Project Air Strategy Virtual Brief Intervention Manual

PROJECT AIR

A PERSONALITY DISORDERS STRATEGY

Project Air Strategy for Personality Disorders (2023). Virtual Brief Intervention Manual. Wollongong: University of Wollongong.

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ISBN: 978-1-74128-399-0

Accompanying Resources:
This resource supports the accompanying clinician manuals describing the brief intervention by providing guidance on specific adaptations required for virtual mental health care:

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)

Project Air Strategy for Personality Disorders (2024). Guide to implementing and sustaining a brief intervention clinic. Wollongong: University of Wollongong. (Available here)

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Definitions:

Carers
This term is used broadly to describe the client's legal guardians, parents, family members, cultural elders, mentors, partners, spouses, friends or the client's main support person.

Client
This term is used to describe the individual who is the focus of treatment. This manual has been designed for use with young people and adults.

Emerging Personality Disorder
Young people who exhibit a constellation of behaviours and problems (e.g. emotion dysregulation, physical and verbal aggression, self-harming behaviours, low self-esteem, difficulties making and keeping friends, family dysfunction, learning problems, trauma symptoms) which taken together have been understood here as youth with emerging personality disorder.

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 personality traits that are maladaptive, inflexible, and pervasive in a number of contexts over an extended duration of time, causing significant distress and impairment.

Young Person
This term is used to describe children and adolescents between the ages of 9 and 18 years.

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 the virtual brief intervention

This manual aims to help services in delivering timely, accessible, flexible, equitable, safe and effective support to young people and adults with personality disorders or traits by using virtual platforms of care. It is now recognised that services need to incorporate flexible ways of connecting with clients and carers to increase accessibility and allow continuity of care. This manual outlines the considerations inherent in adapting the brief intervention into a virtual model of care.

The brief intervention for personality disorders is particularly focused on supporting clients with complex needs in crisis, by providing practical therapeutic techniques in the prevention and treatment of high-risk challenging behaviour. It is often the first opportunity to provide effective and compassionate care and can be the first step in a treatment journey for clients with personality disorder. Many sites use the name 'Gold Card Clinic' for the brief intervention approach. Whilst this manual describes the use of virtual platforms of care for the brief intervention specifically, it is likely that some of these principles could apply to the virtual treatment of people with personality disorder more broadly in a larger stepped model of care.

This manual focusses on the considerations for adapting the brief intervention into a virtual modality. The brief intervention for personality disorders is described in detail elsewhere, including the supporting guidelines and evidence-base, implementation and sustainability, clinical structure and session-by-session application. See the associated resources for more detail:

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 early to emerging personality disorder, trauma history, self-harm and suicidal behaviour. Wollongong: University of Wollongong, Illawarra Health and Medical Research Institute. (Available here)

Project Air Strategy for Personality Disorders (2024). Guide to implementing and sustaining a brief intervention clinic. Wollongong: University of Wollongong. (Available here)

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. (Available here)

The virtual brief intervention provides a rapid and accessible intervention that can:

- Provide rapid service delivery by overcoming accessibility barriers in providing the option for virtual engagement
- Provide brief, time-limited and accessible interventions aimed at addressing the immediate crisis that led to a deterioration in functioning
- Provide an alternative to hospitalisation or facilitate early discharge
- Provide a flexible approach to service delivery, integrating virtual models of care to increase accessibility
- Enhance client choice in the modality of service utilization which promotes agency and engagement
- Help services manage high volumes of client presentations, reduce waiting times, and provide triage and referral to other services based on changing needs and risks
- Promote early intervention and provide rapid psychological care to reduce the risk of escalation to severe incidents
- Act as an intermediate point between acute settings and longer-term treatment programs

- Enhance community outreach and equity of service provision by providing effective virtual treatments to clients in rural and remote communities, or clients with other prohibitive barriers to in-person mental health care
- Ensure positive messages are provided to clients, carers and health staff with regards to the treatment for people with personality disorders
- Engage clients with personality disorder who may prefer virtual platforms of care and may otherwise be lost to follow up.

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

- Increasing engagement with family members and carers who would otherwise experience prohibitive barriers to engaging with the service
- Connecting with family and carers in a flexible way 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 psychoeducation 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 virtual brief intervention can support clinicians and services by:

- Enhance rapid follow up of clients in crisis by removing accessibility barriers to engagement
- Provide opportunities to enhance metro, rural and remote service delivery
- Enhance clinician efficiencies by providing flexible mental health care
- Enhancing capacity building by engaging the workforce in opportunities to provide a structured and evidence-based approach to the treatment of people with personality disorder through virtual platforms of care
- Provide opportunities for professional development through broader opportunities for contribution to the virtual brief intervention across teams and/or locations.

The Project Air Strategy 'Key Principles of Working with People with Personality Disorder' continue to apply across virtual or in-person engagement:

Key Principles for Working with People with Personality Disorders

- Be **compassionate**
- Demonstrate **empathy**
- **Listen** to the person's current experience
- **Validate** the person's current emotional state
- **Take the person's experience seriously,** noting verbal and non-verbal communications
- Maintain a **non-judgemental** approach
- Stay **calm**
- Remain **respectful**
- Remain **caring**
- Engage in **open communication**
- **Be human** and be prepared to acknowledge both the serious and funny side of life where appropriate
- Foster **trust** to allow strong emotions to be freely expressed
- Be **clear, consistent,** and **reliable**
- Remember aspects of challenging behaviours have **survival value** given past experiences
- Convey **encouragement** and **hope** about their capacity for change while validating their current emotional experience

Who should use this manual?

This manual focusses on the adaptation of the brief intervention model ('Gold Card Clinic') to a virtual modality of care. Therefore, this manual is for health professionals who are involved in the therapeutic treatment of young people and adults who present in crisis with complex needs and who show symptoms of a personality disorder. The manual can be used by a variety of practitioners, including clinical psychologists, school counsellors, case managers, social workers, mental health nurses, psychiatrists, and family therapists. Clinicians implementing the intervention described in this manual should be adequately qualified and be engaged in regular clinical supervision. It is recommended that this manual is used in conjunction with the associated brief intervention manuals referenced above.

Using this manual to develop a virtual brief intervention clinic ('Virtual Gold Card Clinic')

This manual may guide the development of a specific brief intervention clinic for people with personality disorder ('Gold Card Clinic'), utilizing the technology of virtual platforms of care. The team delivering the brief intervention may be located within acute services in a mental health setting or community setting linked closely to emergency, acute and inpatient services.

The aims, approach and scope of the virtual brief intervention are similar to those outlined in the accompanying clinical manuals with standard face-to-face modality. (see '*Accompanying Resources*' above; Project Air Strategy for Personality Disorders, 2015; 2019). Additionally, the successful implementation and sustainability of a virtual brief intervention may also be guided by the accompanying manual (Project Air Strategy for Personality Disorders, 2024). However, developing a virtual brief intervention requires additional thought regarding various operational, clinical, risk management and ethical considerations. This Manual aims to outline these specific considerations to guide safe and effective virtual brief intervention delivery.

Virtual platforms of care

Virtual platforms of care may include (but are not limited to) using the telephone or online virtual platforms offering real-time face-to-face interactions by videoconference. It is also possible that some brief interventions may be able to offer a hybrid model whereby some sessions are delivered in-person, and the remaining are delivered virtually based on client need and clinical considerations.

It is likely preferrable for virtual sessions to be conducted by videoconference with the camera function turned on to allow maximal engagement. Some services may prefer to arrange in-person appointments for the initial session where possible to facilitate holistic assessment and establish rapport, and then transition to virtual sessions thereafter. The virtual brief intervention approach allows flexibility across modalities based on client, clinician and service needs.

Referral criteria and eligibility

The referral criteria for a virtual brief intervention remains consistent with the criteria outlined in the standard face-to-face model of care (see '*Accompanying Resources*' above). This includes people who present in crisis with suicidal ideation, self-harm, a personality disorder diagnosis, or traits. Clients with a primary problem of psychosis or drug and alcohol abuse are generally not suitable for this specific approach and may be referred to an alternative service. Furthermore, the program utilises a relational approach, and psychoeducational material is incorporated to encourage the client to gain insight into their issues and situation to action change. Clinicians should consider whether prospective clients have this capacity before proceeding and consider appropriate adaptations for both the person-centred care of the individual client, and in consideration of the virtual platform of care.

The virtual delivery of the brief intervention requires clients to be able to access a stable internet or phone connection, private space for the duration of the session, and willingness to engage in virtual mental health care. Other modalities may be needed (e.g., in-person sessions) should the client be unable to access such requirements following attempted problem solving (see '*Clinical considerations of virtual brief intervention delivery*' below), or if the client is unwilling to participate in virtual delivery of the brief intervention.

Operational considerations of virtual brief intervention delivery

The virtual brief intervention model provides flexibility in mode of delivery. Whilst the brief intervention session outline remains the same as described elsewhere (see *'Accompanying Resources'* above), some of the operational, clinical and ethical considerations are amended to ensure safe and effective virtual delivery. An overview of the strengths, limitations and potential solutions for the virtual delivery of the brief intervention are provided in Appendix A.

Appointment confirmation and orientation

Following referral, the receiving brief intervention clinic ('Gold Card Clinic') should contact the client to confirm appointment arrangements. This initial contact may be most effective via phone, and will need to include the details of the appointment (date, time, clinician name) and virtual delivery details (information on the videoconference platform, any applications or software that needs to be installed prior to the appointment, requirements such as earphones with a microphone, a quiet and confidential space for the duration of the session, whether a parent or carer is needed to be nearby, etc.). This orientation will help to establish the expectations of the virtual brief intervention, and requirements of the virtual delivery. This will also assist clinicians to determine whether virtual delivery is appropriate for the client (for instance, if the client does not have access to a reliable internet connection or does not have a private space for the duration of the session) so alternative arrangements can be made as needed. This phone orientation may be conducted by either the virtual brief intervention coordinator (see Project Air Strategy for Personality Disorders, 2024) or the allocated clinician. However, it is likely that the clinician may find benefit in connecting with the client for the orientation call to start building rapport, enhance engagement and provide continuity of care. An example checklist for the orientation is provided in Appendix B. Engagement in virtual mental health care can be enhanced if reminders are sent at least once prior to their appointment (e.g., a few days before and the morning of the scheduled appointment).

If the orientation is done by phone, it can be useful to send a follow up email highlighting the main points, including the videoconference link, a step-by-step guide on how to access the virtual platform, troubleshooting tips, and contact details in case the client is unable to connect. The follow up email might also remind the client of the importance to set up their space 10 minutes or so prior to the appointment time, such as making sure they have sufficient battery charge on their device, having a glass of water and tissues nearby, making sure they are comfortable and reducing any distractions. This follow-up email could include a formal Service User's Agreement on the requirements and constraints of the virtual brief intervention, including confidentiality and risk considerations. See Appendix C for an example. This agreement could be signed and returned (either electronically or in-person) at the first session or agreed to verbally on the phone. It is a service-based decision as to whether a Service-User Agreement is required for the virtual brief intervention, and these agreements could be made informally.

The orientation also provides an opportunity to begin establishing the frame of the intervention (see '*Setting the therapeutic frame'* below). Importantly, this orientation could include brief information on how risk will be managed through a virtual brief intervention, so that the client is aware of procedures that are in place to support them. Clarity regarding these issues can also assist in minimizing any rupture to the therapeutic relationship should risk escalation procedures need to be activated.

If the first session is to be delivered virtually, it is particularly important to establish where the client may be able to access a remote therapeutic space for the duration of the initial session. The client may have limited understanding of the types of questions or topics that will be discussed in the first session, and therefore may not be able to make an informed choice without guidance from the clinician during the orientation. The clinician may also find it useful to guide the client in how to log-in to the platform to reduce technological issues at the time of the appointment. Alternatively, clinicians may arrange to phone the client a few minutes prior to the first appointment time to assist them in connecting to the virtual platform prior to transitioning to the videoconference.

Where an appropriate carer has been identified, the orientation may also provide a fruitful opportunity to establish some brief agreements about virtual engagement with the carer. There may be service-based requirements for the carer to be available for the duration/following the session, in particular if the client is a young person. The orientation therefore may include agreements about the client's setting when engaging virtually to ensure confidentiality, such as a commitment from the carer to protect the client's confidential space during sessions (e.g., by directing other family members away from that particular room), whether the carer will be accessible to the client prior to the session to assist with troubleshooting connectivity issues or following virtual sessions if needed, and any other client or service-based virtual care considerations.

Young people often benefit from the support of parents and/or carers in reminding and transporting them to standard face-to-face therapeutic appointments. It can be similarly beneficial for parents and/or carers to support young people in their engagement with virtual mental health care by actively reminding them of appointments, ensuring they are able to log-in to the platform, and have all required equipment. Parents and/or carers may also benefit from understanding the potentially sensitive nature of the sessions, and how they may be able to support the young person by respecting their private space for the duration of the session. Agreements may also be made on whether, how and when parents and/or carers will be engaged in the session/s (e.g., at the start and end of each session, whether they will be notified when a session has finished so they can check in with the young person, etc.) or provided with feedback at a later time (e.g., on the phone). Similarly, if a young person is connecting to a virtual brief intervention session whilst in a private room at school, it may be beneficial to arrange for an appropriate support person (e.g., the School Counsellor) to be aware of the session and check in at the conclusion of the appointment. However, some young people would prefer to manage their mental health care independently. Clinicians may find it beneficial to understand the preferences of the young client during the orientation call, discussing the various options, and engaging parents and other professionals as needed to facilitate this support as appropriate.

Using online forms and resources

The use of virtual platforms of care necessitates thoughtful consideration of how to share administrative forms and clinical resources. Administrative forms might include sensitive information such as signing informed consent, documentation regarding personal details and next of kin, or Service User's Agreements regarding the client's engagement with the service. Clinical resources may include static documents (such as providing the client with psychoeducational factsheets) or therapeutic working documents (for instance, the brief intervention Care Plan). Forms that include personal details need to be sensitively shared so that the client's data can be protected. This may include service-based decisions on the endorsed methods of document sharing that are consistent with internal policies and procedures (e.g., encryption or password protected files, email correspondence to and from a confidential inbox, etc.).

Requesting the generation of a generic confidential inbox may be useful, including disclaimer sub-text with crisis services, expectation of inbox monitoring during business hours, and options to see whether sent emails to clients have been received/opened (where possible). There may need to be internal agreements regarding monitoring of this inbox, such as a designated person (such as the coordinator, with additional support if this person is unavailable) or rostering system. These considerations may require review of organisational policies and procedures, and consultation with the executive and Information Technology team.

Clinical resources may also need to be adapted for the virtual platform of care. Sharing static resources, such as factsheets, may be achieved by emailing the client, posting these to the client following session, or directing the client to a particular website link. Therapeutic working documents, such as the Care Plan may need additional consideration. It is preferrable for the virtual platform to be equipped to allow interactive screen sharing to facilitate active collaboration. Alternatively, providing website links for editable versions of therapeutic resources could be beneficial. Examples include utilizing editable versions of the brief intervention Care Plan and Carer Plan (these can be located on the Project Air Strategy website here).

Clinic resourcing

Appropriate resources will need to be allocated for a virtual brief intervention. This includes private clinical consultation rooms to be equipped with computers and the technology required for effective virtual engagement (e.g., stable internet connection, webcam, speakers, and microphone capability). This may also include service-based solutions to contacting the client by email (e.g., to send virtual instructions and links, forms and resources) and/or text message (e.g., to remind clients about upcoming appointments). Technological equipment will need to be kept up to date with application and computer updates to ensure streamlined care.

Clinical considerations of virtual brief intervention delivery

Enhancing rapport and engagement

It is particularly important to consider the relational model when delivering interventions virtually. The quality of the therapeutic relationship is an important part of the treatment. Some non-verbal communications may be missed or minimized during virtual sessions, and so the clinician will need to actively attune to the client and clearly demonstrate empathy. This may include considerate use of tone, virtual eye contact, and body language such as facial expression and hand gestures. The clinician may need to consider ways to increase engagement, for instance by using a dyadic conversational style or regularly asking questions to check in with the client. Clinicians may consider using visual tools such as screen sharing videos or handouts, virtual 'ice breakers' or therapeutic games, use of the written 'chat function', or experiential exercises to enhance the engagement capacity of the virtual modality.

The intrapersonal relationship will also need to be considered. This will be particularly salient for virtual platforms of care where the client may be able to see a video image of themselves during the session. For some clients viewing themselves on screen can elicit distressing or intrusive thoughts or feelings. The clinician may be able to guide the client to turn off their own self-screen image, whilst still providing camera visuals to the clinician.

Risk assessment and management

Active and ongoing risk assessment remains an important aspect of the virtual brief intervention. Whilst it is possible that the client is connecting to the session from the home where supportive others (e.g., parents or carers) are present, it is important to consider any acute or changing risk. It can be useful to check in with carers regarding any noted changes in behaviours or distress indicating risk, should the clinician feel the need for further collateral information. It is also important to consider situations whereby the client may connect to the session in the presence of unhelpful or abusive others (e.g., in domestic violence situations) and careful clinical consideration of risk may be required. Clinicians should document any risk assessment and management considerations as per standard procedures.

Session structure

The virtual brief intervention can be flexibly applied to a fully virtual or hybrid model of care. Thereby, it is a service-, clinician- and client-based decision as to whether all four sessions are delivered virtually, or with a mix of standard in-person consults. Some clinics may prefer to deliver the initial session in-person to allow for establishing rapport, assessing and managing risk, and maximising engagement. However, this is not a specific requirement of the virtual brief intervention where this is not possible or necessary.

The brief intervention may be structured as follows:

Orientation: Initial communication (ideally by phone) to confirm the appointment, assess suitability for virtual mental health care, orient the client to the virtual brief intervention (including instructions regarding the videoconference link, equipment required, internet connection, a private therapeutic space, etc.) with a follow up email with step-by-step connection instructions, troubleshooting tips and contact details

Session One: Individual session with the client; plus an introduction to the carer (present for part or whole session based on need) – *can be delivered in-person in hybrid clinics, or can be delivered virtually*

Session Two: Individual session with the client – *delivered virtually*

Session Three: Individual session with carer/s – *delivered virtually*

Session Four: Individual session with the client; plus connection with the carer (present for part or whole session based on need and to communicate options for further treatment) – *delivered virtually*

For a more detailed outline of the session contents, please see the *'Accompanying Resources'*. Notably, the structure of the intervention is flexible and should take into account the individual needs of the client and the organisational setting. For example, if the primary carer cannot attend the sessions, an alternative support person may be included, or all four sessions can comprise an individual intervention for the client. Furthermore, whilst this model was initially developed as a therapeutic crisis intervention, it could also be used as an orientation to treatment for clients not in crisis, or for relapse prevention planning prior to discharge from a longer-term treatment package. Young people are often difficult to engage in treatment, as such utilising this approach provides flexibility in terms of setting (i.e., school) and provides a sample of how further therapy may be of benefit, reducing the stigma often associated with treatment. Additionally, the virtual or in-person modality of this model is flexible when implemented in a hybrid approach based on client, clinician and service considerations.

Checklist for when clients do not attend their appointments

Virtual brief intervention engagement can be enhanced with rapid follow up for non-attendance (e.g., within 5 minutes of the appointment commencing).

1. Clinician to contact the client to ascertain their reason for non-attendance
   a. If answer:
      i. If there is sufficient time to continue with the appointment (e.g., missed only 5 to 10 minutes, and the client / carer is in a suitably confidential space) consider whether to continue with the session either on the phone or transitioning to the virtual platform. If continuing with the session is not appropriate, offer the client another appointment at a time that is suitable.
   b. If no answer:
      i. contact referrer to assess the client's acuity;
      ii. contact the crisis team to determine if there has been contact with the client;
      iii. use any other contact numbers available for the client or their carer and attempt to reschedule an appointment.
2. Clearly document details of the contacts, including any decisions made, actions taken, and outcomes achieved.

After following these steps there will need to be a decision about who is the best person to make contact with the client. A further discussion will also be required between the referrer, the clinician, and other key workers to determine the most appropriate action to be taken.

Premature disengagement from session

Should the client disengage from the session prematurely, the clinician should try to re-establish

connection using all available contact options including attempting to contact the clients next of kin. Should the clinician be unable to re-establish contact within the first 5 minutes, and the clinician has reason to believe that the client's level of risk is anything above medium they should contact emergency services immediately to conduct a welfare check to ensure the clients safety. Should the clinician assess the client's level of risk to be medium or below, the clinician should contact Central Intake to consider a referral to the Acute Care Team. At the first possible opportunity the clinician should consult with the virtual brief intervention coordinator and Team Leader about the risk escalation, and discuss in the next team meeting to consider the most appropriate pathway of care for the client. Clearly document details of all attempts to contact the client and carer, telephone calls made to professionals and significant others, decisions made, actions taken and outcomes achieved.

Setting the therapeutic frame

Attending to the psychological boundaries framing the relationship are critical as the brief intervention emphasises a relational model. The frame establishes the space in which the therapeutic work can take place. This includes practicalities such as the time, location, modality, duration of sessions and outline of therapy (for instance, the aims and limitations of the intervention, what the client can discuss and how the time is managed). The frame also includes the policies of the organisation and service (for instance contact outside of the therapy sessions, rescheduling missed or cancelled appointments and the management of risk). A clear discussion regarding the frame is required at the outset of any therapeutic relationship to establish well-defined expectations for both clinician and client. These clear expectations provide a safe and predictable therapeutic environment, which is particularly important when working with people with personality disorder. For example, it is important to explain that this is an intervention that will only last for up to four sessions. This can assist in managing expectations.

There are particular considerations in managing the therapeutic frame for virtual interventions. This includes agreements on the setting of the virtual sessions to manage confidentiality. From the outset, it may be worthwhile flagging that the client will need a private, quiet and distraction-free location for the virtual sessions. This could be achieved in the orientation phone call confirming the appointment, however may need to be revisited at the beginning of each session. At times, clients may benefit from some assistance in troubleshooting an appropriate remote therapy space and may find it useful to decide on this private location ahead of time. Services may require clients to provide the address they will use for the virtual session to allow effective emergency service response if needed, or the contact details of a carer who will be available to support the client following the session.

The frame may also include agreements on other aspects of the client's environment to reduce distractions. For instance, you may include agreements such as turning their phone on silent, and not having any other programs (including emails) open in the background during sessions to reduce potential distraction. Young people engaging in the virtual brief intervention may require the support of the clinician in explaining the frame to their parents and/or carers to increase confidence that their privacy will be respected during the session. In addition, this initial discussion may include agreement about the use of webcam technology, including service-based expectations about being able to see the client during virtual mental health care (the camera being on for the full duration of the session), and whether the client is comfortable to remain visible on screen. There may be particular case-by-case examples where flexibility may need to be applied (e.g., if the client lives in a remote location with poor internet connection that does not support the camera being switched on). This may also prompt discussion regarding what the clinician will do if the camera is suddenly turned off and the clinician is concerned for the client's safety, or the client is disconnected at any time, and how risk will be managed through the virtual brief intervention.

Enhancing the remote therapeutic space

Virtual mental health care has some unique benefits that can be harnessed to increase the effectiveness of the brief intervention. The therapeutic space consists of the virtual platform of care, the space in which the clinician is connecting, and the space in which the client is connecting. Whilst it is usually the responsibility of the clinician to provide a therapeutically safe space for in-person therapy, this responsibility is primarily transferred to the client during virtual care. Clients may connect to the session from a variety of spaces (e.g., their bedroom, their car, their office, a park, or their

dining room table). It may be beneficial for clinicians to consider the space the client has connected from at the outset of each session and discuss whether this is the most therapeutic option for the client at this time. For instance, this may include suggesting that the client move from the shared family space to a more private location. Asking whether the client is at home alone, whether there is someone nearby, or whether they feel like they are able to say what they need to express in the session can be useful. This will assist the clinician to both understand the confidentiality of the client's space, and any support resources available to the client if needed. Clients may not have a thorough understanding of the types of questions or topics that will be explored in the brief intervention (in particular for the first session), and so it can be useful for the clinician to guide the client to consider their remote therapeutic space and support them in making informed decisions on the physical space they choose to connect from.

Once the client's physical space has been established as quiet and confidential, the clinician may then suggest that the client make this as therapeutic as possible. Examples may include moving paperwork out of sight, putting up a windscreen visor for additional privacy if the client is in a car, shutting down their work computer for the duration of the session, or whether they would like a comfort item (e.g., wrapping a blanket on their legs, having a pet nearby, or having sensory objects within reach). Connecting with clients in their natural environment allows the clinician a unique window into their world, and the opportunity to encourage the client to practice skills in-vivo. For instance, if the client should become distressed, clients may be able to utilise objects around them to practice particular skills (e.g., squeezing a spikey ball or set of keys as a distress tolerance skill, or stroking a pet as a self-soothing strategy). This may then enhance the use of similar skills outside the session, as the client has been able to practice and identify how best to apply the skills in their natural setting.

However, it is important to note that some clients may find it uncomfortable and invasive for clinicians to virtually enter their personal space. Clinicians may suggest ways to overcome this, by suggesting clients find a private space with a neutral backdrop or use virtual background filters. This might allow clients to feel as though they can titrate the personal artefacts they are sharing through the virtual screen. Similarly, some clients may feel as though their home is not a safe or comfortable place to connect from, especially if there are interpersonal tensions or abusive relationships (e.g., domestic violence) that increase the level of anxiety experienced. Clients may elect to move away from their personal space and connect in a private location outside the home, such as using a room at the community mental health service hub (in rural and remote areas), booking a closed library room, asking for a space to be made available at school, a private room at work, a quiet park bench, in the car, or secluded part of a beach. It is important to collaborate with the client on their choice of the most confidential, safe and private location for the session, and some flexibility may be required to ensure person-centred, inclusive and equitable access to the virtual brief intervention.

Ethical considerations of virtual brief intervention delivery

Confidentiality

Providing an ethical service requires some particular considerations when working therapeutically in a virtual space. Confidentiality needs to be considered both from a data management, and an environmental perspective. Some of the data management considerations regarding protecting client's confidentiality have already been addressed (e.g., see '*Using online forms and resources'* above). However, this also extends to the platforms that are utilised to provide the intervention. This includes ensuring that the software or program used to connect the clinician and client is private, secure, encrypted and/or password protected. Some platforms require clinicians to 'lock' the videoconference link, and clinicians should always ensure that the link is only shared with the appropriate client or carer. Some services may have additional requirements regarding the virtual mental health care platform used (e.g., whether servers for the platform are global, or locally based), and therefore clinicians should first consult with the relevant organisational policies, procedures, management and Information Technology team for support and consultation on the endorsed and approved platforms of care.

Confidentiality is also to be considered in the therapeutic setting. This includes the room where the clinician is connecting for the intervention, and the room the client is using. Some of these considerations have already been addressed (e.g., see '*Enhancing the remote therapeutic space*' above). The clinician should book a private interview room to conduct the sessions (e.g., not use their own desk in a shared office). At times, clinicians may feel the need to turn the computer volume up to hear the client, so headphones with a microphone should be utilised where possible to ensure client confidentiality. This may also enhance volume and microphone quality to ensure seamless therapeutic engagement. If clinicians are using the phone to conduct a session, headsets may be preferrable to allow a comfortable hands-free approach without any potential injury (e.g., holding the phone to the ear using shoulder for an extended period of time).

From the outset, clinicians should discuss the importance of clients securing a quiet and private place for the sessions. Confidentiality considerations may need to be revisited should it become obvious that the client is not in a private setting. (e.g., see '*Enhancing the remote therapeutic space*' above). Whilst clients may choose to have a carer present during the session if they prefer, this may need to be decided in the context of a private conversation to ensure that the client is cognizant of their right to confidentiality and whether there are any power or coercive control issues occurring. It may be helpful to provide an outline of the sessions, and that there are opportunities for carer involvement at times, however it can be useful to also have therapeutic private time together. It may be necessary to pause therapeutic discussions until the client is able to move to a more confidential space or make a considered informed choice.

Data management

Services need to consider data security and management when establishing a virtual clinic. Some organisations have specific requirements for software, governing the use of particular virtual platforms or data storage systems. Any system that is used to facilitate the virtual brief intervention must comply with the host organisational requirements.

Data management may also include the sharing of resources and forms, and personal information. Some of this has already been addressed (e.g., see '*Using online forms and resources'* above). Where any concern arises, clinicians should consult with their organizational policies and procedures, management and Information Technology team to ensure safe and secure data storage.

Risk Assessment

Clinicians are ethically required to conduct and document risk assessments for all interactions with clients and families. This may include a variety of risk profiles, such as risk of harm to self (self-harm, suicide, reputation), risk of harm to others (homicide), relational risk (domestic violence), and other

types. Risk assessment needs to be carefully considered across virtual mental health care settings, including whether an accurate risk assessment can be achieved via this modality for this client at this time. For instance, if the client is known to be in a domestically violent relationship, and the perpetrator is at home during the session, it may be difficult to ascertain whether the presentation and discussion is influenced, and thus the level of risk may be under-represented. Alternatively, if a risk assessment results in a low-risk rating during a virtual brief intervention session, but the client then engages in a serious self-harm or suicide attempt immediately following resulting in presentation to acute care, the clinician and team may consider whether further virtual mental health sessions are able to accurately assess risk for this client in subsequent brief intervention sessions.

Risk assessment documentation is also equally necessary across both in-person and virtual modalities for the brief intervention. Whilst there may be supportive others in the client's immediate environment (e.g., home, work or school), it is insufficient to assert that these people assume the care of the client following the session. Risk assessment should be documented as per the standard procedure. Some risk assessments may also benefit from the collaborative input from parents and/or carers on any changes in behaviour, increased concern, and clarification of safety plans.

Equity

It is important to note that the virtual brief intervention may provide a platform for some clients to engage with services who otherwise may have experienced prohibitive barriers to in-person treatment. However, virtual platforms of care may not suit all clients, and may exclude some clients who are unable to commit to this modality. This may include clients who are unable to access a stable internet connection or the technology required, or clients who experience significant difficulties in organising their lives in a way that facilitates independent virtual engagement. It is important to consider the equity of service delivery, and whether offering a virtual service will be inclusive for a particular individual or group. These considerations may be addressed by having an open discussion with the client at the orientation phone call, to assess whether virtual service delivery will be suitable for the client, and whether engagement of any supports may be needed (e.g., ensuring a parent and/or support person is home to assist with troubleshooting connectivity issues, sending additional reminders, etc.).

Virtual mental health care may also be more challenging for clients who have significant difficulty with sustaining attention and sitting still for long periods of time. It may be useful for clinicians to consider adaptations for clients with these difficulties, such as encouraging movement in session, ensuring comprehension by using deliberate dyadic conversation or questions, or incorporating more experiential activities. This may include utilising the unique strengths of the virtual platform, such as an interactive whiteboard, or sharing videos, pictures or therapeutic games to illustrate key points. Alternatively, this could be in utilising the consumers space, such as encouraging mindfulness or distress tolerance skills practice with an object or pet they have close by. This may include some young people or adults who have co-occurring concerns (such as comorbid Attention Deficit Hyperactivity Disorder, Intellectual Disability, or significant issues in impulsivity, anxiety or substance misuse, etc.). At times, clients with such difficulties may require support from others to facilitate attendance at in-person appointments (e.g., transport services via Non-Government Agencies, or parents and/or carers). These supports may assume that the client is able to connect to a virtual appointment independently. However, it is important to discuss any support needs with the client and engage support services, parents and/or carers where required to facilitate virtual brief intervention attendance and ensure equity of service delivery.

Considerations of equity with virtual mental health care may be especially important for particular areas or groups. For instance, this modality may be beneficial for rural and remote areas whereby geographical distance may present a prohibitive barrier to in-person engagement. However, these areas may not have sufficiently stable internet connectivity. These clients and their carers may also be more difficult to reach, and may be less accustomed to appointments at particular times and require a more flexible approach. In addition, clients who are transient or have reduced socioeconomic resources may not have the required technology, internet or data available for effective virtual mental health care. In addition, it is also important to consider cultural equity in virtual mental health care, whereby some cultures may find this approach more or less suitable to their unique person-centred needs. It is suggested that clinicians consider a holistic assessment of the appropriateness of virtual platforms of care for the brief intervention, in particular the suitability of the client's circumstances, and their modality preference.

Sustainability considerations of virtual brief intervention delivery

Research on the successful implementation and sustainability of the brief intervention model has identified five core considerations (Pigot, Miller, Brockman, & Grenyer, 2019):

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

These considerations are adapted below to the unique nature of the virtual modality of care. Additionally, the accompanying resource (Project Air Strategy for Personality Disorder, 2024) may be of use to guide implementation and sustainability.

Policies and frameworks to support virtual mental health care

The virtual brief intervention model of care is best supported by formalised Business Rules. These rules define the operation of the clinic, including eligibility and exclusion criteria, risk escalation procedures, referral pathways and throughcare, alongside required administrative procedures. These Business Rules are usually endorsed at the executive level to demonstrate organisational support for the virtual clinic. Ideally, these Business Rules will sit alongside other existing and associated policies and procedures (e.g., existing risk management, documentation, and virtual mental health care policies). A strongly defined and endorsed Business Rule may assist in the sustainability of the virtual brief intervention model, to allow succession of coordinators and clinicians should staff turnover occur. There are specific considerations that may be useful to define in a virtual brief intervention Business Rule. This includes whether the clinic standard care will occur in a hybrid or entirely virtual model, or on a case-by-case basis. This may also include specifications on the virtual platform used, procedure in sharing resources, storage of data, site-specific eligibility criteria, referral pathways, and clearly defined risk escalation procedures appropriate for the virtual modality. An example virtual brief intervention Business Rule is provided in Appendix D which can be adapted for the local context.

Training

Research has shown that both training and contribution to the brief intervention is beneficial in increasing confidence in working well with this population group (Grenyer & Bailey, 2023). The virtual brief intervention requires specific considerations regarding training. It is important that coordinators and clinicians contributing to the virtual brief intervention feel confident in both using the technology to support virtual mental health care, and in the nuanced way of working with people with personality disorder or traits in a brief virtual intervention. Training requirements may therefore include:

- Use of the technology (platform of care) and organisation-specific policies, procedures and frameworks around virtual delivery of mental health care. This training is usually provided by the host organization. This may include training on how to assist clients with logging in, use of therapeutic interactive functions (such as screen sharing), troubleshooting tips, and how to assist clients with certain issues (e.g., disabling self-view).
- The therapeutic nuance of delivering the brief intervention virtually (e.g., specific considerations of the relational model, brief intervention, rapport building, containment, boundaries, therapeutic frame, and enhancing engagement over a virtual platform of care).

Both training requirements need to be regularly offered to allow new staff to contribute to a sustainable virtual brief intervention.

Resources

The virtual brief intervention requires integrated and interactive resources to support the therapeutic work and to ensure efficacy. This includes the opportunity for virtual platforms of care to allow screen sharing functions and interactive options, or endorsement of associated sites to share resources and co-design a Care Plan. Facilitating resources to enhance engagement and co-design of therapeutic documents empowers clients to take ownership of their Care Plan. These resource-sharing facilities need to be considered in terms of sustainability of the virtual brief intervention model of care.

Supervision and debriefing

Virtual mental health care can increase the accessibility and flexibility of service delivery. However, it is particularly important to schedule regular debriefing and reflective practice supervision to ensure effective service delivery via virtual platforms of care. The nature of the relational model, including the importance of engagement, rapport, relationship and boundary management, can be intricately implicated by the virtual modality. Regularly reflecting on these issues ensures compassionate and best-practice care. This is particularly important if clinicians are working remotely and do not have regular informal access to their team colleagues.

Quality assurance

It is useful for virtual brief interventions to consider quality assurance from the outset. This may include clinician (staff satisfaction and experience), client and carer feedback pathways. This could include formalised studies of client outcomes and symptom improvement (see Huxley et al., 2019 and Bartsch et al., 2024 for examples of measures that may be useful), or more informal data collection including tracking the number of referrals, sessions attended, and throughcare options. Additional quality assurance measures may include service-based data on service utilization, such as acute presentations, inpatient admissions or re-presentations (e.g., see Grenyer et al., 2018 and Bartsch et al., 2024). Well-designed quality assurance processes can assist in sustainability of the virtual brief intervention by providing ideas for improvement, and feedback to executives on the effectiveness and utility of the model of care.

The collection of clinical measures in quality assurance may be more challenging in the virtual space. During in-person sessions, clinicians have more capacity to complete forms together at the start or end of session, or ask for them to be completed in the waiting room prior to or after the appointment. The response rate of measures being completed can be reduced when engaging by virtual platforms. Some clinicians may find it useful to include additional time in their session (e.g., start the session 10 minutes earlier, or finish 10 minutes later) to collaboratively complete required clinical measures prior to the client or carer disconnecting. Alternatively, it can be useful to provide a link where the client is able to complete the measures virtually, and ask for this to be completed immediately after the session or before the next session. Clinicians may find it useful to discuss the benefit of completing these measures, and to offer support if the client experiences any barriers. This may include direct support from the clinician, arranging support from a nearby person (e.g., parent and/or carer, School Counsellor), or link the client with a peer worker.

Appendix A: Limitations, Strengths and Potential Solutions

There are many benefits and limitations of virtual mental health care. Here we present some that have been identified by clinicians actively delivering the brief intervention in a virtual or hybrid modality, with potential solutions to support effective care (see Bailey, Knowles and Grenyer, 2023).

Topic	Limitation	Strength	Potential Solutions
Accessibility	Some clients may not have access to the technology required for virtual mental health care, including a stable internet connection. Examples may include clients with limited financial resources, transient or homeless clients, or clients in rural or remote areas with poor internet connection/data access	Virtual mental health care can enhance accessibility and treatment outreach for some clients who would otherwise be unable to access treatment. Examples include clients with work commitments, geographical and travel limitations, caregiving arrangements, sensory sensitivity that can make in-person attendance distressing, complex mobility issues, or complex and serious mental health concerns Virtual mental health can also mitigate some of the confidentiality concerns for rural and remote clients who would otherwise be limited to accessing care from a clinician in their local community with potentially complicated dual relationships Virtual mental health care may provide opportunities for clients who present with interpersonal concerns to safely engage with the service (for instance, clients with a history of aggression) Virtual mental health allows clinicians to include all relevant parties to the session, which may include the carer, a case worker, or an interpreter	Consider the equity of service delivery to ensure that there are person-centred options meeting the accessibility needs of all clients The orientation discussion can assess the suitability of clients for virtual mental health care, including whether clients have access to the technology, private space, and stable internet connection Sometimes clients may express a preference for virtual mental health care but not have the required technology or stable internet connection. At other times, clinicians may need to use virtual platforms of care due to working remotely, or across a large geographical region. There may be options to problem solve these accessibility issues. This may include arranging for the client to attend a local hub mental health centre or local library to borrow the required equipment for the duration of the session
Attendance	Clients can be more likely to forget virtual sessions, or attend when they are in inappropriate/non-private places Some clients with more complex difficulties with attention may find virtual appointments more challenging when needing to independently organise themselves for the session Some clients may not pick up ‘no caller ID’ phone calls Technological difficulties can prevent timely attendance	Providing virtual options allows continuity of care during times that would otherwise impede on service delivery (such as illness, staffing shortages, natural disasters impacting road access) Virtual mental health care provides flexibility for both the clinician and client to arrange appointment times that may have been otherwise prohibitive Virtual mental health care may facilitate more rapid follow up by overcoming some of the prohibitive barriers to in-person attendance	The orientation discussion can include information on the importance of finding a private, confidential, and quiet place for the duration of the session. This discussion may also include information on the technology being used to connect, any particular software that would need to be installed in advance of the appointment, and a backup plan in case technological issues prevent the session from proceeding Sending a number of reminders (e.g., the day before and the morning of the appointment / an hour before) can increase attendance It can be beneficial to do assertive follow up for missed appointments (after 5 minutes of non-attendance) rather than waiting until there is insufficient time remaining to complete the session either on the phone or virtually Phone calls may be preceded by a text message indicating that a clinician is about to call in regards to the virtual brief intervention Parents and/or carers may be well positioned to assist clients in remembering, setting up for their session, and troubleshooting any connectivity issues

Engagement	General engagement and rapport building can be more challenging in virtual platforms of care, which can be heightened for people with complex interpersonal difficulties such as personality disorder Virtual platforms of care miss some of the informal interaction that can occur on the walk to/from the therapy room, which can be useful to build rapport Some clients find it uncomfortable to see themselves on screen during a virtual session. This may limit their emotional expression during therapy Clients may miss some of the useful rituals around preparing for and traveling to in-person therapy, including the pre-thinking (cognitively reviewing what has happened during the week, prioritizing topics), and the post-reflection (consolidating insights and learnings) as they may be more likely to fluidly move between daily activities to therapy and back rapidly which reduces the opportunity for reflection	Virtual platforms of care can enhance engagement by live sharing of resources (e.g., videos, therapeutic games, etc.) Virtual platforms of care previously allowed clinicians and clients to engage in therapy without the use of personal protective equipment, this enhanced rapport and engagement. For some clinicians and clients with hearing deficit, this also allowed for lip-reading as no facial mask was required	Consider a hybrid model of care, where the first session is delivered in-person where desirable to increase engagement and build rapport Clinicians may need to consider their use of voice, pace, visible body language and expression to clearly portray empathy and understanding. This includes considering virtual eye contact, and if notes should be completed during or after session Therapeutic discussion may need to be more dyadic (asking a question or having the client contribute every 30 seconds or so, rather than long periods of the clinician talking without interruption) to ensure the client remains engaged Utilising the opportunity to practice experiential exercises, use engaging resources (such as share screen for videos emphasizing key points or skills), or prioritising rapport-building activities can increase engagement It may be useful to outline the therapeutic frame from the outset, including minimising distractions during the session (for instance, closing any applications that are open to prevent alerts) Clinicians may prefer to prioritise videoconference platforms of virtual mental health care to allow for full assessments, engagement and rapport building. If there is an established rapport, phone connectivity can be useful if videoconference technology fails, if the person does not like to be seen on camera or if internet connection is an issue Clinicians may discuss the client's reluctance to share their video during the virtual session, and troubleshoot ways for the client to only see the clinician on screen whilst still sharing their own video (e.g., disable self-view) Clinicians may benefit from orienting clients to establish their own virtual therapy ritual. This may include preparing their space and mind prior to the session. Additionally, clinicians may benefit from spending time consolidating the session at the end and allowing time for reflection, and encouraging the client to think about their immediate post-therapy activity (e.g., they may benefit from taking the time to write some of their immediate thoughts in a reflective journal, rather than move on to house, school or work-related activities immediately)
Therapeutic considerations	Some virtual health care platforms do not support screen sharing capabilities Clients may feel anxious or distracted by their immediate surroundings Some clients may feel that they cannot safely express their distress on virtual platforms of care as they may have other family members in the home (e.g., they do not want a spouse or children to over-hear) Clients may utilise engagement with virtual platforms of care in ways that reinforce or enable their particular difficulties (e.g., if they feel anxious about leaving the house, or engaging in social interactions)	Resources can be emailed to the client prior to the session. This provides a prompt for the client to consider the goals of the session and empower a sense of agency of their mental health care sessions Resources can be emailed to the client following the session. This provides an opportunity for the clinician to provide a recap and remind the client of any agreed homework tasks Engaging with clients in their own environment through a virtual platform allows for in-vivo use of self-regulation and soothing resources, which may enhance	Resources can be shared during the session by sharing the screen. Where this is not possible, resources may be shared by emailing the client before or after the session, or sharing a link in the chat function Clinicians may need to consider how to 'hold' clients in the virtual therapeutic space by creating a sense of safety and compassionate support Clinicians may be able to encourage clients to adjust their environment to enhance the therapeutic value (e.g., making sure the space is private and comfortable, using nearby resources such as a blanket or pet) Clinicians may be able to connect with parents or carers and encourage them to assist in protecting the space for the client to engage in their virtual session. This may include directing other

	Clients may devalue the virtual mental health care session through boundary issues (such as clients attending in sleepwear, or engaging in other home-related tasks whilst in session) or engagement limiting-behaviours (such as wearing clothing to obscure the face, or being in a darkly-lit room) Some clients may find it easier to disengage (e.g., hang up) from therapy on virtual care platforms compared to in-person attendance, in particular if the clinician therapeutically challenges them (uses an expressive technique) The momentum of therapy can be lost in phone sessions. Phone sessions may be experienced as a stabilisation or check in, rather than opportunity for therapeutic change Some therapeutic moments may be more challenging to interpret when using virtual mental health care (e.g., whether a silence is comfortable, anxious, dissociated, or reflective) Clients may feel less empowered in their mental health care if they experience the sessions to be less interactive	later independent use Interactive functions of virtual platforms of care may provide additional benefits in engaging the client or highlighting key points or skills (e.g., using screen sharing to show videos, therapeutic games, etc.) Offering virtual sessions may increase a sense of agency in the client being able to choose the most appropriate modality for them at this time Virtual brief intervention may provide clients with an introduction to therapy which may encourage further engagement with mental health services either virtually or in-person Allowing clients to use the chat function may facilitate them to ask questions or raise discussion points that would usually generate anxiety or discomfort	family members away from the room A hybrid model may mitigate some of the concern around reinforcing avoidance strategies Clinicians may move their camera to show the client that the therapeutic room is private with the door closed, and may ask the client to do the same Clinicians may need to focus on rapport-building prior to challenging clients perceptions and behaviours during the brief intervention, to ensure that the client is engaged in the process Clinicians may wish to alternate between looking at the client’s image on-screen to looking directly at the camera whilst talking. This may assist to balance between the need to observe the client’s facial expression and body language, with providing eye contact through the camera Clinicians may find it useful to check in with the client during the session more often when using virtual platforms of care as compared to in-person therapy Asking clients to type their session goals into the chat function at the start of the session can increase engagement, sense of agency, and client-ownership of the session. The clinician might also add some ideas, which together may form the agenda that can be referred to throughout the session Regularly asking for feedback about their experience of the virtual brief intervention allows clients to practice expressing their preferences and promotes agency
Assessing and managing risk	Virtual mental health care can limit the information available during risk assessment. Phone sessions have no visual information, relying on the client’s disclosure of risk and voice cues. Virtual sessions have more visual information (including expression, engagement, some body language, and appearance of immediate surroundings), but still lack the holistic nature of an in-person risk assessment (e.g., unable to see outside of the visual frame, and therefore may miss what is occurring for the rest of the body – such as legs shaking, fidgeting hands) Issues of domestic violence can be difficult to assess on virtual platforms of care if the perpetrator is also within the home Virtual platforms of care can give rise to greater ambiguity of risk, in particular if clients hang up the phone, leave the room or close their computer It can feel as though there are less immediate options for managing risk on virtual platforms of care beyond calling for emergency services where there may be a	Virtual platforms of care can sometimes provide insight into areas that would otherwise be unavailable to contribute to a broader understanding of level of risk (e.g., including immediate surroundings at home)	Strong service frameworks that support the assessment and management of risk in the virtual brief intervention model should be developed. Business Rules should incorporate localized risk management procedures that are supported by senior management. Opportunities for team-based decisions should be integrated into best-practice, including multidisciplinary team meetings, formal or informal supervision, so that risk management is shared It can be useful to consider a hybrid model of care, where the first session is conducted in-person to allow a comprehensive assessment of risk. Subsequent sessions may then be managed by asking for a parent and/or carer to be present in the home at the time of the appointment, or contact details to alert the carer should there be any concern regarding risk Where appropriate, some risk assessments may benefit from the collaborative input from parents and/or carers on any changes in behaviour, increased concern, and clarification of safety plans Depending on the nature of the service, it can be useful to have identified pathways of alerting colleagues should an acute risk arise. This may include text messaging a colleague to call for an ambulance for your client whilst you remain on the phone or on the virtual platform of care It can be useful to have discussions with the client and their carer around the assessment and management of risk at the outset of

	delay		the therapy (e.g., during the orientation phone call) and at the start of each session, including the steps that will be taken if there is any concern regarding safety Risk assessment and management should be monitored closely on virtual platforms of care, and flexibility regarding application of virtual or in-person delivery of sessions may need to be applied on a case-by-case person-centred basis if the risk profile is significantly changeable following or in between sessions Some services may utilise text messages with parents and/or carers to manage chronic risk. For instance, messaging the parent and/or carer when the session has finished, and providing a telephone update at an agreed upon time after the parent has been able to check in on the client. This includes providing feedback to the parent regarding any risks, and updates regarding the safety plan
Family and carer session	It can be more challenging to manage interpersonal tensions in the virtual space, which can cause some difficulties in systemic work	Providing a formalised virtual meeting can provide a safe platform for separated parents or various carers to connect and discuss supporting the mental health care of the client Virtual appointments may assist to overcome otherwise prohibitive barriers for families and carers to engage with services (e.g., work or other caregiving commitments, geographical distance or time constraints) Virtual appointments allow clinicians to share resources on the screen or in the chat function which can assist families and carers in developing further understanding	Clinicians may wish to set the agenda for the session at the outset, including any particular ways that the session will be managed (e.g., one person talking at a time, use of the chat function)
Technology	Virtual platforms of care can experience technological difficulties, resulting in delayed appointments and frustration Clients may experience barriers to using the technology of virtual mental health care depending on their Wi-Fi connection, data allowance and battery life Sound quality can be poor or problematic Similarly, client-based resources may result in poor quality connection, such as a blurry camera or poor microphone quality Clinicians may need to ensure booked rooms have the required equipment and updated software prior to the session time	Clinicians may find that virtual mental health care improves efficiency in allowing notes to be taken in or immediately following a session, opportunities to work remotely when needed, and less walking or travel time between appointments Virtual platforms of care may benefit rural and remote clinicians by reducing the need for travel to conduct home visits for clients who are unable to attend the centre	Clinicians may find it beneficial to guide the client on how to connect to the virtual platform during the initial phone orientation Clinicians may need to consider back up plans in the event that technology is unavailable or non-functional. This may include using the phone to connect with clients where necessary Clinicians may benefit from checking in with clients regularly (e.g., at the end of each session) on any barriers or issues with virtual engagement The coordinator, clinicians and local Clinical Leads may need to provide ongoing feedback to senior management should additional or replacement technological resources be required Clinicians may benefit from the support of senior clinicians or the Information Technology team to set up sessions prior to the appointment time whilst they are new to the system. Consider localised training to ensure all staff are confident in the use of the technology software Clinicians may benefit from familiarising themselves with the organisational policies and procedures for virtual mental health care, including the security of the specifically endorsed platform Some virtual mental health care platforms allows clients to test their equipment prior to the appointment, which may assist their

			confidence in joining at the allocated session time. Such information could be provided in the orientation phone call and a link provided with additional information in the follow up email
Organisational	Senior managers may need to consider workplace health by encouraging clinicians to physically move between appointments to avoid body and eye injury from sitting with the computer for extended periods of time Executives will need to budget for ongoing virtual mental health care resources, including technology, software, training, licensing, and Information Technology support	Organisations may benefit from the enhanced efficiency of virtual mental health care, allowing a greater number of clients to access the service Organisations may benefit from greater staff satisfaction. Virtual mental health care may allow more flexible working arrangements to accommodate continuity of care when it would otherwise be prohibitive for the clinician to be in the office (for instance, during times of non-symptomatic illness, caregiving arrangements or temporary difficulties traveling to the office)	Organisations may wish to implement specific indices in the electronic medical record and reporting systems that capture the delivery of brief intervention sessions, in either in-person or virtual modality to monitor service utilization, efficiencies and effectiveness Organisations may wish to consider providing clear endorsement for platforms of virtual care that allow sharing of screens, resources and documents Organisations may need to consider the ongoing budget allocation for equipment, software, licensing and training for staff in using virtual platforms of care (both in terms of the technology, and in terms of the therapeutic adaptations required) Organisations may need to incorporate formalised debriefing or supervision sessions into the activity structure of the virtual brief intervention to prevent staff from feeling isolated. This may be particularly important for staff working remotely or in rural and remote areas

Appendix B: Checklist for Virtual Orientation

Orientation phone call:

Orient to the brief intervention:
Provide information on the brief intervention aims and scope (3-4 sessions) ☐

Assess suitability for virtual modality:
Reliable internet connection ☐
Earphones with microphone function ☐
Device with a camera ☐
Private and quiet space for each session ☐
Confirm address that will be used for the session/s ☐
Confirm client and next of kin contact details ☐
Set expectations (minimize distractions, prepare space for sessions, etc.) ☐
Whether a support person will be available following the session ☐
Any software that needs installing prior to the first appointment ☐
Confirm email address to send follow up email with the videoconference link ☐
Explain the risk escalation procedure and when this would be enacted ☐
Arrangements for the first session (date, time, clinician name, virtual details) ☐
Where appropriate, orient the parent and/or carer to the above agreements ☐

Follow up email:
Provide the videoconference link with step-by-step joining instructions ☐
Provide troubleshooting tips ☐
Provide the clinician/service contact details in case of difficulties connecting ☐
Attach the Service-User Agreement (if using) ☐
Attach any clinical measures to be completed and returned (if using) ☐
Attach any resources for the client to have on hand during the first session ☐

Each session:

Commencement:
Confirm address client is connecting from ☐
Confirm whether there are any other people nearby
(assess privacy and confidentiality, and support options) ☐
Briefly re-iterate risk escalation procedures and the circumstances
in which these would be enacted ☐
Collect any pre-session clinical measures or feedback surveys from
last session (if provided) ☐

Conclusion:
Confirm arrangements for next appointment (if appropriate) ☐
Discuss any barriers to virtual engagement and troubleshoot ☐
Provide any clinical or feedback measures for quality assurance ☐
Provide opportunity for reflection, and orient to next task (e.g., reflective journal) ☐

Appendix C: Sample virtual brief intervention Service-User Agreement

To be adapted as appropriate for local service utilization.

By signing (or verbally consenting to) this document I understand:

- The virtual brief intervention consists of 3 individual sessions, and 1 session for my nominated family member or carer. Further referral options will be discussed.
- The brief intervention will be conducted virtually by videoconference link. There may be occasions where an in-person session is offered.
- The videoconference link platform used by this service is [include platform of care name]. This is a secure platform endorsed by the health department. If I have any concerns about the security of this platform or the storage of my data, I can ask my clinician.
- To ensure that my therapy is of most use, I understand that I need to arrange the below prior to each session:
    - A stable internet connection
    - A device with a webcam
    - Earphones with a microphone
    - A private and quiet space for the duration of the session
    - Ensure I am comfortable (a box of tissues, glass of water, etc.)
    - Minimise any distractions (including turning my phone on silent, not accessing any other applications or engaging in any other activity whilst in session).
- If I experience any difficulties arranging the above, I can contact my clinician to discuss alternative arrangements.
- I understand that I should not be multitasking (including driving) whilst engaging in the session.
- I understand that if there are any concerns about my safety (including if I disconnect from the session and am uncontactable for 5 minutes), my clinician will need to action risk escalation procedures. This may include contacting my next of kin and/or contacting emergency services. A welfare check may be conducted if deemed to be required.

Signed: ______________________________ (Service User)

______________________________ (Parent where applicable)

Date: ______________________________

☐ OR discussed and provided verbal consent.

Signed: ______________________________ (Clinician)

Date: ______________________________

Appendix D: Sample virtual brief intervention Business Rule

Modified by manual developers for use as an example. To be adapted as appropriate for local service utilization.

Name	Virtual brief intervention ('Gold Card Clinic') intake, allocation and discharge processes
Risk Rating	High
What it is	An outline of the procedures involved in making referrals to the virtual brief intervention, the intake and allocation of referrals within the virtual brief intervention, and the process by which clients are discharged or transferred to other services.
What to do	**Overview** The virtual brief intervention ('Gold Card Clinic') is a service for people in the [SERVICE] catchment area who have recently experienced a mental health crisis involving self-harm and/or suicidal thoughts or behaviours, with personality disorder or traits. The virtual nature of the brief intervention aims to increase accessibility and flexibility in the model of care to suit the client and/or carer preference, clinician and service. The virtual brief intervention aims to offer an appointment within 1-3 working days of referral and offers an initial 3 sessions that focus upon identifying and addressing psychological and lifestyle factors that contributed to the crisis. An additional (1) session for carers, partners and family members is included in the intervention. The key aims of this intervention are to: • provide an accessible and flexible service to clients in crisis by providing a service via virtual mental health care • provide a timely and rapid response to people seeking treatment in crisis • provide an alternative to hospitalisation or facilitate early discharge • provide brief interventions to help manage the client's immediate needs • provide brief clinical services aimed at helping the client solve their problems • provide assessment and psychoeducation to help the client understand their problems • provide tools and strategies to help the client prevent and better manage future crises • provide an opportunity to assess the client's needs, including the possible need for referral to other services or programs where necessary • provide an opportunity to connect with the person's family, partner or carer • provide treatments with an evidence-base that are effective for people with personality disorders The virtual brief intervention will operate during the usual opening hours of [SERVICE] (Monday-Friday, 0830-1700) and will not be available to receive referrals or meet with clients or carers out of hours, or weekends or public holidays. **Staffing** The virtual brief intervention sits within the [SERVICE] Community Mental Health Team. As such, the virtual brief intervention is able to access the broader multidisciplinary team as required, including the Consultant Psychiatrist, social workers, peer workers, etc. The virtual brief intervention is led by the designated coordinator who supports the operationalization and clinical best-practice of the clinic. The virtual brief intervention is integrated into the [SERVICE] Community Mental Health Team in a whole-of-service approach. Therefore all staff working at [SERVICE] are expected to contribute to the virtual brief intervention model of care as part of core business. **Virtual platform of care** The virtual brief intervention utilises the endorsed platforms of virtual care (SPECIFY HERE). These platforms are licensed by the organization to support secure and encrypted sessions that both clinicians and clients can be confident are confidential. Client data storage remains prioritized when delivering the virtual brief intervention. This includes ensuring that sensitive information is shared across endorsed and secure platforms. To ensure safety and privacy, all resources that need to be shared with clients must be sent from the confidential email address. [provide details as appropriate].

	It is the virtual brief intervention coordinator's role to regularly (at least daily) check the confidential email inbox for correspondence or referrals. Should the coordinator be unavailable or on leave for more than one day, the coordinator will delegate this responsibility to another team member to ensure coverage.
	
	The virtual brief intervention is founded on a hybrid model of care, whereby the first session can be delivered in-person where appropriate, with subsequent sessions delivered on the virtual platform of care. There may be case-by-case circumstances whereby sessions may be delivered entirely virtually, or sessions may revert to in-person modality. This determination is based on clinical considerations in consultation with the multidisciplinary team, and in consideration of client, clinician and service preference.
	
	Referrals
	Referrals to the virtual brief intervention can be made by a range of services, including:
	• Emergency Department (ED)
	• Acute Care Team (ACT)
	• Psychiatric Emergency Care Centre (PECC)
	• Mental Health Inpatient Unit
	• Mental Health Intensive Care Unit (MHICU)
	• Community Mental Health Team
	• Community Rehabilitation Team
	• Aboriginal Community Health Centre
	• Early Psychosis Program (EPP)
	• PACER (Police, Ambulance, Clinical, Early, Response) Team
	• Others, as appropriate (e.g., School Counsellors, GP's)
	• Suicide Prevention Interventions where the client does not meet their criteria or would be better suited to the virtual brief intervention (e.g., Suicide Prevention Outreach Team SPOT, SafeGuards)
	
	Eligibility criteria
	• Adults (aged 18 and upwards) with primary problems such as:
	    • 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 (note, a formal diagnosis of personality disorder is not required)
	• Referral is designated at triage by Central Intake as *non-urgent* (as defined by the *Mental Health Triage Policy*)
	
	Exclusion criteria:
	• *Urgent* referrals (as defined in the *Mental Health Triage Policy*).
	Action: contact emergency services/refer to Central Intake who will consider referring on to the Acute Care Team or emergency services
	• Evidence of psychosis as the primary presenting problem.
	Action: refer to Central Intake to access the Acute Care Team
	Evidence of a *primary* alcohol/drug dependence disorder.
	Action: refer to Central Intake to access Acute Care Team and appropriate drug and alcohol services
	• The person could be more appropriately supported by (and expresses a preference for) an alternative *Suicide Prevention Pathway.*
	
	Referral to virtual brief intervention over the alternative suicide prevention pathways (e.g., SPOT) may be preferable when:
	• The client is already being or is about to be supported by community mental health services
	• The client presents with complex mental health concerns, or a long-standing history of acute service engagement due to psychosocial crises
	• A diagnosis of a personality disorder has already been made or is being considered, and a personality disorder-friendly service may be more helpful
	• There are carers/family members/partners who are in need of information and support
	• The client prefers to access the virtual brief intervention rather than the alternative suicide prevention pathway.

	Referral procedure If the referrer feels that a client meets the criteria for the virtual brief intervention they should make their referral by telephoning **Central Intake (PHONE NUMBER)** and asking to make a referral. The Central Intake Clinician will triage as usual, making a careful assessment with the

referrer as to the urgency of the referral and whether the virtual brief intervention is the most appropriate option at that time.

Should the client's presenting difficulties not fit with the virtual brief interventions referral criteria, or if any of the exclusion criteria are met, the Central Intake Clinician will refer on to other services as appropriate.

If the Central Intake Clinician decides that the referral is appropriate for the virtual brief intervention they should:

1. Ask the referrer to inform the client that a virtual brief intervention clinician will contact them to arrange an appointment and they will be seen within 1-3 working days of the time of the original referral to Central Intake
2. Ask the referrer to provide the client with the *Gold Card Clinic Information Leaflet*, which provides information about the service and 'crisis contacts' in case of an escalation of risk while they are waiting for their first appointment
3. Ask the referrer to forward any appropriate documentation, including the *Mental Health Assessment* form
4. Forward the following information to the virtual brief intervention coordinator:
    a. *Virtual brief intervention Referral Form*
    b. *Mental Health Triage* form
    c. *Mental Health Assessment* form
    d. Any other relevant documentation
5. The information should be sent to the virtual brief intervention coordinator first via fax to the designated fax number [or by the confidential email inbox if using] with the hard copies of the paperwork to follow via the internal mail along with the client's community file (existing or newly made-up).
6. Place the client's details on the *virtual brief intervention-Unconfirmed White Board* until the coordinator has confirmed acceptance of the referral
7. If the coordinator or designated deputy has for any reason not confirmed receipt/acceptance of the referral within 1 working day of the referral being sent to them, attempt to make contact with the virtual brief intervention coordinator directly via telephone.
8. If you are unable to make contact with the virtual brief intervention coordinator at this point: Central Intake Officer to discuss at Acute Care Team handover to agree the next appropriate follow-up as per the usual Acute Care Team procedure and in accordance with the degree of urgency assigned at triage.

Intake into the virtual brief intervention
The virtual brief intervention coordinator (or the 'designated deputy', who will follow the same procedure in their absence) checks for referrals on a daily basis.

Upon receiving a referral, the coordinator will review the information to check that the referral appears appropriate and none of the exclusion criteria are present.

Once the coordinator has decided that the referral is appropriate and is to be accepted, they will telephone Central Intake to confirm receipt and acceptance of the referral.

If the coordinator is concerned for any reason that the referral may be urgent rather than non-urgent, or better served by an alternative service, they will discuss this further with Central Intake when they call to confirm receipt of the referral and consider whether the Acute Care Team or another service should be involved.

The coordinator allocates appropriate referrals to a virtual brief intervention clinician so that the first session of the brief intervention can be offered within 1-3 working days of the original referral to Central Intake.

Orientation phone call
The allocated clinician contacts the client to inform them of the appointment time and orients them to the virtual nature of the brief intervention. This includes (but is not limited to):

- Assessing suitability and willingness for virtual sessions (including reliable internet connection, a private space to use for the duration of the session/s). See '*Checklist for Virtual Orientation*' as a guide.
- Provide any information about software or equipment (e.g., webcam, earphones with microphone) required for the virtual session/s.
- Access to supports during / following sessions (e.g., whether a carer will be available).
- Physical address the client will use for virtual sessions, any additional contact details for the client, and phone numbers of next of kin.
- Briefly assess level of risk, and orient the client to the risk escalation procedures for the clinic (e.g., if the client discloses risk during the session or the clinician is concerned about acute risk, if the client disconnects from

	the session unexpectedly and contact cannot be re-established within 5 minutes, ensure the client has a safety plan in place in the event that they experience distress – for instance the phone numbers for local acute and emergency services). • Back up connection plan in the event that technological issues prevent virtual connection (e.g., use of the phone as needed). The clinician and client may then discuss whether the first session will be delivered in-person, with subsequent sessions by virtual care (hybrid model), or all sessions will be virtual (fully virtual model). If the use of virtual mental health care platforms would prevent the client from engaging with the clinic (e.g., the client does not have the technology or private space to engage virtually even after troubleshooting these barriers), consider alternative options to ensure an equitable service delivery. The clinician should email the client following this phone call highlighting the main points. This email should include the session details and videoconference link, a phone number for the client to contact the clinician if they experience difficulties connecting, a step-by-step guide to connecting and troubleshooting tips. The virtual brief intervention Service-User Agreement should also be included as an attachment [if using], to be returned at the commencement of the first session. If the client is not contactable for any reason the clinician should contact Central Intake to discuss concerns and consider a referral to the Acute Care Team for more assertive follow up. The clinician should also advise the virtual brief intervention coordinator. **Sessions 1-4** At the outset of each virtual session, clinicians should: • Confirm the address where the client is connecting from to facilitate rapid emergency service assistance if required • Ask whether there is anyone else in the location (e.g., a parent, partner, carer or next of kin nearby) • Confirm whether the client is connecting from a suitably confidential space • Briefly re-iterate the safety escalation procedure At the conclusion of each session the clinician should request feedback from the client on the virtual intervention, and whether there were any prohibitive barriers that require troubleshooting prior to the next appointment. **Non-attendance of virtual brief intervention appointments** If a client fails to attend a virtual brief intervention appointment without having called to reschedule, the allocated clinician should: 1. Call the person within the first 5 minutes to ascertain their reason for non-attendance a. If they answer: i. carry out a brief assessment of why they were unable to attend, being vigilant for any signs of increasing risk ii. should increasing risk be identified, consider referring the person to crisis services (see below) iii. if the person is in an appropriate location and there is sufficient time (e.g., missed only 5 or so minutes of the session), the clinician and client may agree to continue with the session via phone or by transitioning to the virtual platform iv. otherwise offer the person another appointment at a time that is suitable. b. If there is no answer: i. where possible leave a message asking the person to contact the virtual brief intervention clinician and remind the person of the crisis contacts should these be needed ii. contact the referrer to assess the person's motivation and check for any changes in the person's situation that might account for non-attendance iii. contact the Acute Care Team to determine if there has been any contact with the person iv. use any other contact numbers available for the person or their next of kin and attempt to reschedule the appointment. 2. Wherever the person's non-attendance has involved an escalation in risk or it has not been possible to make contact with them to reschedule, liaise with the virtual brief intervention coordinator, the Consultant Psychiatrist and the Acute Care Team to determine what is the most appropriate action to be taken, which may include considering a referral to the Acute Care Team for more assertive follow-up. 3. Clearly document details of all attempts to contact the client, telephone calls

made to professionals and significant others, decisions made, actions taken, and outcomes achieved.

Premature disengagement from session
Should the client disengage from the session prematurely, the clinician should try to re-establish contact with the client using all available contact options including attempting to contact the client's next of kin. Should the clinician be unable to re-establish contact within the first 5 minutes, and the clinician has reason to believe that the client's level of risk is anything above *medium* they should contact emergency services immediately to ensure the clients safety by requesting a welfare check. Should the clinician assess the client's level of risk to be *medium* or below, the clinician should contact Central Intake to consider a referral to the Acute Care Team.

At the first possible opportunity the clinician should contact the virtual brief intervention coordinator and Team Leader about the risk escalation and discuss in the next team meeting to consider the most appropriate pathway of care for the client. Clearly document details of all attempts to contact the client, telephone calls made to professionals and significant others, decisions made, actions taken, and outcomes achieved.

Risk escalation procedure
If the virtual brief intervention clinician assesses at any time that the level of risk requires an *extremely urgent* response, they should always contact emergency services immediately. Where possible, the clinician should stay connected to the client while waiting for the emergency response to arrive and should contact the client's next of kin (especially if they are nearby and able to immediately assist). This may require the clinician to call for an emergency response on another telephone or requesting a colleague or Team Leader to assist.

At the first available opportunity, the clinician should advise the virtual brief intervention coordinator and Team Leader about the risk escalation, and discuss in the next team meeting to consider the most appropriate pathway of care for the client.

If the level of risk appears to require a response of any other level of urgency (i.e., *medium* or *high urgency*) the virtual brief intervention clinician should contact Central Intake to consider a referral to the Acute Care Team.

If a virtual brief intervention clinician identifies any risk to a child they should consult appropriately with the Consultant Psychiatrist, social work colleagues, and the Child Wellbeing Unit [provide details]. They can also use the *NSW Health Online Mandatory Reporter Guide* (or equivalent in other states, territories and countries as appropriate) to aid decision-making in relation to any child protection concerns.

Discharge procedure
As a virtual brief intervention clinician is approaching the end of their work with a client they will bring the case to the multidisciplinary Review Meeting for discussion and discharge planning in consultation with the Consultant Psychiatrist, who will ultimately authorise the person's discharge from the service.

If, as the client approaches the end of the brief intervention, there are concerns about safety and a judgement that a further mental health response of some level of urgency is required, the Consultant Psychiatrist will, in consultation with the clinicians, consider making a referral to appropriate services, including the Acute Care Team and inpatient mental health services.

As a central part of the discharge procedure the virtual brief intervention clinician will carry out careful and collaborative consideration of further treatment and support options with the client and, where possible, with carers, family members and partners. This may involve a variety of actions, including but not limited to:

- Provision of resources and information about services and supports
- Signposting to specific resources, supports, services and local specialist clinicians
- Formal referrals to specific services and local specialist clinicians, and where possible providing a 'warm handover' by linking the client with the receiving clinician
- Liaison with identified local specialist clinicians to facilitate transition into longer-term treatments
- Liaison with primary health care providers (e.g., GP's) to facilitate arrangements for follow-up in primary care and access to private therapeutic services as appropriate.

Documentation
There are 4 key documents which are to be completed and filed appropriately for any client accessing the virtual brief intervention:

- The *Mental Health Assessment* form must have been completed prior to the

	client's entry into the virtual brief intervention. It is expected that this document will have usually been completed by the referring clinician/service prior to the original referral to Central Intake and this form should be forwarded to the virtual brief intervention coordinator when the initial referral is received. • The *Mental Health Triage* form will be completed by the Central Intake Clinician as they receive the referral and forwarded to the virtual brief intervention coordinator when the initial referral is received. • The *Mental Health Review* form will be completed for all cases discussed at the virtual brief intervention multidisciplinary Review Meeting. • The *Mental Health Transfer/Discharge Summary* form will be completed by the Consultant Psychiatrist for all clients when they are discharged or transferred from the virtual brief intervention. • The completed Care and Carer Plan will be uploaded into the client's electronic medical record. **Training** Regular training opportunities are arranged through the virtual brief intervention coordinators liaison with Project Air Strategy. All new staff, and staff who have previously been trained in excess of 5 years prior, will be allocated to training opportunities in support of their contribution to the virtual brief intervention. **Quality assurance** It is the virtual brief intervention coordinators responsibility to keep track of the service utilization and throughcare of referrals. All clinicians must complete documentation and provide feedback to the coordinator as required. Clinicians are also responsible for ensuring quality assurance measures are offered to clients for completion [insert site-specific quality assurance measures and procedures here]. **Supervisory processes** Provision of the virtual brief intervention is founded on best-practice principles for the treatment of people with personality disorder. This includes a commitment to attend regular (at least monthly) supervision meetings, in addition to the routine multidisciplinary team meetings for allocation and risk escalation. The virtual brief intervention team meeting is held on the (first Monday of every month at 1-3pm). The virtual brief intervention coordinator (or delegate) also regularly attends the Air Academy meetings to ensure fidelity and best-practice. Feedback from these meetings is provided to the broader team at the following virtual brief intervention team meeting.
When to use it	At each stage of a client's pathway into and through the virtual brief intervention: at the point of referral, at triage, when passing a referral from Central Intake to the virtual brief intervention, at the point of intake into the virtual brief intervention, and when discharging the client from the virtual brief intervention.
Why the rule is necessary	To ensure consistency is applied to the processes underpinning the virtual brief intervention and to promote safe and effective clinical practice.
Who is responsible for (Stakeholders)	Service Managers and Team Leaders are responsible for disseminating the Business Rule and all clinical staff referring to or working for the virtual brief intervention are responsible for implementing the Business Rule.
Developed by (Author)	Name: ________________________________ Position: ________________________________ Mental Health Service: ________________________ Signed: ________________________________ Date: ________________________________
Endorsed by (Executive)	I (Name), (Position), (Mental Health Service; as below) attest that this Business Rule is not in contravention of any legislation, industrial award or policy directive. I support the virtual brief intervention operationalization as it is described in this Business Rule. Name: ________________________________ Position: ________________________________ Mental Health Service: ________________________ Signed: ________________________________ Date: ________________________________

Document reference number	
Revision details and due dates	

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