attend or disengages
    - The allocated clinician or acute care team determines that either the brief intervention is inappropriate and/or alternative follow-up would better meet the client needs.

Additional supports:

- The Project Air website has resources for clinicians, clients and carers.
- As the implementation phase matures, the brief intervention clinic working party will evolve into a peer group capable of providing monthly group supervision.
- Acute care Team Leader provides corporate governance.

Suitability: (the following is a guide and should not be considered absolute or exhaustive)

- The brief intervention identifies a focus on (it is expected that one of the below areas will be central to the reason for presentation);
    - Relationship difficulties
    - Changing emotions and strong, overwhelming feelings
    - Problems with identity and sense of self
    - Impulsive and self-destructive behaviour
    - Thoughts and feelings of suicide
    - Personality disorders

- Recent crisis presentation.
- Levels of risk and changeability appropriate for short term, weekly follow up.
- Other reasons to consider brief intervention clinic;
    - Client has consistently failed to engage with longer-term therapies despite their indication.
    - First presentation of this type.
    - Limited engagement.
    - Limited motivation.
- Exclusions (the brief intervention clinic should not be considered when);
    - The primary presenting problem suggests that other pathways of care would be more suitable.
    - A substance use problem is the primary presenting problem.
    - A significant intellectual or developmental disability is affecting the presentation.
    - A client who is currently engaged with other care providers for these issues.

Appendix B: Example Brief Intervention Business Rule – 2

Modified by manual developers for use as an example

Name	Brief intervention clinic referral, intake, intervention, discharge and rostering processes.
Risk Rating	High.
What it is	An outline of the procedures involved in making referrals to the brief intervention clinic, the intake and intervention processes, the process by which clients are discharged or transferred to other services, and rostering needs.
What to do	**Overview** The brief intervention clinic is a rapid follow up service for clients with evidence of personality disorder or traits in the defined catchment area who have recently experienced a mental health crisis involving self-harm, suicide ideation, or other maladaptive emotion regulation behaviours. The brief intervention clinic aims to offer an appointment within 1-3 working days of referral. It offers 4 sessions with the same clinician, aiming to address psychological and lifestyle factors that contributed to the crisis. One of these sessions (usually Session 3) is reserved as a carer/partner/family education and support session. This ensures carers, partners, and/or families are included in the intervention. The key aims of this intervention: • Timely response to people seeking treatment in crisis. • Brief intervention to address the client's immediate needs and help the client to understand their difficulties and solve their problems. • Tools and strategies to help the client prevent and better manage future crises. • Opportunity to assess the client's needs, including the possible need for other services where necessary. • Opportunity to connect with the person's family, partner or carer. • Treatments with an evidence-base that are effective with people with personality disorders. • Alternative to acute inpatient admissions and/or facilitate early discharge. • Alternative to lengthy and infinite Psychology Team or Case Management referral. • Reduction in acute care brief intervention demands. The brief intervention clinic will operate during the usual opening hours of [Local] Community Mental Health Services (Monday-Friday, 0830-1700) and will not operate on weekends or public holidays.

Referrals

Referrals to the brief intervention clinic can only be made by the acute care team via the usual service pathways: Emergency Department assessment, booked assessment, and transfer of care from other services such as early acute inpatient discharge (provided a comprehensive assessment was completed).

Eligibility criteria

- Youth through to and including older adults (aged 12 and upwards) with evidence of personality disorder or traits presenting in crisis as manifested by self-harm, suicide ideation, or other maladaptive emotion regulation behaviours.
- The client's risks are sufficiently low enough to permit safe community treatment. For the majority of referrals, this would not require regular acute care team support, but there may be instances where this is clinically indicated.

Exclusion criteria:

- Urgent referrals (outlined in the Mental Health Triage Policy).
- Evidence of primary presenting concern of psychosis.
- Evidence of a primary alcohol/drug dependence disorder.
- Delirium.
- Dementia.
- Primary diagnosis of brain injury.
- The client is already engaged in other psychology interventions and the brief intervention clinic would be counterproductive or disruptive. It will be the responsibility of the acute care clinician to consider this in the assessment prior to referral, and address why the client is still being referred to the brief intervention clinic. The brief intervention clinician may need to consider contacting the private psychologist to negotiate a plan to mitigate dual servicing. This may require suspending private psychologist sessions while a brief intervention is in progression and transferring care back to the private psychologist at the end of the intervention.
- The client has already accessed the brief intervention within a 6-month period.

Referral Procedure:

General:

- Acute care will be the team who identify and submit all brief intervention clinic referrals.
- Gold referral cards will be used and provided to suitable clients to ratify all brief intervention clinic referrals.
- The brief intervention clinic will utilise the shared calendar system within Microsoft Outlook for all initial appointments. Subsequent sessions (sessions 2-4) are arranged privately between clinician and client.

Acute care clinicians are given 'editor' access within Microsoft Outlook, enabling them to edit pre-existing appointment information in the shared calendar system. This will enable them to assign a client to a rostered clinician in order to "book" the appointment.

- All first brief intervention appointments require the acute care clinician to advise the client to present 20 minutes prior to the Outlook appointment time (to complete an intake survey). For example, for adult brief intervention appointments, the client will need to be advised the appointment time is 2:10pm in preparation for their 2:30pm session with the clinician.

Emergency Department Assessments and Reviews:

- If the client appears suitable for the brief intervention clinic, the assessing acute care clinician discusses this with the on-call psychiatrist during the regular care plan phone discussion, prior to ending the session with the client. The acute care clinician can then offer the client a brief intervention appointment and provide them with a gold referral card outlining the appointment date, time, and clinician name according to the brief intervention clinic availability in Outlook.

Booked Assessments:

- The acute care clinician uses their clinician autonomy during booked assessments in identifying suitable brief intervention clinic referrals. The acute care clinician can then offer the client a brief intervention appointment and provide them with a gold referral card outlining the appointment date, time, and clinician name according to the brief intervention clinic availability in Outlook.
- Contacting the acute care manager or on-call psychiatrist to discuss brief intervention clinic referrals would only be necessary in instances of heightened risk, complicated presentations, or other 'grey area' circumstances.

Booking a Brief Intervention Clinic Appointment:

- The acute care clinician 'books' the appointment by selecting the relevant slot in Outlook and entering the client's details.
- As a failsafe, the acute care clinician also emails the brief intervention clinician the client's name, medical record number, and appointment details to advise that an appointment has been booked. The acute care clinician must also Cc administration by using the generic administration email address so as the client's file can be prepared for their first appointment.
- The acute care team adds the client to the brief intervention clinic section of the Intake Board.

General Brief Intervention Clinic Process

Session 1:

- The client will present to Mental Health Reception with their gold referral card, 20 minutes prior to their first appointment.
- The receptionist gives the client pre-intervention surveys (as required) in a quiet space of the Mental Health/D&A waiting rooms.
- The receptionist will contact the brief intervention clinician.
- The brief intervention clinician attends Mental Health Reception and escorts the client to the allocated treatment room.
- The brief intervention clinician completes the relevant documentation and measures in the client's electronic medical record following the appointment.

Sessions 2-4:

- The brief intervention clinician independently books an appointment time that suits client/clinician (or carer/clinician if session 3) and books an available consultation room.
- The brief intervention clinician completes the relevant documentation and measures in the client's electronic medical record following the appointment.

Non-attendance at Brief Intervention Clinic Appointments

- It will be the responsibility of the brief intervention clinician to contact the client or carer if they fail to attend an appointment to explore the absence and reschedule.
- If concerns emerge over the phone regarding mental status, a risk assessment will need to occur, along with a suitable accompanying care plan to manage any risks.
- In the instance of missed appointments and/or difficulty contacting a client, the following hierarchy of contact attempts should be followed:
    1. Phone call attempt, voicemail message, and regular text message (from a work phone).
    2. If no reply contact after a few days, contact the client's carer (if there is pre-existing client consent to do so).
    3. If no outcome from points 1 and 2 after waiting a week, mail the client a brief letter requesting reply contact. Notify the client in the letter that their brief intervention clinic referral will be closed if no reply communication is received by *X date* (10 days from the date the letter was posted). Re-presentation and acute pathways to service details should be outlined in the letter as per usual templates.
- The Mental Health Reception number should be the only return contact number provided to any clients or carers. This will need to be made explicitly clear to the client/carer, particularly in the instance of any text messages, to avoid the client/carer developing a false expectation that they can contact you for urgent matters on a work mobile.
- If after the aforementioned contact attempts there is still no connection with the client, the brief intervention clinician may consider:
    1. Discussion with the acute care team triage worker/manager to determine any benefits in requesting acute support. This may afford additional follow-up resources.
    2. Discussion with the acute care team psychiatrist about unplanned discharge and proceeding with any regular discharge procedures (see Discharge Procedure below).
- Clearly document details of all contact attempts and clinical actions, along with any outcomes obtained.

Referral to crisis services

Acute care and brief intervention clinicians should make clients aware of out-of-hours and self-help pathways to crisis services such as the Mental Health Line and presenting to the Emergency Department. If the client's risk variables increase during the brief intervention, the clinician considers:

- Increasing community supports for the client such as liaising with the carer/family for increased monitoring and assistance.
- Speaking with the acute care triage worker/manager about requesting additional acute care support.
- Contacting the on-call psychiatrist to discuss an acute inpatient admission.
- Contacting emergency services in the event of an extremely urgent community response.

If the brief intervention clinician identifies any risk to a child they should consider:

- Completing the online Mandatory Reporter Guide (and following any recommended actions).
- Contacting the NSW Health Child Wellbeing Unit.
- Contacting the Family and Community Services notification line.
- Contacting emergency services in the event of immediate risk of harm concerns.

Discharge Procedure

- If the client appears suitable for discharge, the brief intervention clinician must contact the acute care psychiatrist to discuss this plan.
- If the client is being discharged from the service, the brief intervention clinician must complete all required documentation, including on the client's electronic medical record and on the tracking sheet.

In addition to the aforementioned discharge processes, the brief intervention clinician will carry out a careful and collaborative consideration of further treatment and support options with the client and, where possible, with carers, family members and partners. This may include:

- Provision of resources and information about non-government organisations and government services, peer and carer supports, and local specialist clinicians. This may include formal referrals.
- Liaison with primary health (e.g. General Practitioners) to facilitate arrangements for follow-up in primary care and private psychology referral pathways.
- Liaison with identified local specialist clinicians to facilitate transition into longer-term treatments.

	Documentation There are 4 key documents which require completion for the brief intervention clinic: • All required assessment and session documentation on the client's electronic medical record. • All required client-rated outcome measures, including monitoring client improvement, and for specific research and/or quality assurance projects. • All required clinician-rated outcome measures. • All required discharge documents on the client's electronic medical record. **Rostering** • Brief intervention clinicians will generally operate according to a 6-week rostering system, meaning they should complete a single client brief intervention within 6 weeks. • If a brief intervention clinician is taking planned or unplanned leave, it is his/her responsibility to manage any existing brief intervention rostering requirements. This will include swapping with another clinician, updating the roster, and updating the shared calendar booking system in Outlook. The brief intervention coordinator should also be emailed.
When to use it	When considering a brief intervention referral and at all stages of the brief intervention.
Why the rule is necessary	To ensure consistency is applied to the processes underpinning the brief intervention and to promote safe and effective clinical practice.
Who is responsible for (Stakeholders)	Executive and Team Managers/Nurse Unit Managers are responsible for disseminating the Business Rule and all clinical staff referring to or working for the brief intervention are responsible for implementing the Business Rule.

Appendix C: Example ‘Gold Card’

Appendix D: Example Tracking Tool

Client Identifier (e.g., name or medical record number)	DOB	Sex	Referred	Referral source	Brief intervention 1st appt offered	No. of Days between referral and offer	Allocated clinician	Date First appt	# Appts attended	Carer session? (Y/N)	Discharge/ last appt	Length of GCC (days)	# missed appts	Outcome/ Discharged to	Research consent
1	1/03/1980	F	01/01/2022	Emergency Department	03/01/2022	2	Jo Smith	03/01/2022	3	Y	24/01/2022	21	0	DC GP	Y
2						0						0			
3						0						0			
4						0						0			
5						0						0			
6						0						0			
7						0						0			
8						0						0			
9						0						0			
10						0						0			
11						0						0			

Appendix E: Example Gold Card Clinic Checklist

[Include any useful local operational or administration steps here] ☐

Session 1

Materials:

[Include completion of any baseline measures here] ☐

[Include any required consent form completion here] ☐

[Include any standard brochures or written information here] ☐

Project Air Care Plan ☐

Session Tasks:

Build rapport and focus on developing a positive therapeutic relationship ☐

Set the frame for treatment ☐

Provide information on the purpose of the intervention ☐

Understand what led to crisis and provide space to talk ☐

Begin Care Plan, focusing on ('my crisis survival strategies') ☐

Conduct a risk assessment ☐

Provide psycho-education ☐

Discuss carer session and connect with carers if applicable ☐

Discuss need and ascertain willingness for further appointments ☐

Encourage the client to think more about their values and goals ☐

After Session:

[Include after session tasks here – for instance required record keeping] ☐

[Include after session tasks here – for instance attend handover] ☐

Session 2

Materials:

- [ ] Handouts (refer to Project Air website and include any relevant)
- [ ] Client's Project Air Care Plan

Session Tasks:

- [ ] Further engage the client
- [ ] Discuss the client's goals and values
- [ ] Develop Care Plan further, focusing on "my main therapeutic goals and problems I am working on"
- [ ] Provide an opportunity for the client to discuss any issues
- [ ] Provide psycho-education about the development and maintenance of specific symptoms or issues
- [ ] Conduct a risk assessment
- [ ] Encourage the client to begin to think about their plans after the intervention sessions are complete. Flag this to discuss further in session 4
- [ ] Provide psycho-education on the benefits of longer-term treatment for people with more enduring problems (if clinically indicated)
- [ ] Continue Care Plan

After Session:

- [ ] [Include after session tasks here – for instance required record keeping]
- [ ] [Include after session tasks here – for instance attend handover]

Session 3: Carer Session

Materials:

- [ ] Handouts relevant to session (refer to Project Air Strategy website)
- [ ] Project Air Carer Plan

Session Tasks:

- [ ] Set the frame of the session including aims, purpose and confidentiality issues
- [ ] Build rapport and focus on the needs of the carer
- [ ] Assess the carers current needs and responses to the client's recent crisis and provide a space for them to talk
- [ ] Develop a Carer Plan with the carer for their own self-care
- [ ] Provide information and education regarding mental health, personality disorders, self-care and navigation of the mental health system including who to call in a crisis
- [ ] Discuss need, and ascertain willingness, for referral to family and carer services

After Session:

- [ ] Action any referrals as indicated and agreed
- [ ] [Include after session tasks here – for instance required record keeping]
- [ ] [Include after session tasks here – for instance attend handover]

Session 4

Materials:

- ☐ Handouts relevant to session (refer to Project Air Strategy website)
- ☐ Client's Project Air Care Plan
- ☐ [Include any post-intervention measures here]

Session Tasks:

- ☐ Discuss the clients future plans further
- ☐ Consider and discuss future treatment options
- ☐ Conduct a risk assessment
- ☐ Finalise the Care Plan, focusing on "my support people" section and relapse prevention strategies and skills
- ☐ Ensure client has completed Care Plan and take a copy to be kept in the medical record
- ☐ Link the client with other services, and provide referrals if needed

After Session:

- ☐ Action any referrals as indicated and agreed
- ☐ Send a letter to General Practitioner and client, including details of referrals actioned
- ☐ Close file and process discharge in medical records where appropriate
- ☐ [Include after session tasks here – for instance required record keeping]
- ☐ [Include after session tasks here – for instance attend handover for discharge]

Appendix F: Example brochure

What is the Gold Card Clinic?

THE GOLD CARD CLINIC is a brief intervention service that offers people in crisis a set of specific individual appointments. During these sessions, an experienced clinician will talk with you and provide support, help you navigate your way through the crisis, and link you into further services as needed.

Gold Card Clinic

Contact

www.projectairstrategy.org

Crisis & Emergency Contacts
DIAL 000
LIFELINE 13 11 14
NSW MENTAL HEALTH LINE 1800 011 511

gold card clinic

NSW Health

PROJECT AIR

Who can attend the Gold Card Clinic?

THE GOLD CARD CLINIC provides help for young people and adults. You or your local health professional can call your closest service and discuss a referral to the clinic. The clinic works in specific ways so it is important to ensure it will suit your needs.

Who can refer to the Gold Card Clinic?

THE GOLD CARD CLINIC accepts referrals from emergency departments and hospitals and other services such General Practitioners whose clients present in crisis, including with recent self-harm or thoughts of suicide. Where appropriate, clinicians may refer to the Gold Card Clinic rather than sending clients to hospital. Often it is more helpful to refer clients in crisis for community treatment rather than hospital services.

Problems addressed in the Gold Card Clinic

It is normal for people to experience difficulties in life. Sometimes these difficulties may create greater distress than usual and lead to a crisis situation or event. People who attend the Gold Card Clinic often report

- Impulsive and self-destructive behaviour
- Changing emotions and strong, overwhelming feelings
- Problems with identity and sense of self
- Thoughts and feelings of suicide and self-harm
- Challenging personality features

What will I do in the Gold Card Clinic sessions?

An experienced clinician will work with you to:

- Provide support and encouragement
- Explore factors that led to your current situation
- Develop a plan to assist in the prevention of future crises & problems
- Gain clarity on your goals and help you maintain focus
- Provide you with additional information and resources to aid your recovery
- Link you into other services where desired