Brief Intervention Manual for Personality Disorders

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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 their 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.
Introduction to the brief intervention

This manual is designed to help services intervene early and better support young people and adults with personality disorders. It is particularly focused on clients in crisis, who have complex needs, by providing practical therapeutic techniques in the prevention and treatment of high-risk challenging behaviours. It describes a four session brief intervention that can act as the first step in a treatment journey for people with this disorder.

It provides a rapid and predictable intervention that can:

- Provide brief, time-limited interventions aimed at addressing the immediate crisis that led to a deterioration in functioning
- Provide an alternative to hospitalisation or facilitate early discharge
- 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
- Ensure positive messages are provided to clients, carers and health staff with regards treatment for personality disorders

A brief intervention:

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

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

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

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

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

The treatment aims to help the client understand and modify any unhelpful relationship patterns in order to more effectively get their needs met. The model recognises that responsibility for effective relationships also rests with others involved in the client’s life. Therefore, clinicians, case managers, carers, youth and support workers, teachers, school counsellors and the broader community share a joint responsibility to respond effectively to the person in a way that is helpful and encouraging. Caring for and helping people with personality disorders is everyone’s business and everyone can choose to adopt the key principles from the Project Air Strategy relational model.

There is growing recognition that service systems need to work as a whole in an integrated fashion, rather than particular sectors working in isolation. Therefore, this brief intervention is one part of a larger system of care, including acute psychiatric consultation, longer-term treatments, and care options in the wider community. Providing brief immediate psychological care may better support young people and adults who are at risk of significant harm. There needs to be a shared approach to keeping vulnerable young people and adults safe. The risks of not intervening rapidly and meeting the needs of young people (especially those aged 9 - 15 years) and adults can include the development of high-risk and complex needs such as personality disorder and associated mental health problems, criminal offending and criminal justice system involvement, drug and alcohol abuse, suicide, employment instability, high-use of mental health services, social isolation, and homelessness.

Young people and adults with complex needs and high-risk challenging behaviours often present with:
• Emotion dysregulation
• Physical and verbal aggression
• Self-harming behaviours
• Low self-esteem
• Interpersonal difficulties
• Family dysfunction
• Learning problems
• Trauma symptoms

Who should use this manual?
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.

Developing a specific ‘gold card’ clinic
This manual may guide the development of a specific brief intervention clinic for personality disorder, which may be located within acute services in a mental health setting or community setting linked closely to emergency and inpatient services. Clients who may be suitable can include people who have recently presented to an Emergency Department, or been discharged from an inpatient psychiatric unit following self-harm or suicidal thoughts or behaviours, or other crisis related to personality disorder problems. The intervention draws its inspiration from the St Vincent’s clinic piloted by Wilhelm and colleagues (2007). The approach here has broadened the focus to personality disorders and extended the scope from inpatient to community-based services. The term ‘gold card’ refers to a specific gold referral card that is provided to clients when they are booked into the first and subsequent appointments. Having the gold card gives them access to the clinic. The clinic can go by other names.

The approach aims to offer an appointment within one to three days of referral, such as after discharge from a hospital setting or following a crisis presentation at an Emergency Department, or from a local doctor or school principal, and acts as an intermediary point between acute services and longer-term treatment programs. The approach offers four sessions that focus on psychological and lifestyle factors, while maintaining a relational approach to treatment at all times. There is enough clinical material included to support more than four sessions, so the duration should be based on service requirements and clinical need. However, this model as described here is based on four sessions. During this treatment, an appropriate carer will be identified and approached by the clinician to engage in a session. This session typically focuses on the current needs of the carer, while remaining mindful of the key principals for working with personality disorders.

Referral criteria
Clinics that use this manual may choose to focus on people who present in crisis with suicidal ideation, self-harm, or a personality disorder. That is, 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 psycho-educational 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. The Project Air Strategy emphasises that compassion towards these clients is critical, and has developed these key principles.
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

Procedures and session plans

People meeting criteria for the clinic are given an appointment by the referring body, which staff should confirm with the client in the 24 hours preceding their scheduled appointment time.

Ideally, when an appropriate carer has been identified, the brief intervention may be structured as follows:

<table>
<thead>
<tr>
<th>Session One: Individual session with the client; plus an introduction to the carer (present for part or whole session based on need)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session Two: Individual session with the client</td>
</tr>
<tr>
<td>Session Three: Individual session with carers</td>
</tr>
<tr>
<td>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).</td>
</tr>
</tbody>
</table>

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 initial orientation to treatment for clients not in crisis. 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.
Checklist for when clients do not attend their appointments

1. Clinician to contact the client to ascertain their reason for non-attendance
   a. If answer:
      i. 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.

Setting the therapeutic frame

Because the treatment emphasises a relationship model, attending to the psychological boundaries
framing the relationship are critical. The frame establishes the space in which the therapeutic work
can take place. This includes practicalities such as the time, location, duration of sessions and
outline of therapy (for instance, the aims and limitations of the Clinic, what the client can discuss
and how the time is managed). The frame also includes the policies of the organisation or therapist
(for instance contact outside of therapy, rescheduling missed or cancelled appointments or 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 therapist 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.

How to use the resources in this manual

This manual links to resources for clinicians seeing young people and adults. All resources (Care
Plans, Fact Sheets and Guidelines) referred to in this manual are available online at
www.projectairstrategy.org. These resources should be downloaded from this website for use with
clients.

When working with mental health clients, clinicians need to be careful how they introduce Care
Plans and Fact Sheets. Written material can become confronting for people who have experienced
learning difficulties. Such material can be viewed as threatening and may lead clients to disengage
in order to avoid embarrassment. Furthermore, Care Plans could seem like behavioural contracts to
people who often find themselves in trouble, and they may resist attempts to utilise it as a resource
due to feeling like they are being punished. None of the resources have been designed as a means
of controlling the client’s behaviour. They are therapeutic tools to be used collaboratively with the
client.

In particular, the Care Plan is the client’s opportunity to communicate strategies that they find useful
when managing difficult emotions. The Care Plan and Fact Sheets have been designed simply to
cater for the broader audience whilst containing the pertinent information regarding care planning
and psycho-education for people with personality disorders. Many people will have no difficulty
utilising the resources as they have been designed. However, clinicians are encouraged to adapt
the relevant information contained within the provided resources and present it in a fashion that is
both engaging and pitched at the developmental level of the client. Often people are not interested
in carrying pieces of paper around, so clinicians are encouraged to provide a folder for clients to
keep handouts together. Alternatively, if the client has a smart phone they could take photos of their
Care Plan and Fact Sheets so that they are easily accessible and inconspicuous. Once the client
has engaged in the process, and rapport has been established, introduce the Care Plan as a means of communicating with other individuals in their care. Remind the client that even if they prefer to use another method to remind themselves of helpful strategies, resources, and contacts, by contributing to the Care Plan they get a say in how others support them whilst in crisis.

Connecting with carers

Interpersonal and intrapersonal relationships are critical to the wellbeing of everyone. Mental health problems cannot be understood in isolation from the rest of the system in which the client lives. Carers are often the people with the most involvement with the client, therefore including them can be very wise.

Ideally the primary carer should be invited to attend the first session. The manual has also included a single carer-only appointment (Session Three). Flexibility in including an appropriate carer is part of the clinical judgement of the clinician and should take into account the specific circumstances of the client. If you see a client under 18 years of age, the parent/s or guardian/s usually attend.

Here are some tips for connecting with carers:

• First, discuss the value and importance of engaging with carers with the client (e.g. “To help support and understand your treatment”). The fact that the carer remains entitled to a level of information enabling them to care effectively should be clearly explained to the client at the outset. Ideally, the primary carer will be present at the first session, however, if not, the client may either choose to take home an information pack for their carer, or this may be sent to the carer directly (“Would you like to take this or shall we send it by post?”).

• Second, seek agreement to make contact with the carer. You may approach this with; “We have spoken today about some of the important people in your life. And even though things are sometimes tough with your carer it seems that they could also be a good support for you. I’ve found that for most people I work with things turn out a little better if their carer know what’s going on. I think it would be good for me to contact your carer and connect about what is going on. What do you think? We can spend some time now figuring out what I should and shouldn’t share with your carer.” This carer may then be included on the clients Care Plan.

If the client refuses to allow contact with their carer, explore their concerns (“What are your concerns about me contacting your carer?”; “Can we talk through what you think might happen if we contact your carer?”). Highlight the value and importance of involving carers in treatment. A discussion about confidentiality (e.g. you won’t be telling the carer what the client says about them or private information that has been discussed in session) and the benefits to the carer and client (e.g. collaborative, supportive treatment) can help allay any concerns the client may have.

Should the client refuse (after discussion) to consent for the clinician to contact their carer, the clinician should be aware that the carer remains entitled to a level of information enabling them to care effectively. The minimal level of care for all carers is general education regarding mental illness, treatments and options, navigation of the mental health service, and services available to carers (Mottaghipour & Bickerton 2005). Information for carers can be found on the Project Air Strategy website.

Here is a potential script for a client who is refusing carer involvement in their treatment:

“Ok, so you’ve told me that you really don’t want to involve your carer in your treatment, and I respect your right to make that decision. If your carers call me I don’t need to discuss your treatment with them. I can provide them with general information regarding mental illness, treatments options, how to navigate the mental health service, and the services available to themselves. This information in no way will be related specifically to you, and I will not discuss your treatment, unless you decide otherwise later on.”

Procedure for the carer if they are not attending the first session but permission is given to contact them:

• First, make contact with the carer and provide an overview of the program.
• Second, invite the carer to a single carer-only session. You may choose to post the carer an invitation letter and send some carer Fact Sheets (see Session Three for suggested carer Fact Sheets). Suggested wording for the carer invitation letter:

“The person you care for has been referred to the Brief Intervention Clinic. The Brief Intervention Clinic offers four structured sessions to people presenting in crisis. During these sessions, a clinician offers support to help the person navigate their way through this crisis and link them in with further services if needed. We would like to invite you to attend the third session of the Brief Intervention Clinic. This appointment aims to provide an opportunity for us to offer you some tools and strategies to support you and the person you care for. These strategies might also help in the event of any future crises or problems. During this session you will have an opportunity to discuss with us any other concerns you may have. Enclosed are some Fact Sheets to provide an introduction to some of the topics that may be discussed at the appointment. If you feel you would like to attend this clinic please contact us. If you choose not to attend, we wish you well and hope the enclosed materials are interesting and helpful.”

Working with clients from other cultures

When working with clients from other cultures there may be a need to modify this approach. For example in working with some aboriginal people and their families it may be relevant to consider the role of intergenerational trauma and seek advice from cultural experts. Holistic family approaches should be adopted, providing for the physical, mental, emotional and spiritual wellbeing of the client and their family. Resilience can be encouraged by utilising the healing value of culture, which affirms identity and connection to community.

Intergenerational trauma also needs to be a consideration when working with culturally and linguistically diverse clients and their families. Often refugee and migrant communities are struggling with unresolved trauma, grief and loss. Further, adjusting to a new culture, language and way of life can put increased stress on already vulnerable people and their families. Second generation migrant families may also struggle with different social expectations.

Therefore the Project Air Strategy aims to provide positive intervention that is culturally sensitive and utilises an integrated service delivery model which includes government and non-government agencies and community leaders. The clinician may also provide key services with general information and Fact Sheets that support their work with the client.

Working with schools

There is growing recognition that children and young people at risk of significant harm require the involvement of the service system as a whole working in an integrated way rather than any particular sector in isolation (HM Government, 2013). Therefore, with consent, schools and other key organisations involved in the person’s care should be made aware of their engagement with the Brief Intervention Clinic. Involving key people in the young person’s life is vital for the development of insight. The young person may not be able to address these issues without the engagement of carers and significant people in other settings, such as school. It would be useful to identify a trusted adult from the school setting to be engaged in this process. If appropriate, the clinician may even consider utilising the structure of the carer session to organise a psycho-educational session with the trusted school contact. The importance of liaison with schools, the place in which young people spend a large percentage of their time, cannot be underestimated. Increasing young peoples’ engagement with schools and communities better equips them to achieve improved educational, social and behavioural outcomes. School staff will be better placed to support improved outcomes for young people with emerging personality disorders when they are aware of the issues that affect these young people.
**Working with clients with cognitive deficits, intellectual disability, dissociative features or difficult trauma symptoms**

Clinicians may consider the use of simplified language and a range of communication strategies such as verbal, visual and object symbols for clients who have difficulties such as cognitive deficits, intellectual disability, dissociative features or difficult trauma symptoms. When discussing values, goals and Care Plans, personal illustrations may be useful in communicating ideas. Make sure to go at the clients’ pace whilst assessing understanding, and consider the use of behavioural rehearsal, technology such as audio and visual recordings, and recruiting carers to provide assistance. Subjective information about thoughts and emotions can be difficult to elicit in those with more significant deficits. Simplified mindfulness can be a useful way of encouraging self-observation. Furthermore, exercises which focus on the external world (i.e. taste, touch, smell, hearing, sight) can be useful to keep easily dissociative clients present.

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**Care plans**

For instructions on using the care plan, consult the Project Air Strategy (2011) Treatment Guidelines for Personality Disorder.

**Example Care Plan Wallet Card**

<table>
<thead>
<tr>
<th>CARE PLAN</th>
<th>CARE PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>My warning signs</td>
<td>Things that don’t help</td>
</tr>
<tr>
<td>Things I can do that help</td>
<td>My support people</td>
</tr>
</tbody>
</table>
Example Care Plan - Client version
Available for download from www.projectairstrategy.org

Name:                                                     Clinician Name:

My main therapeutic goals and problems I am working on
(1) In the short term

(2) In the long term

My crisis survival strategies
Warning signs that trigger me to feel unsafe, distressed or in crisis

Things I can do when I feel unsafe, distressed or in crisis that won’t harm me

Things I have tried before that did not work or made the situation worse

Places and people I can contact in a crisis:
LifeLine 13 11 14   Emergency 000   NSW Mental Health Line 1800 011 511   Kids Helpline 1800 551 800

My support people (e.g. partner, family members, friends, psychologist, psychiatrist, teacher, school counsellor, social worker, case worker, GP)

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Details</th>
<th>Role in My Care</th>
<th>OK to Contact?</th>
</tr>
</thead>
</table>

Signature:                                             Clinician’s Signature:
Date:                                                  Date of next review:
Copy for: Client / Clinician / Emergency / GP / School / Case Worker / Other (please specify)
Example Carer Plan - for families, partners, relatives and carers
Available for download from www.projectairstrategy.org

<table>
<thead>
<tr>
<th>Name:</th>
<th>Clinician Name:</th>
</tr>
</thead>
</table>

**My main goals and problems I am working on in relation to my carer role**

1. In the short term
2. In the long term

**My carer crisis survival strategies**

Warning signs that the person I support is unsafe, in distress or crisis

Things I can do when the person I support is unsafe, distressed or in crisis that won’t harm them or me

Things I have tried before that did not work or made the situation worse

What I can do to take care of myself in stressful times

Places and people I can contact in a crisis:

- Lifeline 13 11 14
- Emergency 000
- NSW Mental Health Line 1800 011 511

**My support people** (e.g. friends, family members, partner, psychologist, psychiatrist, social worker, GP)

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Details</th>
<th>Role for me</th>
<th>OK to Contact?</th>
</tr>
</thead>
</table>

Signature:  
Clinician's Signature:

Date:  
Date of next review:

Copy for the: Carer / Clinician / Other (please specify)
Session One

Individual session with the client; plus an introduction to the carer (present for part or whole session based on need)

Objectives:

- focus on developing rapport and a positive therapeutic relationship;
- explore factors that led to the crisis;
- begin to develop a Care Plan;
- conduct a risk assessment;
- provide psycho-education;
- connect with carers.

Outline:

1. Build rapport and focus on developing a positive therapeutic relationship (throughout the sessions)
2. Set the frame for treatment (i.e. discuss the duration of the current and future sessions including the four session intention)
3. Provide information on the purpose of the clinic
4. Understand what led to the client’s crisis and provide a space for them to talk
5. Begin to develop a Care Plan, focusing on the ‘My crisis survival strategies’ section
6. Conduct a risk assessment
7. Provide client with psycho-education
8. Connect with the carers
9. Discuss need, and ascertain willingness, for further appointments
10. Encourage the client to think more about their values and goals.

Resources (available online at www.projectairstrategy.org):

- Project Air Strategy Treatment Guidelines for Personality Disorders (2011) including chapters on Working with People in Crisis, Conducting a Risk Assessment, Involving Family Members and Carers, Developing a Care Plan
- Care Plan
- Project Air Factsheets. Examples: What is a "Personality Disorder"?; What Treatment is Available To Me?; What is Mindfulness?; Problems with Drug and Alcohol Use; Relationship Difficulties, Arguments & Conflicts; Self-Harm: What is it?; The Importance of Self-Care; Managing Anger; Managing Distress; Managing Emotions; Effective Communication; What Else Can I Read?
- Carer Fact Sheets as appropriate (i.e. The Basics; The Importance of Self-Care; Looking After Yourself; Managing Anger; Helpful Tips for Challenging Relationships)
Steps to follow for Session One:

Focus on building rapport and a positive therapeutic relationship
Acknowledge the client’s efforts to attend the session.

Focus on the here-and-now. “I know I’ve got this referral information in front of me, but I’d find it really helpful to find out from you in your own words why you think you’re here today?” or “Who can tell me what’s brought you here today?”

Go slowly, move away from talking about the client’s trauma history (refocus by saying “It’s often helpful to think about what’s going on for you now”).

Refer to the Key Principles for working with personality disorders outlined above.

Set the frame for treatment and check contact details
Discuss confidentiality and its limits, provision of four sessions and the length of each session.
Check the client’s current contact details.
Inform the client that the session length is typically 50 minutes, but is flexible if they wish to finish earlier.

Understanding of the Brief Intervention Clinic and client’s hopes for attending
Enquire about the client’s understanding of the clinic. Provide them with further information where necessary. The following explanation may be useful:

“The Clinic provides four sessions to people who have recently been in crisis. We will explore what led to the crisis and identify ways to help you manage these difficult feelings/thoughts/experiences in the future. We will look at lifestyle factors and psychological factors and relationships. We can also link you into other resources or services in the community to help you continue your recovery process”.

Enquire what the client would like to achieve by attending the clinic. “What are three things that you would like to achieve by coming to the clinic?”

Ensure that the client is aware of the limited nature of the service, however the clinic will provide care planning and linking to additional supports where required.

Let them know that for some clients one to four sessions is adequate to meet their needs, while others will come to the realisation that additional work is required to address any underlying issues. In the latter case, inform them that referral to further treatment providers will be given.

“Sometimes people might need help for a bit longer, we can also help you find other people or groups for you to talk to about your problems”.

Understanding what led to the client’s crisis and provide a space for them to talk
This should be the main focus of Session One. Gain an understanding of what happened for the client to end up in crisis.

Go slowly, move away from talking about the client’s history. Refocus by saying “It’s often helpful to think about what’s going on for you right now… Can you give me an example of a recent situation which you found challenging/difficult/hard?” If the client and/or their carer go off track or start blaming each other say “Imagine that you are a fly on the wall, what is it that you would have seen?”.

Encourage the client to describe everything leading up to the event, sticking to the facts and using a non-judgemental stance.
Be mindful to maintain a relational approach to treatment.

**Begin to develop a Care Plan, focusing on the ‘My crisis survival strategies’ section**

See the Project Air Strategy Guidelines on Developing a Care Plan to inform this process and document the information gathered in the session so far (e.g. what led to the client’s crisis, warning signs) on the Care Plan.

Discuss problem solving strategies to help prevent escalation of future crises, for example, what tools does the client have such as lifestyle factors (diet, exercise, sleep) and psychological strategies (emotion regulation skills, distress tolerance skills, social supports) that could be used in the future. “What kinds of things help or make you feel better when you are overwhelmed or in crisis? Let's think of some more things you can do when you feel like this. These are things that won’t necessarily fix the problem, but they won’t make it worse or get you into trouble”.

Keep a copy of the original Care Plan with you until it has been fully completed. Once fully completed, provide the original Care Plan to the client and make a copy for your own records and, where consent has been provided, for distribution to other individuals/organisations involved in their care (i.e. GP, case manager).

Offer the client a Care Plan Wallet Card to record this information so they may carry it with them in a more convenient manner if they wish.

**Conduct a risk assessment**

See the Project Air Strategy Guidelines on Working with People in Crisis and Conducting a Risk Assessment to inform this process.

**Provide the client and carers with psycho-education**

Introduce these by saying: “Here are some Fact Sheets that you might find helpful given what you’ve told me today”.

At a minimum, give the client the following Project Air Strategy Fact Sheets: What Treatment is Available To Me?, The Importance of Self-Care; Managing Emotions; Managing Distress.

**Connect with the carer**

It is ideal for the primary carer to attend the first appointment with the client, whereby a joint agreement around care planning can occur.

If the carer did not attend the first appointment, you may approach this with; “To work effectively with you and for good outcomes it will help if your carer can be involved in your treatment”. The carer may then be included on the client’s Care Plan.

At a minimum the carers should be supplied with an invitation letter and an information pack (i.e. Fact Sheets as appropriate). See Connecting with carers section of this manual.

If the carer does not attend the first session, the client may either choose to take home an information pack for their carer, or this may be sent out to the carer directly (“Would you rather take this or shall we send it by post?”).

Optimally, the client will allow the clinician to arrange a carer-only session.

See Project Air Strategy Treatment Guidelines - chapter on Guidelines for Involving Family Members and Carers.
Discuss need, and ascertain willingness, for further Clinic appointments

Advise the client they have the option to attend three more Brief Intervention Clinic appointments.

Discuss the client’s need for further clinic appointments in the context of their current life circumstances. “Given what you’ve told me today, I think there are some more things we can talk about to help make things a bit easier for you (at home/work/school).”

Where a need is ascertained, discuss the client’s willingness to engage in future clinic sessions. “So do you think you’d find it helpful to come back and spend a bit more time talking about these problems and learn ways in which to respond that doesn’t make the situation worse?”

Where a need and willingness exists, make another appointment in approximately one week’s time. Ensure that the appointment is made with the same clinician.

Encourage the client to think more about their values and goals

Where the client is continuing treatment, encourage them to consider their values and goals in-between appointments and flag this to discuss further in Session Two. “I’m really glad that you found today helpful. Over the next week I’d like you to have a think about what kinds of things you’d like to achieve for yourself in the future and your goals in life. That way we can make sure you’re doing things each day which will help lead you in the direction you want to go.”

Where the client is not continuing treatment, encourage them to continue to think about their future goals and values and act in ways that are consistent with these. Provide the client with referrals to other services where required. Complete the Care Plan in session. Provide the client with the original and keep a copy for your own records and, where consent has been given, to distribute to other professionals involved in the client’s care.

“I think it’s really great that you came here today and decided to talk about your problems. And even though you’re not coming back (for now), it can still be helpful to have a think about what kinds of things you’d like to achieve for yourself in the future, and keep that in mind as you go about your life. That way you’re more likely to feel good about the things you do.”

Document the session and distribute the Care Plan (where completed and consented)

Fully document the session, paying particular attention to the risk assessment.

When the Care Plan is completed, ensure the client holds the original, a copy is placed in their file, and copies are distributed to other individuals/organisations involved in their care and the referring body, where the client has given consent.
Session Two
Individual session with the client

Objectives:
- further engage the client;
- understand the client’s goals and values;
- further develop the Care Plan;
- provide further psycho-education and support.

Outline:
1. Engage the client further
2. Discuss further the client’s goals and values
3. Develop the Care Plan further, focusing on ‘My main therapeutic goals and problems I am working on’ section
4. Provide an opportunity for the client to discuss any other issues
5. Provide psycho-education about the development and maintenance of specific problems
6. Conduct a risk assessment
7. Encourage the client to think about their plans after the Clinic sessions are complete in-between appointments and flag this to discuss further in Session Four
8. Provide psycho-education on the benefits of longer-term treatment for people with more enduring problems.

Resources (available online at www.projectairstrategy.org):
- Project Air Strategy Treatment Guidelines for Personality Disorders (2011) including chapters on Working with People in Crisis, Conducting a Risk Assessment, Involving Family Members and Carers, Developing a Care Plan.
- Care Plan
- Project Air Factsheets. Examples: What is a “Personality Disorder”?; What Treatment is Available To Me?; What is Mindfulness?; Problems with Drug and Alcohol Use; Relationship Difficulties, Arguments & Conflicts; Self-Harm: What is it?; The Importance of Self-Care; Managing Anger; Managing Distress; Managing Emotions; Effective Communication; What Else Can I Read?
- Carer Fact Sheets as appropriate (i.e. The Basics; The Importance of Self-Care; Looking After Yourself; Managing Anger; Helpful Tips for Challenging Relationships)
Steps to follow for Session Two:

Engage the client further
Do this by asking the client how they have been since the last session. “Last week we talked a bit about what's been going on for you (expand and give examples of difficulties the client has identified)… I'd also like to know how you think you've been since the last time I saw you.”

Discuss further the client's goals and values
Maintain a focus in treatment by linking back to Session One and the discussion of the client's goals and values. “At the end of last week's session I asked you to have a think about what kinds of things you'd like to achieve for yourself in the future. What have been your thoughts about this?” If the client says they did not think about it say “That's ok, what comes to mind when you think about what you'd like your future to look like? What kinds of things do you think you'd have to do for that to come true?” Identify the difference in short-term and long-term goals. Focus on things that the client can do, rather than on other people.

Develop further the Care Plan, focusing on ‘My main therapeutic goals and problems I am working on’ section
See the Project Air Strategy Treatment Guidelines - chapter on Guidelines on Developing a Care Plan to inform this process.
Use the information gathered in the sessions to date to assist this process. For example, the client’s future goals and problems they are working on. “Ok so we know what your goals are and/or we know what you want your future to look like, so based on that what kinds of things do you think you need to work on right now (short-term) and what sorts of things might you want to work on later (long-term)?” Document this on the Care Plan, continuing from Session One.
Include any additional crisis survival strategies to the Care Plan, “Since last week have you tried anything different to help you cope when... (target behaviour/thought/event)?” “Let's have a look at some more things you might find helpful when... (target behaviour/thought/event)” You may wish to use the Fact Sheet What is Mindfulness?
Keep a copy of the original Care Plan with you until it has been fully completed. Once fully completed, provide the original Care Plan to the client and make a copy for your own records and, where consent has been provided, for distribution to other professionals.

Provide an opportunity for the client to discuss any other issues
This will help with further engagement in treatment and provide the client with a feel for what longer-term treatment may entail. “Do you have any other concerns or worries that you'd like to talk about?”
Be mindful to maintain the relational approach to treatment.

Provide psycho-education about the development and maintenance of specific problems
Attempt to raise the client’s awareness by engaging in problem solving around how a problem or issue mentioned earlier may have developed and be currently maintained. If no issue was identified previously use an example. You may wish to use the Fact Sheet How Did I Get Here?
“Sometimes it can be really unclear how we find ourselves in particular situations. When something keeps happening to us time and time again, there's usually a pattern of things (actions, thoughts, sensations, feelings, events) that, when put together, can lead to problems. Some of these things
are due to our environment (i.e. weather/other people), and some of these are things that we do and have control over. This Fact Sheet (How Did I Get Here?) can be a really simple way of working out what things you can try to do differently next time to help stop yourself ending up in problematic situations.”

Discuss strategies to help the client manage this problem. Consider the use of Fact Sheets to aid your discussion. If drug and alcohol issues have been identified you may wish to use the Fact Sheet Problems with Alcohol and Drug Use.

Conduct a risk assessment
This may be briefer than the risk assessment conducted in Session One. See the Project Air Strategy Treatment Guidelines - chapter on Guidelines on Working with People in Crisis and Conducting a Risk Assessment to inform this process.

Encourage the client to think about their plans after the Clinic sessions are completed
Encourage the client to think about their plans between appointments and flag this as a topic for further discussion in Session Four (the next client session).

Provide psycho-education on the benefits of further treatment
Inform the client on the benefits of longer-term treatment for those with more enduring problems or greater severity of insecure attachment style.
Where a need and willingness to engage further exists, discuss briefly the client’s treatment options and flag this as a topic for further discussion in Session Four.

Make another appointment for the Clinic
Ensure the appointment is made for one week’s time and is with the same clinician.

Document the session and distribute any revisions made to the Care Plan (where consented)
Fully document the session, paying particular attention to the risk assessment.
Ensure the client holds the original Care Plan, a copy is placed in their file, and copies are distributed to other individuals/organisations involved in their care and the referring body, where the client has given consent.
Session Three

Individual session with carers

Objectives:

- focus on connection, assessment of needs and education;
- allow the carer space to voice their concerns and needs;
- assess the current needs of the carer and draft a Care Plan with the carer for their needs;
- provide information and education regarding mental illness, personality disorders, self-care and navigating the mental health system;
- provide further referrals to more intensive family and carer interventions or other services.

Outline:

1. Set the frame of the session including the aims, purpose and confidentiality issues
2. Build rapport and focus on the needs of the carer
3. Assess the carer’s current needs and responses to the client’s recent crises and provide a space for them to talk
4. Develop a Care Plan with the carer for their own self-care (see: Care Plan)
5. Provide information and education regarding mental illness, personality disorders, self-care and navigation of the mental health system including who to call upon in a crisis
6. Discuss need, and ascertain willingness, for referral to family and carer services.

Resources (available online at www.projectairstrategy.org):

- Project Air Strategy Treatment Guidelines for Personality Disorders (2011) including chapters on Involving Family Members and Carers.
- Care Plan
- Project Air Factsheets for Families Partners and Carers. Examples: What is a “Personality Disorder”?, ‘What Treatment is Available To Me?’, The Basics; The Importance of Self-Care; Looking After Yourself; Managing Anger; What Else Can I Read?; Helpful Tips for Challenging Relationships
Steps to follow for Session Three:

Set the frame of the session (including the aims and purpose, confidentiality issues, etc.)
Note confidentiality and its limits, this may be addressed as “what you say in here remains confidential, but if I become concerned about your safety, or the safety of someone else, I may need to tell others about this. I will work in partnership with you if such a concern arises.”
Note the provision of the session and limits to further involvement with the service.
Check and record the care recipient’s current contact details including address and phone numbers.

Build rapport and focus on the needs of the carer
Refer to the Project Air Strategy Treatment Guidelines - chapter on Guidelines for Involving Family Members and Carers and the Project Air Strategy Key Principles for working with personality disorders to inform this process.
Acknowledge the carer’s efforts in attending the session, and the struggles they experience in their caregiving role - for example, “I’m really struck by the way you’ve come in today and the way you talk about her/him, and your ability to think and connect with him/her during difficult times”.
Acknowledges that you understand they are doing the best they can - for example, “You’re doing really well. It’s hard to live with someone with these types of difficulties. I imagine sometimes you feel like you are walking on eggshells – what do you need to do to support yourself?”
Actively move the carer away from concerns regarding aetiology and possible causes of the disorder (refocus by emphasising that the most constructive issue they can attend to is how to cope with the ongoing problems they face in their caregiving role). It may be helpful to say “I’m sorry to hear that that happened, but what’s important today is not to focus on the past, but rather talk about today and tomorrow, about what we can do to help the situation now.”
Focus on the here-and-now. For example, redirect carers by “that issue sounds really important and it may be something you want to work on. At the end of this session we can talk about options to talk to someone about this.”
Focus on the needs of the carer (rather than just the client’s needs).

Assess the carers current needs and responses to the client’s crises and provide a space for them to talk
Briefly screen for any risks to children and presence of family violence (this could be achieved through your organisations Domestic Violence and Child Protection screening tools). This may be addressed with “sometimes difficult things happen in a family, I am wondering if there has been any violence? Who in the family might be unsafe?”
Allow the carer to talk through the challenges they have experienced including the impact of the recent crisis that involved the client’s engagement with the Brief Intervention Clinic.
Assess the carers current needs such as level of self-care, carer service engagement, own supports, knowledge of the disorder and navigation of the mental health system.
Assess the needs of the family unit as a whole, particularly the family dynamics: “Who has been tossed around most by the client’s behaviour?”
Ask what the carer would like to acquire by attending the session, and what they think would be most helpful in supporting them in their caregiving role.
Develop a Care Plan with the carer for their own self-care

See the Project Air Strategy Guidelines on Developing a Care Plan to inform this process, remembering the focus is on the carer rather than the client.

Discuss the carer’s short and long-term goals and focus the carer on their own needs and desires and document this on the Carer Plan. Emphasise that due to the brief nature of the carer-only intervention, work and change will need to continue after the session.

Discuss problem solving strategies to help the carer respond to future crises. For example, what are the client’s warning signs that a crisis is approaching, what the carer can do to respond to this (e.g. call the mental health team, encourage the client to engage in distress tolerance skills), and what the carer can do to take care of themselves during these stressful times (e.g. engage in self-care, call their own support person).

Carers can sometimes feel frustrated or confused when clinicians emphasise the importance of their own self-care. Carers can find it difficult to balance caring for themselves and caring for the client, often resulting in the carer subjugating their own needs. It can be helpful to frame this conversation in the need to engage in self-care to be in the best position to support the client and enhance caregiving longevity (rather than burn out).

Once completed, provide the original Carer Plan to the carer and make a copy for your own records and place in the client’s file.

Provide psycho-education

At a minimum, give the carer the following Project Air Strategy Fact Sheets: Looking After Yourself, The Basics, Effective Communication, Managing Anger and other Fact Sheets as relevant.

Discuss need, and ascertain willingness, for referral to family and carer services

Provide information on services that may be appropriate for the carer.

Occasionally carers are hesitant to engage with services for their own needs. Discuss the importance of carers being supported. If appropriate, remind the carer that services do not blame the carer/family for the client’s difficulties. Carers also need support to be effective in their role and support better outcomes for themselves and the client.

Discuss limitations in the carer’s further involvement with the service and yourself.

Document the session

Fully document the session within the client’s file.

Ensure the family or carer holds the original Carer Plan and a copy is placed in the client’s file.
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)

Objectives:
1. discuss the client’s plans for the future;
2. provide information on treatment options;
3. finalise the Care Plan and discuss relapse prevention;
4. provide referral to other services.

Outline:
1. Discuss further the client’s future plans
2. Consider and discuss treatment options
3. Finalise the Care Plan, focusing on ‘My support people’ section, and relapse prevention strategies
4. Link the client with other services, and provide referral where necessary.

Resources (available online at www.projectairstrategy.org):

• Project Air Strategy Treatment Guidelines for Personality Disorders (2011) including chapters on Working with People in Crisis, Conducting a Risk Assessment, Involving Family Members and Carers, Developing a Care Plan.
• Care Plan
• Project Air Factsheets. Examples: What is a “Personality Disorder”; What Treatment is Available To Me?; What is Mindfulness?; Problems with Drug and Alcohol Use; Relationship Difficulties, Arguments & Conflicts; Self-Harm: What is it?; The Importance of Self-Care; Managing Anger; Managing Distress; Managing Emotions; Effective Communication; What Else Can I Read?
• Carer Fact Sheets as appropriate (i.e. The Basics; The Importance of Self-Care; Looking After Yourself; Managing Anger; Helpful Tips for Challenging Relationships)
Steps to follow for Session Four:

**Discuss further the client’s future plans**
Maintain a focus in treatment by linking back to Session Two and the discussion of the client’s future plans. Ask the client what their thoughts were in-between the sessions on their future plans.

**Consider and discuss treatment options**
Provide the client with options for further treatment and discuss these with them.
Where ambivalence about willingness to engage in further treatment exists, but a need is evident, adopting a motivational interviewing approach may be useful to help the client make a wise decision.
Complete the final session as the end of this particular brief intervention.

**Finalise the Care Plan, focusing on ‘My support people’ section, and relapse prevention strategies**
See the Project Air Strategy Guidelines on Developing a Care Plan to inform this process.
Use the information gathered in the sessions to date to assist this process (for example, identifying the client’s support people and what their plan is for further treatment).
Include any additional crisis survival strategies, therapeutic goals or relapse prevention strategies to the Care Plan.
Give the original Care Plan to the client to keep, make a copy for your own records, and distribute copies to other professionals and the referring body where consent has been provided.
Offer the client a Care Plan Wallet Card to record this information so they may carry it with them in a more convenient manner if they wish.

**Link the client with other services, and provide referral where necessary**
Based upon your knowledge of the client that has developed over the sessions, and their willingness to seek further help, provide them with information about other services that may be of benefit. Where necessary, provide them with a referral to these services.
Give the client written details (including any available brochures) of the service being referred (and/or specific individuals), the phone number, and the address.

**Document the session and distribute any revisions made to the Care Plan (where consented)**
Fully document the session, paying particular attention to the risk assessment and to any other services the client has been referred for further treatment and support.
Ensure the client holds the original Care Plan, a copy is placed in their file, and other copies are distributed to other individuals/organisations involved in their care and the referring body, where the client has given consent.
Sample Gold Card Clinic Poster

Do you experience any of these?

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

Talk to your clinician about a referral to the **GOLD CARD CLINIC**

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

Who can attend?
The Gold Card Clinic provides help for young people and adults. You or your local health professional can call your closest service and discuss a referral to the clinic. The clinic works in specific ways so it is important to ensure it will suit your needs.

What will I do in the Gold Card Clinic sessions?
An experienced clinician will work with you to:
- Provide support and encouragement
- Explore factors that led to your current situation
- Develop a plan to assist in the prevention of future crises & problems
- Gain clarity on your goals and help you maintain focus
- Provide you with additional information and resources to aid your recovery
- Link you into other services where desired

Who can refer to the Gold Card Clinic?
The Gold Card Clinic accepts referrals from emergency departments and hospitals, other services such as Headspace, School Counsellors and General Practitioners whose clients present in crisis, including with recent self-harm or thoughts of suicide. Where appropriate, clinicians may refer to the Gold Card Clinic rather than sending clients to hospital. Often it is more helpful to refer clients in crisis for community treatment rather than hospital services. Some Gold Card Clinic services may require an assessment prior to booking in an appointment, call the nearest service for information on how to refer.

to contact the GOLD CARD CLINIC
FOR YOUNG PEOPLE, contact the Wollongong Child and Adolescent Mental Health Team
1 Atchison Street, Wollongong, Ph: (02) 4254 1600.

FOR ADULTS Contact the Illawarra Community Mental Health Team
1 Atchison Street, Wollongong, Ph: (02) 42541500.

For referrals outside the public mental health service call the NSW Mental Health Line: 1800 011 511.
**Example Gold Card Clinic Business Rule**

**Prince of Wales - Brief Lifeworks Intervention Program (BLIP)**

**BUSINESS RULE:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Gold Card Clinic (GCC) intake, allocation and discharge processes</th>
</tr>
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<tbody>
<tr>
<td>Risk Rating</td>
<td>High</td>
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</table>

**What it is**

An outline of the procedures involved in making referrals to the GCC, the intake and allocation of referrals within the GCC, and the process by which consumers are discharged or transferred to other services.

**What to do**

**Overview**

The Gold Card Clinic is a brief intervention service for people in the SESLHD catchment area who have recently experienced a mental health crisis involving self-harm and/or suicidal thoughts or behaviours.

The GCC 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 session for carers, partners and family members is included in the intervention.

The key aims of this intervention are:

- 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 psycho-education 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 other services where necessary
- provide an opportunity to connect with the person’s family, partner or carer where desirable
- provide treatments with an evidence-base that are effective with personality disorders

The GCC will operate during the usual opening hours of SESLHD community health services (Monday-Friday, 0830-1700) and will not be available to receive referrals or meet with consumers or carers on weekends or public holidays.

**Referrals**

Referrals to the ESMHS Gold Card Clinic can be made by a range of services, including:

- Emergency Department (ED)
- Psychiatric Emergency Care Centre (PECC)
- Kiloh Centre
- Mental Health Intensive Care Unit (MHICU), from early 2013
- Community Mental Health Team
- Community Rehabilitation Team
- Aboriginal Community Health Centre, from early 2013
- Early Psychosis Program (EPP)
- Acute Care Team (ACT)

**Eligibility criteria**

- Adults (aged 18 and upwards) with primary problems such as suicidal thoughts or plans, recent episodes of self-harm behaviours or suicide attempts, and/or a personality disorder.
- 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 ACT or emergency services
- Evidence of psychosis. **Action:** refer to Central Intake to access the ACT/EPP
- Evidence of a primary alcohol/drug dependence disorder. **Action:** refer to...
Central Intake to access ACT and appropriate drug and alcohol services

- The person could be more appropriately supported by the ATAPS Suicide Prevention Service (see Business Rule 12/001)

Referral to GCC over the ATAPS Suicide Prevention Service is preferable when:

- The consumer is already being or is about to be supported by NSW Health community mental health services
- A diagnosis of a personality disorder has already been made or is being considered, and an explicitly personality disorder-friendly service may be more helpful
- There are carers/family members/partners who are in need of information and support
- The consumer prefers to access the GCC rather than the ATAPS scheme

Referral procedure

If the referrer feels that a consumer meets the criteria for the GCC they should make their referral by telephoning Central Intake (9382 2950) and asking to make a referral to the Gold Card Clinic.

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 GCC is the most appropriate option at that time.

Should the consumer's presenting difficulties not fit with the GCC’s 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 GCC they should:

1. Ask the referrer to inform the consumer that a GCC clinician will contact them to arrange an appointment and they will be seen by the GCC within 1-3 working days of the time of the original referral to Central Intake
2. Ask the referrer to provide the consumer 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 GCC Co-ordinator:
   a. Gold Card Clinic 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 GCC Co-ordinator first via fax to the GCC’s designated fax number (see the GCC-Unconfirmed White Board, located at Central Intake) with the hard copies of the paperwork to follow via the internal mail along with the consumer’s community file (existing or newly made-up).
6. Place the consumer’s details on the GCC-Unconfirmed White Board until the GCC-Co-ordinator has confirmed acceptance of the referral
7. If the GCC Co-ordinator 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 GCC directly via telephone.
8. If you are unable to make contact with the GCC at this point: Central Intake Officer to discuss at ACT handover to agree the next appropriate follow-up as per the usual ACT procedure and in accordance with the degree of urgency assigned at triage.

Intake into the GCC

The GCC Co-ordinator (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 GCC Co-ordinator will review the information to check that the referral appears appropriate and that none of the exclusion criteria are present.

Once the GCC Co-ordinator 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 GCC Co-ordinator is concerned for any reason that the referral may actually 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 ACT or another service should be involved.

The GCC Co-ordinator allocates appropriate referrals to GCC clinicians so that the first session of the brief intervention can be offered within 1-3 working days of the original referral to Central Intake.

The allocated GCC Clinician contacts the consumer to inform them of the appointment time and the location for the appointment.

If the consumer is not contactable for any reason the GCC Clinician contacts Central Intake to discuss concerns and consider a referral to the ACT for more assertive follow-up.

Non-attendance of GCC appointments
If a consumer fails to attend a GCC appointment without having called to reschedule, the allocated GCC Clinician should:
1. Call the person 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. 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 GCC 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 ACT to determine if there has been any contact with the person
      iv. use any other contact numbers available for the person or their significant others 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 GCC Co-ordinator, the GCC Consultant Psychiatrist and the ACT to determine what is the most appropriate action to be taken, which may include considering a referral to the ACT for more assertive follow-up.

3. Clearly document details of all attempts to contact the consumer, telephone calls made to professionals and significant others, decisions made, actions taken and outcomes achieved.

Referral to crisis services
If the GCC Clinician assesses at any time that the level of risk requires an extremely urgent response they should always contact the emergency services immediately.

If the level of risk appears to require a response of any other level of urgency (i.e. low, medium or high urgency) the GCC Clinician should contact Central Intake to consider a referral to the ACT.

If a GCC Clinician identifies any risk to a child they should consult appropriately with the GCC Consultant Psychiatrist, social work colleagues, and the Child Wellbeing Unit (1300 480 420). They can also use the NSW Health Online Mandatory Reporter Guide to aid decision-making in relation to any child protection concerns.

Discharge procedure
As a GCC Clinician is approaching the end of their work with a consumer they will bring the case to the GCC Review Meeting for discussion and discharge planning in consultation with the GCC Consultant Psychiatrist, who will ultimately authorise the person’s discharge from the service and where appropriate arrange a transfer of care to another SESLHD mental health service.

If, as the consumer approaches the end of the GCC brief intervention, there are concerns about safety and a judgement that a further mental health response of some level of urgency is required, the GCC Consultant Psychiatrist will, in consultation with GCC Clinicians, consider making a referral to appropriate services, including the ACT and inpatient mental health services.
As a central part of the discharge procedure the GCC Clinician will carry out a careful and collaborative consideration of further treatment and support options with the consumer 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
- Liaison with identified local specialist clinicians to facilitate transition into longer-term treatments
- Liaison with GPs to facilitate arrangements for follow-up in primary care and access to ATAPS and Better Access Initiatives

Documentation

There are 4 key documents which are to be completed and filed appropriately for any consumer accessing the GCC:

- The Mental Health Assessment form must have been completed prior to the consumer’s entry into the GCC. 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 GCC Coordinator when the initial referral is passed to the GCC by the Central Intake Clinician.
- The Mental Health Triage form will be completed by the Central Intake Clinician as they receive the referral and forwarded to the GCC Coordinator when the initial referral is passed to the GCC by the Central Intake Clinician.
- The Mental Health Review form will be completed for all cases discussed at the GCC Review Meeting.
- The Mental Health Transfer/Discharge Summary form will be completed by the GCC Consultant Psychiatrist for all consumers when they are discharged or transferred from the GCC.

<table>
<thead>
<tr>
<th>When to use it</th>
<th>At each stage of a consumer’s pathway into and through the GCC: at the point of referral, at triage, when passing a referral from Central Intake to the GCC, at the point of intake into the GCC, and when discharging the consumer from the GCC.</th>
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<tbody>
<tr>
<td>Why the rule is necessary</td>
<td>To ensure consistency is applied to the processes underpinning the GCC and to promote safe and effective clinical practice.</td>
</tr>
<tr>
<td>Who is responsible for (Stakeholders)</td>
<td>Service Managers and Team Leaders are responsible for disseminating the Business Rule and all clinical staff referring to or working for the GCC are responsible for implementing the Business Rule.</td>
</tr>
<tr>
<td>Developed by (Author)</td>
<td>Clinical Psychologist, Kiloh Centre</td>
</tr>
<tr>
<td>NSW Ministry of Health / SESLHD reference</td>
<td></td>
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</tbody>
</table>
References


Project Air Strategy for Personality Disorders (2011) Treatment guidelines for personality disorders. NSW Health and Illawarra Health and Medical Research Institute. Available at: www.projectairstrategy.org